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Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Health and Wellbeing Board AGM

Agenda

Date:	**Thursday 29th May 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. **Appointment of Chairman**

   To appoint a Chairman for the 2014/15 Municipal Year.

2. **Appointment of Vice Chairman**

   To appoint a Vice-Chairman for the 2014/15 Municipal Year.

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

3. **Apologies for Absence**

To receive any apologies for absence.

4. **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.

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

To approve the minutes of the meeting held on 25 March 2014.

6. **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.

7. **Health and Wellbeing Board Terms of Reference** (Pages 9 - 16)

To note the Terms of Reference for the Cheshire East Health and Wellbeing Board, as agreed at Council on 14 May 2014.

8. **Pharmaceutical Needs Assessment Pre-Consultation Draft** (Pages 17 - 48)

To review the draft version of the Pharmaceutical Needs Assessment and agree to it being further developed and expanded with a view to the formal 60-day consultation commencing in either September or October 2014.

9. **Community Pharmacy Five Year Vision**

To receive an oral report on the Community Pharmacy Five Year Vision.

10. **Minor Ailments Scheme**

To receive an oral report on the Minor Ailments Scheme

11. **Connecting Care - A Transformational Approach to the Integration of Health and Social Care in Central Cheshire 2014 -2019** (Pages 49 - 102)

To consider a report seeking support regarding the developing Central Cheshire Connecting Care 5 year Strategy across Health and Social Care.

12. **NHS South Cheshire CCG - Quality Premium 2014-15** (Pages 103 - 106)

To review the Quality Premium 2014-15 for NHS South Cheshire CCG and discuss the plans in relation to the draft Health and Wellbeing Strategy across Cheshire East.

13. **Review and Refresh of the Cheshire East Joint Health and Wellbeing Strategy** (Pages 107 - 124)

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

14. **Better Care Fund Update**

To receive an oral update on the Better Care Fund.

15. **Health and Wellbeing Peer Challenge** (Pages 125 - 144)

To note the forthcoming Peer Challenge and the published Methodology and Guidance and nominate lead officers to assist with the preparation for the Peer Challenge.

16. **Memorandum Of Understanding in respect of Safeguarding between Key Strategic Public Protection Partnerships in Cheshire East** (Pages 145 - 146)

To receive for information a draft of the Memorandum of Understanding in respect of safeguarding between key strategic public protection partnerships in Cheshire East.

17. **Implementation of Domestic Violence Prevention Notices and Domestic Violence Prevention Orders** (Pages 147 - 150)

To receive for information a report on the Implementation of Domestic Violence Prevention Notices and Domestic Violence Prevention Orders.

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Agenda Item 5

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 25th March, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT
Councillor J Clowes, Cheshire East Council, (Chairman)

Cllr Rachel Bailey, Cheshire East Council
Cllr A Harewood, Cheshire East Council
Dr H Grimbaldeston, Director of Public Health, Cheshire East Council
Simon Whitehouse, South Cheshire CCG
Dr Andrew Wilson, South Cheshire CCG
Mike O'Regan, Healthwatch

Substitute
Neil Evans, Eastern Cheshire CCG

Councillor in attendance:
Cllr B Murphy.

Officers/others in attendance:
Mike Suarez , Chief Executive, Cheshire East Council
Lorraine Butcher, Executive Director Strategic Commissioning, Cheshire East Council
Anita Bradley, Head of Legal and Monitoring Officer, Cheshire East Council
Guy Kilminster, Corporate Manager Health Improvement, Cheshire East Council
Tony Crane, Director of Children's Services, Cheshire East Council
Brenda Smith, Director of Adult Social Care and Independent Living, Cheshire East Council
Duncan Whitehead, Housing Policy Officer, Cheshire East Council
Glenn Coleman, Head of Primary Care, Cheshire, Warrington and Wirral NHS England

Apologies

Dr P Bowen, J Hawker, Cllr S Gardiner.

34 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

35 **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes of the meeting held on 26 November 2013 be approved as a correct record.

36 **PUBLIC SPEAKING TIME/OPEN SESSION**

Cllr B Murphy used public speaking time to ask a question concerning a recent television programme relating to the incineration of foetuses, which claimed that 27% of hospital trusts incinerated foetuses, rather than cremating them. Cllr Murphy sought assurance that this was not the case in Cheshire.

The Chairman undertook to look into this matter and consider the most effective way of answering Cllr Murphy's question. It may possibly be an issue for the Health and Wellbeing Scrutiny Committee to consider. However, she would discuss this with other members of the Board in order to agree a way forward.

37 **DRAFT CCG TWO YEAR OPERATIONAL PLANS/FIVE YEAR STRATEGY AND NHS ENGLAND TWO YEAR PLAN**

EASTERN CHESHIRE CCG

Consideration was given to the NHS Eastern Cheshire Clinical Commissioning Group Two Year Operational Plan 2014-16.

The Clinical Commissioning Group (CCG) had submitted a first draft of its operational plans to NHS England. The time horizon for the Operational Plan was two years. The components of the submission included 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. The Commissioning Intentions had been developed to deliver the key national and local requirements based on both national benchmarking and local intelligence.

The final submission would be submitted on 4th April 2014 and the next steps would be for the CCG would 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.

The Board noted: -

- 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.

SOUTH CHESHIRE CCG

Consideration was given to a report, which provided 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.

It was reported that NHS South Cheshire CCG sought to be a responsive organisation that listened and took into account a wide range of perspectives, but at the same time kept its principles central to commissioning decisions. Those principles were:

- 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 its work as a clinically led commissioning organisation was the focus on improving outcomes for its patients. It had, therefore, focussed key actions (commissioning intentions) on each of the 5 Domains of the NHS Outcomes Framework. These domains had now become the CCG's strategic objectives for 204-16. A summary of the CCGs vision, principles, ways of working, strategic objectives and organisational objectives were set out in the report.

It was reported that the CCGs 5 year plan was still in development. A request to post an "easy read" version of the document on the CCG's website was agreed to.

RESOLVED

That the NHS South Cheshire Clinical Commissioning Groups (CCG) Draft Two Year Operational Plan, 2014-16 be noted.

NHS ENGLAND

Glenn Coleman, Head of Primary Care, Cheshire, Warrington and Wirral, NHS England, attended the meeting and presented the NHS England Accountability report to the Board.

NHS England provided a quarterly Accountability report to each Health and Wellbeing Board. The report outlined national and regional context together with specific update on priorities that the Area Team was responsible for delivering and how these priorities were progressing.

The report summarised the proposed initiatives in the Operational 2 year plan for commissioned services. It also provided a brief report card on the initiatives pursued in 2013-14 and the outcomes from these so far.

A request was made to provide an uptake of the flu vaccination for 2 year olds in 2013/14 in Eastern Cheshire and it was agreed that this information would be circulated to the Board.

RESOLVED

That the NHS England Accountability report to the Board be noted.

38 **BETTER CARE FUND PLAN**

Consideration was given to a report relating to the Better Care Fund Plan. It was reported that the Better Care Fund had been announced by Government in June 2013 and provided an opportunity to transform local services so that people were provided with better integrated care and support. It encompassed a substantial level of funding to help local areas manage pressures and improve long term sustainability of their health and care economies. It was noted that the Fund would be an important enabler to take the integration agenda forward at scale and pace, acting as a significant catalyst for change.

The Cheshire East Better Care Plan united 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 worked together. The Better Care Fund provided the level to drive a transformed model of integrated care, which would ensure that residents experienced care and support of quality that was appropriate to their needs and supported them to live as independent and fulfilling lives as possible. Critically it would ensure that when needs required it, specialist care and support was provided by services best equipped to cater for those needs.

There was a requirement to submit the Better Care Fund Plan to NHS England by the 4th April. A first draft had submitted in February and the second draft was appended to the report**.** It was noted that the Metrics and Finance Technical Appendix was being worked on**.** This had been compiled following extensive work by a team of officers from across the Council and the two CCGs and consultation with provider organisations.

The Board was requested to consider and endorse the Better Care Fund Plan submission.

RESOLVED

That the Board notes that following BCF submission and for pragmatic reasons separate operational plans are progressed using the BCF resources to drive the intended outcomes for residents via Connecting Care (South) and Caring Together (East).

Noted

- The Board noted the difficulties associated with aligning the proposed schemes within the Caring Together work programme.
- Following advice from NHS England the Board noted that the BCF submission would be subject to review as a consequence of work being undertaken within the Eastern Cheshire part of the Borough as a consequence of its identification as a 'Challenged Economy' and that this review may impact upon the performance metrics and schemes identified. The BCF facilitated work into Caring Together may be subject to scrutiny and challenge via the challenged economy work and may as a consequence change.
- The Board also noted that the BCF submission would be subject to an assurance process by NHS England and asked that that process acknowledge the difficult context, namely the challenged economy in the eastern part of the Borough and that a negative judgement of the submission was not made which might reflect poorly upon the wider health and social care economy in the rest of the Borough, or the agencies driving the required changes, namely Cheshire East Council, South Cheshire CCG and associated provider organisations. All Agencies would however, continue to work together wherever possible.

39 **REVIEW AND REFRESH OF THE CHESHIRE EAST JOINT HEALTH AND WELLBEING STRATEGY**

Consideration was given to a report relating to the review and refresh of the Cheshire East Joint Health and Wellbeing Strategy. It was reported that 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 had been approved in December 2012.

The interim Strategy was a one year Strategy. A refreshed Strategy had 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 was appended to the report**.**

It was noted that improving the physical health of those with serious mental illness had been highlighted as a new priority a specific reference to reducing social isolation and loneliness in the Ageing Well priority had also been introduced.

With reference to Annex one, Partner Priorities – CEC Children's Services, "What we will do", item 6 – Improving Access to timely support for families with mental health issues, it was agreed that a Child and Adolescent Mental Health Services (CAMHS) reference that families would recognise should be included.

Consideration had been given to the review and refresh of the Strategy at the Council's informal Cabinet meeting in the previous week and there had been a request to link the Performance Indicators with each of the key priorities in the matrix. This work was now being carried out and it was then proposed to produce

an Action Plan, in order to incorporate some of the activities from the CCG Operational Plan. The Strategy would then be brought back to the Board to be finalised.

RESOLVED

That, subject to the above, the refreshed Cheshire East Joint Health and Wellbeing Strategy be endorsed.

40 **VULNERABLE PERSONS HOUSING STRATEGY**

Consideration was given to a report relating to the Vulnerable Persons Housing Strategy. It was reported that work was underway to construct a Strategy for Cheshire East Borough Council, to ensure an appropriate landscape of specialist and supported accommodation was engendered in the local area. The report summarised the findings of the draft Strategy and requested the support of the Board in engaging with and promulgating the Strategy's on-going consultation. The public consultation on the draft strategy would run until 3 April 2014, which represented a six week consultation period.

The Strategy assumed a central role in Cheshire East's strategic forward planning and was one of the two major change programmes 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 was, in turn, a crucial policy in realising Outcome 5 of the Plan: *People Live Well and for Longer.*

RESOLVED

1. That the draft Vulnerable Persons Housing Strategy and its preliminary findings be noted.

2. That the Health and Wellbeing Board support the development of the Strategy and act as advocates for the on-going Strategy consultation.

41 **UPDATE ON THE "STARTING AND DEVELOPING WELL" SECTION OF THE JOINT STRATEGIC NEEDS ASSESSMENT**

Consideration was given to an update report on the "Starting and Developing Well" section of the Joint Strategic Needs Assessment.

It was reported that the Ofsted recommendation in relation to the JSNA was to "Ensure that the Joint Strategic Needs Assessment (JSNA) incorporated 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". A large number of additional measures had been included in the JSNA following the new framework agreed by the Health and Wellbeing Board. Work continued to develop the depth and breadth of the JSNA. There had been a significant rewriting and refreshing of the Starting and Developing Well section of the JSNA and this section now included a comprehensive analysis of children and young people's safeguarding and child protection needs.

The Cheshire East Children's Improvement Board had agreed that the first part of the Ofsted recommendation had been completed and the next stage was to demonstrate that these needs were reflected in the Joint Health and Wellbeing Strategy.

The current structure of the Starting and Developing Well section of the JSNA was appended to the report and the completed sections highlighted. It was noted that many of the remaining sections represented areas where information was difficult to obtain. Evidence was currently being gathered to show how the JSNA had influenced commissioning actions to improve outcomes.

RESOLVED

That the report be received and noted.

The meeting commenced at 2.00 pm and concluded at 4.05 pm

Councillor J Clowes (Chairman)

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Agenda Item 7

Appendix E

Cheshire East Statutory Health and Wellbeing Board

Terms of Reference:

1. Context

1.1 The full name shall be the Cheshire East Health and Wellbeing Board.

1.2 The Board assumes statutory responsibility from April 2013.

1.3 The Health and Social Care Act 2012 and subsequent regulations provide the statutory framework for Health and Wellbeing Boards (HWB).

1.4 For the avoidance of doubt, except where specifically disapplied by these Terms of Reference, the Council Procedure Rules (as set out in its Constitution) will apply.

2. Purpose

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).

- To lead integrated working between health's and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (i.e. lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.

- To lead close working between commissioners of health-related services and the board itself.

- To lead close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services

- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. Such delegated functions need not be confined to public health and social care.

- To provide advice assistance and support for the purpose of encouraging the making of arrangements under section 75 of the National Health Service Act 2006 in connection with the provision of such services.

3. Roles and Responsibilities

3.1 To work together effectively to ensure the delivery of the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy.

3.2 To work within the Board to build a collaborative partnership to key decision making that embeds health and wellbeing challenge, issue resolution and provides strategic system leadership.

3.3 To participate in Board discussions to reflect the views of their partner organisations, being sufficiently briefed to be able to make recommendations about future policy developments and service delivery.

3.4 To champion the work of the Board in their wider work and networks and in all individual community engagement activities.

3.5 To ensure that there are communication mechanisms in place within partner organisation[s] to enable information about the Health and Wellbeing Boards priorities and recommendations to be effectively disseminated.

3.6 To share any, changes to strategy, policy, and the system consequences of such on budgets and service delivery within their own partner organisations with the Board to consider the wider system implications.

4. Accountability

4.1 The Board carries no formal delegated authority from any of the individual statutory bodies.

4.2 Core Members of the board have responsibility and accountability to their individual duties and to their role on the Board.

4.3 The Board will discharge its responsibilities by means of recommendations to the relevant partner organisations, which will act in accordance with their respective powers and duties.

4.4 The Council's Core Members will ensure that they keep Cabinet and wider Council advised of the work of the Board.

4.5 The Board will report to Full Council and to both NHS Clinical Commissioning Groups (CCG's) Governing Bodies by ensuring access to meeting minutes and presenting papers as required.

4.6 The Board will not exercise scrutiny duties around health or adult social care services directly. This will remain the role of the Cheshire East Health and Wellbeing Scrutiny Committee. Decisions taken and work progressed by the Board will be subject to scrutiny by this committee.

4.7 The Board will provide information to the public through publications, local media, and wider public activities by publishing the minutes of its meetings on the Council's website. The Board is supported by an Engagement and Communications Network across Board organisation to ensure this function can operate successfully.

5. Membership

5.1 The core membership of the Board will comprise the following:

- Portfolio Holder – Health & Adult Social Care,
- Portfolio Holder – Children & Families,
- Major Opposition Group Member
- The Director of Public Health,
- The Director of Children's Services,
- The Director of Adult Social Care and Independent Living
- The Chief Executive of the Council (Associate Non Voting Member)
- The Executive Director of Strategic Commissioning (Associate Non Voting Member)
- Accountable Officer of the South Cheshire Clinical Commissioning Group
- Chair. GP Lead of the South Cheshire Clinical Commissioning Group
- Accountable Officer of the Eastern Cheshire Clinical Commissioning Group
- Chair. GP Lead of the Eastern Cheshire Clinical Commissioning Group
- A designated representative from Local Health Watch
- Member of NHS England Local Area Team (Associate Non Voting Member)

5.2 The Core Members will keep under review the Membership of the Board and if appropriate will make recommendations to Council on any changes to the Core Membership.

5.3 The above Core Members [1] through a majority vote have the authority to appoint individuals as Non Voting Associate Members of the Board. (Committee Procedure Rule 20.1 refers). The length of their membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting "AGM". Associate Members will assist the board in achieving the priorities agreed within the Joint Health and Wellbeing Strategy and may indeed be chairs of sub structure forums where they are not actual Core Members of the Board.

[1] Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards

5.4 The above Core Members [2] through a majority vote have the authority to recommend to Council that individuals be appointed as Voting Associate Members of the Board. The length of their membership will be for up to one year and will be subject to re-selection at the next Annual General Meeting "AGM".

5.5 Each Core Member has the power to nominate a single named substitute. If a Substitute Member be required, advance notice of not less than 2 working days should be given to the Council whenever practicable. The Substitute Members shall have the same powers and responsibilities as the Core Members.

6. Frequency of Meetings

6.1 There will be no fewer than six public meetings per year (including an AGM), usually once every two months as a formal Board.

6.2 Additional meetings of the Board may be convened with agreement of the Board's Chairman.

7. Agenda and Notice of Meetings

7.1 Any agenda items or reports to be tabled at the meeting should be submitted to the Council's Democratic Services no later than seven working days in advance of the next meeting. No business will be conducted that is not on the agenda.

7.2 In accordance with the Access to Information Legislation Democratic Services will circulate and publish the agenda and reports prior to the next meeting. Exempt or Confidential Information shall only be circulated to Core Members.

8. Annual General Meeting

8.1 The Board shall elect the Chairman and Vice Chairman at each AGM, the appointment will be by majority vote of all Core Members present at the meeting.

8.2 The Board will approve the representative nominations by the partner organisations as Core Members.

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[2] Regulation 5(1) removes this restriction in relation to health and wellbeing boards by disapplying section 104(1) of the 1972 Act to enable the local authority directors specified in the 2012 Act to become members of health and wellbeing boards

9. Quorum

9.1 Any full meeting of the Board shall be quorate if the following are represented Eastern CCG, South CCG, Local Health Watch, a Portfolio Holder, and an Officer of Cheshire East Council.

9.2 Failure to achieve a quorum within thirty minutes of the scheduled start of the meeting, or should the meeting become inquorate after it has started, shall render the meeting adjourned until the next scheduled meeting of the Board. This will also be the case when attending development or informal Board meetings.

10. Procedure at Meetings

10.1 General meetings of the Board are open to the public and in accordance with the Council's Committee Procedure Rules will include a Public Question Time Session. Papers, agendas and minutes will be published on the Cheshire East Health and Wellbeing website.

10.2 The Council's Committee Procedure Rules will apply in respect of formal meetings subject to the following: -

10.3 The Board will also hold development/informal sessions throughout the year where all members are expected to attend and partake as the agenda suggests.

10.~~3~~4 Core Members are entitled to speak through the Chairman. Associate Members are entitled to speak at the invitation of the Chairman.

10.5 With the agreement of the Board, subgroups can be set up to consider distinct areas of work. The subgroup will be responsible for arranging the frequency and venue of their meetings. The Board will approve the membership of the subgroups.

10.6 Any recommendations of the subgroup will be made to the Board who will consider them in accordance with these terms of reference and their relevance to the priorities within the Joint Health and Wellbeing Strategy and its delivery plan.

10.7 Whenever possible decisions will be reached by consensus or failing that a simple majority vote.

11. Expenses

11.1 The partnership organisations are responsible for meeting the expenses of their own representatives.

11.2 A modest Board Budget will be agreed annually to support Engagement and Communication and the Business of the Board.

12. Conflict of Interest

12.1 In accordance with the Council's Committee Procedure Rules, at the commencement of all meetings all Board Members shall declare disclosable pecuniary or non-pecuniary interests and any conflicts of interest.

12.2 In the case of non-pecuniary matters Members may remain for all or part of the meeting, participate and vote at the meeting on the item in question.

12.3 In the case of pecuniary matters Members must leave the meeting during consideration of that item.

13. Conduct of Core Members at Meetings

13.1 Board members will agree to adhere to the seven principles outlined in the Board Code of Conduct when carrying out their duties as a Board member [Appendix 1].

14. Review

14.1 The above terms of reference will be reviewed annually at the Health and Wellbeing Board AGM.

14.2 Any amendments shall only be included by consensus or a simple majority vote, prior to referral to the Constitution Committee and thereafter Council.

March 2014

Definition

Exempt Information
Which is information falling within any of the descriptions set out in Part I of Schedule12A to the Local Government Act 1972 subject to the qualifications set out in Part II and the interpretation provisions set out in Part III of the said Schedule in each case read as if references therein to "the authority" were references to "Board" or any of the partner organisations.

Confidential Information
Information furnished to, partner organisations or the Board by a government department upon terms (however expressed), which forbid the disclosure of the information to the public; and information the disclosure of which to the public is prohibited by or under any enactment or by the order of a court are to be discussed.

Conflict of Interest
You have a Conflict of interest if the issue being discussed in the meeting affects you, your family or your close associates in the following ways;
- *The issue affects their well being more than most other people who live in the area.*

- *The issue affect their finances or any regulatory functions and*
- *A reasonable member of the public with knowledge of the facts would believe it likely to harm or impair your ability to judge the public interest.*

Associate Members
Associate Member status is appropriate for those who are requested to chair sub groups of the board.

Health Services
Means services that are provided as part of the health service.

Health-Related Services *means services that may have an effect on the health of individuals but are not health services or social care services.*

Social Care Services
Means services that are provided in pursuance of the social services functions of local authorities (within the meaning of the Local Authority Social Services Act 1970

Appendix 1

Cheshire East Shadow Health and Wellbeing Board Member Code of Conduct

1. Selflessness

Members of the Cheshire East Health and Wellbeing Board should act solely in terms of the interest of and benefit to the public/patients of Cheshire East. They should not do so in order to gain financial or other benefits for themselves, their family or their friends

2. Integrity

Members of the Cheshire East Health and Wellbeing Board should not place themselves under any financial or other obligation to outside individuals or organisations that might seek to influence them in the performance of their duties and responsibilities as a Board member

3. Objectivity

In carrying out their duties and responsibilities members of the Cheshire East Health and Wellbeing Board should make choices based on merit and informed by a sound evidence base

4. Accountability

Members of the Cheshire East Health and Wellbeing Board are accountable for their decisions and actions to the public/patients of Cheshire East and must submit themselves to whatever scrutiny is appropriate

5. Openness

Members of the Cheshire East Health and Wellbeing Board should be as transparent as possible about all the decisions and actions that they take as part of or on behalf of the Board. They should give reasons for their decisions and restrict information only when the wider public interest clearly demands

6. Honesty

Members of the Cheshire East Health and Wellbeing Board have a duty to declare any private interests relating to their responsibilities and duties as Board members and to take steps to resolve any conflicts arising in a way that protects the public interest and integrity of the Cheshire East Health and Wellbeing Board

7. Leadership

Members of the Cheshire East Health and Wellbeing Board should promote and support these principles by leadership and example

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	29th May 2014
Report of:	Consultant in Public Health
Subject:	Pharmaceutical Needs Assessment Pre-Consultation Draft

1.0 Report Summary

Pharmaceutical Needs Assessments (PNAs) are carried out to assess the pharmacy needs of the local population. The PNA ensures that community pharmacy services are provided in the right place and meet the needs of the communities they serve. NHS England will rely on the PNA when making decisions on applications to open new pharmacies. Each Health and Wellbeing Board must publish its first pharmaceutical needs assessment by 1st April 2015.

A Survey of Community Pharmacists commenced on the 7th April and responses are currently being collated.

Cheshire East Council's Research and Consultation Team will be sending a survey via an on-line method to the Council's Citizens Panel during June. The Citizens Panel is a representative sample of the demographic (age, gender, postcode, social grade) make-up of the Cheshire East population. Around 1,500 people will be sent the survey and the response rate is expected to be good with 750 or more responses. The survey will ask about people's experiences when using a community pharmacy, what works well, and what could be improved.

2.0 Recommendation

The Health and Wellbeing Board is asked to review the current draft version of the PNA and agree to it being further developed and expanded with a view to the formal 60-day consultation commencing in either September or October 2014.

3.0 Reasons for Recommendation

This draft PNA has been prepared by a Steering Group led by Public Health and including NHS England, NHS Eastern Cheshire CCG, NHS South Cheshire CCG and Cheshire Local Pharmaceutical Committee, The Steering Group was required to submit the draft PNA to the Board before the end of May 2014, together with detailed recommendations for the proposed consultation process.

Following comments from the Board, the draft PNA will be sent to Cheshire Local Medical Committee and to Healthwatch Cheshire East for their initial views, before the PNA is developed into a version for the formal consultation process.

4.0 The Proposed Consultation Process

The Health and Wellbeing Board must then consult the following about the contents of the assessment it is making:

(a) any Local Pharmaceutical Committee for its area (including any Local Pharmaceutical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
(b) any Local Medical Committee for its area (including any Local Medical Committee for part of its area or for its area and that of all or part of the area of one or more other HWBs);
(c) any persons on the pharmaceutical lists and any dispensing doctors list for its area;
(d) any LPS chemist in its area with whom the NHSCB has made arrangements for the provision of any local pharmaceutical services;
(e) any Local Healthwatch organisation for its area, and any other patient, consumer or community group in its area which in the opinion of the Health and Wellbeing Board has an interest in the provision of pharmaceutical services in its area; and
(f) any NHS trust or NHS foundation trust in its area;
(g) the NHSCB; and
(h) any neighbouring HWB.

The persons consulted on the draft PNA will be given a minimum period of 60 days for making their response to the consultation, beginning with the day by which all those persons have been served with the draft.

