Public Document Pack

Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday 25th March 2014**
Time:	**2.00 pm**
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**

   To receive any apologies for absence

2. **Declarations of Interest**

   To provide an opportunity for Members and Officers to declare any disclosable pecuniary and non-pecuniary interests in any item on the agenda.

3. **Minutes of Previous meeting** (Pages 1 - 8)

   To approve the minutes of the meeting held on 26 November 2013

For requests for further information
Contact: Julie North
Tel: 01270 686460
E-Mail: julie.north@cheshireeast.gov.uk with any apologies

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

In accordance with Procedure Rules Nos.11 and 35 a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the meeting. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers. Members of the public are not required to give notice to use this facility. However, as a matter of courtesy, a period of 24 hours' notice is encouraged.

Members of the public wishing to ask a question at the meeting should provide at least three clear working days' notice in writing and should include the question with that notice. This will enable an informed answer to be given.

5. **Draft CCG Two Year Operational Plans/Five Year Strategy and NHS England Two Year Plan**

To consider the CCG draft Two Year Operational Plans and Five Year Strategy and the NHS England Two Year Plan

a) **Eastern Cheshire CCG** (Pages 9 - 50)

b) **South Cheshire CCG** (Pages 51 - 180)

c) **NHS England** (Pages 181 - 190)

6. **Better Care Fund Plan** (Pages 191 - 232)

To consider and endorse the Better Care Plan submission.

7. **Review and Refresh of the Cheshire East Joint Health and Wellbeing Strategy** (Pages 233 - 244)

To consider and endorse the refreshed Cheshire East Joint Health and Wellbeing Strategy.

8. **Vulnerable Persons Housing Strategy** (Pages 245 - 256)

To note the draft Vulnerable Persons Housing Strategy and its preliminary findings.

9. **Update on the "Starting and Developing Well" section of the Joint Strategic Needs Assessment** (Pages 257 - 260)

To receive an update on the "Starting and Developing Well" section of the Joint Strategic Needs Assessment.

Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 26th November, 2013 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor J Clowes (Chairman)

Cllr Rachel Bailey, H Grimbaldeston, A Harewood, Hawker, Whitehouse, Wilson, Crane, Smith, Tonge and O'Regan - Healthwatch

Non voting member
Chief Supt Guy Hindle, Cheshire Police

Councillors in attendance:
Cllrs H Gaddum and B Murphy.

Officers/others in attendance:
Mike Suarez – Chief Executive, Cheshire East Council
Lorraine Butcher – Executive Director Strategic Commissioning, Cheshire East Council
Iolanda Puzio - Legal Team Manager, Children Families and Adults, Cheshire East Council
Guy Kilminster – Corporate Manager Health Improvement, Cheshire East Council
Fintan Bradley Head of Service: Strategy, Planning & Performance, Cheshire East Council
Salli Jeynes, Director of Education, Cheshire Hospices Education

Apologies

Dr P Bowen, Cllr S Gardiner.

22 **MINUTES OF THE MEETING HELD ON 24 SEPTEMBER 2013**

RESOLVED

That the minutes be approved as a correct record.

23 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

24 **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public present wishing to use the public speaking facility.

25 **PRESENTATION ON END OF LIFE PARTNERSHIP**

The Board received a report and presentation from Salli Jeynes, Director of Education, Cheshire Hospices Education, relating to the End of Life Partnership, Cheshire.

Cheshire Hospices Education, the End of Life Care Service Model and Cheshire Living Well Dying Well were joining together to create a more complete and holistic approach to living well, death and loss. The merger would be more cost-effective, financially viable and sustainable in the future. It would reduce duplication of effort, maximise and develop team member's skills and create a more joined-up, integrated, co-ordinated and outcome driven approach. The overall aim was to lead, educate and facilitate excellence and best practice in palliative and end of life care; and to influence and enable communities to live and die well, supported by the health, social and voluntary workforce. It was noted that the Work Plan was already being driven by the needs of the population, as set out in the JSNA.

A partnership board/forum would represent the local stakeholders in palliative and end of life care, including service providers, service users, commissioners and workforce developers. Local advisory/operational groups/public health teams would feed in their priorities and local intelligence to the Partnership Board. These groups were already well-established in each locality, with a membership of practitioners and care workers from all areas of care. Public/patient/user engagement would be developed as a priority and would be an integral part of the partnership in terms of feedback, identifying needs and priorities.

The End of Life Partnership would have four work streams; education and practice development; service co-ordination, development and redesign; research evaluation and systems analysis outcomes; public health approach Cheshire Living Well Dying Well programme. It was being set up to meet specific outcomes which support staff and organisations to achieve their purpose in relation to quality, effectiveness, equality and efficiency in palliative and end of life care. Core funding of the partnership was, therefore, dependent upon stakeholders. Details of the potential funding sources were set out in the report.

In considering the report the Board considered that it would be helpful to have a shared/common set of outcomes and felt that it would be useful to have a connection with the Health and Wellbeing Strategy, particularly in respect of the priority relating to a reduction in unnecessary hospital admissions.

RESOLVED

That the report be received and noted.

26 **RELATIONSHIP WITH THE ADULTS SAFEGUARDING BOARD**

Sean Reynolds, Independent Chair Local Safeguarding Adults Board (LSAB), attended the meeting and presented a report relating to the relationship of the LSAB with the Health and Wellbeing Board (HWBB).

It was noted that the LSAB had responsibility for Safeguarding and protecting vulnerable adults from abuse and sought to ensure that all its work was carried out in such a way that positively influenced improved outcomes in all areas of the lives of vulnerable adults in Cheshire East. The main purpose of the Board was to ensure that all organisations providing or commissioning services for vulnerable adults in Cheshire East worked in a co-ordinated way that promoted health and well-being, safeguarding and the protection of vulnerable adults from abuse. Therefore, it was vital that effective partnership relationships were established between the HWBB and LSAB. Analysis of the roles of the HWBB and LSAB revealed connectivity between their core business. Both Boards needed to carefully consider the nature of the relationship, the governance arrangements that secure effective inter-action and the approaches that would enable robust, inter-active working between the two.

It was proposed that the LSAB and HWBB work together to agree interactions and distinctions between the JSNA process and safeguarding specific analysis undertaken by LSAB; agree an approach to understanding and evaluating the effectiveness of service outcomes, including capturing the service user's voice where services needed to be improved, re-shaped or developed; integrating work around the LSAB Business Plan and the Health and Well-Being Strategy, cross-Board communication and engagement in priority setting; arrangements for cross-Board scrutiny and challenge; a co-ordinated approach to performance management and evaluation of success in securing outcomes.

The Chairman of the Health and Wellbeing Scrutiny Committee, who was in attendance at the meeting, queried whether there may be an opportunity to increase public awareness of the LSAB. It was noted that this co-ordinated approach would provide for shared communication of information.

RESOLVED

1. That the Chair of the LSAB attend the HWBB on a 6 monthly basis to present the LSAB’s Annual Report & Business Plan and a mid-year safeguarding update.

2. That the HWBB present the HWBB strategy at the LSAB.

3. The LSAB will also provide the HWBB with LSAB expertise to support the comprehensive analysis of safeguarding in the local area as a direct feed into the JSNA. The LSAB will also evaluate the impact of the Health and Well-Being Strategy on safeguarding and highlight any issues to be addressed in the subsequent Health and Well-Being strategy. The LSAB will also be a key stakeholder in the redrafting of the Health and Well-Being Strategy to ensure an appropriate inclusion of safeguarding issues for consideration by the H&W Board.

4. That the HWBB and LSAB collaborate in sharing information and communications together and promote the Service Users Voice

5. That the HWBB will be committed to incorporating Safeguarding data in the JNSA and the sharing of the JNSA with the LSAB.

27 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**

The Director of Public Health for Cheshire East, Dr Heather Grimbaldeston, presented her first annual report (Living Well for Longer in Cheshire East), since the responsibility for Public Health across England and Wales had transferred from the NHS to Local Authorities in April 2013. She was required by law to write an annual report on the health of the local population. This was an independent report which described a number of key aspects of local health, highlighted areas of excellence and concern and set out headline recommendations to tackle these issues.

In June 2013, Public Health England published “Longer Lives”, which described premature mortality (defined as deaths under the age of 75), by local authority area. It broke down premature deaths by the top four killers; cancer, heart disease and stroke, lung disease and liver disease. This report focused on premature mortality within Cheshire East. National comparisons revealed that Cheshire East had relatively low levels of premature mortality, ranked 38th out of 150 local authorities. The number of premature deaths locally had also fallen over the past nine years by 22%. It was considered that there was a lot to celebrate, however, it was noted that further improvements in health and reductions in premature mortality were possible as :-

- Over 1,000 people die before the age of 75 each year.
- Nearly 800 of these deaths were avoidable.
- More men died prematurely than women in Cheshire East, though the number of men dying prematurely has been reducing since 2001.
- The reduction in premature deaths in women has stalled since 2005-2007.
- There were wide variations within Cheshire East, depending on where people lived, on your risk of premature death.

It was noted that the data started to illustrate local health inequalities and the potential impact of the wider determinants of health on early death. These issues had been highlighted by The Marmot Review, Fair Society Healthy Lives, published in 2010. This report linked poor health outcomes with lower socioeconomic standing and highlighted that 'the link between social conditions and health is not a footnote to the 'real' concerns with health – health care and unhealthy behaviours. The Marmot Review highlighted that to reduce health inequalities it was not enough to focus just on the most disadvantaged, but that action should be taken across a community with 'an intensity that is proportionate to the level of disadvantage' This was the significant challenge for all who lived and work in Cheshire East.

It was noted that in addition to the four top causes of premature mortality highlighted in 'Living Well for Longer', consideration would also be given to issues around mental health and premature death.

RESOLVED

That the report be noted and that it be submitted to future meeting of the Board, to enable Board members to give more detailed consideration to the report, before making comment and considering appropriate public engagement.

28 **PRESENTATION ON SAFEGUARDING IMPROVEMENT BOARD**

The Director of Children's Services, Tony Crane, gave a short presentation providing an update in respect of the Safeguarding Improvement Board.

Significant progress had been agreed by the Improvement Board, including a new 'front door' for referral and assessment; improved management oversight; improved quality and timeliness of assessments; real momentum for change in respect of the LSCB, including the completion of a review of levels of need and the undertaking of an audit of neglect; and good early help offer being delivered.

It was noted that there were continuing challenges in respect of recruitment and retention of permanent Social Workers and middle managers and in ensuring practice was consistently good, as well as the implementation of the new case management system and in demonstrating impact and improved outcomes across the partnership.

Accepting that the majority of recommendations were partnership driven, the Ofsted report had stated *"Ensure that the Joint Strategic Needs Assessment (JSNA) incorporates an analysis of children and young people's safeguarding and child protection needs and that these are accurately reflected and prioritised in the local area's joint Health and Wellbeing Strategy."*

It was noted that initial sign off of activity completed was not accepted and that work was ongoing as part of the wider JSNA activity and HWBB priority setting.

RESOLVED

That the content of the presentation be noted.

29 **SPECIAL EDUCATIONAL NEEDS STRATEGY**

Consideration was given to a report and presentation which set out Cheshire East strategic priorities relating to Special Educational Needs (SEN) and the implementation of the new Code of Practice, as part of the Children's Act. It was noted that the strategy was supported by a detailed action plan and was set in the context of the Life Course Project. Details of the seven key areas and the action plan for implementation were reported.

The Bill placed legal duties on local authorities, early education providers, schools, colleges, health bodies and those who work with them for identifying children and young people with SEN, assessing their needs and providing support to them and their families. The detailed requirements of those legal duties were set out in the draft regulations and guidance on carrying out the duties in the Bill and regulations were given in a draft 0-25 Special Educational Needs Code of Practice. Subject to Parliament, the Bill would come into force from September 2014.

It was noted that the Life Course project had specific activities in relation to the new SEN Code of Practice and issues for the Health and Wellbeing Board would be the roll out of the new Code of Practice across agencies, implementation and delivery of a coordinated assessment and Education Health Care plan, joint planning and commissioning (including pool budgets) and the local offer and preparation for adulthood. It was noted that consideration would also need to be given to the impact on services commissioned and the challenges faced with regard to the delivery of a co-ordinated care plan and structural changes, as well as process

RESOLVED

1. That the report be noted.

2. That request regular updates on the progress of the strategic priorities be submitted to the HWB.

30 **NHS ENGLAND ACCOUNTABILITY REPORT**

Consideration was given to the NHS England Accountability report. It was noted that the first report to the Board, in July, had set out the remit of NHS England, the priorities being are working on, how this work supported the overall strategy of the Board and the partnership. A report would be submitted quarterly to the Board as part of a formal update. It was vital that

NHS England was fully engaged and participated in the partnership work of the Board. Therefore, as the report was developed proposals would be invited from partners on how this integrated working could be improved and developed. The report was a strategic report and did not focus on operational performance issues. A quarterly joint meeting between CCG, NHSE and LA partners had been established to review the performance and quality improvement achieved by primary care and public health commissioning.

The report provided an update on work and also set out the commissioning intentions of NHS England and how it was envisaged engagement in the planning cycle for the next 2 and 5 year health and wellbeing plans would take place.

It was noted that it would be necessary to start focusing on the 5 year plan and it was suggested that a small group of Board members should be established to start framing the plan with regular update reports to the Board.

RESOLVED

That the report be received and noted.

31 **CARING TOGETHER PROGRAMME**

A report summarising the work to date to develop the Caring Together Programme across Eastern Cheshire had been circulated with the agenda for the meeting. It had been presented to supply the Health and Wellbeing Board members with background information to support their understanding of the development of the programme through collaborative working with multiple partners and its objectives and the current activities and plans. The Caring Together Programme was a large scale transformational change programme, aimed at finding and implementing solutions to complex issues which could not be resolved by individual organisations working alone, as opposed to normal scale change projects and programmes which all organisations were continually engaged in to ensure on-going improvements to their own business delivery.

Due to time constraints it was not possible to give full consideration to this important issue at the meeting and it was agreed that it should be included as the first item on the agenda for the next private meeting of the Board, to enable full and proper consideration of this matter.

Jerry Hawker, Chief Officer NHS Eastern Cheshire CCG, undertook to circulate the link to a short animation on the Caring Together Vision and principles, to Board members and requested that any comments be submitted to him or Sam Nichols, the Caring Together Programme Director.

32 **HEALTHWATCH UPDATE**

Mike O'Regan presented a report which provided the Board with an update on progress on the first nine months of Healthwatch Cheshire East. The "Local Healthwatch Outcome and Impact Development Tool", published jointly by the Local Government Association and Healthwatch England, had been used as a framework for the report. This tool was designed to support local Health Watches to identify outcomes and impacts and ultimately demonstrate that they were meeting their objectives and were fit for purpose.

It was reported that Healthwatch Cheshire East had advertised and recruited Board members from across the community during March 2013. Over April and May the members had met with Directors from the Voluntary Sector Consortium, who held the Healthwatch contract and underwent an induction programme and agreed how they would work together. From June Board members had been meeting on a six weekly cycle agreeing their working practice, policies and work plan. A number of Task and Finish Groups had been established to develop policy and help form action plans around key work streams, details of which were reported.

As Healthwatch's representative, Mr O'Regan had attended the Health and Wellbeing Board since April and the wider Healthwatch Board had agreed to become "Healthwatch Champions", linking into partner organisations, including Cheshire East Council, Eastern and South NHS Clinical Commission Groups, the three NHS Trust's. These Champions would attend and actively participate in the governing bodies of partners. They would both raise Healthwatch's profile and better understand the challenges and opportunities that face these organisations.

Details of the body's work in respect of community engagement, youth engagement, scrutiny, information and sign posting service and advocacy service were also provided.

RESOLVED

That the progress to date be noted and that the HWB continue to support Healthwatch Cheshire East in it work as "Consumer Champion for the Health and Social Care Economy of Cheshire East".

The meeting commenced at 3.00 pm and concluded at 5.20 pm

Councillor J Clowes (Chairman)

Agenda Item 5a

Eastern Cheshire
Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group Two Year Operational Plan 2014-16

1. Executive Summary

1.1 The Clinical Commissioning Group (CCG) has submitted a first draft of its operational plans to NHS England. The time horizon for the Operational Plan is two years.

1.2 The components of the submission include:

- self-certification against national priorities e.g. NHS constitution standards
- five-year trajectories to improve performance against key national outcome indicators
- targets for the coming year in relation to delivery of the national Quality Premium measures, including submission of a local priority indicator
- trajectories for secondary care (hospital) based activity levels
- commissioning Intentions for the coming year

1.3 The Commissioning Intentions have been developed to deliver the key national and local requirements based on both national benchmarking and local intelligence.

1.4 Improvement trajectories have been set to deliver key nationally defined outcomes and ***"reducing emergency readmissions"*** has been proposed as our local quality premium indicator.

1.5 A conservative approach has been taken when setting the expected reduction in secondary care (Hospital) activity pending the development of Caring Together plans during the coming year.

1.6 The final submission will be submitted on 4th April 2014.

2. Recommendations

2.1 The Cheshire East health and Wellbeing Board is requested to note:

- the trajectories used, and contained within the appendices
- our local quality premium indicator of "emergency readmissions"
- the approach taken in developing our "operational plan" in year commissioning intentions

3. Next Steps

3.1 The CCG will further develop the programmes of work in order to deliver the commissioning intentions including:

- assignment of human resources
- development of project plans and milestones
- development and negotiation of contractual levers to support delivery e.g. CQUIN schemes
- development of remaining outcome based performance trajectories

4. Background

4.1 The CCG is required to submit operational plans to NHS England. These are linked to the Strategic Plan, Better Care Fund and Finance Plans. The time horizon for the Operational Plan is two years.

4.2 The nationally defined requirements contained within two template based submissions include:

- self-certification against national priorities e.g. NHS constitution standards
- five-year trajectories to improve performance against key national outcome indicators
- targets for the coming year in relation to delivery of the national Quality Premium measures, including submission of a local priority indicator
- trajectories for secondary care (hospital) based activity levels

4.3 In addition to these predefined submissions the CCG is required to develop its Commissioning Intentions for the coming year (2014/15).

4.4 The CCG submitted its first draft plans on 14th February 2014 with an iterative update due on 5th March 2014 and then a final submission on 4th April 2014.

4.5 **Operational Plan Components**

4.5.1 National Priorities. The CCG has self-certified that our plan supports:

- delivery of the NHS Constitution Commitments e.g. treatment within 18 weeks of referral
- that the CCG will assure Providers CIP (Cost Improvement Plans) so they do not negatively impact patient safety or quality
- that we will manage health care associated infections in order to avoid any cases of MRSA

4.5.2 **Appendix One** shows the submitted information.

4.6 **Improving Outcomes**.

4.6.1 The following indicators have been nationally mandated as areas where the CCG should seek to improve current performance. The CCG has analysed historical performance trajectories and set a 5-year improvement trajectory for the following areas:

- a reduction in “potential years life lost” for conditions considered amenable to healthcare
- improving the health-related quality of life for people with long term conditions (also a Quality Premium Measure)
- a reduction in emergency admissions to hospital (also a Better Care Fund Measure)
- increasing the proportion of people having a positive experience of hospital care
- increasing the proportion of people having a positive experience of out of hospital care (GP and Community)

4.6.2 **Appendix Two** shows the submitted information.

4.7 **Quality Premium Measures**

4.7.1 The CCG Quality Premium is an incentive system designed to reward CCGs for delivering key national standards and improving outcomes. The total value of the Quality Premium is £5 per head of population. Any income received from the Premium must be invested in future improvements in the quality of healthcare, outcomes achieved or reducing inequalities. We will receive any income in the first quarter of 2015–16. The measures are:

- reducing potential years of lives lost through causes considered amenable to healthcare and addressing locally agreed priorities for reducing premature mortality (15% of quality premium);
- improving access to psychological therapies (15% of quality premium);
- reducing avoidable emergency admissions (25% of quality premium);
- addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in 2014/15 and showing improvement in a locally selected patient experience indicator (15% of quality premium);
- improving the reporting of medication-related safety incidents based on a locally selected measure (15% of quality premium);
- A further local measure that should be based on local priorities such as those identified in joint health and wellbeing strategies (15% of quality premium).

4.7.2 The CCG has elected to use “emergency readmissions” as our local indicator due not only as this is an area where the CCG continues to be below expected levels of performance but also as there is a close link with the key initiatives already being implemented through the Caring Together Programme, including neighbourhood teams. This measure was one of three we chose in 2013–14 and whilst we have made good progress in this area we are now setting a stretch target in 2014–15 which increases our target reduction against a 2012–2013 baseline from 5% to 10%.

4.7.3 Within the criteria for Quality Premium a “quality gateway” is included. The total quality premium payment for a CCG will be reduced if its providers do not meet the NHS Constitution rights or pledges for patients in relation to (a) maximum 18-week waits from referral to treatment, (b) maximum 4-hour waits in A & E departments, (c) maximum 14-day wait from a urgent GP referral for suspected cancer, and (d) maximum 8-minute responses for Category A red 1 ambulance calls.

4.7.4 **Appendix Three** and **Four** shows the submitted information for the local and national measures.

4.8 **Other mandated areas**

4.8.1 Within the planning process NHS England has required the CCG to confirm our improvement targets for the following areas:

- reducing C-Difficile infection rates
- diagnosis of dementia
- rates of recovery for patients using IAPT (Improving Access to Psychological Therapies)

4.8.2 **Appendix Five** shows the submitted information.

4.9 **Secondary Care (Hospital) activity planning assumptions**.

4.9.1 One of the planning assumptions included within the Caring Together Programme is that there will be a shift in care from a Hospital to a Community setting. In defining the trajectories required within the 2014–15 planning submission a consistent approach has been used to reflect that changes in Hospital activity levels are more likely to be seen from 2015–16 rather than in the coming year. The assumption is that activity will be stable in year 1 (0%) with activity falling by 2% for the following years 2–5. It is recognised that this is a simplistic approach and as the Caring Together assumptions are refined, and further developed, during 2014 then they can be adjusted to be more sensitive to the expected changes.

4.9.2 **Appendix Six** shows the submitted information.

4.10 **Our Commissioning Intentions**

4.10.1 In developing the CCG commissioning intentions it considers not only the nationally defined information listed above, and linked to the "Everyone Counts[1]" planning guidance, but also a range of local and nationally sourced information. Within the Everyone Counts guidance the five outcome domains and seven ambitions, set by NHS England, have been carefully reviewed and considered when developing our commissioning intentions.

- Securing additional years of life for the people of England with treatable mental and physical health conditions
- Improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people with mental and physical health conditions having a positive experience of hospital care
- Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

4.10.2 The local sources reviewed to form the commissioning intentions include included Joint Strategic Needs Assessment, Health and Wellbeing Strategy, Public Health Annual Report, Feedback from Locality Practices and Eastern Cheshire Community HealthVoice, Quality Outcomes Framework Primary Care data and intelligence drawn from our contracts with existing providers.

4.10.3 A set of tools have also been issued nationally to benchmark the CCG performance against a range of outcomes including CCG Outcomes Pack, Atlas of Opportunity, "Any town health system" guides and Commissioning for Value Packs. These packs have allowed the CCG to identify the greatest opportunities for improvement.

[1] http://www.england.nhs.uk/everyonecounts/

4.10.4 Following assessment of all these data sources the CCG is able to produce a long list of initiatives which is then prioritised using a prioritisation matrix which has been developed for the CCG by Public Health, and which was also used to develop our previous year's priorities. This prioritised list has then been validated by one of the CCG's GP leads, Public Health and Eastern Cheshire Community HealthVoice.

4.10.5 The draft commissioning intentions can be seen in **Appendix Seven**.

5. Access to Further Information

5.1 For further information relating to this report contact:

Name	Neil Evans
Designation	Head of Business Management
Organisation	NHS Eastern Cheshire Clinical Commissioning Group
Telephone	07767670497
Email	neilevans@nhs.net

This page is intentionally left blank

01C Name: NHS EASTERN CHESHIRE CCG

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template

1. Self Certification

		Yes/No	If No, please provide commentary (max 4000 characters)
	i) Do your plans ensure that the performance standards in the NHS Constitution will be delivered throughout 2014/15 and 2015/16? Yes/No	Yes	
	ii) Have you assured provider CIPs are deliverable without impacting on the quality and safety of patient care from 2014-15 till 2018-19? Yes/No	Yes	The CCG has agreed with East Cheshire NHS Trust to undertake this process commencing April 2014. This is delayed as the Trust has not yet finalised its CIP schemes.
E.A.S.4	iii) Do you plan to manage HCAIs so that your local population have no cases of MRSA in 2014-15 and 2015-16? Yes/No	Yes	

01C Name: NHS EASTERN CHESHIRE CCG

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template
Read 'Setting 5-year ambitions for improving outcomes A how-to guide for commissioners' before completing the template

2. Ambitions for Improving Outcomes

Outcome Ambition 1

E.A.1

i) What is your ambition for securing additional years of life from conditions considered amenable to healthcare?

E.A.1	PYLL (Rate per 100,000 population)	
Baseline	1743.2	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	1730.1	
2015/16	1717.1	
2016/17	1697.9	
2017/18	1656.0	
2018/19	1553.5	

Note: PYLL forms part of the 2014/15 Quality Premium.

Outcome Ambition 2

E.A.2

ii) What is your ambition for improving the health-related quality of life for people with long-term conditions?

E.A.2	Average EQ-5D score for people reporting having one or more long-term condition	
Baseline	77.50	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	78.60	
2015/16	79.70	
2016/17	80.80	
2017/18	81.90	
2018/19	83.00	

Outcome Ambition 3

E.A.4

iii) What is your ambition for reducing emergency admissions?

E.A.4	Emergency admissions composite indicator	
Baseline	2026.6	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	2026.6	
2015/16	2016.5	
2016/17	2006.3	
2017/18	1965.8	
2018/19	1823.9	

Note: the composite avoidable emergency admissions indicator forms part of the 2014/15 Quality Premium and is a measure in the Better Care Fund.

Outcome Ambition 5

E.A.5

iv) What is your ambition for increasing the proportion of people having a positive experience of hospital care?

E.A.5	The proportion of people reporting poor patient experience of inpatient care	
Baseline	139.8	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	138.0	
2015/16	137.5	
2016/17	137.0	
2017/18	136.5	
2018/19	136.0	

Outcome Ambition 6

E.A.7

v) What is your ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community?

E.A.7	The proportion of people reporting poor experience of General Practice and Out-of-Ours Services	
Baseline	3.30	Please insert baseline - these are provided in the Levels of Ambition Atlas
2014/15	3.25	
2015/16	3.18	
2016/17	3.08	
2017/18	2.96	
2018/19	2.80	

01C Name: NHS EASTERN CHESHIRE CCG

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template
Read the Quality Premium Guidance before completing the template

3. Quality Premium Measures

E.A.1

i) Potential years life lost (PYLL) from ammenable causes in 2014/15

E.A.1	PYLL (Rate per 100,000 population)
2014/15	1730.1

E.A.4

ii) What trajectory are you aiming for in the composite avoidable emergency admissions indicator in 2014/15?

E.A.4	Emergency admissions composite indicator
Q1 2014/15	486.4
Q2 2014/15	506.7
Q3 2014/15	526.9
Q4 2014/15	506.7

E.A.3

iii) For IAPT, what proportion of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16?

E.A.3	The number of people who receive psychological therapies	The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)	Proportion
Q1 2014/15	430	5117	8.4%
Q2 2014/15	453	5117	8.9%
Q3 2014/15	343	5117	6.7%
Q4 2014/15	385	5117	7.5%
2015/16	1692	20469	8.3%

E.A.6

iv) Do you plan meet the nationally set objective for the Friends and Family Test in 2014-15 and 2015/16? Yes/No

Yes/No: Yes

If No, please provide commentary (max 4000 characters)

E.A.9

v) Have you agreed (in conjunction with your Health and Wellbeing Board and NHS England area team) a specified increased level of reporting of medication errors from specified local providers between Q4,2013/14 and Q4, 2014/15? Yes/No

Yes/No

Yes

Please provide commentary, explaining the specified level of increase and if you do not plan to meet this, why? (max 4000 characters)

Not yet formalised

vi) Where there are requirements for Quality Premium measures and/or planned levels of improvement to be agreed with the relevant Health and Wellbeing Board and NHS England area team, do you have their agreement to each of these? Yes/No

Yes/No

Yes

If No, please provide commentary (max 4000 characters)

Not yet formally ratified

	Indicator Definition (please specify the local measures chosen) max 4000 characters	2014/15		
		Numerator	Denominator	Measure
Local Priority 1	C3.2 Emergency readmissions within 30 days of discharge from hospital	1965	2183	0.90

01C Name: NHS EASTERN CHESHIRE CCG

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and Area Teams before completing the template

5. Other Measures

E.A.S.5

i) Number of C.Difficile infections in 2014/15

E.A.S.5	2014									2015			2014/15 Total
	April	May	June	July	August	September	October	November	December	January	February	March	Total
Number of C. Difficile infections	4	4	4	4	4	4	4	3	3	3	3	3	43

E.A.S.1

ii) What dementia diagnosis rate are you aiming for in 2014/15 and 2015/16:

E.A.S.1	Number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	1744	3426	0.509048453
2015/16	1806	3497	0.516442665

E.A.S.2

iii) What level of IAPT recovery are you aiming for in 2014/15 and 2015/16?

E.A.S.2	The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and at final session did not)	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)	% recovery rate
2014/15	609	1667	36.5%
2015/16	651	1750	37.2%

01C Name: NHS EASTERN CHESHIRE CCG

Read the definitions in the Everyone Counts: Planning for Patients 2014/15 - 2018/19 Technical Definitions for CCGs and
Please be aware CCGs are expected to provide further activity figures in the ProvCom planning template

E.C.7-8

4. Activity Measures

i)

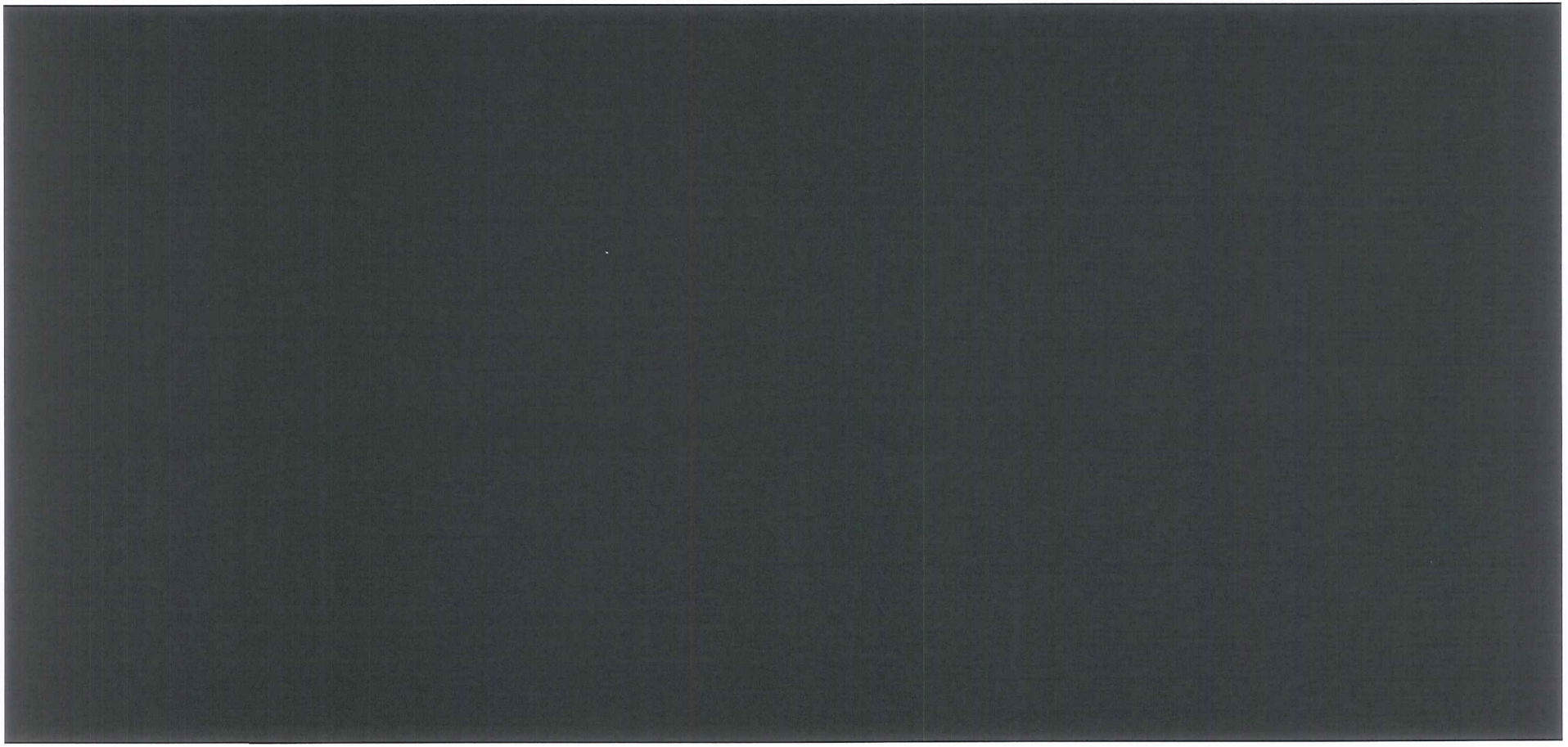
E.C.7-8	Activity Trajectories	A&E Attendances - All types
2014/15 Total		54733
2013/14 Forecast Outturn		54733
Forecast growth in 2014/15		0.0%
2015/16 Total		53639
Forecast growth in 2015/16		-2.0%
2016/17 Total		52566
Forecast growth in 2016/17		-2.0%
2017/18 Total		51515
Forecast growth in 2017/18		-2.0%
2018/19 Total		50484
Forecast growth in 2018/19		-2.0%

Planning Round 2014-15

01C NHS EASTERN CHESHIRE CCG

		E.C.1	E.C.2	E.C.3	E.C.9	E.C.10	E.C.11	E.C.4	E.C.5	E.C.12	E.C.6
CCG Activity		Elective Admissions - Ordinary Admissions	Total Elective Admissions - Day Cases (FFCEs)	Total Elective FFCEs	GP Written Referrals (G&A)	Other referrals (G&A)	Total Referrals	Non-elective FFCEs	All First Outpatient Attendances	First Outpatient Attendances - following GP Referral	All Subsequent Outpatient Attendances (All specialities)
2014/15	April	345	1409	1754	3010	1736	4746	1679	4346	2686	
	May	403	1626	2029	3278	1890	5168	1716	4734	2926	
	June	356	1471	1827	3252	1877	5129	1617	4696	2905	
	July	407	1617	2024	3295	1899	5194	1666	4760	2941	
	August	378	1564	1942	3038	1751	4789	1571	4387	2712	
	September	387	1566	1953	3244	1871	5115	1640	4684	2897	
	October	366	1596	1962	3223	1857	5080	1651	4653	2875	
	November	364	1547	1911	3363	1941	5304	1685	4857	3005	
	December	310	1278	1588	2839	1639	4478	1729	4101	2535	
	January	268	1224	1492	3107	1791	4898	1622	4489	2773	
	February	328	1377	1705	3027	1746	4773	1599	4374	2703	
	March	396	1599	1995	3334	1924	5258	1778	4816	2981	
	Quarter 1										29912
	Quarter 2										30037
	Quarter 3										29568
	Quarter 4										29704
2014/15 Total		4308	17874	22182	38010	21922	59932	19953	54897	33939	119221
2013/14 Forecast Outturn		4308	17874	22182	38010	21922	59932	19953	54897	33939	119221
Forecast growth in 2014/15		0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
2015/16	April	336	1381	1717	2949	1702	4651	1644	4260	2633	
	May	396	1596	1992	3210	1850	5060	1683	4639	2866	
	June	348	1442	1790	3186	1838	5024	1584	4603	2844	
	July	399	1587	1986	3227	1861	5088	1630	4663	2881	
	August	369	1530	1899	2976	1718	4694	1540	4300	2659	
	September	380	1533	1913	3179	1831	5010	1608	4592	2838	
	October	360	1566	1926	3159	1821	4980	1615	4561	2820	
	November	356	1513	1869	3296	1900	5196	1652	4763	2941	
	December	305	1254	1559	2782	1606	4388	1695	4021	2485	
	January	262	1198	1460	3044	1756	4800	1589	4397	2718	
	February	320	1350	1670	2969	1712	4681	1567	4288	2648	
	March	389	1568	1957	3269	1885	5154	1744	4722	2919	
	Quarter 1										29311
	Quarter 2										29435
	Quarter 3										28975
	Quarter 4										29110
2015/16 Total		4220	17518	21738	37246	21480	58726	19551	53809	33252	116831

Forecast growth in 2015/16		-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
		-	-	-	-	-	-	-	-	-	-
		-	-	-	-	-	-	-	-	-	-
2016/17 Total		4137	17165	21302	36507	21048	57555	19160	52729	32589	114497
Forecast growth in 2016/17		-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
2017/18 Total		4055	16820	20875	35779	20627	56406	18779	51672	31936	112209
Forecast growth in 2017/18		-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%
2018/19 Total		3974	16484	20458	35063	20215	55278	18403	50638	31301	109963
Forecast growth in 2018/19		-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%	-2.0%



This page is intentionally left blank

Programmes of Work	Schemes	Primary Outcomes*	E.A	Baseline	Year 1	Year 2	Year 3	Year 4	Year 5
Urgent Care	9b Commissioning of urgent primary care services (including referral service and re-procurement of NHS111) 9a Development of integrated Rapid Response/Urgent Care services as part of Better Care Fund 9c Expand the pathways for ambulatory care to develop community based treatment services, including NWAS Pathfinder, COPD, Diabetes, Heart Failure, Community Minor Ailments and Intermediate Care Services 12 Develop access to a range of voluntary, community and faith sector support available in the community 13 Improving communication with patients, carers and other services, including Primary Care, on discharge from hospital based services	7 Rates of avoidable Hospital admissions 6 Emergency readmissions within 30 days 3 A&E 4 hour performance 9b Implementation of 111 to defined timescales 13 Friends and Family Test (Hospital Care)	E.A.4 E.A E.A E.A	2026.6 2183 95% N/A	2026.6 1965 95% Delivered	2016.5 tbc 95% N/A	2006.3 tbc 95% N/A	1965.8 tbc 95% N/A	1823.9 tbc 95% N/A
Mental Health & Children	9d Improved access to Liaison Psychiatry 2 Implement a system to identify and recall patients with serious mental health or learning disability for health checks. 13a Ensuring appropriate transition between children's and adults services 14a Developing a community facing memory service for dementia patients. 14b Improve access to services and promote dementia friendly communities through the Dementia Alliance 15 Redesign of our IAPT service specification to improve access, develop outcomes whilst providing best value for money 8b Develop CCG capability to meet statutory responsibilities for children with Special Educational Needs (SEN) 8c Commission redesigned neurodevelopment pathways	9d People Feeling Supported to manage their long term condition 8c Waiting Times for access to appropriate service 15 Achievement against IAPT trajectory 2 People with Severe Mental Illness who have received a list of physical checks 13 Improving experience of community mental health services 14 Estimated diagnosis of dementia	E.A.2 E.A. E.A. E.A. E.A. E.A	77.50 tbc 7.9 91.1 89.6 46.6	78.60 tbc 7.9 tbc tbc 50.9	79.70 tbc 8.3 tbc tbc 51.6	80.80 tbc tbc tbc tbc tbc	81.90 tbc tbc tbc tbc tbc	83.00 tbc tbc tbc tbc tbc
Learning Disabilities and Care Pathways	1a Redesign ENT, Upper GI, Urology, Gynaecology and Hepatobiliary pathways 1b Provide Macmillan funded training for practice nurses on early recognition and staging of cancer 5 Identify hidden carers (adult and children) ensuring those entitled to support receive it, signposting to other agencies, support services and information ensuring carers are offered regular health checks 6a Develop and implement a quality framework for care homes 6b Re-commission care homes doctors service where required 11a Commission best practice stroke care including completion of the re-commissioning of hyper-acute services and a new community stroke rehabilitation service 11b Re-procure Wet Age Related Macular Degeneration (AMD) and related macular services 19 Apply and disseminate best practice and innovation e.g. through NICE and through engagement with the Academic Health Science Network 8a Support the Life Course Review for Learning Disabilities 7a Roll out end of life planning tools across primary care and improve the capture of information regarding patients actively on the Gold Standards Framework	5 Health related quality of life for carers 4 Bereaved Carers views on the quality of care in the last three months of life 1b One Year Survival (by cancer group) 1a Potential Years of Life Lost (PYLL) from causes considered amenable to healthcare (Adults, children and young people) 1b Cancer record of stage at diagnosis 11a Reduction in LOS for stroke patients	E.A. E.A. E.A.1 E.A E.A E.A	O.81 tbc 66.0 1743.2 83% 15.7	tbc tbc tbc 1730.1 tbc tbc	tbc tbc tbc 1717.1 tbc tbc	tbc tbc tbc 1697.9 tbc tbc	tbc tbc tbc 1656.0 tbc tbc	tbc tbc tbc 1553.3 tbc tbc
Improving Quality of Services	16a Development of a whole health economy approach to prevent and effectively manage pressure ulcers including a review of the community equipment service 16b Reduce rates of healthcare acquired infections (MRSA and CDIFF) 16c Development of services to ensure high quality "24-7" care 16d Continued development of services for Military Veterans 17 Reduce the incidence of Falls in a hospital setting 18a Ensuring systems support consistently safe prescribing practice 18b Development of the Eastern Cheshire prescribing formulary	16 Improved Reporting of Patient Safety Incidents 16 Pressure Sore Prevalence 16 Incidence of C-Diff & MRSA infections 17 Falls prevalence (hospital admissions) 18 Formulary Compliance 13 Patient Experience of Hospital Care	E.A E.A E.A E.A E.A	6.31 tbc 7.21 0 809	tbc tbc 43 0 809	tbc tbc tbc tbc tbc	tbc tbc tbc tbc tbc	tbc tbc tbc tbc tbc	tbc tbc tbc tbc tbc
Caring Together Early Adoption Schemes	4 Development of an Integrated Model of Care built around a wider Primary Care service, integrated with community services, social care and the third sector with greater emphasis on supporting our population to manage their own health 4b Implementation and development risk stratification and case management to identify and support proactive management of "high risk" patients. Improve information sharing through effective use of "patient passports" and "shared records" 6c Expand the care home doctors service to include multi-professional support through neighbourhood teams	9a Avoidable Admissions Baseline/Trajectory 9c Reduction in hospital excess bed days 5 Health related quality of life for people with LTC 9d Patients feeling supported to manage their long term condition 14 Patient Experience of GP Care 14 Patient Experience of Out of Hours Care	E.A. E.A E.A.2 E.A.5 E.A. E.A.7	2026.6 1.77 77.5 53.5 139.8 3.30	2026.6 tbc 78.6 54.3 138.0 3.25	2016.5 tbc 79.7 55 137.5 3.18	2006.3 tbc 80.8 53.8 137 3.08	1965.8 tbc 81.9 56.5 136.5 2.96	1823.9 tbc 83.0 57.3 136.0 2.80

**Whilst primary responsibility for outcomes has been assigned to one programme many outcomes will cut across multiple programmes*

This page is intentionally left blank

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group
Five Year Plan

1. Executive Summary

1.1 This paper presents the 'draft' NHS Eastern Cheshire Clinical Commissioning Group (CCG) Five Year Strategic Plan (Appendix One)

1.2 The draft Strategic Plan has been developed in accordance with the standard template stipulated in *Everyone Counts: Planning for Patients 2014/15 to 2018/19.*

1.3 The draft strategic plan will need to be amended accordingly so that a submission of the final version of the Five Year Strategic Plan will be submitted to NHS England on 20th June 2014

2. Recommendations

2.1 The Cheshire East Health and Wellbeing Board is requested to:

- note the content of the strategic plan and provide initial comments and feedback

3. Next Steps

3.1 The draft strategic plan will be submitted to the CCG governing body on the 26th March 2014, and to NHS England on the 4th April. Amendments and updates to the draft plan are likely until a final version is ready for submission by 20th June 2014.

4. Background

4.1 NHS England published strategic and operational planning guidance on 20th December 2013. The guidance sets out the healthcare system challenges of significant and enduring financial pressures. People's need for services will continue to grow faster than funding, meaning that we have to innovate and transform the way we deliver high quality services, within the resources available, to ensure that patients, and their needs, are always put first.

4.2 '*Everyone Counts: Planning for Patients 2014/15 to 2018/19* sets out a bold framework within which commissioners will need to work with providers and partners in local government to develop strong, robust and ambitious five year strategic plans to secure the continuity of sustainable high quality care for all. The planning guidance is accompanied by a suite of support tools intended to assist commissioners with their planning considerations to maximise the best possible outcomes for their local communities.

4.3 The planning guidance seeks:-

- **Strategic plans covering a five year period**, with the first two years at Operating Plan level
- **An outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them
- **Citizen inclusion and empowerment** to focus on what patients want and need;
- **More integration between providers and commissioners**

- **More integration with social care** cooperation with Local Authorities on Better Care Fund planning
- Plan to be explicit in dealing with the **financial gap and risk and mitigation strategies**

4.4 The CCG's draft five year strategic plan is based around the Caring Together programme transformation strategy.

4.5 It is important to note that it is expected that year one and two of the five year strategic plan will be fixed as per the final submission of the two year operational plan on 4th April 2014

4.6 Key timelines to note are:

Activity	Deadline
First submission of draft plans	14th February 2014
Plan approved by Governing Body	31st March 2014
Submission of final two year operational plan and draft five year strategic plan	4th April 2014
Submission of final five year plan	20th June 2014

5. Access to Further Information

5.1 For further information relating to this report contact:

Name	Jerry Hawker
Designation	Chief Officer
Date	19th February 2014
Telephone	01625 663764
Email	jerry.hawker@nhs.net

NHS England

Strategy templates

2014/15 – 2018/19

THE NHS CONSTITUTION
the NHS belongs to us all

Strategy templates

Part of the set of templates that support Everyone counts: Planning for patients 2014/15 – 2018/19

First published: 19 December 2013

Introduction:

A strategic plan differs from an operational plan in many ways; it should be short, focussed and describe in a motivational way the direction of the organisation (s) that have signed up to it. It describes to those outside the system what the system plans to achieve in a way that informs and engages. It provides the basis for further detailed planning and should stimulate change in a system. That said, the strategic plan must also be realistic and attainable, to allow those within the system to understand and align with the strategic vision whilst working at all operational levels.

It is essential for these plans to be at the forefront of the planning process; they set the vision, ambitions and framework against which the two year detailed operational plans will be set. To help the submission of attainable and ambitious plans, templates have been developed that we hope are simplistic, flexible and helpful to commissioners and health systems generally.

What are we asking for?

Strategic planning should include the following elements:

- A long term strategic vision
- An assessment of the current state and current opportunities and challenges facing the system
- A clear set of objectives, that include the locally set outcome ambition metrics
- A series of interventions that when implemented move the health system from the current position to achieving the objectives and implementing the vision

Each strategic plan needs to be tested against the six characteristics of a sustainable health and care system (outlined below and from page 10 of *Everyone Counts*) ensuring that it reflects the needs of local citizens, the conclusions of local Call to Action conversations and informed by modelling tools such as Any town.

The structure of the submission has two core sections that we are asking to be completed and returned to us, in accordance with the timelines issued separately. These sections are a plan on a page and a key lines of enquiry submission – the strategic template will be deemed incomplete unless both sections are returned.

1. A *system* wide description of what the health economy should look like in five years. This system vision should identify how the health system will shape itself to meet future health demands without compromising quality outcomes or financial sustainability –the plan on a page is a helpful approach to describing this vision and a draft guide has been included in Appendix A.

2. A unit of planning[1] specific narrative describing how each organisation would reach this desired state through a high level road map that captures the high impact interventions planned within the health economy. This narrative takes the form of a key lines of enquiry submission. While this Strategy template looks for a narrative, this narrative must relate to, and underpin, the five year plans submitted in the related templates covering finance, activity and outcomes. To reduce duplication we have not asked for this material to be repeated in this document. In addition, the two year operational plans need to be consistent with the strategic direction set out here and triangulation across these various elements will be part of the assurance process.

This template contains the requirements of both sections of the template.

[1] The unit of planning will be determined by CCGs in accordance with letter issued on 04 November 2013

Section one | System narrative plan on a page- See attached 5 year strategy plan document and additional comments for Section Two- Key Lines of Enquiry

The plan on a page should have stakeholder sign up to its goals at a local health economy level. It should include the following characteristics:

Segment	Covering:	Supported by:
1. System vision	A statement describing what the desired state would be for the health economy in 2018/19 – this should ideally describe the health and care system rather than an individual organisation view – and which accounts for the six characteristics of a high quality, sustainable health and care system	See 5 year strategy
2. Improving quality and outcomes	A) Looking at the seven improving outcome ambitions identified in *Everyone Counts*: planning for patients, how does the health economy plan to improve these and where appropriate, what level of improvement does it expect?	See 5 year strategy
	B) What other local quality improvement plans are in place and how do these align with the local strategic needs assessments?	See 5 year strategy
3. Sustainability	In five years, what are the health economy goals for sustainability including reference to financial position, other resources and points of service delivery. This work should reference the do nothing gap calculated for the system by 2018/19 that aligns to the challenges identified in A Call to Action[2]	See 5 year strategy
4. Improvement interventions	To achieve the desired end state what are the key improvement interventions planned at an organisational level and how will these deliver the quality and sustainability outcomes required?	See 5 year strategy
5. Governance overview	A summary of the governance processes in place to oversee the delivery of the plans, including high level description of what success looks like and who is responsible for measuring it	See 5 year strategy
6. Key values and principles	A summary of the agreed values and principles that underpin the system wide working required to deliver the vision	See 5 year strategy

As part of the assurance process, the plans on a page will be reviewed to understand alignment to detailed organisational metrics submitted through the operational and financial templates.

Examples of plans on a page are available separately

[2] http://www.england.nhs.uk/2013/07/11/call-to-action/

Section Two | Key lines of enquiry (KLOE)

The following table template asks key lines of enquiry and contains space for the organisation to add their responses.

Segment	Key Line of Enquiry	Organisation Response	Supported by:
Submission details	Which organisation(s) are completing this submission?	NHS Eastern Cheshire Clinical Commissioning Group	
	In case of enquiry, please provide a contact name and contact details	Mike Purdie - Governance Manager – Tel 01625 663470 email: mike.purdie@nhs.net	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
a) .System vision	What is the vision for the system in five years' time? ;	Caring together **'Caring together': Joining up local care for all our wellbeing** Over the last 18 months local commissioners and providers have united behind a common vision and purpose of transforming care services in Eastern Cheshire. This has been driven by a shared desire to join up care, improve outcomes and our citizens experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England. Quite simply, the transformation programme, called Caring Together is about organisations and people working together to make care as straightforward and integrated (joined up) as possible Our local clinical, health and social care partners believe that: • People in Eastern Cheshire deserve services that are high quality and delivered as locally as possible. • Patients should sit at the heart of a proactive care system centred on them. • Carers are one of the most important resources which allow people to be independent and believe that they need to be supported to provide this care.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		• Local people should be supported to take responsibility for their own health as much as possible. Over the next 5 years the Caring Together programme will achieve this vision through the commissioning of a radical and innovative new care system built on 4 environments of care, and delivered through each of the following elements; 1. Transformation of Primary Care *(in partnership with NHS England CWW Area Team and our involvement in the Challenge Fund)* 2. Development of a new Integrated Community care model *(Whole system partnership in Eastern Cheshire and aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund).* 3. Reconfiguration of acute care *(in partnership with the Greater Manchester Healthier Together programme & the "Challenged Economy" initiative)* 4. A range of Productivity initiatives to underpin the transformation programme. The four environments of care include; *1.* The empowered person – *Proactive empowerment of individuals to take responsibility for their own health* *2.* Community provided care – *Fully integrated and coordinated community care provided by multiprofessional teams* *3.* Local specialist care – *High quality specialist care delivered with a reasonable distance from peoples home* *4.* Regional specialist care – *Highly trained specialists delivering world-class care from centres of regional excellence.* **What do we want to achieve over the next 5 years?** Our ambitions for the future can be summarised as being to:	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		□ Increase the number of people having a positive experience of care □ Reduce the inequalities in health and social care across Eastern Cheshire □ Ensure our citizens access care to the highest standards and are protected from avoidable harm □ Ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services □ Increase the proportion of older people living independently at home and who feel supported to manage their condition □ Improve the health-related quality of life of people with one or more long term conditions, including, mental health conditions □ Secure additional years of life for the people of Eastern Cheshire with treatable mental and	
	How does the vision include the six characteristics of a high quality and sustainable system and transformational service models highlighted in the guidance? Specifically: 1. Ensuring that citizens will be fully included in all aspects of service design and change, and that patients will be fully empowered in their own care 2. Wider primary care, provided	***Engagement of our Citizens*** The Caring Together programme has from its inception maintained a strong ethos of citizen engagement. All of our clinical design groups have public representation and the Caring Together Executive Board includes public representatives. The CCG has recently launched "*Caring Together - Seizing the opportunity for better care: Join the Conversation*," This is a local call to action to everyone in Eastern Cheshire to work with us to address many of the challenges we face in striving to provide health and care services that meet the needs of our population.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	at scale 3. A modern model of integrated care 4. Access to the highest quality urgent and emergency care 5. A step-change in the productivity of elective care 6. Specialised services concentrated in centres of excellence (as relevant to the locality)	This is the start of a conversation with the public, which will be running until the end of April, after which we will be feeding their views into a consultation exercise that will take place later in the year. As a well as listening to the public, we will be talking to a wide range of other interested parties, including staff, clinicians, partners in the voluntary and independent sectors, patient groups and sections of the community with particular interests or needs. ***Wider Primary care provided at Scale*** Utilisation of community assets and empowering people to effectively engage with a managed primary care delivery model in partnership with NHS England CWW Area Team and our 23 member practices to deliver 100% access to clinicians working in primary care. ***A modern model of integrated care*** The development of a new Integrated Community care model leading to a whole system partnership in Eastern Cheshire to deliver Risk stratification, neighbourhood teams, care planning, care coordination and case management. This is aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund ***Access to the highest quality urgent & emergency care*** The Caring Together Transformation programme will enable the CCG to bring a radical change to our approach to Urgent and emergency care shifting the focus from reactive care to proactive preventative care. The introduction of our integrated community care teams will enhance care management of those people with the most complex care needs, pre-empting and planning for escalating need whether that be physical , mental or social care. Through our	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		work with the Ambulance service we are strongly supporting the introduction of see and treat and hear and treat approaches under-pinned by the introduction of “pathfinders”. We recognise the scale and scope of the opportunity that exists for primary care to take a leading role in urgent & emergency care and our 5 year plans include expanding the role of practices in pre-emptive care in care homes, the introduction of new Urgent Primary care services and improving overall access to primary care. The CCGs plans also include the need to improve access to more specialised urgent and emergency care. The population of Eastern Cheshire is already accessing and receiving the benefits from being part of the Greater Manchester Trauma network and our operational plans include the introduction of improved access to hyper-acute stroke care. ***A step-change in productivity of elective care*** Analysis of the Commissioning for Value packs indicates opportunities in Circulatory and Musculoskeletal care and will form part of our operational QIPP plans. Our 5 year plan for elective care is focused on the wider system reconfiguration that is necessary to support long term productivity gains and will address three key inter-related themes; The need to secure long term high quality, sustainable elective care services, the creation of innovative community based elective care solutions and maintaining our focus on efficient high quality referrals in-line with our current upper quality performance when compared to our peer group. Through our involvement in Healthier Together and the Challenged economy programme the CCG will be working in partnership with South Manchester and Stockport CCG’s to ensure access to sustainable high quality elective services commissioned collaboratively and supporting elective care providers to seek greater network solutions compliant with the Healthier Together standards.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		The CCG has a successful track record on increasing access and productivity of elective care by increasing the range of market providers (Audiology, diagnostics, minor surgery etc) and will continue to expand this commissioning approach in both its operational and 5 year plans. ***<u>Specialised services concentrated in centres of excellence</u>*** NHS Eastern Cheshire has a long history of working with specialist centres in Greater Manchester including Salford Royal (Neurosciences), Central Manchester (Paediatrics, Renal) and the Christie Hospital (Cancer). Our involvement and partnership with the Healthier Together programme forms a key part of our 5 year plans ensuring continued access for our population to the highest standards of specialist care. Our plans include the development of access to 24/7hr specialist hyper acute care and work with the clinical networks and Academic Science networks to ensure our population continue to have access to the latest NICE guidance and technological developments.	
	How does the five year vision address the following aims: a) Delivering a sustainable NHS for future generations? b) Improving health outcomes in alignment with the seven ambitions c) Reducing health inequalities?	Over the next 5 years the Caring Together programme will achieve this vision through the commissioning of a radical and innovative new care system built on 4 environments of care, and delivered through each of the following elements; 5. Transformation of Primary Care *(in partnership with NHS England CWW Area Team and our involvement in the Challenge Fund)* *6.* Development of a new Integrated Community care model *(Whole system partnership in Eastern Cheshire and aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund).*	**Error! Reference source not found.**

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		7. Reconfiguration of acute care *(in partnership with the Greater Manchester Healthier Together programme & the "Challenged Economy" initiative)* 8. A range of Productivity initiatives to underpin the transformation programme.	
	Who has signed up to the strategic vision? How have the health and wellbeing boards been involved in developing and signing off the plan?	The Caring Together programme forms the heart of our 5 year plans and has been signed up to by all the major partners in Eastern Cheshire, including; NHS Eastern Cheshire CCG and all 23 member practices Cheshire East Council East Cheshire NHS Trust Cheshire & Wirral Partnership Trust Venova CIC NHS England NHS Trust Development Authority In addition the CCG is an Associate member of the Healthier Together Committee in Common and a partner of the Connecting Cheshire pioneer programme. The Caring Together programme has been submitted and endorsed by the Cheshire East Health & Wellbeing Board and regular updates on the Caring Together Programme are provided to the Health & Wellbeing Board, and Scrutiny committee including presenting the Strategic Outline Case and Case for Change.	
	How does your plan for the Better Care Fund align/fit with	The Better Care fund plan unites a shared vision of Cheshire East Council and	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	your 5 year strategic vision?	NHS Eastern Cheshire Clinical Commissioning Group for improving outcomes for residents through improving how health and social care services work together. The Better Care Fund is a supportive enabler to the Caring Together 5 year plan and our shared plans to commission a transformed model of integrated care, which will ensure that residents experience quality care and support that is appropriate to their needs, and supports them to live as independent and fulfilling lives as possible.	
	What key themes arose from the Call to Action engagement programme that have been used to shape the vision?	The Call to Action key themes have been fully embedded and localised in the Caring Together Programme as reflected in our Strategic Outline Case, Case for Change, the recently launched *Seizing the opportunity for better care: Join the Conversation*," and the "Caring Together" website. (www.caringtogether.info)	
	Is there a clear 'you said, we did' framework in place to show those that engaged how their perspective and feedback has been included?	The Caring Together programme has a well-established platform for engaging with the general public, patients, staff and stakeholders. This includes a communications and engagement group, and appointment of external public relations and media expertise. The CT programme has demonstrated the "you said we did" approach has been applied to our general public, our patients our service users and the staff who work in all of our organisations.	
a) Current position	Has an assessment of the current state been undertaken? Have opportunities and challenges been identified and	The CCG has undertaken a comprehensive and thorough assessment of the current health & social care system evidenced through the Strategic Outline Case and Case for Change.	