A person is to be treated as served with a draft if that person is notified by the Health and Wellbeing Board of the address of a website on which the draft is available and is to remain available (except due to accident or unforeseen circumstances) throughout the period for making responses to the consultation.

If a person consulted on a draft requests a copy of the draft in hard copy form, the Health and Wellbeing Board must as soon as is practicable and in any event within 14 days supply a hard copy of the draft to that person free of charge.

The following groups of people could also be consulted on the draft PNA. A local decision needs to be made whether these groups are going to be contacted.

- Patient Participation Groups in primary care
- Local Voluntary Community and Faith Groups

5.0 Access to Information

The background papers relating to this report can be inspected by contacting the report writer:
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Cheshire East Local Authority

Pharmaceutical Needs Assessment

Pre-Consultation Draft

For Discussion by

Cheshire East Health and Wellbeing Board
29th May 2014

ACCURACY OF THE PNA, INCOMPLETE OR DRAFT SECTIONS

All statements and figures shown in this draft pre-consultation version of the Cheshire East Pharmaceutical Needs Assessment (PNA) are subject to further checking and confirmation, and at this time should be regarded as provisional. The following paragraphs and sections of the PNA require completing or have been presented in a draft form for illustrative purposes.

1.0 Foreword and Executive Summary

2.3 Ensure consistency with Cheshire East Local Plan, Joint Strategic Needs Assessment (JSNA), Children and Young People's Plan, Community Strategy, and Community Safety Strategy

6.2 Ownership of community pharmacies – figures for Cheshire East

7.3 Local Enhanced Services commissioned by Central and Eastern Cheshire PCT in 2012-13 – details for Cheshire East, and number of contractors who provided emergency contraception

9.1.4 Medicines Use Review – number of contractors and MURs for Cheshire East

9.2.4 Appliance Use Review – number of contractors and AURs for Cheshire East

9.3.2 Stoma Appliance Customisation – number of contractors and SACs for Cheshire East

9.4.4 New Medicines Service – number of contractors and NMSs for Cheshire East

12.8 Prescription items dispensed per pharmacy per month – checking items

14.0 Prescribing information for Cheshire East in 2013 – checking items and costs

15.2 Top 20 drugs used in Cheshire East, by number of items and cost – will show the top 20 drugs used in Cheshire East. Population need for medicines in relation to the JSNA

16.1 Table with populations by broad age group for 2014, 2019 and 2024

18 All Six of the Statements required by Legislation

19 Map – some of the dispensing practices are not visible

Appendix A List of community pharmacies, opening hours, and services provided

Appendix B Maps of the major towns identifying the locations of community pharmacies

Appendix C The findings of a survey of community pharmacists

Appendix D The findings of a population survey about local pharmacy provision

Appendix E The Equality Impact Assessment

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Appendices

2.0 Purpose of the Pharmaceutical Needs Assessment

2.1 Under the Health Act 2009, NHS Primary Care Trusts (PCTs) prepared Pharmaceutical Needs Assessments (PNAs) and used these as the basis for determining market entry to NHS pharmaceutical provision. The Health and Social Care Act 2012 established Health and Wellbeing Boards (HWBs) and transferred the responsibility to develop and update PNAs from PCTs to HWBs. The responsibility for using PNAs as the basis for determining market entry to a pharmaceutical list transferred from PCTs to NHS England from 1 April 2013.

2.2 The NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013 came into force on 1 April 2013. These require HWBs to produce their first assessment by 1 April 2015 and to publish a revised assessment within three years of publication of their first assessment (or as soon as is reasonably practical after identifying significant changes to the availability of pharmaceutical services).

2.3 The statutory requirements for PNAs are set out in Regulations 3 to 9 and Schedule 1 of the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. This Pharmaceutical Needs Assessment is written in accordance with these Regulations. The PNA also takes account of the Cheshire East Local Plan, the Joint Strategic Needs Assessment (JSNA), Children and Young People's Plan, Community Strategy, and Community Safety Strategy.

2.4 The PNA is of particular importance to NHS England who, since 1 April 2013, has been identified in the Health and Social Care Act 2012 as responsible for maintaining pharmaceutical lists. The PNA is a key document in making decisions with regard to applications made under the NHS (Pharmaceutical Services and Local Pharmaceutical Services) Regulations 2013. Under the revised market entry arrangements, routine applications are assessed against the PNA.

2.5 In addition to being used as a basis for determining market entry, PNAs are intended to be used to inform commissioning decisions by NHS England, by Local Authorities (public health services from community pharmacies), and by Clinical Commissioning Groups.

3.0 Structure of the Cheshire East Pharmaceutical Needs Assessment

3.1 This Pharmaceutical Needs Assessment for Cheshire East contains seventeen introductory sections. These are followed by the six statements required by the legislation, and a map identifying the premises at which pharmaceutical services are provided in the area of the HWB. The six appendices contain:

- a list of the names and addresses of all community pharmacies, a summary of the services that they provide, and the opening hours of the dispensing contractors
- maps of the major towns identifying the locations of community pharmacies
- the findings of a survey of community pharmacists
- the findings of a population survey about local pharmacy provision, people's experiences when using a community pharmacy, what works well, and what could be improved
- the equality impact assessment
- a glossary of terms and phrases defined in regulation 2 of the 2013 Regulations

4.0 Pharmaceutical Lists and Market Entry

4.1 The following individuals may apply to be included in a pharmaceutical list:

- community pharmacy contractors, who are healthcare professionals who practice in pharmacy, the field of health sciences focusing on safe and effective medicines use
- appliance contractors, who supply appliances on prescription such as incontinence and stoma aids, trusses, surgical stockings and dressings. They cannot supply medicines. However, community pharmacists and dispensing doctors can also supply appliances
- dispensing doctors, who are medical practitioners authorised to provide drugs and appliances in designated rural areas known as "controlled localities" to those patients who have difficulty accessing a community pharmacy service

4.2 Under the NHS (Pharmaceutical Services) Regulations 2005 and up to the 1st September 2012, four categories of pharmacy applications were exempted from the "control of entry" test. Existing pharmacies that opened under the 2005 exemption categories will still be expected to meet the conditions of the category under which the application was granted, and this will be monitored by NHS England. These categories were:

- pharmacies based in approved retail areas (large retail shopping areas of 15,000 square metres or more leasehold gross floor space away from town centres). There is one of these pharmacies in Cheshire East – in the Handforth Dean shopping centre
- pharmacies that intend to open for at least 100 hours per week. There are eleven of these pharmacies in Cheshire East – three in Congleton, three in Crewe, three in Macclesfield, one in Knutsford, and one in Nantwich
- consortia establishing new one stop primary centres. There are none of these pharmacies in Cheshire East
- wholly mail order or internet-based (distance-selling) pharmacy services. There are two of these pharmacies in Cheshire East

4.3 If a person wants to provide NHS pharmaceutical services, they must apply to be included on the pharmaceutical list by proving they are able to meet a pharmaceutical need as set out in the PNA. Under the NHS (Pharmaceutical Services) Regulations 2012, control of entry is determined by a market entry test, with the only exemption being for distance selling (wholly mail order or internet-based) pharmacy services. This is known as the NHS "market entry" system. Under the market entry test, NHS England assesses an application that offers to:

- meet an identified current or future need or needs
- meet identified current or future improvements or better access to pharmaceutical services
- provide unforeseen benefits. These are applications that offer to meet a need that is not identified in a PNA but which NHS England is satisfied would lead to significant benefits to people living in the area

4.4 The market entry test applies equally to urban and rural areas. However, where NHS England has determined that an area is "controlled" (generally rural in character); doctors as well as pharmacy contractors can dispense NHS medicines. General Practitioners (GPs) may

dispense NHS prescriptions only with NHS approval and only to their own patients who live in such controlled localities and live more than 1.6 km (as the crow flies) from a pharmacy. This is to ensure that patients in rural areas who might have difficulty reaching their nearest pharmacy can access the dispensed medicines they need.

4.5 Generally, when a pharmacy application is granted in a controlled area, any GPs within 1.6 km of the pharmacy have to cease dispensing. The exception to this is where the patient population is under 2,750 ("reserved location"). Where this is approved, both dispensing by doctors and pharmaceutical contractor services can be provided.

4.6 One of the objectives of the current regulatory framework is to improve access by patients to community pharmacies and to ensure access in deprived areas.

5.0 Essential Small Pharmacies

5.1 One of the community pharmacies in Cheshire East is in the Essential Small Pharmacies Local Pharmaceutical Services (ESPLPS) scheme. Essential Small Pharmacies are contracted under the Local Pharmaceutical Services (LPS) provisions. The Pharmaceutical Services Negotiating Committee (PNSC) and the Department of Health agreed as part of the contract negotiations in 2004-05 that LPS contracting would be used to provide support to existing Essential Small Pharmaceutical Services (ESPS) pharmacies. The Essential Small Pharmacies were all transferred to an Essential Small Pharmacy contract from October 2006. Originally scheduled to end in 2011, PNSC secured two extensions to the scheme, and the contracts have been amended to end in March 2015. Further discussions will be held between NHS England and PNSC about any support available to Essential Small Pharmacies from that date.

6.0 Ownership of Community Pharmacies

6.1 Under the Medicines Act 1968, a registered pharmacist must be in charge of each community pharmacy. Community pharmacies can be owned by a pharmacist sole trader, a limited liability partnership (where all partners are pharmacists) or bodies corporate (where a superintendent pharmacist must be appointed). These are collectively known as pharmacy contractors. Conventionally, pharmacy contractors who own six or more pharmacies are known as "multiple contractors" (also known as pharmacy chains), and those who own five or less pharmacies are known as "independents".

6.2 In 2012/13, 23% of pharmacies in Central and Eastern Cheshire PCT were classified as independent and 77% were owned by multiple contractors (England 38.6% and 61.4%). In 2012/13, Somerset PCT recorded the highest figure for multiple contractors at 88.2 per cent and Islington PCT the lowest at 17.8 per cent. A patient survey undertaken by the Department of Health in 2007 indicated that the public value a variety of types of pharmacy.

7.0 Definition of Pharmaceutical Services

7.1 The NHS Act 2006 sets out the definition for pharmaceutical services. Pharmaceutical services are generally provided by virtue of Part 7 of the Act. Under section 126(1) – (3), NHS England is required to secure, on the basis of Regulations made by the Secretary of State, the

provision of services to people in their area of medicines and listed appliances and "such other services as may be prescribed" (section 126(3)(e)). Prescribed services must be set out in Regulations. Therefore, these prescribed services, and the dispensing services referred to in section 126(3)(a) to (d), constitute the core “essential” NHS pharmaceutical services. Section 127 also provides for “additional pharmaceutical services” to be set out in Directions to NHS England. Directed services include advanced and enhanced services for pharmacy contractors and advanced services for dispensing appliance contractors.

7.2 The Community Pharmacy Contractual Framework was introduced in 2005. Under the framework, there are three types of service which can be provided by community pharmacy and/or appliance contractors. Pharmaceutical services in relation to PNAs therefore include:

- “essential services” which every community pharmacy providing NHS pharmaceutical services must provide. These are the dispensing of medicines, promotion of healthy lifestyles, and support for self-care including appropriate signposting
- “advanced services” currently comprise four services. The first to be introduced was Medicines Use Reviews which community pharmacies can provide if they are providing all the essential services and have suitable training and accredited premises. In April 2010 a further two advanced services were introduced for both community pharmacy and appliance contractors. These are Appliance Use Reviews and Stoma Customisation Service. In October 2011 the fourth advanced service was introduced for community pharmacies, the New Medicines Service
- locally commissioned services (previously known as “enhanced services”) that are commissioned by NHS England. The Cheshire, Warrington and Wirral Area Team of NHS England do not currently have any locally commissioned services

7.3 Prior to April 2013, each PCT was authorised to arrange for the provision of specific pharmaceutical services to persons within or outside its area with pharmacists included on its pharmaceutical list or on the list of a neighbouring PCT. In 2012-13 there were twenty specified services nationally although only six were commissioned by Central and Eastern Cheshire PCT. The table shows the proportion of community pharmacies providing these services in 2012-13.

	England	North West	CECPCT
Stop Smoking	20.2%	51.2%	47.5%
Supervised Administration	18.8%	46.5%	67.3%
Minor Ailment Service	12.1%	52.5%	100%
Patient Group Direction	11.7%	42.0%	100%
Medication Review	9.2%	20.8%	93.1%
Needle and Syringe Exchange	7.4%	19.9%	24.8%

7.4 From April 2013, pharmaceutical services **do not include** any services commissioned from pharmaceutical contractors by Local Authorities and Clinical Commissioning Groups.

8.0 Essential Services

8.1 **Dispensing Medicines or Appliances**. Pharmacies are required to maintain a record of all medicines dispensed, and also to keep records of any interventions made which they judge to

be significant. Whilst the terms of service requires a pharmacist to dispense any (non-blacklisted) medicine 'with reasonable promptness', for appliances the obligation to dispense arises only if the pharmacist supplies such products 'in the normal course of his business'. The Electronic Prescription Service (EPS) is also being implemented as part of the dispensing service. Prescription-linked interventions can be identified during the dispensing process. Pharmacists could identify patients with specified health needs which should be addressed. The health needs that the HWB wish to be targeted could be agreed with the Cheshire, Warrington and Wirral Area Team of NHS England and the Local Pharmaceutical Committee (LPC).

8.2 **Repeat Dispensing**. Pharmacies will dispense repeat prescriptions and store the documentation if required by the patient. They will ensure that each repeat supply is required and seek to ascertain that there is no reason why the patient should be referred back to their General Practitioner (GP). This service is aimed at patients with long term conditions who have a stable medication routine and hence may have less opportunity to discuss any health issues with their GP or nurse. Pharmacists are required to check if a patient is using their medication. This gives them an opportunity to identify if a patient is not using their mediation as intended and hence may not be giving the desired health outcomes for which they were prescribed.

8.3 **Disposal of Unwanted Medicines**. Pharmacies are obliged to accept back unwanted medicines from patients. The pharmacy will, if required by NHS England or the waste contractor, sort them into solids (including ampoules and vials), liquids and aerosols, and the Cheshire, Warrington and Wirral Area Team will make arrangements for a waste contractor to collect the medicines from pharmacies at regular intervals. Additional segregation is also required under the Hazardous Waste Regulations. Pharmacy staff have the opportunity to identify patients who have not taken the medicines they were prescribed. This can initiate a discussion and problems such as side effects or dosage regimes can be addressed to help improve the patients' health outcomes. A significant amount of wasted NHS resource is attributed to medications being used incorrectly or not at all.

8.4 **Public Health Campaigns and Promotion of Healthy Lifestyles**. Each year pharmacies are required to participate in up to six public health campaigns at the request of the Cheshire, Warrington and Wirral Area Team. Three will be national campaigns (yet to be agreed nationally) and three are local campaigns across the geography of Cheshire, Warrington and Wirral (and agreed by Directors of Public Health). These campaigns involve the display and distribution of leaflets provided by NHS England. In addition, pharmacies are required to promote healthy lifestyles and undertake prescription-linked interventions on major areas of public health concern, such as encouraging smoking cessation.

8.5 **Signposting**. The Cheshire, Warrington and Wirral Area Team will provide pharmacies with lists of sources of care and support in the area. Pharmacies will be expected to help people who ask for assistance by directing them to the most appropriate source of help.

8.6 **Support for Self Care**. Pharmacies will help to manage minor ailments and common conditions, by the provision of advice and where appropriate, the sale of medicines, including dealing with referrals from NHS Direct/NHS 111. Records will be kept where the pharmacist considers it relevant to the care of the patient.

8.7 **Clinical Governance**. The clinical governance requirements of the community pharmacy contractual framework cover a range of quality related issues.

9.0 Advanced Services

9.1 Medicines Use Review and Prescription Intervention Service (MUR)

9.1.1 The Medicines Use Review and Prescription Intervention Service is an advanced service provided under the community pharmacy contractual framework. MURs can only be provided by pharmacies. The service includes MURs undertaken periodically or when there is a need to make an adherence-focused intervention due to a problem that is identified while providing the dispensing service (a prescription intervention MUR). The purpose of the MUR service is to improve patient knowledge, adherence and use of their medicines by:

- establishing the patients actual use, understanding and experience of taking medicines
- identifying, discussing and resolving poor or ineffective use of medicines
- identifying side effects and drug interactions that may affect adherence
- improving the clinical and cost effectiveness of prescribed medicines and reducing medicine wastage

9.1.2 The following three national target groups for MURs were introduced in October 2011:

- patients taking the following high risk medicines: non-steroidal anti-inflammatory drugs, anticoagulants including low molecular weight heparin, antiplatelets and diuretics
- patients recently discharged from hospital who had changes made to their medicines while they were in hospital. Ideally patients discharged from hospital will receive an MUR within four weeks of discharge but in certain circumstances the MUR can take place within eight weeks of discharge
- patients with respiratory disease taking the following medicines for asthma or COPD: adrenoreceptor agonists, antimuscarinic bronchodilators, theophylline, compound bronchodilator preparations, corticosteroids, cromoglycate and related therapy, leukotriene receptor antagonists and phosphodiesterase type-4 inhibitors

9.1.3 The service is nationally available to a national service specification, but is established locally between the Cheshire, Warrington and Wirral Area Team of NHS England and community pharmacies. A fee per MUR is payable to all pharmacy contractors that choose to provide the services and meet the requirements for this service. The maximum any contractor can be paid for under the advanced service is 400 MURs a year and at least 50% of all MURs undertaken by each pharmacy in each year should be on patients within the national target groups.

9.1.4 In 2012-13, a total of 24,656 MURs were carried out in Central and Eastern Cheshire PCT, representing an average of 252 in each community pharmacy providing the service compared to an average of 246 in the North West and 267 in England. The three Primary Care Trusts with the highest use of MURs in the North West had averages of 281, 286 and 300.

9.2 Appliance Use Review (AUR)

9.2.1 Appliance Use Review (AUR) is the second advanced service and was introduced into the NHS community pharmacy contract on 1 April 2010. This service can be provided by either community pharmacy or appliance contractors and can be carried out by a pharmacist or a specialist nurse either at the contractor's premises or at the patient's home.

9.2.2 The service has a national service specification, but was established locally between Primary Care Trusts and their pharmacy contractors. A fee is payable to all community pharmacy and appliance contractors for each AUR they have carried out. There is a different fee depending on whether the AUR was carried out in the patient's home or on the contractor's premises. The maximum number of AURs for which a contractor is eligible to be paid for under this service is not more 1/35th of the aggregate number of specified appliances dispensed by the contractor during the financial year.

9.2.3 AURs should improve the patient's knowledge and use of any specified appliance by:

- establishing the way the patient uses the appliance and the patient's experience of such use
- identifying, discussing and assisting in the resolution of poor or ineffective use of the appliance by the patient
- advising the patient on the safe and appropriate storage of the appliance
- advising the patient on the safe and proper disposal of the appliances that are used or unwanted

9.2.4 Only one community pharmacy in Central and Eastern Cheshire PCT provided this service in 2012-13. In that year a total of 13 AURs were carried out, representing an average of 13 in each community pharmacy providing the service compared to an average of 115 in the North West and 197 in England. The number of Cheshire East patients who access the service in other areas is not known.

9.3 Stoma Appliance Customisation (SAC)

9.3.1 Stoma Appliance Customisation (SAC) is the third advanced service in the NHS community pharmacy contract and was also introduced on 1 April 2010. The service involves the customisation of a quantity of more than one stoma appliance, based on the patient's measurements or a template. The aim of the service is to ensure proper use and comfortable fitting of the stoma appliance and to improve the duration of usage, thereby reducing waste. This service can be provided by either pharmacy or appliance contractors.

9.3.2 In 2012/13 a total of 18 (17.8%) contractors provided a SAC service in Central and Eastern Cheshire PCT compared to an average of 17.1% of contractors in the North West and 15.2% in England. Across the PCT a total of 277 SACs were carried out compared to a total of 155,629 for the North West which represents an average of 15 SACs per contractor providing the service compared to an average of 497 in the North West and 635 in England. It is likely that the needs of local patients are being addressed by services based outside the HWB area.

9.4 New Medicines Service (NMS)

9.4.1 The New Medicines Service (NMS) is the latest advanced service to be introduced in the NHS community pharmacy contract and was introduced on 1 October 2011. This service can be provided by pharmacies only. Although the NMS was implemented as a time-limited service commissioned until March 2013, NHS England has been considering the short term future of the service, in discussion with the Pharmaceutical Services Negotiating Committee, and it has been agreed that the NMS will continue in 2014/15, subject to the outcome of a Department of Health funded academic evaluation of the service which is expected to report in mid-2014.

9.4.2 This means that pharmacy contractors can continue to provide the NMS to all eligible patients, with all service requirements and payment arrangements remaining the same, until further notice is given or the end of 2014/15 is reached. When the final evaluation is published, NHS England will use it to decide whether to continue commissioning the service.

9.4.3 The New Medicines Service aims to:

- help patients and carers manage newly prescribed medicines for a long-term condition (LTC) and make shared decisions about their LTC
- recognise the important and expanding role of pharmacists in optimising the use of medicines
- increase patient adherence to treatment and consequently reduce medicines wastage and contribute to the NHS Quality, Innovation, Productivity and Prevention agenda
- supplement and reinforce information provided by the GP and practice staff to help patients make informed choices about their care
- promote multidisciplinary working with the patient's GP practice
- link the use of newly-prescribed medicines to lifestyle changes or other non-drug interventions to promote well-being and promote health in people with LTCs
- promote and support self-management of LTCs, and increase access to advice to improve medicines adherence and knowledge of potential side effects
- support integration with LTC services from other healthcare providers and provide appropriate signposting and referral to these services
- improve pharmacovigilance, and
- through increased adherence to treatment, reduce medicines-related hospital admissions and improve quality of life for patients

9.4.4 In 2012-13, the New Medicines Service was provided by 84 (83.2%) of the community pharmacies in Central and Eastern Cheshire PCT. A total of 6,049 NMSs were carried out, representing an average of 72 in each community pharmacy providing the service compared to an average of 63 in the North West and 68 in England. The Primary Care Trusts with the highest use of NMSs in the North West had averages of 84, 86 and 89.

9.4.5 The NMS is focused on the following patient groups and conditions. For each, a list of medicines has been agreed. If a patient is newly prescribed one of these medicines for these conditions, they will be eligible to receive the service:

- asthma and chronic obstructive pulmonary disease

- type 2 diabetes
- antiplatelet/anticoagulant therapy (mainly but not exclusively used for atrial fibrillation)
- hypertension

9.4.6 It is estimated that in Cheshire East each year:

- 1,446 patients will be diagnosed with asthma or chronic obstructive pulmonary disease
- 870 patients will be diagnosed with type 2 diabetes
- 720 patients will be diagnosed with atrial fibrillation
- 2,588 patients will develop hypertension although most will not be diagnosed

9.4.7 There is no routine information available about the use of NMSs for each condition, so it is not currently possible to estimate the proportion of new patients in Cheshire East who receive this service. However, the current overall volume of service is likely to be sufficient to meet need, if service use can be appropriately targeted.

10.0 Services Commissioned by Cheshire East Council

10.1 Under the Health and Social Care Act 2012 the responsibility for commissioning certain services now sits with public health in Local Authorities. In Cheshire East these services are supervised administration, needle exchange, stop smoking and emergency contraception. Except for stop smoking (which has increased), the proportion of pharmacies that provide these services has not changed significantly since the transfer of commissioning responsibility.

10.2 The table illustrates the number and proportion of community pharmacies that provide these services, by Local Area Partnership and by CCG area. There is a consistent level of service provision across both CCG areas, and all four services are available in every Local Area Partnership except for needle exchange in the Poynton LAP (there is access to needle exchange in the adjacent Wilmslow LAP and Macclesfield LAP).

Services commissioned by Cheshire East Public Health					
	Community pharmacies	**Supervised consumption**	**Needle exchange**	**Stop smoking**	**Emergency contraception**
Congleton LAP	**22**	11	6	21	18
Crewe LAP	**16**	12	4	16	14
Knutsford LAP	**6**	2	1	5	3
Macclesfield LAP	**13**	8	6	13	10
Nantwich LAP	**7**	5	1	6	8
Poynton LAP	**4**	1	0	3	1
Wilmslow LAP	**11**	4	3	11	8
NHS Eastern Cheshire CCG	**47**	22 (47%)	13 (28%)	44 (94%)	33 (70%)
NHS South Cheshire CCG	**32**	21 (66%)	8 (25%)	31 (97%)	29 (91%)
Cheshire East	**79**	**43 (54%)**	**21 (27%)**	**75 (95%)**	**62 (78%)**

10.3 **Supervised Consumption**. This service provides supervised administration of prescribed opiate maintenance treatment (Methadone or Buprenorphine) at the point of dispensing in the

pharmacy, ensuring that the dose has been administered to the patient. Clients are also given support and advice, including referral to primary care or specialist centres where appropriate.

10.4 **Pharmacy Based Needle Exchange**. This service aims to assist clients to remain healthy until they are ready to cease injecting and achieve a drug-free life with appropriate support. The service also aims to reduce the rate of blood-borne infections and drug related deaths among service users by:

- reducing the amount of sharing and other high risk injecting behaviours
- providing sterile injecting equipment and other support
- promoting safer injecting practices
- providing and reinforcing harm reduction messages including safe sex advice and advice on overdose preventions (e.g. risks of poly-drug use and alcohol use)
- improving the health of local communities by preventing the spread of blood borne infection and ensuring the safe disposal of used injecting equipment

10.5 **Stop Smoking**. This service improves access to stop smoking services by establishing a one to one stop smoking service in community pharmacies, with Nicotine Replacement Therapy (NRT) dispensing and stop smoking consultation. The service aims to improve the health of the local population by supporting as many quitters as possible to the four week quit target, especially through the targeting of disadvantaged smokers.