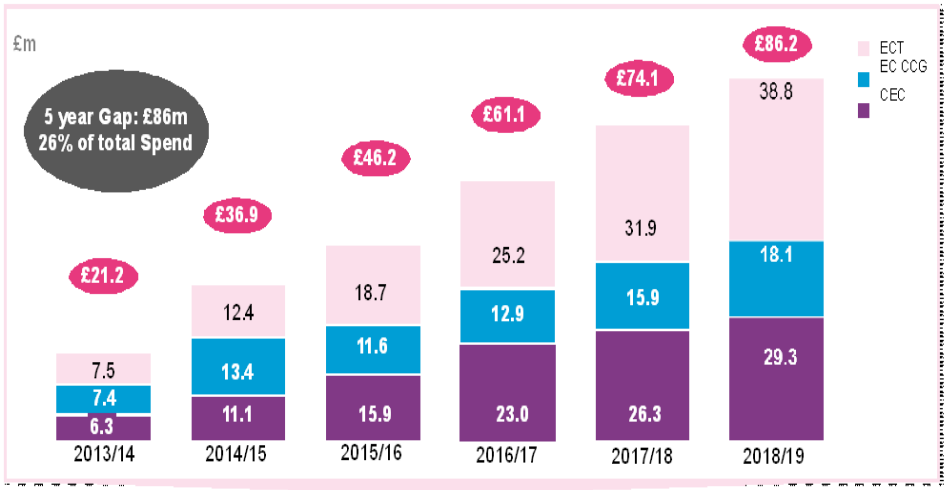
Segment	Key Line of Enquiry	Organisation Response	Supported by:
	agreed? Does this correlate to the Commissioning for Value packs and other benchmarking materials?	The CCG has worked with McKinsey to complete a full assessment of the current state of the economy, along with all stakeholders and partner organisations in Eastern Cheshire. The Strategic Outline Case and draft Case for Change has used local (JSNA), Regional (Healthier Together), National (Commissioning for Value), Peer Group comparisons, CCG data packs etc. and international benchmarks in the development of the Caring Together programme.	
	Do the objectives and interventions identified below take into consideration the current state?	The CCG has worked closely with NHS England to follow recognised international best practice methodology for major transformation programmes. The CCG Caring Together programme which forms the heart of our 5 year plans is based on a through baseline assessment articulated through the Strategic Outline case and the production of a Case for Change document.	
	Does the two year detailed operational plan submitted provide the necessary foundations to deliver the strategic vision described here?	The CCGs Operational plan has been developed to address immediate operational and quality improvement initiatives and to capture the full range of innovative pilots and early adopter innovations that support the 5 year plan. The operational plan covers the following 5 thematic areas; • Urgent care • Mental Health & Children services • Learning Disabilities & care pathways • Improving Quality of services • Caring Together early adoption schemes.	CCG 2 year Operational plan
b) Improving quality and outcomes	At the Unit of Planning level, what are the five year local outcome ambitions i.e. the aggregation of individual organisations contribution to the outcome ambitions?	Eastern Cheshire 5 year strategic plan is not based on a single unit of planning , but on the recognition that its transformational programme must work across a geographic footprint that covers Cheshire (Connecting Cheshire), North Derbyshire and Greater Manchester (Healthier Together / Challenged Economy) in order to deliver the greatest benefits for its local population. The	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
		following ambitions have been developed and supported by all partners of the Caring Together programme; **Ambition One** To secure additional years of life for the people of Eastern Cheshire with treatable Mental and Physical Health conditions **Ambition Two:** To improve the health related quality of life of people with one or more long term conditions, inc. mental health conditions **Ambition Three:** To ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services. **Ambition Four:** To increase the proportion of older people living independently at home and who feel supported to manage their condition **Ambition Five:** To increase the number of people having a positive experience of care **Ambition Six:** To reduce the inequalities in health and social care across Eastern Cheshire **Ambition Seven:** To ensure our citizens access care to the highest standards and are protected from avoidable harm. The CCG's 2 year Operational plan sets out the primary outcome measures and trajectories for improvement against each ambition over the 5 year strategic plan.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	How have the community and clinician views been considered when developing plans for improving outcomes and quantifiable ambitions?	The 5 year plan as delivered through the Caring Together program includes a number of clinically lead design groups supported by a Care Professionals Board (CPB). This extensive consultation process has ensured Caring Together is delivering plans with quantifiable, improved outcomes as agreed by all persons under CPB.	
	What data, intelligence and local analysis were explored to support the development of plans for improving outcomes and quantifiable ambitions?	The CCG has worked in partnership with McKinsey to undertake a system wide economic modelling with engagement from all stakeholders (Commissioners and Providers) in Eastern Cheshire. This has provided a detailed evidence base of the financial gap over the next 5 years as a consequence of a “do nothing “scenario. Details of the economic modelling have been provided in a detailed strategic outlined case which has been presented to the Caring Together Partnership board in October 2013. The financial analysis of this demanding scenario is presented in the following diagram.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:

Commissioner (Healthcare and Social Care) and Acute Provider financial gap under a 'do nothing' scenario



- It is our ambition in 2018/2019 that the Eastern Cheshire economy and all its partner organisations are able to discharge all their regulatory financial duties including surpluses

1. CWP broadly financially sustainable and therefore does not contribute significantly to financial challenge
2. Cheshire East Council (Adult Social Care) financial gap.
3. CEC and ECT financial gap for 2017/18 and beyond extrapolated from previous years positions.

SOURCE: East Cheshire Integrated Care model; EC CCG; Cheshire East Council; East Cheshire Trust (as at 8 Jan 14)

Caring together — Integrating Care in Eastern Cheshire

In addition, the CCG is working closely with Stockport and South Manchester CCG to establish a Commissioning Framework to support the "Challenged economy" programme that covers the three CCGs and four local hospitals. A critical friend will be appointed to work across the economic footprint providing addition demand and activity analysis and establishment of a baseline position.

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	How are the plans for improving outcomes and quantifiable ambitions aligned to local JSNAs?	The Caring Together programme and the identified ambitions and outcomes have been developed from the local Health & Wellbeing Strategy and associated JSNA. The Director of Public Health and associate Director of Public Health have provided additional scrutiny and assurance of the plans.	
	How have the Health and well-being boards been involved in setting the plans for improving outcomes?	The structure of the Caring Together programme has been established in a way that the programme reports into the Health & Wellbeing Board (HWB). The programme direction for Caring Together provides regular progress reports to each HWB.	
c) Sustainability	Are the outcome ambitions included within the sustainability calculations? I.e. the cost of implementation has been evaluated and included in the resource plans moving forwards?	The Caring Together programme is a key driver to delivering a sustainable health economy over the next five years. Within the Case for Change, the "do nothing" scenario indicates a deficit that increases to circa £18m by 2018/19. The plans reflect a number of assumptions ranging from both national and local initiatives. These range from the Better Care Fund to the impact of the Caring Together transformation programme from 2018/19 onwards. The Local Health economy has been meeting routinely to ensure consistency where applicable in assumptions and future plans. Whilst the Caring Together programme is the key QIPP initiative from 16/17 onwards, the first 2 years are targeted against the areas of opportunity when compared to our peers as outlined in the "Commissioning for Value – insight pack". This enables the CCG underlying financial position to gradually improve over the next five years to a position that is sustainable looking forward. In addition, the plan includes the Caring Together programme costs in years 1&2 aimed at supporting the Caring Together programme up to and including consultation. It does not take account of any pump priming costs associated with the system redesign as these will emerge during the next 6 months.	Detailed metrics supplied in the financial templates

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	Are assumptions made by the health economy consistent with the challenges identified in a Call to Action?	Yes, with adaptions to reflect local demographics and local JSNA	
	Can the plan on a page elements be identified through examining the activity and financial projections covered in operational and financial templates?	The activity and financial projects reflect the elements outlined within the plan at a strategic level. The constraints and rigidity of the financial template do not support each area to be individually recorded and as such has been aggregated in many instances.	
d) Improvement interventions	Please list the material transformational interventions required to move from the current state and deliver the five year vision. For each transformational intervention, please describe the : • Overall aims of the intervention and who is likely to be impacted by the intervention • Expected outcome in quality, activity, cost and point of delivery terms e.g. the description of the large scale impact the project will have • Investment costs (time, money, workforce) • Implementation timeline • Enablers required for	In line with NHS England published guidance on service transformation the CCG is following recommended best practice. The Care Professionals board and Care design groups are currently completing work on establishing the new care models and supporting care standards which will inform future transformational interventions. Detailed information on transformational interventions will be completed as part of the Caring Together pre-consultation business case which will be published in June 2014. Please refer to the Caring Together programme as evidence of the timetable and schedule of work to be undertaken.	

Segment	Key Line of Enquiry	Organisation Response	Supported by:
	example medicines optimisation • Barriers to success • Confidence levels of implementation The planning teams may find it helpful to consider the reports recently published or to be published imminently including commissioning for prevention, Any town health system and the report following the NHS Futures Summit.		
e) Governance overview	What governance processes are in place to ensure future plans are developed in collaboration with key stakeholders including the local community?	Caring Together Governance Structure(Slide 2 in CT Governance & Timelines presentation) including links to Eastern Cheshire Health Voice, Health Overview and Scrutiny Committee and Health and Wellbeing Board	 CT Governance a timelines.pptx
f) Values and principles	Please outline how the values and principles are embedded in the planned implementation of the interventions	Refer to the attached document for further information	**Error! Reference source not found.Erro r! Reference source not found.**  NHS Eastern Cheshire - 5 year

Agenda Item 5b

Cheshire East Council

Health and Wellbeing Board

Date of Meeting:	25th March 2014
Report of:	Simon Whitehouse, Chief Officer, NHS South Cheshire CCG
Subject/Title:	NHS South Cheshire CCG Draft Operational Plan 2014-16

1.0 Report Summary

1.1 The following report provides the Health and Wellbeing Board with an overview of NHS South Cheshire Clinical Commissioning Groups (CCG) Draft Two Year Operational Plan, 2014-16 as submitted to NHS England on the 14th February 2014.

2.0 Recommendations

2.1 The Board are asked to:

I. Review the direction of travel and key points presented by the CCG plan;

II. Discuss the plan in relation to the developing draft Health and Wellbeing Strategy across Cheshire East including the direction of travel enabling health and social care to work in more integrated ways.

3.0 Report Details

3.1 The Planning Process:

The publication of *The NHS belongs to the people – a call to action*[1] in July 2013 began a national discussion about the major transformational change that is required to ensure that the NHS responds to increasing pressures such as an ageing population, increasing prevalence of long term conditions, and rising healthcare costs. *A Call to Action* outlines the 'case for change' across the system and called on the public to get involved in shaping the future of their NHS service.

Given the scale of the challenges we are facing within the NHS, we are now moving away from incremental one year planning and instead developing bold and ambitious plans which cover the next five years, with the first two years mapped out in the form of detailed operating plans.

As a CCG we see this as crucial to enabling us to take a longer term, strategic perspective of the direction of travel across the health and

[1] *The NHS belongs to the people: a Call to action*, July 2013, NHS England

social care landscape. We must develop and implement transformative long-term strategies and plans to enable us to be financially sustainable and uphold safety and quality of patient care.

The national planning guidance seeks:-

- Strategic plans covering a five year period, with first two years at operating plan level;
- An **outcomes focused approach**, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them;
- **Citizen inclusion and empowerment** to focus on what patients want and need;
- **More integration between providers and commissioners**;
- **More integration with social care** – cooperation with Local Authorities on Better Care Fund planning;
- Plans to be explicit in **dealing with the financial gap** and risk and mitigation strategies.

The following table illustrates timescales for the planning process:

Action Required	By When
1st Draft Submission of CCG Operational Plans	14th February 2014
Refresh of plan post contract sign off	5 March 2014
Plans approved by Boards	31 March 2014
Submission of final 2 year plans and draft 5 year strategic plans	4 April 2014
Submission of final 5 year strategic plans or which years 1 & 2 of the 5 year plan will be fixed per the final operational plan submitted on 4 April 2014	20 June 2014

3.2 Key points from the NHS South Cheshire CCG Operational Plan

NHS South Cheshire CCG seeks to be a responsive organisation that listens and takes into account a wide range of perspectives but at the same time keeps its principles central to commissioning decisions. Those principles are:

- Working to provide care 'upstream' (seeking prevention and avoiding crisis);
- Focus care on patient goals and where appropriate, carer and family goals;
- Building services around the patients' needs;
- Championing quality in all its forms across all we do.

At the heart of our work as a clinically led commissioning organisation is the focus on **improving outcomes for our patients**. We have

therefore focussed our key actions (commissioning intentions) on each of the 5 Domains of the NHS Outcomes Framework. **These domains have now become our strategic objectives for 2014-16:**

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

(Further detail of specific projects can be viewed in the full Draft Operational Plan).

The CCG is committed to help improve the general health of the population, reduce health inequalities, ensure equitable access to healthcare and to work with partners on the Health and Wellbeing Board and providers of care so that patients are treated with dignity and respect at all times.

The CCG is also committed to ensuring that services are commissioned to support people with both physical and mental health conditions and also those who have learning disabilities (**parity of esteem**). The CCG recognises that historically there has been inequity in services for people with physical and mental health problems, and have identified a number of key commissioning priorities and areas of action to address this.

The CCG see the following as **key enablers** to deliver the operational plan:

Making a Difference – Engagement, Involvement and Communication – The CCG ensures that patients, carers and their families are fully included in all aspects of service change and those patients are fully empowered in their own care.

Quality, Safeguarding and Patient Safety – The CCG commissions high quality services, that are delivered in the most effective way possible whilst ensuring a positive experience. Our main quality drive is centred on patient feedback to ensure they get the right services in the right location delivered by the right health care professionals at the right time. We have prioritised quality and safeguarding vulnerable adults and children.

Commissioning for Quality in Primary Care – The CCG has a shared responsibility with NHS England, for the continual improvement of

quality in primary care. The CCG is ideally placed to support practices to improve the quality of GP services that not only meet the changing needs of the local health economy but also put the needs of the patient at the centre of primary care development.

Information Technology (IT) and Information Sharing – The CCG will be working with our partners to mobilise our IT programme and portfolio of projects to ensure that a robust governance structure is in place to monitor delivery and provide appropriate decision making.

Prescribing and Medicines Optimisation - The CCG Medicines Management Team will support the CCG to commission services that make best use of medicines.

A summary of our vision, principles, ways of working, strategic objectives and organisational objectives are presented below:

OUR VISION	
To maximise health and wellbeing and minimise health inequalities, informed by local voices and delivered in partnership	
OUR PRINCIPLES	
Working to provide care 'upstream' (seeking prevention and avoiding crisis)	
Focus care on patient goals and where appropriate, carer and family goals	
Building services around the patients' needs	
Championing quality in all its forms across all we do	
OUR WAYS OF WORKING	
Develop 'Accountable Care Systems' Locally • Put the patient at the centre of all commissioned services • Educate providers in accountable care system • Align workforces across health and social care • Explore new contracting options • Manage within a defined budget • Co-design with the public • Active support for self care, self management	
Enhance local professional networks	
Co-produce metrics with public, patients and providers	
Shape commissioning of services with partners	
OUR STRATEGIC OBJECTIVES	
Domain 1	**Preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long-term conditions**
Domain 3	**Helping people to recover from episodes of ill health or following injury**
Domain 4	**Ensuring that people have a positive experience of care**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
ORGANISATION WIDE OBJECTIVES	
Good Governance - We will be a well-governed and adaptable organisation - with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs.	
Value for money - We will ensure resources are directed to maximise benefit to make the best use of public money.	
Engagement - We will embed meaningful and sustainable patient and member practice engagement into CCG decision making processes.	
Better communication and sharing of information - We will develop strong partnership working with our local authority partners to achieve shared outcomes and will also develop communication material in an accessible format	

4.0 Strategic Context

4.1 Our two year Operational Plan has been developed within the context of the five year Strategic vision, as developed by the Connecting Care programme.

4.2 Our strategic vision and plans are ambitious and we will lead a programme of work to ensure that people within our local communities are empowered and supported to take responsibility for their own health and wellbeing. They will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on:

- integrated communities
- integrated case management
- integrated commissioning and
- Integrated enablers to support these new ways of working.

More details on this strategic context can be found within the full draft of the two year Operational Plan.

5.0 Access to Information

A copy of NHS South Cheshire CCG Draft Operational Plan, 2014-16 is attached. Other copies can be accessed by contacting the CCG directly via telephone on 01270 275391 or via email at joanne.vitta@nhs.net

If any reports are likely to contain confidential or sensitive information that should not be made available to the general public please contact Democratic Services for advice.

NHS
South Cheshire
Clinical Commissioning Group

Draft
2 Year Operational Plan
2014 - 2016

Submitted to NHS England – 14th February 2014

CCG Information Reader Box	
Document Purpose	For information
CCG Website Link	www.southcheshireccg.nhs.uk
Title	NHS South Cheshire Clinical Commissioning Group Year Operational Plan 2014-16
Author	NHS South Cheshire Clinical Commissioning Group
Publication Date	April 2014
Target Audience	NHS North of England, Local Area Team, CCG Shared Management Team, NHS Trust Chief Executives, Directors of Nursing, Local Authority Chief Executives, Councillors, NHS Trust Board Chairs, Directors of Commissioning, PPG Chairs, CCG Membership Council, GPs, Healthwatch
Circulation List	NHS North of England, Local Area Team, CCG Shared Management Team, NHS Trust Chief Executives, Directors of Nursing, Local Authority Chief Executives, Councillors, NHS Trust Board Chairs, Directors of Commissioning, PPG Chairs, CCG Membership Council, GPs, Healthwatch
Description	The 2 Year Operational Plan of NHS South Cheshire Clinical Commissioning Group outlines its Strategic objectives and commissioning intentions for the next 2 years and the approach to improving the health outcomes and quality of care for its population.
Action Required	N/A
Timing	N/A
Contact Details	NHS South Cheshire Clinical Commissioning Group Bevan House Barony Court Nantwich Cheshire CW5 5QU T: 01270 275283 F: 01270 618392 Email: nhssouthcheshire.ccg@nhs.uk
For recipients use	

Contents

Foreword

It is with great pleasure that I present the operational plan for NHS South Cheshire CCG.

No plan is perfect and we do not claim that this one will be different! However, we do believe we have made important changes to how we approach our role as commissioners. I hope that readers find this plan to be “workmanlike”, to be a sensible analysis of what needs to change in our health service and where priorities should lie. I sincerely hope that it is clear that this document draws on a passionate drive to understand and improve our health services whilst honestly acknowledging the difficulties within it and the difficulties that lie in changing it.

No plan is immune to change, nor should it be. However, we believe that the main pillars of this plan are those that our public and our partners will recognise and would wish to maintain and we look forward to working to improve the plan with them.

Lastly, no plan is ever complete. On one level this plan makes no attempt to be complete. To pretend to have every answer in the face the financial challenges we have and the nature and extent of the changes needed to overcome this would be dishonest. We need to acknowledge where there are difficulties, and work with people using health services, and our partners, to overcome these problems. More fundamentally it may feel incomplete because part of the plan is to hand more of the responsibility for design and redesign of health services to those that work day in, day out, in the frontline services and those who day in, day out use those services. This way of working is outlined in the plan, inherent is outcome based commissioning and the concepts of accountable care systems and explicit in our desire to introduce quality improvement methodologies as core, day-to-day roles for all workers. But this way of working means that details of every change that will be made is not in the plan, as it is not yet decided and will not be until the teams on the ground have been formed and start their work. This can feel uncomfortable to those used to commissioning in a different way. Our role becomes one of systems manager, specifying outcomes with our population, ensuring that the environment of payment, incentive and contracts are aligned and then facilitating, encouraging and challenging.

The challenge

No informed person would doubt the challenge faced by both our health and social care systems. Our population lives with increasingly complex health needs, coupled with continual advancement of care options, means that each year more and more can be done for more people and that more money is needed. However, more and more money is not available and continual improvements can only be funded largely from being more efficient.

Build Services around Patients/the Person

Such efficiency savings are possible by building services around patients and their most significant needs. Services have grown up divided into health and social care, into physical or mental health, divided by the organisation that delivers them and restricted in scope by referral criteria, specifications or the requirements laid down central funding streams. Good people, working hard in such systems often fail to meet the needs of those they are trying to help. The patient, with their needs unmet tries again, apparently driving up demand. Cutting out this ‘failure demand’ is possible, and doing so provides better services for less money.

Quality and Systems Improvement Methodologies

Quality improvement methodologies are well-established, from the work of Dr W Edwards Deming to the contemporary work of Professor Don Berwick at the National Institute for Health Improvement in the USA, to more local examples like the work undertaken at Royal Bolton Acute Trust under the leadership of David Fillingham. This body of work, applied carefully to healthcare systems, improves care and improves efficiency when it is in the hands of clinicians and managers working on the front line. Our ambition is to implement it widely throughout our care systems

However, our fragmented system with different organisations having different methods of payment, competing interests, different regulators and commissioners, lends itself poorly to applying these ways of working across organisations and the boundaries of care where much of the demand waste is generated.

Our Solution

Our plans essentially attempt to carve out a space, within our complex health and social care systems where services can be rebuilt with patients' needs at their centre and within which improvement methodology can be consistently applied to improve the quality and efficiency of what is delivered. In order to do this we wish to contract multiple organisations together to deliver a common set of patient outcomes with payment based on capitation. The work mirrors strongly the Programme budgeting approach advocated by the right care movement and Professor Muir Grey.

Accountable Care Systems and Accountable Care Teams - Commissioned for patient outcomes

We are calling each, 'carved out space' an 'Accountable Care System'. Each containing 'accountable care teams', responsible for delivering care on the ground to a defined population, but also the continuous improvement of the systems of care within which they work.

To oversee the improvement of care systems, professionals are brought together from across health and social care and different care organisations on 'Care Improvement Panels'. Such panels would, we propose, have strong patient representation and we would hope, local councillors representing their constituents. All members would be trained together in quality improvement methodologies. Via this mechanism the care teams become accountable to the users as Patient Accountable Care Teams.

We hope to restore professional pride in the delivery of the highest quality. We know that mastery, self-determination and the ability to deliver the best are strong motivators for health and social care workers, both clinicians and managers. If the clinicians role is to change to include a responsibility to improve the systems of care, then managers roles will need to change to one of facilitation for clinicians in their new role, their focus moving from the achievement of targets to understanding what patients need and helping clinicians deliver it.

Barbara Starfield and Principles of Efficient Healthcare

Barbara Starfield identified that health systems that contained strong primary care teams delivered: continuity of care, person and not disease centred care, a solution for all common problems and the coordination of care if more complex or specialist care was required, and so therefore provided higher quality and more cost-effective healthcare.

To build on this work, we wish to build our main 'accountable care teams' around primary care with a community focus and an explicit recognition of public health. We must work closely with

our local authority colleagues with whom we would wish to have significant joint commissioning of such care systems.

New Models of Care

We need to develop new models of care, moving away from the medical or nursing model towards more person centred integrated models of care that recognise the importance of patient goals, care, carers and self-care, shared decision-making, health coaching, motivational support and move towards true partnerships with those who use services. We must recognise that sometimes, quite often, our population's plea is "help me" not "fix me" but that we work in a system primarily designed to fix, where help can be an afterthought or missing altogether. Our new models must include a wider perspective, to include social elements and an understanding of the wider determinants of health.

By delivering these efficiencies we safeguard the quality and availability of the highest tech, most specialist services that we all wish to see available to us. When the plea is "fix me", we want that fix to be as effective, complete and timely as is possible. In other regards we wish to see more flexible specialist care, better able to support the work of the 'accountable care teams' and again more focused on patient goals. The principle of accountable care and service improvement methodologies can also be applied here and should be!

I am very aware that not every section of the plan that is presented contains every aspect of these new ways of working and that not everything needed to deliver this new way is in this 2 year operational plan but will need to be developed in future plans.

I hope that our focus on improving outcomes and on establishing changes that support a major shift in care delivery for the better can already be seen.

Dr Andrew Wilson,
GP Chair NHS South Cheshire CCG

Vision: To maximise health and wellbeing and minimise health inequalities, informed by local voices and delivered in partnership

Strategic Objectives

5 outcome domains

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

+ 7 outcome measures

+ Improving health, reducing health inequalities, parity of esteem

Delivering Transformational Service Models

- New approach to ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Access

- Convenient for everyone
- NHS Constitution

Quality

- Francis/Berwick
- Patient Safety
- Compassion in Practice
- Staff Satisfaction
- Seven Day working
- Safeguarding

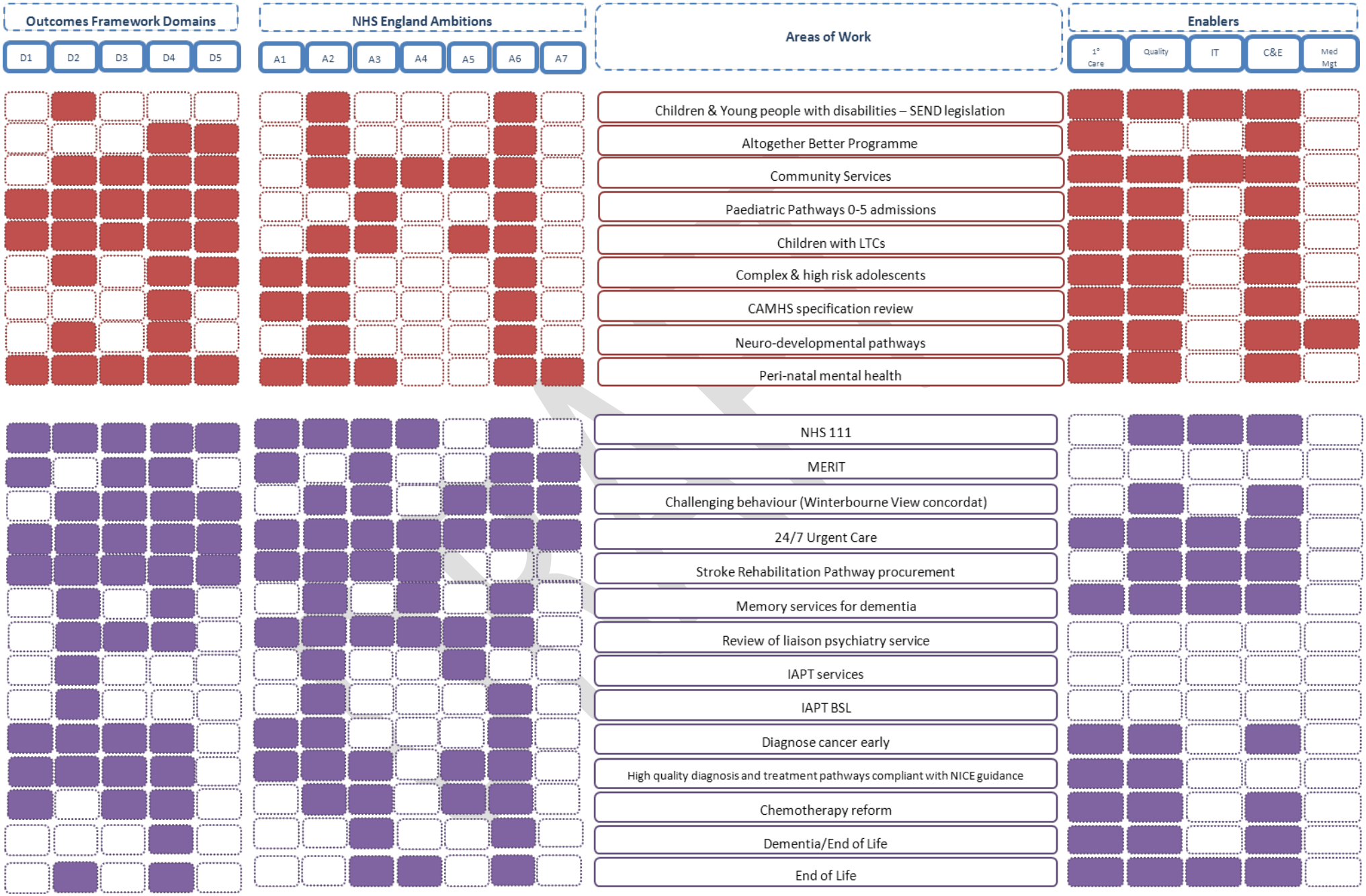
Innovation

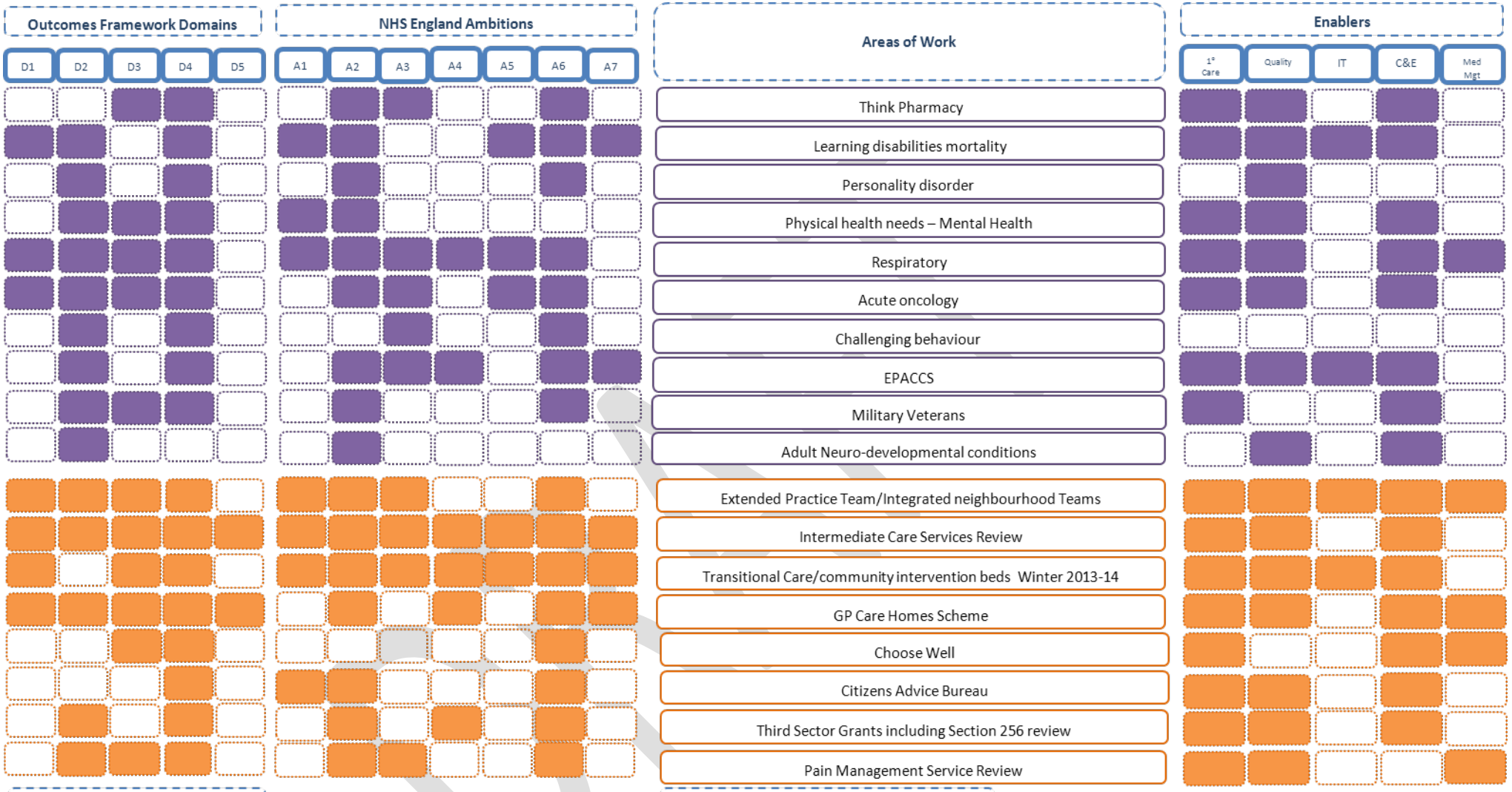
- Supporting our staff to innovate
- Research

Value

- Value for money
- Effectiveness
- Efficiency
- Procurement

Commissioning for Transformation (with Clinical Leadership)


Outcomes Framework Domains
D1
D2
D3
D4
D5
NHS England Ambitions
A1
A2
A3
A4
A5
A6
A7
Areas of Work
Enablers
1° Care
Quality
IT
C&E
Med Mgt
Children & Young people with disabilities – SEND legislation
Altogether Better Programme
Community Services
Paediatric Pathways 0-5 admissions
Children with LTCs
Complex & high risk adolescents
CAMHS specification review
Neuro-developmental pathways
Peri-natal mental health
NHS 111
MERIT
Challenging behaviour (Winterbourne View concordat)
24/7 Urgent Care
Stroke Rehabilitation Pathway procurement
Memory services for dementia
Review of liaison psychiatry service
IAPT services
IAPT BSL
Diagnose cancer early
High quality diagnosis and treatment pathways compliant with NICE guidance
Chemotherapy reform
Dementia/End of Life
End of Life



Outcomes Framework Domains	
D1	Prevent people from dying prematurely
D2	People with long term conditions have the best possible quality of life
D3	Patients are able to recover quickly and successfully from episodes of ill health & injury
D4	Patients have a positive experience of care
D5	Patients in our care are kept safe and protected from all avoidable harm

NHS England Ambitions	
A1	Securing additional years of life for people with treatable mental and physical health conditions
A2	Improving the health related quality of life for people with long term conditions, including mental health conditions
A3	Reducing the amount of time people spend avoidably in hospital through better, more integrated care in the community
A4	Increasing the proportion of older people living independently at home following discharge from hospital
A5	Increasing the number if people having a positive experience of hospital care
A6	Increasing the number of people with mental & physical health conditions having a positive experience of care outside hospital, in general practice & in the community
A7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

1. Introduction

The publication of *The NHS belongs to the people – a call to action*[1] in July 2013 began a national discussion about the major transformational change that is required to ensure that the NHS responds to increasing pressures such as an ageing population, increasing prevalence of long term conditions, and rising healthcare costs. *A Call to Action* outlines the 'case for change' across the system and called on the public to get involved in shaping the future of their NHS service.

Given the scale of the challenges we are facing within the NHS, we are moving away from incremental one year planning and instead developing bold and ambitious plans which cover the next five years, with the first two years mapped out in the form of this detailed operating plan.

As a CCG we will work with local NHS Trusts and local government organisations to identify and communicate the larger footprint strategy within which they will sit. This will inform the five year strategic plan. As CCG sizes, and local configurations differ, a larger unit of planning is required for the development of consistent and integrated long-term strategic plans**.** As a CCG our strategic planning will take a PAN-Cheshire approach, aligning to our main priorities regarding the integration of health and social care.

As a CCG, we see this as crucial to enabling us to take a longer term, strategic perspective of the direction of travel across the health and social care landscape. We must develop and implement bold and transformative long-term strategies and plans to enable us to be financially sustainable and uphold safety and quality of patient care.

Our two year operational plan is intended to inform local people, partners and staff about the healthcare services that will be commissioned during 2014-16 on behalf of the population (173,000) covered by NHS South Cheshire Clinical Commissioning Group (CCG).

Underpinning the large amount of work represented in this plan is the CCGs commitment to ensure that our population receives high quality healthcare.

Whilst each of the areas highlighted in this plan are important we always need to decide on the areas that we are going to focus on as a priority. We endeavour to do this in a transparent manner, involving patients, carers, local people, clinicians, voluntary organisations, local authorities and other interested parties.

It is important that the CCG is seen as a responsive organisation that listens and takes into account a wide range of perspectives but at the same time keeps its core principles central to commissioning decisions, valuing:

- self-care;
- carers;
- quality of personal care;
- The family, community, voluntary and informal care structures.

We are committed to help improve the general health of the population, reduce health inequalities, ensure equitable access to healthcare and to work with our partners on the Health and Wellbeing Board and providers of care so that patients are treated with dignity and respect at all times.

[1] *The NHS belongs to the people: a Call to action*, July 2013, NHS England

At the heart of our work as a clinically led commissioning organisation is the focus on **improving outcomes for our patients**. We have therefore focussed our key actions on each of the 5 Domains of the NHS Outcomes Framework. Indeed these domains have now become our strategic objectives for 2014-16. We have identified local levels of ambition, based on evidence of local patient and public benefit, against a common set of indicators that place our duty to tackle health inequalities front and centre stage. This will ensure that we can clearly articulate the improvements we are aiming to deliver for patients across the 5 key areas:

Poorly Coordinated Care It surprises many people to discover that a very small portion of the UK population — approximately 5 per cent — accounts for nearly half of total spending on health care, while 20 per cent accounts for four-fifths of total spending. This relatively small slice of the population incurs such high costs because most of these individuals have complex medical problems. The problems include common but difficult-to-manage chronic diseases like diabetes and heart failure, as well as mental and behavioural health issues. Chronically ill people take more prescription drugs, undergo more tests and procedures, and are hospitalised more often than people in good health.

But the costs for these patients increase dramatically when the care they receive is poorly coordinated i.e. when patients are referred by their GP to a specialist; move in and out of the hospital; and transition from the hospital to home care or a long-term care facility, often with poor oversight or communication between providers. Patients may undergo the same lab tests multiple times, they may get the wrong combination of medications, and serious conditions may get misdiagnosed. This not only leads to unnecessarily high costs but it also means poor care for the patients who most need help.

Avoidable Hospital Readmissions One in five elderly patients discharged from hospitals in the UK ends up being readmitted within 30 days. Many of these readmissions could be prevented if hospitals, doctors, and community health programme worked together to assist patients who are returning home, moving on to a nursing home or rehabilitation facility. Discharged patients need clear instructions on how to care for themselves at home, as well as help in scheduling and keeping follow-up appointments, sticking to a prescribed medication plan, and making necessary lifestyle changes.

The failure to provide genuine integrated care leaves most patients who suffer from long-term conditions with a patient pathway with gaps and frequent duplication of care. The experience for the patient is, in some cases, so disjointed that the term 'pathway' cannot be applied in any real sense. It is the gaps in most patient pathways that lead to many of the health exacerbations that in turn lead to hospital beds that are filled with unnecessary emergencies. Therefore, one of the unplanned and unintended outcomes from this episodic approach to the patient experience is many more and longer stays in hospital.

If we are to construct a patient centred future for the NHS, it will have to deliver genuinely integrated care, based around both the needs of patient groups (for example the frail elderly or children/adults with complex disabilities) and also based around the personal needs of individual patients within those groups.

If we are to construct a sustainable future for the NHS, it will have to deliver genuinely integrated care, which provides powerful incentives to keep patients at home and out of hospital.

To that end, the entire Health and Social Care Bill was amended to put a duty on all NHS bodies to promote integrated care.

However, there are only a few examples of this policy being put into practice. If we look at the delivery of most care to most NHS patients, in most parts of the country, for most conditions, it remains traditional episodic and fragmented care.

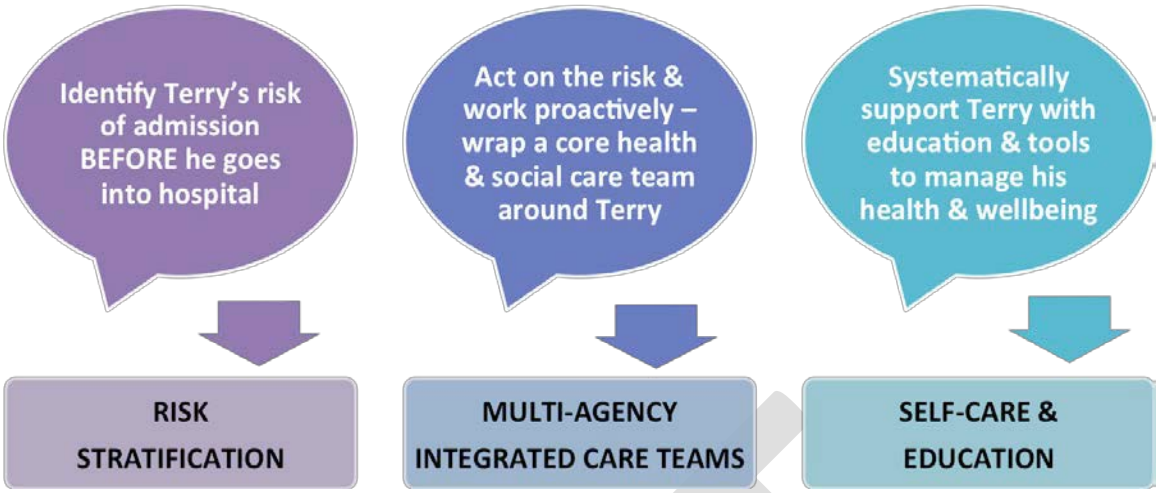
Outcome-based contracts for integrated care with an Accountable Lead Provider This is a different process from the traditional input/activity based contract that has been at the core of NHS commissioning. To get to a health care system that's affordable yet provides high quality, we need to tackle the issues that have made things so expensive in the first place. It is the inefficiencies within the system as a whole that drive up fragmentation, and subsequently, cost.

Accountable care systems - A new language is starting to emerge around outcomes and about population health in its entirety. This is the language describing both delivering and paying for patient care that is starting to take hold slowly. Typically, an accountable care system is a partnership between commissioners and a group of providers—primary care clinicians, community services, hospitals, specialists, rehabilitation centres, mental health services, social care and long-term care facilities - that agree to share responsibility, and sometimes the financial risk, for delivering quality health care to a population of patients.

The accountable care system receives a payment through an outcomes based contract that covers the cost of providing all the care needed by these patients. In addition, the 'system' providers get to share in the savings if they meet cost and quality targets for their patients. On the flip side, providers that participate also agree to accept penalties if they go over budget or fail to deliver a quality service.

We know for certain that more spending does not translate into better care or a better-functioning health care system!

So what does all this mean locally? Some of our really key programmes of work (community health services, Extended Practice Teams, urgent care review) are moving in a direction that starts to develop this system approach. The example below demonstrates the point:



To support this direction of travel and respond to the very real cultural challenges, it is important to develop system improvement education and training across all staff working in health and social care.

2. Who are we?

NHS South Cheshire Clinical Commissioning Group exists to improve the health and healthcare of the local population. Our aim is to use the local knowledge of our GPs and their Practice teams to develop the way that health services are delivered and help our patients to make full use of the services that are available.

NHS South Cheshire Clinical Commissioning Group comprises of 18 member practices. They cover a geographical area of Cheshire stretching from Nantwich in the south to Middlewich in the north. Crewe is the largest manufacturing town and much of the surrounding area is made up of smaller, rural market towns. The total registered population is 173,000,

The South Cheshire area falls entirely within the boundary of Cheshire East Council.

Close relationships exist between ourselves and NHS Vale Royal CCG, with whom we share a management team. We also working closely with NHS Eastern Cheshire CCG which lies to the east of our patch and with whom we share community health services and the Local Authority.

The acute general hospital, our main provider, is Mid Cheshire Hospital Foundation Trust (MCHFT), which is situated just outside Crewe. Mental health services are provided by Cheshire and Wirral Partnership Trust and East Cheshire Community Business Unit, which forms part of East Cheshire NHS Trust, provides community health services, such as district nursing, health visiting and therapy services

We have responsibility for designing and commissioning local health services and will do this by commissioning or buying health and care services including:

- Elective hospital care
- Rehabilitation care
- Urgent and emergency care
- Most community health services
- Mental health and learning disability services

We work with patients and healthcare professionals and in partnership with local communities and local authorities. On our Governing Body, in addition to GPs, we have a registered nurse and a doctor who is a secondary care specialist. We are responsible for arranging emergency and urgent care services within our boundaries, and for commissioning services for any unregistered patients who live in our area. All GP practices have to belong to a Clinical Commissioning Group.

Commissioning Support

South Cheshire CCG receives Commissioning Support Services from Cheshire and Merseyside CSU. (CMCSU) Commissioning Support Units were set up as part of the recent Health and Social Care reforms to support CCGs and NHS England in undertaking their commissioning responsibilities and delivering the best possible outcomes for Patients.

The CCG works with the CSU as a key partner. There is a Service Level Agreement established between the CCGs and the CSU to manage the quality of the services that the CSU provides. The services that are provided to the CCG are:

- Technology Support (Information and Communication Technology)

- Business Intelligence and Data Management
- Process Centre and Governance Support (Management of Incidents, Complaints, Individual Funding Requests, Freedom of Information, Information Governance, Compliance and Assurance Claims)
- Communications Support including graphic and digital design
- Human Resources Support
- Organisational Design Support
- Procurement advice and guidance
- Continuing Healthcare, Complex Care and Clinical Quality

This support is developed through a locality model so that CCG services can be understood and accessed locally. Each of these functions has a locality lead that is situated within the South Cheshire CCG team. This partnership approach has been enhanced during 2013/14 by the CCG and CSU sharing office space at Bevan House in Nantwich.

3. Our Vision and Strategic Objectives

To maximise health and wellbeing and minimise health inequalities, informed by local voices and delivered in partnership

We believe that the overarching priority for the CCG is to improve quality of care and health outcomes for patients. Therefore we have set the five domains of the NHS Outcomes Framework as our key Strategic Objectives. All our programmes of work and projects must align to each of the 5 Domains.

OUR VISION	
To maximise health and wellbeing and minimise health inequalities, informed by local voices and delivered in partnership	
OUR PRINCIPLES	
Working to provide care 'upstream' (seeking prevention and avoiding crisis)	
Focus care on patient goals and where appropriate, carer and family goals	
Building services around the patients' needs	
Championing quality in all its forms across all we do	
OUR WAYS OF WORKING	
Develop 'Accountable Care Systems' Locally • Put the patient at the centre of all commissioned services • Educate providers in accountable care system • Align workforces across health and social care • Explore new contracting options • Manage within a defined budget • Co-design with the public • Active support for self care, self management	
Enhance local professional networks	
Co-produce metrics with public, patients and providers	
Shape commissioning of services with partners	
OUR STRATEGIC OBJECTIVES	
Domain 1	**Preventing people from dying prematurely**
Domain 2	**Enhancing quality of life for people with long-term conditions**
Domain 3	**Helping people to recover from episodes of ill health or following injury**
Domain 4	**Ensuring that people have a positive experience of care**
Domain 5	**Treating and caring for people in a safe environment and protecting them from avoidable harm**
ORGANISATION WIDE OBJECTIVES	
Good Governance - We will be a well-governed and adaptable organisation - with high standards of assurance, responsive to members and stakeholders in transforming services to meet future needs.	
Value for money - We will ensure resources are directed to maximise benefit to make the best use of public money.	
Engagement - We will embed meaningful and sustainable patient and member practice engagement into CCG decision making processes.	
Better communication and sharing of information - We will develop strong partnership working with our local authority partners to achieve shared outcomes and will also develop communication material in an accessible format	

4. Central Cheshire Connecting Care - Our 5 Year Strategy (A Modern Model of Integrated Care)

Integration and Pioneer Status in Cheshire

It is widely accepted that there is a need to commission integrated care or, as patients and their carers would more likely call it, “joined up care”. The current model of care for patients is often a fragmented and disjointed one. It is driven by the fact that contracts, and an increasing drive towards specialism, means that organisational priorities can take preference over the needs of the patient.

At the same time, we have a health and social care system that is unaffordable in the current climate. The ageing population means that demand for healthcare services will continue to increase. The current ‘episodic’ nature of care provision does not really meet the patients’ needs. Whilst individually patients and service users will often praise the service that they received at a specific time, there is an increasing theme “being heard” around improving the overall experience.

Nationally the need to improve the **integration of services** has been recognised and **there is a need for radical transformational change in the health and social care system,** because the money that is available to meet the increasing health and social care needs of our population is not sustainable. Therefore we have to change what we are doing quickly before we can no longer afford healthcare for the population of South Cheshire. However this will not be easy and moving to a more coordinated system for patients whilst delivering control in the current system will be very challenging.

In an attempt to try and learn more about this very real challenge nationally and assist in the delivery of transformational changes, implementation of new integrated care delivery models and new contracting models, it was agreed that some geographic areas should be supported to lead the way and go faster and for other areas to learn from them. Hence the national **‘Pioneers for Integrated Care’** programme was launched. The Government, NHS England, Monitor and the Local Government Association along with others, launched this initiative and asked for local areas to apply to become a ‘Pioneer Site’.

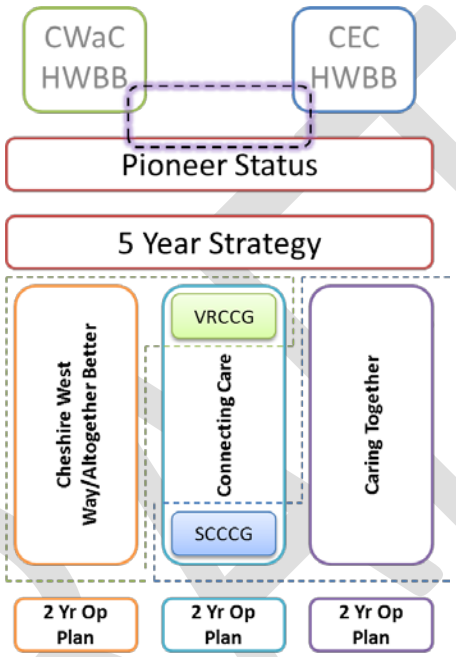
At a local level this was something that we were really interested in. A submission was therefore made that covered both the Health & Well Being Board areas (one Health & Well Being Board for each Local Authority in Cheshire) and the 4 Cheshire CCGs (NHS South Cheshire, NHS Vale Royal, NHS Western Cheshire & NHS Eastern Cheshire). The application that was submitted was about recognising the 3 communities that exist in Cheshire and that the Pioneer Proposal would provide an overarching umbrella across these 3 communities. The local communities are important as they reflect patient flow and primary care provision.

The strong history of partnership working in Cheshire was a key strength contributing to our success with our Cheshire wide partners in becoming one of the fourteen national ‘Integration Pioneer’ sites.

Whilst the Pioneer proposal responds to the local challenges, it really focusses on the key themes being heard from patients about their overall experience:

- Being asked the same questions over and over again
- Spending time ‘hanging’ between bits of the service
- Having lots of people involved in their health care but not being really sure who is responsible for what and who is overall charge of their care
- Not really knowing what is going on
- ‘Falling through the gaps’

Across the South Cheshire and Vale Royal footprint we have established a Partnership Board for our **Connecting Care Programme**. This Board has representation from commissioners (both CCGs, both Local Authorities & NHS England), and our main providers (Mid Cheshire Hospital Foundation Trust, East Cheshire Trust for community services, Cheshire and Wirral Partnership NHS Foundation Trust, North West Ambulance Service and Primary Care). It has the Chief Executive, Medical Director and/or lead Executive Director from all of these organisations sitting on it. The commitment to the Connecting Care Board is strong and the recent announcement that we are one of the Pioneer sites has helped to bring a real focus and energy to its work.



We are committed to delivering the National Voices narrative below:

For the individual:

'I can plan care with people who work together to understand me and my carer/s, allow me control and bring together services to achieve the outcomes important to me'.

(National Voices & Making it Real)

Ours plans are ambitious and we will lead a programme of work to ensure that people within our local communities are empowered and supported to take responsibility for their own health and wellbeing. They will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on:

- integrated communities
- integrated case management
- integrated commissioning and
- Integrated enablers to support these new ways of working.

Integration (Connecting Care) and the Better Care Fund

We will only make good progress and improve 'joined up care' if we invest in services that help reduce the demand on secondary care. These services need to be community based and not just limited to health. Primary care, social care and community services are all needed to deliver care in a more coordinated manner if we are to tackle the rising secondary care demand.

To support health and social care organisations to work more closely in local areas and to facilitate shared funding models, for 2014/15 a national 'Better Care Fund' (BCF) has been created. The fund has been created through the movement of existing grants and resources and it mandates the pooling of funds *across health and social care that will fully come into effect in 2015/16*. We will utilise this pooled fund to create a significant opportunity to transform the way that services are commissioning and delivered jointly across health and social care to support improved outcomes for our local populations. BCF truly supports the local impetus of our Connecting Care Programme.

The 2 Health and Wellbeing Boards within Cheshire are leading this transformational change through a large-scale change programme with support from the national pioneer team. The Cheshire wide pioneer footprint encompasses a range of shared commitments and the following 3 core components based on local populations:

- Central Cheshire (South Cheshire and Vale Royal) 'Connecting Care' programme
- East Cheshire 'Caring Together' programme
- West Cheshire 'The West Cheshire Way'/'Altogether Better'.