10.6 **Emergency Hormonal Contraception**. This service involves the supply of Levonorgestrel or Ulipristal Acetete emergency hormonal contraception when appropriate to clients in line with the requirements of the Patient Group Direction (PGD). Under 16s must be competent to consent to the treatment. The service constitutes a particularly important component of the total contraceptive and sexual health service provision and is essential in order to support the service already provided by other Contraception and Sexual Health (CaSH) clinics. The service also helps to support the reduction of teenage pregnancy.

11.0 Services Commissioned by South Cheshire CCG and Eastern Cheshire CCG

11.1 **Think Pharmacy Urgent Palliative Care Medicines Service**. This service is commissioned to ensure that residents in Cheshire East have access to a defined list of medicines that should be provided to patients nearing the end of their life. Each pharmacy providing the service receives a retainer payment to hold the palliative care formulary list of medicines in stock in anticipation of receiving prescriptions to dispense at short notice. The medicines can then be provided to the patient to have at their home so that they can be administered if needed for palliative care. Not all of the medicines may be needed by each patient, but all are prescribed to ensure that they are available if the need arises.

11.2 **Think Pharmacy Minor Ailments Service**. The Think Pharmacy Minor Ailments Service aims to support patients to recover quickly and successfully from episodes of ill health that are suitable for management in a Community Pharmacy setting. The service aims to divert patients with specified minor ailments from general practice and urgent care settings into community pharmacies, where the patient can be seen and treated in a single episode of care.

12.0 Community Pharmacy Provision in Cheshire East

12.1 At the end of March 2014 there were 79 community pharmacies, 2 distance selling pharmacies and 7 dispensing general practices on the pharmaceutical list in Cheshire East. There were no dispensing appliance contractors.

Community Dispensing in Cheshire East, March 2014	Community Pharmacies	Distance Selling Pharmacies	Dispensing Appliance Contractors	GP Practices	Of which, Dispensing GP Practices
Congleton LAP	22	2	0	10	3
Crewe LAP	16	0	0	7	0
Knutsford LAP	6	0	0	3	1
Macclesfield LAP	13	0	0	8	0
Nantwich LAP	7	0	0	6	2
Poynton LAP	4	0	0	3	0
Wilmslow LAP	11	0	0	5	1
NHS Eastern Cheshire CCG area	47	1	0	23	3
NHS South Cheshire CCG area	32	1	0	19	4
Cheshire East	**79**	**2**	**0**	**42**	**7**

GP Practices have been allocated to Localities according to their physical position
GP Practices include Bunbury and the Handforth branch surgery as they lie within Cheshire East

12.2 The Central and Eastern Cheshire PCT Pharmaceutical Needs Assessment published in February 2011 identified 93 community pharmacies, of which 70 fell within the Cheshire East Local Authority boundary. The number of pharmacies is now 79, an increase of 9 (13 %). Within this, the number of 100 hour pharmacies has increased by 5, from 6 to 11 (83%). The table below shows the change across the various localities.

Locality	PNA2011		Current		Movement from 2011	
LAP	Community Pharmacies	100 hr	Community Pharmacies	100 hr	Community Pharmacies	100 hr
Congleton LAP	18	1	22	3	4	2
Crewe LAP	15	2	16	3	1	1
Knutsford LAP	5		6	1	1	1
Macclesfield LAP	11	2	13	3	2	1
Nantwich LAP	6	1	7	1	1	0
Poynton LAP	4		4		0	0
Wilmslow LAP	11		11		0	0
Town						
Crewe	14	2	15	3	1	1
Nantwich	6	1	6	1	0	0
Alsager	3	0	3	0	0	0
Congleton	8	1	11	3	3	2
Middlewich	2	0	2	0	0	0
Sandbach	4	0	4	0	0	0
Knutsford	4	0	5	1	1	1
Macclesfield	11	2	13	3	2	1
Poynton	2	0	2	0	0	0
Wilmslow	9	0	9	0	0	0
Eastern Cheshire CCG Rural	6	0	7	0	1	0
South Cheshire CCG Rural	1	0	2	0	1	0
CCG						
NHS Eastern Cheshire CCG	40	3	47	7	7	4
NHS South Cheshire CCG	30	3	32	4	2	1
Cheshire East	70	6	79	11	9	5

12.3 There is a correlation between population size and the number of local community pharmacies. Crewe, Macclesfield, Congleton and Wilmslow have between nine to fifteen pharmacies. Most of the main towns in Cheshire East are served by at least two pharmacies. Several towns and villages have a single community pharmacy, including Alderley Edge, Audlem, Bollington, Disley, Goostrey, Haslington, Holmes Chapel, Mobberley, Prestbury and Shavington.

12.4 In 2013, 94.9% of prescriptions issued in Cheshire East were dispensed by community pharmacies located inside Cheshire East. Another 3.4% were dispensed in the surrounding HWB areas, reflecting close geographical proximity and/or commuter or shopper flows (this proportion was highest for Poynton at 15.1%, Middlewich 6.8%, Wilmslow 6.4%, Knutsford 6.0%, and was under 1% for Macclesfield and Crewe). The main map illustrates where most prescriptions were dispensed in surrounding HWB areas. This includes Altrincham in the Trafford HWB area; Central Manchester in the Manchester HWB; Cheadle Hulme, Hazel Grove and Stockport in the Stockport HWB; Chester, Winsford and Northwich in the Cheshire West and Chester HWB; Biddulph and Kidsgrove in Staffordshire HWB; and Hanley in the Stoke-on-Trent HWB area. A further 1.7% of prescriptions were dispensed by community pharmacies elsewhere in the country or by distance selling pharmacies.

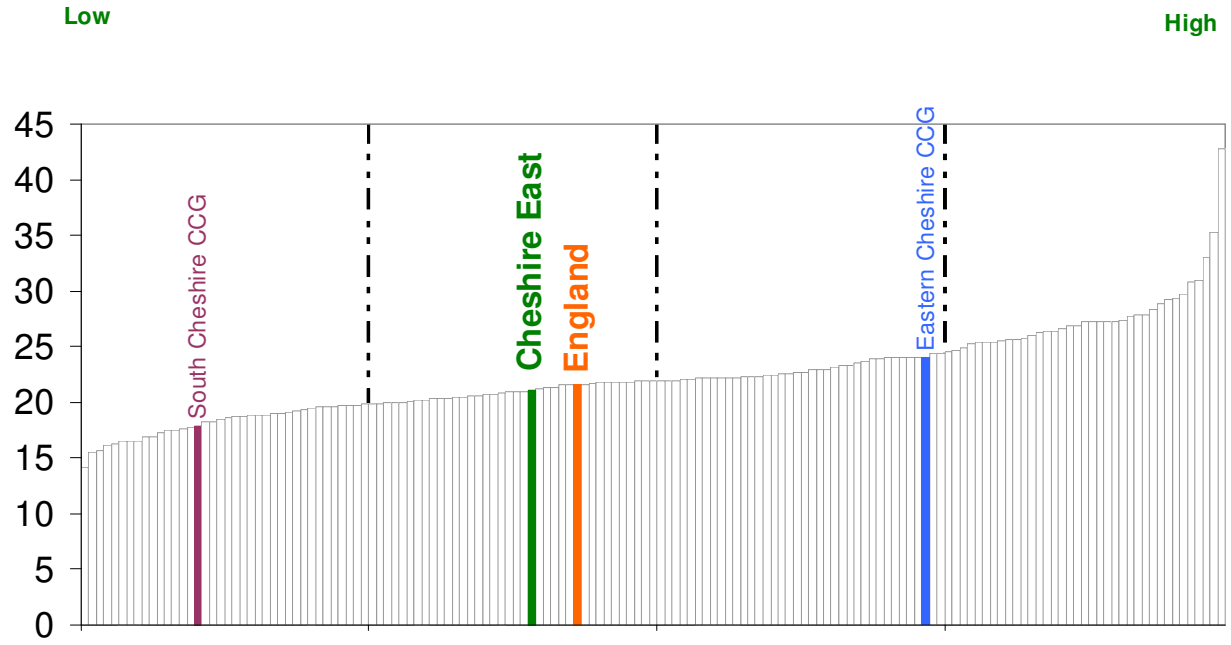
12.5 The majority of prescriptions issued by the general practitioners in each town are dispensed by community pharmacists in that town. The major flows between towns occur as inflows to Crewe and Macclesfield. There is also a significant inflow to Nantwich from prescriptions issued in Crewe.

Flows of Prescription Items from Town of Issuing to Town of Dispensing, 2013

Crewe to Nantwich	37,600
Nantwich to Crewe	27,400
Alsager to Crewe	17,400
Knutsford to Macclesfield	13,900
Poynton to Macclesfield	13,100
Sandbach to Crewe	10,600
Middlewich to Crewe	10,200

12.6 The chart overleaf illustrates the national distribution of the number of community pharmacies per 100,000 population. At 31 March 2013 there were 22 pharmacies per 100,000 in England. Westminster PCT (London) had the most pharmacies per 100,000 with 43 and Herefordshire PCT (West Midlands) the least pharmacies with 14. Cheshire East's rate of 21 per 100,000 was the lowest in the North West, behind Warrington, Bury and Cumbria (all 22 per 100,000) and the North West average of 26 per 100,000. The chart also shows that there are fewer community pharmacies in the NHS South Cheshire CCG area (18 per 100,000) than in the NHS Eastern Cheshire CCG area (24 per 100,000).

PNA Pharmacies per 100,000 population, 2012-13



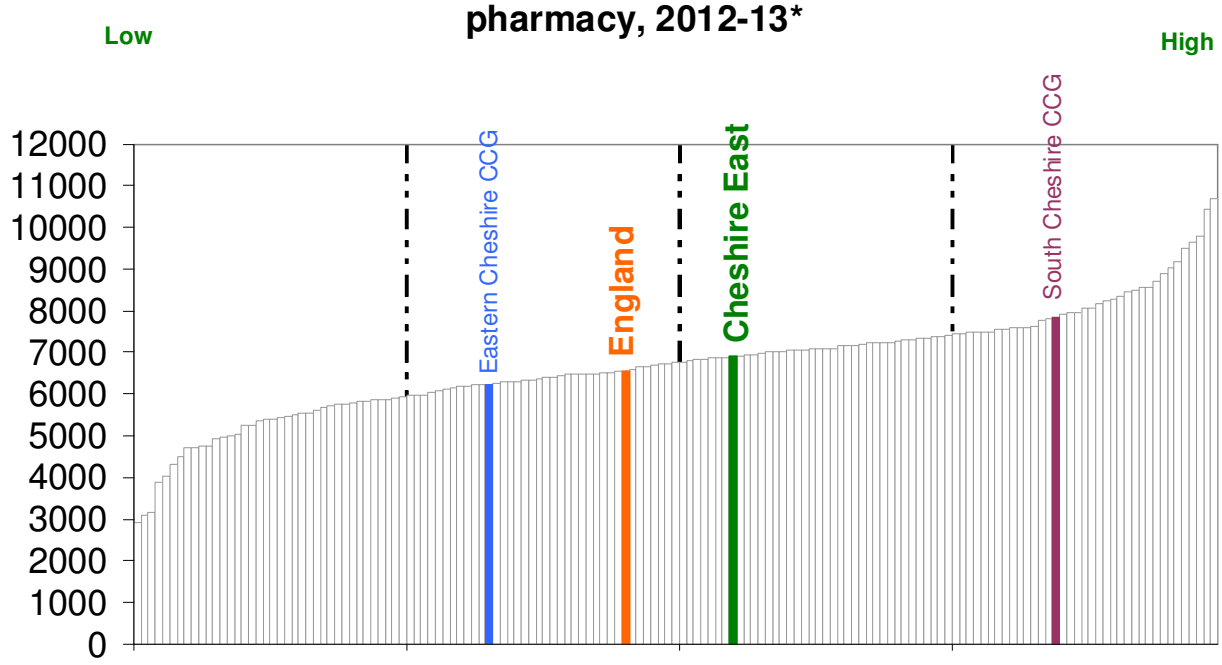
12.7 The table shows the number of community pharmacies per 100,000 population for the seven Local Area Partnership (LAP) areas in Cheshire East. The Wilmslow, Knutsford and Congleton LAPs have more pharmacies per 100,000 than the Cheshire East average, while Poynton, Crewe, Macclesfield and Nantwich LAPs have fewer. The LAP area with the lowest number of community pharmacies per 100,000 is Poynton, although several pharmacies in Cheadle Hulme and Hazel Grove lie just outside the LAP area. Congleton LAP straddles two CCG areas. It contains fewer pharmacies per 100,000 in its South Cheshire CCG portion than in its Eastern Cheshire CCG portion.

Community pharmacies per 100,000 population			
	Community pharmacies	**Population Mid 2011**	**Pharmacies per 100,000 population**
Congleton LAP	22	92090	24
Crewe LAP	16	85836	19
Knutsford LAP	6	25056	24
Macclesfield LAP	13	69585	19
Nantwich LAP	7	36057	19
Poynton LAP	4	23804	17
Wilmslow LAP	11	38308	29
NHS Eastern Cheshire CCG	47	194793	24
NHS South Cheshire CCG	32	175943	18
Cheshire East	**79**	**370736**	**21**

12.8 In 2012-13, the average number of prescription items dispensed per pharmacy in Central and Eastern Cheshire PCT was 7,293 per month, higher than the North West of 6,807 and England 6,628 per month. Central and Eastern Cheshire PCT had the sixth highest rate in the North West. Westminster PCT (London SHA) had the lowest average number of items per pharmacy per month (2,927). North Tyneside PCT (North East SHA) had the highest average

number of items per pharmacy per month (10,691). In 2013, community pharmacies in the South Cheshire CCG area dispensed over 1,000 items more per month than those in the Eastern Cheshire CCG area, which is consistent with having fewer pharmacies per 100,000 population.

PNA Average prescription items dispensed per month per pharmacy, 2012-13*

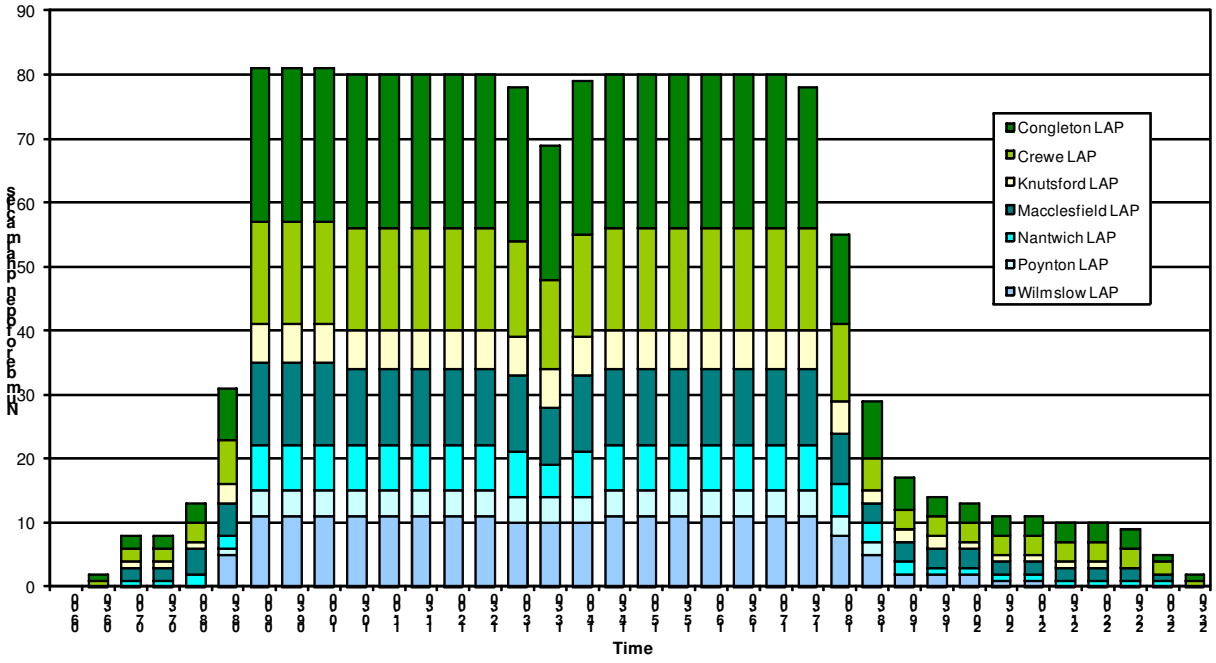


*CCG & Cheshire East figures calculated from Jan-Dec 2013 Calendar Year data

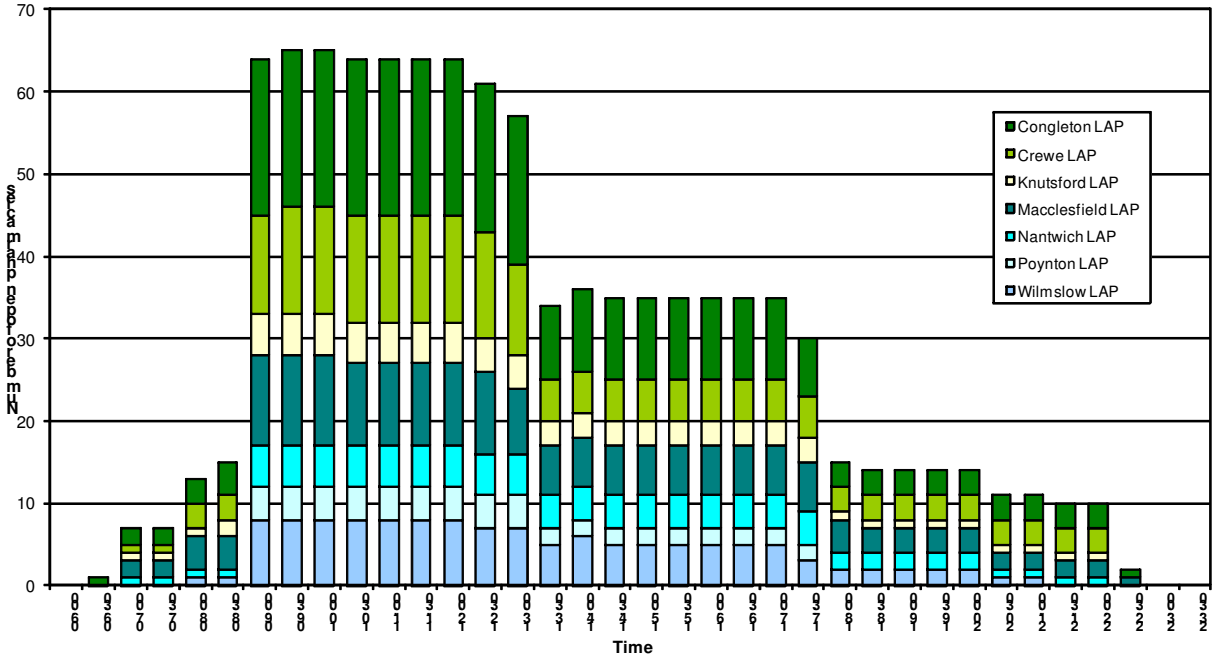
13.0 Community Pharmacy Opening Hours

13.1 Extended opening hours are a beneficial feature of pharmacy provision locally, and there is weekday access to community pharmacies from 6.30 in the morning and throughout the day up to midnight. There is some geographical difference in access on Sundays, with no community pharmacies open after 5.30pm in the South Cheshire CCG area.

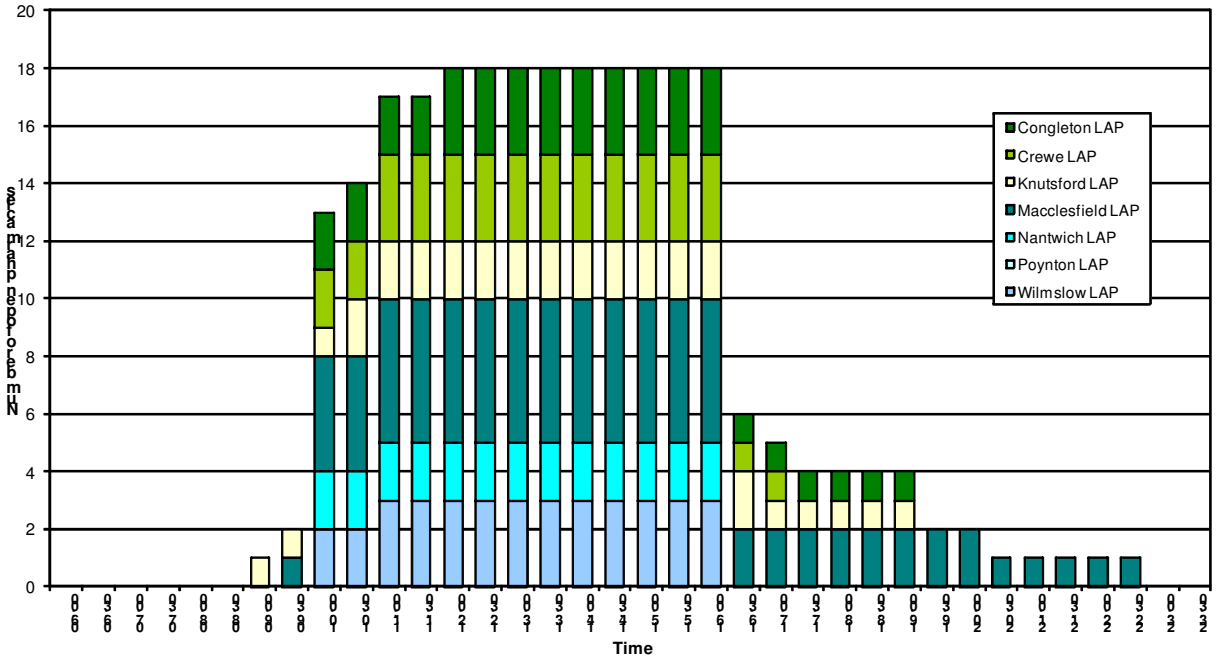
Pharmacy Open Hours by Area Partnership Areas - Weekday



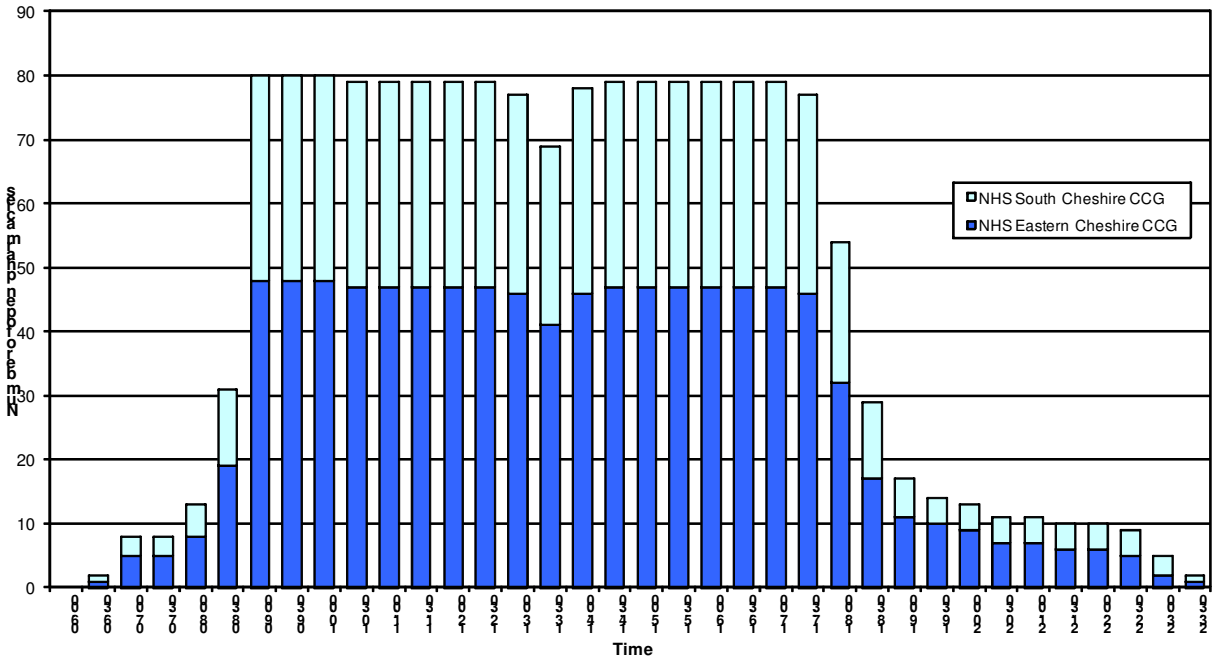
Pharmacy Open Hours by Area Partnership Areas - Saturday



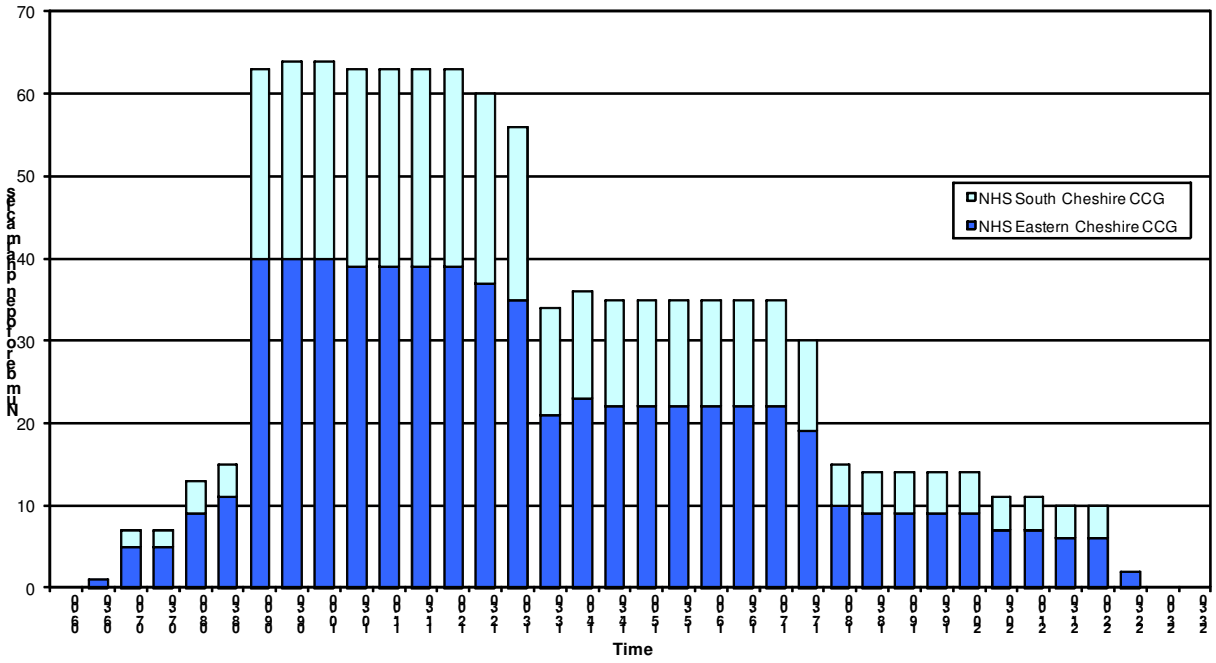
Pharmacy Open Hours by Area Partnership Areas - Sunday



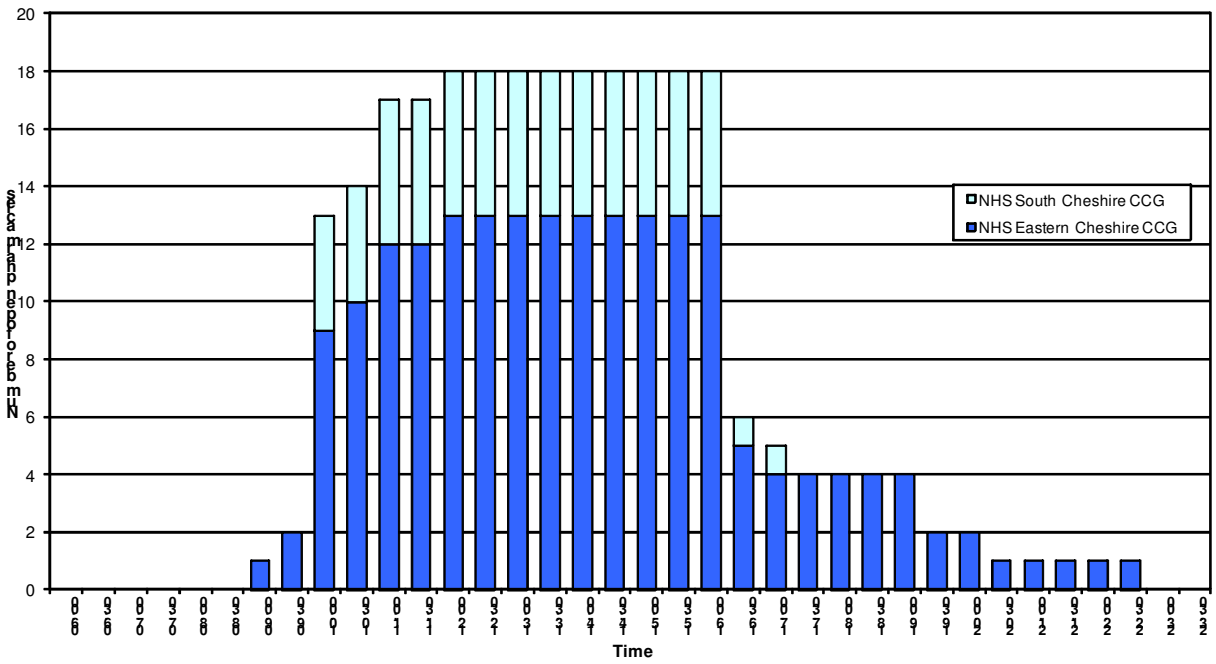
Pharmacy Open Hours by Clinical Commissioning Groups - Weekday



Pharmacy Open Hours by Clinical Commissioning Groups - Saturday



Pharmacy Open Hours by Clinical Commissioning Groups - Sunday



14.0 Prescription Items and Prescription Costs

14.1 Prescriptions written by General Medical Practitioners (GPs) and non-medical prescribers (nurses, pharmacists, dentists) comprise the vast majority of prescriptions dispensed in the community. In England in 2011, 98.3 per cent of prescriptions were written by GPs and 1.7 per cent by nurses and other non-medical prescribers.

14.2 A prescription item refers to a single item prescribed by a doctor or non-medical prescriber on a prescription form. If a prescription form includes three medicines, these are counted as three prescription items. The Net Ingredient Cost (NIC) of each medicine refers to the cost of each drug before discounts and does not include any dispensing costs or fees. Within this PNA the terms 'prescribing' and 'dispensing' are used interchangeably to mean 'the number of items' dispensed. The term 'cost' refers to 'net ingredient cost'.

14.3 In relation to the prescribing of items in Cheshire East in 2013:

- 7.39 million items were dispensed overall. The average number of items per head of the population in 2013 was 19.64, compared to 18.3 per head in England in 2011
- The total cost of prescriptions dispensed was £55.4 million. The average cost per head of the population was £147.16, compared to £167.22 per head in England in 2011. The average cost per item was £7.49, compared to £9.16 in England in 2011

14.4 Prescriptions are subject to a prescription charge but many people are eligible for free prescriptions. The groups that are eligible for free prescriptions are:

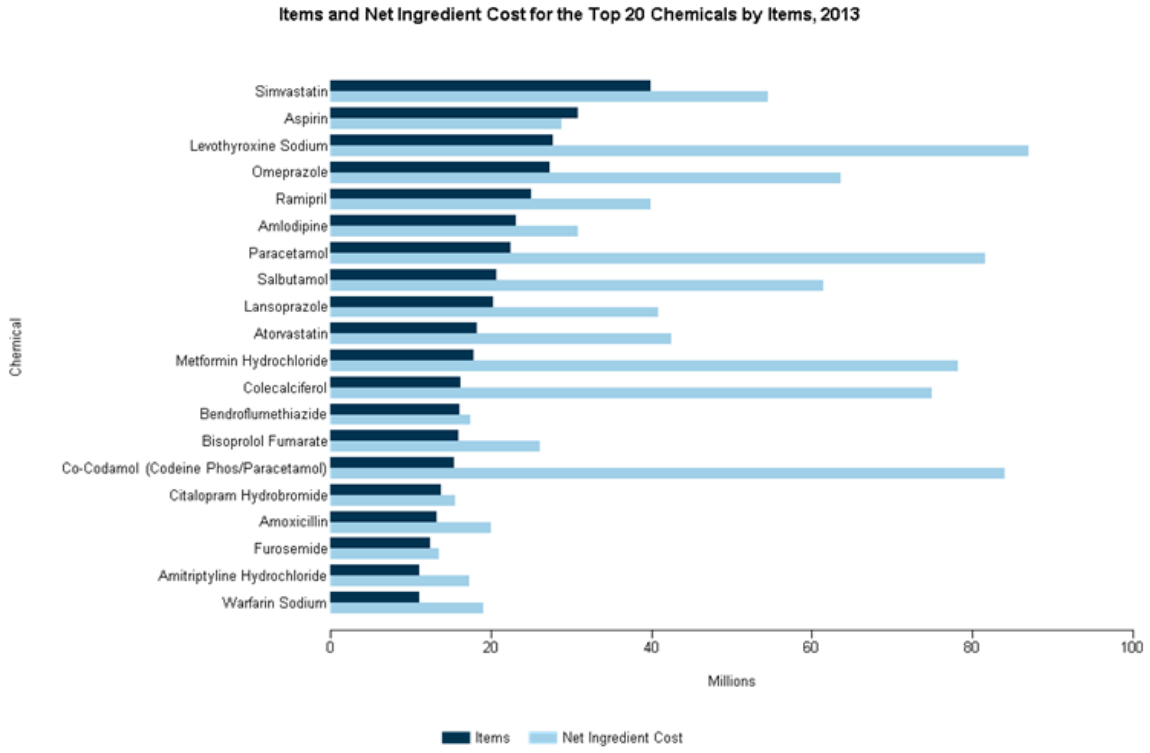
- where the patient holds a valid prescription pre-payment certificate
- men and women aged 60 and over
- children under age 16, and young people aged 16, 17 and 18 in full time education
- exemption certificate holders, these are: pregnant women, women who have given birth in the previous 12 months, and people with specified medical conditions
- war pensioners, but only in respect of prescriptions for their accepted disablement and an exemption certificate is held
- patients undergoing treatment for cancer
- NHS Low Income Scheme in respect of means tested entitlement
- all prescribed contraceptives are free and do not attract a prescription charge
- personally administered items

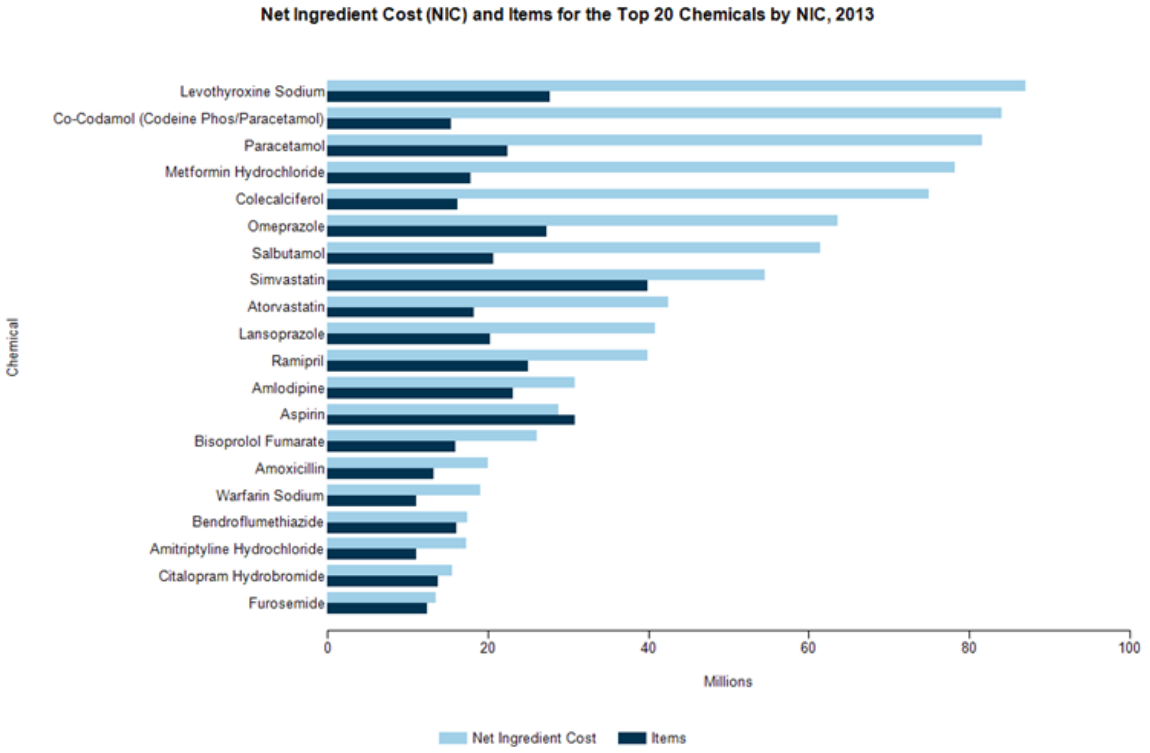
14.5 The majority of items are exempt from the prescription charge on the grounds of patients being aged 60 and over. In England, 94.6 per cent of prescription items were free in 2011, although this figure includes prescriptions purchased with pre-payment certificates.

15.0 The Top 20 Drugs used in Cheshire East, by Number of Items and Cost

15.1 Total community dispensing in Cheshire East covers all prescriptions dispensed by community pharmacies, appliance contractors and dispensing doctors, as well as prescriptions for items personally administered in general practices. This section of the PNA includes prescriptions dispensed by community pharmacies. It does not include prescriptions dispensed by distance selling pharmacies, or items personally administered in general practices, or dispensing by general practices that are registered as dispensing practices.

15.2 These charts illustrate the top 20 most commonly used drugs in 2013, in term of the number of prescribed items and the costs of the most expensive drugs.





16.0 Population Demography

16.1 From a base of 376,400 people in 2014, the population of Cheshire East is projected to grow by 10,500 (2.8%) over the next five years (to 386,900 people in 2019) and by a further 10,500 (2.8%) over the following five years (397,400 people in 2024). The majority of this growth will take place in the Crewe LAP (10.2%) and the Congleton LAP (6.9%). There will be relatively little population growth in the Knutsford LAP (1.8%), and a net fall in population is projected for the Poynton LAP (-1.2%).

16.2 People's need for prescribed medicines increase with age. Although Cheshire East is only growing moderately in terms of the overall number of people in the population, the population is living longer and there will be a proportionately higher growth in the number of people in age groups over 65. Based on Item ASTRO-PU 2013 weighted populations there will be an 8.6% growth in medicines use by 2019 and a further 9.9% increase by 2024, a total increase in medicines use of 18.5% over the next ten years. This growth in prescribing will occur in all areas but will be highest in the Congleton LAP (22.1%), Nantwich LAP (19.4%) and Crewe LAP (18.5%), and lowest in the Knutsford LAP (16.1%), Poynton LAP (16.1%) and Wilmslow LAP (14.4%).

16.3 About 8% of the population of Cheshire East live in Lower Level Super Output Areas (LSOAs) that are among the 20% most deprived areas in England. Eleven of these LSOAs are in Crewe, two are in Macclesfield, two in Handforth and one in Congleton. The Annual Report of the Director of Public Health 2012-2013 found that these areas experienced higher rates of premature mortality from cancer, heart disease, stroke, lung disease and liver disease. People living in these areas will have higher levels of pharmaceutical need than in other areas.

16.4 According to the 2011 Census, 93.6% of the population of Cheshire East gave their ethnicity as 'White British'. Wilmslow LAP has the most ethnically diverse population, with 11% 'Non-White British' – 3.9% are Asian and 3.4% 'Other White'. Crewe LAP has the highest percentage classing themselves as 'Other White' (5.4%) – presumably Polish or East European.

17.0 Factors Affecting Future Prescribing

17.1 Factors which may influence the future growth in prescribing, and so the need for pharmaceutical services, include:

- the size of the population
- the age structure of the population, notably the proportion of the elderly, who generally receive more prescriptions than the young
- improvements in diagnosis, leading to earlier recognition of conditions and earlier treatment with medicines
- development of new medicines for conditions with limited treatment options
- development of more medicines to treat common conditions
- increased prevalence of some long term conditions, for example, diabetes
- shifts in prescribing practice in response to national policy, and new guidance and evidence, for example, in cardiovascular disease

18.0 The Six Statements required by Legislation

18.1 A statement of the pharmaceutical services that the HWB has identified as services that are provided:
(a) in the area of the HWB and which are necessary to meet the need for pharmaceutical services in its area; and
(b) outside the area of the HWB but which nevertheless contribute towards meeting the need for pharmaceutical services in its area (if the HWB has identified such services).

18.1.1 Provisional Statement: There is currently an adequate level of community pharmacy provision in every major town in the Borough, although the level of provision is lower in the South Cheshire CCG area than in the Eastern Cheshire CCG area. The maps show that this provision is mostly located either in the town centres or close to GP surgeries. As pharmaceutical need is predicted to increase to a greater extent in South Cheshire than in Eastern Cheshire, additional community pharmacy provision is likely to be needed in the South Cheshire CCG area during the coming years. Additional pharmacies should where possible serve the needs of rural areas and/or the peripheral areas of towns, and should take into account the needs of people who will move into the new housing developments that are identified in the Cheshire East Local Plan.

18.2 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-
(a) need to be provided (whether or not they are located in the area of the HWB) in order to meet a current need for pharmaceutical services, or pharmaceutical services of a specified type, in its area;
(b) will, in specified future circumstances, need to be provided (whether or not they are located in the area of the HWB) in order to meet a future need for pharmaceutical services, or pharmaceutical services of a specified type, in its area.

18.2.1 Provisional Statement:

The prescribing of medicines is predicted to grow by 8.6% by 2019 and then a further 9.9% increase by 2024, a total increase in medicines use of 18.5% over the next ten years. Existing pharmacies will either have to increase their capacity to meet this need, or additional pharmacies will be required. Extended opening hours are a beneficial feature of pharmacy provision locally, and there is weekday access to community pharmacies from 6.30 in the morning and throughout the day up to midnight. There is some geographical difference in access on Sundays, with no community pharmacies open after 5.30pm in the South Cheshire CCG area. There are seven dispensing practices in Cheshire East. Some of these dispensing practices cover very rural areas where the population may experience difficulty in accessing the wider range of essential and advanced services that community pharmacies can provide.

The town of Crewe has the greatest level of deprivation in the Borough and also has the highest levels of disease prevalence and premature mortality. The needs of the population of Crewe are described in the Annual Report of the Director of Public Health 2012-2013 and in the Cheshire East JSNA. Crewe would benefit from having a greater level of outreach provision of community pharmacy services by the current pharmacy services.

18.3 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are provided-
(a) in the area of the HWB and which, although they are not necessary to meet the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access to pharmaceutical services in its area;
(b) outside the area of the HWB and which, although they do not contribute towards meeting the need for pharmaceutical services in its area, nevertheless have secured improvements, or better access, to pharmaceutical services in its area;
(c) in or outside the area of the HWB and, whilst not being services of the types described in sub-paragraph (a) or (b), or paragraph 1, they nevertheless affect the assessment by the HWB of the need for pharmaceutical services in its area.

18.3.1 Provisional Statement:

18.4 A statement of the pharmaceutical services that the HWB has identified (if it has) as services that are not provided in the area of the HWB but which the HWB is satisfied-
(a) would, if they were provided (whether or not they were located in the area of the HWB), secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type, in its area,
(b) would, if in specified future circumstances they were provided (whether or not they were located in the area of the HWB), secure future improvements, or better access, to pharmaceutical services, or pharmaceutical services or a specified type, in its area.

18.4.1 Provisional Statement:

The Annual Report of the Director of Public Health 2012-2013 has highlighted the high numbers of people in the Borough who have undiagnosed risk factors for cardiovascular disease. There are believed to be 35,300 residents with undiagnosed high blood pressure, 20,300 with undiagnosed kidney disease, and over 3,300 with undiagnosed diabetes. There is a need to identify people with these risk factors using a wide range of community settings, which will include community pharmacies. New approaches to case-finding will need to be considered.

18.5 A statement of any NHS services provided or arranged by the HWB, NHS CB, a CCG, an NHS trust or an NHS foundation trust to which the HWB has had regard in its assessment, which affect-
(a) the need for pharmaceutical services, or pharmaceutical services of a specified type, in its area; or
(b) whether further provision of pharmaceutical services in its area would secure improvements, or better access to pharmaceutical services, or pharmaceutical services of a specific type in its area.

18.5.1 Provisional Statement:

18.6 An explanation of how the assessment has been carried out, in particular –
(a) how it has determined what are the localities in its area;
(b) how it has taken into account (where applicable)-
(i) the different needs of different localities in its area, and
(ii) the different needs of people in its area who share a protected characteristic; and
(c) a report on the consultation that it has undertaken.

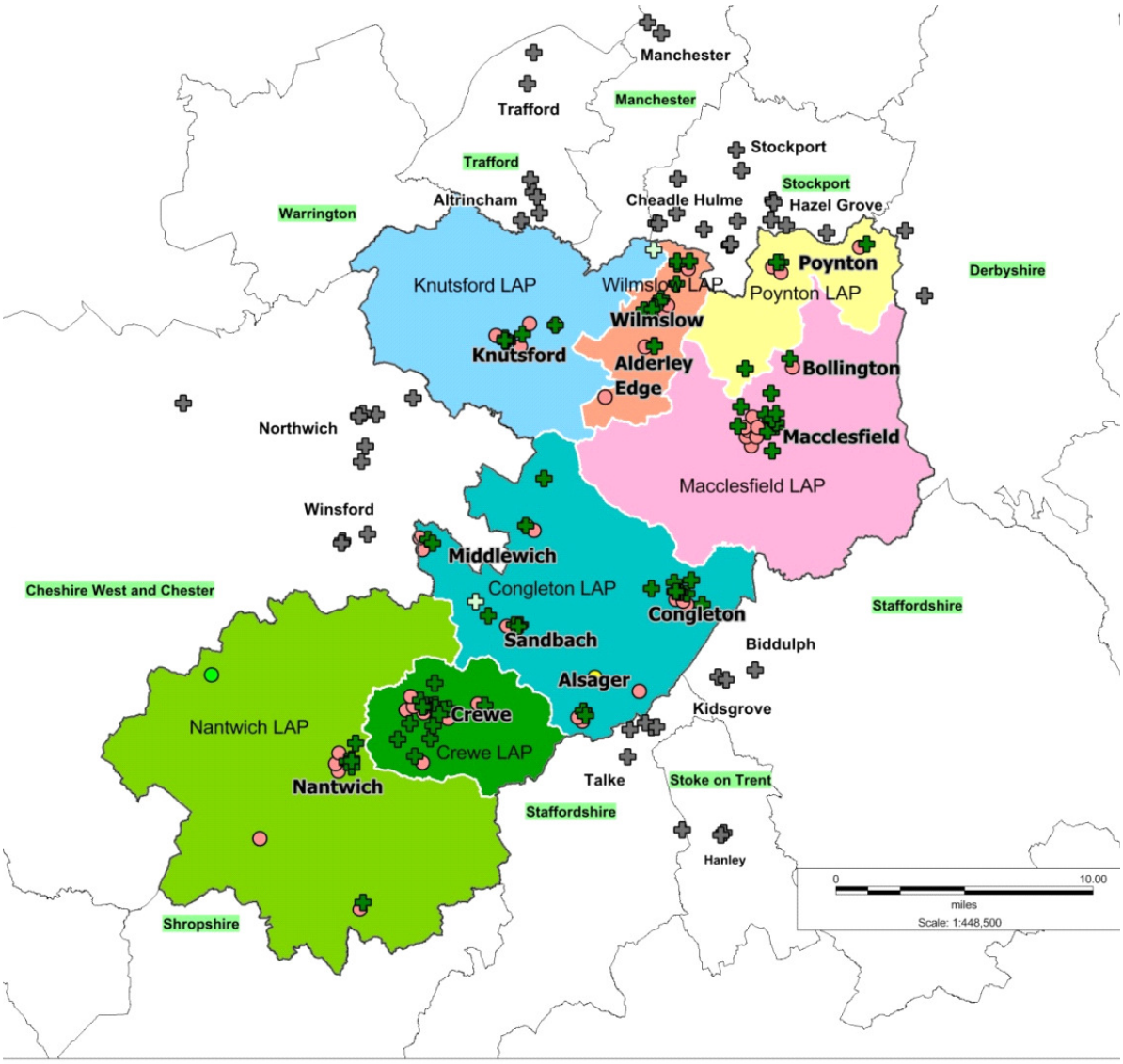
18.6.1 Provisional Statement:

Most of the analyses in this Pharmaceutical Needs Assessment have been based on the geography of Cheshire East's Local Area Partnerships. The advantage of using this geography is that it combines major towns with their surrounding rural populations, and so better fits general practice and community pharmacy patient flows. Another advantage of the LAP geography is that population projections have been prepared by the Local Authority. The key disadvantage is that one of the LAP areas (Congleton LAP) is particularly large and has internal variations. Congleton LAP contains five distinct towns and straddles both of the local Clinical Commissioning Groups.

Town groupings based on Middle Level Super Output Areas (MSOAs) have also been used in the Pharmaceutical Needs Assessment. These town groupings are better than LAPs for illustrating variations between communities. They also relate to the geography used in the JSNA.

NHS Eastern Cheshire CCG covers 52.5% of the population of Cheshire East and NHS South Cheshire CCG covers 47.5% (as per mid-2012 estimates). There are two general practices within the Borough that are aligned to CCGs in neighbouring HWB areas. Bunbury Medical Centre links to NHS Western Cheshire CCG but geographically sits within Cheshire East. In Handforth there is a branch surgery of Cheadle Hulme Health Centre which links to Stockport CCG.

19.0 Paragraph 7 of Schedule 1 of the 2013 Regulations specifies that HWBs are required to include a map in their PNA identifying the premises at which pharmaceutical services are provided in the area of the HWB.