Our Connecting Care Vision is **"to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing".**

To secure this vision, the Cheshire partners have given organisational and personal commitment to transform the health and social care system by:

- Working much more closely together and in smarter ways to provide reliably, and without error, all the care that will help people and ONLY the care that will help
    - Putting the individual at the centre of all care – 'no decision about me, without me', improving their experience of care
    - Assure quality by employing high quality, well trained staff with strong leadership and development skills
    - Focusing on the multiple determinants of both physical and mental ill-health and creating innovative solutions across partners
    - Creating more opportunities for and embedding cross organisational working that reduces duplication and achieves the best use of available resources
    - Adding value to the lives of individuals and their families/carers and decommissioning care that does not add value
    - Exploiting the use of new technologies to support independence, self-care and information sharing across partner organisations

- Building and strengthening community based services and support
    - More care will be organised and delivered outside of traditional hospital settings, in local communities with closer collaboration across teams

- People will access services differently:
  - with GP practices/Extended Practice Teams teams and community services delivering care and support 'closer to home'
  - with a smaller, more flexible community facing hospital delivering emergency and specialist care and
  - regional specialist hospitals continuing to deliver specialist care, some of which will be in the community setting
- Traditional 5 day per week community services will be extended to offer support when needed, 7 days per week
- Care and support will be personalised, timely, responsive and seamless

- Developing our workforce and community assets to deliver new ways of working

  - Empowering individuals at a local level to lead change and problem solve with full support from their colleagues
  - Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
  - Offering education and training programmes tailored locally to support the implementation of new ways of working, self-care, local leadership, change management and quality improvement approaches. We are exploring a local academy approach to this programme.
  - The most effective use is made of resources across health and social care, involving partnership working, joint commissioning, sharing of information, new contracting and funding approaches, exploiting new technologies and avoiding waste and unnecessary duplication. Again continuous quality improvement approaches are critical to this success.

A Strategy for Transformation

A strategy of 7 key integration health and social care outcomes have been established to ensure that all work stream activity and work plans are outcomes focused and driven. A large number of composite work plans are being delivered, or are in development, to achieve our integration outcomes and these are described within our programmes of work later in this document.

The table below provides a summary of the Connecting Care Board priorities aligned to the '7 Integration Health and Social Care outcomes' framework.

National Health And Social Care Outcomes Framework	Local Connecting Care Programme Board Priorities
Communities that promote and support healthier living	Individuals and communities are able, motivated to and supported to look after and improve their health and wellbeing, resulting in more people being in good health or their best possible health for longer with reduced health inequalities.
Personalised care that supports self-management and independence and enhances quality of life	People with physical or mental Long Term Conditions, those with complex needs and the elderly frail are able to live as safely and independently as possible in the community. They will plan care with people who work together to achieve the outcomes important to them. Care will have a focus on prevention, self-management and independence and the individual will have control over their care and support.
Individuals will have positive experiences and outcomes	People have positive experiences of health, social care and support services, which help to maintain and improve their own health and wellbeing
Carers are supported	People who provide unpaid care for others are supported, are consulted in decisions about the person they care for and they are able to maintain their own health and well-being and achieve quality of life
Services are safe	People using health, social care and support services feel safe and secure, are safe-guarded from harm, have their dignity and human rights respected and are supported to plan ahead and have the freedom to manage risks the way that they wish
Empowered and engaged workforce and public	People who work in health, social care and community support/voluntary sector support are positive about their role, are supported to improve the care and support they provide and are empowered at a local level to lead change and develop new ways of working through continuous quality improvement approaches. Citizens are engaged in the shaping and development of health and care services and supported to make positive choices about their own health and wellbeing.
Effective resource use	The most effective use is made of resources across health and social care, involving partnership working, joint commissioning, sharing of information, new contracting and funding approaches, exploiting new technologies and avoiding waste and unnecessary duplication.

Joint Commissioning and Partnership Working

SCCCG, ECCCG and CEC have established shared priorities for joint work over the next 2 years. These shared priorities support the Connecting Care transformational strategy and some will also form part of the Better Care Funding arrangements.

The priorities cover children, adults and older people age groups with each commissioner organisation having taken part in a prioritisation process.

The priorities are:

- Early Help for Children – integration of children's workforces (health, education, social care and VCFS)
- Domestic abuse
- Community Services including Extended Practice Teams
- Urgent Care/ Rapid Response/ Community Intervention/ Transitional/ Intermediate Care Services as an alternative to hospital/ acute care
- Community based stroke and rehabilitation services
- Dementia - early detection, diagnosis and support services
- CAHMS and transition to adult services
- Primary mental health - early detection, diagnosis and support services
- Supported self management of people with long term conditions including shared risk profiling for early detection.

Special Educational Needs (SEN)

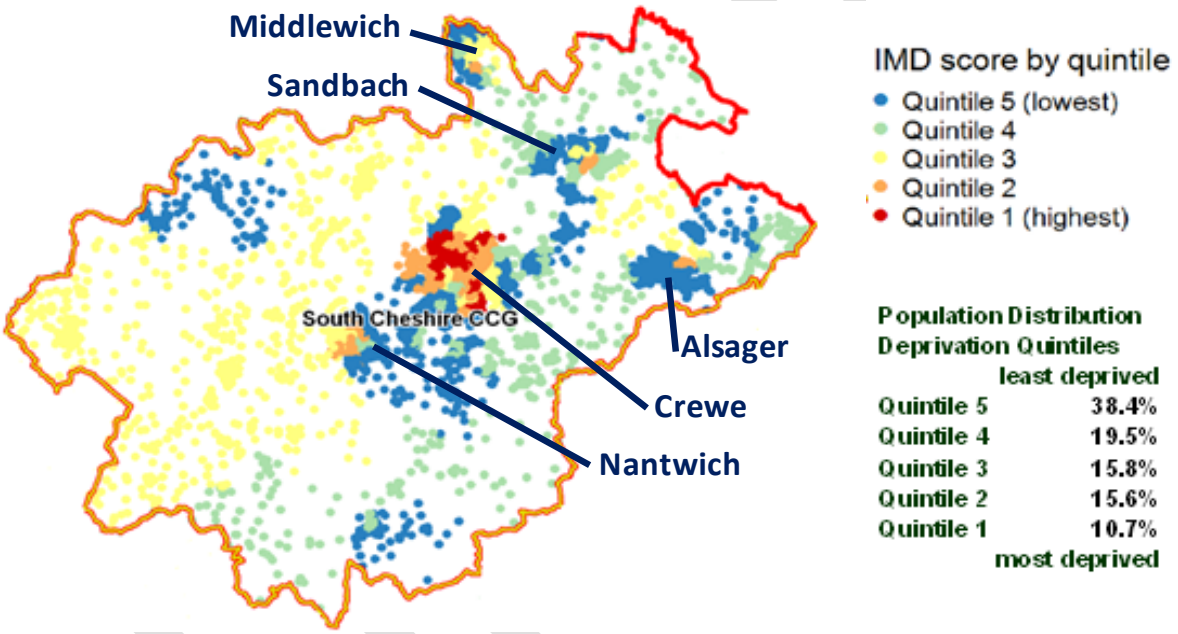
National changes through the Children and Families Bill 2013 are extending the support for young people up to the age of 25 with Special Educational Needs (SEN). These children and young people will have an education, health and care plan (EHC) that will support them outside of school age into further education and apprenticeships up to 25 years old. Parents and the young person will be more equal in the plan and potentially personal health budgets will be applicable in some cases. The CCG will need to work closely with Cheshire East Council to ensure a seamless transition into the new system.

The changes to the commissioning of services has meant that some services that support children with SEN are now shared between the Public Health team within the council (school nursing) and special school support services – nursing and therapy services which is the CCGs responsibility. SCCCG is working closely with CEC through the Joint Commissioning Leadership Team to ensure joint commissioning of services is seamless and delivers targeted services with better health outcomes to children and young people with SEN. The CCG is undertaking a review of all community services as commissioned through East Cheshire Trust (ECT) which currently includes the SEN support services through 2014-15.

5. Overview of Health Needs and Health Inequalities in South Cheshire

Around 10.7% of South Cheshire CCG's population live in small areas (LSOAs) that are among the 20% most deprived areas in England. A further 15.6% live in the next most deprived fifth of areas in England. The map colours individual postcodes to illustrate geographical variations in deprivation. The areas of solid colour represent the towns, while areas with white spacing represent rural villages and rural communities. It shows that:

- Large parts of Crewe town are very deprived
- Each of the four other main towns contain some deprived areas
- All of the five main towns have a mix of very affluent areas as well as deprived areas
- There is rural deprivation to the west and north of Nantwich, and from Sandbach to Alsager



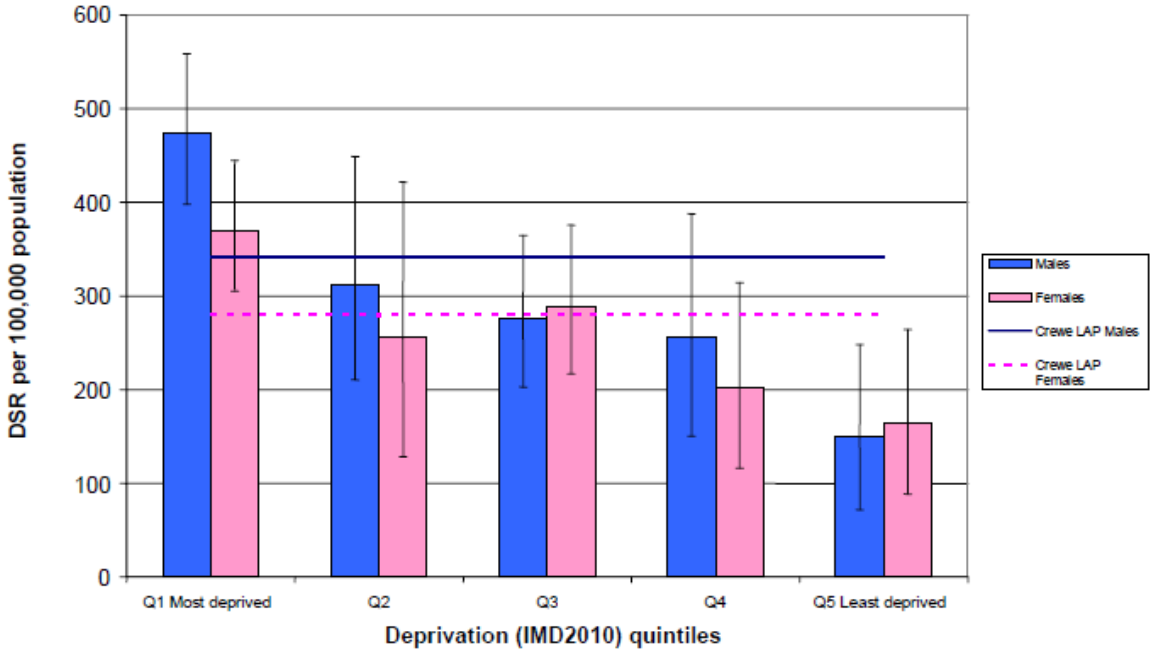
The Annual Report of the Director of Public Health has highlighted the stark difference that living in deprivation makes to premature death, with a twofold difference in death rates between the most deprived and least deprived areas in South Cheshire CCG. The Joint Strategic Needs Assessment shows that there are similar differences in the occurrence of many acute and chronic diseases, and also in many of the lifestyle factors that are known to cause disease in both children and adults.

Within the area of the Crewe Local Area Partnership, there is a clear pattern of higher premature death rates among people experiencing higher levels of deprivation, whereas those who are less deprived have better health and a reduced risk of dying prematurely. The significantly worse health outcomes experienced by the people of Crewe adversely affect the average premature mortality rates for South Cheshire CCG, and also for Cheshire East Borough Council as a whole.

The local variations are multi-factorial but are due in part to the health experience of people living in

socioeconomically deprived areas. Local levels of socioeconomic deprivation affect early death rates in several possible ways. These include the health effects of material deprivation (e.g. through poorer housing, education and income), higher prevalence of harmful lifestyle behaviours (e.g. smoking and alcohol) and possibly reduced access to good quality healthcare.

Directly Standardised Mortality Rates for All causes by deprivation quintile, Crewe LAP, aged under 75, Males & Females, 2009-11 provisional (using Mid2011 population estimates)



Where differences in health exist, are measured, deemed to be inappropriate, and can be reduced through the actions of GP practices or the CCG (either working alone or with partners), South Cheshire CCG can help to ensure that actions are targeted to all areas at a level that is appropriate to their needs. In so doing we will achieve maximum health gains within the available resources.

Some of the areas that can be used for targeting initiatives in South Cheshire CCG include:

- 25 electoral wards with an average population size of 6,800
- 24 middle level super output areas (MSOAs) with an average population size of 7,100
- 109 lower level super output areas (LSOAs) with an average population size of 1,600
- 18 general practices with an average population size of 9,500

Although many interventions will focus on populations defined by GP practices and/or the super output areas, we recognise the importance of ward level action and the role of elected Councillors as a force for change locally within the wards they represent.

As already stated, the main towns across SCCCG have communities that are affected by deprivation. Some areas of Crewe are in the 20% most deprived areas in England, and people's lives are up to nine years shorter than in other parts of the town. The main causes of premature death in these areas are cancer, heart disease, stroke, respiratory and liver disease.

Unhealthy lifestyles and harmful environments can lead to adverse health effects at each stage of people's lives. Tobacco smoke is a major risk factor for poor health, and 25% of pregnant women in Crewe still smoke. In addition to the significant health hazards to babies and young children from being exposed to cigarette smoke, teenagers are at higher risk of becoming smokers if they live in a smoking household.

In some areas of Crewe around a third of adults are smokers. These areas also have the highest rates of children admitted to hospital with respiratory problems. Most chronic respiratory disease in childhood is caused by repeated exposure to cigarette smoke, and the CCG has over 1,120 children with chronic respiratory disease. Preventing respiratory ill-health in future generations of children is a key health need and one of our local priorities.

General practices in the CCG provide care for over 40,000 patients with a chronic health condition, including 1,500 children. People with mental health problems have important but often hidden needs, and there are over 20,000 patients in the CCG with a history of depression, about forty percent higher than expected.

There are high rates of excess mortality among adults with serious mental illness in Cheshire East. The risk of death in this group of people is over four times higher than in the general population. They need better detection and management of their risk factors by general practices working in partnership with local mental health services. Addressing mental illness is a key health need and one of our local priorities.

Crewe has higher than average cancer death rates among both men and women, and in this town there are fewer than expected numbers of people who have survived cancer. This may relate to lung, upper gastrointestinal and colorectal cancers. The priority actions for the CCG (in conjunction with Cheshire East Council and other partners) are to increase colorectal, breast and cervical screening, increase public awareness of cancer symptoms, encourage people to present early with symptoms to general practitioners, and strengthen specialist cancer referrals from general practices.

The CCG's registered population of 173,200 people is forecast to increase by 0.6% annually to 177,400 by 2015, and to 183,000 by 2020. In NHS South Cheshire CCG the increase in the number of people over 75 will be around fifty percent higher than is occurring nationally, increasing by 3.6% annually from 13,700 to 18,800 in 2020.

Ageing populations have additional health and social care needs, and more people require support to remain independent and live at home. Some older people develop disabling sensory impairments including loss of hearing and loss of vision. Others may suffer from multiple chronic conditions. The number of people with dementia is increasing in our CCG, although more slowly than anticipated. In 2009/10, there were 925 people with dementia, which rose to 945 in 2010/11 and 984 in 2011/12. As fewer than 50% of patients with dementia are believed to be known to general practices, unrecognised dementia is becoming an important health need locally.

6. Delivering Improved Outcomes (and Ambitions)

6.1. Domains and Ambitions

The 5 year strategic plan has been developed across organisational boundaries including the local authority, NHS provider Trusts and our neighbouring CCG's. This approach allows us to develop consistent and integrated long term strategic plan.

This two year Operational plan maps out how we will evolve and deliver this strategy. It has been developed within the context of the NHS Outcomes Framework, the NHS Constitution and the Mandate set between the Department of Health and the NHS Commissioning Board:

The overarching priority for Clinical Commissioning Groups is to improve quality of care and the outcomes for patients. Key to delivering this is ensuring our plans are aligned to the five domains of the NHS Outcomes Framework, which NHS South Cheshire CCG have adopted as their main Strategic Objectives in order to remain focused on commissioning for improved outcomes

A CCG Outcomes Indicator Set (set within and including the NHS Outcomes Framework indicators) has been developed to provide clear, comparative information for CCGs, Health and Wellbeing Boards, local authorities and patients and the public about the quality of health services commissioned by CCGs and the associated health outcomes.

NHS South Cheshire CCG has used the CCG Outcomes Indicator Set to help identify local priorities for quality improvement. They will also help contribute to deliver improved outcomes across the five domains of the NHS Outcomes Framework.

Tackling health inequalities and being focused on advancing equality has also been a key component for the CCG in developing its Commissioning Intentions for 2014-16. Each of the 5 domains will address inequalities so that those most in need have the most to gain from the interventions we make.

What will success look like for NHS South Cheshire CCG:

The NHS Outcomes Framework 2014/16 sets out the outcomes and corresponding indicators that are used to hold NHS South Cheshire CCG to account for improvements in health and wellbeing. The Framework describes the five main categories (domains) of better outcomes NHS South Cheshire CCG aspires to deliver. To transform these five outcomes into measurable goals, NHS South Cheshire CCG will also target action against the seven Ambitions defined by NHS ENGLAND:

DOMAIN	OUTCOME(s)	NHS ENGLAND AMBITIONS(S)
1	•Prevent people from dying prematurely	i •Securing additional years of life for people with treatable mental and physical health conditions
2	•People with Long Term Conditions (including mental illness) have the best possible quality of life	ii •Improving the health related quality of life for people with long term conditions, including mental health conditions
3	•Patients are able to recover quickly and successfully from episodes of ill-health and injury	iii •Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
4	•Patient have a positive experience of care	iv •Increasing the proportion of older people living independently at home following discharge from hospital
5	•Patient in our care are kept safe and protected from all avoidable harm	v •Increasing the number of people having a positive experience of hospital care
		vi •Increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
		vii •Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

In developing our two year operational plan we have worked with our partners on the Health and Wellbeing Board, our provider organisations and the voluntary sector to consider the key challenges that together we need to address to make a real difference to the health and wellbeing of our communities over the coming years. Therefore during 2014-16 we aim to deliver a number of key ***Commissioning Intentions***; all of which deliver key outcomes across the five NHS Outcome Domains (CCG Strategic Objectives) and key ambitions.

Our Commissioning Intentions are aligned under three Strategic Programmes for NHS South Cheshire:

Starting Well **Living Well** **Ageing Well**

These programmes also have to deliver work that we call 'business as usual' which is core business around performance, contract management, risk management, quality improvement and assurance and financial probity. They also undertake partnership commissioning alongside other CCGs, local authorities and NHS England. This programme approach brings clarity to our work and projects and aligns with our Joint Health and Wellbeing Strategy. As members of the Health and Wellbeing Board with Cheshire East Council we have identified a set of joint priorities that we will address to make a real difference to the health and wellbeing of our community:

- Integration of teams (Extended Practice Teams)
- Integration of systems
- Joint Carers Strategy
- Joint equipment services
- Prevention work with children and young people
- Dementia Services

Domain 1 — Preventing People from dying prematurely

Currently, England's rates of premature death are worse than those in many other European countries for big killers like cancer, heart and liver disease. There are also significant inequalities between different communities and groups within England for both overall life expectancy as well as the quality of health people can expect to enjoy towards the end of their life (Source: NHS England).

NHS South Cheshire CCG aims to prevent people from dying prematurely by promoting good health and discouraging decisions and behaviours that put health at risk. Where people do develop a condition, we aim to commission services that diagnose this early and manage it in the community so that it does not deteriorate.

The main focuses on potential years of life lost, specifically around under 75's mortality rate by:

- **Reducing premature mortality from all major causes of death**
- **Reducing premature deaths for severe mental illness**
- **Reducing deaths in babies and young children**
- **Reducing premature deaths in people with a learning disability (*no CCG measure at present*)**

Our JSNA findings state:

Any death under the age of 75 is considered to be a premature death. Each year in South Cheshire CCG around 545 people die before their 75th birthday, and three quarters of these deaths are avoidable[2]. Around half of the deaths are occurring in the town of Crewe, where death rates for both men and women are significantly higher than in other parts of the CCG and are comparable to local authorities in the third highest decile for premature mortality in the country.

Premature Mortality under 75, annual deaths and directly standardised rate/100,000 2009-11				
	Male deaths	**Male rate (CI)**	**Female deaths**	**Female rate (CI)**
Alsager	21	288 (220-368)	15	184 (134-247)
Crewe	145	358 (326-392)	117	286 (258-317)
Middlewich	20	277 (213-353)	19	260 (198-333)
Nantwich	30	346 (279-423)	19	199 (149-258)
Sandbach	31	276 (223-337)	23	188 (146-238)
Rural areas of CCG	61	216 (185-249)	45	162 (136-192)
South Cheshire CCG	**308**	**300 (281-319)**	**238**	**225 (209-242)**
Source: Annual Report of the Director of Public Health 2012-2013				

In the town of Crewe there is also a clear "North – South" divide, with higher death rates in the central and northern areas of the town. The highest rates of premature deaths are seen in the most deprived areas, and in some parts of Crewe female deaths are higher than among men. Focussing initiatives in Crewe would enable the CCG to achieve early and significant success in this domain.

Reducing premature deaths for severe mental illness (Parity of Esteem)

NHS South Cheshire CCG values mental health equally with physical health. There is significant evidence that links poor mental health with poor physical health, and poor physical health can lead to poor mental health. Mental health illness influences premature mortality in the following ways:

[2] Avoidable deaths are those that would not have happened if appropriate medical and/or public health interventions had taken place to reduce a person's risk of dying prematurely.

- People with schizophrenia and bipolar disorder die on average 20 years earlier than the general population, largely owing to physical health problems.
- People with mental disorder(s) smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths. Rates of smoking on in-patient mental health units are 70% compared to 21% in the general population. [3]
- Depression doubles the risk of developing coronary heart disease
- People with depression have a significantly worse survival rate from cancer and heart disease
- People with two or more long-term physical illnesses have a seven-fold greater risk of depression
- Excessive consumption of alcohol is associated with higher levels of depressive and affective problems, schizophrenia and personality disorders as well as with suicide and self-harm[4]

This highlights that many of the problems are circular. For example if you drink large amounts of alcohol you increase your risk of poor mental health. Poor mental health increases your risk of developing physical poor health. Physical illnesses can lead to poorer mental health which can in turn lead to an increased risk of premature mortality. By increasing the focus on mental health some of these issues can be addressed which will have knock on benefits for poor physical health and premature mortality rates.

Reducing premature deaths from cancer

Crewe has a lower proportion of patients on practice cancer registers, which is related to historically high mortality amongst cancer patients in this town. Premature mortality from cancer in men is currently higher that the CCG average in Nantwich, Sandbach, Alsager and Crewe. In women there are higher rates in Crewe (where cancer mortality is higher than in men) and in Nantwich.

Patients with cancer in 2010/11, under 75 directly standardised deaths/100,000 in 2009-11				
	Patients with cancer (all ages)	**Proportion of practice list size**	**Male death rate <75 (CI)**	**Female death rate <75 (CI)**
Alsager	324	2.6%	119 (78-174)	82 (50-124)
Crewe	1,334	1.7%	113 (95-132)	124 (105-144)
Middlewich	326	2.4%	102 (66-151)	100 (64-148)
Nantwich	320	2.3%	141 (100-191)	115 (78-161)
Sandbach	414	2.2%	121 (87-162)	85 (57-119)
Rural areas of CCG	938	2.2%	101 (81-123)	72 (55-91)
South Cheshire CCG	**3,656**	**2.0%**	**112 (101-124)**	**100 (89-111)**
Source: Annual Report of the Director of Public Health 2012-2013				

Local patterns of cancer give a good indication about where the CCG can focus action to improve lifestyle, screening, diagnosis and treatment. Looking at new cases of cancer in each town by tumour type for all ages for the six-year period from 2005 to 2010, the statistically significant outliers are:

- Crewe has high incidence and high mortality from lung cancer in both men and women
- Middlewich has high incidence and high mortality from prostate cancer and lung cancer in men
- Nantwich has high incidence and high mortality from breast cancer in women
- Alsager has low incidence but high mortality from breast cancer in women
- Nantwich has low incidence but high mortality from colorectal cancer in both men and women

Reducing premature deaths from cardiovascular disease

While there have been significant improvements in the detection and recording of risk factors in primary care, more could be done to identify and effectively manage people with conditions which contribute to cardiovascular disease. In South Cheshire CCG there are an estimated 14,300 people

[3] 'Living Well for Longer in Cheshire East', The Annual Report of the Director of Public Health 2012-13

[4] Royal College of Psychiatrists, 2010. No health without public mental health: the case for action

with undiagnosed hypertension and a further 12,200 people who have hypertension that is diagnosed but not sufficiently well controlled. The two figures together give an estimate of over 26,500 people whose high blood pressure is damaging their health and are directly leading to 51 avoidable heart attacks or strokes every year.

Identification and Management of Hypertension, estimated numbers of patients, 2011/12					
	Diagnosed hypertension	**Undiagnosed hypertension**	**Proportion undiagnosed**	**Undiagnosed and/or poorly controlled hypertension**	**Heart attacks or strokes that could be avoided**
Alsager	2,229	985	31%	1,852	4
Crewe	11,005	6,240	36%	11,181	21
Middlewich	2,256	749	25%	1,741	3
Nantwich	2,403	1,030	30%	2,070	4
Sandbach	2,716	1,707	39%	3,003	6
Rural areas of CCG	7,024	3,589	34%	6,682	13
South Cheshire CCG	**27,633**	**14,300**	**34%**	**26,529**	**51**
Source: Annual Report of the Director of Public Health 2012-2013					

There are also 915 high-risk patients with atrial fibrillation who are not receiving blood thinning (anticoagulation) treatment. Every year, an estimated 47 of them will have a stroke that could have been avoided if they had been prescribed effective blood thinning treatment.

2014-16 Areas of Action (Commissioning Intentions):

The CCG have identified a number of areas of action and key commissioning priorities to address the health needs identified, which support this Domain. Some of this actions/ Projects will need to be taken forward in partnership with our partners, such as public health, third sector, providers and other Clinical Commissioning Groups.

The projects highlighted below are given as examples of work contributing towards this domain, but it's important to note that they also contribute towards other domains (in brackets).

Project and aims	Outcome	Milestones
Diagnose Cancer Early (D2,3,4) **GP and practice nurse education focused on early detection of cancer particularly colorectal, lung and Upper GI cancers.** **Risk assessment and clinical guidance on early signs and symptoms to aid clinical management.** **Campaigns: national, local and targeted to raise awareness of early signs and symptoms of cancer.** **Age extension to cancer screening programmes and introduction of bowel scope.**	Reduce the proportion of cancers that are diagnosed following an emergency presentation by 3% over three years. Cancer screening uptake to be in the top 20% compared to England. Cancers diagnosed at an earlier stage of disease progression – 20% of GP suspected referrals for cancer are diagnosed at an earlier stage over next three years (baseline in development). Reduction in premature mortality from cancer (under 75):- Reduce to 110 per 100,000 in 2 years (South Cheshire). Reduce to 140 per 100,000 in 2 years (Vale Royal).	• GP education – PLTs (March and May 2014) – workshop on early signs and symptoms prompting early diagnosis. On-going: • clinical education on cancer • MacMillan Practice nurse education course • Age extension to screening programmes • National Campaigns • Introduction of bowel scope (May 2014) • Lung cancer pathway redesign
Learning Disabilities Mortality (D2,4) **To improve mortality rates of those with learning disabilities by the following:** **Introduction of health equalities framework to measure individual health outcomes** **Promotion of health screening including national health screening programmes** **Improving health outcomes resulting from annual health checks** **Learning lessons from a cross organisational audit of deaths among the LD population**	The key outcome for this work will be a reduction in avoidable mortality, improved quality of life for this population.	Introduce CQUIN – April 2014 Primary Care audit of health checks – June 2014 Audit of LD deaths – September 2014

Enablers

There are a number of areas of work that need to take place in order to 'enable' the delivery of the above projects and the overall delivery of the domain:

Enabler	Projects/Activity
Primary Care	Innovation in Primary care to support improved outcomes for lung cancer. At least 3% fewer strokes admitted to Acute/intermediate care, - as average for all practices, for each long term condition - hypertension, diabetes, AF; compared to March 2013. At least 3% fewer myocardial infarctions admitted to Acute services – as average for all practices; compared to March 2013 Targeted health inequalities interventions at community level that provide support and interventions where greatest need has been identified. i.e. improving cancer outcomes in Crewe.
Quality	CCG Response Report to Francis (on-going action plans)
Information Technology	Development of integration Disease registers **-** hospital disease registers will enable audit and research and provide better joined up care across boundaries as well as supporting detailed information needs and analysis on the causes of hospital admissions and allow the CCG to target commissioning more effectively Cheshire Health Record **–** access to a (consenting) patient's summary of their GP patient record. To provide partner health professionals up to date and accurate information that will enable more coordinated decision making about the treatment provided for the patient, which is also vital to the provision of coordinated and seamless services. Improved Data Sharing and Transparency **-** Working with colleagues and current / new partners to identify and plan for the delivery of integrations across Primary Care, community and Social care settings by connecting data and information across pathways, seamlessly integrating across organisations and systems
Communication and Engagement	Paediatric Pathway 0-5 • Understand what services are used and when. • Understand current patient/parent experience • Understand current patient flows • Understand what drives parent choices Integrated Neighbourhood Teams • Understand what drives patient choices • Understand what services are used and when – and how this can be improved • Intermediate Care Services Review • To gather information on whether patients feel supported in returning to their own home and whether the support they were given helped reduce admissions to care homes (following discharge from hospital) and helped reduce readmissions to hospital. Transitional Care/ Community Intervention Beds (Winter 2013-14) • Understand patient experience in order to change, develop etc. • Identify gaps in current service

	• Understanding patient experience of returning home from hospital <u>GP Care Homes Scheme</u> • To engage with the GP's and homes to learn, understand and develop the new service spec. • To understand the patient experience and what are the benefits of the scheme.
Medicines Management	Maintain and develop the Local Health Economy Formulary including a work plan taking into account NICE Technology Appraisals programme, new product introductions and patent expiries Develop the capability of prescribing support software (Eclipse Live and Scriptswitch) to support improvements in patient safety

Domain 2 — Enhancing quality of life for people with long-term conditions

Over a quarter of our population in England have a long term condition, and an increasing number of these have multiple conditions (the number with three or more is expected to increase from 1.9 million in 2008 to 2.9 million in 2018). People with long term health conditions use a significant proportion of health care services (50% of all GP appointments and 70% of days spent in hospital) and their care absorbs 70% of hospital and primary care budgets in England (Source: NHS England).

NHS South Cheshire CCG is committed to supporting people to be as independent and healthy as possible if they live with a long-term condition such as heart disease, asthma or depression, preventing any complications and the need to go into hospital. If they do need to be treated in hospital, the CCG will support NHS provider services to work with social care and other services to ensure that people are supported to leave hospital and recover in the community.

We will work to commission services that assist and help patients take charge of their care, supported by good quality primary care and continuity of care. It is also important to us that there is a parity of esteem for mental health.

This domain focuses on the health related quality of life for people with long-term conditions:

- **Ensuring people feel supported to manage their condition**
- **Improving functional ability in people with long-term conditions**
- **Reducing time spent in hospital by people with long-term conditions**
- **Enhancing quality of life for carers, people with learning disabilities, mental illness and people with dementia (*no CCG measure at present*)**

Our JSNA findings state:

The Joint Strategic Needs Assessment and Annual Public Health Report have both drawn attention to the increased risk of hospital respiratory admissions among young children who live in areas that have high rates of adult smoking. Crewe has high rates of adult smoking and more pregnant women smoke at the time of delivery than the England average. Children in Crewe have higher rates of respiratory admissions and asthma than elsewhere in the CCG.

NHS South Cheshire CCG has acted quickly to look into the reasons why children are being admitted to hospital, and is working closely with the specialist children's service at Mid Cheshire Hospitals Trust to develop alternatives to hospital admission and improve primary care clinical pathways for children with chronic respiratory disease and develop community-based alternatives in the early stages of the clinical pathway.

Smokers with asthma have poorer control of their condition with a higher frequency of asthma attacks than non-smokers. Locally, emergency admissions to hospital for asthma seem to reflect this. South Cheshire CCG has significantly worse emergency admission rates (per 100 patients on the asthma register) compared to the England average (2.5% vs 1.8%). Compared to its peers within the ONS Cluster of Prospering Smaller Towns, South Cheshire CCG has the worst rates of emergency admission for asthma (55th out of 55).

Management of respiratory disease, numbers of patients, 2011/12				
	14-19 year olds with asthma	14-19 year olds with asthma with smoking status recorded	All patients with asthma and % with a review recorded	All patients with COPD and % with a review recorded

Alsager	25	21 (87%)	784 (79%)	248 (73%)
Crewe	113	94 (83%)	4,588 (70%)	1,299 (77%)
Middlewich	26	23 (89%)	851 (70%)	301 (81%)
Nantwich	27	24 (87%)	851 (72%)	218 (81%)
Sandbach	14	12 (84%)	1,211 (63%)	224 (83%)
Rural areas of CCG	150	137 (91%)	2,602 (75%)	645 (81%)
South Cheshire CCG	355	311	10,887 (71%)	2,935 (79%)
Source: Annual Report of the Director of Public Health 2012-2013				

The occurrence of dementia starts to increase over the age of 65. Dementia is most common in people in their eighties (10-20% affected) and nineties (30% affected). Women are about 30% more likely than men to develop dementia. Because more women live to a very old age, there are about twice as many women living with dementia than men. Early diagnosis and intervention is cost-effective, although these figures suggest that fewer than half of people with dementia in Cheshire East have received a formal diagnosis.

The national benchmark rate for new referrals into a memory assessment service is 190 per 100,000 population per year, which means that memory assessment services in Cheshire East need to be able to see around 700 new patients each year. 450 patients were diagnosed with dementia in Cheshire East in 2010, and again in 2011. Prescriptions for antipsychotics in people newly diagnosed with dementia have also reduced from 12.5% in 2006 to 1.04% in 2011 (the national figure was 4.46% in 2011). This indicates that diagnosis is taking place much earlier.

2014-16 Areas of Action (Commissioning Intentions):

Under this domain a number of key areas have been identified. These are actions/ Projects which will need to be taken forward (in some cases in partnership with our partners – public health, third sector, providers and other Clinical Commissioning Groups) in order to make an impact on improving outcomes.

Project and aims	Outcome	Milestones
Extended Practice Teams (D1,3,4) Improve care for adults with one or more long-term conditions / complex needs by treating efficiently within community setting. To reduce fragmentation, duplication and communication between healthcare services. Care will be better co-ordinated around patient needs. Patients will be better informed and involved in their care.	• Reduction in admissions to hospital from baseline. • Reduction in the number of re-admissions. • Reduction in the number of admissions to long term care • Increased number of people dying in their referred place of care. • Increase in number of patients that feel informed about their care. • Increased number of people that have a positive experience of care. • Increase in number of patients that feel able to manage their condition. The core teams will include the following posts: - General Practitioner - Care Coordinator (administrative support for the team) - Advanced Community Nurse - Community Nurse - Mental Health worker (health and wellbeing focus) - Social Worker - Wellbeing Practitioner (Third Sector) Aligned to practices with a community focus, the teams will work together to re-design the way care is delivered for adults with multiple long term conditions/complex needs, so that patients' needs are at the centre of everything the team does and collectively they are able to deliver a common set of patient outcomes.	Early adopters will be implemented during 2014/15. This will include the necessary IT Infrastructure. Full implementation will be aligned with the Community Services Review (March 2015) taking into consideration the learning from our early adopter sites.

Paediatric Pathways 0-5 Admissions (D1,4,5) To reduce overall number of avoidable Paediatric 'Short Stay' (<12 hours) Admissions. Develop alternative pathway to hospital admission for this cohort when appropriate.	Reduction in avoidable paediatric admissions to hospital for common childhood illnesses by 1% (at a practice level with the top 25% in the country where safe and appropriate) • Care closer to home • Improving the patient experience of children and young people in healthcare settings • Improve the ability of 'Primary Care GP's' and 'Out of Hours' to manage common paediatric self-limiting conditions in the community • Change in parental behaviours with confidence of access to advice, guidance and management with GP or Community Nursing as first port of call (rather than directly accessing A&E)	To put in place a clear and robust care pathway and protocols for the management of the sick infant (what happens, by when and to what quality standard). To develop appropriate and accessible information for children, young people, their families and professionals in terms of making positive choices and the management of common childhood illness. Phase 1 – establish nurse home visiting scheme Phase 2 – Options appraisal and business case regarding an enhanced community provision for observation of children
Respiratory (D2,3,4) Build on the 'Improving Inhaler Technique' project and 'Integrated Respiratory' Teamwork to: Ensure compliance with NICE quality standards for COPD and asthma Deliver care close to home for patients with bronchiectasis. Reduce variation between practices and CCGs for respiratory admissions Improved consistency of provision of spirometry within general practice	Service Specifications updated Quality of primary care services through a primary care CQUIN or other contracting vehicle. Develop bronchiectasis service – community IV antibiotic and physiotherapy service is developed to reduce the number spells/ LOS for patients with bronchiectasis. Implement guide on spirometry – to improve the certainty of diagnosis and reduce variation between practitioners. Prevention of exacerbations of COPD	Audit current provision against NICE Quality Standards – June 2014 Establish Steering Group with clinical leadership and management support (as project links to planned care, urgent care, long term conditions and integrated care)– May 2014 Develop work programme (linking to existing work – improving inhaler technique project, review of asthma/COPD register, supporting early discharge) – July 2014
Children with LTC (D1,3,4,5) Improve care for children with long-term conditions Reduce avoidable admissions	Improved self-management, reduction in avoidable admissions/ LOS for children with LTC including use of inhalers. Introduction of self-care/self-management methodology Reduction in time spent in hospital by children and young people with Long Term Conditions Improved transition pathways for children with LTC (possible CQUIN)	Review local data – Within Q2 2014-15

	People feel supported to manage their condition	
Neuro-developmental Pathways (D4) To review existing pathways and ensure equity of access to diagnosis of autism and ADHD and on-going support Ensure local services reflect requirements of NICE guidance and prescribing (interdependency with CAMHS specification reviews – See Domain 4)	• As a 'review' the specific and measurable outcomes for this area have yet to be defined. The outputs for this work already agreed: • Recommendation as to the required changes in existing multi-agency pathways. • NICE guidance benchmarking	• Mapping existing provision and pathways – Qtr 1 2014 • Benchmarking data collated and review – Qtr 1 2014 • Provider and user engagement – Qtr 2 & 3 • Report produced - Qtr 3
Adult Neuro-Developmental Conditions • Review of existing diagnostic pathways and service capacity for adults with suspected ADHD. • To ensure that services for adults with neurodevelopment conditions are able to meet current and future demand. • Implementation of the autism strategy.	• improved quality of life for people with a long-term mental health condition (CCG OIS) • Adults with ADHD and/or autism are able to receive an accurate diagnosis • Appropriate follow-up is in place.	• Review of existing diagnostic pathways – June 2014 • Staff and service user engagement – July – Sept 2014
Memory Services for Dementia (D4) To review the current configuration and sustainability of memory services in the context of the rise in numbers with the condition. To develop shared care arrangements with secondary care to benefit of patients and their families. This will form part of an accountable care system linking into Extended Practice Teams.	Increased capacity in memory services, through a shift in activity from secondary to primary care. More timely access leads to earlier and more accurate diagnosis. Skilled primary care workforce Patients receive care closer to home. Enhance quality of life for people with dementia Improve dementia diagnosis rates - % target. Enhance quality of life for carers Improve the effectiveness of post- diagnostic care in sustaining. Improve the effectiveness of post- diagnostic care in sustaining independence and improving quality of life	Full business case presented in Feb 2014 Engagement with partners March – April 2014 Implementation from April 2014. Monthly highlight reports monthly to Living Well Programme Board.

Commissioning of Personality Disorder (PD) Service (D3) To consider and commission models for future delivery of a personality disorder service based on best available evidence and best practice.	Establish a new service to: Reduce premature death of people with severe mental illness - % disorder. Ensuring people feel supported to manage their condition Enhancing quality of life for people with mental illness.	Pathway and service review April 2014- June 2014. Business case development August 2014 – October 2014. Implementation April 2015.
Military Veterans IAPT Service To commission an effective service this focuses on the needs of ex-service personnel, reservists, and their families.	• Decreased rates of re-admission for ex- service personnel • Improve recovery following talking therapies • Improve recovery from injuries and trauma • Increased access to psychological therapies for ex- service personnel	Contract negotiations December 2013- January 2014. Commissioning and new contract commence April 2014. Quarterly monitoring.
Stroke Rehabilitation Pathway Procurement (1,3,4,5) To procure a specialist community rehabilitation team to work in conjunction with the acute provider, social care and the voluntary sector. The current stroke service has been reviewed and the commissioning team identified a gap in service provision relating to the stroke pathway. Our intention is to integrate the acute provision with community to ensure stroke survivors realise their full potential and improve quality of life.	Improved outcomes for stroke survivors and their families which will enable them to achieve their potential and improve their quality of life. Decrease length of stay in hospital. (Determined by individual patient need). Decrease the rate of readmission within 30 days by working within a multi-disciplinary team to address each stroke survivor's individual support needs (health, social care and voluntary organisations, including carer support). E.g. supporting people to return to employment or activities of daily living. Improve patient access to the Community Stroke Rehabilitation Service by improving patient flow through the stroke unit, leading to earlier discharge by achieving 90% stay target. Reduction in acute bed days, working towards achieving the optimum length of stay of 19 days.	Full tender process to be complete by April 2014. Full implementation of new service by October 2014. The new service will be formally reviewed after the first 3 months following implementation in collaboration with the provider. This will also include service user and carer feedback to assure the CCG that the procured service does meet patient need, providing a quality service. This will be repeated on a quarterly basis as well as monthly meetings with the provider.
GP Care Homes Scheme (D1,3,4,5) • Review current service and provide recommendations on changes to service specification for contracting. • Develop revised service specification. • Implement revised service specification	• Care Homes less likely to call 999 and admit patients to hospital. • Patients feel they receive better co-ordinated care • Reduce risk of Hospital Acquired Infection • Sustain current low levels of emergency attendances and admissions to hospital	Service review is currently underway and to be concluded by April 2014. A decision on the future of this scheme will be made by April 2014 based on the review.

Children & Young People with Disabilities (SEND) To meet the requirements of the Children and Families Bill 2013 (SEND)	Improvements in Education, Health and Social outcomes, Compliance with Children and Families Bill 2012-13 (Clause 26) - legal requirement on CCGs Clear joint commissioning strategy is in place for CCGs and LAs to commission services that support children and young people with special educational needs and disability (up to age 25) Implementation of the single 'Education, Health & Care Plan' that replaces "statement" needs treating the child/ young person's needs holistically. Transitional Care Pathways between Children's and Adult services are seamless removing transition risks to the young person./ Personal Health Budgets give patients and children more autonomy to buy their healthcare.	Start review of commissioning implications for CCG – Quarter 1 & 2, 2014-15. Whole project infrastructure established with both local authorities (CWaC, CEC) and partners, to set action plan. Delivery according legislative timetable.
Pain Management Service Review This is a project to find improvement to the current community pain management patient pathway.	An aligned NHS contract will be in place for 2014/15. A reviewed pain management patient pathway service will be complete for 2015/16 Measurable outcome indicators will be developed during the review period.	Align existing contract with current best practice – Complete by April 2014 Review of patient pathway to commence – April 2014 Tender for new contract – During 2014/15 New contract awarded to commence – April 2015 (for 2015/16)
Third Sector Grants (D4) To work in partnership to review current spend and develop a strategic approach to working with and commissioning from the 3rd Sector. This programme of work will be reviewed in light of the Better Care Fund. It includes: - Pathway Support (e.g. Stroke service support) - Partnership Carer support - End of life review - Partnership work with CWAC (dementia) - Other grants (e.g YMCA homeless	There are a wide range of outcomes based on individual grants. They support people with LD, Older People, lower socio-economic status and disabilities. E.g. Stroke survivors, Neuromuscular patients. We aim to have one standard contract jointly commissioned by health and social care for the financial year 2015/16.	April 2014 - Collating current levels of spend to identify duplication, identify gaps in locality provision, and to identify future joint commissioning opportunities. June 2014 - Production of a commissioning plan identifying services to be jointly commissioned August 2014 - Agree an approach to developing the Third Sector's opportunity and ability to deliver local services, this will include info sessions, workshops and

worker in Crewe, Drop in centre in Winsford for people with mental health difficulties)		networks Dec 2014 - Work with Locality commissioners to develop protocols to ensure that the needs identified in locality action plans are reflected in any newly commissioned.
Community Equipment Services To provide equipment to support independent living. Community equipment is to aid independent living, usually for the elderly or disabled. This is provided locally by way of an innovative nationally recognized model of best practice via a local retailer (or a supplier for larger items that are then reused). The current service is a collaboration of 6 partners – the 4 CCGs and 2 local authorities.	• People are supported to live independently • Support effective discharge from hospital • Value for money based on partnership approach • Prevention hospital admissions • Supports Reablement • People have the ability to test equipment locally to suit their needs • Equipment is available quickly to people at a local level	Memorandum of Understanding (MoU) between the 6 partners is due for renewal form April 2014. Pilot scheme on extended hours provision in West Cheshire is due to conclude by June 2014. Review of current project plan will take place in light of the pilot in this area during July 2014.
Community Services Review During 2014-2015 South Cheshire CCG will be developing proposals for the future configuration of community provision that will deliver improvements in patient care.	To provide care in a way that better meets the needs of the whole person. A range of different approaches to the organisation and delivery of care will be explored. These include: • Integration of services across health and social care providers • Better coordination of care between professional groups, for example, case management, disease management programmes, virtual wards, care pathways and hospital at home • A range of financial incentives to encourage higher-quality and integrated care • Commissioning of services on an outcome basis • Tools to help patents better understand and self-manage their health problems • Technology devices aimed to deliver health care at a distance • Efforts to increase personalisation, such as personal health budgets	This review and subsequent actions/ commissioning will conclude by March 2016.

Enablers

There are a number of areas of work that need to take place in order to 'enable' the delivery of the above projects and the overall delivery of the domain:

Enabler	Projects
Primary Care	Innovation in Primary care to support Patient self-management Innovation in Primary Care to support improved outcomes for circulatory disease, diabetes, cancer, COPD and dementia. At least 3% fewer hospital admissions for COPD, acute adult asthma, acute child asthma – as average for all practices; and per practice that attains clinical targets; compared to March 2013. Practice average prevalence rate at least 70% of expected for COPD, diabetes, CHD, asthma, CKD, hypertension (compared with most recent public health observatory figures and NHS England benchmarks). Practice identification of carers at least 60% of expected carers register as identified by The Carers Association. Improved outcomes for patients with one or more long term conditions through tailored single care planning and wider access to patient self-management resources and education, with a focus on diabetes and hypertension. Target quality improvements and interventions towards our changing demographics and increasing frail, elderly population with multiple morbidities. Supporting the adoption and implementation of the Dementia strategy
Quality	Quality report on stroke pathways will monitor improvement to services as community responses improve. Quality and Performance Dashboard assurance reports Nurse leadership process to engage harder to reach groups
Information Technology	Electronic Prescribing Service (EPS) Release 2 - to send prescriptions electronically to a dispenser (pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. Development of integration Disease registers **-** hospital disease registers will enable audit and research and provide better joined up care across boundaries as well as supporting detailed information needs and analysis on the causes of hospital admissions and allow the CCG to target commissioning more effectively Cheshire Health Record **–** access to a (consenting) patient's summary of their GP patient record. To provide partner health professionals up to date and accurate information that will enable more coordinated decision making about the treatment provided for the patient, which is also vital to the provision of coordinated and seamless services. Risk Profiling and stratification – will identify patients earlier at risk of crisis to

	reduce likelihood EMIS Developments – move towards integration systems across primary, secondary services to improve communications about individual patients needs. Telehealth/ Telecare Improved Data Sharing and Transparency **-** Working with colleagues and current / new partners to identify and plan for the delivery of integrations across acute care, Primary Care, community and Social care settings by connecting data and information across pathways, seamlessly integrating across organisations and systems
Communication and Engagement	Integrated Neighbourhood Teams • Understand current patient experience of NHS and social care services following individual patient story to identify improvements at practice level.. • Understand current patient flows GP Care Homes Scheme • To engage with the GP's and homes to learn, strength and weaknesses and develop the new service specification. • To understand the patient experience and what are the benefits of the scheme. Choose Well • To check brand awareness of Choose Well amongst groups and revise if necessary • Engagement of 'expert patients' who can devise appropriate Choose Well messages for people with LTC. Third Sector Grants • To ensure that the sector are engaged in the suggested new process of commissioning, ensuring that funds are allocated in the best way to meet the needs of the population. It is intended that this will be done jointly with Cheshire East Council 2014-16.
Medicines Management	Maintain and develop the Local Health Economy Formulary including a work plan taking into account NICE Technology Appraisals programme, new product introductions and patent expiries Develop the capability of prescribing support software (Eclipse Live and Scriptswitch) to support improvements in patient safety Work with the local Acute Trusts to improve financial and clinical governance for patients receiving medicines from Homecare services

Domain 3 Helping people to recover from episodes of ill health or following injury

There has been an ever-increasing demand on our hospitals over the past 10 years – a 35% increase in people being admitted to hospital as an emergency and a 65% increase in the episodes of care in hospitals for over 75s. Patients in our hospitals are older and frailer, and around 25% have a diagnosis of dementia. Care that is not joined up, particularly between health and social care services is causing increased admission and readmission amongst those with long term conditions and the elderly. The outcomes of care vary significantly across the country (Source: NHS England).

NHS South Cheshire CCG is committed to ensure that if people do experience an episode of ill health or suffer an injury, our NHS provider services should treat them effectively and support them to recover and restore their maximum independence as quickly as possible.

This domain focuses on helping people to recover from episodes of ill health or following injury. In particular it targets:

- **Improvement of outcomes from planned treatments**
- **Preventing lower respiratory tract infections in children from becoming serious**
- **Improving recovery from injuries and trauma (*no CCG measure at present*)**
- **Improving recovery from stroke**
- **Improving recovery from fragility fractures**
- **Helping older people to recover their independence after illness or injury (*no CCG measure at present*)**
- **Improving recovery from mental illness**

Our JSNA findings state:

The Stroke Improvement National Audit Programme (SINAP) assesses the quality of stroke care in hospitals in England by describing the pathway followed by patients with acute stroke in the first three days and assessing the quality of care provided to them during this time. This information is helping South Cheshire CCG to steer improvements in care for acute stroke patients.

Stroke Improvement National Audit Programme (SINAP) – selected results for Oct to Dec 2012			
	Leighton	**Nth Staffs**	**England**
Stroke patients brain scanned within 1 hour of arrival at hospital	23%	43%	40%
On a stroke bed within 4 hours of hospital arrival (out of hours)	42%	86%	65%
Seen by stroke consultant or associate specialist within 24 hours	78%	100%	85%
known time of onset for stroke symptoms	57%	53%	66%
Eligible stroke patients who received thrombolysis	67%	100%	70%
Nutrition screening and swallow assessment within 72 hours	83%	87%	68%
Average score of 12 key stroke indicators (high is good)	**71.7**	**86.3**	**74.7**
Quartile ranking on 12 key stroke indicators (high is good)	**3rd**	**1st**	

Results are available for each quarter from April 2011 to December 2012, during which time Leighton improved from the fourth to third quartile of hospitals in the country, and North Staffs from the second to first quartile. A new Sentinel Stroke National Audit Programme (SSNAP) is now measuring acute

care, rehabilitation, 6-month follow-up, and outcome measures. These longer-term outcomes have not yet been published for local areas.

2014-16 Areas of Action (Commissioning Intentions):

Under this domain a number of key areas have been identified. These are actions/ Projects which will need to be taken forward (in some cases in partnership with our partners – public health, third sector, providers and other Clinical Commissioning Groups) in order to make an impact on improving outcomes

- Keeping people out of hospital when appropriate
- Effective interfaces between primary, secondary and community care
- High quality, efficient care for people in hospital
- Co-ordinated care and support for people following discharge from hospital

Project and aims	Outcome	Milestones
Intermediate Care Services Review (D1,4) To understand the Capacity and Demand requirements for Intermediate Care Services Beds (Home Based Capacity and Bed Based Capacity) and the Quality and Performance Issues within the current contracted services. This work will run alongside the review of transitional care/ community intervention beds to develop "alternative beds to an acute setting" bed.	The CCG will gain an understanding of the capacity and demand requirements for Intermediate Care Services Beds (Home Based Capacity and Bed Based Capacity) for the: - short term (next 12 months) - medium term (next 5 years) - long term (next 10 years). The CCG will gain an understanding of the Quality and Performance Issues within the current contracted services. - The report will then be used to; - Inform the Community Services Review - Inform the Connecting Care Board Inform the Better Care Fund transfer of funding arrangement to Cheshire East Council	Review commenced - December 2013 Engagement with GP's, Patients, primary care, secondary care and social care providers – Complete by March 2014 Review complete – May 2014 (this will inform and contribute to other related projects within 2014-16)
Transitional Care/Community Intervention Beds Winter 2013-14 (D1,4) To provide additional step-up and step-down capacity. Evaluate pilot from 2013-14 and develop a business case to inform the Community Services Review contracting. Work to timescales for Better Care Fund. Extend contracts with pilots to ensure continuity of service between end of pilot and permanent service commencing.	90% of patients are to be discharged home from the community intervention beds 100% of patients transferred to the service within 16 hours of the decision of the transfer being made The maximum LOS is not to exceed 21 days A 20% reduction in delayed discharges from MCHFT compared to 2012/13 baseline Reduction in emergency admissions outcome measure (CCG measure to be in place following evaluation of the pilot) Improvement in patient experience Improvement of staff experience	Evaluation to be completed by June 2014. Tendering for permanent service to form part of the Community Services Review process and subsequent timescales.
24/7 Urgent Care (1,2,4,5) To develop and implement an integrated urgent care system across health and social care that is both responsive to patient need and delivers quality	Reduction in A&E attendances - 7% reduction from April 2015 Reduction in non-elective Admissions - 30% reduction from	Project Implementation Plan to be developed and approved by March 2014. • Q1 – The development of protocols, processes and governance with providers

care in the most suitable setting. Delivering a high quality, cost effective, seamless, responsive services both in and out of hours.	April 2015 Improvement in A&E 4hr target - 97% from April 2015 Patients feel better supported for their ambulatory care sensitive condition (in the community) - 55% feel supported from April 2015 Reduction in unplanned hospital admissions for chronic ambulatory sensitive conditions per 100,000 population - VR 850 SC 800 Per 100,000 from April 2015To improve people's experiences of A&E services via the Friends and Family test to the national upper quartile.	for the integration of ED, Urgent care Centre and Out of Hours • Q2 – Implementation of an integrated ED, UCC and OOH. • Q3 – Identification of other services for integration to the urgent care system. • Q4 – The development of protocols, processes and governance with providers for integration of additional services into the urgent care system. 1st April 2015 – New integrated Urgent care systems fully operational.
Diagnosis and Treatment Pathways Compliant with NICE Guidance (1,2,4) • Choose and Book progressed for suspected cancers from GP • One stop or direct access diagnostic clinics for lung, colorectal and breast cancer to speed diagnosis • Pathway redesign of Urology, Gynaecology and Skin Cancers to ensure NICE Improving Outcome Guidance compliant pathways in partnership with Greater Manchester • Lung pathway review across primary and secondary care • Macmillan Practice Nurse Course to train a Practice Nurse from 15 practices as Cancer champions in recognising earlier signs and symptoms of cancer and support the cancer care reviews in Primary Care	• Reduction in premature mortality from cancer (under 75) • High quality Patient Experience measures • Cancer Waiting Time Standards achieved • Stretch of 2ww Cancer Waiting Time standard to Day 9 by 2014 • Cancer Peer Review assures of NICE Improving Compliant pathways • Enhanced recovery for lung cancers with reduced LOS • Patients in GP practice receive faster support at an earlier stage of cancer from the practice nurse.	• Pathway redesign of the following cancers – urology, gynae and skin (2014-16) • Lung pathway review across primary and secondary care (March 2015) • Cancer peer review (Sept 2014, 2015, 2016)
MERIT Response (1,4) There is a National requirement for CCG to commission ambulance service providers to deliver Medical Emergency Response Incident Teams (MERIT). The CCG will work with North West Ambulance Service to deliver an appropriate level of clinical care at the scene of major incidents across the health footprint during 2014/16.	• Lives saved and clinical outcomes improved • Medical implications reduced for casualties by using advanced specialist clinical interventions at the point of delivery in the pre-hospital environment. • To bring senior clinical decision making and critical care interventions closer to the point of injury. • Greater public confidence in anticipated clinical assistance in the event of becoming a casualty	Service specification prepared by NWAS by April 2014. Service will commence from Q2-3 2014. Annual service review to be carried out by the Lead Commissioner (Blackpool CCG).

'Think Pharmacy' - Minor Ailments Service To provide patients with access to advice and treatment for a range of Minor Ailments from every community pharmacy in the CCG area to: • Reduce presentations in A&E • Reduce attendance at urgent care and out of hours primary care services • Release opportunity costs through freeing up GP consultations.	Rapid access to treatment for a range of minor conditions provided by a health care professional for no more than the price of prescription charge (and free if patients are eligible for free prescriptions). Manage the costs of medicines for minor ailments by enforcement of a limited formulary. Empower patients to care for themselves in a community setting. • Service to be launched by 1 April 2014. • Reduced attendance at general practice and urgent care facilities for the named conditions to be demonstrated by 1 April 2015 Community Pharmacy will provide consultations at a lower unit cost than other urgent care providers	• Define range of conditions and protocols for treatments by 31 March 2014 • Determine method of self - accreditation for provision of service by 31 March 2014 • Register providers from 1 Apr 2014 • Increase number of consultations throughout 2014 and 2015

Enablers

There are a number of areas of work and assurance mechanisms that will/do take place in order to 'enable' the delivery of the above projects and the overall delivery of the domain:

Enabler	Projects
Primary Care	Innovation in Primary Care to reducing emergency admissions for respiratory conditions High quality general practice with sufficient capability and capacity to support reductions in avoidable referrals and admissions to secondary care
Quality	Quality and Performance Dashboard assurance reports monitor the progress of services delivered to patients.
Information Technology	Electronic Prescribing Service (EPS) Release 2 - to send prescriptions electronically to a dispenser (pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. Development of integration Disease registers **-** hospital disease registers will enable audit and research and provide better joined up care across boundaries as well as supporting detailed information needs and analysis on the causes of hospital admissions and allow the CCG to target commissioning more effectively Cheshire Health Record **–** access to a (consenting) patient's summary of their GP patient record. To provide partner health professionals up to date and accurate information that will enable more coordinated decision making about the treatment provided for the patient, which is also vital to the provision of coordinated and seamless services. Improved Data Sharing and Transparency **-** Working with colleagues and current / new partners to identify and plan for the delivery of integrations across Primary Care, community and Social care settings by connecting data and information across pathways, seamlessly integrating across organisations and systems Risk Stratification – identifying patients at an earlier stage, before a crisis, then care/support can be arranged to reduce the risks.
Communication and Engagement	Think Pharmacy • Engagement of local community to test existing knowledge of minor ailments scheme • Development of engagement and communication strategy to promote the 'Think Pharmacy' brand to target audiences. Integrated Neighbourhood Teams • Understand current patient experience of health and social care services • Understand patient concerns about lack of joined up services • Understand what drives patient choices • Understand what services are used and when – and how this can be improved Transitional Care/ Community Intervention beds (Winter 2013-14) • Understand patient experience in order to change, develop etc. • Identify gaps in current service provision • Understanding patient experience of returning home from hospital GP Care Homes Scheme • To engage with the GP's and homes to learn, strengths and weaknesses

	and develop the new service specification.
Medicines Management	Maintain and develop the Local Health Economy Formulary including a work plan taking into account NICE Technology Appraisals programme, new product introductions and patent expiries Implement the extended Think Pharmacy; Minor Ailments service to support the Urgent Care Working Groups to reduce demand in general practice and Accident and Emergency departments

Domain 4 Ensuring that people have a positive experience of care

Positive patient experience is common in NHS. However, care is inconsistent, as seen in recent examples of the unacceptable care documented in the Francis and Winterbourne View reports. The poorest care is often received by those least likely to make complaints, exercise choice or have family to speak up for them, and there is evidence of unequal access to care.

Patient experience is everybody's business, yet evidence suggests the NHS does not consistently deliver patient-centered care, and that there are particular challenges in coordinating services around the needs of the patient (rather than passing the patient between services). Good patient experience is associated with improved clinical outcomes and contributes to patients having control over their own health. We also know that good staff experience is also fundamental for ensuring good patient experience (Source: NHS England).

NHS South Cheshire CCG is committed to achieving and supporting our providers to achieve consistently: compassion and respect for patient's preferences and expressed needs; equal access to services; good communication and information; physical comfort; emotional support; welcoming the involvement of family and friends.

We are also introducing to our providers the requirements to adopt "quality improvement" and "systems thinking", meaning all providers have to continually critically question "how" and "what" they provide and seek to improve it to meet the needs of their patients. This is done across the whole system that the patient uses, not just the part that any one provider provides.

As a CCG we will continue to improve the mechanisms by which we seek out, listen to and act on patient feedback, ensuring the patient and carer voice is heard and directly influences improvements across our health and social care landscape.

This domain focuses on the introduction of the Friends and Family Test (FFT) – aiming to achieve 'real-time' feedback. In particular it targets:

- **Improving people's experience of outpatient care**
- **Improving hospitals' responsiveness to personal needs**
- **Improving peoples experience of A&E services**
- **Improving women and their families ' experience of maternity services**
- **Improving the experience of care for people at the end of their lives**
- **Improving the experiences of healthcare for people with mental illness**
- **Improving children and young people's experiences of healthcare (*no CCG measure at present*)**
- **Improving people's experience of integrated care (*no CCG measure at present*)**
- **Improving the experience for people with learning disabilities experience – implementing reasonable adjustments**

Our JSNA findings state:

The adult social care survey in 2012-13[5] provides an invaluable insight into user experience of adult social care and within the context of personalisation and transformation of social and health care provide is critical analysis for understanding the impact and outcomes achieved, enabling choice and informing service development.

The introduction of Adult Social Care Survey (ASCS) in 2010-11 was the first time all service users had been surveyed on a national basis using the same methodology and questionnaires. The 2012-13 survey aims to build on this to provide another set of survey data which can be benchmarked

[5] Cheshire East Council, Adult Social Care Survey, 2012-13, Internal Report, July 2013

across councils and within councils with the 2010-11 and 2011-12 results. A summary of the results is given below:
Overall 92% of respondents said they were extremely/very/quite satisfied with the care and support service they received.
Quality of life:

- 90% felt that care and support services help them to have a better quality of life and the majority of respondents, nearly half felt they had adequate control over their daily life.
- 80% of respondents sadi they had as much social contact as they want or adequate social contact and
- 70% felt they were able to spend time as they wanted doing enough of the things they value or enjoy.
- 59% felt that the way they helped and treated made them feel better about themselves. Only 1% felt that they way they were helped or treated completely undermined the way they felt about themselves.

Your health:

- Nearly half of respondents felt the health was fair. 17% felt their health was bad or very bad.
- 13% of respondents said they had extreme pain or discomfort.
- 8% of respondents said they were extremely anxious or depressed.
- Over half (59%) of respondents said they couldn't manage finances and paperwork by themselves.
- 41% of respondents said they couldn't manage to wash all over, using a bath or shower, by themselves.

About your surroundings:

- 91% of respondents said their home met all or most of their needs.
- Just over a quarter said they could get to all the places in their local area that they want. Over half said they found it difficult at times or they were unable to get to all the places in their local area that they wanted to. Just under a quarter do not leave their home.

The NHS Patient Survey has been in place for several years and presents a picture of the public's satisfaction with the way in which the NHS runs and with important parts of its services such as general practice, inpatients and outpatients as well as satisfaction with social care provided by local authorities.with patients reporting. The latest survey was carried out over the summer of 2012 and

Satisfaction with the way the NHS runs now stands at 61%, the third highest level since the survey began in 1983. This follows a record fall in satisfaction, from 70% in 2010 to 58% in 2011.

The survey also measured satisfaction with individual services. Satisfaction with A&E services increased by 5 percentage points from 54% to 59% while satisfaction with outpatient services (64%) and inpatient services (52%) showed no real change from 2011.

Satisfaction with GP services (74%) and dentists (56%) are also unchanged. In contrast to the high levels of satisfaction with the NHS, satisfaction with social care services was much lower, at only 30 per cent.

2014-16 Areas of Action (Commissioning Intentions):

Under this domain a number of key areas have been identified. These are actions/ Projects which will need to be taken forward (in some cases in partnership with our partners – public health, third sector, providers and other Clinical Commissioning Groups) in order to make an impact on improving outcomes.

Project and aims	Outcome	Milestones
Citizens Advice Bureau To improve patient's health and wellbeing, by addressing the underlying issues affecting health outcomes that often relate to non-medical issues such as welfare benefits, debt, employment, housing and relationships.	• More people kept in work – retaining jobs • Reduction in child poverty • Increase in disabled people's income • Supporting people with mental health • Helping people remain in their own homes • The overall health and wellbeing in our deprived population is improving as identified by the Marmot Report.	• Service review currently taking place, to complete by April 2014. • New contracts to be in place subject to service review – from April 2014.
Chemotherapy Reform AND Acute Oncology (1,2,3) To provide care closer to home by transferring the delivery of chemotherapy from Christie's and North Staffs to Leighton Hospital. To Purchase and set up of electronic prescribing of chemotherapy with each tumour group regimes uploaded Acute Oncology team accessed from A&E and extended into primary care	• 80% solid tumour chemotherapy delivered locally by 2015 • Patients travel no more than 45 minutes for specialist chemotherapy and 20 minutes for local chemotherapy by 2015 • E-prescribing of chemotherapy • Reduction of mortality within 30 days of chemotherapy • Emergency admissions for cancer related reasons reduced by the primary care and acute oncology teams • Average length of stay for cancer related admissions reduced from 9 days to 6 days by end 2014.	• To identify next tumour group where chemotherapy can be moved from the Christie to Leighton Hospital and implement change by 31st March 2015. • E-prescribing to be in place by 31st December 2014 • Establish pathway to develop primary care implementation to the acute oncology service by 31st March 2015
Dementia/EoL • 2 year Pilot of a specialist Dementia EOL team across the 3 CCGs (to commence July 2014) • Education and training programmes for staff on dementia EOL • Consultancy / case management where the specialist team will co-work clinical complex cases with "mainstream" clinical teams • Practice development to facilitate best practice pathways within care settings • Brief educational work with families / carers re: disease trajectory, difficult conversations, and planning for future care • Increase in the knowledge, skills and confidence of the workforce	• 70% of people with dementia, their carers and families, report a positive experience of End of Life care • 10% reduction in unplanned hospital admissions at EOL for people with dementia • 10% reduction in hospital length of stay for people with dementia at EOL • 10% increase in the number of people being treated in and dying in their preferred place of care • Increase in patient and carer satisfaction and experience • 80% of NHS patient facing staff will have accessed communication skills by 2015 • EOL Care will be a core component on education and induction programme for staff who care for people in their last years of life. • 20% reduction in A&E attendance over 2 years for people with dementia • 60% of people with dementia who have a recorded	• Recruitment to dementia/EOL team – July 2014 • Engagement and Communication on the new service – July – December 2014 • Formal evaluation to the service to commence April 2014 • Education and training programmes for staff on dementia EOL – July 2014 • Formal evaluation against agreed outcomes (31st March 2016)

	preferred place of care achieve this. • 10% increase in patients with dementia on the GP GSF (Gold Standards Framework)register	
End of Life (D1,2,3) • Normalising death, dying and loss within communities • Enabling future life planning and making informed choices • Increased knowledge, skills and confidence of workforces in EoL care • Enabling public/patient/carer experience to shape future behaviour and practice in EoL care • Development of robust evidence base in EOL • Facilitating excellent and compassionate EoL care • Leading, influencing and developing behaviour and practice in EoL Care	• 1% of practice population are on the GSF register by December 2015 • 25% of ALL deaths had an advanced care plan by December 2015 • 80% with a preferred place of death achieve their choice by December 2015 • Increase in usual place of residence to 48% by March 2016 • 15% reduction in A&E attendances for people in their last year of life by December2015 • Reduce average length of hospital stay for people at end of life by 2 days by March 2016 • Support 8 Care Homes through quality programmes in EoL care by March 2016 • Have 2 research based published articles on EoL Care by December 2015 • Obtain research funding from a national research body December of 2015 • 80% of staff can evidence change practice due to modules of learning in EoL	• Development of EoL Partnership to support delivery of project outcomes
EPACCS (D1) • To implement an end of life electronic shared care record that is accessed from all care settings including NWAS, OOHs, hospices, primary and acute care.	• Improve communication between services and enable access to real time palliative care real time information for clinicians 24/7 • 80% with a preferred place of death achieve their choice by December 2015 • Increase in usual place of residence to 48% by March 2016 • 15% reduction in A&E attendances for people in their last year of life by December2015 • Reduce average length of hospital stay for people at end of life by 2 days by March 2016	• information standard by December 2014 • Procure AMIG to allow data sharing across organisations by December 2014 • Ensure data sharing agreements in place across practices by September 2014 • Support hospices with N3 connectivity and consider development of EMIS Web as preferred clinical system by September 2014 • Roll out of EPACCS by March 2016 • Engagement and Communication with primary care, throughout development and implementation
NHS 111 (1,2,3,5) Commissioning of national NHS 111 service across the Cheshire and Merseyside footprint.	• 13%* decrease in A&E • and UCC attendances by April 2015 • 15%* reduction in 999 calls by April 2015 • ** reduction in number of	1st April 2014 – 31st March 2015: Limited service provided by NWAS as stability partner. Development of service specification and

	• RRVs/ambulances activated prior to grading • of call by April 2015 • 4%* reduction in ambulance conveyance by April 2015 • ** reduction in Ambulance response times by April 2015 • 5%* reduction in out of hours contacts by April 2015 • Achieve national target (consider stretch target locally). • Achieve national target (consider stretch target locally).	financial plan. 31st March 2015: • Full service commences • Decision on re-procurement • 1st September 2015 – New contract in place.
CAMHS Specification Review All CAMHS specifications to be reviewed Delivered under Living Well programme project review of specifications (interdependency Neuro-developmental Pathways – See Domain 2)	• Better understanding of un-met need/ required pathway improvements • Better understanding of CAMHS offer/cost/activity	• CWP provide current specifications with details of spend and resources – timescale to be agreed • Agree a mandate in order to progress further redesign as required - timescales to be agreed • Report identifying next steps to ensuring specifications are fit for purpose and reflect the required provision and needs of children and young people (including benchmarking analysis and review of best practice)
Complex & High Risk Adolescents (D5) Ensure robust system and care pathway across agencies that can identify and support vulnerable young people Improving commissioning process across partners (governance improved and assurance)	• Ensure robust transitional arrangements between services • All young people with complex and chronic mental health needs have planned and robust transition arrangements in place.	Strategic oversight group established (CCG and LA) – timescales to be agreed

Enablers

There are a number of areas of work and assurance mechanisms that will/do take place in order to 'enable' the delivery of the above projects and the overall delivery of the domain:

Enabler	Projects
Primary Care	Innovation in Primary Care to support reducing the incidence of teenage pregnancy Improved access to a wider range of Primary Care based services, through 7 day working
Quality	Quality and Performance Reports to monitor progress of improvements to patient services . Quality Surveillance Group and Action Plans to challenge current providers improvements Nurse leadership to plan quality visits to provider organisations to identify any improvements needed 6 C's Plan to drive quality through commissioning activity
Information Technology	Electronic Prescribing Service (EPS) Release 2 - to send prescriptions electronically to a dispenser (pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff. National Summary Care Record (SCR) **-** will improve patient safety, increase efficiency and effectiveness and increase quality of patient care. GPs will know that their patients are being treated in out of hours or in urgent care settings across England using accurate, up to date information. Patient access to their digital clinical information
Communication and Engagement	Paediatric Pathways 0-5 • Focus groups with parents of under-fives to identify strengths and areas for improvement CAMHS specification review • Understand patient experience • Identify gaps in current service • Gather information on accessibility of service • Identify potential improvements within current services • Find out what is working well and what needs to be improved Integrated Neighbourhood Teams • Understand what drives patient choices • Understand patient experience • Identify gaps in current service of health and social care services Intermediate Care Services Review • Understand patient experience and identify gaps in current service • To gather information on whether patients feel supported in returning to their own home and whether the support they were given helped reduce admissions to care homes (following discharge from hospital) and helped reduce readmissions to hospital.

	Transitional Care/ community intervention beds (Winter 2013-14) Understand patient experience in order to develop and reshape services. Identify gaps in current service Understanding patient experience of returning home from hospital GP Care Homes Scheme • To understand the patient experience and what are the benefits of the scheme. Choose Well – understand patient and public expectations of NHS through use of alternatives to a hospital Third Sector Grants • To ensure that the sector are engaged in the suggested new process of commissioning and ensuring that funds are allocated in the best way to meet the needs of the population. This work will be done in partnership with Cheshire East Council.
Medicines Management	Continue phased introduction of the Blueteq system to capture the information on usage and provide clinical assurance of compliance with NICE guidance and local protocols

Domain 5

Treating and caring for people in a safe environment and protecting them from avoidable harm

Although research suggests around 90% of patients admitted to hospital will not experience an adverse incident, around 10% of patients will experience an adverse event, half of which are considered avoidable. Older patients are disproportionately affected by patient safety incidents causing severe harm or death. Over a million patient safety incidents are reported to the National Reporting and Learning System each year, over 90% of which involved low or no harm. However, we know this is an underestimate of the true burden of harm (Source: NHS England).

NHS South Cheshire CCG is committed to protecting people from avoidable harm and ensuring care is provided in a safe environment.

This Domain focuses on measuring the broader outcomes resulting from development of a patient safety culture across the NHS, in particular it targets:

- **Reducing the incidence of avoidable harm**

Our JSNA findings state:

South Cheshire CCG is committed to support our providers to ensure there is a zero tolerance approach for MRSA (as required by national targets). The CCG supports our providers to ensure that infection prevention and control (IPC) practices are robust, meet best practice standards and are adopted at all levels within each organisation.

South Cheshire CCG is committed to support our providers to meet national targets for C Difficile.

2014-16 Areas of Action (Commissioning Intentions):

This Domain focuses on measuring the broader outcomes resulting from development of a patient safety culture across the NHS, in particular it targets:

- Reducing the incidence of avoidable harm
- Caring for patients in a safe environment

NHS South Cheshire CCG has identified a number of areas of action to address the identified health need above. In the table on the following page we have identified a number of management methods to enable the CCG to seek and gain assurance regarding quality and patient safety (This is not an exhaustive list but highlights three key areas of work):

Project and aims	Outcome	Milestones
Quality and Performance Committee The aims of the committee are to develop, implement and audit our Quality strategy that commissions appropriate actions from providers to ensure quality outcomes measures are realised. This group also has a sub-group looking in detail at all complaints, SUIs and professional concerns raised by clinicians about providers.	Information from a number of sources is triangulated to identify areas or risk and to mitigate risk and identify actions.	Meets on a monthly basis, action plans monitored to meet individual milestones.
Quality dashboard This dashboard has been developed by the CCG to provide information on all providers to identify trends in quality issues, performance and patient safety. This also includes complaints and SUI's.	By identifying areas of concern this allows the CCG to efficiently and timely act upon and mitigate risk.	All provider information/ data will be available via the quality dashboard by July 2014. The dashboard will be reviewed on a monthly basis at the Quality and Performance Committee.
Provider Quality Review Meetings The aims of the meetings are to discuss performance relating to quality and patient safety. This also includes patient story.	• Providing support and developing relationships with our providers to foster a culture of openness and transparency in reporting. • Enabling all organisations to act quickly in response to areas of concern regarding quality and patient safety. • To review serious untoward incidents and lessons learned.	All providers Quality Review Meetings to include a patient story by September 2014. These review meetings are held monthly with all providers.
Safeguarding Contract Review Meetings A scorecard is in place for our 3 main providers (MCHFT, ECT and CWP), which is monitored by the CCGs and gaps/ improvements identified to be addressed.	• Regular performance monitoring of safeguarding activity addresses weaknesses at an early stage to protect vulnerable adults/ children locally. • The LSCB/LSAB are assured that health commissioners/ providers are addressing safeguarding issues systematically and pro-actively.	• Action plans have individual milestones relevant to the issue. • Quarterly meetings are held.

Enablers

There are a number of areas of work and assurance mechanisms that will/do take place in order to 'enable' the delivery of the above projects and the overall delivery of the domain:

Enabler	Projects
Primary Care	
Quality	Safeguarding Dashboards Local Commissioner Regulator Action Plans
Information Technology	National Summary Care Record (SCR) **-** will improve patient safety, increase efficiency and effectiveness and increase quality of patient care. GPs will know that their patients are being treated in out of hours or in urgent care settings across England using accurate, up to date information.
Communication and Engagement	Paediatric Pathways 0-5 • Patient feedback and patient stories from MCHFT Children with LTC • Identify gaps in current service • Gather information on accessibility of service • Identify potential improvements within current services Find out what is working well and what needs to be improved.
Medicines Management	Develop the capability of prescribing support software (Eclipse Live and Scriptswitch) to support improvements in patient safety Work with the Quality team and local Acute Trusts and Primary Care to implement the Medicines Safety Thermometer and medicines-related CQUIN schemes and Quality Schedule requirements. Develop a local strategy to reduce the pressure on antibiotic resistance and support providers to meet targets for incidence of Healthcare Acquired Infections including MRSA and *Clostridium difficile*

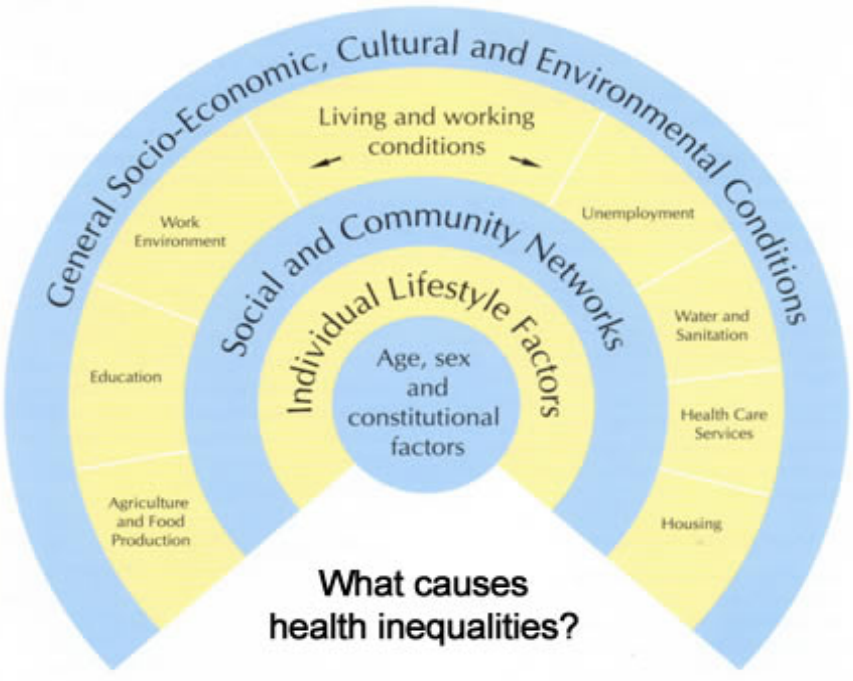
6.2. Improving Health & Reducing Health Inequalities

The Marmot Review "Fair Society, Healthy Lives" found that health inequalities result from social inequalities, and that action on health inequalities requires action across all the social determinants of health. Reducing health inequalities will involve concerted action by the CCG and its partners across six objectives:

- giving every child the best start in life;
- enabling all children, young people and adults to maximise their capabilities and have control over their lives;
- creating fair employment and good work for all;
- ensuring a healthy standard of living for all; creating and develop healthy and sustainable places and communities; and
- strengthening the role and impact of the prevention of ill health.

Marmot also found that focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the gradient in health, actions must be universal but with a scale and intensity that is proportionate to the level of disadvantage. This is called proportionate universalism and it has particular significance in South Cheshire CCG because of the local variations that include widespread social deprivation (in Crewe), small communities experiencing deprivation (parts of Alsager, Middlewich, Nantwich, Scholar Green and Sandbach), and areas of rural deprivation (to the west of Nantwich and Crewe, and around Sandbach). All three CCG Locality Groups are developing health inequality strategies for their areas.

NHS South Cheshire CCG is committed to systematic action to meet this concern and to commission services effectively to meet this challenge.



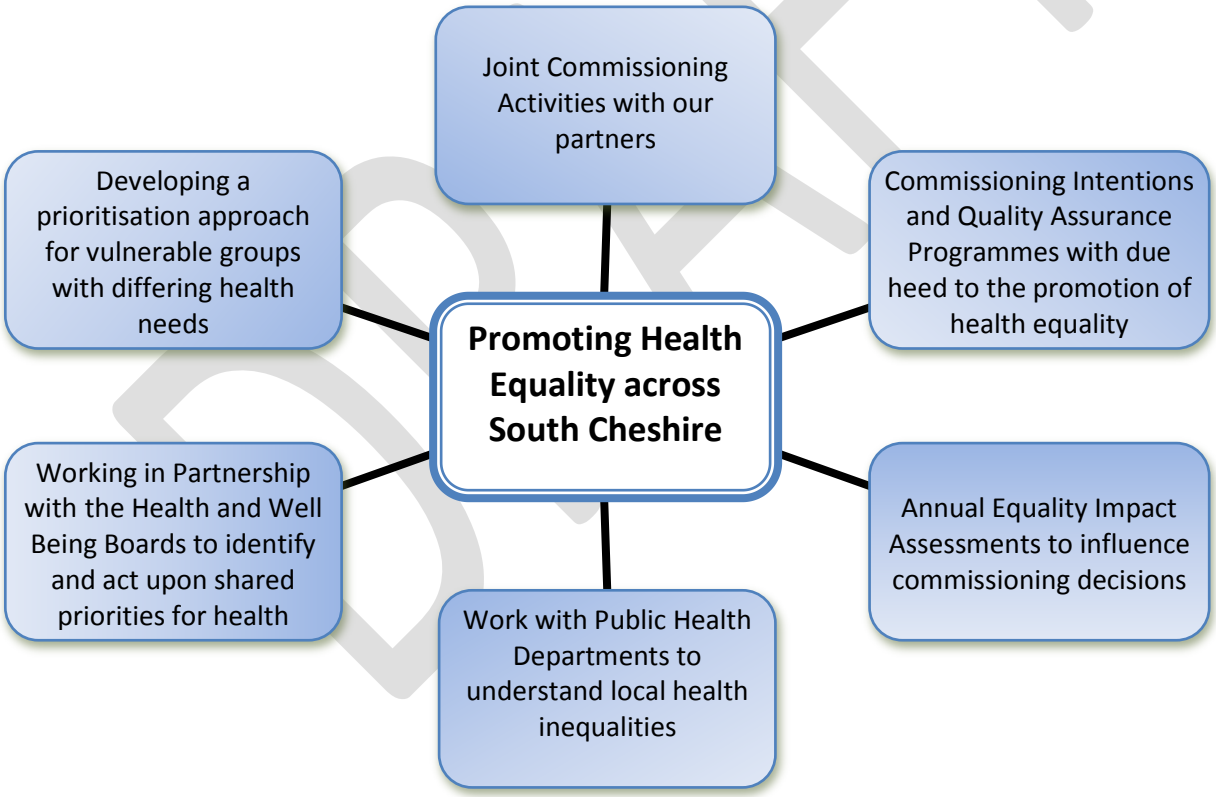
Institute of Public Health

Public Health Resources

The principles of 'proportionate universalism' apply also to the allocation of Public Health resources; and focussing public health interventions on reducing the health impacts of social gradients will mean that there is a differential preventive investment in the more deprived communities such as Crewe. Public Health will lead on the following actions:

- Promoting the NHS Health Check for people aged 40-74 years; identifying those with major or multiple risk factors which could lead to premature death and reducing these risks
- Ensuring maximum uptake of current national cancer screening programmes and promotion and support of early detection
- Reducing harmful drinking
- Reducing smoking amongst highly addicted smokers and reduce the number of young people starting to smoke
- Increasing physical activity; helping people to build it into their day and promoting low cost physical activities which are accessible to all
- Working with local businesses and food banks and others to promote healthy eating; encourage and support people to eat healthier, locally grown, cheaper unprocessed foods
- Using readily available data to identify people at greatest risk of premature mortality and target action appropriately

Aligning our Health Inequality Plan in South Cheshire CCG



The diagram demonstrates the various partnerships and work streams that the CCG is involved with to improve health and social care for all our populations. However, each of these elements has a distinct contribution to make to also reducing health inequalities as an overarching factor, i.e. all children have universal health checks but we have to target additional resource in our more deprived areas of Crewe to make sure local children have additional chances of improved health through

additional nursing or GP sessions through schools or children's centres.

The CCG priorities are aligned to the main health inequalities in South Cheshire:

HEALTH INEQUALITY	CCG COMMISSIONING PLAN 2014-16 PRIORITY
Male life expectancy	Targeted work needed in Crewe, particularly 'north' Crewe.
Female life expectancy	Targeted work needed in Crewe, particularly 'north' Crewe.
Higher than (national) average incidence for long term condition (respiratory disease, cancers, strokes, heart disease) and higher than (national) average ageing population.	Commissioning intentions to improve community and primary care provision for people with long term conditions including stroke, respiratory conditions and cancers. Once again targeted work needed in Crewe, especially in women, but also for men in Nantwich, Sandbach, Alsager and Crewe. Commissioning intentions to improve end of life services, dementia care and hospital admissions avoidance schemes.
High levels of deprivation in some towns and medium super output areas (MSOA)	Commissioning intentions to improve outcomes for children experiencing domestic abuse/safeguarding /admission to hospital. Commissioning intention to improve access to mental health services, particularly relates to parity of esteem with higher mortality rates in Crewe. Alignment with Cheshire East Health and Wellbeing priorities from JSNA and Joint Health & Wellbeing Strategy to include: • Alcohol • Smoking • Obesity

Tackling Health Inequalities in South Cheshire CCG 2014-16

Working alongside Cheshire East Council we will:

For Children and Young People:

- Target effective outreach services on identified 'troubled families' (shared between health and council services) to increase early prevention work increasing understanding of primary care services and access.
- Target schools in deprived parts of Crewe to have additional health input to increase understanding of /and access to healthcare – GPs to visit schools to educate young people in primary care services and how best to access services.
- Support women to put their health first before and during pregnancy, to stop smoking and drinking alcohol, and to obtain good quality healthcare throughout their pregnancy (*this may be considered as a possible CQUIN*). The Family Nurse Partnership nurses are particularly focussed on very young mothers in Crewe, currently to improve outcomes for their children.

For Adults:

- Assist Public Health programmes to be targeted to specific geographic areas where health

outcomes are poorest.
- Assist public health to investigate access to diagnostics and access to early treatment in deprived populations.
- Actively publicise when to seek medical help for cancer/liver disease/heart disease/respiratory disease, specifically in deprived areas.
- Target help for patients with multiple lifestyle issues in deprived areas alongside Public Health i.e. weight loss and motivational support.
- Improve preventative support in secondary care services (hospital) to target advice/help patients on lifestyle support (weight/smoking/exercise)

For Older People:

- Assertive outreach through Extended Practice Teams to frail older people to avoid hospital admission/breakdown of carer support.
- Work with Cheshire East Council and East Cheshire CCG to shape the local nursing/care home market to improve quality and create the right capacity and services to meet identified need.

In developing our plan, we have discussed and aligned our priorities with Cheshire East Health and Wellbeing Board. This ensures our plan:

- Aligns with and supports delivery of the Joint Health & Wellbeing Strategy
- Gives a focus for the future work of our established joint commissioning arrangements with Cheshire East Council and East Cheshire CCG.
- Reflects the Joint Strategic Needs Assessment.
- Contributes to the wider vision for our communities shared with partner commissioners in Cheshire East (other CCGs, council)
- Shapes other local commissioning plans to enable integration of services/pathways.
- Integrates local planning with Cheshire East Council to use local resources to better effect in the most deprived areas.
- Develops a shared vision (and consensus) with Cheshire East Council and local communities about the priorities for local services (including integrated services.)

Equality and Diversity

As Commissioners we know and understand that there is clear evidence that people's health, their access to health services and experiences of services are affected by their age, gender, race, sex, sexual orientation, religion/belief, transgender, marital/civil partnership status and pregnancy/maternity status (known as the nine protected characteristics).

We also understand the benefits of commissioning services that meet the needs of our communities and we will strive to improve access and outcomes for patients, by:

- Meeting our Public Sector equality Duty and our requirements under the equality Act 2010
- Our commitment to reduce health inequalities.

The mechanisms we will use to improve access and outcomes are by:

- Delivery against our strategic Equality Objectives
- Strong Leadership and Governance via our health inequalities Sub group
- Ensuring we make fair and transparent commissioning decisions using Equality Analyses so we consider our Public Sector Equality Duty and improving the equality performance of our providers

through the quality contract schedule
- Undertaking a Equality Delivery System 2 (EDS2) self-assessment
- Working closely with HealthWatch Cheshire East and other expert patients and stakeholders to engage meaningfully in the process
- Partnership working with the local authority and community, voluntary, and faith sector.

Through Equality Analysis on priority commissioning intentions and an annual Equality Analysis, the CCG will ensure it is taking into consideration the 9 protected groups and is not increasing health inequalities or access to services.

As South Cheshire CCG, we have a duty to have due regard for the need to eliminate unlawful discrimination, harassment and victimisation; advance equality of opportunity and foster good relations between different groups.

As part of our Health Inequalities Plan, we have also identified certain groups within the 9 protected characteristics that need specific targeting of commissioning resource in order to reduce their potential health inequality:

- the Polish community in Crewe unable to access health services easily due to language barriers;
- children in deprived wards in Crewe with poor health outcomes;
- higher level of cancer in women in parts of Crewe;
- earlier deaths at a younger age in parts of Crewe;
- higher admission to care/nursing homes for older people;
- higher paediatric admissions due to respiratory issues.

7. Parity of Esteem (Physical and Mental Wellbeing)

'Parity of esteem' means that, when compared with physical healthcare, mental healthcare is characterised by:

- equal access to the most effective and safest care and treatment
- equal efforts to improve the quality of care, the allocation of time, effort and resources on a basis commensurate with need
- equal status within healthcare education and practice
- equally high aspirations for service users; and
- equal status in the measurement of health outcomes.

NHS South Cheshire CCG values mental health equally with physical health and aims to commission high quality care for all. However there has been, historically inequity in services for people with mental health problems who also have physical problems. There is significant evidence that links poor mental health with poor physical health, and poor physical health can lead to poor mental health.

For example; over 75% of those with heart disease are in treatment, for people with diabetes or hypertension more than 90% are in treatment. Conversely only 25% of people with depression or anxiety receive treatment. If you have mental illness it can reduce your life expectancy by 10 years because of your poor physical health.

Mental health illness influences premature mortality in the following ways:

- People with schizophrenia and bipolar disorder die on average 20 years earlier than the general population, largely owing to physical health problems.
- People with mental disorder(s) smoke almost half of all tobacco consumed and account for almost half of all smoking-related deaths. Rates of smoking on in-patient mental health units are 70% compared to 21% in the general population. [6]
- Depression doubles the risk of developing coronary heart disease
- People with depression have a significantly worse survival rate from cancer and heart disease
- People with two or more long-term physical illnesses have a seven-fold greater risk of depression
- Excessive consumption of alcohol is associated with higher levels of depressive and affective problems, schizophrenia and personality disorders as well as with suicide and self-harm[7]

This highlights that many of the problems are circular. For example if you drink large amounts of alcohol you increase your risk of poor mental health. By increasing the focus on mental health some of these issues can be addressed which will have knock on benefits for poor physical health and premature mortality rates.

We are committed to ensure that we commission services to provide services to support people with both physical and mental health conditions and also those who have learning disabilities. To this end, a number of key commissioning priorities and areas of action have been identified to address the identified health inequalities identified above:

[6] 'Living Well for Longer in Cheshire East', The Annual Report of the Director of Public Health 2012-13
[7] Royal College of Psychiatrists, 2010. No health without public mental health: the case for action

Project and aims	Outcome	Milestones
Challenging Behaviour (including Winterbourne View Concordat) **'Transforming Care' and the 'Winterbourne Concordat' set out a number of recommendations for the development of community based services to support people with challenging behaviours. In line with this concordat the CCG working with local partners will agree a joint strategic plan to commission high quality health, housing and support services for people of all ages with challenging behaviours.**	• Review of current provision and develop proposals for future models of care • People with challenging behaviour will be able to continue to live locally near their families and social networks with high quality services to support them.	Local partners are committed and have agreed to develop the joint strategic plan. We have a national target to meet by June 2014 to review the individual cases of those currently placed out of area with a view to bringing people closer to home.
Physical Health Needs – Mental Health **This commissioning intention builds on the work done during 2013/14 to address physical health needs, working with providers to systematically improve health screening, and to commission a programme of brief interventions targeted at this vulnerable group of people. Much of the learning has come from the AQUA programme 'Don't just screen, intervene'. This new programme of work will take things to the next step and provide a service to 'intervene' to support this population group.**	• The monitoring of physical health needs of this client group will be carried out in a systematic way. • A brief intervention programme will be available to deliver targeted interventions. This will focus on weight management, stop smoking, alcohol awareness, healthy eating and physical activity. • A brief intervention programme will be available specifically focused on the physical health of children and young people who experience their first episode of psychosis. • The physical health of people with mental health issues will be dealt with quickly and as a part of their overall health and wellbeing.	• CQUIN will be agreed in April 2014 • Adult brief intervention programme will be available by June 2014. • A children and young people's brief intervention programme will be available by October 2014. • Programmes will be reviewed on a monthly basis throughout.
Review of Liaison Psychiatry Service **To review the existing liaison psychiatry service, with a view to understanding the demand and scope of such a service. To create a service re-design project extending the scope and capacity of the existing service.** **This will form part of an accountable care system linking into Extended Practice**	• Prevention of unnecessary admissions for patients with physical and mental ill health • Reduced length of stay for patients with physical and mental ill health • Reduces rates of re-admission for patients with physical and mental ill health • Reduction in rates of frequent attenders for patients with physical and mental ill health	• Full business case presented Feb 2014 • Engagement with partners by April 2014 • Project implementation from April 2014

Teams.	• Improved clinical outcome for patients with physical and mental ill health • Improving experience of healthcare for patients with physical and mental ill health • (The baseline assessment for this project will form part of the scope of the project. A balanced scorecard approach to assessing performance will be developed as part of the re-design of the service).	
Perinatal Mental Health (links with Liaison Psychiatry Service) **Review provision of perinatal mental health support in CCG commissioned services, primarily midwifery** **With Local Authority and NHS England partners ensure a joined up commissioning approach to peri-natal health** **Develop a robust, integrated and evidenced based pathway of care and ensure commissioned services can effectively support this.** **Implement findings of review into year 2.**	Early identification of mental health problems and prevention of further ill health (mental and physical) for mother and baby ('Parity of Esteem') to reduce risks of poor mental health.	• Review findings of Liaison Psychiatry Service review – Qtr1 • Commence the review of commissioned per-natal mental health services – Qtr 2 2014-15 • An understanding of the quality of existing provision, gaps in services, total resources, met and un-met need for maternity services - Qtr 2 • Identify any joint commissioning opportunities that exist – Qtr 3-4.

Carers are key to integration and delivering transformation

Carers – quality of life

The statutory 'Carers survey' (Caring for others), commissioned by the Department of Health, is the first of its kind. The Cheshire carers survey completed in June 2013 presented its key findings:

- Over two thirds of carers do some of the things they value or enjoy with their time, but not enough
- Over a quarter of carers have as much control over their daily life as they want
- Almost two thirds are able to look after themselves (this is in relation to getting enough sleep and eating well)
- The majority of people have no worries about their personal safety
- Almost half of the respondents have as much social contact as they want with people
- Almost half feel they have encouragement and support in their caring role.

Supporting carers can help CCGs meet priority areas for improvement in the NHS and ensure that they are meeting the post-Francis agenda. We believe that commissioning services for carers can improve the interface between health and social care by improving information sharing between services and through joined up aftercare. Integration between health and social care can also be improved if statutory services also promote the involvement of carers.

Commissioning for carers can help meet a number of Outcomes Framework domains. This can be achieved through:

Reducing the amount of time spent in hospital by people with long-term conditions

Admission or readmission to hospital by a person with a long-term condition can be an indication that the carer is no longer able to care, often due to the strain of caring causing physical or mental ill health, or that discharge planning is poor and the carers is not involved as an expert partner in care.

Tackling health inequalities

Carers are more likely to have poor health compared to those without caring responsibilities. Health problems such as stress, anxiety and depression and poor physical health can occur due to their caring role. Their health can also suffer as they consider their own health needs unimportant compared to the needs of the person they look after and their caring role means they can find it difficult to attend clinical appointments.

Support for young carers can also tackle health inequalities. Young carers' health and wellbeing can be impacted by feelings of stress, anxiety, depression, panic and problems such as poor sleep, risk of self-harm, and neglect of their own health, and failure to do well at school.

Improving the care of people with dementia

Improving the diagnosis, treatment and care of people with dementia in England and support for their carers is a key part of the NHS Mandate and one of the Secretary of State's key priorities.

Carers support people with dementia to stay independent for as long as possible which delays and prevents the cost of residential care. However, many carers feel unsupported and uninformed about the condition of the person they care for, and the demands of caring for someone with dementia are challenging. Carers of people with dementia experience particular difficulties, they are older people themselves and many have their own long-term health conditions or disabilities. Often carers who

support someone with mental health issues know best about how the condition affects the person but least about the diagnosis and prognosis due to issues around confidentiality.

Improving the quality of life of people with long-term conditions and help people recover from illness

Carers often provide the majority of care that would otherwise be the responsibility of health or social care professionals. They therefore need support the appropriate knowledge and skills to care safely and in a way that promotes wellbeing for the care recipient. When carers are well supported they provide better care to the person they care for and are able to enjoy the caring experience whilst having some time for themselves as well.

Ensuring people have a positive experience of care and are protected from harm

The Francis Report called for CCGs to work with NHS England to develop enhanced quality standards to drive improvements in the Health Service.

The NHS Mandate states that NHS England's objective is to ensure the NHS is better at involving patients and carers and that by 2015 carers have access to information and advice about support available.

For carers, as well as patients, information relating to conditions and services and how these are to be paid for can be complicated and confusing. Many carers struggle alone not knowing what help is available to them through local carers support services.

It is important that carers are able to access information and advice on balancing their employment and education with their caring role,. They need advice about welfare, respite breaks and training in areas such as first aid, moving and handling and stress management. If carers build up a relationship with a trusted local provider of advice, such as a local carers organisation, they are more likely to seek support in advance of a future crisis.

One of the key recommendations from the Francis Report is to create a system that is more responsive to feedback from friends and family. Involving carers in a patient's care can then ensure that any potential problems or concerns are picked up quickly and dealt with to reduce harm and distress.

Areas of Action:

NHS South Cheshire CCG, NHS East Cheshire CCG and Cheshire East Council are jointly developing an action plan for its joint Carers strategy. Key areas of action over the next two years are highlighted below:

Key Areas of Action	By When
Deliver the carer break application and commission activities	2013 /14
Finalise reviewed strategy and ensure delivery of the 5 objectives: • **To help and advice carers so that they are not forced to into financial hardship** • **To ensure carers will be respected as expert care partners and will have access to integrated and personalised services they need to support them in their caring role**	April 2014 – March 2015

• **To ensure children and young people are protected from inappropriate caring roles and have the support they need to learn, develop and train and to enjoy positive childhoods** • **To support carers to stay mentally and physically well and ensure they are treated with dignity** • **To support carers to have a life of their own alongside their caring role**	
Commence delivery against reviewed strategy	April 2015 - March 2016

The commissioning of carers support services will be done jointly by South Cheshire CCG, Cheshire East Council and ECCCG from 2014.

8. Our 'Enablers' to Transformation

For CCG's as commissioners, the enduring challenge is to transform the way care is delivered, improving the quality and outcomes that matter most to patients (and carers), their friends and family and the public. We have the ability to use our resources for investment in what matters most to patients and the public in different ways.

8.1 Making a Difference – Engagement, Involvement and Communication

To achieve improvements in quality and to enable change to meet our challenges we see great value in ensuring that citizens are fully included in all aspects of service design and change and that patients are fully empowered in their own care.

NHS South Cheshire Clinical Commissioning Group (SCCCG) holds patient and public involvement in high regard and believes that true success occurs when we share, involve and engage with our local population. Much emphasis has been placed on ensuring this has occurred over the last year, and every effort is being made to ensure our engagement activity increases and becomes a sustainable and vital role within the development and transformation of the health and social care system.

Therefore our engagement, involvement and communications plans to enable this transformational change do not start from scratch but builds on that early work and it's subsequent developments.

The CCGs transformation agenda, embedding the Connecting Care vision is "to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing" is a central driver in all of our forthcoming engagement, involvement and communications work, to ensure the most insightful results can no longer take place in isolation. To this end, an **Engagement Network** of all those working within engagement and communications from our partner organisations has been initiated, so that we can maximise our partnership working, ensuring consistency of message and approach and reduce duplication of effort.

During the next year, our emphasis will be on the integration of care systems and joint working across health and social care and different care organisations, developing Care Improvement Panels. These

panels will feature strong patient representation, professionals, local councillors, clinicians, CCGs and social care and will add a further dimension to the way that patients have a local voice in shaping locally delivered healthcare.

Working, communicating and engaging with our stakeholders to make a difference.

NHS South Cheshire CCG has a wide range of stakeholders that it needs to engage, involve and communicate with in order to deliver its commissioning vision, objectives and operational plan. In order to ensure that all communication and engagement activities are tailored to individual stakeholder needs, it is very important to analyse the various audiences and plot their level of interest and influence in the success of SCCCG.

It is important that specific stakeholder analysis is carried out regularly and routinely to underpin all specific programmes of work. By carrying out a formal stakeholder analysis this will further support the deliverables within *Transforming Participation in Health and Care (NHS England, 2013)* as it will allow us to, 1) Identify key messages for each identified audience (or participation level) and, 2) identify communication opportunities and challenges

Below is an overview of NHS South Cheshire CCG's stakeholders:

Public ➢ Public ➢ Carers ➢ Patients ➢ Cheshire East HealthWatch ➢ Patient Participation Groups ➢ South Cheshire Federation of Patient Participation Groups ➢ Community organisations which represent local people/service users (CVS) ➢ Local, regional and national press ➢ Local radio ➢ Websites/social networking sites/Twitter ➢ Newsletters – internally produced and partner newsletters	**Commissioners** ➢ South Cheshire GPs ➢ SCCCG staff ➢ Cheshire East Council ➢ Vale Royal CCG ➢ Eastern Cheshire CCG ➢ Public Health (within Cheshire East Council)
Providers ➢ Practice staff ➢ MCHFT staff ➢ North West Ambulance Trust ➢ Other specialist Trusts (Cheshire and Wirral partnership Trust) ➢ Voluntary sector providers ➢ Cheshire and Merseyside Commissioning Support Unit ➢ Pharmacists ➢ Dentists ➢ Ophthalmologists	**Public Partners** ➢ Cheshire East Council ➢ Parish Councils ➢ Voluntary sector representatives ➢ Regulatory bodies ➢ Health and Wellbeing Board
Professional Bodies ➢ NHS England ➢ Royal Colleges ➢ Unions (GMC etc.) ➢ Public Health England	**Political Partners** ➢ Department of Health ➢ Members of Parliament ➢ Health Overview and Scrutiny Committee ➢ Council leaders ➢ Councillors from parish to County level ➢ MPs and MEPs

Embedding engagement in the whole health and social care system working with our partners is the key to achieving excellent, safe and quality services. We consider our local population to be the 'experts'; knowing what services and support they may need to support their health and wellbeing. We would like to harness their local knowledge to commission the most appropriate services that provide value for money.

For NHS South Cheshire CCG 'engagement', 'involvement' and 'communications' means the full

spectrum of patient and public relations work that leads to the public conversations that will influence health and wellbeing outcomes. This is at all levels, individual, organisational and population levels.

In developing our plans NHS South Cheshire CCG has taken into account the duties for NHS commissioners as set out within the Health and Social Care Act (2012) with respect to public and patient participation:

NHS commissioners should:	At NHS South Cheshire CCG:
Make arrangements for and promote individual participation in care and treatment through commissioning activity.	We actively encourage individual participation through **patient stories and experiences**. These have been used in order to investigate issues of quality and service improvement.
Listen and act upon patient and carer feedback at all stages of the commissioning cycle – from needs assessment to contract management.	Embedding patient and carer feedback is a crucial part of the commissioning cycle. At present patient and carer feedback is included during the initial stages of commissioning cycle. However during 2014-16 we want to **build patient and carer insight** into the expectations of our local providers **to deliver accountable care systems around patient's needs.**
Engage with patients, carers and the public when redesigning or reconfiguring healthcare services, demonstrating how this has informed decisions.	We base our public engagement and communication planning around the *Engagement Cycle of Participation*; this ensures that patients, carers and public are involved. **You Said, We Did** is the mechanism that the CCG uses to demonstrate how feedback informs our decisions.
Make arrangements for the public to be engaged in governance arrangements by ensuring that the CCG governing body includes at least two lay people.	We have a **lay member of Participation and Public Engagement**, who sits on the Quality and Performance Committee and who also proactively supports the South Cheshire Federation Of Patient Participation Groups. We also have **2 lay audit members** that support the Governance and Audit Committee of the CCG. Our meetings of the Governing Body are held in public bi-monthly.
Publish evidence of what 'public and patient voice' activity has been conducted, its impact and the difference it has made.	We will be collating information during 2014-2016 (and onwards) gathered from public and patient voice activity into a **monthly insight report**, which will be issued to all Service Delivery and Clinical Project Managers and lead GP commissioning clinicans.
CCGs will publish the feedback they receive from local HealthWatch about health and care services in their locality.	We will **publish feedback from HealthWatch Cheshire East** about our locality as and when it becomes available. This will be published via all methods we have available to us to suit audience requirements.
Patients and carers to participate in planning, managing and making decisions about their care and treatment, through the services they commission	We will ensure that engaging with patients and carers is at the forefront of all elements of the commissioning process via a transformational shift to **person-centred commissioning** We will invite patient/ public to be involved in specific service areas i.e. cancer/ stroke/ urgent care/ mental health or the transformational changes i.e. Extended Practice Teams, Connecting Care.
The effective participation of the public in the commissioning process itself, so that services provided reflect the needs of local people	We will report back via You Said, We Did to ensure that engagement, involvement and communications activity has been effective and reflects the needs of local people.

The overarching aims within our approach to public engagement, involvement and communications are:

- To continue to build meaningful engagement with the public, patients, carers, stakeholders and our own staff to influence the shaping of health services and improve the health of people in South Cheshire.
- Deliver effective communications that encourage patients, stakeholders and our own staff to better understand and take advantage of CCG led developments.
- To further develop the culture within the CCG that promotes open engagement, involvement and communication within and outside our clinical commissioning group to demonstrate how engaging people helps to make a difference.
- Develop effective communication channels that encourage leadership, involvement and engagement across the 18 GP practices within South Cheshire.
- Increased involvement at commissioning level via person-centred commissioning.
- To increase confidence in the CCG as a responsive commissioning organisation.
- Increase awareness of the CCG vision, strategic objectives, principles and ways of working.

Public engagement, involvement and communications work within NHS South Cheshire CCG does and will include the following activity:

- Using a range of activities and approaches to ensure that the public voice visibly influences and is directly involved in the decisions made by the CCG, underpinned by our '**Making a Difference - Good Engagement Charter'. We plan to launch the Charter at the same time as our new Membership Scheme in June 2014.**
- A wide range of communication channels will be used to reach and receive feedback from a wide range of audiences including those groups and individuals whose voices are not always heard. **We have recently reviewed the Paediatric Pathway with parents and grandparents within the Polish and Bengali community. Other planned work includes engaging with frail elderly to gain their perspective of the GP Care Home Pilot. A proactive assessment of all protected characteristics underpins all engagement activity.**
- Continuing to develop the external reputation of the CCG as a leading commissioning organisation. As leader of the local health economy, the reputation of the organisation is critical to successful relationships. **Effective management of the CCGs identity and house style is an important element in protecting the organisations reputation and it is important that the CCGs identity is not used inappropriately.**
- Proactive and planned internal and external communications assist South Cheshire CCG to operate effectively and gain the support of staff and stakeholders needed to implement wider scale changes. **For example – regular team brief, CCG Intranet (which is also accessible to all 18 member practices), quarterly GP Member Newsletter, Stakeholder Newsletters, CCG website, Twitter feed, LinkedIn members group.**

Engaging with our location population to make a difference

In line with **Transforming Participation in Health and Care (September 2013)**

Individual Participation

Why?

People's lives can be transformed when they have knowledge, skills and confidence to manage their own health, when they are able to shape their care and treatment to fit with what is important to them. When health outcomes and goals are agreed, needs are better met and people are supported to manage their own care.

There is now a growing body of literature to show that patient participation:

- Improves outcomes (linked to achieving the CCG Strategic Objectives of the Domains 1-5)

- Improves quality of life (linked to achieving the CCG Strategic Objectives of Domains 2 and 3)
- Provides value for money

Ways of communicating and measuring success – Individual Participation

- Patient stories and voices

It is often said that individuals are the best experts to manage their own health and care. Patient stories are an incredibly rich, powerful but underused source of information. They bring to life issues that really matter to people, in their own words. Engaging at an 'individual' level, means that SCCCG will be able to work closely with 'experts' (the individual) in order to create a real difference, not only to the individual concerned, but by taking this expert guidance and making the insight real and meaningful for those who deliver services, so they can change their service.. Insight gathered from individual participation links directly to Domains 1, 2, 4 and 5.

Public Participation to make a difference

Why?

Evidence suggests that engaging and involving communities in the planning, design and delivery of health and care services can lead to more, co-ordinated and efficient services that are responsive to local community needs. Public participation can also build partnerships with communities, learn more about their aspirations for their health and care and identify areas for service improvement.

Ways of communicating and measuring success – Public Participation

- Patient Participation Groups
- The South Cheshire Federation of Patient Participation Group
- The South Cheshire CCG Readers Panel
- Membership Scheme (to commence June 2014)
- Making a Difference Good Engagement Charter (to commence June 2014)
- Use of electronic survey with registered patients

Not everyone will want to participate in the same way or at the same times and therefore it is essential that a range of options is provided.

This will include:

- Online survey tools
- Dedicated events to enable discussion about proposals
- Seeking views from the community at local events or venues e.g. attending local festivals, markets, schools, leisure centres, libraries etc.
- Understanding the assets within our local community and collaborating to identify and solve problems together (Asset Based Community Development)
- Pro-active work through local voluntary and community sector organisations, including small grass roots organisations in order to collaborate and solve problems together, particularly with communities of interest e.g. mental health charities, homeless organisations.