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KEY

- Community pharmacy
- Distance selling pharmacy
- Community pharmacy in neighbouring HWB dispensing >500 items per annum to Cheshire East residents
- Cheshire East GP practice
- Cheshire East dispensing practice
- Non- Cheshire East GP practice

Appendix F Glossary of terms and phrases defined in regulation 2 of the 2013 Regulations

Term or phrase	Definition as per regulation 2 of the 2012 Regulations	Explanation
Controlled localities/controlled locality	Means an area that is a controlled locality by virtue of regulation 36(1) or is determined to be so in accordance with regulation 36(2).	A controlled locality is an area which has been determined, either by NHS England, a primary care trust a predecessor organisation or on appeal by the NHS Litigation Authority (whose appeal unit handles appeals for pharmaceutical market entry and performance sanctions matters), to be "rural in character". It should be noted that areas that have not been formally determined as rural in character and therefore controlled localities, are not controlled localities unless and until NHS England determines them to be. Such areas may be considered as rural because they consist of open fields with few houses but they are not a controlled locality until they have been subject to a formal determination.
Core opening hours	Is to be construed, as the context requires, in accordance with paragraph 23(2) of Schedule 4 or paragraph 13(2) of Schedule 5, or both.	Pharmacies are required to be open for 40 hours per week, unless they were approved under Regulation 13(1)(b) of the 2005 Regulations in which case they are required to open for 100 hours per week. Dispensing appliance contractors (DACs) are required to be open for not less than 30 hours per week.
Directed services	Means additional pharmaceutical services provided in accordance with directions under section 127 of the 2006 Act.	These are advanced and enhanced services as set out in Directions.
Dispensing doctor(s)	Is to be construed in accordance with regulation 46(1).	These are providers of primary medical services who provide pharmaceutical services from medical practice premises in the area of NHS England; and general practitioners who are not providers of primary medical services but who provide pharmaceutical services from medical practice premises in the area of the HWB.
Distance selling premises	Listed chemist premises, or potential pharmacy premises, at which essential services are or are to be provided but the means of providing those services are such that all persons receiving those services do so otherwise than at those premises.	These premises could have been approved under the 2005 Regulations in which case they could be pharmacies or DACs. Under the 2012 and 2013 Regulations only pharmacy contractors may apply to provide services from distance selling premises. Distance-selling contractors are in the main internet and some mail-order, but they all cannot provide "essential services" to persons face to face at their premises and must provide a service across England to anyone who requests it.
Enhanced services	Means the additional pharmaceutical services that are referred to in direction 4 of the Pharmaceutical Services (Advanced and Enhanced Services) (England) Directions 2013.	These are pharmaceutical services commissioned by NHS England, such as services to Care Homes, language access and patient group directions.
Essential services	Except in the context of the definition of "distance selling	These are services which every community pharmacy providing NHS pharmaceutical services must provide

	premises", is to be construed in accordance with paragraph 3 of Schedule 4.	and is set out in their terms of service – these include the dispensing of medicines, promotion of healthy styles and support for self-care. Distance-selling pharmacy contractors cannot provide essential services face to face at their premises.
Neighbouring HWB	In relation to a HWB (HWB1), means the HWB of an area that borders any part of HWB1.	Used when, for example, an HWB is consulting on their draft PNA and needs to inform the HWBs which border their HWB area.
NHS chemist	Means an NHS appliance contractor or an NHS pharmacist.	

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CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	29th May 2014
Report of:	Diane Eden
Subject/Title:	Connecting Care - A Transformational Approach to the Integration of Health and Social Care in Central Cheshire 2014 -2019

1.0 Report Summary

1.1 This paper is seeking support regarding the developing Central Cheshire Connecting Care 5 year Strategy across Health and Social Care (see Appendix One).

2.0 Recommendation

The Board is asked to:

2.1 Review and provide feedback on the draft 5 year Central Cheshire Connecting Care Strategy.

2.2 To support the direction of travel and key themes outlined within the document.

2.3 To note that the Central Cheshire Connecting Care Board will approve the submission to NHS England on 20 June 2014.

2.4 Agree to proceed with further key stakeholder engagement and involvement to shape this initial draft into a final strategy.

3.0 Reasons for Recommendations

3.1 To support the Central Cheshire Connecting Care Board's submission to NHS England of their Five Year Strategy

4.0 Background

In January, the Central Cheshire Connecting Care Board established the Strategy Task and Finish Group to develop the Connecting Care Strategy incorporating the Pioneer Integration Programme. The group comprises representatives from each of the 8 partner organisations:

- Cheshire West and Chester Council
- Cheshire East Council
- NHS South Cheshire Clinical Commissioning Group
- NHS Vale Royal Clinical Commissioning Group
- Mid Cheshire Hospitals NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust

- East Cheshire NHS Trust
- NHS England.

4.1 The outline framework produced by the group was presented to and agreed by the Connecting Care Board in February and an early draft was subsequently presented to the Connecting Care Board again in March. This early draft was 'sense checked' be NHS England on 9 May and feedback was received with suggested areas for further development.

4.2 This paper represents the current working draft of the Central Cheshire Connecting Care 5 year strategy and the group will continue to work on the strategy on behalf of the Central Cheshire Connecting Care Board through an iterative process of engagement, consultation and involvement across our key stakeholders.

4.3 The Connecting Care Board Strategy Task and Finish Group have resolved to ensure that individual partner boards and key stakeholders are offered the opportunity to shape this draft prior to the agreed draft for submission to NHS England and following this to reach agreement of the final document.

4.4 The draft Connecting Care strategy provides details of the following:

- Our vision and ambition
- The national and local context for the Connecting Care programme
- Our challenges and our opportunities in Central Cheshire
- Our approach to integration and transformation
- An outline of current progress
- An outline of the overall programme and its composite elements
- A description of our integrated health and social care model and its intended impact
- Our 6 key health and social care integration outcomes framework/foundation stones
- Our aspirations for transformation, our approach and measures of success
- Our plans to achieving a sustainable care system for the future.

4.5 In line with NHS England requirements, an agreed strategy must be submitted on 20 June 2014. It is expected that further local refinement and engagement will continue beyond this date.

5.0 Access to Information

5.1 This report was produced by Diane Eden, Programme Director for Connecting Care, All Cheshire partner organisations in collaboration with the members of the Strategy Task and Finish Group

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A Transformational Approach to the Integration of Health and Social Care in Central Cheshire 2014-2019

Version 1.3
13 May 2014

Document Control

Title	A Strategy for Connecting Care in Central Cheshire 2014 - 19
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Contributors	Connecting Care Board members
Owner(s)	Central Cheshire Connecting Care Board
File Ref	CC Strategy May 2014

Approver	**Role**
Connecting Care Board members	Multi-stakeholder consensus
Health & Wellbeing Board	Multi-stakeholder consensus
All partner organisations respective boards	Multi-stakeholder consensus

Change History			
Version	**Date**	**Author/Editor**	**Summary of Change**
1.1	26 Mar 2014	D Eden	Incorporation of feedback comments from Connecting Care Board on duplicated areas and gaps
1.2	9 May 2014	D Eden	Feedback from strategy group, stakeholders and NHSE peer review event and reworking of document

Foreword

To be completed.

- *Seeking a public rep/community leader to write the foreword*
- *To include a description of what integrated care will look like and feel like for a service user or member of the care team e.g. where, by whom, how is it accessed etc.*
- *Include messages from the 'you said, we did' work*

Contents

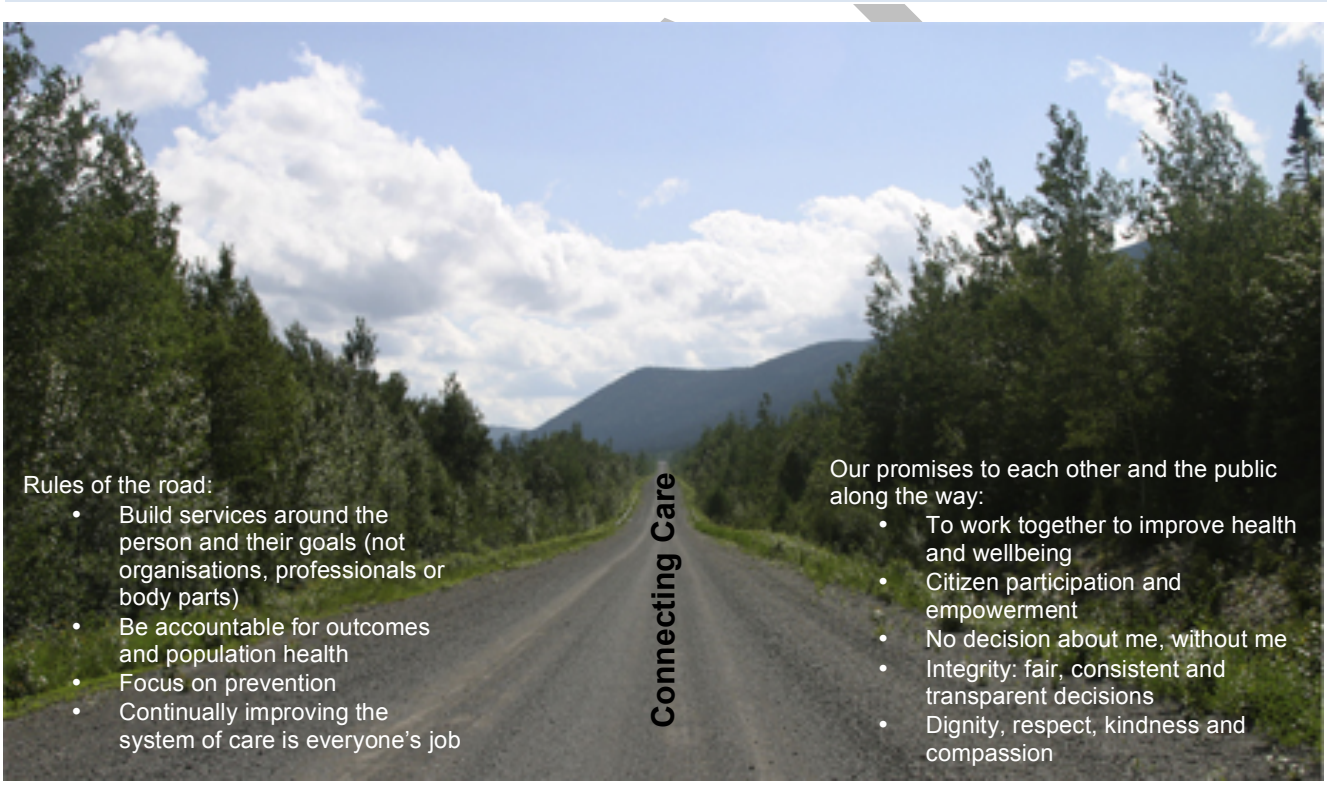
Vision

'Connecting Care in communities to ensure good quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'

Our citizens boast: **'I can plan my care with people who work together to understand me, and my carers, allow me control and bring together services to achieve the outcomes important to me'**

Communities that promote & support healthier living	An empowered and engaged public and workforce leading the way	Personalised care that supports self-care, self-management, independence & enhanced quality of life	People have positive experiences of high quality, safe care, delivered with kindness and compassion	Strengthening our assets – Carers are supported	All the 'care' pounds are spent wisely

OUR DESTINATION



Our Transformational Journey

1. Our vision and ambition

Our 5 year strategic vision is that we will consistently and for all be:

'Connecting Care in communities to ensure good quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'.

In 5 years, the Central Cheshire health and social care system will:

- Centre all care around the individual, their goals, communities and carers
    - Have shared decision-making and supported self-management as integral components to care in all settings
- Focus its attention on prevention, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities and the wider causes of ill-health and need for social care support e.g. poverty, isolation
- Have a strong clinically led primary care and community care infrastructure offering an comprehensive network of extended practice/neighbourhood and integrated care teams delivering modern models of integrated care at scale
- Be delivering fully integrated and co-ordinated care, 7 days a week, close to home for populations of 20-40,000 with a focus on the frail elderly and those with complex care needs
- Provide care that is rated by our citizens as being the best in terms of quality, outcomes and experience.

Supported by:

- Service redesign across the care system – co-produced by our public and our workforce
- Shared information systems across health and social care so that people will only ever have to tell their 'story' once
- New contracting approaches that facilitate costs being moved from the acute sector to the community and that promote collaborations across multiple providers e.g. Alliance contract/Innovation Fund, GP federations
- Joint commissioning utilising the Better Care Fund and other approaches
- A range of new roles to support models of care across traditional providers of care/support in the public, private and voluntary sector e.g. community geriatricians
- Have a robust continuous quality improvement programme in the form of a 'Cheshire Learning and Improvement Academy' (CLIA).

To achieve:

- Accountability for care to the public
- High quality, safe care and a robust system of continuous improvement
- Improved physical/mental health, wellbeing & independence of our citizens, those with chronic disease & those with long term/complex social care needs
- A sustainable and financially stable care system
- Ensure that people receive care in the most appropriate setting with a reported reduction of a fifth in avoidable hospital, care home admissions, delayed transfer of care in 2019 compared to 2014

This will be delivered through a large-scale 5-year transformation programme entitled **Connecting Care,** which is described in outline below and in detail in chapters 5-8**.**

The Connecting Care Programme

The Connecting Care Programme is based on international evidence of integrated care. The Connecting Care Board is leading the programme, with oversight from our two Health and Wellbeing Boards.

We are wholly committed to delivering the National Voices narrative below for all of our citizens requiring care and support:

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

National Voices & Making it Real 2013

The Programme comprises the following:

- A 'care system' plan co-produced and delivered by all partner organisations that is focused on prevention, early help and maximising health and wellbeing, informed by local people and delivered in partnership
- Large scale change and systems thinking methodology to drive the transformation programme that will lead to people thinking and behaving differently e.g. NHS Change Model
- Formal programme management infrastructure which is resourced with the money, talent, capability and capacity to deliver at pace and scale
- Working much more closely together and in smarter ways to have in place reliably and without error all the care that will help people and only the care that will help
- Building, strengthening and expanding primary and community based services, support and information around individuals and their needs, their carers and communities
    - Build teams that work to individuals goals but are accountable to populations and accountable for population outcomes (accountable care teams)
- Co-production and transformation of primary care with NHS England
- Developing our workforce, our citizens and our local communities capability and capacity to maximise opportunities for our populations health and wellbeing
    - to identify and deliver new ways of working in a cycle of continuous improvement that is developed in partnership with our staff & public
- Transforming and innovating primary care, urgent care, planned care, specialist care and achieving parity of esteem in mental and physical health care
- An overarching framework of 6 key integration outcomes to which progress will be measured:

The Central Cheshire health and social care integration outcomes framework:

1. Communities that promote and support healthier living
2. An empowered and engaged public and workforce leading the way
3. Personalised care that supports self-care, self-management, independence and enhances quality of life
4. People have positive experiences of high quality, safe services delivered with kindness and compassion
5. Strengthening our assets - Carers are supported
6. Al the 'care' pounds are spent wisely.

These integration outcomes have been created to provide a single framework for integration and transformation, which aligns directly to the existing health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

There are formal programme governance arrangements in place to lead the work and oversee the delivery and progress against these outcomes. Please see **Appendix 1.**

All our future plans, proposed initiatives and redesign work will need to be contribute to delivery of these outcomes if they are to be approved.

The development and execution of this strategy is a work in progress. Some of our objectives and plans require more detailed work and clarification and in breaking new ground we will test out new ways of working and share learning along the way.

Our purpose in publishing this document is to generate debate and elicit feedback in an effort to ensure that our approach is informed by the best ideas available.

2. The national and local context for Connecting Care

The Health and Care system in the UK is recognised internationally as a 'jewel' and as a high performing system particularly in relation to spend per head of population and quality of care. We have a first class primary care service with near universal and fast access to General Practice, a free at the point of access healthcare system and a wide range of care support systems for the most vulnerable in our communities.

We have and continue to make significant advances in the prevention of ill-health, reducing inequalities, ensuring high quality care, shorter waiting times for advice, information, treatment and support, maintaining independent living and increasing life expectancy.

However, worldwide care systems face the twin challenges of rising demand as a consequence of people living longer, increasing number of system interventions and the rising cost of paying for their care. Although, longevity is worthy of celebration, as our population ages, there is a related increase in the number of people living alone, living with multiple health conditions and increasing complexity of care needs.

There is therefore both an increase in need and a change in the nature of need. Our present care systems were originally designed to deal with episodic problems, with the assumption that modern care would solve problems and cure. This remains true for many but there is now increasing need to deal with on-going problems and to help people who need support in addressing personal goals that relate to a mix of social, physical and mental health. We have to learn to better address the need to help when there is no cure and to address all social, physical and psychological needs together. If we do not learn, we will be unable to deliver wellbeing and care costs will increase as people seek further care when their needs are not met.

With such changing need, the definition of health has been challenged (Huber et al 2011) and new definitions have been suggested. New definitions describe health in terms of the ability to cope with social, physical and psychological challenge and the ability to adapt and to self-manage. These definitions are more dynamic in nature and may have more meaning and usefulness for those with increasing frailty or living with disability.

Changing need, together with the current financial challenge and significant failures within the care system, has and continues to force a fundamental rethink of how health and social care should be organised in future. The Francis and Winterbourne reports, amongst others have exposed significant variances in quality within our current system and provide a steer to us on how we need to change our existing system.

There are long-standing fault lines in the current provision of care that result from historic divisions between budgets, between the major groups of healthcare providers and between health and local authority funders of care. Care is often fragmented and poor co-ordination can be a recurrent problem, resulting in frustration for the individual receiving care but also in delays, duplication, higher costs, waste, sub-optimal care and avoidable ill health.

Many people accessing care feel that they must 'slot into a number of services' rather than the service being tailored to their own needs and situation. Current policy to address this is to provide 'integrated care' in a 'personalised' way, wrapping care around those who need it, provided by teams who work effectively together to improve outcomes.

The premise of personalised, integrated care is that it will not only help to improve the co-ordination of care for a person and therefore prevent avoidable ill health, but also that it will result in greater value for money. The current climate embodies a strong commitment from all our partners across health, social care and the voluntary sector to radically reshaping how we care for our citizens.

In reality, our care systems have seen little fundamental change of organisation and delivery since their inception decades ago. The existing system, in the main, is designed to respond reactively to urgent care need and ill health but we need a system with pro-active approaches to support our aspirations for wellbeing and sustainability.

The focus of recent years has been on moving care closer to people's own homes, making care more personalised and supporting people to live independently for longer. However, it is now apparent that the scale of achievement has fallen short of the ambition and we can no longer afford the current rising demand for care.

By integrating care across health and social care, we aim to improve the physical and mental health and wellbeing of people living in our communities, to prevent ill health wherever possible, to continually drive up standards of care and to improve the care experience. By working together across disciplines, teams, care settings and organisations, we believe that we can drive out current inefficiencies across our fragmented systems and achieve our aims within our existing resources.

A National Integration Pioneer site

In the UK, the need to encourage integrated care is central to current government policy and system reform. As a result, a shared cross government commitment – the National Collaborative for Integrated Care and Support, was created in May 2013 with the aim of generating a new culture of co-operation and co-ordination between care sectors.

In early 2013, partners in 'care' across Central Cheshire united behind a common purpose of transforming and integrating services to improve the health and wellbeing for local people during a period of austerity. This resulted in the creation and initiation of the 'Connecting Care' Programme. In parallel to this, Cheshire was successfully selected as a national pioneer site for integration in December 2013.

The contents of the Pioneer plan '**Connecting Care Across Cheshire 2013'** provides a summary of our joint and ambitious 'Pioneer-wide' plans to deliver better care outcomes through integration which focus on the following 4 key areas: ***integrated communities, integrated case management, integrated commissioning and integrated enablers*** - ***Please see Appendix 2.***

The Connecting Care Board is leading integration locally within Central Cheshire, with local partners across the Cheshire wide Pioneer footprint and nationally as a Pioneer site.

Key national documents outlining the drive for integrated care are highlighted below:

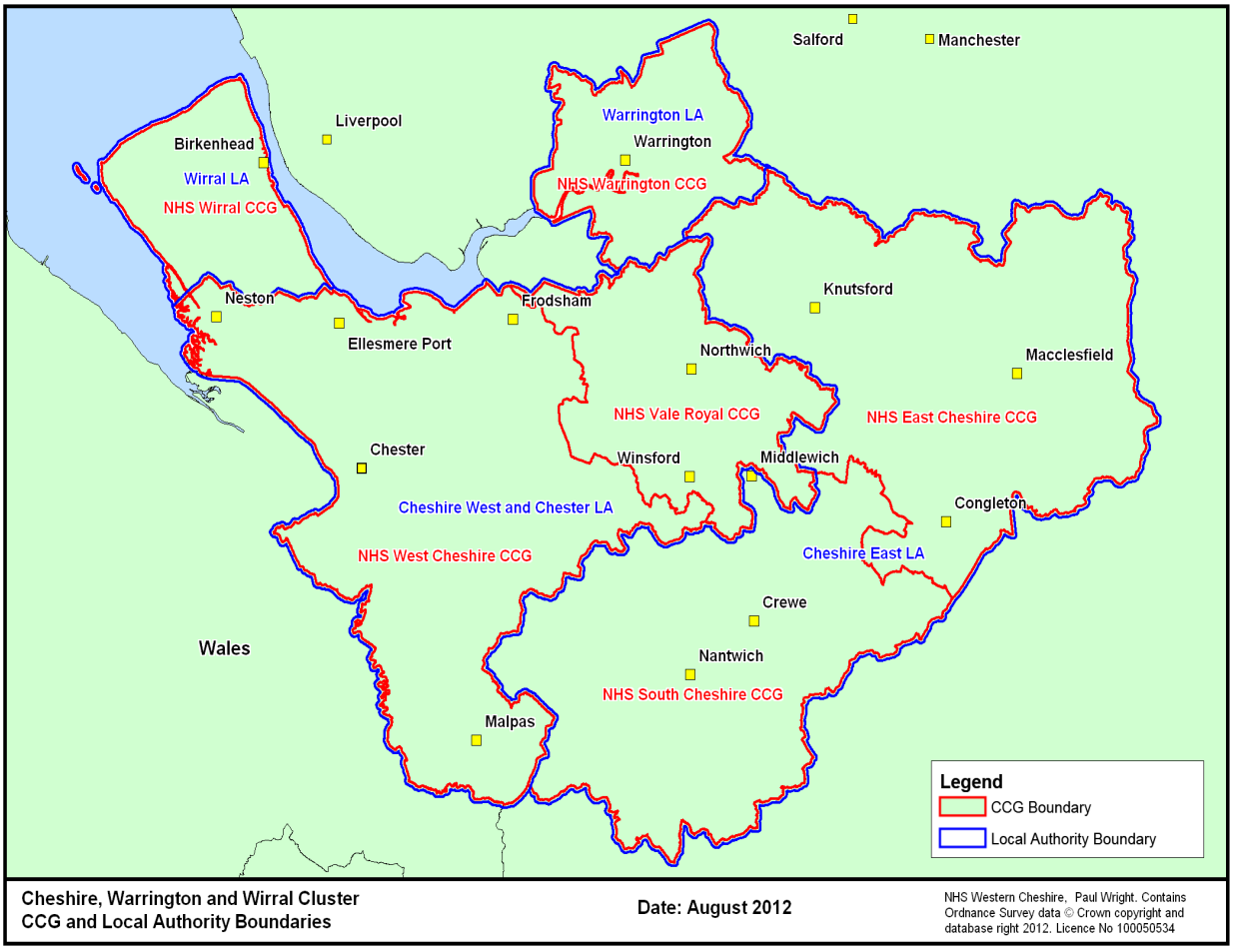
- The NHS belongs to the people: A call to Action - July2013
- Everyone Counts: Planning for patients – December 2013
- Closing the Gap: Priorities for essential change in Mental Health – Feb 2014
- The Better Care Fund 2014
- The Care Bill 2014.

'Every One Counts: Planning for Patients' places a focus on delivering transformational change. Our task is to translate the political philosophy of integrated care into an actionable agenda designed to achieve quantifiable outcomes, and then execute that agenda effectively, measuring progress towards them as we go.

3. An overview of Central Cheshire

Cheshire represents a large geographical county covering a population of over a million residents. Cheshire has a rich diversity of urban centres, market towns and rural communities, Cheshire is an area of outstanding beauty with its idyllic scenery and parkland but it also has urban towns with a comprehensive range of shops, businesses, local amenities high performing schools and can boast its low crime rates, great commuter links, rolling plains and stunning parkland. The population comprises of both affluent areas and deprived areas.

The map below shows in outline the county of Cheshire and the composite Clinical Commissioning Groups, Local Authorities and their boundaries.



The National Integration Pioneer Site footprint encompasses the Central Cheshire *Connecting Care* programme together with our partner health and social care organisations in western and eastern Cheshire and their respective programmes of integration: '*Altogether Better'* and '*Caring Together'* respectively. The population covered is more than 700,000.

The 'Connecting Care' programme is the local approach covering the Central Cheshire area.

The Central Cheshire area

Central Cheshire is a descriptive term used to describe the 'central belt' of Cheshire that includes the 2 local populations of NHS Vale Royal Clinical Commissioning Group (CCG) and NHS South Cheshire CCG. The Vale Royal CCG falls completely within the boundary of Cheshire West and Chester Council and the South Cheshire CCG within the boundary of Cheshire East Council.

NHS Vale Royal CCG has a total registered population of 102,000 and South Cheshire CCG has 173,000. The population has a higher than national average of older people. In terms of ethnicity, the population is predominantly white British.

The 2 CCGs and the 2 local authorities have responsibility for commissioning local health and social care services to meet the needs of local citizens, a total central Cheshire population of 275,000.

NHS England commission primary care services from the 30 GP practices within Central Cheshire. Community services are provided by East Cheshire NHS Trust and Cheshire & Wirral NHS Partnership Foundation Trust (CWP). CWP also provide mental health services. Mid Cheshire NHS Hospital Foundation Trust provides urgent, emergency and elective care. Specialist services are provided across the region, commissioned by NHS England.