Insight and Feedback to make a difference

Why?

The NHS Constitution is clear that every individual deserves to have as good an experience of the NHS as we can possibly provide. To ensure this happens, we need to listen to people in order to understand what they need and what works for them, this is what we mean by insight and feedback.

Using insight and feedback at South Cheshire CCG

Insights occur when people recognize relationships or make associations between objects and actions that can help them solve new problems. Therefore, South Cheshire CCG will start to

create insight reports which draw together the various strands of feedback which we receive. In order to become more insightful with this information we need to be asking more thoughtful questions, looking beyond the obvious and not being afraid to reframe what is it is that we need to find out. Equality and Diversity work (and the nine protected characteristics), is embedded into our regularly public engagement and communications work as standard in order to gain insight from as wide a range of our public as possible.

Engagement and Communication within our work programmes

In development of our Plan, each of the three work programmes have been identifying their public engagement and communications priorities for the coming year, examples of the priorities are presented across each of the Domains.

Insight from Partners

The following are sources of information and insight from external sources to SCCCG. Together, these sources of information allow us to develop a broader context to any engagement, involvement or communications activity which takes place:-

- **Working with our local authority and partner CCGs**

In order to maximise the insight which we gain from our engagement and involvement activity, South Cheshire CCG, Cheshire East Council and Eastern Cheshire regularly share updates on what our local citizens are telling us. This allows us to share best practice and to avoid duplication.

Our shared management team arrangements means South Cheshire CCG also works very closely with Vale Royal CCG on much of our commissioning work.

- **Healthwatch Cheshire East**

Healthwatch is the independent consumer champion that gathers and represents the public's views on health and social care services in England. It operates both on a national and local level ensuring that the views of the public and people who use the services are taken into account. Healthwatch Cheshire East is our local partner. South Cheshire CCG has formed close working arrangements with Healthwatch through sharing public engagement work (minor ailments/pharmacy and Prior Approval Policy Review), introducing Healthwatch to our Patient Participation Groups and supporting Healthwatch with their Youth Engagement project.

- **NHS Patient Survey**

The NHS patient survey programme systematically gathers the views of patients about the care they have recently received. Patients are asked specific factual questions about what happened to them during their recent healthcare experience. These 'reporting' style questions highlight where the problems are and what needs to be done to improve care.

- **Patient Choices**

We make choices all the time, whether it is about our lifestyle or healthcare, most people would agree that it's important to be involved in the decision process. Carrying out desktop research into what the general public are telling us about their experiences services commissioned by South Cheshire CCG, we can capture an array of almost ‘real-time’ information.

- **Patient Opinion**

Patient Opinion is an independent feedback service that aims to promote honest and meaningful conversations between patients and health services. It believes that telling your story can help make health services better. Whilst the reports generated via Patient Opinion may not always be directed linked to our local context, they can provide us with further insight. However, there is good use made of this site by patients using Mid Cheshire Hospitals Foundation Trust.

8.2 Commissioning for Quality in Primary Care (Wider primary care, provided at scale)

NHS South Cheshire CCG has a shared responsibility with NHS England, for the continual improvement of quality in primary care. We believe the CCG is ideally placed to support practices to improve the quality of GP services, that not only meet the changing needs of the local health economy but also put the needs of the patient at the centre of primary care development, achieving excellence together.

NHS South Cheshire CCG firmly believes that Primary Care quality, in all of its forms - engagement, development and education should be embedded throughout the culture of our organisation. We recognise the pivotal role Primary Care plays in supporting a reduction in health inequalities and the valuable contribution general practice makes towards achieving the aims of the 5 domains of the NHS Outcomes Framework, as our strategic objectives. Our member practices support our belief that Primary Care acts as an enabler for the successful delivery of many of our commissioning intentions and in doing so, strengthens the resolve of the CCG to ensure that we get in right.

We recognise the scope of this challenge and over the course 2014/16 we will fully developing and implementing our Primary Care Strategy in consultation with our stakeholders, including lay members, public, clinical representatives as well as NHS England and Social Care. Key elements of our strategy will be:

Engagement – South Cheshire CCG is a membership organisation so robust and regular engagement with our member practices is a fundamental activity. We do this through numerous methods, which include monthly Membership Council, regular newsletters, Locality Lead GP (who are also Governing Body members) and also through strengthening the role of our Practice Engagement Managers. Our Practice Engagement Managers are a visible presence in Primary Care, acting as a “critical friend” enabling all members of the CCG to share experiences and to voice the views of Primary Care. South Cheshire CCG is also intending to support practices to improve the quality of primary care delivery through the introduction of quality improvement processes. Resources are being identified to support this quality initiative.

The CCG also recognises the increasing value in public, patient, third sector contributions towards shaping Primary Care and are working closely with the CCG Practice Engagement Managers to develop this important relationship further over the next two years.

South Cheshire are keen to empower a strong nursing voice, particularly from practices nurses who have well developed relationships with patients and take a big role in supporting patients to manage their own health needs and have valuable knowledge and skills relating to impact for and approaches with patients.

Practice Nurses across South Cheshire want to ensure consistently high quality care for all patients, delivering on all of the 6C's of the nursing strategy. Therefore a Practice Nurse Membership Council is being established. This Council will provide the opportunity for consistent approach to achieve quality and share best practice within practice nursing and also to influence nursing developments and approaches within the South Cheshire area.

The Practice Nurse Membership Council will therefore be a mechanism to:

- facilitate implementation of the national nursing strategy- 'Compassion in Practice',
- provide consistency in policy, procedure and protocols
- Development of quality framework detailing practice nurse quality standards
- Facilitate and share best practice across South Cheshire
- Consistent approach to quality within practice nursing, benchmarking, peer review

- Workforce development
- Raise awareness of key nursing issues and implications in practice locally for patients to the Governing Body
- Mechanism for communication with CCG membership council, CCG shared management team, wider primary care, community and acute care

Transformational Change - The CCG has established a Primary Care Quality, Engagement, Development and Education Group (the Primary Care Group) to oversee the delivery of Primary Care quality initiatives supporting the delivery of the integration and transformational change agenda within primary care. The group benefits from strong clinical leadership, through which the Membership allows the development of ideas and initiatives to grow, specifically those that involve the voluntary sector to target vulnerable or isolated communities. Over the next 12 months we will be gathering intelligence and ideas to plan and prioritise our innovation opportunities, channelling these through Programme Boards to understand the health needs or gap analysis within existing work streams.

Data Quality/ Dashboard Development – The CCG is working towards developing a comprehensive and meaningful set of Practice level information ('Primary Care Quality Dashboard'), encompassing clinical benchmarks as well as supporting the delivery of improved quality measures to support the practice and inform the population. This information will provide relevant, timely and benchmarked information based on practice demographics and performance. Information from the CCG Quality team will also help to develop the 'dashboard' to capture, triangulate and audit professional concerns and significant events. We also recognise the role of NHS England has in reporting significant events and professional concerns, and we aim to work collaboratively to ensure that any such concerns are dealt with quickly and sensitively.

The information will be able to support practices in understanding the requirements from both NHS England as well as CQC as their regulatory body. Through supportive engagement it is the ambition of the CCG to raise the bar of quality across the CCG and for practices to be held up as exemplars of best practice.

The CCG is working in conjunction with the Cheshire and Mersyside Commissioning Support Unit (CSU) to tailor and develop our Primary Care data sets, it is envisaged that this information will be available in practice by the end of June 2014. We will then start to work with practices around action planning for the next 12 months.

Enhanced Quality Frameworks (CQUIN)

The Locally enhanced Quality Framework (LeQOF) - Primary Care CQUIN affords South Cheshire CCG an opportunity to examine local health need and develop a system of targeted improvement initiatives for roll-out in General Practice.

The scheme aims to improve the quality of services for patients as well as reward innovation in GP commissioning. We will continue to align several of the LEQOF initiatives for primary care with those in place with our main secondary care providers as a means of promoting integrated quality improvement schemes – linked to delivering the CCG intention of quality improvement embedded with all our providers across systems.

These initiatives will continue to benefit the quality, range and access of primary care services in South Cheshire as well as the proactive management of long term conditions. It is the intention of the CCG to align the initiatives for 2014/15 closely with the health needs of the population. Through the Primary Care Quality Group, the CCG is taking informed decisions to the areas that are to be identified for quality improvement. We know we have specific health issues in certain

geographies i.e. Crewe, Alsager and Nantwich, so will be targeting specifically to improve health outcomes. The CCG has outlined some ambitious targets within the Primary Care CQUIN that not only draws from Public Health intelligence, Right Care data models and directly from the Membership. The CCG recognises the value in the improvement scheme - over the next two years we will be developing the programme to encapsulate Innovation in Primary Care. At a locality level, we will draw support from Public Health to identify service improvement opportunities that are tailored to meet the needs of specific communities, e.g. dementia awareness, improving outcomes for lung cancer, reducing teenage pregnancy, reducing emergency admissions for respiratory disease, targeting isolated or vulnerable groups. These pieces of work are currently CCG commissioning intentions now supported through primary care interventions as well as work with other commissioned health, social care providers.

We will continue to maximise our use of IT systems to ensure data accuracy. We will encourage practices to undertake audit and validation to support quality, education and shared learning. We will be promoting peer review across the CCG to develop transparency and openness.

Education

South Cheshire CCG firmly believes in the importance of education and mentorship for all of its members which provides a platform across General Practice that promotes pastoral and developmental learning.

Diabetes, chronic heart failure, paediatrics, asthma, COPD, mental health, atrial fibrillation, cancer, self-care, medicines management, substance misuse and patient experience continue to be clinical areas prioritised for learning and development support in 2014-16 - a selection of local workshops will take place to promote the best practice guidelines. A programme of review for elective referrals to support the delivery of efficient use of health resources and promote best practice across all of our primary care providers is also on-going locally.

We will try to anticipate knowledge, skills and professional behaviour required to deliver clinical pathways that support a secondary to primary care shift. We will actively interface with CCG localities / membership and their provision of learning & development to ensure that we minimise duplication and optimise a range of learning and development opportunities to match local practitioners' needs. We will continue to enhance exemplary clinical care in relation to patients with long term conditions (LTCs).
We will continue to commission accredited courses and other learning activities to promote effective working for practice managers, practice nurses, GPs and others.

Innovation

Local priorities for innovation will be derived from the Joint Strategic Needs Assessment and other associated public health needs.

Our challenges and innovations will be mapped to the CCG commissioning priorities – in particular the prevailing health issues including long term conditions: circulatory disease, diabetes, cancer, COPD and dementia. The CCG profile generated by NHS England highlights our high levels of respiratory disease, cancer mortality and the challenges to achieve improved patient outcomes. Patient self-management is highlighted as an area for potential improvement across South Cheshire. High quality general practice with sufficient capability and capacity is seen as key to reductions in avoidable referrals and admissions to secondary care – avoiding deterioration of patients' long term conditions, meeting QIPP targets, and enhancing patients' health and wellbeing.

South Cheshire CCG believes a key part of clinical commissioning is the recognition of innovative ideas coming from staff and patients within primary care. We will ensure that GPs

have access to a formal system to follow any suggestions or ideas through. The system will actively support the delivery of one or more of the following areas:

- Improving quality of care provision
- Admission Avoidance initiatives
- Preventing of exacerbations
- Preventing attendance at emergency points of care
- Areas for commissioning or service improvement
- Improving access to local Primary General Medical Services .

Transformation and Integration

The CCG is committed to delivering the transformational change and integration agenda across the whole health economy. In doing so, we recognises the need to develop resilience within primary care in order for it to meet the increasing needs and expectations of the residents of South Cheshire and as a body of NHS providers, be able to compete and achieve an level of expectation for service delivery that this programme of change will expect.

NHS England has emphasised that 'primary care professionals' are best placed to make effective preventative interventions and to impact positively on the quality and efficiency of the whole health service to deliver a consistent offer to patients of high quality, patient centred services and build on the very best practice to deliver continuous improvements in health and care outcomes. The CCG will be able to drive greater integration between primary care and other services. Services that are provided in individual practices form part of a broader network of integrated, community based care for patients (Extended Practice Teams) with shared clinical leadership, clinical pathways/protocols and clinical information systems. This approach is our CCG's 5 year Strategic Plan (Connecting Care), and is supported by the Membership.

Over the next 12 – 18 months, the CCG will be working to develop the systems that deliver improvements, such as enhanced access to Primary care services through 7 day working, developing patient centric care through extended practice teams, developing a model of co-ordinated care that at its core, marries patient need and wellbeing to a named GP or Nurse co coordinator, that prioritises effective care management through single care plans including social care, mental health, end of life and therapy teams support.

Over the next 6 – 9 months, the CCG will looking at the workforce requirements across general practice in South Cheshire in order develop a greater understanding of what level of nursing and clinical workforce will be required to deliver our ambitious plans, this is also being considered as part of Connecting Care Board priorities for transformation.

We are looking to develop training programmes on quality improvement and system change for all health and social care staff locally to deliver changes "on the ground" to patient facing services.

Suggested outcomes by March 2016 through Primary Care initiatives

The following initiatives are areas of work that primary care will focus on over the next 2 years, to support the delivery of the CCG Strategic Objectives (Domains). There are also other initiatives that will developed to support the wider integration strategy.
(To be developed in line with Primary Care CQUIN suggestions and ratified through membership, by 1st April 2014)

Domain1

- At least 3% fewer strokes admitted to Acute/intermediate care, - as average for all

practices, for each long term condition - hypertension, diabetes, AF; compared to March 2013.
- At least 3% fewer myocardial infarctions admitted to Acute services – as average for all practices; compared to March 2013.
- Enabling flexibility within the Primary Care Quality Improvement scheme to enable targeted health inequalities interventions at community level that provide support and interventions where greatest need has been identified. i.e. improving cancer outcomes in Crewe.

Domain 2
- At least 3% fewer hospital admissions for COPD, acute adult asthma, acute child asthma – as average for all practices; and per practice that attains clinical targets; compared to March 2013. (Domain 2)
- Practice average prevalence rate at least 70% of expected for COPD, diabetes, CHD, asthma, CKD, hypertension (compared with most recent public health observatory figures and NHS England benchmarks). (Domain 2)
- Practice identification of carers at least 60% of expected carers register as identified by The Carers Association.
- Improved outcomes for patients with one or more long term conditions through tailored single care planning and wider access to patient self-management resources and education, with a focus on diabetes and hypertension.
- Target quality improvements and interventions towards our changing demographics and increasing frail, elderly population with multiple morbidities.
- Supporting the adoption and implementation of the Dementia strategy

Domain 2, 3 and 4
- Implementation of Extended Practice Teams - the CCG will support the practices to transform the care of patients aged 75 or older and reduce avoidable admissions by providing funding for practice plans to do so. We will be providing additional funding to commission additional services which practices, individually or collectively, have identified to further support the accountable GP in improving quality of care for older people. This funding will be at around £5 per head of population for each practice, which broadly equates to £50 for patients aged 75 and over. The implementation of Extended Practice Teams as a major transformational point supports this initiative and has been included in the Better Care Fund with Cheshire East Council.

Domain 4
- Improved access to a wider range of Primary Care based services, through 7 day working
- Delivery of the Primary Care strategy in conjunction with NHS England Area Team

Domain 5
- To embed a culture of quality improvement and clinical safety in each practice, delivered through a named practice clinical champion for quality and safety.

8.3 Quality Premium

The 'quality premium' is intended to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing health inequalities.

For 2014-15 the 'quality premium' is based on six measures that cover a combination of national and local priorities these are:

Domains	National Measures	Local Measure
Domain 1 **Prevent people from dying prematurely**	• Reducing potential years of life lost from amenable mortality (15%)	Addressing locally agreed priorities for reducing premature mortality. (Please see projects outlined on page 31)
Domain 2 **Enhancing quality of life for people with long term conditions**	• Improving access to psychological therapies (15%)	
Domain 2 **Enhancing quality of life for people with long term conditions** **&** Domain 3 **Helping people to recover from episodes of ill health or following injury**	• Reducing avoidable emergency admissions (25%)	
Domain 4 **Ensuring people have a positive experience of care**	• Addressing issues identified in the 2013-14 FFT, supporting roll-out of FFT in 2014-15 (15%)	Showing improvement in a locally selected patient experience indicator (Please see projects outlined on pages 53-55)
Domain 5 **Treating and caring for people in a safe environment and protecting them from avoidable harm**	• Improving the reporting of medication-related safety incident based on a locally selected measure (15%)	
		To develop a clinical audit in primary care focussed on deaths within 30 days discharge, to support the work being undertaken by MCHFT and AQUA. This work will also focus on deaths occurring in Nursing homes patients admitted and subsequently discharge back to the home i.e. appropriateness of original admission. (to be confirmed)

The Quality Premium payment for achieving 2013-14 will be invested locally during 2014-15. A summary of the position for 2013-14 is shown below:

NHS South Cheshire CCG Quality Premium 2013-14 6 Month Summary Progress		
	Measure on Target – End of Quarter 2	**RAG**
Four National Measures		
Reducing potential years of life lost from amenable mortality (12.5%)	Yes	
Reducing avoidable emergency admissions (25%)	Yes (one of composite measures is currently failing)	
Improving patient experience of hospital services (12.5%)	Yes	
Preventing healthcare associated infections (12.5%)	No (MRSA breaches June & Sept)	
Three Local Measures		
People feeling supported to manage their condition (12.5%)	Yes	
Reduce emergency readmissions within 30 days of discharge hospital (12.5%)	Yes	
Reduce unplanned hospitalisation for asthma, diabetes epilepsy u19s (12.5%)	In development	

8.4 Access to the Highest Quality Urgent And Emergency Care

A cross-organisational, clinically led, review of current urgent care services was undertaken by NHS South Cheshire CCG in 2013. The review included local engagement events: a set of workshops designed to develop understanding of the current services and issues faced locally; a provider day that was advertised on Connecting For Health, and a review of national guidance and independent reports.

The following key objectives were identified for this project:

- Develop and implement an Integrated Urgent Care System across health and social care that is both responsive to patient need and delivers quality care in the most suitable setting.

- The New Model of Care must deliver a high quality, cost effective, seamless, responsive services both in and out of hours.

Successful implementation of a new model of care will require a co-ordinated commissioning approach across health and social care, involving primary, community, ambulance, acute, mental health and social care services. There will be no scope for additional funding; all developments will have to be undertaken within the current financial envelope of current health and social care services.

The urgent care work during 2014/15 will focus on establishing the most effective and robust contracting models for our urgent care services, while delivering these policy objectives.

System redesign: A new model of care

Emerging principles for urgent and emergency care locally and nationally outline a system that:

- Is simple and guides good choices by patients and clinicians;
- Provides consistently high quality and safe care, across all seven days of the week;
- Provides the right care in the right place, by those with the right skills, the first time;
- Is efficient in the delivery of care and services.

The system redesign opportunities identified through work undertaken in 2013 and the national documentation and guidance, will be evaluated within the full business case prior to implementation in 2014/15.

CQUINs will be used as a lever to incentivise services within the urgent care system to work together to develop an integrated urgent care team (IUCT). Commissioners and providers will work together to agree pathways, protocols and governance that meet the vision of the IUCT across urgent care services.

8.5 A Step Change in Productivity of Elective Care

Commissioning Intentions and service developments

South Cheshire CCG will continue to support the development and delivery of Out-Patient, Elective In-Patient and Diagnostic services within the local health economy. This programme of work will review planned care service provision, patient outcomes, health needs and health Inequalities to establish priorities for pathway improvements and developments. The CCG will establish priority areas of action to initiate service developments and pathway changes across Primary Care, Community Services and Secondary Care.

The CCG will complete a number of service/pathway reviews during 2014-16 that will improve outcomes, quality and productivity within the local healthcare system, we will triangulate current patient outcomes, health needs, health inequalities and the NHS England benchmarking data to establish which of these priorities will be agreed.

CQUIN – incentivising Partnership working

South Cheshire CCG will incentivise the provider trust to work with the CCGs to:

- Review planned care service provision, patient outcomes and health Inequalities to establish priorities for pathway improvements and developments by July 2014.
- Establish the benchmarking data for the areas of development against indicators to measure contribution towards the delivery of Health Needs, Health Inequities and the NHS Outcome Domains by July 2014.
- Incentivise trusts to work together on the integration of services locally i.e. urgent care and extended practice teams.

South Cheshire CCG will incentivise the trust to work with the CCGs to undertake pathway/service review and implementation of priority 1 by September 2014.

South Cheshire CCG will incentivise the trust to work with the CCGs to undertake pathway/service review and implementation of priority 2 by December 2014.

South Cheshire CCG will incentivise the trust to work with the CCGs to undertake pathway/service review and implementation of priority 3 by January 2015.

South Cheshire CCG will incentivise the trust to work with partner providers to deliver extended practice teams by March 2015.

8.6 Specialised services concentrated in centres of excellence.

We will be working with NHS England Area Team to ensure our local providers, where required, are able to offer specialised centres of excellence. However we also recognise that geographically our patients will need to travel greater distances to access the full range of specialist services and we will need to co-commission local integration of care and clinical oversight of patients.

9 A FOCUS ON ESSENTIALS

9.1 Access

Convenient access for everyone:

South Cheshire CCG is committed to ensure good access for everyone to a full range of services, including general practice, community services, and mental health services in a way which is timely, convenient and also consider the needs of disadvantaged and minority groups. To deliver meaningful outcomes, the CCG will engage and consult with patients, carers and the public to develop and improve our constitutional commitments.

It is important that patients don't have to wait for treatment. The CCG acknowledges that waiting can be very distressing. Evidence also suggests that waiting can make health outcomes worse and can even make services unsafe. We also know that to improve outcomes for patients:

- Services need to be available and easily accessible to them
- they receive those services quickly
- when they need them
- In a way which is convenient for them and fits with their daily lives.

Disadvantaged and minority groups (e.g. people who live with mental health conditions) need tailored services which suit their circumstances or they will simply not be accessible to them. There are many minority groups who will struggle to get the care they need if they are expected simply to fit in with what works for the majority.

During 2014/15 the CCG, will explore opportunities to develop pilots designed to extend access to general practice services and stimulate innovative ways of providing primary care services, supported by the Prime Minister's £50 million Challenge Fund.

Meeting the NHS Constitutional Standards

The NHS Constitution identifies a range of standards to which patients are entitled and which NHS England has committed to deliver. The CCG strategic and Operational Plan seek to make services accessible and deliver the standards in the constitution.

South Cheshire CCG is committed to ensuring delivery of the full range of NHS Constitution measures and support measures:

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

NHS Constitution Support Measures
Mixed Sex Accommodation Breaches
Minimise breaches
Cancelled Operations
All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.
Mental health
Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period – 95%
Referral To Treatment waiting times for non-urgent consultant-led treatment
Zero tolerance of over 52 week waiters
A&E waits
No waits from decision to admit to admission (trolley waits) over 12 hours
Cancelled Operations
No urgent operation to be cancelled for a 2nd time
Ambulance Handovers

9.2 Quality, Safeguarding and Patient Safety

Quality is about delivering an excellent service in an effective way as possible whilst ensuring a positive experience. It is central to all aspects of commissioning within NHS South Cheshire CCG. Our main quality drive is centred on patient feedback to ensure they get the right services in the right location delivered by the right health care professionals at the right time *(NHS Outcome Framework Domain 4.*

We work collaboratively with Vale Royal CCG on the quality agenda as both CCGs have prioritised quality and safeguarding vulnerable adults and children. We have a joint approach in with our providers and have a joint Quality and Performance Committee. We ensure delivery of a cohesive strategy and makes best use of shared resources with monthly reporting on quality and performance with all our main providers. *(Domain 4 & 5).*

NHS South Cheshire ensures all providers deliver the expected rights and pledges from the NHS Constitution, complies with national quality standards such as the National Institute for Health & Care Excellence (NICE) and they operate to the high standards expected within the NHS Standard Contract.

The safety of patients is the highest priority for the *CCG;* we will expect our providers to comply with national standards set out in the NHS contract for example relating to safeguarding vulnerable adults and children and reducing Hospital Acquired Infections such as MRSA. We also have quarterly safeguarding contract meetings to ensure providers are meeting statutory and contractual duties through a balanced scorecard methodology. *(Domain 1,2,3,4,5)*

NHS South Cheshire CCG monitors the quality of healthcare provision in South Cheshire and Vale Royal by reviewing quality and performance indicators, serious incidents, patient experience information, complaints, morbidity and mortality data and GP feedback through a variety of means including professional concerns (this is an internal system that GPs/ providers use to raised clinical concerns about patients care as they arise). The CCGs use a standard escalation policy to ensure providers rapidly improve sub optimal services. This includes the use of contractual levers where necessary such as contract enquiries and financial penalties. *(Domain1,3,4,5)*

NHS South Cheshire undertook a reflective review on the recommendations of the Francis Report into the failings at Mid Staffordshire NHS Trust. We used feedback from patients, staff, clinician, members and partners to pinpoint actions we need to take: increasing the amount of information on quality we receive and broadening the resources from which we receive it. From 2013/14, we now use information from commissioner service review visits; information from provider complaints, serious incidents, workforce indicators and information directly sourced from clinicians and patients. These additional multiple sources of information has built a comprehensive view of quality in provider organisations that is triangulated to ensure we have a comprehensive picture of local providers i.e. mortality rates and safeguarding incidents, stroke services. We will ensure a duty of candour is embedded in all provider organisations through the contract requirements as per recommendation 181 of the Francis report *(Domain 1,3,5)* from 2014.

NHS South Cheshire CCG participates in Cheshire Warrington and Wirral Quality Surveillance Group to look more broadly at quality issues across the health economy. Led by NHS England Cheshire Warrington and Wirral Area Team, participants include HealthWatch from all areas, Care Quality Commission, Monitor and the Trust Development Agency, Cheshire West and Chester Council, Cheshire East Council, Health Education England, and representatives from all Clinical Commissioning Groups in Cheshire Warrington and Wirral. The purpose of the group is to share quality/safeguarding concerns and improve services on a thematic basis across a larger footprint.

(Domain 4,5,)

There is also a local monthly meeting with CQC, South Cheshire CCG, Eastern Cheshire CCG, Cheshire East Council and HealthWatch to triangulate and share poor quality care concerns or safeguarding issues on the Council footprint. The work is action planning, based on local intelligence working with our main providers (and the nursing home sector) to prompt improved quality of care. The new rating system from CQC will be included in the shared intelligence at these meetings.

NHS South Cheshire CCG currently receives reports from our main providers on the Patient Safety Alerting System, this is overseen through the quality reporting process within the CCG.

MRSA and C.Diff targets are challenging for our local health economy and were not achieved in 20313-14. However the CCG continues to require that providers demonstrate they are actively working to achieve their specific targets. There are action plans in place when an incident occurs and these are monitored by the CCG. CCG clinicians regularly attend provider reviews to ensure robust and challenging investigation is carried out when an incident has occurred.

The New Patient Safety Alerting system will be included in the contracts for 2014-15 for our main providers. The NHS Safety Thermometer in included in the 2014-15 contracts and there has been work happening with our local nursing home sector to investigate whether the same system could be applied to this sector. This work is on-going.

We hold monthly Clinical Quality and Performance Review meetings with our providers. When issues arise and/or performance is failing, action plans are put in place. An example of this was in Stroke services, where targets were not being met. A multi-agency working group was convened to address the issues. This led to a set of proposed change in the stroke pathway that has been approved by the Commissioning Advisory Board and will commence in 2014/15.

Quality visits to provider organisations form an integral part of how the CCG assures itself that quality standards are being implemented. These visits can be reactive – in response to concerns, or proactive to review the safety, quality and effectiveness of commissioned services. These visits also help develop and strengthen good working relationship between the commissioner and the provider.

We routinely monitor commissioner and provider Quality, Innovation, Productivity and Prevention plans (QIPP) and Cost Improvement (CIP) plans to ensure that we deliver on quality whilst meeting financial challenges. We use the operational delivery system to ensure quality impact assessments are carried out on proposed service changes and we will use the Star Chamber Methodology to determine the overall impact.

South Cheshire CCG has a statutory duty to safeguard children and adults in partnership with other agencies locally. We are members of both statutory Safeguarding Boards and contribute to various working groups that ensure improvement in safeguarding activity continues. There are regular quarterly contract meetings with our main providers as well as multi-agency meetings with CQC regulators and CEC to ensure intelligence from providers is shared at an early stage of concerns locally.

Friends and Family Test

In April 2013 the Friends and Family Test was introduced across the NHS in England. The Friends and Family Test (FFT) is a survey which asks patients whether they would recommend the NHS service they have received to friends and family who need similar treatment or care. It also provides the opportunity for general feedback.

The FFT for acute in-patients and patients discharged from A&E became mandatory on 1 April

2013. From 1 October 2013, all providers of NHS funded maternity services in England will ask women the same question.

The results of the FFT are published online on the NHS Choices website. The FFT enhances patients' choice with patients' able to use the information to make decisions about their care and make comparisons between different providers.

NHS South Cheshire CCG uses the information from the FFT to:

- Work with providers to identify areas of good practice, acknowledge what is going well and identify areas of weak performance to improve services for patients and families
- Look at trends in the FFT results to provide triangulation with other quality measures to provide a more in-depth understanding of issues and areas for improvement.

Complaints, Management of Serious Incidents and FOIs

NHS South Cheshire Clinical Commissioning Group (CCG) is responsible for discharging its duty in respect of a number of statutory and regulatory requirements, together with NHS directives; which focus on patient safety for the population which we serve. The key components which the CCG are committed to ensuring on-going compliance with and continual improvement of service are summarised in the table below:

Management of Complaints and PALS (Patient Advice and Liaison Service)	How we will deliver this
The Local Authority, Social Services and NHS Complaints (England) Regulations 2009 and The NHS Constitution places specific duties on the CCG. Duty to ensure complaints are: • Dealt with efficiently. • Properly investigated. and complainants are: • Fully informed of the outcome of the complaint investigation. • Advised of their rights to take Independent advice from The Independent Complaints Advocacy Service and the Parliamentary & Health Service Ombudsman.	Systems and processes are in place to provide a comprehensive complaints management service which includes: • A single point of contact for members of the public/complainants. • Recording and documenting system for the management and investigation of concerns and complaints. • Act as a co-ordinating hub for the process of investigation of multiple commissioned provider complaints. • Respond promptly to complainants on the outcome of complaint investigations, providing clear and concise explanations. • Trend analysis of complaints to identify repeated occurrences and monitor effectiveness of implemented actions to improve commissioned service provision.

Management of Serious Incidents, Never Events and Incident Management	How we will deliver this
Patient safety directives set by the NHS Commissioning Board require the CCG to ensure key actions are undertaken as follows: • When a serious incident or never event does occur, that there are systematic measures in place for safeguarding people, property and the services it commissions; and for understanding why the event occurred.	Systems and processes are in place to provide a comprehensive Serious Incident, Never Event and Incident Management service which includes: • Single point of contact to receive notifications of serious incidents, never events and incidents. • Monitoring progress of provider investigation reports to ensure mandatory 45 day deadline is

• Steps are taken to learn from incidents and to reduce the chance of a similar incident happening again in order to: o Improve the safety of patients, staff and visitors o Improve the work and care environment o Improve patient experience	adhered to. • Facilitation and co-ordination of sharing lessons learned across the CCG health economy. • Trend analysis monitoring to identify repeat occurrences and monitor effectiveness of implemented actions to improve commissioned service provision.

Freedom of Information Act 2000 (FOIA)	**How we will deliver this**
The aim of the FOIA is to promote greater openness in public authorities, about operational decisions and how public money is used. The CCG is obliged to publish certain information regarding its function and commissioning activities. In addition, the CCG is required to respond to information requests made by members of the public, except where an exemption applies.	Systems and processes are in place to provide a comprehensive Freedom of Information service which includes: • Single point of contact for receipt, logging and management of requests for information. • Establishment and maintenance of the CCG Publication Scheme. • Statistical analysis of information requests.

SMART Objectives 2014-2016:

- Continue to monitor the provision of systems and processes which allow the CCG to discharge its statutory duties in respect of patient safety. This process is managed through the Performance & Quality monthly meetings.
- Continue to monitor for changes in legislation and/or statutory regulations which impact on current CCG systems and processes which relate to patient safety.
- Continue to develop the Serious Concerns system to improve quality of commissioned services, this will include primary care (GP) services from April 2014.

Compassion in Practice

The National Nursing and Care Strategy states that leadership is necessary at every level of health and social care, *'every person involved in the delivery of care needs to contribute to creating the right environment and providing clear leadership to patients, carers, staff and colleagues'.*

The values and action areas of Compassion in Practice align with the CCG's vision in particular the 4 facets of quality identified and agreed with patients/service users and staff across South Cheshire referred to as **CASE**:

Care- the patient experience must be positive. Patients are treated as individuals and afforded dignity and respect

Accessibility- Patients must be able to readily access services. Services are designed to meet the different needs of communities and individuals

Safe- it is vital that we protect our patients and staff, and manage all risks effectively

Effectiveness- it is important that our interventions result in positive outcomes and that our work is cost-effective. Services must co-ordinate with other health and social care services to ensure patients receive seamless care

The CCG has responsibility for assuring quality in all commissioned services and driving up quality in primary care. The 6C's present an opportunity to embed core values and provide a framework to develop quality putting the person at the centre, focusing on quality and challenging poor practice.

Actions/objectives taken and planned:

- Proposal for Governing Body to use the 6C's as a checkpoint for all commissioning decisions
- A Practice Nurse Membership Council established to: facilitate implementation of the Compassion in Practice within primary care, ensure a consistent approach to quality within practice nursing and primary care, to have a clear nursing voice into the governing body
- Executive Nurse is working with a number of colleagues to develop a Leadership programme for Practice nurses the focus of which will be Compassion in Practice
- Through quality visits, patient feedback and contract monitoring actively seek evidence of how provider organisations are embedding the 6 C's
- Quality and safeguarding strategy incorporates the values of Compassion in Practice
- Work together with provider trust to develop and pilot a quality visit framework based on the 6 C's identified in the Nursing and Care Strategy

Our approach to quality is based on the well-established measures of patient experience, safety and clinical effectiveness as set out in the NHS Outcomes Framework. The aims of South Cheshire CGG are to:

- Put the patient at the centre to ensure that we listen, hear and learn from their experience
- Support learning and development of all our staff to embed quality and safeguarding as the foundation for all that we do
- Continually improve our systems and processes for ensuring and assuring quality in all commissioned services and primary care so that standards of patient safety and quality are understood, met and effectively demonstrated
- Work in partnership with key stakeholders to increase choice maximising the health and wellbeing of all patients and service users.

2014-16 will see the implementation of our **South Cheshire Quality and Safeguarding Strategy**; to ensure quality is incorporated into all aspects of our commissioning activities and our key aims achieved. The key components of the South Cheshire Quality and Safeguarding Strategy and the activities we have planned for the next two years are summarised in the table below:

Priority	Action	By when
Bringing Clarity to Quality	Use information collated from focus group events around Francis to confirm with patients, partners and staff what we mean by quality and implementing different approaches to monitor and improve Continue to develop mechanisms and ways of working together with providers, Local Authority partners, Health Watch and 3rd Sector to gather patient, carer and staff experience, data and evidence of impact on outcomes Work together with provider trust to develop and pilot a quality visit	May 2014 December 2014 April 2014

	framework based on the 6 C's identified in the Nursing and Care Strategy Work together with NHS England to further develop systems for quality improvement and monitoring	 December 2014
Measure Quality	Implement the Quality of Health Principles as part of quality monitoring approach Work with local patient /service user groups and Health Watch to develop patient experts as part of quality visits Plan and carry out announced and un-announced quality visits to our providers, with Governing Body GP and lay members Develop quality assurance in care homes, implementing a quality dashboard Revise framework for Quality monitoring visits within Care Homes	March 2015 March 2015 Plan April 2014 June 2014
Publish Quality	Publish and share this quality and safeguarding plan with patients, public and providers including an easy read version and accessible presentation Quality reports to Governing Body in public will be published with the meeting paper s on the CCG website Ensure that take trends/themes to Quality Surveillance Groups in order to work collaboratively with other CCGs, NHS regulators, Local Authorities, Health Watch and NHS England in order to have whole system intelligence that informs quality improvement Statutory safeguarding inspection reports, improvement plans and annual safeguarding report	May 2014 May 2014 On-going
Reward Quality	Commissioning for Quality and Innovation (CQUIN) schemes will be developed to incentivise local priorities for improvement with providers Primary Care CQUIN/QoF will be reviewed annually and re focused to maximise health outcomes where the CCG has any influence over indicators	From April 2014 From April 2014
Leadership for Quality	Use the organisation development plan to build a culture throughout the organisation that supports the CCGs vision and values, embracing the 6C's, valuing quality at the heart of everything we do Develop and deliver a leadership programme for Practice Nurses focused on implementation of the 6C's Delivery plan to Ensure GPs and other clinicians are fully engaged in the quality assurance system and processes via on-going workshops, GP and Practice Nurse Membership council/assembly. Agree and implement a mechanism to always engage clinical and service user expertise in commissioning of services to ensure consideration of 'reasonable adjustments' for patients with disability(physical, mental health and learning disability) Continue to build relationships with our health and social care providers, patients and public in providing information about the quality of health services to inform service redesign	April 2014 Plan in place by May 2014 Plan in place by September 2014 On-going Achieved April 2014 Achieved

	Establish a Practice Nursing Membership Council/Assembly to implement the 6C's and empower PN voice Develop a local implementation plan for 6C's in Practice Nursing Establish a primary care quality development group Develop a primary care quality framework Establish a clear process to engage with all patient and carer groups in particular increasing the voice of 'harder to reach' groups i.e. children and young people, people with disability (physical, mental health, learning disability) Develop a system of quality continual improvement that is provider led	March 2015 June 2014 October 2014
Innovate for Quality	Work with key partners to agree and develop innovative ways to use clinical audit approaches, evidence and research to support quality improvement Work in partnership with all key partners to ensure that vulnerable groups have fair and equal access to services and experience best care ensure that there is a structure in place to follow any suggestions or ideas through, provide feedback and understand how innovation can align to clinical priorities Patient stories to be presented at Governing Body to provide further opportunity for learning and challenge	December 2014 On-going March 2015 September 2014
Safeguarding Quality	Contracts with our providers to include safeguarding, all elements of quality and patient safety Seek evidence through contract monitoring and quality visits Have safeguarding dashboards for both children and adults in the main contracts that are monitored quarterly Completion of the annual safeguarding assurance framework, organise confirm and challenge focus group Support providers to have robust systems to monitor and respond to trends and themes Share lessons learnt from serious incidents, complaints and any patient safety issues and build systems to ensure necessary changes are implemented Work with Membership assembly/council to identify a lead for safeguarding in each GP practice Develop a robust partnership with Regulators (CQC) and Local Authority safeguarding teams to have early warning systems in place across all providers locally	Achieved September 2014 June 2014 On-going May 2014 On-going May 2014 April 2014 On-going On-going

Staff Satisfaction and Workforce Development

South Cheshire CCG has developed both an Organisational Development Plan (OD Plan) for the next two years 2014-16 and an HR Strategy to cover the same period. The OD Plan identifies needs fed

from the Personal Development (PDP) processes, as well as Membership and Governing Body analysis. The OD Plan supports the transformational agenda ensuring that knowledge and skills in leading change, applying new techniques such as quality systems improvement (for example Lean and Vanguard), developing a robust Governing Body with the required skills, project management skills, senior leadership and management skills, clinical leadership skills etc.

The OD plan:

- Has been developed with staff
- Draws from the Francis Report, bringing together key Francis report recommendations and priorities for example staff training, the promotion of good governance and leadership
- Identifies employed staff, lead clinicians, Governing Body and Membership needs.

The OD plan and agreed objectives cover the following areas of development:

- Leadership, Workforce and Team Development
- Member Practice Engagement
- Values, Style and Change Management
- Complaints and SUI's
- Strategy and Performance Management
- Communications, Engagement and Collaboration

The HR strategy supports the CCG to ensure good HR policies and procedures are in place and are understood by employees of the CCG. This ensures the CCG meets its statutory requirements as an employer and is also able to include GPs, and practices as Member constituents, in a fair and equitable manner.

The CCG has carried out a staff survey internally to help shape and improve the organisation and demonstrate staff involvement and engagement at an early stage. The CCG intends to repeat staff surveys on a regular basis for staff to continue to feel involved in the development of the organisation. This approach has also included Membership Council and practices to identify additional actions the CCG needs to take, to ensure continued engagement of its Members. i.e. the introduction of a regular newsletter to practices about the work of CCG and Quality Improvement Facilitators to improve quality of primary care and delivery of CCG objectives.

Seven Day Working

South Cheshire CCG is identifying in Local contracts for 2014/15 that they should include an action plan to deliver the clinical standards identified within the Service Development and Improvement Plan section of the 7-day Forum's report;

A local Commissioning for Quality and Innovation scheme should be considered based on time from arrival to initial consultant assessment

9.3 Innovation & Research

South Cheshire CCG is not a teaching CCG and the PCT had research support from Keele University. This was largely primary care research with Keele; studies that were separately or centrally funded. The practices and patients provided the population base for the primary care musculoskeletal focus of the university. This work continues unchanged at the moment.

Other areas of interest require contact and travels to other centres. It is possible to undertake postgraduate study at many Universities but there is contact with Manchester and Liverpool. There is no funding from the CCG to support these clinicians and no list of those engaged.

The CCG has contacted and is working with Lancaster University School of Design to understand and help to design Mental health services.

Funding for research into the CCG is based in Liverpool. Liverpool University holds the CLAHRC funding in this area. Their bid was created with Liverpool Teaching CCG. Participation requires matched funding from the CCG. The CCG would like to be involved with projects on health inequalities and the use of Generalism to redesign services. This will require specific research questions and funds and as yet no money has been committed.

The CCG is keen to be involved in research and is actively working with NIHR research project into leadership style involving Open University and University College London. CCG leaders are actively co-producing this research. This project is externally funded.

9.4 Information and IT

At South Cheshire CCG we recognise that to deliver system change and integration across our health and social care landscape we need to make improvements and changes across Information Technology and the way in which we share information. We aim to deliver a better standard and experience of joined up care focusing on the support, integration and interoperability across existing clinical systems. Our ambition is to bring together health and social care to commission and deliver seamless patient flows and care packages: linking these with the aims of the Pioneer proposal and Connecting Care Boards requirements.

We have an IT Strategy agreed, which sets out a framework for the transformation of services across the health and social care system..

Throughout 2014/16 South Cheshire CCG will be working with our partners including, HSCIC, Cheshire and Merseyside Commissioning Support Unit (CSU) and the NHS Area Teams to mobilise our IT programme and portfolio of projects to ensure that a robust governance structure is in place to monitor delivery and provide an appropriate decision making. In addition to the Capital Bid Programme, the CCG will continue to support national, regional and local initiatives to improve service delivery. A summary of some of our key projects are detailed below.

We have achieved over 90% adoption of the NHS number across local health and social care providers in 2013 through extensive use of EMIS and local authority agreement.

Electronic Prescribing Service (EPS) Release 2:

This has been nationally mandated for implementation across all GP Practices. EPS enables prescribers - such as GPs and practice nurses - to send prescriptions electronically to a dispenser (pharmacy) of the patient's choice. This makes the prescribing and dispensing process more efficient and convenient for patients and staff.

The rollout will run from Q1 2014 until end of Q4 2015.

The CCG will work with their CSU partners, GP Practices, Medicines Management and EMIS to ensure planning and delivery is scheduled in a joined up process across Cheshire ensuring the identification of key pilot sites and that minimum impact to practices is maintained.

It is anticipated that the lifecycle for each practice will be twelve weeks from engagement to implementation.

Benefits:

- Patients can collect repeat prescriptions and will not have to visit the GP practice to pick up your paper prescription. GPs will send the prescription electronically to the place you choose, saving time. The prescription is an electronic message so there is no paper prescription to lose.

- Increased Patient choice about where to get medicines from because they can be collected from a pharmacy near to where patients live, work or shop.

- If the prescription needs to be cancelled the GP can electronically cancel and issue a new prescription without patient return to the practice.

- Patients may not have to wait as long at the pharmacy as the repeat prescriptions can be made ready before they arrive.

National Summary Care Record (SCR):

The Summary Care Record (SCR) is an electronic summary of key health information from a patients GP practice record which is securely held on the National Spine. A core SCR contains a patient's medications, allergies and adverse reactions. Changes made to these core data items in the GP record will be updated in the SCR automatically. The SCR is optional; the patient is in control and can choose to opt out of having an SCR or change their mind at any time. Authorised healthcare staff can access the record to help with the care they provide to patients in urgent and emergency situations, where access to this information can be difficult to obtain in a timely manner. Summary Care Record is the only national record sharing solution, SCR has many high level benefits including improving patient safety, increasing efficiency and effectiveness and increasing quality of patient care.

The rollout is due to be completed by end of Q4 2014 in South Cheshire.

Benefits to GP Practices include:

- GPs will be able to view an SCR for treating temporary residents / unregistered patients
- GPs will know that their patients are being treated in out of hours or in urgent care settings across England using accurate, up to date information.
- Hospitals and pharmacies often have to telephone GP practices and ask for clinical information when admitting a patient. This is a significant inefficiency for both the acute staff and GP staff. The SCR has been shown to reduce the need for many of these types of calls.

SCR is in the GP Contract for 2014, all of the population of England have been informed that their GP practice is going to be creating SCRs. Currently there are over 32 million patients in England that have an SCR created (circa 53% of the national population), and this figure is expected to rise significantly over the coming months (increasing at a rate of circa 200,000 records a week).

Windows XP to Windows 7 and Office 2012 Upgrade:

There is a requirement to upgrade the operating system on all Desktop / Laptop devices in the GP Practices following Microsoft's formal statement released to the public and private sectors, with a clear date for end of their current product support for Windows XP of April 8th 2014. This will include the replacement of GP Practice PCs that are five years or older.

The rollout will run from Q1 2014 until end of Q2 2014.

Benefits to GP Practices include:

- Enhanced technology and upgraded operating system enabling future requirements
- Remove potential security risk due to Microsoft support finishing
- Upgrade of Microsoft Office suite to ensure compatibility to with other organisations

Wireless into GP Practises:

South Cheshire CCG is developing proposals for submission to NHS England for the provision of Public Wi-Fi across all South Cheshire GP Practices by March 2015. It is proposed this development will also incorporate the installation of patient access and information screens as required in the GP Practice and public access to services and potential for information capture and patient feedback.

Benefits to GP Practices include:

- Installation of patient access and information screens as required in the GP Practice
- Public access to services and potential for information capture and patient feedback

Development of integration Disease registers:

The CCGs are working with MCHfT in the development of hospital disease registers. Currently Hospital IT is targeted at single aspects of care, but disease registers will enable audit and research and provide better joined up care across boundaries. Disease Registers will support detailed information needs and analysis that is currently only available from paper records, and to a very limited extent.

Disease registers will enable audit of the whole hospital population with a disease and a move to criteria and standards to demonstrate the hospital performance on finding managing and controlling disease.

Integration planning with primary care provided scheduled Q.2 2014. CCG input will be required in the planning and implementation of this work.

Benefits:

- Disease register at MCHfT will provide better information of the causes of hospital admissions and allow the CCG to target commissioning more effectively.

- Disease registers will enable a step change in quality and information on performance for dissemination to the public.

- Population disease registers will enable information on whether specialist care treats or helps the whole population with a disease and audit of which diseases benefit form specialist management.

Cheshire Health Record:

The Cheshire Health Record utilises the EMIS Web application to enable doctors, nurses and other local healthcare professionals working in Cheshire accessing a consenting patient's summary of their GP patient record. This may occur in hospital or unplanned care settings such as A&E or Out of Hours centres.

Access will also be available to some community providers. The system is designed to provide essential, timely medical information that will allow other health professional staff to make decisions about the treatment they provide for the patient, based on up to date and accurate information.

Work commenced in Q4 2013 with colleagues at MCHfT, CSU, GPs and Cheshire NHS colleagues to re-establish requirements and data sharing activations for key clinical conditions across Cheshire. Further work with EMIS is required to evaluate activate data sharing agreements where required and resolve outstanding issues with notifications in the Primary system, this is causing a potential risk of delay until resolved. All required activations and sharing agreements planned to be in place before end of Q4 2014.

Benefits:

- Sharing information between partner organisations is vital to the provision of coordinated and seamless services. In addition, the sharing of information can help to meet the requirements of statutory and local initiatives.

Risk Profiling and Stratification:

There are currently multiple options available within the CCG for use by GP practices, to date these options have yet to deliver the required outcomes and data expected with development still progressing. A new option for has been discussed with EMIS potentially removing some issues experienced with processing the data extracted. Once a viable solution is agreed this can be used as an enabler but not limited to Neighbourhood teams.

Eclipse Third Party: Primarily focuses on medicines and assesses the risk to the patient based on the individual patient's current medicines. There is a view in the CCG that risk profiling should be more patient focused and include a wider range of risk factors than medicines. If risk assessment involves installing safety fittings in patients home, e.g. to reduce risk of falling, then cost will increase. To date Eclipse have been unable to prove any tangible solutions for their product, therefore a short term solution is being explored using a CSU offering being used across Vale Royal practices.

EMIS: The CCG has recently engaged with EMIS to be a part of their Early Adopter Programme (EAP) in the North of England. This EAP will involve the development with a GP practice of the functionality and outputs for this module. EAP will be a free development programme with the supplier and will look to start Q2 2014 after CCG Board approval.

EMIS developments:

The CGG is currently working with the EMIS accounts team on future developments of the Primary Care system, the below examples will be the enablers to fulfil the required integration for commissioning intentions, Extended Practice teams, Mandated requirements, and providing patients with fuller and easier access to their GP record.

- New Risk Stratification Early Adopter Programme
- Care Planning modules
- Integration of EMIS Community and EMIS Web datasets
- Patient access to GP records
- TeleHealth Integration via Black Pear Partnership
- EPaCCS - (Electronic Palliative Care Data set and Integration)
- Integration with new MCHfT EPR
- Integration with existing Primary Care system and "out of hours" and 111
- MIG integration for associated providers

A full schedule of deliverable timescales and associated pilots will follow during 2014 and will be part of the on-going development programme with our EMIS Partner, CSU, Cheshire NHS organisations and required integration with Social Care and MCHfT.

Telehealth/ Telecare:

The CCG will use latest risk profiling technology and Telecare / Telehealth technology to identify people at risk and to treat more patients within their own homes, Patients will be able to use technology in their own home to participate in the management of their condition.

The CCG is currently working with MCHfT and a third party provider, Tunstall, on a pilot in South Cheshire. This will include the identification of the correct type of conditions and associated patients.

The Pilot, upon GP partner approval, will begin in Q2 2014 for 6 months, and for an expected 10 patients. There will be a benefits review after the pilot and decision on future Telehealth and Telecare requirements. Other providers are also being considered for similar type of pilots.

Improved Data Sharing and Transparency:

Working with colleagues and current / new partners to identify and plan for the delivery of integrations across Primary Care, community and Social care settings by connecting data and information across pathways, seamlessly integrating across organisations and systems including:

- health & social care
- separate specialities within health services
- services provided in the community and services provided in the hospital

To pursue this strategy the CCG will improve and extend the sharing of clinical information within primary care, and between primary care and secondary care.

We are planning for care.data to join up clinical data sets through HSCIC improving access for commissioners to high quality delivery data and for individual patients to access their own health record to improve transparency of information. By summer 2014 at least 5% of GP practices should be linked to hospital data and our strategic plan 100% coverage will need to be refreshed with partners during 2014.

Benefits to clinicians:

- Analysis of the patterns of care received by patients with long-term conditions would lead to significant improvements in care.
- Improved monitoring of outcomes through linkage between primary and secondary care.
- Improved monitoring of performance through linkage between primary and secondary care
- Earlier diagnosis of illness
- Improving contribution of primary care to wider CCG outcomes
- Improved data quality
- Monitoring and understanding trends
- Predictive modelling
- Evaluation of prevention services and interventions
- Exploring patient pathways
- Detecting unwarranted variation

GP Access to Radiology Reports:
2014/15 will see South Cheshire CCG delivering a pilot to promote GP access to radiology reports in primary care.

Medical Information Gateway (MIG):
This will be a joint venture with other Cheshire NHS organisations to establish technical

interoperability and potential use for our Pioneer objectives.

Benefits:

- Shared view of interoperability future
- Improve patient care
- Improve clinical efficiency
- Recognition GP systems contain rich clinical records
- Open to ALL Healthcare system suppliers
- Secure Gateway for exchanging bi-directional Real time data between Primary Care and other health and Social Care Settings plus a best price option
- **MIG Infrastructure**
    - Intelligent brokering, routing and mediating
    - Single technical entry point
    - Accredited by NICA Technology Office- Department of Health
- **Use Case Services**
    - Data flows- based on Message sets
    - Accredited to NHS ITK Toolkit Standards
    - Payload Message independent

9.5 Medicines Management – Priority Objectives 2014-16

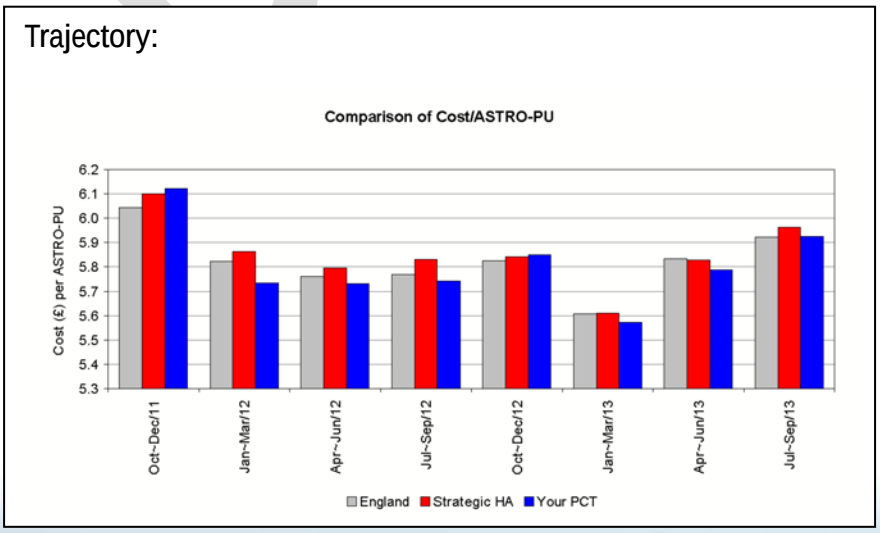
The Medicines Management Team supports the Starting Well, Living Well and Aging Well Programmes with commissioning services that make best use of medicines. In addition, pharmacists and technicians work closely with general practices and Acute Trust clinicians to:

- Maintain control of primary care prescribing costs to manage growth and remain within the allocated budget.
- Develop systems for managing use of High Cost Drugs (excluded from Payment by Results [PbRe]) to allow monitoring of activity and budgetary impacts and provide assurance of compliance with guidance (e.g. NICE Technology Appraisals).
- Implement projects/ actions to optimise the use of medicines to improve outcomes, enhance patient safety and improve capacity within the local health economy.

Compared with peers, South Cheshire CCG has had lower costs per population (population weighted for age and sex) in 6 of the last 8 quarters with costs being slightly higher in the Oct-Dec quarter in the past 2 years. The Medicines Management Team working with the GP Prescribing Lead and local prescribing and medicines management committees will support the CCG to continue to maintain prescribing growth at or below the national average.