What we know about health & social care need in our local area

A significant proportion of our population enjoys good health and seldom needs to seek care services or support. Our 2 local authority Joint Strategic Needs Assessments steer our strategy and inform us of where to focus our attention in order to improve the health and wellbeing of our population.

There are a range of different groups within our population that require episodic, intermittent or continuous care and support. These groups and the challenges they present to the capability and capacity of the existing care system are outlined in brief below:

- The population is predominantly older than the national average creating a continuing and spiraling higher level of need for care
- Due to the higher numbers of older people, the number of people with long term health conditions e.g. heart disease, respiratory disease, Dementia is rising
- There are wide variations in life expectancy among our population groups, with some being well below the national average
- There is a higher than national average number of people who live alone and increasing the incidence of social isolation and loneliness

- Inequalities in health persist creating gaps in access to care, life chances and wellbeing
- A proportion of our citizens, both children and adults live in the most deprived areas in England and experience poor health, poor educational attainment, deprived income, employment and living environment
- Certain localities have a high incidence and high mortality rate for a range of diseases e.g. lung cancer and stroke rates in Crewe town
- There are high numbers of excess deaths of adults with serious mental illness
- High levels of fuel poverty and winter deaths
- We have higher utilisation rates for a range of conditions, above the national average e.g. alcohol related emergency admissions
- Increasing levels of obesity in all age groups
- Some of the biggest health and wellbeing problems are avoidable but are being caused by peoples lifestyle choices including smoking, drinking alcohol, a lack of exercise and poor diet
- Our partner organisations are operating in an austere financial climate.

In Central Cheshire, there is a long history of successful partnerships and collaborative ventures across our partners' organisations.

4. Our challenges and our opportunities

We have undoubtedly made major progress in tackling the principle causes of premature death, successful secondary prevention and addressing risk factors such as smoking over the past decade. However, in many key areas such as health outcomes, potential years of life lost, life expectancy and deaths amenable to health care intervention, there is still further room for improvement to be among the 'best in the world'.

New challenges have emerged that pose a threat to population health and wellbeing in the future, for example demographic changes and increasing levels of obesity and we need to exploit every opportunity to address these, building on our existing strengths and developing new models of care.

Can our current care system address these challenges?

We have an outdated system

The current delivery models in all providers, hospitals, primary care and across community services, social care and mental health, are based in the main on outdated ways of working that result in poor value for money and a lack of user responsiveness.

The health and social care systems are largely concerned with the treatment of ill health and complex/critical social care need rather than on the promotion of health and wellbeing. It gives too little priority to preventing illness and actively supporting people to live independently and healthy lives. We need to flip this to a strong focus on pro-active and preventative approaches.

The focus of care commissioning is often on the hospital. Hospitals are open all day every day and until we can provide robust care services with similar coverage, they will continue to be the default setting for any lack of alternative options of support. We need to rapidly develop robust alternatives to hospital care. Currently, our pathways are set up to deal with single illnesses and need to be adapted to deal more effectively and efficiently with people experiencing multiple conditions and ongoing chronic illnesses.

One of our key strengths is our primary care system. However, it also brings with it some challenges as our current general practice infrastructure is akin to a cottage industry. GPs are independent contractors running their own small businesses, which can be isolated from each other and they are constrained in the range of services they are able to provide. Working much more closely together would enhance both their capability and capacity.

Nationally, mental health services have been radically transformed over past decades and have seen the adoption of a dramatically different approach to historical care, with a range of community care services, assertive outreach, early intervention and crisis resolution services. Although there is still more to do, these are successes that we can learn from and develop further.

Presently, our guidance and our measurements are formulated around single disease models. Guidance needs to be more flexible and informative to support shared decision making and to offer guidance when care becomes more complex.

At present there are significant health inequalities for those with mental health conditions compared with physical health conditions and we need to develop a care model that embeds parity of esteem for both mental and physical health to improve care outcomes.

Can we meet our productivity and efficiency challenge?

In terms of measuring how our current care system operates, we tend to measure episodic snapshots of activity, process, interventions and outcomes. There is very limited measurement of impact across longitudinal pathways, across organisational boundaries and incorporating impact of care on quality of life. Developing person level pathway and/or end-to-end measures will facilitate the identification of areas for improvement and increased efficiency e.g. E W Deming/Toyota approaches. We need to develop measures that measure improvement and care experience and embed them within our everyday care delivery and evaluation.

We have implemented changes and improvements by means of short-term fixes to parts of our system, which has been in part a response to our short term planning cycle and short term funding mechanisms. We need to move to longer term planning timelines.

We now know that small-scale change approaches will not assist us in meeting the current productivity and efficiency challenges. Radical system change is now required.

Moving care 'closer to home' – in spirit and in geography

Medical advances and advances in treatments have enabled care to be delivered in different ways or in different settings. They have revolutionized treatment, leading to a major shift away from in-patient to outpatient and day-case treatments and from hospital care to community care. This has led to a reduction in the number of beds in our hospitals and more care services being delivered in the community.

However too much care is still provided in hospitals and care homes and treatment services continue to receive higher priority than prevention and community care services. Specialist treatment services have been funded in preference to generalist services. We are currently planning to build our community services capacity but to do this we have a key challenge of how to release resource currently spent in hospitals and move that spend to the community.

To date, changes to how General Practice and community services are organised and delivered have only been small scale and at the margins and we know that we need to undertake change on a larger scale and at greater pace.

Technology

Current models of care are outmoded particularly with respect to use of technology. In our wider society, technologies are evolving rapidly and are changing the way in which we interact with each other. Our care systems have and continue to be very slow in utilising technology to improve care and transform how it is delivered.

Locally there is some testing of telehealth and telecare models but there is significant untapped potential here for delivering care more effectively. Technology should enable greater shared decision-making and a move of focus of control towards individuals.

Fragmented and reactive care

The case for integration has been argued for decades now, yet our services remain fragmented and fail to act together, other than at the margins. This is in part due to the fragmentation between organisations, between physical health and mental health, between primary care and hospitals, but also due to professional group boundaries and specialisms creating false silos of care. These separations are 'hard-wired' into service provision, payments, professional training and each organization in the main continues to work on separate strategies, initiatives and outcomes.

The separation between general practitioners and hospital based specialists and between health and social care inhibits the provision of timely and high quality integrated care to people who need to access a range of services.

Services have not kept pace with changing demands. We know that if we spend more time involving the individual in their care planning in a proactive way that the need for interventions reduces.

There is poor recognition of the importance of investing in public health, which is often influenced by long lead times for impact on outcomes. We currently spend over 95% of our resource on reactive care and only 5% on public health preventative initiatives and interventions. Increasingly, pressures on social care budgets are making it more difficult to act early with relatively simple and inexpensive interventions that help people in their own homes.

It seems that we are always responding reactively to pressures in the system rather than pro-actively managing them and there is little concerted effort to tackle the wider determinants of health.

Quality

There are wide variations in access to services, the quality of both health and social care provision and clinical outcomes across all care settings. Recent national publicity over the serious failings at Mid Staffordshire NHS Foundation Trust and Winterbourne View, underline the need for change in all parts of the system. We currently work on a number of targeted areas to improve quality yet they tend to focus only on individual parts of the system and individual organisations.

We need to consider quality from an individual's perspective, across pathways and the system of care.

Much of our care system operates on a 5-day 9am to 5pm working week with reduced support over the weekend yet we know that this does not meet the needs of our population. Concerns have also been raised over the quality of these reduced services and the impact that this has on outcomes e.g. increased weekend mortality rates in hospitals. Locally we know that our mortality rates are higher than the national average and we need to continue to work hard to reduce these with our partners.

Another particular area of concern is patient and service user experience of health and social care. International comparisons show that we are not doing as well as many other countries (Davis et al 2010 & Cornwell et al 2012). We will need to develop a robust approach to citizen partnership to gain insights into experiences of care and co-produce actions to address poor experiences of care.

Staff/workforce capacity and capability

We know that the people working in our care system are strongly motivated to providing the best possible care to service users but are often frustrated in their ability to do so.

Constant re-structuring of the health and social care system has focused on organisational changes which has diverted staff attention from the real key area of focus, which is continuous quality improvement in care services.

A major challenge for us today and for the future is to align the skills of the workforce with the needs of our service users. There is a growing awareness that the current workforce is not well matched to patient needs. We need to ensure that more senior skilled staff are supporting those who are acutely ill and who have complex health and social care needs rather than those who are junior or in training. Training schemes have been designed from a professional standpoint, not an individual's and this leads to gaps in skills, knowledge, ability from the individuals perspective. If a professional is unable to meet an individuals need, then the question should be asked 'do I need to learn to do that' rather than 'who can I pass this onto'.

Our current system is built on specialisms and sub-specialism but the growing burden of disease demands a growth in generalist skills across all care settings. There are particular gaps, where our general workforce, lack key skills to meet future models of care. These need to be incorporated into core training programmes across a range of staff groups e.g. dementia care, caring for those with complex physical and mental health needs and providing health promotion and prevention advice e.g. Every Contact Counts.

The workforce has been changing slowly over recent years with new roles emerging and new ways of working involving delegating roles from one professional group to another e.g. medical to nursing. This needs to happen across a range of areas if we are to utilize our workforce differently to meet our challenges.

If the inappropriate use of hospital care is to be reduced and care closer to home is to be enhanced, then much more attention needs to be given to the work of nurses, allied health professionals, mental health and social care workers. Their separate systems of work need to move to an integrated care model across community services, social care and primary care teams.

Historically professional training models have reflected a paternalistic approach to care and although significant progress is being made, our citizens tell us that they are not as involved as they would like in decisions about their care.

Our plans are to move to increasing community capacity yet workforce intelligence predicts that soon we will have an oversupply of hospital doctors and a shortfall in a wide range of community health, social care and supporting roles. There is also a significant cohort of the workforce with extensive knowledge, skills and experience that will retire in the next decade leaving a large deficit in our care system. It is clear that we need to use our workforce differently and we need to plan to address discrepancies in future supply or manage over-supply of key staff groups.

A large part of care is delivered informally from a group we call 'carers'. A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. Taking on a caring role can mean facing a poverty, isolation, frustration, ill health and depression. Many carers juggle work and caring or they can often give up an income, future employment prospects and pension rights to become a carer. At present, the number of carers accessing support is in the minority. We need to strengthen our carer assets to enable them to feel supported in their caring role, to maintain their own health and that of the person they are caring for.

Third sector and community organisations locally also provide significant additional capacity but their work if often poorly resourced and small scale. Public funding of third sector organisations needs to be increased to support their work on a larger scale and a substantial basis but at present their funding is being reduced.

Public expectations

Patient and public expectations are changing with people expecting improvements in how and where care is delivered, how it is organized and how they can be supported to manage their own health. Our public has an expectation that care services will be similar to services in other service industries such as leisure and retail. In many instances there is a significant gap in the expectation and the reality.

Increasingly our citizens expect more involvement in decisions about their care, their level of choice and that care will be local, accessible, personalised and provided in modern buildings. At the moment, access, choice, public engagement and involvement are variable across organisations. Participation needs to increase to a level never seen before.

Finance

We face an unprecedented period of financial constraint as a consequence of the banking crisis in 2008 and its impact on the economy and its impact on public finances. The effects have been felt strongly by local authorities, with the NHS having had a degree of protection. This constraint will continue for the foreseeable future.

The funding for health and social care is allocated using different formulae, with services being delivered in the health sector free at the point of demand whilst services remain means tested within the social care environment. This is a significant difference, which causes pressures across the system. Nationally, spending constraints on social care have led to local authorities to tighten eligibility criteria. This has resulted in resources being increasingly focused on people whose needs are substantial/critical/those with the lowest means and is associated with an increase in the level of unmet need. As a result, the care offer to those deemed eligible has and continues to be reviewed and refined.

In the short term, additional funds are being transferred through the NHS to local authorities to help tackle the shortfall with greater efficiencies achieved through integrated commissioning across health and social care. We will need to maximise the opportunities that the Better Care Fund offers. However, it is unlikely that this will be sufficient to cover the financial challenges within our local authorities. In addition to this the new Social Care Bill will increase the number of people who will be eligible for social care support from April 2014.

In Central Cheshire there is a combined budget of Health and Social Care expenditure relating to 2014/15 of c£420m for the Connecting Care Area. This represents the expenditure on health, strategic commissioning in Cheshire West and Chester and adult social care and independent living in Eastern Cheshire Council. Expenditure in future years will be limited by the available resources of the commissioning organisations.

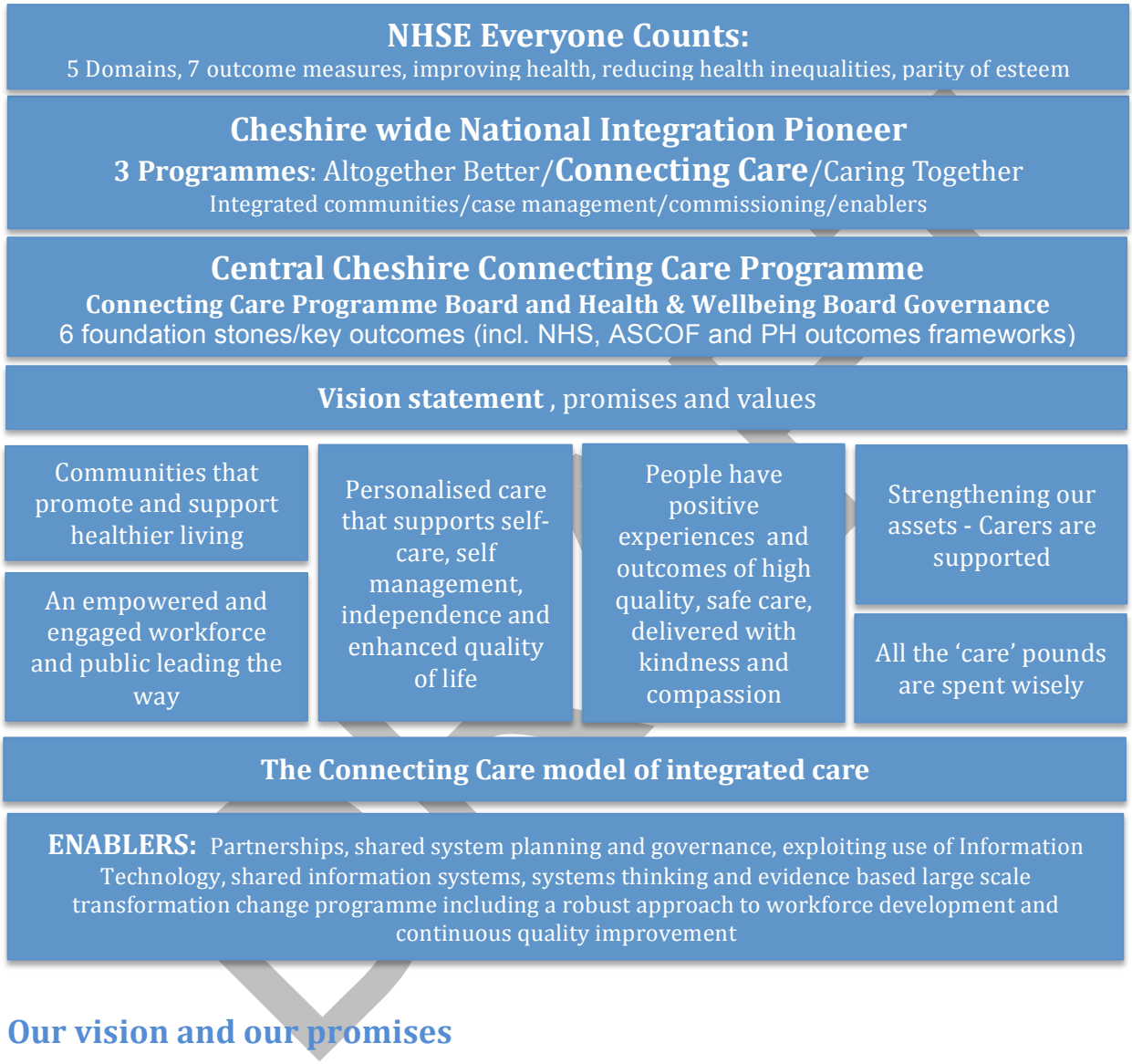
At present across the Central Cheshire local health and social care system, there is an existing financial gap of c£20m and an increasing financial gap across the commissioning and provider landscape, which is predicted to rise to a shortfall of c£59m by 2019. Individual organisations may see larger financial challenges but the figure above relates to the Central Cheshire element of contract activity or relative population. Continuing on this trajectory is not an option and we need to implement radical transformation in order to maintain a sustainable care system.

Public spending constraints mean that any improvements to our system and care will have to be funded out of existing budgets although there will be a small annual increase. However, within the health sector, it is envisaged that the Quality, Innovation, Prevention and Productivity initiatives, which are included in this plan, will deliver the required proportion of the £30m Nicolson Challenge over the next 5 years. Remaining financially viable across the health and social care system is one of our most significant challenges ahead.

5. Transforming, integrating and connecting care

This chapter will outline the overall connecting care programme and go on to describe our model of integrated care that will facilitate the planned transformation.

The following diagram illustrates how all the differening elements of the Connecting Care Programme come together.



Our vision and our promises

In order to '***Connect Care in communities to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing***' we make the following promises to each other and the public along the journey:

- To work together to improve the health and wellbeing of our citizens
- Citizen participation and empowerment
- No decision about me, without me
- Integrity, fair, consistent and transparent decisions
- Dignity, respect, kindness and compassion.

What is 'integrated' or 'connected' care?

There is no one definition of integrated care. It can be defined as an approach that seeks to improve the quality of care for service users and carers by ensuring that services are well co-ordinated around their needs regardless of professional, team, service or organisational boundaries. The citizen's perspective is the organising principle of care delivery.

The definition of integrated care selected for use in the Connecting Care Programme is one produced by the public during the recent National Voices and Making it Real national public consultation exercise:

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

The Connecting Care integrated care model –in 2019

The diagram below illustrates the model of integrated care that the Connecting Care programme is aiming to delvelop and implement over the next five years.

Core aspects of the Connecting Care integrated care model include:

- The person is at the centre of all care – 'no decision about me, without me' with all care services and resources wrapped around them for when they are in need
- People will get the right care, at the right time, by the right person, in the right place and only the care that they need
- More care will be organised and delivered outside of traditional hospital settings, in local communities with closer collaboration across teams
- People will use services differently with more provided in primary care/community and less in the hospital:
    - with integrated extended GP practice/neighbourhood teams and integrated community services delivering integrated care and support 'closer to home' incorporating physical & mental health, social care & the voluntary sector
    - Traditional 5 day per week community services will be extended to offer support, when needed 7 days a week
    - with a smaller, more flexible community facing hospital delivering planned, emergency and specialist care and
    - regional specialist hospitals continuing to deliver supra specialist and specialist care, some of which will be in the community setting
- Asking people what they want - Personalised care planning with embedded shared decision making and the individual's identified goals driving care
- Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
    - Supported self care and self management through targeted programmes and 'making every contact count' approaches
- Much more cross organisational planning, commissioning and provision of care, that reduces duplication and achieves the best use of resources
    - A focus on prevention, and early detection and interventions/support through risk stratification, care co-ordination &proactive case management
- Be accountable to our citizens for outcomes and population health
- Focus on the multiple determinants of both physical and mental ill-health and creating innovative solutions across partners
- Supporting 'enablers' of integration
    - Workforce – development of CLIA – 'Cheshire Learning & Improvement Academy' to support cultural change, workforce education and development, leadership capacity and capability within individuals and teams across the lifespan of the programme to support the new model of care and developing new roles e.g. interface geriatrician, generic care roles
    - Information Technology – Creating shared information systems and exploiting the use of technology to support care
    - Public and workforce Engagement, Communications and Participation using range of techniques/approaches e.g. campaign methodology.

Impact of the Connecting Care integrated care model

The model will shift focus from episodic and reactive care to longitudinal, long term, chronic care and from a paternalistic to a person centred model. This new integrated care model aims to deliver services in a way that puts the citizen at the centre, giving them more control. This means that instead of citizens trying to navigate their way around the multitude of services that currently exist, we are redesigning services to fit around their needs. We want to avoid any duplication of care, prevent people having to tell their story multiple times and to minimise waste across care settings.

Key to the new model is the formation of Integrated Extended Practice and Neighbourhood Teams. The core component of the approach is scaling up access to generalist services and scaling down unnecessary access to more specialist services. These are multi-disciplinary teams comprising GPs, geriatricians, nurses, palliative care, allied health professionals across physical and mental health disciplines, social workers and social care support workers and voluntary sector support workers, working together in a specific geographical area. The population covered by each team is planned for between 20-50,000. Services will be planned on the basis of each defined population and timely response is a key factor. Populations will be risk stratified and by aligning health, social care and voluntary sector teams and resources, we will be better able to work together around our population's needs, share information and combine experience to provide a positive experience of care for our citizens and shape continuous improvement.

Initially, the newly established primary care/community teams will focus their attention on those aged over 60, the frail elderly and those with the most complex health and social care needs. Primary and community care will be expanded and strengthened and will work with new models of care e.g. Starfield principles. Incrementally the teams will be expanded to cover all needs of their relevant populations and teams will focus support on the individuals own goals with the lead professional e.g. GP being in an accountable role for their care. There will be embedded systems of quality improvement within the teams.

These integrated extended practice and neighbourhood teams will pro-actively manage their population groups, offering higher levels of support than is possible at present, innovating support, care pathways and processes that will maximise care provision in the home or community, providing self-care support and education, manage down the existing growth in avoidable hospital and care home admissions, implement admission avoidance plans and incrementally increase the numbers of people being supported to live independently in their community. People will have their own key worker and they will know how and where to access information, care and support when it is needed.

Building services around individuals means that their needs come before those of organizational priorities, professional groups or the conventions of payment mechanisms. It requires closer, smarter working between organisations and the development of new relationships between care professionals and between care professionals and those using services. It means strengthening community and generalist based services and developing the workforce to ensure they have the right balance of skills and knowledge.

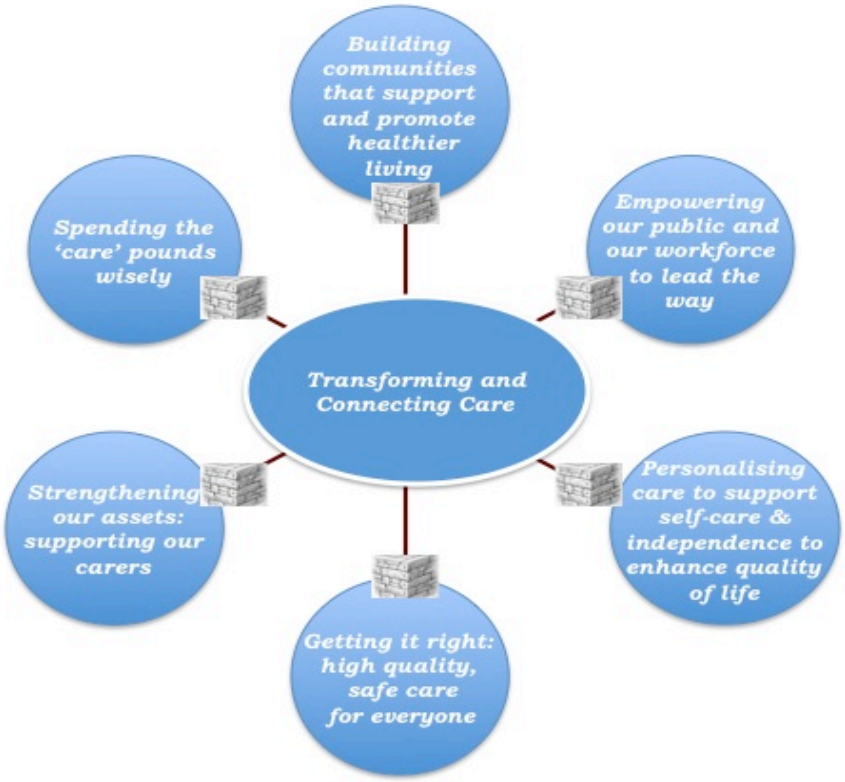
The model will use the defined outcomes, metrics and quality evidence to support ongoing development, shared learning and evaluation of impact at key stages over the lifespan of the programme. Learning will no doubt lead to recommended changes.

The above model will be implemented through a framework of 6 key outcomes or foundation stones and these are described below.

6. Laying the six foundation stones for success

The followign chapter describes the 6 key foundation stones for success that comprise our strategy. Each stone identifies the specific area of the Connecting Care Programme Plan and the relative plans, aspirations and measures of success that relate directly to the 6 health and social care integration outcomes outlined in chapter 1.

These 6 foundation stones will form the key building blocks of our transformed health and social care system and will build capacity and capability across the care system and move us incrementally towards our goals.



6.1 Building communities that promote & support healthier living

Our strategic objective

Our citizens will be enabled, motivated and supported to look after and improve their health and wellbeing to live healthier and happier lives in their communities.

Our plans

To create a culture and mindset that focuses on people's capabilities rather than deficits and the collective assets of the communities in which they reside. We will develop and implement an integrated approach to community capacity building across all partner organisations, that supports independent living at all levels, tackles social isolation, increases personalisation and maximises the use of assistive technology.

Our plans will be built around a public health approach that addresses the root cause of disadvantage.