Higher level actions to achieve the priority objectives are set out in the table below:

Trajectory:



Priority Objective	Planned Actions	Deliverables
Maintain control of primary care prescribing costs	Maintain and develop the Local Health Economy Formulary including a work plan taking into account NICE Technology Appraisals programme, new product introductions and patent expiries (D1,D2,D3)	Forward schedule completed by 1 April 2014 Formulary updated monthly thereafter Action plan developed by 1 April 2014
	Understand and address savings opportunities identified in the Right Care data packs[8] (prescribing savings have been identified in the data pack for South Cheshire CCG in the following areas: Gastrointestinal Respiratory System Problems Neurological System Problems Endocrine, Nutritional and Metabolic Problems Genitourinary)	Savings of £522,000 delivered by 31 March 2016 (based on capturing 50% of the potential savings if the CCG performed at the average of 10 similar CCGs)
	Work with practices to minimise variation between them and so improve overall performance on the nationally identified medicines QIPP topics[9] .	South Cheshire CCG has improved the status of at least 3 QIPP indicators by at least 1 quartile by 31 March 2016
	Continue to develop locally identified prescribing savings opportunities for implementation at practice level including selection of more cost effective prescribing choices (e.g. blood glucose testing strips) and systems (e.g. alternative means of managing the supply of appliances).	Savings on Blood glucose testing strips to be delivered by 1 June 2014
Develop systems for managing use of High Cost Drugs (excluded from Payment by Results [PbRe])	Continue phased introduction of the Blueteq system to capture the information on usage and provide clinical assurance of compliance with NICE guidance and local protocols (D4)	Blueteq system in use by dermatology, gastroenterology and rheumatology in MCHFT by 1 September 2014
	Develop budget management processes for High Cost Drugs (PbRe).	Develop budget management process by 1 April 2015
Implement projects/ actions to optimise the use of medicines to improve outcomes,	Develop the capability of prescribing support software (Eclipse Live and Scriptswitch) to support improvements in patient safety (D1, D2, D5)	Eclipse Live available to all practices by 1 April 2014
	Work with the Quality team and local Acute Trusts and Primary Care to implement the Medicines Safety Thermometer and medicines-related	By 1 June 2014

[8] http://www.england.nhs.uk/resources/resources-for-ccgs/comm-for-value/
[9] Quality Innovation Production and Prevention topics see http://www.nice.org.uk/mpc/keytherapeutictopics/KeyTherapeuticTopics.jsp

enhance patient safety and improve capacity within the local health economy.	CQUIN schemes and Quality Schedule requirements. (D5)	
	Develop a local strategy to reduce the pressure on antibiotic resistance and support providers to meet targets for incidence of Healthcare Acquired Infections including MRSA and *Clostridium difficile (*D5)	By 1 June 2014
	Implement the extended Think Pharmacy; Minor Ailments service to support the Urgent Care Working Groups to reduce demand in general practice and Accident and Emergency departments.[10] (D3)	Service launched by 1 April 2014
	Work with the local Acute Trusts to improve financial and clinical governance for patients receiving medicines from Homecare services.[11] (D2)	Hackett report implemented by 1 April 2015

9.6 Procurement of Healthcare

The CCG has developed and implemented a local policy on the Procurement of Healthcare services. This policy follows the implementation of the NHS (Procurement, Patient Choice and Competition) (No2) Regulations which were implemented under section 75 of the Health and Social Care Act 2013 on 01 April 2013. The Policy also takes into consideration the substantive guidance published by the Regulator – Monitor in May and December of 2013.

The aims of our approach are specifically to promote:

- **Choice**: ensuring a range of providers for our population to choose from
- **Competition**: encourage a degree of competition within the health system, with the aim of continuously improving quality of service and innovation
- **Consistency**: ensuring clinical safety, equity of access and quality of outcomes for our patients

Implementing our approach will ensure that through the utilisation of best practice procurement processes we are able to:

(i) Demonstrate value for money for all expenditure of public money,
(ii) Adhere to relevant legislation governing the award of contracts by public bodies,
(iii) Comply with our own Standing Financial Instructions/Standing Financial Orders (SFI's/SFO's)

The CCG has adopted a proactive stance towards securing services that meet the needs of the local patient population and competitive procurement will be a key part of this in the coming years; as will the option for greater integration within the existing health economy. To support consistency in the decision making process regarding the use of competitive procurement, a key part of our approach will be to adopt a decision making matrix which will support a clear and unbiased decision.
The CCG will adopt a fair, open and transparent approach, publishing procurement opportunities and decisions related to the contracting of services.

[10] http://www.monitor.gov.uk/closingthegap
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213112/111201-Homecare-Medicines-Towards-a-Vision-for-the-Future2.pdf

To facilitate the procurement process, the CCG will utilise the professional procurement team at the Cheshire and Merseyside Commissioning Support unit to provide an overarching procurement support service. Utilising one of the nationally accredited CSU's will ensure that the CCG remains compliant with the procurement regulations and obtains maximum benefit from the procurement process.

The CCG is reviewing contracting and commissioning activity as contracts expire, areas currently subject to a competitive procurement process include Community Stroke services as a competitive tender and additional Elective Services via an Any Qualified Provider exercise. An annual work-plan of activity will be developed each year so there is full oversight of the competitive procurement activity at CCG level.

In addition to the proactive approach to the procurement of healthcare services, the CCG will encourage the adoption of the 'Better Procurement, Better Value, Better Care' guidance which was published in 2013. As well as adopting the principles in the procurement of all internal goods and services, the CCG aims to include a mandate around the adoption of the same principles into all standard contracts held with local NHS Providers, ensuring that the overarching health economy takes responsibility for improving procurement efficiency for the benefit of patient care.

9.7 Delivering Value – Financial Summary

The financial plan is intended to cover a 5 year period with the first two years providing the detail required to monitor the CCG financial performance at an operational level. The financial plans are prepared based on assumptions and rules set out by NHS England. Additional information on local trends and the impact of local commissioning intentions are also included in the plan to giving a view of the financial health of the CCG. The financial plan is aimed at producing a sustainable, high performing organisation commissioning care for its population.

Revenue Resource Limit

CCGs are funded based on the size of their population and its demographic make-up. The details of the South Cheshire population are included in section 5 and so are not discussed here.

A new allocation formula was developed and tested during 2013/14 and is being introduced in 2014/15. The new formula takes into account three main factors in healthcare needs: population growth, deprivation and the impact of an ageing population.

Ten percent (10%) of the total available funding is based on a deprivation indicator to reflect unmet need, enabling CCGs to tackle the impact of health inequalities.

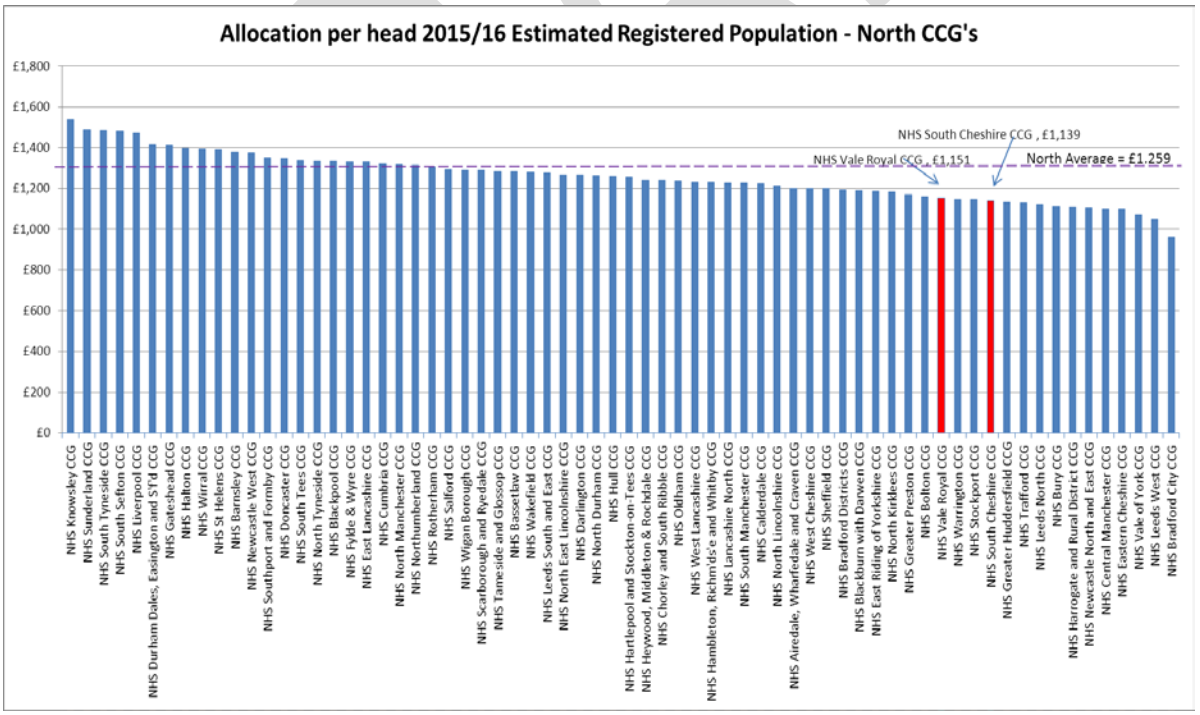
In 2013/14 South Cheshire CCG had been funded at (£1.085 per head) a lower than average allocation per head of population (£1.115 per head). If NHS England had moved the CCG to the national target allocation per head the CCG would have received an additional £12million, however only a small element of this has been reflected in the new allocations, as nationally it is recognised that a pace of change is required.
South Cheshire CCG has received notification of a two year allocation, a summary is shown in the table below:-

Programme Allocation	2013/14	2014/15	2015/16
	£'000's	£'000's	£'000's
Allocation	187,094	191,446	197,482
Growth	4,352	6,036	5,634
Sub total	191,446	197,482	203,116
Population (registered)	176,449	177,339	178,251
% Growth		3.15%	2.85%
Revenue Allocation Per Head of Population	1.085	1.114	1.139
Target Revenue Allocation per Head of Population		1.187	1.202
Distance from target		-0.073	-0.063
% distance from target		-6.19%	-5.17%

It can be seen that the revenue funding per head has increased by £29 per head of population for 2014/15. The allocation for 2015/16 increases again by £25 per head and the CCG moves closer to target by 1.02%.

The movement towards target is positive for the CCG however South Cheshire still remains below the average for the North of England in 2015/16 by £120 per head of registered population and below its target allocation by £63.

The graph below shows the relative funding for South Cheshire CCG in comparison to other CCGs in the North of England:-



Planning Assumptions

The plan developed by the CCG is governed by a number of planning assumptions issued by NHS England.

The table below indicates the planning assumptions relating to provider services. The providers are required to make year on year efficiencies of 4% for the next 5 years with recognition of an inflation increase of between 2.2% to 3.4%

Table of Assumptions	2014/15	2015/16	2016/17	2017/18	2018/19
Secondary Care Health Cost Inflation	2.30%	2.20%	3.00%	3.40%	3.40%
Provider Sector Efficiency	-4.00%	-4.00%	-4.00%	-4.00%	-4.00%
Tariff Deflator	-1.70%	-1.80%	-1.00%	-0.60%	-0.60%

Nationally the CCGs are provided with the following commissioning assumptions. A number of areas are identified for local determination based on local knowledge. These are supported by a number of business rules from NHS England in relation to allocating monies either to protect the CCG from risk (contingency 0.5%) or to indicate where non recurrent spend should be identified to be targeted at transformational change.

CCG Commissioning Assumptions		
Demographic growth	Local Determination using age profiled population projections	
Demographic growth	Local Determination based on historic analysis and evidence	
Tariff Changes	See Below	
Price Inflation-Prescribing	Local Determination - expected to be in a range of 4% to 7% per annum increase	
Price Inflation - Continuing Health Care	Local Determination - expected to be in a range of 2% to 5% per annum increase	
Business Rules	2014/15 - Minimum 0.5% Contingency - 1% cummulative Surplus - 2.5% non recurrent spend (including 1% for transformation)	2015/16 - Minimum 0.5% Contingency - 1% cummulative Surplus Carry Forward - 1% non-recurrent spend - Better Care Fund as notified £10.481(additional) (including 1% for transformation)

These assumptions are derived or adopted to allow the CCG to produce financial plans which reflect the on-going commissioning of services in South Cheshire to ensure that finances are in place to support additional demand or to support service redesign.

Better Care Fund

One of the main strategic drivers nationally is for social and health care commissioners to work more closely together. In order to facilitate closer working the Government has identified the Better Care Fund which will be a pooled resource to facilitate joint planning, information sharing and services.

The Department for Communities and Local Government and the Department of Health has identified £3.8 billion of funds for investment in this integration. £3.4 billion is expected to come from CCG

budgets; in order that the creation of the fund does not result in a financial pressure the associated investments will need to identify significant transformational change to reduce demand for social and health care. If these changes do not lead to more effective use of services this could result in a financial pressure across the health and social care system.

Draft plans will be jointly agreed between South Cheshire CCG and Cheshire East Council by the 14th February. The overarching local Pioneer Project Connecting Care will provide a structure for the development of these plans.

The total better care fund to be identified by the CCG is £10.481 million. The table below shows the National and local picture.

Better Care Fund	National £3.8bn	2014/15	2015/16
	£ billion	£'000's	£'000's
£0.9 billion already transferrd to fund social care in 2013/14 (via NHS England)	0.9		2.4
An additional £0.2 billion in social care from CCG resources in 2014/15(via NHS England in 14/15)	0.2		0.8
£0.4 billion of Capital Grants carruently Administered by the Department of Health and other Government Departments	0.4		
£0.3 billion Reablement	0.3	1.1	1.1
£0.1 billion Carers Breaks	0.1	0.2	0.2
An additional investment from CCG budgets of £1.9 billion	1.9		5.9
Total	3.8	1.3	10.4

The funding will formally sit with the local authority and will be overseen by the Health and Well Being Boards and be subject to assurance from NHS England.

Financial Plan 2014/15 -2015/16

An early draft financial plan was produced and early presented to the Governing Body in January 2014, a summary is shown below:-

Summary of initial 2 year plan	Initial Plan 2014/15 %	Recurrent £000	Non recurrent £000	Total £000	Initial Plan 2015/16 %	Recurrent £000	Non recurrent £000	Total £000
Planned Resource								
Allocations		195,706		195,706		201,316		201,316
Growth	3.2%	6,036		6,036	2.9%	5,634		5,634
Return of surplus from previous year	1.0%		1,935	1,935	1.0%		2,020	2,020
Better Care Fund Resource to Council Via NHS England 14/15					1.5%	3,182		3,182
Total Resource	**4.2%**	**201,742**	**1,935**	**203,677**	**5.4%**	**210,132**	**2,020**	**212,152**
Expenditure budgets		212,568	355	212,923		211,651	0	211,651
Integration Agenda (Earmarked for better Care Fund)					5.0%	10,481		10,481
Planning Gap	-5.5%	(10,826)	(440)	(11,266)	-6.0%	(12,000)	(50)	(12,050)
Planned Expenditure		**201,742**	**(85)**	**201,657**	**-1.0%**	**210,132**	**(50)**	**210,082**
Planned Surplus	**1%**	**0**	**2,020**	**2,020**	**1%**	**0**	**2,070**	**2,070**

The initial budget has identified a planning gap which will be removed over the period to March producing a balanced budget. The financial plan for the CCG will be finalised and presented to the CCG Governing Body in March 2014. The national planning assumptions previously identified have been adopted in producing the financial plan.

The key challenges have been to identify the contingencies and non-recurrent funding to allow for risk and non-recurrent support to transformational change and the creation of the Better Care Fund.

Key Budget Background

Provider Services (Acute, Ambulance, Community and Mental Health Services)

Planning assumptions have indicated a reduction on the overall provider funding of 1.7% in 2014/15 (1.8% in 15/16) this is constructed from an increase for inflation of 2.3% in 2014/15 (2.2% in 2015/16) and a cost improvement target of 4%. The quality and innovation payment (CQUIN) remains a non-recurrent allocation of 2.5% as in 2013/14.

There has been on-going pressure on the CCG provider services budgets during 2013/14, previously pressure has mainly resulted from additional urgent care demand, however in 2013/14 the additional pressure on resources has resulted from increasing referrals and the resultant elective care. In 2013/14 there was a significant risk related to Specialist Commissioning and the changes identified, it is anticipated that this area has now mainly resolved.

The main challenges in 2014/15 are;-

- the on-going drive to improve the effectiveness of the Urgent Care Services leading to a reduction in demand and;
- maintaining the 18 week target and other constitutional requirements whilst keeping financial control on the elective services costs.
- The impact of counting changes proposed by our main acute provider

The CCG is in 2014/15 – 2015/16 trying to develop a new collaborative contracting approach between our main acute, community and mental health providers using either alliance or lead contractor models.

DN insert list of contracts over £250k for 2013/14 and subsequent years

Prescribing

Primary care providers within South Cheshire CCG have always maintained a focus on efficient and effective prescribing, the details of the medicines management actions to control expenditure can be seen in the dedicated section 9.5.

Continuing Health Care and Funded Nursing Care

There is pressure on these budgets locally due to the demographic changes and the increasingly aged population.

Primary Care

The planning guidance has indicated the need to increase expenditure in services identified by primary care which will support the transformation of care of patients aged 75 and older. It is expected that this will be in the region of £5 per head (£885,000)

Running Cost Allowance

The CCG has planned to reduce its expenditure in this area by 10% in 2015/16 in line with national guidance.

DN for the final plan a full analysis of expenditure with graphical representation will be inserted at this point.

Quality Innovation Productivity and Prevention (QIPP) 14/15-2018/19

In 2009/10, it was recognised nationally that the NHS would be required to save £20 billion by 2014/15 in order to fund increased costs and demand pressure. It has been further recognised that the NHS savings required in the four years from 2015/16 to 2018/19 will be an additional £30 billion i.e. a total NHS savings requirement of £50 billion over a period of 8 year.

The potential challenge to the CCG's local economy can be seen in the table below:-

Scale of Challenge	Provider price efficiency 4%	CCG Estimated Planning Shortfall	Total Planning shortfall
	£million	£million	£million
2013/14	5	3	8
2014/15	6	12	18
2015/16	6	12	18
2016/17	6	7	13
2017/18	6	7	13
2018/19	6	7	13
Total	**35**	**48**	**83**

Locally the initial CCG requirement in respect of the £20 billion has been achieved. The additional financial challenge has been identified above. The response to this challenge is limited in the next two years as the transformation change is embedded particularly in respect of the Better Care Fund.

The most significant projects delivering change and productivity are:-

- Transitional Care Beds impact Urgent Care
- Extended Practice Teams impact Urgent Care
- Redesign Urgent Care 24/7 impact Urgent Care
- Stroke Rehabilitation impact Urgent Care
- Better Care Fund impact Urgent Care
- CCG Commissioning for Value impact Elective Care
- Improved Procurement driving Value for Money
- Information Sharing and additional ICT developments in Primary Care

Quality, Innovation and Prevention is included within the appropriate sections of the plan.

DN Insert the analysis of projects and associated productivity savings.

Key Financial Priorities for 2014/15 to 2018/19

The CCG has a number of statutory financial and national requirements the key items are identified:-

- To maintain a balanced position and deliver the 1% surplus as required by the NHS England;
- To deliver our QIPP targets whilst ensuring that we are delivering improved care to patients;
- To invest the commissioning budget to maximise value for money;
- To ensure the financial resources are applied to support the CCG commissioning Strategy;
- To utilise the Better Care Fund in 2015/16 locally on health and care to drive closer integration and improve outcomes for patients and service users and carers;
- To remain within the CCG running cost allowance of £25 per head of population;
- To set aside 2.5% of recurrent resource for non-recurrent expenditure in 2014/15; 1% of this spend to be applied to transformation of local services, focusing on preparation for the introduction of the Better Care Fund.

Key Financial Risks:

- increased pressures in elective and non-elective care, continuing health care, funded nursing care and learning disabilities services;
- changes to the learning disabilities pooling arrangements
- ensuring the drive to closer integration can be achieved within existing allocations and change recognised through provider contracts;
- ensuring the 2.5% in 2014/15 and 1% in 2015/16- 2018/19 is identified for non-recurrent expenditure to enable change, given the scale of the challenge and the requirement to maintain financial balance, this is a key risk;
- ensuring the financial risks associated with the introduction of Personal Health Budgets is managed, particularly in respect of safeguarding;
- the productivity requirements are achieved to deliver the CCG element of the £30 billion national productivity challenge
- identification of an additional £5 per head to invest in primary care identified additional support services for the over 75s.

Capital Plan

Capital Programme	2014/15 £000	2015/16 £000
Capital Grants -Commissioning Intentions	96	
Rolling IT Equipment	26	26
Bevan House refurbishment	128	
Total	**250**	**26**

The CCG has applied for the capital resource identified above.

Cash

The planning assumption is that cash matches the CCG planned resource, adjusted for working balances.

Statement of Financial Position (Balance Sheet)

The CCG planned Statement of Financial Position is shown in the table below:-

	2014/15	2015/16
PPE	250	276
Accumulated Depreciation	(25)	(50)
Net PPE	**225**	**226**
Non-Current Assets	**225**	**226**
Cash	6	6
Accounts Receivable	700	700
Inventory		0
Investments		0
Other Current Assets		0
Current Assets	**706**	**706**
TOTAL ASSETS	**931**	**932**
Trade & Payables	(11,000)	(11,000)
Provisions	(400)	(400)
Short Term Borrowing		0
Current Liabilities	**(11,400)**	**(11,400)**
Non-Current Payables		0
Provisions		0
		0
Long Term Liabilities	**0**	**0**
total Assets Employed	**(10,469)**	**(10,468)**
General Fund	(12,489)	(12,538)
Retained Earnings In Year	2,020	2,070
Total Taxpayers Equity	**(10,469)**	**(10,468)**

The above statement shows anticipated assets, liabilities and taxpayers' equity for the next two years.

10 Key Trajectories

The following section of this plan provides the key trajectories needed to support the assurance of, and measure performance against the strategic plan. The plan will deliver improvement against the measures to support the seven outcome ambitions are as follows:

Clostridium Difficile

DN: The national target has not yet been defined but will be reduced by a small proportion. We await final number.

Dementia diagnosis

The CCG seeks to improve the ability of people living with dementia to cope with symptoms, and access, treatment, care and support.

The table below illustrates the CCG projected diagnosis rate for people with dementia, expressed as a percentage of the estimated prevalence.

E.A.S.1	number of people diagnosed	Prevalence of dementia	% diagnosis rate
2014/15	1460	2194	66.55%
2015/16	1497	2234	67.01%

IAPT coverage and recovery

The table below illustrates that over the next year we will support our provider to achieve a 50% recovery rate.

	The number of people who have completed treatment having attended at least 2 treatment contacts and are moving to recovery (those who at initial assessment achieved "caseness" and final assessment did not)	(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)	% recovery rate
2014/15	562	1124	50.00%
2015/16	579	1135	51.00%

Other Activity Measures: E.C.7-8: A&E Attendances

This activity measure considers the number of attendances at accident and emergency departments.

(Data Source: A&E Attendance figures are sourced from weekly SitRep data provided to a central Unify2 collection by Trusts – this is a weekly total taken from a reporting period of 00.01 Monday to 24.00 Sunday).

Threshold

The CCG seeks to ensure that patients requiring urgent and emergency care get the right care by the right person at the right place and time. There are instances where people presenting to accident and emergency departments because they either do not know how, or are unable, to access the care they feel they need when they want it. NHS 111 will assist patients in finding the most appropriate and convenient service for their needs so they receive the best care first time. A reduction in the growth of the number of A&E attendances may indicate a more appropriate use of expensive emergency care, and improve use of other services where appropriate.

The table below illustrates attendances calculated according to prov/Com allocations 2012/13.

	A&E Attendances -All Types
2013_14 OT	44613
2014_15	44672
Forecast Growth	0.13%
2015_16	44782
Forecast Growth	0.25%
2016_17	44892
Forecast Growth	0.25%
2017_18	45002
Forecast Growth	0.24%
2018_19	45111

Seven Outcome Ambition Measures

Outcome Ambition One

(Please note that this is draft at the point of submission)

Our ambition for securing additional years of life from conditions considered amenable to healthcare.

A table to show the percentage years of life lost per 100,000 population

E.A.1	PYLL Rate per 100,000 population
Baseline	2028.9
2014/15	1964.0
2015/16	1901.1
2016/17	1840.3
2017/18	1781.4
2018/19	1724.4
2019/20	1669.2

Outcome Ambition Two

(Please note that this is draft at the point of submission)

Our ambition for improving health-related quality of life for people with long term conditions.

A table to show the average EQ-5D score for people reporting having one or more long-term conditions

E.A.2	Average EQ-5D score for people reporting having one or more long-term conditions
Baseline	74.1
2014/15	74.2
2015/16	74.3
2016/17	74.5
2017/18	74.6
2018/19	74.7

Outcome Ambition Three

(Please note that this is draft at the point of submission)

Our ambition is to reduce the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

A table to show the avoidable emergency admissions indicator

E.A.4	Emergency admissions composite indicator
Baseline	2159.2
2014/15	2137.6
2015/16	2116.2
2016/17	2095.1
2017/18	2074.1
2018/19	2053.4

Outcome Ambition Four

(Please note that this is draft at the point of submission)

The CCG are currently identifying a quantifiable level of ambition for this outcome ambition. The CCG level of ambition will form part of the Better Care Fund, set for 2 years at Health & Wellbeing Board level. This will be included within our final submission in April 2014.

Outcome Ambition Five

(Please note that this is draft at the point of submission)

The following table shows the CCG ambition for increasing the proportion of people having a positive experience of hospital care.

The proportion of people reporting poor patient experience of inpatient care	This rate is at Provider Level for MCHFT	
162.7		
157.7	2012 Baseline: 162.7	
152.7		
149.0	Lower Limit : 151	Upper Limit 175
146.7		
142.0	England Average :142	

Outcome Ambition Six

(Please note that this is draft at the point of submission)

The table below shows the CCG ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community.

E.A.6	The proportion of people reporting poor experience of General Practice and Out-of-Hours services
Baseline	6.1
2014/15	6.0
2015/16	5.9
2016/17	5.8
2017/18	5.7
2018/19	5.6

England Average :6.1

Reduction of 0.1 per year

SC CCG Currently on England Average

Outcome Ambition Seven.

(Please note that these figures are draft at the point of submission)

The CCG seeks to make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

DN: The CCG are continuing to work to define and calculate appropriate outcome measures for this ambition. The Quality Premium measure will be to improve the reporting of medication errors.

Quality Premium Measures

Domain One: Preventing people from dying prematurely

Potential years of life lost (PYLL) from causes considered amenable to healthcare: adults, children and young people

To earn this portion of the quality premium, the CCG will need to:

a) agree with Health and Wellbeing Board partners and with the NHS England area team the percentage reduction in the potential years of life lost (adjusted for sex and age) from amenable mortality for the CCG population to be achieved between the 2013 and 2014 calendar years*.

b) Demonstrate that, in developing the reduction to be achieved and its plans to deliver it, the CCG and its partners have taken into account:

i) The local causes of premature mortality for those living in areas of deprivation;
ii) Other relevant needs set out in the local joint health and wellbeing strategy;

c) Achieve the planned reduction.

* This should be based on the 10-year average annual reduction in potential years of life lost from amenable mortality.
(Data Sources: Primary Care Mortality Database, ONS population estimates, Ambitions Atlas)

Value: 15% of quality premium.

DN: Please note that Quality Premiums are still to be agreed by the Health and Wellbeing Board

CCG Projection is to achieve a 3.2% decrease against baseline (12/13) as illustrated below.

E.A.1	PYLL Rate per 100,000 population
2014/15	1964.0

Domain 2: Enhancing quality of life for people with long term conditions.
Domain 3: Helping people to recover from episodes of ill health or following injury.

Avoidable Emergency Admissions

Composite measure of:

- unplanned hospitalisation for chronic ambulatory care sensitive conditions (adults)
- unplanned hospitalisation for asthma, diabetes and epilepsy in children
- emergency admissions for acute conditions that should not usually require hospital admission (adults)
- emergency admissions for children with lower respiratory tract infection.

Threshold

To earn this portion of the quality premium, there will need to be a reduction or a zero per cent change in emergency admissions for these conditions for a CCG population between 2012/13 and 2013/14, or the Indirectly Standardised Rate of admissions in
2013/14 is less than 1,000 per 100,000 population.

Value: 25% of quality premium.

DN: Please note that Quality Premiums are still to be agreed by the Health and Wellbeing Board

The table below shows the avoidable emergency admission composite indicator

E.A.4	Emergency admission composite indicator
Q1 2014/15	385
Q2 2014/15	599
Q3 2014/15	727
Q4 2014/15	428
2015/16	2116

Improving access to psychological therapies (IAPT)

Threshold

To earn this portion of the quality premium, the CCG will need to:

a) Achieve IAPT access levels of at least 15% by 31 March 2015; and

b) if the CCG IAPT access level was 13% or greater by 31 March 2014, to further increase access levels by 31 March 2015 to an additional amount agreed by the CCG with the relevant Health and Wellbeing Board and with the NHS England area team which should be no less than an additional 3%.

For a) and b), CCG plans to increase access levels during 2014/15 should include plans to increase the proportion of individuals accessing IAPT services from communities where use of IAPT is known to be disproportionately low.

(Data source: CWP, HSCIC)

Value: 15% of quality premium.

The table below illustrates for IAPT, the proportion of people that enter treatment against the level of need in the general population planned for 2014/15 and 2015/16. The CCG projection is to achieve 15% by March 2015 against 12/13 baseline (Nationally Mandated).

E.A.3	The number of people who receive psychological therapies	The numbers of people who have depression disorders (local estimate based on National Adult Psychiatric Morbidity survey 2000)	Proportion
Q1 2014/15	431.0	10345	4.17%
Q2 2014/15	441.0	10345	4.26%
Q3 2014/15	331.6	10345	3.21%
Q4 2014/15	348.1	10345	3.37%
2015/16	1655.2	10345	16.00%

Domain of NHS OF Domain 4: ensuring that people have a positive experience of care

Addressing issues identified in the 2013/14 Friends and Family Test (FFT), supporting roll out of FFT in their local health economy in 2014/15 and showing improvement in a selected indicator from Domain 4 of the CCG Outcomes Indicator Set.

To earn this portion of the Quality Premium:

1. The CCG will need to:
a) Agree a plan with their local providers with specified actions and milestones for addressing the issues that are identified from 2013/14 FFT results, particularly where they highlight issues which relate to poor care, and for:

i) These actions to be achieved in line with the milestones;
ii) The number of negative responses received via FFT from patients in respect of local providers to reduce between Q1 and Q4 of 2014/15;

b) Obtain appropriate assurance and evidence that providers have taken action in response to FFT feedback;

c) Support local providers to co-ordinate the roll out of FFT by the end of 2014/15 and to address roll-out issues as required. Appropriate evidence of advice and support being provided where this has been sought should be recorded by the CCG, and:

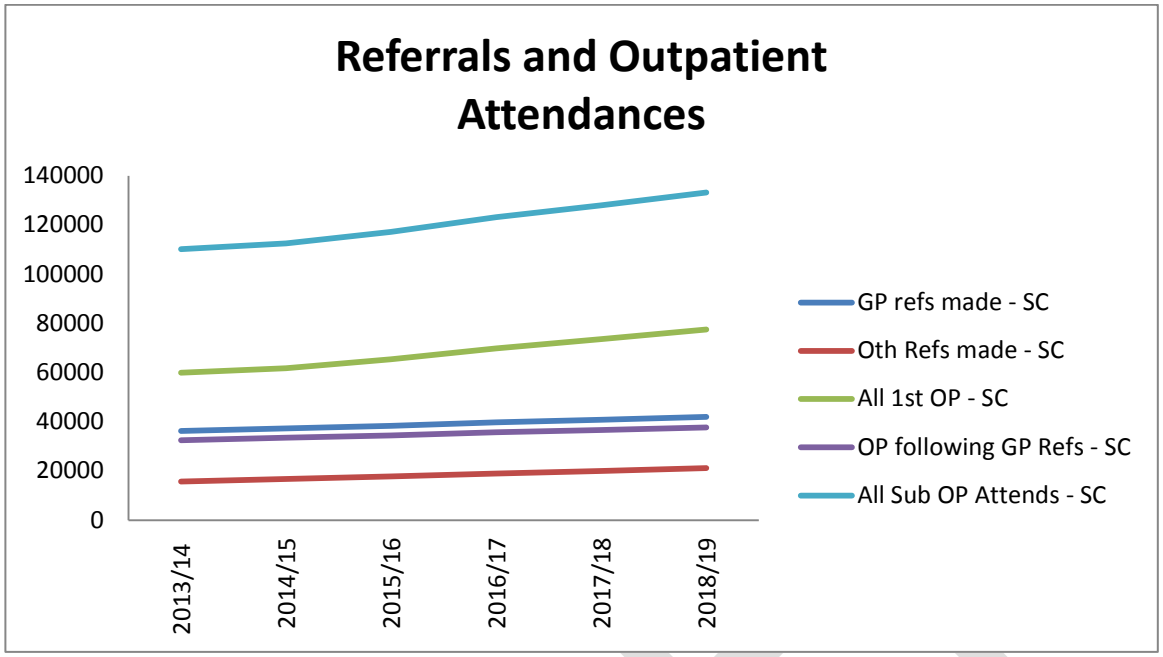
2. There is an improved average score achieved between 2013/14 and 2014/15 for one of the patient improvement indicators set out in the CCG Outcomes Indicator Set with the specific indicator agreed by the CCG with the Health and Wellbeing Board, the NHS England area team and the relevant local providers.

Value: 15% of quality premium.

The CCG plans to meet the national set objective for the Friends and Family Test in 2014/15 and 2015/16. The CCG plans to meet the nationally set objective from 2014/15 till 2018/19 for improving the reporting of medication errors.

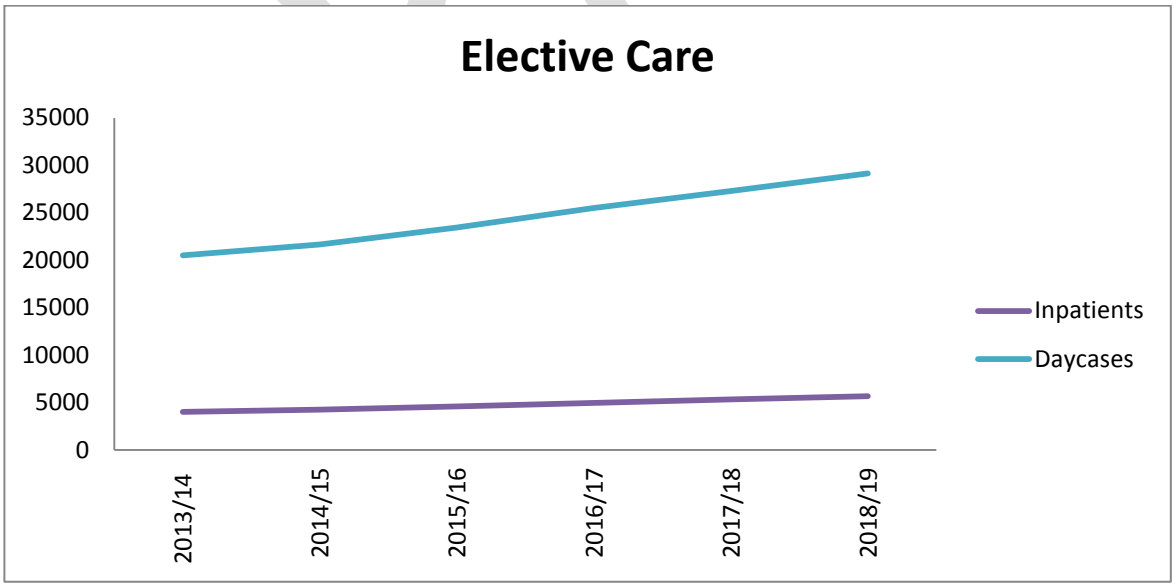
Activity trajectories

Referrals and Outpatient Attendances



The CCG has experienced an increase in GP referrals over the last year and it is anticipated that this may grow due to the change in demography and the increasing pressure in primary care. The local trust operates at peer level for first to follow up ratios.

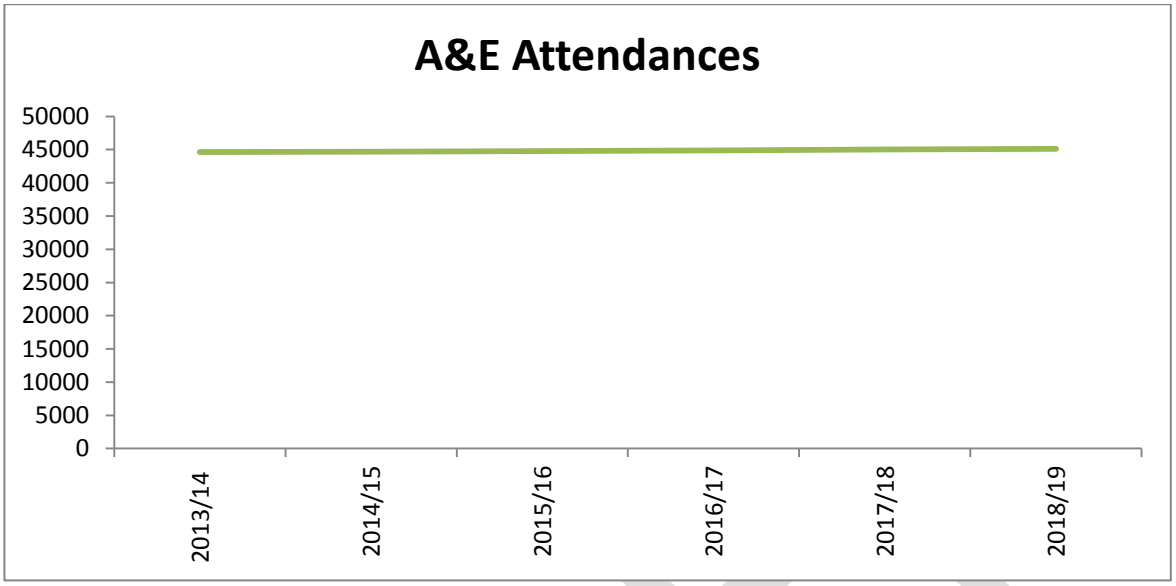
Elective Care



The CCG and local main provider are increasing the ratio of day-case to elective procedures to improve efficiency. The provider has recently implemented a new theatre suite and has a dedicated day-case unit. The CCG and trust are reviewing locally the commissioning for Value pack to improve

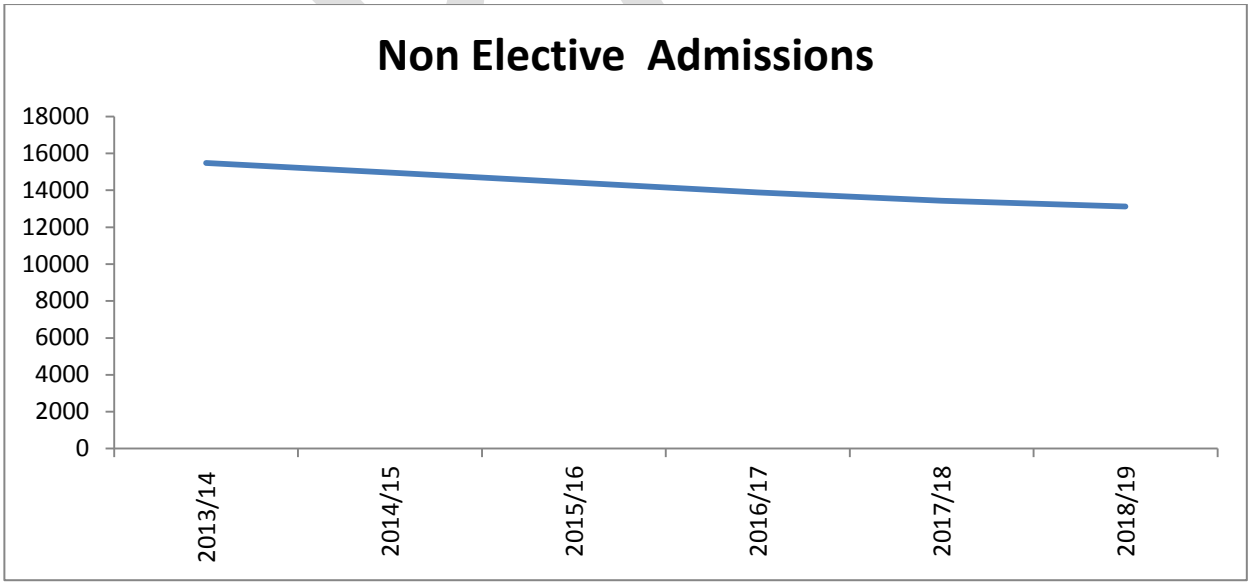
effectiveness. The impact of this has not been taken into account above but it is anticipated that this will have a significant effect in a number of specialties e.g. gastroenterology.

A&E attendances



A&E attendances have remained stable over 2013/14 and have been predicted to continue at the current level. A number of initiatives have been carried out at the local provider to achieve this level of stability additional schemes will be put in place over the planning period to ensure that the level remains stable.

Non Elective Admissions



The connecting care strategy focusses on decreasing non elective activity. The main drivers of a reduction in NEL admissions are Extended Practice Teams and additional beds in community to prevent admission and ensure earlier discharge.

Better Care Fund

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

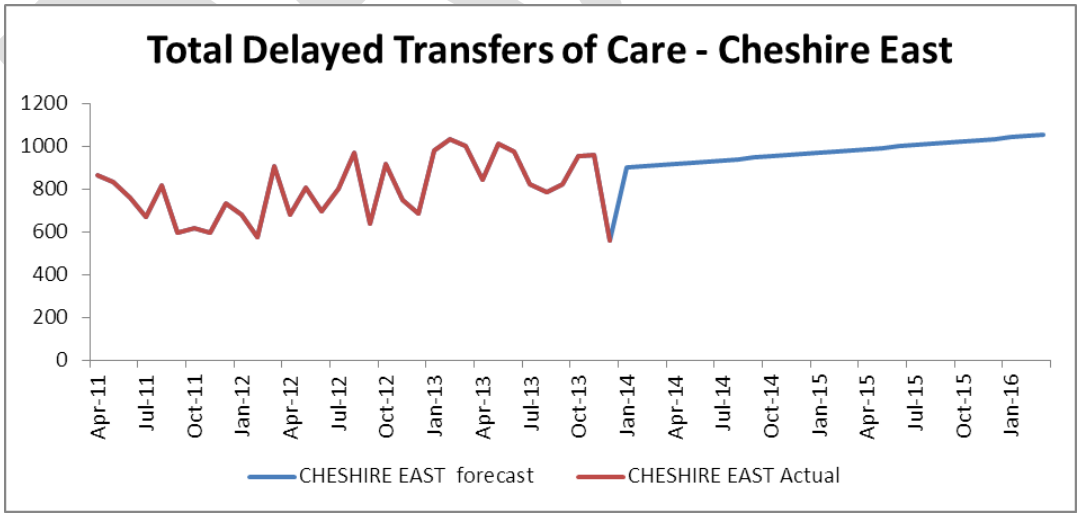
The English average is currently 690.3 admissions per 100,000 population, whilst across the Cheshire East area we currently reporting achievement at 561.1. We know that current performance reported is distorted by the treatment and categorisation of our respite care, which we believe is incorrect, resulting in an increased baseline. We will review our baseline during the early part of 2014/15 and following this review we will determine our collective ambition around the level of improvement we wish to achieve.

Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services:

The English average is currently 82.6% of older people remaining in their own homes after 91 days from discharge from hospital, whilst across Cheshire East 79.3% were still at home. It is important to note that across the Cheshire East area whilst our % performance is lower than the national average our delivery is to a larger % of the population, which will have a greater impact as we improve the proportion of older people still at home after 91 days. Our aim is to improve performance by continuing to expand the number of older people who have received reablement services whilst also seeking to increase those staying at home more than 91 days by 1% each year, until we reach our ambition of being upper quartile.

Delayed transfers of care from hospital per 100,000 population:

The English average is currently not known so it is not possible to compare the local performance against the national delivery. Locally across the Cheshire East area we are currently achieving 302.75 and will aim to reduce this by 5% from our baseline by 31 March 2015, continuing to improve on that performance year on year until we are recording high quartile performance. Detailed below is a graph showing the average monthly delays from April 2011, which is one of the indicators being monitored locally:



Avoidable emergency admissions:

We have detailed our performance below for our two CCGs along with our collective ambition to improve performance, reflecting the differing age profiles of the two CCGs.

Await the information provided by NHS England.

CCG	English Avg	Baseline	March '15
South	-	2,093.3	Tbc
East	-	2,211.0	Tbc

The projected trajectory below is Eastern Cheshire CCG's plan, included in the " year 2014/16 Operational Plan.

Baseline	2014/15	2015/16	2016/17	2017/18	2018/19
2026.6	2026.6	2016.467	2006.334	1965.802	1823.94

At Mid Cheshire Hospital Foundation Trust (MCHFT), South Cheshire CCG and Vale Royal CCG we have invested in additional services within the hospital setting (A&E) in particular to increase levels of staffing to treat patients quickly. There has been detailed analysis of the flow of patients both in A&E, but also across the wider hospital services to target those areas needing improvement to ensure the " front door" is not in crisis. The CCGs have also invested in alternatives to acute care beds – these are multi agency services outside of the hospital setting ensuring patients can be discharged quickly, either from A&E or from hospital wards. The combination of investment and new services in place have meant that MCHFT has managed to deliver the four hour A&E target, and non elective admissions have remained on or slightly under plan for 2013/14.

The experience of patients and service users:

Proportion of people who feel supported to manage their long-term condition:

The English average is currently tbc, whilst across the Cheshire East area we are currently achieving % of 74.1 in the South Cheshire CCG area and 77.5 in the Eastern Cheshire CCG area, with an aim to increase this to upper quartile levels by 31 March 2015. It is notable to state that within the south there are 18 GP practices and 23 GP practices in the east.

The table below is the Eastern Cheshire CCG submission in the operating plan to cover "what is your ambition for improving the health related quality of life for people with long term conditions"

	Average EQ-5D score for people reporting having one or more long-term condition
Baseline	77.50
2014/15	78.60
2015/16	79.70
2016/17	80.80
2017/18	81.90
2018/19	83.00

Locally important indicators:

Whilst these national indicators will provide an important measure of success in creating a more integrated model of care and support services, it is also important that partners monitor local outcomes that are tailored to the pressures that we know exist within local services. Therefore, alongside these national outcomes, we have focussed on the area where we know we need to make significant improvements

Direct admissions from hospital to long-term care settings:

Information needed, this is a common theme across the CE HWB area for both Councils as we both have challenges with direct admissions from hospital to long term care settings.

Our local performance is x against our regional comparator performance of y. We will seek to improve this performance to upper quartile levels within a three year period.

APPENDICIES

Glossary of Terms

A Call to Action This is an NHS England document and programme of action focused on the challenge to staff, the public and politicians to help the NHS meet future demands and tackle the funding gap through honest and realistic debate.

Better Care Fund (BCF) A single pooled budget for health and social care services to work more closely together in local areas, based on a plan agreed between the NHS and local authorities.

Care.data An information system which will make increased use of information from medical records with the intention of improving health services. The system is being delivered by the Health and Social Care Information Centre (HSCIC) and NHS England on behalf of the NHS.

Commissioning for Quality and Innovation (CQUIN) The system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

Everyone Counts: Planning for Patients 2013/14 outlines the priorities, incentives and levers that were used to improve services from April 2013, the first year of the new NHS, where improvement was driven by clinical commissioners.

Friends and Family Test The Friends and Family Test (FFT) aims to provide a simple headline metric which, when combined with follow-up questions, can drive a culture change of continuous recognition of good practice and potential improvements in the quality of the care received by NHS patients and service users.

CCG Outcomes Indicator Set (CCG OIS) The CCG Outcomes Indicator Set is part of the NHS England's systematic approach to promoting quality improvement. Its aim is to support clinical commissioning groups and health and wellbeing partners in improving health outcomes by providing comparative information on the quality of health services commissioned by CCGs and the associated health outcomes – and to support transparency and accountability by making this information available to patients and the public.

Compassion in Practice Compassion in Practice is the three year vision and strategy for nursing, midwifery and care staff drawn up by NHS England and the Department of Health.

NHS Outcomes Framework The NHS Outcomes Framework sets out the outcomes and corresponding indicators used to hold NHS England to account for improvements in health outcomes.

Quality Premium The Quality Premium rewards CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

Unit of Planning A number of CCGs who have joined together with relevant Area Teams, providers, Local Authorities and Health and Wellbeing Boards to create a footprint of a size large enough to enable effective strategic planning.

NHS ENGLAND

ACCOUNTABILITY REPORT TO CHESHIRE EAST HEALTH & WELL BEING BOARD

MARCH 2013

1 CONTEXT

NHS England is the national body, tasked by Government, to improve health and care, underpinned by the NHS Outcomes framework and the NHS Constitution. The mandate given to NHS England sets out objectives and deliverables for the next two years. NHS England has established agreements for successful working alongside Public Health England, and Monitor. A concordat with the LGA recognises Health and Wellbeing Boards as system leaders comprising of membership drawn from Local Government, CCG's and NHS England.

NHS England is structured by Region and Area. Each Area Team is responsible for three main activities- system development, assurance and commissioning.

NHS England undertakes some commissioning on behalf of the NHS directly, rather than through local government or CCG's. This commissioning is in five areas. Offender, Military, Public Health, Primary Care and Specialised Services.

These areas were retained by NHS England due to the scale and geography of commissioning, the expertise required and to drive England wide service standards in these areas, so they are not impacted by local variation.

2. THIS REPORT

NHS England provides a quarterly Accountability report to each Health and Wellbeing Board. This report outlines national and regional context together with specific update on priorities that the Area Team is responsible for delivering and how these priorities are progressing.

This report summarises the proposed initiatives in the Operational 2 year plan for commissioned services. It also provides a brief report card on the initiatives pursued in 2013-14 and the outcomes from these so far.

3 2013-14 SUCCESS AND PROGRESS ON PRIORITIES

NHS England has now completed the first full year of operation, which has been formative in developing new structures, building teams and relationships both locally but also between the national team responsible for standard setting and strategy and the local team responsible for implementation.

Governance structures have been developed internally, NHS England has become a member of health and wellbeing boards, communication and engagement structures have been established with CCG's across the area and with Area Teams and CCG's in the North West in respect of Specialised Services.

Assurance systems have been developed, and this will now enable the team to move forward with a more developmental and enabling approach for CCG's and joint commissioning structures with partners. NHS England has taken up the opportunity to support sub regional health and wellbeing transformation under the auspices of the regional Leaders Board.

Primary Care

The following has been achieved since April 2013:

- A robust Area Team Primary Care Governance process has been established to monitor and manage primary care providers. Currently the dashboard which supports this process is mainly paper based and needs to be developed where it becomes electronic.
- Performance of Primary Care providers has generally been very good and where providers have been identified as low performers the Area Team has acted promptly with those providers.
- Regular Assurance meetings with the Clinical Commissioning Groups have been established which focus on the Medical providers and the co-commissioning responsibility between the Area Team and Clinical Commissioning Groups.
- There are a number of service reviews which have been completed or will continue into 2014/15, with the following services :-

    - Salaried Dental Services
    - All Day health centre, Wirral
    - Willaston GP Surgery
    - Orthodontic Service
    - Primary Care Oral Surgery Service
    - Optometry enhanced Services
    - Public health initiatives within Dental, Pharmacy and Optometry providers – initially focusing on smoking cessation but with the opportunity to expand this to other initiatives.

- Completion of the procurement and mobilisation of the successful bidders of primary medical services for Townfield Medical Centre and TG Medical Centre, Wirral.
- Progress the procurement of Primary Medical Services for the patients and residents of Willaston, Cheshire.
- Commissioning and performance management of 2ndry care dental services.
- Management of budget within challenging financial limits.

Public Health

The following has been achieved since 1 April 2013:

- Performance for Screening & Immunisation programmes have continued to be at high levels and to either improve or at least be maintained
- Nationally specified additions and amendments have been made to vaccination programmes including Rotavirus, Shingles, Childhood flu, Meningococcal C
- The first phase of the MMR Catch-Up programme resulted in improvements in MMR coverage amongst the target 10 to 16 year age group
- Midwives have been delivering the seasonal flu vaccine to pregnant women after being trained by the Area Team
- A joint procurement with Warrington BC has taken place for an integrated 0 to 19 Public Health Nursing Service. This was an innovative joint procurement, and is a model that will be developed further with the other LA partners.

- A review of breast screening services has been conducted and will lead to changes in programme configuration
- Seasonal flu vaccination performance has been at target levels for age 65 and over and has improved for all groups
- The team is on track to achieve workforce expansion targets for Health Visitors
- The team has established programme boards for all service areas to ensure there is appropriate governance and accountability
- The team have a managed a wide range of issues and incidents to a conclusion
- There are a number of areas where gaps in services should be addressed, specifically:
- Three of the Breast screening programmes are below specified minimum population size
- The Wirral Diabetic Eye Screening Programme has fragmented commissioning arrangements
- The CHIS services do not meet national requirements

Specialised Commissioning

The following has been achieved since April 2013

- Financial frameworks have been developed between CCG's and NHS England to enable budgets to be agreed and risks managed (As resources moved to NHS England from CCG;s in the allocations process)
- A full review of services against national standards (called a 'compliance review) which has revealed improvements required by providers to meet these standards within 1 year and where more strategic changes are required to close this gap, these are identified as commissioning reviews.
- Governance structures have been established to effectively provide oversight on £2bn budget across the North West with contracting teams and specialised service advisors.
- A service review has been completed on Neuro rehabilitation with a point prevalence study for required capacity across all providers in the North West. This has resulted in an agreed business case for capacity and the project is now moving toward procurement for a lead provider
- A service review has been completed in Cancer services for both Greater Manchester and C&Merseyside. This review has resulted in a proposed consolidation of provision into fewer centres together with future procurements.
- Vascular services in Lancashire have been reviewed and will be taken forward in 2014-15 as part of the work plan for next year along with Greater Manchester Vascular services.
- Learning Disabilities review of individual clients and placement in response to Winterbourne,
- Trauma services have been reviewed in terms of sustainability and will feature as a key priority area for 14-15
- Matrix working between Area Teams has been developed for Quality Teams, so that providers in each of the Area Team sub regions will have a local Quality team providing oversight on quality improvement.
- Operational Delivery Networks have been established in Trauma, Critical Care, Neonatal services.

2. PLANNING GUIDANCE 2014

In November 2013, NHS England, NHS Trust Development Agency and Monitor wrote to all NHS Organisations to outline their requirements for all organisations to develop a five year strategic plan and two year operational plan by 20th June 2014.

The Planning Guidance "Everyone Counts" defined that the 6 characteristics of high quality, sustainable health and care systems in 5 years' time are as follows:

- Citizen inclusion and empowerment
- Wider primary care, provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step-change in the productivity of elective care
- Specialised services concentrated in centres of excellence

Organisations would need to work together to develop their plans for the local population based on the agreed "unit of planning". For Cheshire, Warrington and Wirral, these are as follows:

- Eastern Cheshire CCG
- South Cheshire CCG & Vale Royal CCG
- Cheshire West CCG
- Warrington CCG
- Wirral CCG

Both NHS England and Clinical Commissioning Groups have been working to develop both their five year strategies and two year operational plans. The first draft of the operational plan was submitted on 14th February and organisations are now refining their plans before the final draft is submitted on 4th April. The purpose of this report is to outline NHS England's key priorities for the next two years and how these are linked to the Health and Wellbeing Strategy.

3. CHESHIRE, WARRINGTON AND WIRRAL NHS ENGLAND TWO YEAR OPERATIONAL PLANS

This 2 year operational plan represents the first 2 years of a 5 year strategic plan for Cheshire, Warrington and Wirral. CWW AT is committed to driving improvements to secure equity of access and a reduction in variation in the services all patients across Cheshire, Warrington and Wirral and the North West (for specialised services) receive.

There are a number of service priorities that will be addressed over the next 2 years. These service issues have been identified through a number of routes:

1. Legacy Issues from previous commissioning organisations (some dating back several years)
2. Quality Improvement reviews and improvements relating to national standards
3. Capacity issues arising from growth in need for services

The service priorities for each area of direct commissioning include:

Primary Care

- Work with CCG's on the Primary Care Strategy which is envisaged as embedded within new community based integrated teams for population outcome improvement.
- Complete all the Dental Service reviews and redesign the model of service delivery and care pathways (based on national models when available) to deliver a sustainable and financially viable service model for the future.
- Complete the amalgamation and redesign of Primary Care Support Services to deliver a safe and robust service within the financial envelope available, which will result in a 40% reduction in costs.
- Complete and recommission (where appropriate) the reviews for the 3 APAMS contracts due to end on 31 March 2015.

- Complete and recommission (where appropriate) the review of the Warrington Local Pharmacy Provider.

Public Health

- Deliver the Health Visiting workforce targets, alongside a transformed outcome-focused service and a safe transition to local authority commissioning
- Identify and address health inequalities in screening & immunisation services
- Identify services that are not compliant with national specifications and deliver changes to ensure compliance
- Achieve high performance in commissioned services against key measures

Specialised Services across the North West

- Securing specialised cancer services that comply with national standards and guidance
- Ensuring sufficient capacity at each level of care for neurorehabilitation patients
- Addressing need for intermediate step down for spinal injuries patients
- Working with CCGs in providing comprehensive obesity services
- Implementing in partnership with CCGs the findings of the national CAMHs tier 4 review
- Ensuring Major Trauma care across the North West is optimised to drive improving outcomes
- Ensuring compliant cardiac services and taking into account the impact of the paediatric cardiac surgery review
- Implementing the output from the vascular reviews that have been undertaken, undertaking procurement as required.
- HIV services are reviewed and connected in a network of sexual health services.
- Review of medium and low secure services across the northwest for capacity and flow

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

Public Health	• Expansion of childhood flu vaccination programme to 4 year old children
	• Commissioning of maternity services to implement pertussis programme.
	• Review of Immunisation programmes to include:
	  ○ Hep B Neonatal programme review
	  ○ targeted MMR catch-up exercise
	  ○ Pharmacy flu programme
	  ○ Men B
	  ○ Shingles extension
	• Planning for potential expansion of new born blood spot screening.
	• Implementation of information systems review in respect of new born, infant physical exam (NIPE).
	• Healthy Child Programme 0-5years, implementation of national expansion for health visiting and family nurse partnership
	• Implementation of Men C vaccination for university entrants
	• Extension of screening programmes to include bowel screening at 55, Implementation of findings following
		L
		M
		L
		M
			L
			M
			L
			M
				M	L
					L
					M
						M
						L
						M
						M
						M
						M
						M

Commissioning Area	Commissioning developments	DOMAIN 1 Preventing People from dying prematurely	DOMAIN 2 Enhancing quality of life for people with long-term conditions	DOMAIN 3 Helping people to recover from episodes of ill healt or following injury	DOMAIN 4 Ensuring People have a positive experience of care	DOMAIN 5 Treating and caring for people in a safe environment and protecting them from avoidable harm
	breast screening review taking place during 2013-14. • Strategic review of Cervical screening laboratory arrangements in Cheshire & Merseyside • Diabetic eye screening review and implementation of findings. • Review of Sexual Assault Services • Ensuring that Offender Health have the full provision of screening and immunisations as appropriate. Health needs assessment at Risley and Thorn Cross.	L L	M	M		L M M
Specialised Commissioning	• Securing sufficient capacity in compliant providers for CAMHs tier 4 services, working in partnership with CCGs to ensure availability of appropriate services across the patient pathway. • Addressing long waiters for paediatric spinal surgery through agreed action plan with providers • Establishment of compliant clinical models for cancer, cardiac and vascular services across the North West • Securing compliant services across HIV networks, working in partnership with CCGs and Local Authorities.	M	M M	M	H M M	H M

Commissioning Area	Commissioning developments	DOMAIN 1 Preventing People from dying prematurely	DOMAIN 2 Enhancing quality of life for people with long-term conditions	DOMAIN 3 Helping people to recover from episodes of ill healt or following injury	DOMAIN 4 Ensuring People have a positive experience of care	DOMAIN 5 Treating and caring for people in a safe environment and protecting them from avoidable harm
	• Working with CCGs to secure sufficient capacity at each level of care for neurorehabilitation patients and intermediate step down beds for spinal injured patients in order to prevent a blocking of the major trauma centre inpatient capacity. • Ensure financial and clinical sustainability of major trauma centres across the North West	M	M	M	M	M
Primary Care	• Developing the Primary Care Strategy for Area Team with patients groups, CCGs, LAs, providers and local committees. This will be based on the CCGs strategies and will form part of their Integrated Care Models. • Improving access to medical services, including improved availability of primary care services • Pilot new NHS Dental contract. • Completing the review of Orthodontic Services		M M M		M M M	

4. CHESHIRE, WARRINGTON AND WIRRAL FIVE-YEAR STRATEGIC PLANS

It is anticipated that as 5 year plans are formulated across the Area by CCG;s and in partnership with Local Government, these will be aggregated and tested to ensure there is alignment and coherence. It is important that these plans represent the total plan for 'place' and take account of prevention through to specialist care. The impact assessment of these plans in terms of identification of opportunities, risks, and any gaps will be developed over the coming month in anticipation of the first cut submission.

NHS England Cheshire Warrington and Wirral Area Team is also responsible for development of 5 year plans, these are being formulated with a strong collaborative and partnership model in the three commissioning areas: Specialised Services, Public Health and Primary Care. Each of these areas will have a first 'cut' plan for the 4th of April which will focus on vision and scope, direction. The detailed road map of change toward this vision will be fleshed out during the following 3 months.

Primary Care

A Primary Care Transformation Board has been established with membership from NHS England, Regional and National level, and CCG's,/ providers. This Board operates as a joint model of leadership between NHS England and CCG's in developing the 5 year plan for primary care. NHS England will ensure there is a strong emphasis on integration, innovation, standards and value alongside the CCG overall integrated care strategies for primary and wider community and social care services. the vision is to create integrated primary and community teams operating as accountable teams for improving care and outcomes for a defined population. These teams will have services build around the needs of these populations as well as core service offered universally. There is a focus on care co-ordination, early intervention and developing specialist teams accessible for treatment and care of complex patients. A national strategic framework for Primary Care is also under development which will be utilised in developing this work further

Public Health

NHS England is responsible for commissioning child health, immunisation and screening programmes. All of these interventions are integral to maintaining and developing healthy communities, but clearly are only part of the plans for change in this area. It has therefore been agreed that the Directors of Public Health together with Public Health England and NHS England will work collaboratively alongside 'CHAMPS', to develop a 5 year framework. This work will map out the contributions of partners toward healthy individuals and communities, identify how this relates to the priorities and needs within the JSNA's and opportunities and risks arising from this initial work. For example any opportunities to collaborate to address inequalities. The work will also address the opportunities for greater collaboration in developing and improving outcomes through pathways of care and integrated commissioning models. Four areas have initially been prioritised in this work. Obesity, Alcohol. Children's and Sexual Health. The initial work from this framework in terms of mapping contributions will be provided by the 4th April .

Specialised Services

There is a national strategy under development which sets out the vision for concentration of services into centres of excellence, initially outlined as 15-30 nationally. These centres will operate as networks and will comply with national standards of care. The service provided in these centres will be 'bundled' in accordance with best practice of co-location of service for improved outcomes, and ensuring that services provided between sites within a centre will not impinge on quality of care. The strategy will seek to optimise equity of outcomes and access whilst driving value for money through larger centres and sustainable workforce. Three sub regional planning groups have been established for Greater Manchester, Cheshire and Merseyside and Lancashire. An initial report will be provided on vision, current state and gaps by the 4th of April.

This page is intentionally left blank

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	25th March 2014
Report of:	Executive Director Strategic Commissioning
Subject/Title:	Better Care Fund Plan
Portfolio Holder:	Councillor Janet Clowes Portfolio Holder for Health and Adult Care

1.0 Report Summary

1.1.1 The Better Care Fund was announced by Government in June 2013. It provides an opportunity to transform local services so that people are provided with better integrated acre and support. It encompasses a substantial level of funding to help local areas manage pressures and improve long term sustainability of their health and care economies. The Fund will be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

1.2 The Cheshire East Better Care Plan unites a shared vision of Cheshire East Council, NHS Eastern Cheshire Clinical Commissioning Group and South Cheshire Clinical Commissioning Group, for improving outcomes for residents through improving how and social care services work together. The Better Care Fund provides the level to drive a transformed model of integrated care, which will ensure that residents experience care and support of quality that is appropriate to their needs and supports them to live as independent and fulfilling lives as possible. Critically it will ensure that when needs require it, specialist care and support is provided by services best equipped to cater for those needs.

1.3 There is a requirement to submit our Better Care Fund Plan to NHS England by the 4th April. A first draft was submitted in February. The second draft is attached as **Appendix One.** The Metrics and Finance Technical Appendix is being worked on**.** This has been compiled following extensive work by a team of officers from across the Council and the two CCGs and consultation with provider organisations.

2.0 Recommendation

2.1 That the Health and Wellbeing Board consider and endorse the Better Care Fund Plan submission.

3.0 Reasons for Recommendations

3.1 To ensure that the Better Care Plan is submitted by the Health and Wellbeing Board in line with the 'NHS England Planning Guidance - Developing Plans for the Better Care Fund Annex'.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications including - Health

6.1 Following Local Government reorganisation in 2009 and the NHS reforms of 2013, Social Care and Health Services in Cheshire East have strengthened opportunities to secure improved outcomes for residents. This is evidenced through stronger engagement at strategic and operational levels of the organisations and focussing upon identifying opportunities to secure integrated working.

6.2 Across Cheshire all organisations recognise the need to better connect the business of health and social care, in order to ensure that our residents receive the most effective and responsive care and support appropriate to their needs. We also acknowledge that we all need to take greater responsibility for preventing our own ill-health, enabling us to live longer and more fulfilling lives.

6.3 The Health and Wellbeing Board's Joint Health and Wellbeing Strategy identifies the priorities for commissioners to address over the next two years. The principle of integrating services where appropriate underpins the Strategy.

7.0 Financial Implications

7.1 The Better Care Fund is a national pooling of £3.8b from a variety of existing sources within the health and social care system, with £23.9m being pooled locally within the Cheshire East Health and Wellbeing Board area. The local pooling is made up of LA funding from the Disabled Facilities Grant and Capital Allocation for Adult Social Care of £1.8m, South and Vale Royal CCG funding of £10.5m and Eastern Cheshire CCG of £11.6m. The local health and social care economy is expected to work together to deliver better care arrangements for its population, seeking to keep individuals within the community, avoiding hospital/residential nursing care.

7.2 During 2014/15 Council, CCGs and its providers are expected to plan to deliver services in a way that impacts on the system to improve the

outcomes for its population, through improving Community Services (including Primary Health Care [GPs]). A small development team has been created that is establishing schemes that will deliver the required funding and the governance changes from 2015.16 (i.e. achieving the £23.9m changes).

7.3 It will be important that during 2014/15 financial and governance arrangements between the various partners are agreed, to include the risk sharing arrangements, funding to invest in the system initially and the arrangements for dealing with the potential double running costs and any savings arising.

8.0 Legal Implications

8.1 Under the National Health Services Act 2006 local authorities and NHS bodies can enter into partnership arrangements to provide a more streamlined service and to pool resources, if such arrangements are likely to lead to an improvement in the way their functions are exercised. For the purposes of that act clinical commissioning groups are

8.2 The powers under that Act allow for pooled budgets, lead commissioning and integrated provision and therefore enable the kind of working suggested in the Better Care Plan.

8.3 Advice needs to be taken as the project develops to ensure that specific issues such as sharing of information are dealt with in a legally sound way.

9. Risk Management

9.1 An initial risk assessment is included within the Better Care Fund submission.

10. Integrating Health and Care in Cheshire East

10.1 The opportunity afforded by the Better Care Fund is to translate the ideas that are already well established within the Cheshire East health and care economy into action, to drive change and transformation at pace.

10.2 This commitment is acknowledged by the ambitions of the Cheshire Pioneer Programme which aims to ensure that individuals in Cheshire stop falling through the cracks that exist between the NHS, Social Care and support provided in the Community, and we will avoid:-

- duplication and repetition of individuals experience, with people having to re-tell their story every time they come into contact with a new services;

- people not getting the support they need because different parts of the system don’t talk to each other or share appropriate information and notes;

- the “revolving door syndrome” of older people being discharged from hospital to homes not personalised to their needs, only to deteriorate or fall and end up back in A & E;

- home visits from health or care workers are not co-ordinated, with no effort to fit in with people’s requirements;

- delayed discharges from hospital due to inadequate co-ordination between hospital and social care staff.

10.3 The clear commitment is that we will move away from commissioning costly, reactive services and commission those that will develop self-reliance, focus on prevention, improve quality of care, reduce demand and take cost out of the system for re-investment into new forms of care. Across Cheshire we are aligning our commissioning approaches and where relevant jointly commissioning services to deliver consistency and integration in the wider service landscape.

10. 4 By 2015, the communities of Cheshire will begin to experience **world class** models of care and support that are **seamless,** high quality, cost effective and locally sensitive. **Better outcomes** will result from working together with:-

- **Better experiences** of local services that make sense to local people rather than reflecting a complex and confusing system of care;

- More individuals and families with complex needs are able to **live independently and with dignity** in communities rather than depending on costly and fragmented crisis services;

- **Enhanced life chances** rather than widening health inequalities.

10. 5 Every community in Cheshire is different and that is true in Cheshire East. Local solutions will reflect local challenges, but our shared action will be united around **four shared commitments:**

i. **Integrated communities:** Individuals will be enabled to live healthier and happier lives in their communities with minimal support. This will result from a mindset that focuses on people’s capabilities rather than deficits; a joint approach to community capacity building that takes social isolation; the extension of personalisation and assistive technology; and a public health approach that addresses the root causes of disadvantage.

ii. **Integrated case management:** Individuals with complex needs – including older people with longer term conditions, complex families and those with mental illness will benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

iii. **Integrated commissioning:** People with complex needs will have access to services that have a proven track record of reducing the need for longer term care. This will be enabled by investing as a partnership at real scale in interventions such as intermediate care, re-ablement, mental health services, drug and alcohol support and Housing with support options.

iv. **Integrated enablers:** We will ensure that our plans are enabled by a joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework, and a joint approach to workforce development.

10.6 We recognise that the current position of rising demand and reducing resources make the **status quo untenable**. Integration is at the heart of our response to ensure people and communities have access to the care and support they need.

10.7 Locally within Cheshire East, two integration programmes are at the heart of this work, connecting workstreams across the Cheshire footprint as appropriate, while also affording opportunities for learning and remodelling care according to the needs of local populations.

10.8. **Caring Together** (including NHS Eastern Cheshire Clinical Commissioning Group and Cheshire East Council) - This area covers a population of approximately 201,000 residents, and includes the urban areas of Macclesfield, Congleton and Knutsford. Whilst life expectancy is above the national average, there are significant disparities between areas. The main causes of premature death are circulatory and respiratory disease, cancers, and diseases of the digestive system, with particular links back to lifestyle issues of obesity and alcohol consumption. This area includes 23 GP practices, and works closely with the Local Authority of Cheshire East.

10.9 A partnership of health and social care organisations have developed a shared vision across Eastern Cheshire that is called ‘Caring Together’ – joined up local care for all our wellbeing. This is aimed at bringing about a radical shift in care from reactive hospital based approach to a proactive community based care model. Our approach is patient-centred and will use a new and enhanced primary care approach as the foundation. The notion of the empowered person is at the starting point of great care. The model builds out from this using a locality team approach and specialist in-reach to support primary and community care more effectively.

10.10 The vision in this area was developed in partnership between professionals and the public, and is clinically driven, incorporating the National Voice Principles. In Eastern Cheshire we believe that integration cannot be delivered by one organisation working alone in isolation, but must be delivered through genuine collaboration.

10.11 **Connecting Care** (including NHS South Cheshire Clinical Commissioning Group and Vale Royal Clinical Commissioning Group, Cheshire East Council and Cheshire West and Cheshire Council) - This locality has a population of approximately 278,500 and includes 30 GP practices (18 in South Cheshire CCG, 12 in Vale Royal CCG). This area covers a proportion of Cheshire East and Cheshire West and Chester Council. The two Clinical Commissioning Groups share a management team to provide efficiencies. Patient flows to the DGH have illustrated that 92% are from people living within the boundaries of the two Clinical Commissioning Groups. There are significant financial pressures that exist within the health and social care geographies in this locality and this is due in part to a relative lack of deprivation against national benchmarking making it difficult for local organisations to individually draw resources to create the headroom for innovation.

10.12 The local Partnership Board recognises the work that is already taking place with regards to developing integrated services to meet the needs of the local communities. Our approach so far has been to deliver integrated services locally, led by empowered staff groups and with a clear focus on improving outcomes and reducing health inequalities. This has engaged front line health and social care staff, clinicians, patient groups, the voluntary sector and commissioners. The Partnership Board has now acknowledged the need for further work to produce an integrated plan that will ensure this 'bottom up' approach is co-ordinated and meets the needs of the local Health and Wellbeing strategies to achieve real scale and pace.

10.13 Commissioning of Integrated Services

Effective commissioning of services to secure improved outcomes for residents is at the heart of the Better Care Fund, and the partnership within Cheshire East acknowledges this.

10.14 Consideration has been given to whether additional joint activity and commissioning resources should be included in the Better Care Fund pooled budget from April 2015. The partners, through our Joint Commissioning Board, have discussed this extensively and determined that we would wish to take a cautious and measured approach to growing the pool as we extend our collective reach in identifying appropriate activity to be included. Common areas for commissioning reviews have been identified for 14/15 and 15/16 across the partnership. Currently commissioning reviews are underway in the areas of alcohol and substance misuse, and learning disabilities. At the point of each review decisions will be considered to joining the activity and commission to the pool. Part of the reason for doing this is to ensure we do not lose a focus, via BCF on addressing the shared outcomes and measures that we are aiming to secure. For this reason we do not wish to get ahead of ourselves or overstate our ambition early and then under-deliver.

10.15 The ambition of the partnership is clearly to connect commissioning activity to improve the health and care outcomes for residents. The Better Care Fund, commencing in 2015 is seen as a staging post on the journey which will result over time in significant combining of resources to more effectively drive innovation and improvement.

11.0 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Phone: 01270 686560
Email guy.kilminster@cheshireeast.gov.uk

This page is intentionally left blank

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Cheshire East Health and Wellbeing Board
Better Care Fund planning template

1) PLAN DETAILS

a) Summary of Plan

Local Authority	Cheshire East Council
Clinical Commissioning Groups	NHS South Cheshire Clinical Commissioning Group
	NHS Eastern Cheshire Clinical Commissioning Group
Boundary Differences	Cheshire East Health and Wellbeing Board (HWB) has a population of approximately 370,000 residents. This area is coterminous with the geographic boundaries of the Local Authority, and the area contains two Clinical Commissioning Groups; NHS Eastern Cheshire CCG and NHS South Cheshire CCG. Our two CCGs whilst established from the same Primary Care Trust come with some quite different population needs and requirements, high numbers of the frail elderly in parts of the area and differences in the levels of affluence, both of which affect the care needs and the drivers for change. The health needs of Eastern Cheshire patients are provided mainly by a small District General Hospital in Macclesfield, however the patient flow for additional acute and the majority of specialist services is into the Greater Manchester configuration. South Cheshire CCG was formed in close collaboration with Vale Royal CCG (within Cheshire West and Chester) – the close working relationship and shared management arrangements are due to the patient flows of patients around Leighton, a small District general hospital (Mid Cheshire Hospital Foundation Trust).Over 90% of patients from both CCGS use MCHFT as their acute provider of services. We are working closely with our neighbouring Cheshire West and Chester Health and Wellbeing Board to help improve the patient flows across the broader Cheshire geography as well as into neighbouring areas beyond the Cheshire boundary, in line with our joint and collective involvement in the Cheshire area Pioneer Programme.
Date agreed at Health and Well-	Draft version approved: 14.02.2014

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Being Board:	Final version approved: 25.03.2014
Date submitted:	Draft version approved: 14.02.2014 Final version submitted: 05.04.2014
Minimum required value of BCF pooled budget: 2014/15	£1.209m
2015/16	£23.891m
Total agreed value of pooled budget: 2014/15	£9.221m
2015/16	£23.891m The above £23.891m includes the S256 funding from the Council and two CCGs for Reablement and Carers Breaks.

b) Authorisation and signoff

Signed on behalf of the Clinical Commissioning Group	NHS South Cheshire CCG
By	Simon Whitehouse
Position	Chief Operating Officer
Date	Informally approved 14/2/14 Formal approval for April.

Signed on behalf of the Clinical Commissioning Group	NHS Eastern Cheshire CCG
By	Jerry Hawker
Position	Chief Operating Officer
Date	Informally approved 14/2/14 Formal approval for April.

Signed on behalf of the Council	Cheshire East Council
By	Lorraine Butcher
Position	Executive Director of Strategic Commissioning
Date	Informally approved 14/2/14 Formal approval for April.
Signed on behalf of the Health and Wellbeing Board	Cheshire East Health and Wellbeing Board
By Chair of Health and Wellbeing Board	Councillor Janet Clowes
Date	Informally approved 14/2/14 Formal approval for April.

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

c) Service provider engagement
Please describe how health and social care providers have been involved in the development of this plan, and the extent to which they are party to it.

The Cheshire East Health and Wellbeing Board's Better Care Plan builds upon the work already underway as part of our successful Integrated Care Pioneer submission.

The Cheshire Integrated Care Pioneer involves providers from across the health and social care economies within the geographies of the two authorities (Cheshire East and Cheshire West and Chester). The vision and ambition of the Pioneer submission has been endorsed by both commissioners and providers who worked together to secure Pioneer status.

The Better Care Plan supports and integrates the change programmes from Cheshire East Council (CEC) and our two CCGs; 'Caring Together' in Eastern Cheshire and 'Connecting Care' in South Cheshire.

In the development of the Plan a number of engagement events have been undertaken, seeking the views and engagement of our various providers. This engagement builds upon the local engagement activity underway within the CCG integration programmes. Both are proactively involving providers in their planning. For example the four work-streams developing the caring Together future care model all include provider representatives, from the hospital and mental health trusts, GPs and the community and voluntary sector. Additionally there are a number of ongoing multi-agency programmes of work involving a range of partners – namely Cheshire East Council, East Cheshire Trust (as the main provider of community health services), housing and voluntary, community and faith sector providers. These are all contributory activities towards the broader integration agenda.

Further work will be required to continue the dialogue with Providers, particularly in relation to the outcomes of the Plan and the risks and impacts of the changes that will be taking place. A meeting of Hospital and Mental Health Trust Chief Executives with the Health and Wellbeing Board took place recently and further telephone conference calls are booked in with the BCF steering group. This is in addition to the ongoing provider engagement in the two CCG localities in relation to the detailed work already underway.

d) Patient, service user and public engagement
Please describe how patients, service users and the public have been involved in the development of this plan, and the extent to which they are party to it

Health Watch Cheshire East are engaged with the Better Care Fund planning through their representation on the Health and Wellbeing Board and the integration programmes of the two CCGs. They are also assisting with aspects of the Adult Social Services improvement initiative which links into the integration agenda (for example in relation to developing the Carer Strategy).

Within the Eastern Cheshire part of the HWB area the **Caring Together** Programme has undertaken detailed engagement with the community with the support of 'Participate' who, working in partnership with the CCG and partner's communications teams, have

captured insight from patient/carer groups through previous work undertaken and new engagement events and street surveys. This has been analysed and coded for common themes.

Participate have undertaken a series of interviews with individuals from three different stakeholder groups to capture their insight on the barriers to achieving integrated care and how they can be overcome within Eastern Cheshire. The three stakeholder groups were GPs, representatives from NHS and social services workforce and leadership (Other Professionals), and representatives of voluntary, community, and faith sector organisations (VCFS).

In addition the four work-streams that are developing the new care model all include patient representatives.

A full breakdown of all events is included in the embedded document below:

engagement log.docx

The outcomes and relevance of the engagement to the whole community is currently being assessed, aiming to identify where additional engagement might be beneficial, taking into account the different aspects of the community in the south of our area. The early assessment suggests that the engagement will be sufficiently representative at this stage, ahead of more detailed engagement around the Better Care Fund.

Connecting Care for Vale Royal and South Cheshire CCG footprints is to undertake engagement with patients and public alongside key stakeholders to ensure, at an early stage of planning, that the valuable engagement with our population is embedded. Initial engagement has taken place through a workshop based on the SCCCG operational plan which highlighted the strategic direction of travel for Connecting Care.

e) Related documentation

Please include information/links to any related documents such as the full project plan for the scheme, and documents related to each national condition.

Document or information title	Outline
Pioneer Programme Expression of Interest  Integrated Care and Support - ... http://caringtogether.info/videos/8?project_id=1&client_id=1	This Pioneer programme outlines the commitment and plans of the Cheshire West and Chester and Cheshire East Health and Wellbeing Boards to integrate care and support services across the County area of Cheshire. The Pioneer programme sets out the common framework for integration; Communities, Case Management, Commissioning and Enablers as reflected in our BCF submission.
Caring Together (Eastern Cheshire CCG)	This programme outlines NHS Eastern Cheshire CCGs and partners proposals to redesign services

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

The Case for Change document will be supplied once signed off by all parties. **Need to Insert**	across the Eastern Cheshire area, including the integration of activity across health and social care functions. This is the pre consultation document which describes the rationale behind the Caring Together Programme. Key headlines are the imperative to change to enable the population of Eastern Cheshire to be empowered to manage their own health, and the delivery of a sustainable health and social care system both in terms of cost and capacity
Connecting Care (South CCG)  Connecting Care vision statement 9De	This programme outlines NHS South Cheshire CCGs and partners proposals to redesign services across the South Cheshire area, including the integration of activity across health and social care functions.
Joint Strategic Needs Assessment **http://www.cheshireeast.gov.uk/social_care_and_health/jsna.aspx**	This is a joint CCG and local authority assessment of the needs of residents across Cheshire East Council. This provides a common evidence base for the design and delivery of services.
Additional documentation/links to documentation  Health and Wellbeing Strategy 2014 - 16 v  The Provision of Early Help in Cheshire  Briefing Paper The Strategic Direction of **Need to Insert** **Need to Insert**	Cheshire East Health and Wellbeing Draft Strategy 2014 - 2016 Early Help Strategy – Cheshire East Council Promoting Open Choice – Strategic Direction of Travel for CE Adults Social Care – Cheshire East Council Adult Social Care – Informal Support to Address Prevention and Early Intervention – Cheshire East Council Draft 2 Year Operational Plans - EC CCG and SC CCG Draft Vulnerable People Housing Strategy – Cheshire East Council

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Draft_VPHS[1].pdf	
National Conditions	Any documentation specific to these to insert??
Plans to be jointly agreed	
Protection for social care services (not spending)	
7 day services in health and social care…	
Better data sharing between health and social care, based on the NHS number	
Ensure a joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care, there will be an accountable professional.	
Agreement on the consequential impact of changes in the acute sector	

VISION AND SCHEMES

a) Vision for health and care services
Please describe the vision for health and social care services for this community for 2018/19.

- What changes will have been delivered in the pattern and configuration of services over the next five years?
- What difference will this make to patient and service user outcomes?

Our submission under the Better Care Fund is designed to deliver our collective vision that within three-years the individual's residing within Cheshire East will enjoy improving standards of health and well-being through the implementation of our joint and collective plans. This will be delivered through our framework of integration, which incorporates that of the Pioneer Programme that is built around:

- **Integrated Communities**: residents will be supported within their communities by employing a mind-set that builds on the principle of community capabilities rather than deficits.
- **Integrated Case Management:** residents will receive a more coordinated experience of care and support services through the use of a single point of access and our support of seven-day working.
- **Integrated Commissioning:** services commissioned for local residents will be based upon strong evidence and proven effectiveness and commissioned as part of a whole system approach to commissioning.
- **Integrated Enablers:** on a pan-Cheshire geography we will use this work-stream to support the issues that will enable long-term integration, addressing issues such as; data-sharing, funding and contracting, and workforce development.

Over the next five years, and starting with those individuals with complex needs, our models of care will focus on:

- empowering people to live full and healthy lives, self-manage and where required supporting people and their families with improved information and technology
- strengthening primary care and its role in proactive long term condition management
- increasing the investment and portfolio of services in the community to support care closer to home where safe and effective to do so
- providing access to specialised services to optimise the safe care and clinical outcomes for patients
- people knowing where to get the right help at the right time
- people feeling safe in their communities
- people being active members of their communities and reducing social isolation
- carers supported to continue caring in partnership with other support services

Partners are committed to the following statements, to ensure that our future model of care and support services deliver the practical outcomes to local stakeholders/

People will agree that the following statements reflect their experience of local care and support:

- I am in control and treated with dignity and respect
- I feel part of a tight-knit team that works with me and tackles any obstacles to getting the help I need
- I only have to tell my story once
- I don't have to wait for a crisis to get the help I need
- I know that I, my family and carers have the support and information to help me
- I only need to go to hospital when I need to and have access to quality support in my local community
- I am in control of what happens to me

With improved outcomes that seek:

- Improved (better compared to current baseline) experiences of care
- Improved (exceed national best practice benchmarks) clinical and care outcomes
- Reduced health inequalities (better access to hard to reach groups)
- Increased range of low level support services

And building on the work from each of our areas we want our public to be able to simply say, *'I am supported to live well and stay well because I can access joined up care and support when I need it'*

Commissioners will agree that the following objectives have been achieved:

- We don't let organisational boundaries get in our way of what is right for our communities
- We jointly invest in the things that our residents need and the things that work
- We work as a team and rarely plan or commission as separate organisations
- We work to a shared plan that will help us secure good outcomes even as demand for services rise and budgets reduce.

Providers will tell us that the new system displays the following features:

- We work in an environment that helps us put people first
- We are given the permission to imagine, experiment and learn
- We work like a single organisation with joint systems, staff and ways of working.

With improved outcomes that seek:

- Improved utilisation of services (including reduced use of acute and residential care and increased use of primary and community services)
- Better use of financial resources through improved productivity because of the reduction of duplication, waste and variation and opportunity to draw on resources from other sources
- Achievement of the national outcome for integration to support sustained health and social care organisations and services
- Collaborative working across organisations

Our plans highlight the activity and approach to the implementation of projects contained within our BCF submission, which will result in continued improvement in the health and well being out comes for the individual's with our area.

b) Aims and objectives

Please describe your overall aims and objectives for integrated care and provide information on how the fund will secure improved outcomes in health and care in your area. Suggested points to cover:

- What are the aims and objectives of your integrated system?
- How will you measure these aims and objectives?
- What measures of health gain will you apply to your population?

The primary aim of our proposals is to provide quality care more efficiently and effectively to local residents. As outlined above we are committed to delivering improvements outlined against the payment by result elements agreed within our BCF against the five national outcomes attached to the BCF.

Caring Together

Within the Eastern Cheshire CCG area of the HWB geography the **Caring Together** programme, a whole health and care economy initiative, aims to transform the way all care is delivered. A case for change has been developed which is based on intelligence and analysis from all partners and is cognisant of challenges to be met, organisational accountabilities and joint outcomes to be achieved across health and social care and the wider communities sector.

Caring Together (CT) brings together professionals, patients, stakeholders, providers, community groups and the public to help shape the future of health and social care services in Eastern Cheshire. The aim is to deliver a new person centred model of care, with a seamless approach to be co-designed and tested in Eastern Cheshire, shaping integrated community focused models of care in conjunction with the other areas within the Cheshire Pioneer area.

There are specific work streams that include providers from the NHS, Social Care and the Community and Voluntary Sector. They are informing the Case for Change, the Quality Standards and the design of the new Care Model.

Given the flow of patients within Eastern Cheshire, the Caring Together Programme links into the Greater Manchester acute service reconfiguration programme to ensure that specialist services can be accessed within agreed pathways.

Connecting Care

Within the South Cheshire area of the HWB area the **Connecting Care** in communities programme, a whole health and care economy initiative has been established to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'.

The overall aim of the programme links closely with the Caring Together programme, where the commitment is that the Cheshire partners will transform the health and social care system by:

- Working much more closely together and in smarter ways to provide reliably and without error, the care that will help people and ONLY the care that will help
    - Putting the individual at the centre of all care – 'no decision about me, without me', improving their experience of care
    - Assure quality by employing high quality, well trained staff with strong leadership and development skills
    - Focusing on the multiple determinants of both physical and mental ill-health and creating innovative solutions across partners
    - Creating more opportunities for and embedding cross organisational working that reduces duplication and achieves the best use of available resources
    - Adding value to the lives of individuals and their families/carers and decommissioning care that does not add value
    - Exploiting the use of new technologies to support independence, self-care and information sharing across partner organisations

- Building and strengthening community based services and support
    - More care will be organised and delivered outside of traditional hospital settings, in local communities with the development of integrated teams and closer collaboration across teams
    - People will access services differently:
        - with GP practices/neighbourhood focused teams and community services delivering care and support 'closer to home'
        - with a smaller, more flexible community facing hospital delivering emergency and specialist care and
        - regional specialist hospitals continuing to deliver specialist care, some of which will be in the community setting
    - Traditional 5 day per week community services will be extended to offer support when needed, 7 days per week
    - Care and support will be personalised, timely, responsive and seamless

- Developing our workforce and community assets to deliver new ways of working
    - Empowering individuals at a local level to lead change and problem solve with

full support from their colleagues
- Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
- Offering education, training and development programmes to support the implementation of new ways of working, self-care, local leadership, change management and improvement approaches.

The HWB will through the BCF, align and integrate the two distinct programmes, so that the specific flavours and requirements unique to the two CCGs areas can be supported and delivered, within the overall co-ordination and oversight of the HWB and the wider Pioneer submission.

Remove below in yellow and add into Metrics Technical Template??

Below we set out our current benchmarks against these outcomes, and highlight the improvements we hope to deliver through the BCF. It is important to note that in examining the local performance against the nationally recorded data there are a number of concerns about the quality of the data. There is continued work in progress on our performance, which will receive further scrutiny and refinement through 2014/15, with the current analysis of our performance being detailed below:

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

The English average is currently 690.3 admissions per 100,000 population, whilst across the Cheshire East area we are currently reporting achievement at 561.1. We know that current performance reported is distorted by the treatment and categorisation of our respite care, which we believe is incorrect, resulting in an increased baseline. We will review our baseline during the early part of 2014/15 and following this review we will determine our collective ambition around the level of improvement we wish to achieve.

Proportion of older people (aged 65 and over) who were still at home 91 days after discharge from hospital into re-ablement / rehabilitation services:

The English average is currently 82.6% of older people remaining in their own homes after 91 days from discharge from hospital, whilst across Cheshire East 79.3% were still at home. It is important to note that across the Cheshire East area whilst our % performance is lower than the national average our delivery is to a larger % of the population, which will have a greater impact as we improve the proportion of older people still at home after 91 days. Our aim is to improve performance by continuing to expand the number of older people who have received reablement services whilst also seeking to increase those staying at home more than 91 days by 1% each year, until we reach our ambition of being upper quartile.

Delayed transfers of care from hospital per 100,000 population:

The English average is currently not known so it is not possible to compare the local performance against the national delivery. Locally across the Cheshire East area we are currently achieving 302.75 and will aim to reduce this by 5% from our baseline by 31 March 2015, continuing to improve on that performance year on year until we are recording high quartile performance. Detailed below is a graph showing the average

monthly delays from April 2011, which is one of the indicators being monitored locally:

Avoidable emergency admissions:

We have detailed our performance below for our two CCGs. We will add our collective ambition within the final submission, which will seek to improve performance and reflect the differing age profiles of the two CCGs.

Await the information provided by NHS England.

CCG	English Avg	Baseline (2012/13)	March '15
South	-	2,093.3	Tbc
East	-	2,211.0	Tbc

At Mid Cheshire Hospital Foundation Trust (MCHFT), South Cheshire CCG and Vale Royal CCG we have invested in additional services within the hospital setting (A&E) in particular to increase levels of staffing to treat patients quickly. There has been detailed analysis of the flow of patients both in A&E, but also across the wider hospital services to target those areas needing improvement to ensure the "front door" is not in crisis. Eastern Cheshire has invested in a 'primary urgent care' service linked to the NWAS pathfinder scheme providing an acute GP visiting services to optimise care outside of hospital and prevent avoidable admissions.

The CCGs have also invested in alternatives to acute care beds – these are multi agency services outside of the hospital setting ensuring patients can be discharged quickly, either from A&E or from hospital wards. The combination of investment and new services in place have meant that both MDGH and MCHFT has managed to deliver the four hour A&E target, and non elective admissions have remained on or slightly under plan for 2013/14.

The experience of patients and service users:

Proportion of people who feel supported to manage their long-term condition:

Across the Cheshire East area we are currently achieving % of 74.1 in the South Cheshire CCG area and 77.5 in the Eastern Cheshire CCG area, with an aim to increase this to upper quartile levels by 31 March 2015.

The table below is the Eastern Cheshire CCG submission in the operating plan to cover "what is your ambition for improving the health related quality of life for people with long term conditions":

	Average EQ-5D score for people reporting having one or more long-term condition
Baseline	77.50
2014/15	78.60

2015/16	79.70
2016/17	80.80
2017/18	81.90
2018/19	83.00

Equivalent information is currently being sought for the south area.

Locally important indicators:

Whilst these national indicators will provide an important measure of success in creating a more integrated model of care and support services, it is also important that partners monitor local outcomes that are tailored to the pressures that we know exist within local services. Therefore, alongside these national outcomes, we have focussed on the area where we know we need to make significant improvements

Direct admissions from hospital to long-term care settings:

We know that across the HWB we have challenges with direct admissions from hospital to long term care settings. We have regularly reviewed the information provided by the North West AQUA survey and will seek to develop strong robust indicators that will stand ongoing measurement.

Our local performance is x against our regional comparator performance of y. We will seek to improve this performance to upper quartile levels within a three year period.

We are currently considering the impact of additional local indicators such as falls and dementia.

It is also important to note that like all HWB areas there will be a need to take into account the recent Zero Based Review of the coding and classification by CIPFA and the Department of Health of Adult Social Care. This will require a full rebaslining of activity and the selection of appropriate indicators during 2014/15. It is suggested that a quick assessment of the situation be undertaken by CIPFA and DH.

c) Description of planned changes

Please provide an overview of the schemes and changes covered by your joint work programme, including:

- The key success factors including an outline of processes, end points and time frames for delivery
- How you will ensure other related activity will align, including the JSNA, JHWS, CCG commissioning plan/s and Local Authority plan/s for social care

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Three key schemes underpin our BCF proposals in the immediacy with recognition that further work programmes will be added as joint commissioning activity progresses and indentified synergies emerge. As these schemes progress, other funding sources for those activities will be added to the BCF as appropriate.

Transition planning during 2014 – 2015 will be facilitated by early changes to current working practices, and learning from changes already introduced (for example the extension of GP urgent care in the Eastern Cheshire CCG area using winter pressures monies which has demonstrated significant impacts upon A and E admissions). We will move towards full implementation in 2015-2016. Section 256 monies will be used to help achieve these quick wins.

PLANNED SERVICE AREA 1	**SELF CARE AND SELF MANAGEMENT INITIATIVES**
SERVICE DESCRIPTION	Within the Connecting Care and Caring Together whole system major change programmes it is recognised that to achieve transformational change which provides lasting benefits to local residents we need to ensure that the individual is empowered to take responsibility for their own care and health. The aim is therefore to continue to develop our voluntary, community and faith sectors to provide vital services to support individuals, families and local communities to support themselves and thereby reducing reliance on statutory services. As individuals, we want to be given the right advice, information and support to be independent. Families want to be enabled to continue to care and share care. Communities want to be self-reliant (with support) to provide for themselves. Statutory commissioners can enable this to happen locally by stimulating and where necessary contracting with the sector to ensure low level advice, information and support services are available at all levels (individual, family, community). The BCF will be utilised to ensure an enhanced range of advice, information, care navigation and community development services are available in a range of settings and where possible to have these work as part of integrated teams and services. The Fund will be further used as investment in the community infrastructure to develop a range of services and initiatives with the aim of these becoming self sustaining over time. The focus on changing the dependency on statutory services to a culture of self help and self management will

	require a range of interventions from public health promotional initiatives through to community development interventions.
Intended Target Group	All Residents of East Cheshire
Impact Assessment on Patient Groups	All patient groups will be positively impacted by the range of information, advice and community support to be made available. The intention will be to have a generic level of support available and fully accessible within local neighbourhoods and communities. Additional targeted support and information for specific high risk groups will be prioritised e.g. mental health, frail elderly.
Impact on Acute Care Sector	The impact on the Acute Care Sector will be to divert people from resorting to attending A&E directly or via NWAS by providing the public with the necessary support and information to ensure that people know how to access appropriate community based support. The initiatives will target prevention measures and early intervention by providing access to early support to prevent a situation escalating. By diverting from A&E attendance and requests for ambulance call outs there will be a reduced likelihood of inpatient admissions. Demand on A&E will also be reduced.
Support for Seven Day Services	Service and support initiatives will ensure consideration of seven day support and selected advice and information sources being available 24/7.
Use of NHS Number as basis for Information Sharing	There will be limited use of NHS number with the lower level support initiatives and advice / information sources. Where this is possible this will be linked into public sector provision.
Protection of Social Care Services	The shift of focus to prevention and early intervention initiatives is critical for the needs of individuals to be appropriately met at an early stage. Utilisation of the BCF pooled budget to deliver low level response services will prevent deterioration and facilitate early access to the appropriate care pathways and will be an essential element of the prioritisation of spend. Services being considered for further investment include care navigators and care brokers for people who are not eligible for social care services or those who choose not to access services via a formal route. The offer of support and care navigation is an essential part of the advice and

	information services which takes account of the need to provide this in a way that is supportive and responsive to an individual who may struggle to make sense of what is available on their own. The development of the personalisation agenda required the support of the whole system to support the principle of the empowered person having access to the range of information and advice and support to ensure they accessed the right help at the right time. The focus of support to enable self help and self management inevitably supports the social care agenda and the wider whole system support for independence and self reliance.
Joint Assessment and Accountable Lead Professional	The initiatives within this planned area of enhanced service development is dependent on linkage with statutory services to ensure those who need a more formal assessment of their health and social care needs are able to access this quickly and appropriately. Once the access is determined the joint assessment and lead professional principles within statutory provision will become effective. There is however the development of the care navigator role which is intrinsic to more specialist types of voluntary sector and community provision which mirrors the principles of a lead professional maintaining oversight of the person and their family to ensure they get to the right help when they need it.
PLANNED SERVICE AREA 2	**INTEGRATED COMMUNITY SERVICES**
SERVICE DESCRIPTION	Integrated health & social care services will be needed for those people likely to be identified through risk profiling with increasing frailty and multiple health and social care needs (largely but not exclusively people over 70 years old). The core teams will be focused around groups of GP practices and will have the team as the single point of access. An appropriate professional will take on the co-ordination of care for each individual within the team – this could be the GP or another professional depending on the needs of the person. We are considering new models for contracting where a lead provider could co-ordinate services from one or more provider and is held accountable for the overall service model of delivery. The Better Care Fund is the opportunity to expand the capacity within social care beyond the

	current levels determined by critical and substantial needs (current Cheshire East Council Fair Access to Care criteria) in order to support those people whose care needs are complex and without such support would be at risk of hospital admission. The integrated teams will be the basis of transformation of services and will extend to wider integrated teams including community based geriatricians, mental health services, alternative beds to the acute hospital and new services to focus the long term care of these patients outside hospital or long term care settings in a co-ordinated, responsive manner. This will include provision currently referred to as Intermediate Care. The voluntary, community, faith and private care sectors will play a key role in supporting the integrated team model by providing additional wrap around services to keep people at home and help co-ordinate services. The range of community care support services will be expanded to increase the range of services which provide short term interventions with a recovery focus which will target specific patient groups e.g. stroke care. Lower level support services which provide a monitoring and oversight role will be included in the service model. This service response aims to provide short term and flexible care and support which may prevent the need for more costly service provision. We believe short periods of monitoring and assessment over time will ensure that the person gets the right care and treatment following a robust and thorough assessment. The plan will be to use the integrated community service model to assess, treat and provide the required interventions to people within the community to prevent the need for people to need to access hospital based services apart from those with the most urgent and/or critical conditions. Further exploration of assistive technology solutions for care and telehealth options will be part of this service development in addition to seeking new and innovative care and support solutions not currently available. The early work completed in designing the new community model of service has included the development of new job roles, which have a multi functional purpose. The aim being to be proactive in engaging people deemed to be in the high risk groups to develop coping strategies linked to their condition/situation and make available to them information and advice regarding a range of issues eg financial support, forward planning, contingency risk planning, local community support etc.

	The early work within the major change programme has seen the emergence of multi disciplinary teams of staff working together around specific GP practices/clusters of practices. The model described above will take this early step change to the next level of incorporating a more structural change to the multi disciplinary working and move to a robust model of care coordination for those within the agreed target group. Single assessments, care plans, care record systems will be key deliverables in addition to single contact number to access the new integrated community service. People having to tell their story once and being central to shaping the care they receive and how it is delivered will be key design criteria of the service model. This model of service is heavily dependent on having a range of skilled and highly trained assessing professionals with the skills to provide treatments and interventions in the community. To support this it is essential that there is a broad and accessible range of wrap around care and support services which will largely be commissioned within the voluntary and private care sector. The intention would be to develop a menu of services which will be flexible and responsive 24/7. This will include domiciliary care support, intermediate care services, bed based community assessment options, home based nursing, allied health professionals.
Intended Target Group	The priority target group will be those individuals who are deemed to be experiencing complex and multiple long term conditions. This will include a significant proportion of the over 70 population. This will for some areas of high deprivation include more people under the age of 70
Impact Assessment on Patient Groups	There will need to be a full equality impact assessment as the service model is further developed. It is however intended that people with dementia and other mental illness diagnoses will be included as part of the target group. The research and evidence available identifies the significance of the co morbidity of dementia and mental illness alongside other long terms conditions. The integrated community service model has a clear interface with specialist mental health services for adults and older adults. The plan is to have link professionals to ensure this interface is a dynamic and effective one to benefit the individuals using the service and the focus will

	be to maintain the concept of care coordinator across the generic and specialist care sector.
Impact on Acute Care Sector	It is intended that the impact will be to reduce the need for A&E attendance and inpatient admission. This impact will be effected by a more proactive and coordinated approach to patient care and the use of risk profiling which will ensure the coordination of care will be aligned with the timely and appropriate response to an exacerbation of condition(s). It is also intended to facilitate early and safe discharge from inpatient stays by developing the seven day service for all relevant service areas. It is intended that the risk profiling will be utilised to identify potential candidates who may become high risk in the future and thereby offer preventative measures linked to self help and self management techniques which will reduce the risk of condition exacerbation becoming critical. Ultimate impact will be to reduce attendance at A&E, admissions to hospital and to facilitate early discharge and reduce lengths of stay. Intention will be to ultimately reduce beds within inpatient units and increase alternatives outside of the hospital setting. Linkage between the integrated community teams and hospital discharge services will ensure a coordinated approach to ensuring the patient profile and wide support network is known at the point of admission which will reduce the need for duplication of assessment whilst an inpatient. The model of service will be dependent on strong team linkages between the secondary care specialists and diagnostics i.e. community physician and mobile diagnostics.
Support for Seven Day Services	Integrated Community services will provide a seven day service according to the needs of the local population. There will be the need to utilise the BCF to review the contract arrangements for all wrap around services which will need to be available and accessible seven days a week. This will include access to packages of care support from a range of services which will need to have staff available and on standby in the same way they are within Monday to Friday service provision. This will include statutory and private and voluntary care support services.

Use of NHS Number as basis for Information Sharing	This will be required to be in place as part of the new service model.
Protection of Social Care Services	The protection of social care services will include further expansion of reablement and recovery based services for older people and people with dementia; extension of services to provide respite for carers within the community setting as a real alternative to residential care options (both short and long term); development of social care focussed assistive technology solutions within an overall health and social care range of assistive technology solutions. The BCF is an opportunity to ensure that the social care sector is fit for purpose in terms of scale and range of social care support and care services. It is necessary to reflect that the focus on the development of integrated community assessment and intervention services will be dependent on a wide range of wrap around care and support services to support the initiatives needed to deliver viable alternatives to residential care provision. These services will be required to be skilled in a range of interventions in a crisis and be able to work as part of a multi professional approach. They will also need to be accessible 24/7 and be sufficiently resourced to work alongside NWAS and OOH medical services.
Joint Assessment and Accountable Lead Professional	The service model will incorporate a single assessment process involving the most appropriate members of the multidisciplinary team. Following assessment the person will be provided with a coordinated plan of care which will be overseen by a named lead professional who will take on the role of Care Coordinator.
PLANNED SERVICE AREA 3	**INTEGRATED URGENT CARE/ RAPID RESPONSE SERVICE**
SERVICE DESCRIPTION	We intend to commission and provide integrated urgent care and rapid response services spanning primary, community and secondary care (, Urgent Care Centre)The range of provision will include elements currently provided by A&E, out of hours social care services, NWAS, GPs, social care, mental health, learning disability and community health services. This will mean patients' urgent care needs will be met in a rapid and responsive way, avoiding duplication of work and unnecessary visits to A&E or hospital admission. Urgent care services will be able to respond to patients in their own home, in a residential care setting or at A&E, OOH, Urgent Care Centres in a co-ordinated system, rather than fragmentation of service

	providers. The model being developed involves the coordination of key services including GPs, NWAS, assessment specialists from health and social care professionals, all of whom will work together to ensure the prompt assessment of people who need a more urgent care and/or treatment response but one which need not be hospital based. The service will develop further the shared contingency crisis plan established by the NWAS pathfinder project and to develop this to a full health and social care plan for an agreed target group identified by an agreed risk profiling tool. The model will be implemented as an early step change in a phased transformation of the whole system within the two major change programmes. The intention is for the urgent care/rapid response service to have access to a range of wrap around services which will facilitate home assessments of both health and social care needs including where appropriate diagnostic services. In addition the range of wrap around provision will include ongoing assessment and treatment over a period of time to stabilise the condition and this will include domiciliary care to provide both personal care, low level health interventions and where appropriate carer support. The use of assistive technology solutions for both health and social care support will be a key element of this service. The intention would be to develop a menu of services which will be flexible and responsive 24/7. This will include domiciliary care support, intermediate care services, bed based community assessment options, home based nursing, allied health professionals. The service will ensure that urgent care where possible is delivered in a community setting. The service will be further developed to provide an effective service response to facilitate early discharge from hospital where a level of health and social care oversight is required for a short period following discharge. This will reduce the length of stay in hospital and avoid residential placements straight from an inpatient stay with the inherent risk of this becoming a longer stay or permanent residential placement. We are considering new methods of contracting for services which will support providers to "own" or be held accountable for the patient journey from urgent need/rapid response to a more stable situation within the home setting. The scheme will include the NWAS pathway pilot, nursing care home discharge initiative, 24/7 working to include increased medical and nursing cover, additional pharmacy access, increased social worker and access to social care services. This will also involve a redesign of urgent care, OOH services and A&E together in order to support patients

	with an urgent need requiring rapid responses to avoid an unnecessary admission to hospital or residential care. The intention is that access to the rapid response/urgent care service can be made from any of the patient contact points.
Intended Target Group	The priority target group will be those individuals who are deemed to be experiencing complex and multiple long term conditions.
Impact Assessment on Patient Groups	All patient groups within the target group will benefit from the ability to access an urgent care and raid response service. The need to access hospital based services for assessment, diagnostics, monitoring and treatment will be reduced. For patients with dementia related illnesses or for those with caring responsibilities there will be a service response appropriate to meet their needs within their own homes wherever this is practicable.
Impact on Acute Care Sector	The impact on the Acute Care Sector will be to divert people from resorting to attending A&E directly or via NWAS by providing the public with a contact point for urgent access to a community based assessment in cases where there is a need for an urgent medical, health and /or social care assessment. By providing a viable and robust urgent care response within the community, there will be a reduction in demand for assessments within A&E departments resulting in a subsequent reduction in admissions. There will be a need to consider how the current arrangement for accessing A&E departments for certain diagnostic tests can be relocated to alternate community settings to ensure that the access to an community based urgent care response can be safe and effective.
Support for Seven Day Services	This service model will deliver 24/7. There will be the need to utilise the BCF to review the contract arrangements for all wrap around services which will need to be available and accessible seven days a week. This will include access to packages of care support from a range of services which will need to have staff available and on standby in the same way they are within Monday to Friday service provision. This will include statutory and private and voluntary care support services. Commissioning of these services will need to reflect the flexible and responsive nature of the service model and will require a focus on service responses having the flexibility of multi tasking. The workforce development plans will reflect

	the need for new types of professional and support staff roles.
Use of NHS Number as basis for Information Sharing	This will be required to be in place as part of the new service model.
Protection of Social Care Services	The BCF is an opportunity to ensure that the social care sector is fit for purpose in terms of scale and range of social care support and care services at times of crisis. It is necessary to reflect that the focus on the development of integrated community assessment and intervention services will be dependent on a wide range of wrap around care and support services to support the initiatives needed to deliver viable alternatives to residential care provision. These services will be required to be skilled in a range of interventions in a crisis and be able to work as part of a multi professional approach. They will also need to be accessible 24/7 and be sufficiently resourced to work alongside NWAS and OOH medical services. The commissioning of care services will require a variety of care and support responses which will be required in an emergency. The risk of providing alternatives to hospital is that there is a default to residential based services. The urgent care/rapid response model of service will ensure an enhanced range of social care provision is available to provide a real alternative to a buildings based service response whenever that can be safely achieved.
Joint Assessment and Accountable Lead Professional (Care Coordinator)	The joint and coordinated assessment of people in a crisis situation will be a critical element of this service. It will draw on the crisis and contingency planning which will be in place for those people deemed to be at risk of crisis or relapse of their condition(s). The accountable lead professional will be nominated according to the individual situation and will ensure that the crisis plan of care is effective and is attending to the medical, social care and health needs of the person. The accountable professionals will be highly trained skilled professionals who are suitably qualified in the assessments of people within crisis situations and who are able to mobilise and coordinate the range of professionals and support staff needed in any given situation.

Other Initiatives/Tasks

We are developing a range of tasks and activity to ensure the outcomes are delivered, for

example developing the governance surrounding the pooled budget, regular risk management, contingency planning etc.

Draft Better Care Fund Initiatives 21 Ja

All of the planned changes detailed above are part of the two transformational change programmes – Connecting Care and Caring Together. The broader context of the Pan Cheshire Pioneer programme is a critical element to our programme of change and planning. The pioneer programme takes account of the strategic ambition of the partner agencies involved and the opportunity to look at the whole system change on a far greater footprint. Inevitably this means that the planning at this stage for the Better Care Fund process is not totally aligned with the final proposal and planning stages of these three key programme areas. The plan therefore reflects a combination of the current position in terms of agreed plans and stated intentions of the whole system redesign.

Alignment of Activity

Across Cheshire East and Cheshire West and Chester a 'Pioneer Panel' has been established to lead and co-ordinate the integration work across the two areas. This will be particularly focussed upon the areas of activity that are better undertaken on a pan-Cheshire footprint, including for example workforce development, ICT infrastructure integration and data sharing.

The alignment of all the health and care economy strategic planning and priority activity is overseen through the Cheshire East Health and Wellbeing Board. The Board meets every other month. Over the last 12 months the Board has received reports on the ongoing refresh of the JSNA, the work to update the Health and Wellbeing Strategy, the CCG commissioning plans and integration programmes and ongoing improvement activity within Adults Social Care. A sub-group of the Board is the Joint Commissioning Board with senior representatives from all commissioners (including NHS England, the Police and Crime Commissioner, the CCGs, Public Health and the local authority). This group is prioritising and co-ordinating the re-commissioning activity across the health and care economy and ensuring joint commissioning where appropriate.

d) Implications for the acute sector

Set out the implications of the plan on the delivery of NHS services including clearly identifying where any NHS savings will be realised and the risk of the savings not being realised. You must clearly quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising. The details of this response must be developed with the relevant NHS providers.