Plans and initiatives:

- Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term acute and specialist services
- A new third sector strategy jointly agreed across partner agencies, setting out an investment plan for voluntary and community sector support
- Implementing a joint information and advice strategy to help individuals make informed choices about their care
- Roll-out of personal health and social care budgets to enhance local choice, independence and local microenterprises
- Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation
- Integrated support for carers across health and social care
- A suite of interventions that tackle the causes of unhealthy lifestyles
- Rolling out time-banks to attract volunteers and mutual support networks
- The Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models
- Implementation of integrated extended practice/neighbourhood teams
- Extend existing models of and implement new approaches to increase levels of self care and supported self management
- Investment in time banking models to foster community delivery and create a closer link between residents and their neighbourhoods
- Extension of schemes such as Street Safe and Nominated Neighbourhoods that promote social inclusion, supporting older people to feel safe within their communities.
- Deliver Falls Awareness training to all frontline staff through online learning
- Develop and implement a new approach to Community Transport Grants that support local transport initiatives
- Extension of telecare and telehealth to support residents to be safely supported to live independently in their own homes for longer.

Our aspirations and measures of success

- Increasing percentage of adult social care users who have as much social contract as measured in the Public Health outcomes framework
- Increasing numbers of people and carers accessing personal budgets

- Increasing numbers of people utilising assistive technologies, telehealth and telecare support that supports healthier living
- Decreasing percentage of people experiencing poverty of all types (fuel, economic etc.) adult social care users who have as much social contract as measured in the Public Health outcomes framework
- Increasing health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks.

6.2 Empowering our public and our workforce to lead the way

Our strategic objective

People who work in health and social care across all sectors 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.

Our citizens are fully engaged in the shaping the development and re-design of health and care services and supported to make positive choices about their own health and wellbeing.

Our plans

It is essential in any service design and service delivery that the people who will use the service and those that deliver the service are recognised as key stakeholders at every stage of the process. From design to implementation and from evaluation to improvement, our commitment is that we will proactively involve and engage the public, those who use our services and also those who care for them and our wide groups of staff.

Our challenge is to ensure that our communication, involvement and engagement is honest, meaningful and effective. We are further challenged by the sheer scale of the numbers of people involved and want to avoid a system of involvement and engagement that becomes tokenistic. We recognise that the people using our services and the staff within them are experts in their own right and clearly have intimate knowledge and views of the world from their own perspective. Our challenge is to ensure that we seek as many expert opinions as possible to ensure we have a balanced and representative view. It is acknowledged that the meaningful involvement and engagement of all key stakeholders takes skill, planning, time and effort. In a climate of time pressures and deadlines this is often an area of compromise. It is our clear intention that this will not be the case within the Connecting Care Programme. We need to recognise that communication and engagement are not the same things and that we cannot reassure ourselves that because we have told people what is happening that we have engaged them.

We will therefore:

- Utilise a joint Communication and Engagement group representing the partner organisations to establish explicit principles regarding our approach to communication and engagement with all stakeholders
- Establish a joint Communication and Engagement Strategy which all partner organisation will sign up to which will govern all activity whether routine business or planned service design
- Ensure that all existing patient/user/carer groups are identified and linked into Connecting Care with effective two-way communication systems and opportunities for direct involvement
- Identify gaps where specific groups are not represented and establish mechanisms to ensure their voices are heard and their involvement is active
- Develop varied systems of engagement with the workforce to facilitate effective two way communication and allow staff to contribute, influence, design and be creative in their individual services and across the whole system of care
- Develop a culture where staff can feel confident in sharing their views and suggestions with an understanding they will be heard and listened to
- Establish mechanisms to have regular evaluation points to include all key stakeholders in our service design, service delivery and service improvement
- Ensure that any service design group has representation from the public and workforce groups and that representation is meaningful and effective
- Ensure that services establish service monitoring and evaluation forums with public and workforce representation to ensure on-going engagement with key stakeholders to ensure their contribution and influence is present in measuring the effectiveness and quality of services and taking an active role in determining continuous service improvements
- Develop a system of regular communication to key stakeholders with the opportunity for feedback and ensure that all means of communication are utilised including social media
- Utilise local Health Watch teams together with wider third sector partners through a newly established Cheshire wide communications and engagement network
- Deliver training programmes for our workforce to ensure that they understand and effectively apply the principles of effective communication and engagement with customers on an individual, service and whole system level
- Utilise the broad range of information already being collected from people and staff and ensure these are constantly referenced and utilised to inform service design and service improvement

Our aspirations and measures of success

- Utilisation of the National Outcomes Frameworks for NHS, Public Health and Adult Social Care
- Evidence of co production with public and staff in the whole system design
- Feedback and evaluation from public and staff of how engaged and involved they have been in the design of the whole system
- Review of consultation feedback using both qualitative and quantative measures
- Evidence of 'You said' 'We Did' communications with public and staff
- Evidence of promotional materials for involvement and engagement opportunities and evidence of take up.
- Use of Think Local Act Personal Markers for Change (ASC measures)
- Evidence of CC Communication and Engagement Strategy
- Evidence of delivery and application of staff training in involvement and engagement skills
- Evidence of staff and public involvement/membership of key design, development and service evaluation groups.

6.3 Personalising care to support self-care, self-management, independence and enhanced quality of life

Our strategic objective

The programme aims to increase the opportunities and scope for an individual to self-care/self-manage and to live as independently as possible within our communities and to make self-care integral to the maintenance of health and wellbeing for people with long-term physical and mental health conditions.

Our plans

Personalised, high quality care will be planned and delivered through a process of discussion of an individuals specific needs and shared decision making between the individual receiving the care, the professional and the carer/family.

The first care is self-care with individuals owning their care. We will support and strengthen this as a right and responsibility.

There is good evidence to suggest that better understanding of a long-term condition can improve people's understanding of their symptoms, prevent disease escalations and complications arising and enhance long-term health and wellbeing. The role of the care professional is to support people by promoting self confidence and self care, help them feel more in control of their lives, support problem solving, and to direct people towards the type of support and information they need. This means listening to their goals and having a more outcome focused approach to planning and reviewing their care plan.

Our plans to support people to be as independent as possible and to self care are:

- Developing a robust self-management strategy which will promote, encourage and support self-care and independence
- Providing advice, information and educational support to the individual to facilitate self-care e.g. test results, pro-active approaches to prevent crises
- Commission self-management education programmes and utilise new models of support
- Helping patients monitor their symptoms and know when to take appropriate action and in managing the social, emotional and physical impacts of their conditions
- Motivating individuals using targeted approaches and structured support e.g. health coaches or befriending services
- Helping patients to monitor symptoms and know when to take appropriate action e.g. Minor ailments schemes
- Shared decision making: Involving the person in all care decision-making at every level
- Developing holistic, whole person 'personalised' care plans as a partnership between the individual and the person providing support and or care
- Individual will tell their own story, set their own care agenda, goals and actions and will lead problem solving discussions supported by their identified key workers/case manager/co-ordinator
- Setting goals with the individual, development of action/care plans with pro-active follow up on achievements
- Implementing new modern models of care, with support wrapped around the individual at practice, neighbourhood or locality level via integrated community teams using care co-ordination and case management approaches
- Utilise technology and telehealth/telecare to support self-care and self management
- Proactively maximise all care 'contacts' to promote healthy lifestyles
- Working together across partners to tackle the wider determinants of ill-health and social care need
- Support and develop our care workforce and the public to ensure that the belief in and environment for proactive personalised care, self-care/self management and shared decision-making are a reality across our system.

Our aspirations and measures of success

- The percentage of people on the GP survey of 'those who feel supported to manage their long term condition' will increase year on year
- Increasing numbers will access self-care/self management information, advice and support and/or attend disease specific education models
- Citizens will feel more involved and in control of their care
- People with Long Term physical and mental health conditions will report higher satisfaction and quality of life
- There will be an increase in the amount of care delivered locally or in the home and an associated reduction in utilization of GP consultations, emergency department attendances and admissions.

6.4 Getting it right – people have positive experiences of high quality, safe care, delivered with kindness and compassion

Our strategic objective

Our citizens will have positive experiences of health, social care and support services to maintain and improve their health and wellbeing, will feel safe, will have their dignity and human rights respected and will be safeguarded from harm.

Our plans

For our citizens accessing care, the programme will:

- Deliver person centred care without service gaps, so users will experience a single service of continuous care with no joins visible to the service user or their family/carer when crossing service or organisational boundaries
- Deliver more care and support in a local setting wherever it is safe and appropriate to do so
- Ensure 'care' is defined by its ability to meet the needs of the individuals rather than being defined by its organisation and service
- Robustly evaluate the 3 key programme workstreams
- Measure care experience by asking those who receive the care, support and information, with the aim of demonstrating a high proportion of service users are experiencing a good standard of care.
- Build incrementally engagement with service users, their carers and families, as well as wider public representatives, so they are able to actively support and influence the design of the programme

- Act swiftly and professionally in pro-actively seeking information on, dealing with and resolving any quality and safety issues within established governance frameworks
- Only approve service developments where service users, carers and citizen participation is evidenced.

It is our vision that the Connecting Care Programme will begin to address the seven improving outcome ambitions identified in the publication '***Everyone counts: planning for patients':***

- Securing additional years of life for in your local population with treatable conditions
- Improving the health related quality of life of people with one or more long term 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 having a positive experience of hospital care
- Increasing the number of people having a positive experience of care outside of the hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

It is fundamental that all partners Operational Plans are consistent with the Connecting Care Programme and can deliver the intended outcomes in line with our populations needs., at the required pace and to the identified sequence of priorities.

Please see ***Appendix 2*** for an illustrated table of the current shared vision, actions and collaborative working between partner organisations across health and social care which will facilitate consistency in approach for delivering quality and which builds upon the findings of the local Joint Strategic Needs Assessments.

Our aspirations and measures of success

The Connecting Care Programme will use a number of different outcome measures, which will be triangulated against each other, to evaluate and therefore determine the success of both the individual components and the overall programme. This will involve:

- **Reporting performance against the national outcome frameworks**: NHS, Public Health and Social Care as a measure of our success, which can then be compared with other care economies and national standards. We will aim for continuous improvement towards the best

- **Achievement of the 'Better Care Fund'** outcome measures
- **Programme evaluation via triangulating national and local data**:. Analysis of primary care, hospital care, public health and social care activity, financial and service user experience data
- **Feedback from service users**, their families and the public: via engagement events, focus groups and citizen participation approaches.

6.5 Strengthening our assets – supporting our carers

Our strategic objective

People who provide unpaid care for others are supported, are consulted in decisions about the person they care for, they are able to maintain their own health and wellbeing and achieve quality of life.

Our plans

There is no single definition of a 'carer'. The law makes reference to carers in many contexts. In general, when a social services department is deciding what services to provide for a disabled person, it should consider the views of significant people in that person's life. This will include people who provide some form of care for that person (usually family members or friends or neighbours), be that physical care or emotional support, advice or advocacy support etc. In this guide a carer is a person who provides care to another person and is not paid for providing that care (nor is she or he providing the care as a volunteer placed into the caring role by a voluntary organisation).

Some commentators have used the term 'informal carer' to distinguish actual carers from paid care workers who are often wrongly described as carers. Many carers actively dislike the term, seeing nothing informal about caring for substantial amounts of time. (Luke Clements- Carers and their Rights 2011)

We are all aware of the significant health and social care inequalities faced by Carers. Having access to a short break, respite services or employment opportunities can make a significant difference to an individuals' ability to cope and maintain their caring role.

Our vision is to 'Enable Carers to experience and have a life outside of caring' and our commitment is to:

- Enable Carers to be respected as Equal Care Partners who are treated with Dignity and Respect
- Enable and support Carers of all ages to feel safeguarded from abuse within their caring role, family and local communities

- Enable Carers to feel empowered through positive engagements and interactions with service providers and professionals, having positive experience of services
- Enabling Carers to live full and meaningful lives in their own right
- Enable Carers to feel supported by offering them a range of support and practical help
- Identify "hidden" carers and supporting them to access services and information appropriate to their needs
- Enable Carers to access Information and Advice – including practical and emotional support in a timely way to support them in their caring role
- Enable Carers to access services and support through their GP and practice staff which supports their health and wellbeing
- Support Carers to access training and learning which helps to maintain or access employment opportunities
- Consider how we will support on-going involvement by people who are in caring roles where respite is required to support that engagement.

Our aspirations and measures of success

- Improved numbers of adult, parent carers and young carers identified in caring roles on GP registers
- Decreasing percentage of adult carers feeling loneliness and isolation as measured in the Pubilc Health Outcomes Framework
- Increasing percentage of adult social care users who have as much social contract as measured in the Public Health outcomes framework
- An increase in the number of carers receiving an assessment
- To provide Carers with the opportunity to take part in an activity or interest of their choice, with or without the cared for person, that improves the carers health and emotional and physical wellbeing
- Increasing numbers of carers receiving respite support
- To increase knowledge, skills and awareness of GPs and other primary care services to identify and support Carers
- Raised awareness of safeguarding issues and management among carers and the workforce
- Measureable improvements in health and well-being of carers including safeguarding events
- Carers feedback indicates positive experience of services
- Aligned commissioning processes and effective use of health, social care and community resources
- Development of Personal Budgets for carers

- Carers are supported and protected from financial hardship
- Carers access training and learning which helps to maintain or access employment opportunities
- Carers access information and advice – including practical and emotional support
- "Hidden" carers access services and information appropriate to their needs.

6.6 Spending the 'care pounds' wisely

Our strategic objective

The most effective use is made of resources across health and social care to create a robust and sustainable system, involving partnership working, joint commissioning, sharing of information, new contracting and funding approaches, exploiting new technologies and avoiding waste and unnecessary duplication.

Our plans

Over the next 5 years, the level of resources available to be invested by our partner organisations to improve the care of our citizens is constrained and may in some areas be reduced. It is therefore essential that we maximize the use of all the resources within the care system and also to minimize duplication and waste at every opportunity.

In developing an integrated approach to the care provided, we will ensure that citizens receive the right care, in the right place and at the right time. To support this, all our staff, regardless of organization will be empowered to act as advocates for this and reduce duplication and ineffective treatment/care.

Initiatives and plans:

- Increased levels of joint working, joint commissioning and planning
- Collaborative working by providers of care and support across all care settings
- Innovate with new collaborative provider models to support integrated care
- Implementation of our Better Care Fund plans and integrated initiatives to support care provision in the most appropriate setting
- Test out new contracting approaches
- Maximise the capability & capacity of our workforce via development and support
- Increasingly using Information Technology to support care processes and systems

- Sustainability plans – QIPP, CIPs, bridging the financial gap
- Working towards the establishment of a population wide, citizen led and governed 'Accountable Care System'.

Our aspirations and measures of success

- Achieve Better Care Fund metrics
- Achieve health, public health and social care system wide outcome measures/quality benchmarks/markers
- All partner organisations meet their statutory and regulatory requirements.

7. The Connecting Care Transformational Roadmap

How are we and how will we Transform Care

We recognize that this level of transformational change is significant and complex. It will require strong leadership, dedicated people, financial resource, collaborative working, and high-energy commitment from a high volume of people and tenacity to the cause. Realising our new ways of working is not about creating new structures or teams but it's about what we all believe and how we behave.

The Groundwork

Over the past year, partners across Central Cheshire have been preparing the landscape for change, building expectations, relationships and trust to create the culture for collaboration and integration. To date we have successfully undertaken the following 'groundwork' across our partners;

- Definition of our collective common cause in overcoming fragmentation between services and developing more integrated models of care better suited to meet the needs of our population and achieve value for money
- Definition of our shared vision and narrative to explain what we mean by Connecting Care and why integrated care matters
- Established shared leadership and governance arrangements to support whole-system working and delivery of our integration outcomes
- Baseline mapping of all integrated work in progress or planned
- Create 'learning space' or 'headroom' for leaders to come together and collectively explore new ways of working and models of care and contracting and the potential roles and impact on all partners
- Agreeing services and user groups where the potential benefits from integrated can have the most impact
- Agreement that change needs to be at scale and pace to ensure a sustainable local care economy.

The following are areas in which work is already progressing or is being planned:

In progress

- Building integrated care from the bottom up as well as top down through the implementation of a single point of access and integrated multi-disciplinary community teams that wrap around the service user and provide whole person care
- Increasing pooled resources to reduce duplication and maximize the available resources through joint commissioning and the Better Care Fund

- Testing of new innovative collaborative contracting approaches including a new 'innovation fund', a collaborative provider contract and an outcomes based contracting model
- Exploration of ways to support and empower more users to take more control of their own health and wellbeing
- Exploration of ways to increase the sharing of information about service users with the support of appropriate information governance
- Bringing challenge to all plans and proposed initiatives in respect of 'do they offer parity of esteem across physical and mental health'
- Reviews of existing services and key work areas in readiness for redesign and transformation in line with the Connecting Care Programme, e.g. Emergency Care, Intermediate Care, Mental Health, Specialist Commissioning and Community Services.
- Build a robust case for change from a detailed analysis of service utilsation and cost across health and social care in order to define our system 'roadmap' to move all partners from the 'here and now' to the 'future system'

In the planning stage

- Build capacity & capability of the workforce to lead improvements, challenge existing practice and systems and to implement and evaluate change
- Utilize the workforce effectively and be open to innovations in skill-mix, staff substitution, new roles, hybrid roles, 7-day working and roles that span organisational boundaries
- Put 'Listening into Action' – to re-engage our workforce to drive and own the changes needed as part of an ethos of continuous improvement
- Create a 'learning network' and 'the Cheshire Learning and Improvement Academy' (CLIA) to support cultural and behavioural changes required to deliver new models of care
- Set specific objectives and measure and evaluate progress towards them.

How will be get to our 2019 vision of 'Connecting Care'?

We appreciate that in seeking to achieve significant rather than 'marginal' change, we must align the way we work with training, contracting approaches, incentives, and key programmes of work.

We envisage our approach to have a number of phases:

- Initial '**direction setting'** during which all our partner organisation leaders will lead within and across their organisations in building a collective understanding with pace for the direction in which we wish our changes to take us. We will aim to communicate our vision, direction and to spread energy throughout the programme, empowering our service users and our staff to look for improvements projects that align with the direction.

- The second, '**power-up'** phase will start not long after the 'direction setting' phase has started, during which critical transformational programmes of work will be initiated by leaders in our partner organisations. Our aim during this phase will be to start to make to necessary changes, to show all how, and how quickly, changes can be done. The focus here will be on both making required changes and involving key well-networked staff in making these changes, so they can see what is required. This phase therefore will include an important communications element to evidence leaders involvement in making changes happen, and modeling the approaches through which we wish this delivered. We will need to get staff together, show them the approaches we wish to use to secure changes, and recognise them where they have done this. We expect an inter-organisational Connecting Care Awards event to be part of this phase, for example
- Our third '**viral-change'** phase will see the number of change projects and programmes accelerated as partner organisation staff take-up initiation of changes in line with the Connecting Care change direction. We will continue to celebrate staff changes but the work during this phase will move more towards coordination and supporting staff initiated changes, ensuring this is done in an aligned way.

During each of these phases, communications and the narrative of what is being done will need increasing refinement. The 'story' of Connecting Care will thus be evolved through the three phases, endeavoring to guide and set the direction for each phase.

The key initial projects for Phase two delivery are those we have identified as being most critical to delivering benefits for all service users of partner organisations' services, and where those organisations will see most initial benefit. The Connecting Care Board have identified these within 3 dedicated key workstreams of the proramme with support from our identified enablers:

- Self-care and self management
- Integrated community services/teams/care
- Integrated urgent care/rapid response

These changes are seen as delivering real benefits and as 'totemic' in communicating our seriousness about securing transformational change.

The matrix below presents an overview of the phases, necessary actions in each, and the changing narrative for them:

Phase	Objective	Deliverables	Narrative
1 – direction setting	• Set-out key characteristics of the journey 'destination' • Explain 'how' we should work to get there • Leaders lead by example; initiate a key project • Ensure delivery 'architecture' is agreed and in place	• Single story used by all leaders to explain our enterprise • Agree a 'Code of Practice' describing model behaviours • Initial projects set-up and delivered • Programme metrics and dashboard agreed to record deliverables progress, communications awareness and behavioural approaches used	A common destination for all with clear benefits and initial priorities Reinforce messages via in-house comms, Connecting Care branding, a 'visual' destination & direction Set-up Connecting Care website and ensure it is a live source of info with Dashboards published
2 – power-up	• Deliver initial programmes of change • Ensure visibility of leaders in delivering this change	• Single assessment • Integrated Extended Practice and Neighbourhood teams • Enhanced care • Sense of pace in programme overall • Rolling our support for staff to get on & recognise where this has been done (shared training, Connecting Care Awards, etc)	'we're all doing it; how will you help' message
3 – viral-change	• Ensuring continued change is aligned and coordinated, and far more extensive & comprehensive	• Joint training • Joint Connecting Care awards • Published Dashbaord	

Connecting Care key milestones

The table below presents a summary of the key milestones planned for the programme:

	Connecting Care Key Milestone Plan for 2014/19					
	2014	2015	2016	2017	2018	2019
Agree shared vision, narrative and strategic approach						
Robust baseline position, activity, financial and impact modelling						
Programmed areas defined, resourced and plans in place for implementation						
New contracting approach agreed: Provider Board and Alliance contract in place						
Develop a robust communication, engagement and citizen participation approach						
Extended Practice Teams established across communities						
Maximise opportunities of Better Care Fund						
New models of care researched, tested, refined and evaluated						
Dashboard metrics agreed, introduced and monitored to inform direction and pace						
Exploit IT capability and functionality to support new models of care						
Cheshire Learning and Improvement Academy (CLIA) - to build capacity and capability of the workforce and support the delivery of a large scale transformational change programme e.g. through systems thinking methodologies						
Information sharing across health and social care						
Teams are seeing impact in terms of improved care quality, experience of care, reducing escalations of need, reduced avoidable admissions						

Box = Delivered milestone

8. 'Building the best' – a sustainable care system for our communities

This chapter is under construction and will be further informed by discussions at the strategy group and by outputs from the Case for Change activity, financial and impact modeling work

The challenge and complexity of delivering this programme can't be underestimated. We know that this strategy will be outdated almost as soon as it is written but it is our first step on a pathway of complex and chaotic change. The Connecting Care Programme is a key driver for delivering a sustainable care economy over the next five years.

At present across the Central Cheshire local health and social care system, there is an existing financial gap of c£20m and an increasing financial gap, which will need to be addressed over the next five years.

Although our modelling work is in its early stages at present, the current financial challenge across Central Cheshire is predicted to increase to be a gap across the commissioning and provider landscape of c£59m by 2019 if we 'do nothing different'.

This gap and the impact that the initiatives within our plans will have to narrow it is yet to be defined. This will be established as part of our modelling work. Our strategic plan is based on the above assumptions that our plans will narrow that financial gap.

Format 1 for consideration:

Our approach to system sustainability is summarised below in terms of 4 key areas:

Improving productivity within existing services

- Citizen and workforce communication, engagement and participation
- A prevention focused care system
- Improving unplanned care services and outcomes
- Productive elective care

Outcome: set out what we will achieve by 2019 (against the everyone counts 7 ambitions or the 6 foundation stones?)

Delivering the care in the most appropriate place

- Supporting self-care and self-management approaches
- Transforming community and primary care services
- Knowing your population and targeting care to meet their needs
- Targeting care at the most in need through risk stratication and preventative and pro-active approaches
- Hgh impact interventions e.g. Dementia, mental health, rapid response, carer support

Outcome:

Developing new ways of delivering care

- Ask the person what they want – real person centred care
- Integration of services across health and social care
- Utilisation of the Better Care Fund and achievement of the metrics
- Care co-ordination and case management
- Integrated extended practice/neighbourhood teams

Outcome:

Allocating spend more rationally

- Adhering to our Everyone Counts planning guidance as described in detail in the 2 year operational plans and trajectories
- Keeping within regulatory frameworks e. g. Monitor guidance
- Delivery of QIPP targets
- Joint commissioning approaches using Better Care Fund and other mechanisms
- New contracting and funding mechanisms e.g. Alliance contract and Innovation Fund which allows pump priming of community resources and when activity in the actute sector reduces, allows cost to be taken our and re-invested in community services expansion in an iterative and cyclical way.

Outcome:

We will reduce the gap year on year by:……..