It is recognised that the Better Care funding is money that is already committed to health and social care services. Savings will be required across our health economies.

The impact of the transformation of services across South Cheshire and Vale Royal CCG collectively, will significantly impact on MCHFT as the local acute provider. The shared

plan – 'Connecting Care', is building the case for fewer beds and services within the hospital setting. Financial resources released from reduction in number of wards will move to community investment.

Locally we have already demonstrated the closure of a winter ward through increased resourcing in community beds/services as alternative provision. Currently 193 beds are available outside the hospital setting, reducing pressure on both A and E and flow through the hospital over winter. We intend to widen the extended practice teams to include community geriatricians (based on the work in Torbay where the inclusion of community geriatricians demonstrated the reduction in acute beds when alternatives are available).

The reshaping of current service providers (community health, social care, mental health and the Third sector)and additional investment from South Cheshire and Vale Royal CCGs into extended practice teams, should ensure community based services are able to support older people for longer at home, react quickly to a deterioration in the person's health or well being and avoid unnecessary admissions to hospital or residential settings.

MCHFT is an outlier in relation to the high number of reported delays to discharges. We also need to identify the potential cohort of patients who could avoid a hospital admission through risk profiling. A full business case is being developed that will clearly identify the potential cost reductions/movements and reductions in hospital activity necessary to achieve this transformation. is being driven by the Connecting Care Board where our main providers are full members.
The risks associated with not delivering the transformation is that the MCHFT will no longer be financially sustainable as a small DGH, and will not be able to deliver the current requirements of the NHS Constitution targets, for example the four hour A and E waiting times; be unable to deliver the required quality improvements and the seven day working requirements across services.

Similarly the Eastern Cheshire health economy is currently mapping services to be delivered across four pillars of care ranging from empowering people to self care and by transforming traditional primary, community acute and specialist care settings. Pillar four of the Caring Together Programme looks specifically at acute and specialist reconfiguration working with commissioning and provider partners in Greater Manchester and the North West of England 'south sector'. The aim of the change programme is to ensure services deliver quality outcomes against recognised best practice standards. The pre consultation business case is scheduled for completion in Summer 2014, which will include a detailed service and economic model.

What is agreed however is that there will be a requirement to close hospital beds and take existing investment out of this part of the care sector to support the health contribution to the BCF. Early estimates are that two 25 bedded wards need to be closed and removed from the system alongside the workforce plans for redeployment etc, to release the level of investment required.

Detailed investment and benefit management plans will be designed throughout 2014 – 2015 in line with CCG and Social Care Commissioning Plans.

Need to add additional info about risks of not realising savings. Also must clearly

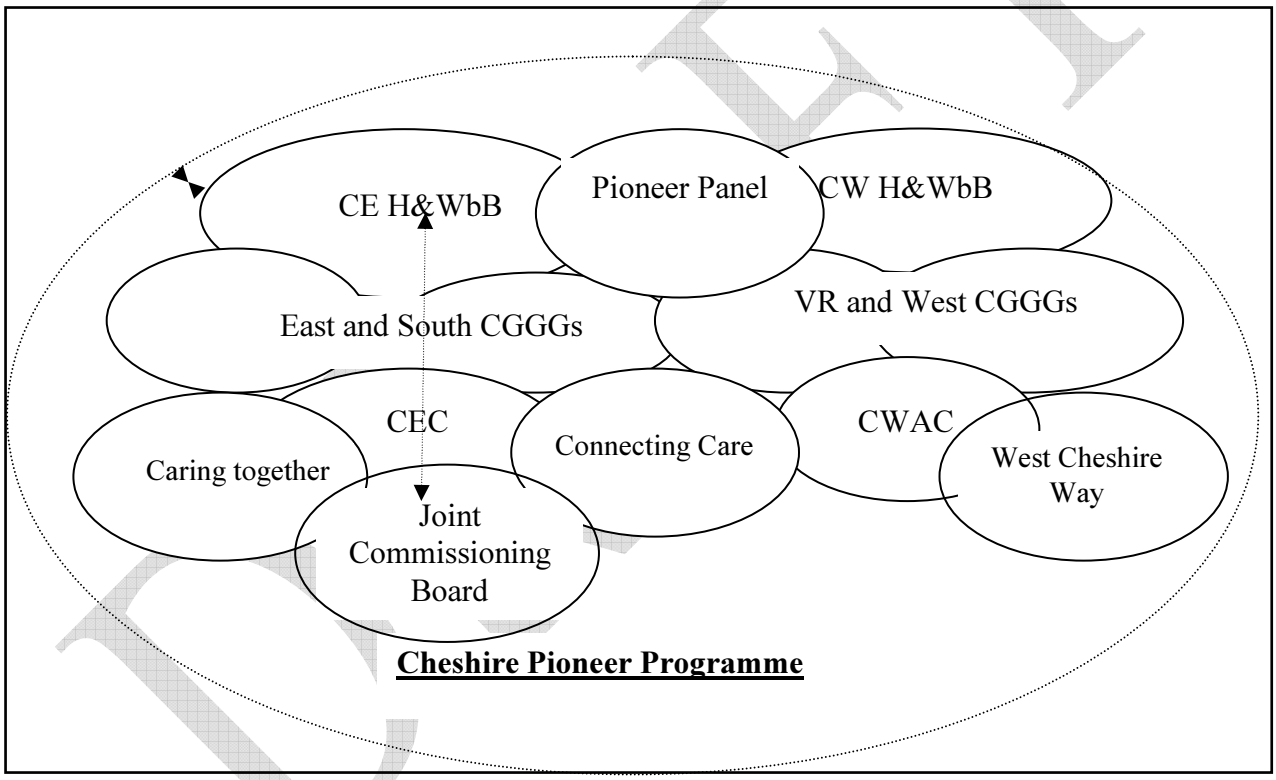
quantify the impact on NHS service delivery targets including in the scenario of the required savings not materialising.

e) Governance

Please provide details of the arrangements are in place for oversight and governance for progress and outcomes

The governance of the BCF will form an integral part of the overall plan of integration across the two CCGs, and inform the wider Pioneer Programme. The diagram below, indicates how the separate programmes of activity across the Councils and CCGs link and combine to form the overall five year Joint Strategy and Plan.

Locally across Cheshire East we will place the HWB at the centre of the management of our BCF programme, representing the shared interests of all partners in an open and established forum. This model of governance is illustrated below:



Our HWB will engage with the following bodies to ensure that we create a collaborative, effective and transparent model of governance:

- **Pioneer Panel:** Made up of representatives from across both Health and Wellbeing Boards to address integration issues on a pan-Cheshire geography.
- **Organisational Governance:** We will continue to use the existing structures and mechanisms that have been established to make sure that the BCF is aligned to mainstream governance and business as usual.
- **Scrutiny and Health-watch**: We will use the existing mechanisms to monitor our progress and champion the views of local residents, patients and service users to ensure there is appropriate accountability for this programme.

Governance will be clearly defined through the following roles:

(i) Health and Wellbeing Board
(ii) The two programmes – Connecting Care and Caring Together
(iii) Pan Cheshire Pioneer Panel
(iv) HWB Joint Commissioning Board

We will continue to align our varying workstreams to ensure that the overall governance framework remains sufficiently robust as we refine our draft plan, seeking to explore the best governance arrangements in place across the HWB area, including reviewing the items below:

Joint commissioning

Joint Commissioning MOU Final Jan 2013jv

This is an undated version can anyone advise on date agreement was finalised?

Health, social care and a wide range of other community partner organisations across Cheshire have made a commitment to working more closely together in new innovative ways to ensure that within the next five years, the people within our communities will enjoy a better standard of health & wellbeing & will have positive experiences of seamless care and support.

We are committed to delivering the National Voices narrative below:

For the individual:

'I can plan care with people who work together to understand me and my carer/s, allow me control and bring together services to achieve the outcomes important to me'.

National Voices & Making it Real

Our plans are ambitious and we will lead a programme of work to ensure that people within our local communities are empowered and supported to take responsibility for their own health and wellbeing. They will place less demand on more costly public services through the implementation of ground-breaking models of care and support based on:

- integrated communities
- integrated case management
- integrated commissioning and
- integrated enablers to support these new ways of working.

The two Health and Wellbeing Boards within Cheshire are leading this transformational change through a large-scale change programme with support from

the national Pioneer team. The Cheshire wide Pioneer plan encompasses a range of shared integration commitments and is structured as three core components based on local populations:

- Central Cheshire 'Connecting Care' programme
- East Cheshire 'Caring Together' programme
- West Cheshire 'The West Cheshire Way'/'Altogether Better'.

The **Connecting Care** programme board has been established to provide strategic leadership to the underpinning work-streams, to stimulate transformation of the local health and social care economy, to ensure close working between all partners, to ensure robust monitoring and risk management. The Board comprises representatives from our key partner organisations across health and social care and meets monthly, supporting a cohesive approach to service delivery for the population of South Cheshire/Vale Royal. Membership is currently being expanded to include representation from Healthwatch.

Within Eastern Cheshire the **Caring Together** Transformation programme is well underway having established a robust framework for governance engagement and programme delivery. The case for change as part of the pre consultation phase is being finalised and consultation scheduled for June 2014. Care model development groups are currently developing ambitious standards for new services across the four pillars of care to ensure improved health and social care outcomes are achieved


Caring Together governance structure

2) NATIONAL CONDITIONS

a) Protecting social care services

Please outline your agreed local definition of protecting adult social care services.

Partners recognise the budget challenges that exist across the health and social care economy. We know that social care services have delivered £30m (30%) of efficiencies over the last five years to 31 March 2014, whilst investing £20m in new services over the same period; health services have similarly delivered significant efficiencies. During this time the Council has struggled to maintain the delivery of services, whilst maintaining the consistent Fair Access to Care Service Eligibility Criteria at Critical and Substantial. The protection of social care services does not merely relate to budgetary issues, it more importantly focuses on the outcomes for people who have social care and support needs to maintain and promote independence wherever possible. It also requires the development of an increased range of services to promote the Prevention, Early Intervention and Well Being agenda in line with the Personalisation agenda and the new Care Bill. It is the Health and Wellbeing Board's intention to maintain services at the critical and substantial level (followed by the national eligibility criteria as determined by the Care Bill) with a commitment to developing targeted services for people with moderate needs.

The Council is committed to protecting and enhancing services required by the frail and

vulnerable individuals of our communities and through combining services provided by both Adult Social Care and Public Health has and continues to enhance services. Protecting services does not necessarily require the protection of funding. The Council, the two CCGs and prior to that the PCT have consistently reduced costs as shown above whilst enhancing service delivery over the first five years of the Council's existence. This work continues with the delivery of improved outcomes within reduced budget targets over the forthcoming years, which will be enhanced by the BCF.

We will not use the BCF to meet the budgetary challenges that are facing social care services over the coming three years. We believe that the BCF represents an exciting opportunity to invest in a wide and varied range of community services and assistive technology with the result of improved outcomes for our population. The changes to the investment pattern will contribute to the development of an integrated and balanced model of care and support that delivers on the ambitions in this plan and complements the range of health care provision.

We will use the BCF to promote the principles of integration and prevention to make sure that we have the appropriate funding for social care provision to extend effective services at scale and pace, and deliver wider benefits across the care and support services of Cheshire East. As the structure of health services change, social care services will also be reshaped to compliment and create coherence across the whole system.

One of the most notable changes that demonstrate this concept in action across the Council has been the development and change in domiciliary services. The Council has developed the external market for domiciliary services, whilst developing internal specialist services for re-ablement, adding improved outcomes at an overall lower cost to the public purse.

Social Care Reform

It is recognised that the BCF needs to incorporate statutory responsibilities as part of the Social Care Reform, Care Bill. Whilst there is a national allocation of £135m to cover carer's assessments and maintaining social care eligibility included within BCF there is no clear allocation to local areas. It is estimated that the funding available to Cheshire East is £1m and work is currently underway to determine the demand for carer's assessments and the impact of maintaining eligibility. The pathway between people requiring services and the assessment of their carer support network will be reviewed and developed as part of the review of health and social care services.

Alongside the Better Care Funding, it has been announced that there is National funding of £335m to support the funding of social care reform in 2015/16. Of this funding, £50m relates to capital which is incorporated within the BCF allocation. The Cheshire East allocation is £0.8m and this is being used to invest in the development of IT systems which incorporate the Social Care Reform policy changes. The allocation to Cheshire East of the £285m revenue allocation to cover increased social care assessments; deferred debt scheme; financial assessments is £1.7m in 2015/16. A recruitment request of 16 social workers is being progressed in February 2014 by the Council to ensure that there are sufficient resources in place to fulfil these additional requirements.

The Department of Communities and Local Government (DCLG) have not announced 2016/17 funding for further changes to eligibility criteria and the introduction of the care cost cap. The Council are working with ADASS to complete modelling information in

relation to the impacts of Social Car Reform changes.

Please explain how local social care services will be protected within your plans.

Key areas of protection:

- Manage and reduce demand on Residential hospital care

- Maintain and enhance current level of provision for domiciliary care and support at home to provide real alternatives to people to stay at home and especially in a crisis
- Increase reablement resource to increase access and benefits to people especially on discharge from hospital
- Introduce dementia reablement service to focus on this client group at early stage of diagnosis to prevent/slow down deterioration in condition and introduce coping strategies/self management for the individual and carers
- Increase flexibility and response to requests for support from care providers over 24/7. Increased funding required for providers to home services available and accessible 24/7 for both routine and crisis responses
- Lower level short-term Social Care support on discharge to people without need for FACs eligibility assessment.

- Maintain Current Levels of Eligibility

- As LA budgets reduce and demand increases the need to maintain a safe and effective service response for people eligible for Social Care becomes more pressured and will need protecting.
- Future national eligibility may include greater numbers of people deemed eligible and resources to meet need need to be protected.
  Care fund criteria includes use of BCF to offset services at risk and the LA response to the Care Bill

- Meeting Responsibilities under Care Bill

  Additional Responsibilities include:
- Increased numbers of people requesting assessments to have their contribution for care counted towards their individual care account to be considered for the 'cap'.
- Increased eligibility for assessments and care and support for carers
- Possibly increased eligibility threshold
- Additional responsibilities for Social Care needs or prisoners in local prisons – ie Styal
- Focus on 'wellbeing and prevention' and support services to deliver/support this

- Integrated with health commissioning and provision
- Commitment to integration of service provision and commissioning activity will require a focus on the Social Care agenda and its contribution to the overall health and wellbeing agenda both in commissioning activity and provision
- Focus on wider determinants of health and the need to invest in whole system developments

Therefore, we will use the BCF to invest into areas of integration, prevention and support rather than using these funds to address budget gaps. We are committed to using this fund as the necessary investment to extend evidenced and proven areas of Social Care spending that support the aims of the plan with three main initiatives, which are; developing our Rapid Response/Urgent Care Services, enhancing our Community Services, including neighbourhood teams and introducing more Self-care, self-management and help to live independently at home.

Further detail is included within the attached document:

Draft Better Care Fund Initiatives 21 Ja

b) 7 day services to support discharge

Please provide evidence of strategic commitment to providing seven-day health and social care services across the local health economy at a joint leadership level (Joint Health and Wellbeing Strategy). Please describe your agreed local plans for implementing seven day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends.

The Health and Well-being Strategy contains a commitment to enabling seven-day health and care services.

We will use the BCF to support residents seven days a week, as a lever to support proposals contained within the CCG operational plans.

Partners are committed to developing timely and effective services that provide timely discharge and prevent unnecessary admissions amongst high-risk cohorts. This will involve a process of risk stratification so that all local organisations have common information when working with common cohorts.

The CCGs and partners have utilised the urgent care board planning process to identify the need for seven day service provision within both hospital and community settings. The BCF will be utilised to ensure that all relevant service areas have appropriate staffing levels, contingency planning to provide rapid response services and also commissioning arrangements for flexible and accessible seven day wrap around care services. Learning from work already underway (for example using the winter pressures monies in Eastern Cheshire CCG) will inform planning.

We will continue to work up the plans utilising the newly formed Provider Board 'innovation fund' as a mechanism to develop appropriate 7 day services tpo meet local need.

c) Data sharing

Please confirm that you are using the NHS Number as the primary identifier for correspondence across all health and care services.

We are currently using the NHS number as the primary identifier on a high proportion of our shared cases, capturing the NHS number within the Social Care Case Management system whenever possible. This builds on the earlier work completed across the Cheshire East area with the Common Assessment Framework Demonstrator, where the NHS number was a key element of that project. We continue to improve on the capture of the NHS number and to verify that with the NHS systems.

If you are not currently using the NHS Number as primary identifier for correspondence please confirm your commitment that this will be in place and when by

We are committed to having the NHS Number as the primary identifier for all local cases by April 2015.

Please confirm that you are committed to adopting systems that are based upon Open APIs (Application Programming Interface) and Open Standards (i.e. secure email standards, interoperability standards (ITK)).

We are committed to adopting market leading case management systems that utilise open APIs and Open Standards.

Please confirm that you are committed to ensuring that the appropriate IG Controls will be in place. These will need to cover NHS Standard Contract requirements, IG Toolkit requirements, professional clinical practise and in particular requirements set out in Caldicott 2.

The Council and its partners are committed to being able to satisfy the IG Toolkit level 2 by March 2014 and Level 3 by March 2015..

d) Joint assessment and accountable lead professional

Please confirm that local people at high risk of hospital admission have an agreed accountable lead professional and that health and social care use a joint process to assess risk, plan care and allocate a lead professional. Please specify what proportion of the adult population are identified as at high risk of hospital admission, what approach to risk stratification you have used to identify them, and what proportion of individuals at risk have a joint care plan and accountable professional.

The model of service for rapid/urgent care response and the community service model is built around the principal of a single assessment process by the most appropriate professional(s) with a single care plan incorporating all elements of the persons care and treatment. The person with complex care needs involving multi professional/service input will be allocated a lead professional who could be any professional within the service area.

The lead professional will have a coordinating role and be accountable for ensuring the plan of care reflects the range of support and treatment to appropriately meet the assessed care needs and manage any identified risks appropriately. The lead professional will be identified as the most appropriate professional involved in the persons care. This will depend on the frequency of contact, knowledge of the person and the skill and/or expertise needed in any given situation. The individual may wish to influence who the lead professional will be and will have their wishes taken into account wherever possible.

The single assessment process will be supported by documentation and a single record system which allows for the professionals involved in the assessment to contribute to the process and record in one place and for a point in time. This assessment will be regularly reviewed and updates in keeping with the needs of the individual.

The crisis contingency care plan for the high risk group will be developed to reflect the intended responses across health and social care including NWAS. The crisis contingency plan will be developed in conjunction with the person and their carers.

Multi disciplinary groups in Eastern Cheshire currently meet regularly around groups of GP practices. This will be extended as a first step to enhancing the communication and coordination of those patients deemed to be in high risk groups. This is a precursor to the ambition to establish the lead professional role as detailed above.

In South Cheshire we are looking to explore a number initiatives, for example in one area, we plan to have three early implementers for extended practice teams by summer 2014 based on town geography clustered around groups of GP practices. There will follow a roll out of four other teams (which are seen as single point of access) through late autumn 2014/early 2015. Coverage of the teams is around 20,000-25,000 patients. The learning will be considered across the HWB area and across the wider Pioneer area to ensure the best practice emerges between the different areas in line with the Pioneer ambition.

Patients will be identified through risk stratification within each team and is likely to be 0.5 - 5% of a practice population, expanding over time. We are currently evaluating the use of various risk stratification tools (such as EMIS and ACG) across the HWB area and may pilot a couple of different approaches to assess the benefits and the potential alignment with the LA systems. MDTs are currently indentifying patients known to services already at high risk.

3) RISKS

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

Please provide details of the most important risks and your plans to mitigate them. This should include risks associated with the impact on NHS service providers

Risk	**Risk rating**	**Mitigating Actions**
Improvement in the quality of preventative services may not achieve outcome improvements by the end of the BCF (2015/15) and would therefore lead to the double-running of costs. This could potentially impact on the funds that are available for preventative services prior to escalation.	High	We have modelled our BCF submission on the best available data, and have applied optimism bias to reduce risk. We will monitor these issues throughout 2014/15 and refine assumptions as far as possible.
Operational pressures will restrict the ability of our workforce to deliver the required investment and associated projects to make the vision of care outlined in our BCF submission a reality.	High	The BCF will be reported to governance and operational groups on a regular basis to ensure this relationship is monitored, and to stress the importance of this work.
The lack of local data provided and available may result in the targets included in our outcomes and metrics section may not be achieved, and therefore we would be left with a shortfall.	Medium	The payment by results targets have been based on the best available local data, including the forecasting for future years. Contingency plans have been developed to highlight potential alternatives should a shortfall occur. Under the Pioneer Programme a wider process of performance benchmarking is being conducted across the County.
The movement of resources may potentially destabilise services and providers, most critically the acute trusts.	Medium	We have engaged with the Acute Trusts and other providers throughout the development of these proposals. These plans have been developed over the past three years, and appropriate time has passed for a meaningful dialogue to take place on these issues.
Lack of investment to adequately resource delivery or integration programmes	Medium	Seek to review all exiting funding across the S256 programme Additional resources to “pump prime” setting up new alternatives before movement of monies as recurrent funding streams are embedded
Cultural change will not be delivered over the short and medium term and thus impact on the identified	Medium	Programme of workforce development to be established to ensure culture issues addressed

Yellow highlight deletion of text proposed GK Version Two 12/03/2014
Green highlight NHS England emphasis on instructions as to what to include
Blue highlight my comment or emphasis

metrics		Development of Leadership Academy programme based on quality improvement systems.
Public/citizen engagement will be weak and not facilitate robust involvement/transformation redesign of health and social care	Medium	Engagement throughout the plan being considered.
Interdependency between programmes and activity, willingness to allow a collective HWB/Pioneer programme to evolve and flourish	Medium	Governance arrangements, providers and commissioners to ensure that activity reductions or increases can be tracked against the shared plan.
Interdependency with other areas of whole system change (for example Mental Health)	Medium	Governance has main providers, including mental health, ensuring the shared plan delivers whole system ownership and changes across health and social care.
Acute and the ability to lever change, the potential for double running costs.	Medium	There is potential for double running costs as the early implementer sites are embedded before resources can be released from the acute sector.

Caring Together Risks:

Programme Risk and Issue Log 8th Jan 20:

Contingency: **To be added**

Draft Metrics and Finance Template **(Needs replacing with updated template)**

To be added

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	25th March 2014
Report of:	Corporate Manager Health Improvement
Subject/Title:	Review and Refresh of the Cheshire East Joint Health and Wellbeing Strategy
Portfolio Holder:	Councillor Janet Clowes Portfolio Holder for Health and Adult Care

1.0 Report Summary

1.1 The Health and Wellbeing Board came into existence on 1 April 2013. The Board has had a fruitful first year, overseeing the process of submitting to the Department of Health the successful bid to be a Health and Social Care Pioneer authority (in conjunction with the Cheshire West and Chester Health and Wellbeing Board) and supporting the ongoing integration programmes with the Clinical Commissioning Groups. In addition the Board has been monitoring the progress of key initiatives such as the Learning Disability Lifecourse Review, the Dementia Strategy and Implementation Review and the work of the Joint Commissioning Leadership Team.

1.2 The Health and Social Care Act (2012) placed a duty upon the Local Authority and Clinical Commissioning Groups in Cheshire East, through the Health and Wellbeing Board, to develop a Joint Health and Wellbeing Strategy to meet the needs identified in the Joint Strategic Needs Assessment (JSNA). The interim Strategy was approved in December 2012.

1.3 The interim Strategy was a one year Strategy. A refreshed Strategy has now been drafted for 2014 – 2016 to provide direction for Commissioners over the next two years. This has been based upon the evidence from the refreshed Joint Strategic Needs Assessment and the Annual Report of the Director of Public Health 2013. The revised Strategy is attached as **Appendix One.**

2.0 Recommendation

2.1 That the Health and Wellbeing Board consider and endorse the refreshed Strategy.

3.0 Reasons for Recommendations

3.1 To ensure that the Joint Health and Wellbeing Strategy is fit for purpose.

4.0 Policy Implications including - Health

4.1 To achieve improved health and wellbeing outcomes for local communities, the Health and Social Care Act 2012 identified the need for increased joint working between the NHS and local authorities, with high quality local leadership and relationships being an essential foundation. The Act described Health and Wellbeing Boards as having the key role of improving joint working by bringing together key commissioners and through their function of encouraging integrated working in relation to commissioning.

4.2 The Joint Health and Wellbeing Strategy will be the mechanism by which the needs identified in the Joint Strategic Needs Assessment are met, setting out the agreed priorities for collective action by the key commissioners, the local authority, the Clinical Commissioning Groups and NHS England

.

5. The Joint Health and Wellbeing Strategy

5.1 The Joint Health and Wellbeing Strategy should demonstrate how the Authority and CCGs, working with other partners will meet the needs identified in the JSNA. This could potentially consider how commissioning of services related to wider health determinants such as housing, education, or lifestyle behaviours can be more closely integrated with commissioning of health and social care services.

5.2 There is a clear expectation within the Act that the JSNA and Joint Health and Wellbeing Strategy will provide the basis for all health and social care commissioning in the local area. This begins with the duty of the Clinical Commissioning Groups, NHS England and the local authority to have due regard to the relevant JSNA and Joint Health and Wellbeing Strategy when carrying out their respective functions, including their commissioning functions.

5.3 Developing the Joint Health and Wellbeing Strategy should incorporate a robust process of prioritisation in order to achieve the greatest impact and the most effective use of collective resources, whilst keeping in mind people in the most vulnerable circumstances. The aim of the Strategy is to jointly agree what the greatest issues are for the local community based on evidence from the JSNA.

5.4 The Department of Health Guidance sets out a number of values that under pin good Strategies:

- Setting shared priorities based on evidence of greatest need;
- Setting out a clear rationale for the locally agreed priorities and also what that means for the other needs identified in the JSNA, and how they will be handled with an outcomes focus;

- Not trying to solve everything, but taking a strategic overview on how to address the key issues identified in JSNAs, including tackling the worst inequalities;
- Concentrate on an achievable amount – prioritisation is difficult but important to maximise resources and focus on issues where the greatest outcomes can be achieved;
- Addressing issues through joint working across the local system and also describing what individual services will do to tackle the priorities;
- Supporting increased choice and control by people who use services with independence, prevention and integration at the heart of such support.

5.5 The Interim Strategy's priorities have been reviewed and tested against the refreshed JSNA and the recently published Director of Public Health's Annual Report, to determine their robustness for 2014. Members of the Board have contributed their thoughts to an earlier draft. Changes have been made to the 'Starting Well' priority in the light of the refresh of the Children and Young People's JSNA. Improving the physical health of those with serious mental illness has been highlighted as a new priority and we have introduced a specific reference to reducing social isolation and loneliness in the Ageing Well priority.

8.0 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Phone: 01270 686560
Email guy.kilminster@cheshireeast.gov.uk

This page is intentionally left blank

The Joint Health and Wellbeing Strategy for the Population of Cheshire East 2014 - 2016

The Joint Health and Wellbeing Strategy for the Population of Cheshire East (2014 – 2016)

A Message from Councillor Janet Clowes, Chair of the Health and Wellbeing Board, Dr Paul Bowen, Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group, Dr Andrew Wilson, Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group and Dr Heather Grimbaldeston, Director of Public Health.

This is a refreshed version of the Joint Health and Wellbeing Strategy for Cheshire East. We have reviewed the priorities identified in the first edition, published in March 2013, against the Joint Strategic Needs Assessment and established that fundamentally those priorities remain the same. However we have made a few changes: specifically referencing 'Social Isolation and Loneliness' which we have identified as a significant issue amongst our older population; emphasising the need to focus upon the physical health needs of those with serious mental illness and targeting interventions to reduce childhood obesity.

This document represents a commitment by the NHS and the Local Authority to work in partnership to tackle the complex, difficult and inequitable health and wellbeing issues together.

The Government's Health and Social Care Act (2012) has set out the requirement for the establishment of Health and Wellbeing Boards and Joint Health and Wellbeing Strategies in each local authority area.

The Health and Wellbeing Strategy provides an overarching framework that will influence the commissioning plans of the local NHS, the Council, and other organisations in Cheshire East. It will be a driver for change, focussing upon those key areas that will make a real impact upon improving the health and wellbeing of all our communities.

Our vision is that the

Cheshire East Health & Wellbeing Board will work together to make a positive difference to people's lives through a partnership that understands and responds to the needs of the population now and in the future. The board will do this by:

- ***Engaging effectively with the public.***
- ***Enabling people to be happier, healthier, and independent for longer.***
- ***Supporting people to take personal responsibility and make good lifestyle choices.***
- ***Demonstrating improved outcomes within a broad vision of health and wellbeing.***

A Delivery Plan will be developed to prioritise the actions necessary to make a difference and achieve our outcomes. This will include engagement with a wide range of partners who have expressed support for the Strategy and a commitment to working with the Health and Wellbeing Board.

Councillor Janet Clowes - Chair of the Health and Wellbeing Board
Dr Paul Bowen – Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group
Dr Andrew Wilson – Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group
Dr Heather Grimbaldeston – Director of Public Health

Context

There are two Clinical Commissioning Groups in Cheshire East, the NHS Eastern Cheshire Clinical Commissioning Group and the NHS South Cheshire Clinical Commissioning Group (CCGs). These CCGs took over the control of the local NHS from the Primary Care Trust in April 2013. Representatives from these two organisations, together with Councillors, the Director of Public Health and senior managers from Cheshire East Council and a patient representative (from Healthwatch), form the core membership of the Health and Wellbeing Board. NHS England, commissioners of Primary Care services, are also represented.

In considering the strategic priorities for the area the Board has considered four key documents:

- **'Ambition for All' Cheshire East's Sustainable Community Strategy *2010 - 2025***
  Visit www.cheshireeast.gov.uk and search for 'Sustainable Community Strategy'.

- **'Living Well for Longer' The Annual Report of the Director of Public Health 2012-2013**
  Visit www.cheshireeast.gov.uk and search for Annual Public Health report 2013

- **The NHS Eastern Cheshire Clinical Commissioning Group 2014-2016 Operational Plan**
  Visit www.ec3health.co.uk and search for 'Annual Plan'.

- **The NHS South Cheshire Clinical Commissioning Group Operational Plan 2014-2016**
  Visit www.southcheshirehealth.org.uk and search for 'Annual Plan'.

These are all informed by and underpinned through the evidence of the **Joint Strategic Needs Assessment** which itself has been refreshed during the course of 2013.

Through the Health and Wellbeing Board, representatives from health, public health, the Council and Local Healthwatch (representing Cheshire East residents), have committed, through this document and future Joint Health and Wellbeing Strategies to work more closely together, with a common focus of ensuring that services are jointly tailored to meet the needs of our residents. Over the last year this work has progressed well with a successful bid (with the Cheshire West and Chester Health and Wellbeing Board) to the Department of Health to become an 'Integrated Care Pioneer', demonstrating their recognition of our effective joint working and the future plans to integrate services. The two CCGS have continued to drive their individual integration programmes with the Council as an active partner in both.

Meaningful engagement with our communities, patients and carers will inform all that we do and we will commission to improve health and health/social care for our local populations and to lead the integration agenda around the needs of individuals.

Our Population and Place

In general, all partners recognise that the health and wellbeing of the residents of Cheshire East is good. However there are still very significant challenges that need to be addressed.

Amongst these are:

- Reducing the number of people leading unhealthy lifestyles;
- preparing for an increasingly ageing population (by 2029 the numbers of people aged 65 or over will increase by more than 50% to 108,000 and those aged 85 or over will more than double to 20,000);

- Improving the mental health and emotional wellbeing of residents;

- Addressing some stark differences across Cheshire East (for example a difference in life expectancy which at its worst sees a gap of 8 years for men and 9 years for women depending on which area you live in Cheshire East).

There is good practice to build upon to tackle these challenges with high quality general practice, effective NHS / local authority joint working and innovative Council led projects already in place. But we recognise that more needs to be done and the Board, through the Strategy will drive improvement in health and wellbeing.

The Joint Health and Wellbeing Strategy is an evolving document, responding to the changes that occur through these new ways of working and to new challenges that we may face in the future, the priorities will modify over time. This refreshed version follows a review of the priorities within the 2013 - 2014 Strategy against the Joint Strategic Needs Assessment and the Annual Report of the Director of Public Health 2012 – 2013.

Every community in Cheshire East is different and local solutions will reflect local challenges. But our action will be united around the four shared commitments from our **Pioneer vision**:

Integrated communities: Individuals will be enabled to live healthier and happier lives in their communities with minimal support. This will result from a mindset that focuses on people's capabilities rather than deficits; a joint approach to community capacity building that tackles social isolation; the extension of personalisation and assistive technology; and a public health approach that addresses the root causes of disadvantage.

Integrated case management: individuals with complex needs – including older people with longer term conditions, complex families and those with mental illness will access services through a single point and benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

Integrated commissioning: People with complex needs will have access to services that have a proven track record of reducing the need for longer term care. This will be enabled by investing as a partnership at real scale in interventions such as intermediate care, reablement, mental health services, drug and alcohol support and housing with support options.

Integrated enablers: We will ensure that our plans are enabled by a joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework and a joint approach to workforce development.

We recognise that the current position of rising demand and reducing resources make the status quo untenable. Integration is at the heart of our response to ensure people and communities have access to the care and support they need. Prevention to support people from needing health or care interventions will be a priority as will addressing the wider determinants of health that are significant contributors to ill health.

Our Principles

Equality and fairness – Provision of services meet need, reduce health outcome variations, and are targeted to areas which need them the most. **Proportionate universalism** will be a key tenet – the idea that health inequalities can be reduced across a community through universal action, but with a scale and intensity that is proportionate to the level of disadvantage.

Accessibility – services are accessible to all, with factors including geography, opening hours and access for disabled people and other vulnerable groups considered.

Integration – To jointly commission services that fit around the needs of residents and patients, encouraging providers to collaborate to create integrated services where appropriate. This will maximise the benefits of delivery through the Health and Wellbeing Board.

Quality – The strategy is based on sound evidence and reasoning, and focuses on quality, within our resources

Sustainability – Services are developed and delivered considering environmental sustainability and financial viability.

Safeguarding – services and staff prioritise keeping vulnerable people of all ages safe.

Our Priorities

What we want to achieve for 2014-2015	What we need to focus on
Outcome one - Starting and developing well… *Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.*	Children and young people feel and are kept safe Children and young people experience good emotional and mental health and wellbeing - Reduce the levels of alcohol use / misuse by Children and Young People - Reduce the numbers of children and young people self harming. Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met Targeted prevention interventions to reduce children and young people's obesity[1]
Outcome two - Working and living well… *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.*	Reducing the incidence of alcohol related harm. Reducing the incidence of cancer. Reducing the incidence of cardiovascular disease. Ensuring the health and wellbeing of carers to enable them to carry out their caring role Better meeting the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness[2].

[1] Following a review of obesity levels in children and young people during 2013, it has been identified that although Cheshire East overall is below the national average, there are some parts of the Borough where rates are significantly higher than that average. This is where activity will be targeted.

[2] The Director of Public Health's report 2012 – 2013 has identified that Cheshire East has one of the highest excess mortality rates for adults under 75 with a serious mental illness.

	Seven day care services provision
Outcome three - Ageing well… *Enabling older people to live healthier and more active lives for longer:*	Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).[3] Providing high quality palliative care service Supporting older people, their families and carers, to prepare for the rest of their lives.

It must be emphasised that the constituent organisations of the Health and Wellbeing board will also be working themselves on other areas that they have identified as key to supporting improvements in health / health and social care.

Conclusion

The Health and Wellbeing Board is committed to ensuring that the NHS and Cheshire East Council (including Public Health) work together on areas of shared need, as expressed through this Health and Wellbeing Strategy.

[3] The Board has recognised the impact upon health and wellbeing of loneliness and social isolation (Holt-Lunstad et al, 2010 Social Relationships and Mortality Risk: A Meta-analytic Review) and with the growing older population of the area identified this as a new priority.

Annex One
Partner Priorities

Partner organisation	What we will do
CEC Adult Social Services	1. To have available information, advice and signposting to enable people to access information about staying well (prevention) and where to get the right help if they need it (early intervention). 2. To develop community services across all sectors to ensure care can be provided at home wherever possible (reduce admission to residential care and avoidable visits to A&E and hospital) 3. To reduce social isolation and loneliness and ensure support is available to promote social inclusion 4. To ensure that all services and organisations in Cheshire both universal and targeted understand their obligation to ensure their services safeguard those adults who may be more vulnerable 5. To ensure that people with dementia are supported to live safely in the community 6. To ensure a range of accessible community activities are available for people to stay fit and health both physically and mentally 7. To ensure a range of accessible services and support for people who take on a caring role to maintain their health and well being 8. To ensure our services are developed to provide joined up care from health and social care services 9. To ensure that people feel safe in their communities to allow them to fully access all the community has to offer 10. To ensure that people in rural communities can access the same types of support , services and activities as those in more urban areas 11. To ensure that support is available to help people gain and maintain stable employment 12. To ensure that support is available to help people secure and maintain stable accommodation
CEC Children's Services	1. Helping families earlier when problems arise 2. Improved identification of children at risk of sexual exploitation 3. Increasing the awareness amongst professionals and the public of the identification of child sexual exploitation. 4. Improving assessment of risk to children and young people including family history, especially in families where there is a history of alcohol misuse. 5. Reducing the risk in key areas such as children living in homes where domestic abuse is present. 6. Improving access to timely support for families with mental health issues. 7. Improved resilience of young people with a range of problem solving skills

	8. Improving understanding of self-harming behaviour in children and young people and support services to develop skills and approaches 9. Improving access to a range of evidence based psychological therapies across the pathway of provision, and children and young people known to be at risk are identified and supported early 10 Improving the percentages of young people aged over 16 in drug treatment services who receive a treatment outcome profile (TOPS) assessment 11. Supporting young people to develop a range of problem solving skills and techniques 12. Supporting young people to make positive choices in respect of risk taking behaviour through awareness, information and access to services 13. Introducing a more streamlined integrated assessment process across education, health and care for children and young people with special educational needs/disabilities. 14. Introducing the new 0-25 Education, Health and Care Plan. 15. Publishing a clear and transparent local offer of services for children with disabilities. 16. Introducing personal budgets. 17. Better preparing children with disabilities for adulthood. 18. Tackling inequalities in low birth weight in order improve health outcomes in childhood and adulthood 19. Targeting approaches to young people who are or are at greater risk of not engaging in education, employment or training (NEET) 20. Continue to target the Family Nurse Partnership programme to support the most vulnerable new parents. 21. Increase the uptake of free early education for two year olds in deprived areas. 22. Narrowing the gap in educational attainment between children and young people from different socio economic backgrounds

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting: 25 March 2014
Report of: Strategic Housing Manager
Subject/Title: Vulnerable Persons Housing Strategy

1 Report Summary

1.1 Work is underway to construct a Vulnerable Persons Housing Strategy for Cheshire East Borough Council to ensure an appropriate landscape of specialist and supported accommodation is engendered in the local area. This report summarises the findings of the draft Strategy and requests the support of the Health and Wellbeing board in engaging with and promulgating the Strategy's on-going consultation.

1.1 The public consultation on the draft strategy will run until **3 April 2014**, which represents a six week consultation period. The relevant links and materials can be located on the Council's online consultation portal, which can be found via the following link: http://www.cheshireeast.gov.uk/housing/strategic_housing/vulnerable_persons.aspx

1.2 The Strategy assumes a central role in Cheshire East's strategic forward planning: it is one of the two major change programmes (5.2) designed to deliver on Priority 5 of the Council's Three Year Plan: *Securing housing that is locally-led, community-based, and meets local needs.* This priority is, in turn, a crucial policy in realising Outcome 5 of the Plan: *People Live Well and for Longer.*

2 Recommendations

2.1 It is recommended that:

2.1.1 The draft Vulnerable Persons Housing Strategy and its preliminary findings are noted.

2.1.2 The members of the Health and Wellbeing board support the development of the Strategy and act as advocates for the on-going Strategy consultation.

3 Reasons for Recommendations

3.1 Finalising the Vulnerable Persons Housing Strategy will be the catalyst enabling the Council to:

3.1.1 Map the current picture of accommodation supply and demand by client group to baseline a picture of vulnerable persons housing within the Borough.

3.1.2 Use this information as a basis for developing an optimal model of accommodation and support provision across all vulnerable client groups to inform Cheshire East's commissioning cycle and development priorities.

3.1.3 Integrate effective and appropriate housing into a multi-disciplinary and cross-agency approach for improving well-being for vulnerable people.

3.1.4 Provide and incite an evolving evidence base to inform planning decisions and emergent policies.

3.1.5 Realise Outcome 5 of the Council's Three Year Plan: *People Live Well and For Longer*.

3.1.6 Realise Priority 5 of the Council's Three Year Plan: *Securing housing that is locally-led, community-based, and meets local needs.* The Vulnerable Persons Housing Strategy is one of the two major change programmes to deliver on this priority.

3.2 Promoting the consultation process and maximising the level of response from residents, services, providers, and partners will:

3.2.1 Ensure that the findings and priorities identified within the Strategy are representative of the views of affected constituents and wider stakeholders.

3.2.2 Ensure that the Council is transparent and participatory in the formation of its strategic direction.

4 Wards Affected

4.1 All

5 Local Ward Members

5.1 All

6 Policy Implications

6.1 The Vulnerable Persons Housing Strategy is prioritised within the Council's Three Year Plan framework:

- Outcome 5: *People Live Well and for Longer*
  - Priority 5: *Securing housing that is locally-led, community-based, and meets local needs.*
    - Change Programme 5.2: *Deliver an accommodation strategy for vulnerable adults and those with learning disabilities.*

6.2 The accommodation of vulnerable people by virtue concerns a host of Council services that collectively work towards improving prospects and well-being for affected client groups. As such, the emergent Strategy champions a holistic and integrated approach, aspiring to catalyse and unite Council services, community partners, and providers in a concerted direction. In its construction extensive liaison has taken place across adults' services, children's services, public health, housing, and planning to ensure that the Strategy reflects the priorities and initiatives of these services. For instance, the Strategy channels the emergent strategic commissioning intentions, has fed into the Lifecourse work surrounding learning disabilities, and reflects the drug and alcohol service recommissioning.

6.3 Principally, the Strategy corroborates and augments the Council's commitment to enabling independence, reablement, and recovery through the appropriate provision of accommodation and support services. Such an approach is increasingly enshrined throughout the Council's commissioning wings, and the Vulnerable Persons Housing Strategy supports this by advocating the provision of accommodation models that foster independence and reablement - such as supported accommodation, sheltered housing, and extra care schemes as an alternative to institutional care.

6.4 Initial findings suggest that such an approach is required to manage the well-documented demographic pressures caused by longer life expectancy and advances in medical and social care. The Council can expect a rise in the number of vulnerable people in need of specialist accommodation, and an opportunity exists to consider the accommodation landscape within the Borough and engineer it so that more vulnerable people are supported to live fulfilling, independent lives within the community.

6.5 As such, the Strategy will set the direction of travel and accommodation priorities. These will then inform future service commissioning work and planning policies to realise the determined approach through provider management and future development.

7 Financial Implications

7.1 Full business cases which consider all financing options (both internal and external) and any potential risks to the Council will be developed for any major projects or developments that arise as a result of the Strategy's priorities. These will be prepared and assessed on a project-by-project basis at the appropriate time. Such business cases will follow the established route for ratification including gateway approvals at the appropriate points in accordance with the Council's project management protocols.

7.2 The exploratory and on-going actions recommended in the Strategy will be met from within existing resources.

7.3 Similarly, the Strategic Housing team will continue to lead and dedicate existing resource to the Strategy's construction, including the incorporation of consultation feedback into the final Strategy iteration.

8 Legal Implications

8.1 The Strategy is the girding by which Cheshire East will provide increasingly appropriate specialist accommodation for vulnerable people that drives superior outcomes. It is the first, agenda-setting stage of the commissioning cycle that will ultimately ensure that vulnerable people are optimally cared for and enabled to live independent and vibrant lives in housing tailored to their needs and supportive of their specific issues.

8.2 In doing so, the Strategy supports the Council in fulfilling its duties to vulnerable people as delineated under legislation including: the Children Act (1989), the Children Act (2004), Children Leaving Care Act (2000), Mental Health Act (1983), Housing Act (1996), the National Assistance Act (1948), the National Health Service and the Community Care Act (1990), the Legal Aid Sentencing and Punishment of Offender Act (2012), and the Homelessness Act (2002). These items of legislation underpin the Council's duties and services to vulnerable people, which the Strategy is a key component in delivering.

8.3 The legal implications of any project or development that arises as a result of the Strategy's direction will be assessed individually as these initiatives progress through the Council's project management gateways.

9 Risk Management

9.1 There are risks that the Council does not possess an appropriate accommodation mixture to deliver optimal outcomes for vulnerable people. Many accommodation support services report large undersupplies, whilst the supply of supported and specialist accommodation is frequently unable to match demand. Moreover, an overreliance on institutional care within certain client groups is heightening costs for self-funders and social services. There is therefore a need to construct a strategy for vulnerable people's accommodation to fathom the accommodation landscape and deduce the strategic priorities for each vulnerable client group. This will inform the commissioning and development process to ensure that there is an optimal specification of vulnerable people's accommodation within the Borough.

9.2 There is a risk that different elements of the Authority have different approaches to accommodation and relevant support services, as well as divergent information on the character and needs of vulnerable client groups. As such, the Strategy will help coordinate and connect the work of Council services and wider partners and providers, ensuring a consistent and strategic approach to vulnerable people's accommodation.

9.3 Vulnerable person's accommodation is complex in nature, involves a large number of agencies, and is a deeply emotive and fundamental issue that has

wide implications across individuals, families, and communities. As such, it is vital that affected individuals and agencies have the opportunity to comment on any relevant strategic direction, to ensure that the full range of opinions, experiences, and knowledge are incorporated. By publically consulting on the draft Strategy, the Council negates the risk of implementing a strategic direction that does not properly reflect the range of needs and views within the Borough, ensuring it is representative.

9.4 In terms of the risks associated with developing and implementing a new strategy, there are a number of associated and inherent risks:

- *Timescale slippage:* depending on the extent of comments received during the public consultation, there is the potential for time pressure in making any alterations. However, this has been mitigated by a well-monitored approval timescale, factoring in potential risks and charting all approval gateways.

- *Momentum, actions, and delivery:* As with any strategy, there is a risk that strategic direction does not translate into transformative action on the ground. This is being mitigated by the creation of a comprehensive action plan for each client group with service responsibilities, which will be connected to an emergent monitoring framework. Moreover, engagement and support has been assured from the relevant services through involvement in the construction of the Strategy and the channelling of service initiatives and priorities. Finally, cross-service working groups are already being established to explore some of the key themes arising from the emergent strategy.

- *Funding for major projects:* The development of new specialist housing is frequently costly and complex, factors that increasingly delimiting in a time of austerity and curtailed public funding. To affect any new developments inspired by the Strategy, there will thus be a need to maximise private finance through partnership and creatively use public funding and Council-held assets to leverage and incite.

10 Background and Options

10.1 The Strategy surveys a wide range of evidence and research to determine the accommodation needs of vulnerable people, before recommending strategic priorities to address these needs. The Strategy stratifies vulnerable people into the following eight primary groups, though there are many sub-group subsumed within these:

- Older people
- Learning disabilities
- Mental health issues
- Cared for children/care leavers
- Drug and alcohol issues
- Physical and sensory disabilities
- Domestic abuse

- Homelessness

10.2 The analysis of available evidence and response to service and partner consultation so far has informed a number of draft priorities for each client group. These can be summarised a number of thematic outcomes that cut across all client groups, represented in the Strategy's policy framework.

- Outcome 1: 'Deliver services to enable vulnerable people to live in their homes independently for longer.' This will be achieved by:
    - Continuing to review and improve care and support services to ensure that independent living and reablement is achievable and promoted to as many vulnerable people as possible.
    - Promoting the use of assistive technologies and home adaptations to ensure that homes are amenable and accessible for vulnerable people across the spectrum of needs.
    - Building links with the local community to draw upon untapped support for vulnerable people, maximising autonomy, limiting social isolation, and minimising care costs.
- Outcome 2: 'Deliver an improved offer of specialist, supported accommodation within the Borough, tailored to the needs of vulnerable people.' This will be achieved by:
    - Continuing to refine and appropriately expand the menu of specialist and supported housing that caters for vulnerable client groups, looking to create synergies across groups where appropriate.
    - Working with partners to develop new housing models for vulnerable people, prioritising sheltered and extra care housing as a means of promoting independent living.
    - Mapping specialist accommodation provision to the stages of each client group's treatment or recovery journey, creating a 'stepped' model of accommodation integrated into client pathways.
- Outcome 3: 'Improve access to services and the quality of information available to vulnerable people and commissioners, so both can make informed choices about accommodation, care, and support.' This will be achieved by:
    - Working to achieve comprehensive and consistent intelligence on vulnerable groups to best inform service commissioning and decision-making.
    - Ensuring that the contact points for accommodation services and advice is accessible and the information clear for all user groups, whilst promoting future planning and proactive service engagement.

- Utilising the Vulnerable Persons Housing Strategy as a flagship strategy to unite and shape the approach to vulnerable person's accommodation Council services and partner organisations.

10.3 This emergent Strategy has built upon Cheshire East's extant work in creating a supported housing strategy, produced by consultants Red Quadrant. However, this revised Strategy greatly expands upon the remit and client groups contained in the previous work. Such expansion was considered necessary to capture the nuance, detail, and overlap between client groups, ensuring a more comprehensive and holistic piece of work.

10.4 The Strategy was constructed through extensive cross-service and pan-organisational consultation. This provided a crux of key-findings and priorities that were then expanded, corroborated, and tested through consultation. A consultation event was held in November 2013, attended by Cheshire East councillors, Council officers, housing providers, and support service providers. The results of this workshop combined with the initial analysis of the evidence base combined to form the first draft of the Strategy. Workshops were held for each client group, the key messages of which are summarised in each chapter under 'consultation response'.

10.5 The Strategy is now out for public consultation until 3 April 2014, after which the views and responses will be compiled and incorporated into the Strategy prior to formal ratification by Cheshire East Cabinet. The finalised Strategy is scheduled to be presented to Cabinet for approval on 29 April 2014.

11 Access to Information

Further information and background papers relating to this report can be found by contacting the report writer:

Name: Duncan Whitehead
Designation: Housing Policy Officer
Tel No: 01270 685643
Email: Duncan.whitehead@cheshireeast.gov.uk

This page is intentionally left blank

Mar 2014

Cheshire East Council: Vulnerable Persons Housing Strategy

Consultation

Cheshire East needs your views to shape the future of vulnerable persons housing within the Borough.

The Council is developing a housing strategy to specifically cater for the needs of vulnerable people. Your response to this consultation will shape the eventual strategy, and subsequently all policy, planning, and commissioning decisions made surrounding vulnerable persons housing.

To have your views considered, you should visit the consultation portal on the Council's website where you can find a copy of the draft strategy, instructions and links to response forms, which must be submitted by **03/04/14**.

http://www.cheshireeast.gov.uk/housing/strategic_housing/vulnerable_persons.aspx

If you require any further information or assistance, please contact:

Duncan Whitehead
Housing Policy Officer
Cheshire East Council
Westfields, CW11 1HZ
Duncan.whitehead@cheshireeast.gov.uk
01270 685643

Cheshire East Council

This page is intentionally left blank

Vulnerable Persons Housing Strategy Consultation

Cheshire East needs your views to shape the future of vulnerable persons housing within the Borough.

The Council is developing a housing strategy to specifically cater for the needs of vulnerable people. Your response to this consultation will shape the eventual strategy, and subsequently all policy, planning, and commissioning decisions made surrounding vulnerable persons housing.

To have your views considered, you should visit the consultation portal on the Council's website where you can find a copy of the draft strategy, instructions, and links to response forms, which must be submitted by 03/04/14.

http://www.cheshireeast.gov.uk/housing/strategic_housing/vulnerable_persons.aspx

If you require any further information or assistance, please contact:

Duncan Whitehead
Housing Policy Officer
Cheshire East Council
Westfields, CW11 1HZ
Duncan.whitehead@cheshireeast.gov.uk
01270 685643

This page is intentionally left blank

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	25th March 2014
Report of:	Director of Public Health
Subject/Title:	Update on the "Starting and Developing Well" section of the Joint Strategic Needs Assessment
Portfolio Holder:	Councillor Janet Clowes Portfolio Holder for Health and Adult Care

1. The Ofsted recommendation in relation to the JSNA was to "Ensure that the Joint Strategic Needs Assessment (JSNA) incorporates an analysis of children and young people's safeguarding and child protection needs and that these are accurately reflected and prioritised in the local area's joint Health and Wellbeing Strategy".

2. A large number of additional measures have been included in the JSNA following the new framework agreed by the Health and Wellbeing Board. Work continues to develop the depth and breadth of the JSNA.

3. There has been a significant rewriting and refreshing of the Starting and Developing Well section of the JSNA. This section of the JSNA now includes a comprehensive analysis of children and young people's safeguarding and child protection needs.

4. At the Cheshire East Children's Improvement Board meeting on 7th February 2014, the Board agreed that the first part of the Ofsted recommendation has been completed. The next stage is to demonstrate that these needs are reflected in the Joint Health and Wellbeing Strategy.

5. The current structure of the Starting and Developing Well section of the JSNA is attached as Appendix One. The completed sections are highlighted in boldface. Many of the remaining sections represent areas where information is difficult to obtain.

6. Evidence is currently being gathered to show how the JSNA has influenced commissioning actions to improve outcomes.

7. The JSNA is publicly available at:

   http://www.cheshireeast.gov.uk/social_care_and_health/jsna.aspx

Recommendation

That the Health and Wellbeing Board receive the report.

Access to Information

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

Name: Guy Hayhurst
Designation: Consultant in Public Health
Phone: 01270 685799
Email guy.hayhurst@cheshireeast.gov.uk

Appendix One

Cheshire East JSNA 2014

Starting and Developing Well Sections

Demography and Census

- Population estimates and projections for children and young people (including birth projections)
- **Ethnicity and health**
- **Children and families in poverty**
- Families in temporary accommodation, including concealed families

Pregnancy and post-natal care

- Pregnancy and birth (including low birth weight and congenital problems)
- **Breastfeeding**
- **Smoking at time of delivery**
- Maternal mental health
- **Whooping cough vaccination**

Family life and parenting

- Parenting ability
- Risks to children in the home, including passive smoking
- Health and development reviews
- Early help
- **School readiness**
- **Pupil absence**
- **Excess weight in 4-5 and 10-11 year olds**
- **Tooth decay in children aged 5**

Immunisation programmes

- **Childhood primary immunisations**
- **Rotavirus vaccination**
- **Hepatitis B vaccination**
- **Measles, mumps and rubella**
- **Vaccination against cervical cancer**

The JSNA sections shown in boldface have been completed, and all but two of these have been uploaded to the JSNA website. The remaining sections are still being written

Safeguarding children and young people

- **Referrals to Children's Social Care**
- **Assessments in Children's Social Care**
- **Children in need**
- **Child protection**
- **Child sexual exploitation**
- **Neglect**
- **Cared for children**
- Care leavers
- **Domestic abuse and sexual violence**
- **Emergency admissions to hospital**
- **Deaths in childhood**

Disabilities and long-term conditions

- **Children with learning difficulties**
- **Children with long term conditions**
- Hearing and vision impairment

Supporting young people

- **16-18 year olds not in education, employment or training**
- Young carers
- Youth justice
- **Young people substance misuse (covers alcohol, drugs and smoking)**

Emotional and mental health

- Young people's mental health
- Self-harm and suicide

Sexual health

- **Under 18 conceptions and teenage births**
- **Chlamydia screening**

This page is intentionally left blank