Format 2 for consideration:

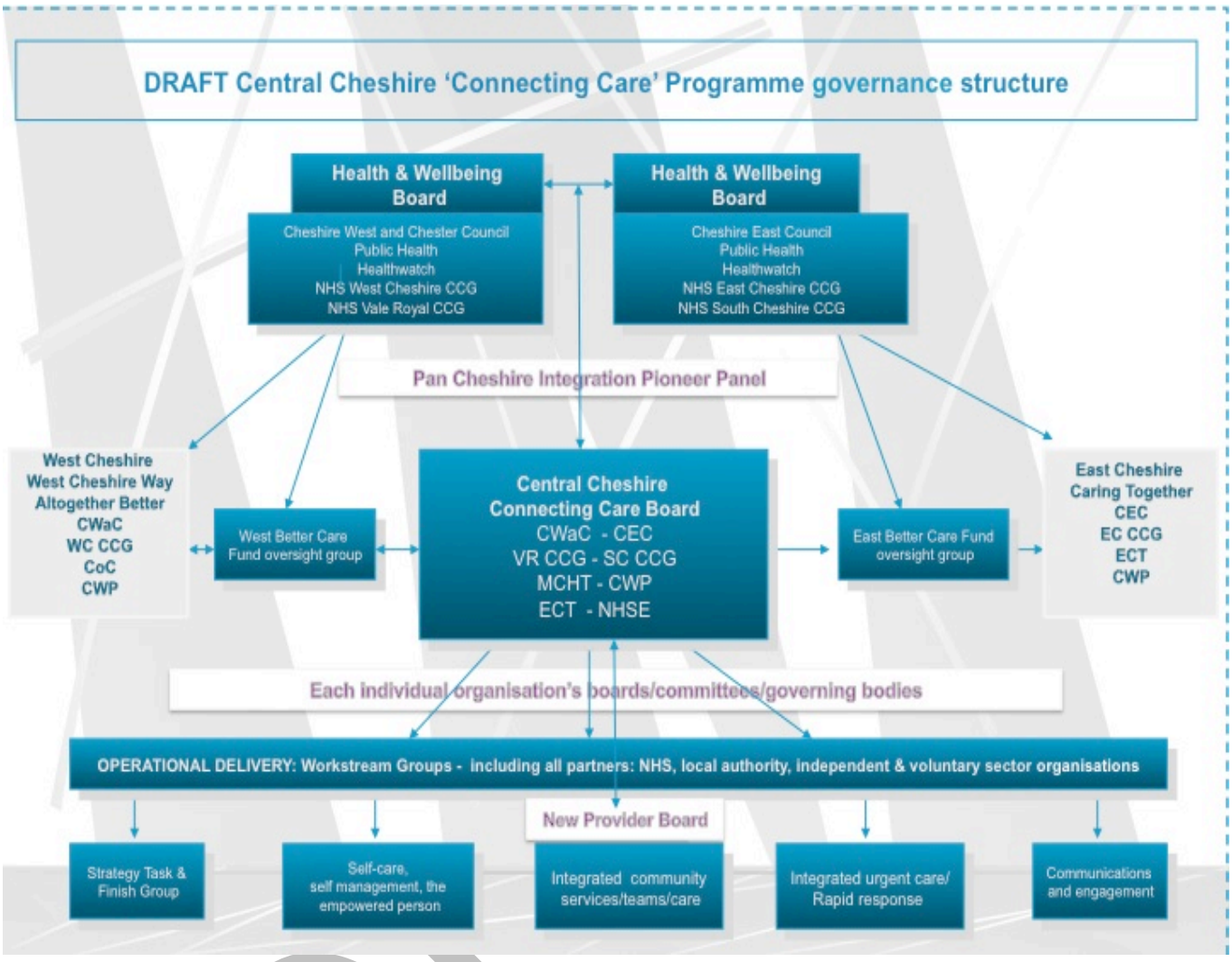
Bulleted list of key improvement interventions and intended impact e.g.:

- Development of a transformational model for moving from existing system to future model through robust financial, activity and impact modeling (Case for Change work)
- Integrated neighbourhood/extended practice teams – all metrics
- Alliance contract/Innovation Fund – working differently and closing wards to re-invest in community services – £3.2m
- Internal organisational CIPs/savings – NHS 4%
- Reduce variances in referral rates
- Redesign of urgent care/rapid response
- Agree shared risk contract – Non-PbR for Non-elective work at MCHT
- 3-5% reduction in avoidable hospital and care home admissions annually

Format 3 for consideration:

Key Outcomes	Improvement interventions	Baseline	Impact
Foundation stone 1			
Foundation stone 1			

Appendix 1: Connecting Care Programme Governance



Appendix 2: The Cheshire wide 'Pioneer' Plan

The following section outlines further detail on the key changes that will be made as a pioneer site both across Cheshire and for each of our three localities:

Pan-Cheshire

Our Commitment	What does this mean?	Key Stakeholders
Integrated communities	• Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term demand on acute and specialist services; • Implementing a joint information and advice strategy to help individuals make informed choices about their care • Rollout of personal health and social care budgets to enhance local choice, independence and local microenterprises; • Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation; • Integrated support for carers across health and social care. • A suite of interventions that tackle the causes of unhealthy lifestyles • Rolling out timebanks to attract volunteers and mutual support networks • Rolling out the Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models	• All residents across Cheshire • The voluntary and community sector • Public Health • All health and social care services • Wider health and social care providers • North West Ambulance Service
Integrated case management	• A single point of access into services in each area. • A risk stratification tool to identify target populations requiring joined-up support • Real and virtual case management teams each working with patient populations of between 30,000 and 50,000. • A common assessment tool to support the sharing of information across professionals with joint information systems to support collaboration. • Care coordinators and lead professionals who will hold the case, step up and step down the appropriate interventions and help the individual and family navigate the system. • Develop a Multi-Agency Safeguarding Hub covering both Adults and Children's that will enable strategic safeguarding leads to work closer together	• Complex families (as per locally defined troubled families cohort) • Individuals with mental health issues • Older adults with long terms conditions • All health and social care services • Vulnerable Children and Adults • Ambulance service
Integrated commissioning	• A redesigned model of bed-based and community-based intermediate care to enable demand for long term care to be better managed. • A full package of interventions which support older adults to live in their own home including assistive technology, admission avoidance/hospital discharge schemes and reablement. • Scaled-up plans for Supported Housing to maximise independence within an additional supported environment. • Evidence-based interventions to support families requiring additional support including triple P and Family Nurse Partnership. • A jointly commissioned community equipment service • A jointly commissioned offer for children in care • A jointly commissioned offer for children with disabilities • Jointly commissioned drug and alcohol services across health and social boundaries. • Move towards a coalition approach to co-ordinated care. • An Integrated Wellness Service that addresses the root causes of poor health outcomes alongside other partners outside of Health and Social Care.	• Clinical Commissioning Groups and Local Authority Commissioners • Transitional care providers • Strategic Housing and Planning • Emergency Services
Integrated enablers	• A joint approach to information sharing • Development of a single case management ICT system • A new funding contracting model to ensure that incentives are in place to shift activity from acute provision to community based care (likely to include capitation or cap and collar supported by new contracting models such as prime provider models, joint ventures or accountable care organisations)	• All health and social care services • Acute Foundation Trusts • Community Health Providers • Monitor • Information Commissioner

Appendix 3: Everyone Counts shared vision, initiatives and outcomes

	Priority Area	Key aims	How the health economy plans to improve these?	Level of improvement expected 2014-2019 These metrics need review to check they represent the care system
1.	**Securing additional years of life for in your local population with treatable conditions**	• Reducing premature mortality from all major causes of death • Reducing premature deaths for severe mental illness • Reducing deaths in babies and young children • Reducing deaths in people with a learning disability	1. **Diagnose cancer early** – through GP and nurse education, use of campaigns to increase awareness of signs and symptoms and through age extensions to cancer screening programmes 2. **To improve the mortality rates of those with learning disabilities –** through promotion of screening and improve health outcomes from Health Checks, introduction of a health inequalities framework and undertaking of a cross organisational audit of deaths in people with learning disabilities	• Decrease premature mortality from cancer in the under 75s to • 110/100,000 in 2 years in South Cheshire • 140/100,000 in 2 years in Vale Royal • Cancer screening uptake to be in top 20% in England • Diagnose at an earlier stage (20% improvement) • Decrease number of avoidable deaths in people with a learning disability • Improve the quality of life in people with a learning disability
2.	**Improving the health related quality of life of people with 1 or more long term conditions**	For people with long term conditions • Ensuring people feel supported to manage their condition • Improve functional ability • Reduce time spent in hospital • Enhance quality of life for carers, people with learning disabilities, mental illness and people with dementia	Generic plans to: Reduce number of admissions to hospital, number of readmissions and number of admissions to long term care Increase the number of people who have a positive experience of care, die in their preferred place of care and who feel able to manage their own conditions There are individual proposals and plans for addressing this by clinical specialty e.g. respiratory, pain management services etc.	• Achievement of all Better Care Fund metrics: • Increasing numbers of people feel supported to manage their condition as per GP survey • High quality patient experience measures • 20% reduction in delayed discharges each year • 2% reduction in injuries due to falls annually
3.	**Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital**			
4.	**Increasing the proportion of older people living independently at home following discharge from hospital**	• Focuses on helping people to recover from episodes of ill health • Improving outcomes from planned treatments • Improving recovery from injuries and trauma, from stroke, fragility fractures and mental illness, • Helping older people to recover their independence after illness or injury	• Keeping people out of hospital when appropriate • E.g. developing an integrated urgent care system to manage patients through ambulatory services and therefore decrease number of unplanned admissions • Effective interfaces between primary, secondary and community care • High quality, efficient care for people in hospital e.g. ensuring clinical pathways are compliant with NICE guidelines • Co-ordinated care and support following discharge e.g. Transitional care intervention beds to provide additional step up/down capacity	• Reduction in non elective admission –of min 3% per year from April 2014 • Reduction in A&E attendances - 7% from April 2015 • 90% patient discharged home from the transitional care beds. Length of stay not to exceed 21 days • 11% reduction in permanent admissions to care/nursing homes by 2016 • increasing proportion of older people still at home 91 days after discharge from hospital • 6% increase in re-ablement effectiveness

5.	**Increasing the number of people having a positive experience of hospital care**	Improving patients experiences of outpatients, A&E, maternity services Improving hospital's responsiveness to personal needs Improving experience of health care for children and young people, people with a mental illness or with a learning disability and people at the end of their lives Improving patient's experiences of integrated care	Working with the Citizens Advice Bureau to help people access support to address underlying issues affecting health Working to enable cancer care to be delivered more locally Pilot for a specialised dementia 'End of Life' team providing training to staff, working with the clinical team to manage complex cases and working to promote best practice Improving the end of life care programmes Review of CAMHS services and services for complex and high risk adolescents	Length of stay and cancer related admissions to decrease 70% of people, and their families for patients being treated for dementia EOL report a positive experience 10% increase in dementia patients at EOL care being treated in their preferred place of residence 84% achieving their preferred place of death by Dec 2015 15% reducing in A&E attendances by people in their last year of life
6.	**Increasing the number of people having a positive experience of care outside of the hospital, in general practice and in the community**			
7.	**Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care**	To reduce the incidence of avoidable harm and to care for people in a safe environment	This will be addressed through: Work of the Quality and Performance Committee Development of the all partner Quality Dashboard Through Quality Review meetings discuss how performance relates to quality and patient safety Safeguarding Review meetings	Annual decline in avoidable deaths until zero is achieved.

Bibliography/references

To be completed……

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Health and Wellbeing Board

Date of Meeting:	29 May 2014
Report of:	Simon Whitehouse, Chief Officer, NHS South Cheshire CCG
Subject/Title:	NHS South Cheshire CCG – Quality Premium 2014-15

1.0 Report Summary

The 'quality premium' was introduced in 2013-14 as a new mechanism to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities. As set out in the Planning Guidance – *'Everyone Counts: Planning for Patients'*[1] the quality premium will continue into 2014-15.

The main aim of the quality premium 2014-15 is to reflect the quality of the health services commissioned by CCGs in 2014/15, which will be paid to CCGs in 2015/16. It will be based on six measures that cover a combination of national and local priorities.

It rewards CCGs for improved outcomes from the services they commission against the main objectives of the NHS outcomes Framework and the CCG Outcomes Indicator Set, that is:

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.

The quality premium also underlines the importance of maintaining patients' rights and pledges under the NHS Constitution and achieving financial and quality requirements.

The quality premium sets broad overarching objectives as far as possible, leaving CCGs to determine with health and wellbeing partners what specific priorities they will need to pursue to achieve improvement in these areas.

The following section of the report provides the Health and Wellbeing Board with an overview of NHS South Cheshire CCG Quality Premium for 20140-15, detailing the national and local measures.

[1] Everyone Counts: Planning for Patients, 2014/15 to 2018/18, NHS England, 20th December 2013

2.0 Recommendations

The Health and Wellbeing Board are asked to:

1) Review the Quality Premium 2014-15 for NHS South Cheshire CCG and confirm support for the local priority measure chosen.

2) Discuss the plans in relation to the 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 QUALITY PREMIUM 2013-14 – NATIONAL AND LOCAL MEASURES

The 'quality premium' 2014-15 is intended to reward clinical commissioning groups (CCGs) for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing inequalities.

The quality premium paid to CCGs in 2015/16 – to reflect the quality of the health services commissioned by them in 2014/15 – will be based on six measures that cover a combination of national and local priorities.

The five national measures (identified in the NHS Outcomes Framework) are:

- Reducing potential years of lives lost through amenable 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 the FFT in 2014-15 and showing improvement in a locally selected patient experience indicator (15% of quality premium)
- Improving the reporting of mediation-related safety incidents based on locally selected measure (15% of quality premium)

The local quality measure that has been identified for NHS South Cheshire CCG (and agreed by NHS England) is:

- to continue their programme of work to appropriately manage patients with Atrial Fibrillation whilst promoting therapeutic optimisation in accordance with best practice. We aim to increase the number of patients who are appropriate anti-coagulated who have been identified most at risk of catastrophic stroke in line with second quartile national average.

The table below presents the rational for the local quality measure and the expected outcomes.

NHS South Cheshire CCG – Local Quality Premium Measure 2014-15	
LOCAL PRIORITY	Continue programme of work to appropriately manage patients with **Atrial Fibrillation** whilst promoting therapeutic optimisation in accordance with best practice. **What is AF?** Atrial fibrillation is when the atrial section of the heart is not working properly. Because this part of the heart is not pumping the blood around the body effectively, the blood can clot and could lead to a stroke. There are two ways to correct this problem: 1. Correct the rhythm of the heart, 2. Introduce a substance into the body to stop the blood from clotting. NHS South Cheshire CCG is committed to promoting the early identification and treatment of AF in order to reduce the risk of patient's suffering a catastrophic stroke. Due to this, South Cheshire CCG has for the past two years included the early identification of AF as part of the Primary Care CQUIN (a local incentive scheme funding Practices to take part in quality improvement initiatives). The results of the AF work in 2012-2013 were fed back to our Public Health Team to assess the impact.
RATIONALE	**Public Health Findings** • South Cheshire CCG's number of patients with confirmed diagnosis of AF has increased from 3,392 – 3,723 (i.e. circa 10%) (from 2012/11 – 2011/12) • 1,593 patients were identified in Year 1 as having possible AF. The above increase represents only 21% of patients with possible AF having confirmed diagnosis and treatment plans • Of the patient's with confirmed AF, following the use of the GRASP tool, use of anticoagulation increased by 3% for those most at risk of stroke (57-60% of the total) • Of those patients with AF, 859 patients are still not anti-coagulated (23%) • Public Health determined that due to this, 50 patients are at risk of avoidable catastrophic stroke in year. There is evidence to suggest that the use of anti-coagulation (e.g. Warfarin or NOACs) for patients with AF will reduce their chance of suffering a catastrophic stroke. The limited number of contra-indications for the use of Warfarin (the evidence presented to the CCG in 2013 by Dr. Guy Hayhurst on behalf of Cheshire East Council's Public Health Team) and the fact that NHS South Cheshire CCG is below average for anticoagulation provides some robust opportunities for improving patient outcomes. **Further JSNA Evidence:** In South Cheshire CCG there are: • An estimated 14,300 people with undiagnosed hypertension • A further 12,200 people who have hypertension that is diagnosed but not sufficiently well controlled. • In total an estimate of over 26,500 people whose high blood pressure is damaging their health and are directly leading to 50 avoidable heart attacks or strokes every year.

	• Within Cheshire East 2011/12 – 516 emergency admissions for stroke. Local data suggests only a small proportion of those suffering a stroke are currently being assessed and treated at a specialist stroke centre. **Joint Health and Wellbeing Strategy for the Population for Cheshire East 2014-2016:** *Strategic Priority:* **Outcome two – Working and living well…** *'Driving out 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'* *Priority for Collective Action:* 'Reducing the incidence of cardiovascular disease'. *Strategic Priority:* **Outcome three - Ageing well…** *'Enabling older people to live healthier and more active lives for longer'* *Priority for Collective Action:* 'Improve the co-ordination of care around older people....and support independent living (including falls prevention)'.
OUTCOMES	Increase the number of patients who are appropriate anti-coagulated who have been identified most at risk of catastrophic stroke in line with second quartile national average. Increased management closer to home and in primary care setting Reduction in long term dependency on specialty services Reduction in health inequalities

4.0 Access to Information

For further details on the Quality Premium 2014-15 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.

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	29th May 2014
Report of:	Corporate Manager Health Improvement
Subject/Title:	Review and refresh of the Cheshire East Joint Health and Wellbeing Strategy
Portfolio Holder:	Cllr. Janet Clowes Portfolio Holder for Care and Health in the Community

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 Draft Strategy has now been presented to the Council's Cabinet and the CCG's Governing Bodies. The amendments have been incorporated into the revised Strategy which 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

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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.

5.6 During the last six weeks the draft Strategy has been through the Council's Cabinet and the CCG Governing Bodies and comments received from all three. The changes requested have been made to the attached version. This includes proposed key performance indicators to help to gauge progress against the Board's priorities.

8.0 Access to Information

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

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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.easterncheshireccg.nhs.uk and search for 'Annual Plan'.

- **The NHS South Cheshire Clinical Commissioning Group Operational Plan 2014-2016**
  Visit www.southcheshireccg.nhs.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. There will be proactive and effective relationships with the Safeguarding Children and Adults Boards.

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

[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.

	improving the physical health of people with serious mental illness[2]. 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 should be noted that some of the areas of focus will apply across more than one priority outcome, for example reducing social isolation and loneliness may be as applicable to some children and young people and as to older people. The Board will ensure that where this is the case appropriate actions will be put in place.

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.

[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.

[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
Eastern CCG Starting & Developing Well	• Improving transition from children's to adult services – initially focussing on CAMHS 16-19 service • Empowered Children, Empowered Parents – looking into resources that encourage self-management • Monitor the progress of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) pilot • Continuing to develop the Joint Early Years and Early Help Commissioning Strategies with Public Health, NHS England, South Cheshire CCG and East Cheshire Council • Implement redesigned neuro-developmental pathways • Developing CCG capability to meet statutory responsibilities for children with Special Educational Needs
Working and living well	• Development of services to deliver "24-7" access to care • Implementation of proactive systems to identify and recall patients with serious mental illness or learning disabilities for health checks • Improved access to primary mental health services, including IAPT (Improving Access to Psychological Therapies) • Improving a range of clinical pathways and services through application of best practice evidence. This includes application of NICE guidance and working with the Academic Health Science Network

	• Redesign of ENT, Upper GI, Urology, Gynaecology and Hepatobiliary pathways
Ageing well	• Developing the Caring Together Model with "early implementation schemes" developed around wider Primary Care Services. This includes stratifying high risk patients, proactive multidisciplinary case management, sharing of relevant information through patient passports and shared records • Development of a quality framework for care homes. Expansion of the care home doctors service and development of multidisciplinary support. • A range of quality improvement projects including reducing the prevalence healthcare acquired infection of falls, pressure sores and medication errors • Developing ambulatory care services and urgent response services in order to support caring for patients closer to home rather than in a hospital setting. This includes ambulance pathfinder, urgent primary care access and • Development of dementia services and promotion of dementia friendly communities • Further development of end of life care services • Enhancement of the range of support and services available for Carers in our community • Continued development of stroke care. The CCG is engaged in the expansion of the Greater Manchester Acute Stroke Model, development of community rehabilitation and early supported discharge from hospital
NHS South Cheshire CCG	1. To introduce Extended Practice Teams in order to improve care for adults with one or more long-term conditions/ complex needs by treating efficiently within community setting in order to reduce fragmentation, duplication and communications between healthcare services. 2. To reduce the overall number of avoidable Paediatric 'short stay' admissions and develop alternative pathway to hospital admission when appropriate. 3. To reduce the proportion of cancers that are diagnosed following an emergency presentation by 3% over three years. 4. To improve mortality rates for those with learning disabilities. 5. To ensure the configuration and capacity of memory services is sustainable in the context of the rise in numbers with the condition. 6. To detect and diagnose dementia earlier and ensure appropriate support services are available. 7. To ensure there is sufficient and appropriate bed capacity for intermediate and transitional care services. 8. To 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. 9. To commission a specialist community based stroke and rehabilitation services in order to improve outcomes for stroke survivors and their families. 10. Supported self-management of people with long term conditions including shared risk profiling for early detection. 11. To support the reduction in the number of direct admissions to long-term care from acute care from baseline by 2% by 2015

	12. Increase in the proportion of older people (65 yrs. and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services from baseline by 6% by 2015 13. Reduction in delayed transfer of care including those attributable to social care from baseline by 4% by 2015 14. Reduction in emergency admissions from baseline by 3% by 2015 15. To increase in the proportion of people who feel supported to manage their long-term conditions(s) from baseline by 6.2% by 2015 16. Reduction in the number of injuries due to falls from baseline by 2% by 2015

Annex Two
Key Performance Indicators

What we want to achieve…	What we need to focus on	Proposed KPIs (NB where bold text the Performance Team proposes these as the selected indicators)
Outcome one - Starting and developing well…	Children and young people feel and are kept safe	The % of cases taking 45 days or less from the start of the combined assessment Percentage of children and young people participating in their child protection plan % of children and young people who self report that they feel safe The number of children in households with reported repeat incidence of domestic abuse Number of children killed or seriously injured in road traffic accidents
	Children and young people experience good emotional and mental health and wellbeing	Number of children and young people accessing tier 2 CAMHS Number of children and young people accessing tier 3 CAMHS
	- Reduce the levels of alcohol use / misuse by Children and Young People	Number of hospital admissions for alcohol misuse for under 18s
	- Reduce the numbers of children and young people self harming.	Number of A&E attendances age 0-19 with deliberate self harm diagnosis or complaint (confirm with Guy Hayhurst)
	Children and young people who	The % of children and young people

	are disabled or who have identified special education needs have their aspirations and hopes met	with a statement achieving 5 A*-Cs (including English and Maths) Number of young people accessing personal budgets (from Sept 2014) Number of learners with learning difficulties and/or disabilities (LLDD) in employment, education and training (EET)
	Targeted prevention interventions to reduce children and young people's obesity	Excess weight in 4-5 year olds Excess weight in 10-11 year olds
		% of pupils achieving a good level of development across the Early Years Foundation Stage Profile % of good and outstanding early years settings Achievement gap at KS4 between the lowest 20% and the rest Number of multi-agency early help assessments/CAFs per 10,000 population
Outcome two - Working and living well…	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	• **ASCOF 1D: Carer-reported quality of life** (score out of 12) – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • **ASCOF 3B: Overall satisfaction of carers with social services** – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • ASCOF 3C: Proportion of carers

		who report that they have been included or consulted in discussion about the person they care for services – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • ASCOF 3D (Disaggregation): Proportion of people who use services and carers who find it easy to find information about services – *N.B. This is from a biennial survey; the next survey results will be available in14/15* • **Carers receiving needs assessment or review and a specific carer's service, or advice and information** • Number of carers receiving a carers specific service (per 10,000 population) • **Number of completed Carers Assessments** • Percentage of carers declining an assessment
	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	• ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment – *N.B. Official outturn not known until after year end* • ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support - *N.B. Official outturn not known until after year end* • **Number of Mental Health service users receiving self-directed support as a proportion of Mental Health service users who would benefit from self-directed support** – *N.B. This would be a disaggregation of an existing measure. This disaggregation is not currently routinely produced but data is available*
	Seven day care services provision	
Outcome three -	Improving the co-ordination of	• ASCOF 1A (Disaggregation):

Ageing well…	care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).	Social care-related quality of life (score out of 24) – *N.B. This is taken from an annual survey.* • **ASCOF 1I (Disaggregation): Proportion of people who use services and their carers, who reported that they had as much social contact as they would like**. *N.B. This is a new measure from 13/14. This is taken from an annual survey.* • **ASCOF 2A: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** • ASCOF 3A (Disaggregation): Overall satisfaction of people who use services with their care and support – *N.B. This is taken from an annual survey.*
	Providing high quality palliative care service	
	Supporting older people, their families and carers, to prepare for the rest of their lives.	

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CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	29th May 2014
Report of:	Guy Kilminster
Subject/Title:	Health and Wellbeing Peer Challenge

1.0 Report Summary

1.1 In June 2013 The Board expressed an interest to the Local Government Association in a Health and Wellbeing Peer Challenge being undertaken in 2014. Peer Challenges are designed to support Health and Wellbeing Boards in implementing their health statutory responsibilities.

1.2 This is done through a systematic challenge by system wide peers in order to improve local practice. Four to six peers from local government, health or the voluntary sector will spend four days on-site. The process involves a wide range of people working with the Council in both statutory and partnership roles and the findings are delivered immediately. The Peer Challenge is to take place from the 18th to the 22nd of November 2014. A preliminary scoping meeting will be taking place with our Peer Challenge Manager Caroline Bosdet on 10th June.

1.3 The guidance on the Challenge is attached as Appendix A.

2.0 Recommendations

2.1 That the Board note the forthcoming Peer Challenge and the published Methodology and Guidance.

2.2 That the Board nominate lead officers to assist with the preparation for the Peer Challenge.

3.0 Reasons for Recommendations

3.1 To advise the Board of the Peer Challenge and ensure that the appropriate work is undertaken to prepare for the visit.

3.2 To benchmark against best practice the Board's work to date and its effectiveness and to identify areas for focus and improvement moving forward.

4.0 Financial Implications

4.1 The Local Government Association covers the cost of the Peer Challenge. There will be staff time taken up in preparing for the visit and during the course of the week.

5 Background

5.1 From 1st April 2013, responsibility for public health and other health services was given to local agencies, including councils, clinical commissioning groups and the new Health and Wellbeing Boards.

5.2 The Local Government Association (LGA) has convened national partners including the Department of Health, NHS England, the NHS Confederation, Public Health England, Healthwatch England and the Association of Directors of Public health to provide a 'Health and Wellbeing System Improvement programme'.

5.3 The Peer Challenge is one of a number of elements that make up this Programme. It is a voluntary and flexible process commissioned by a Council or a partnership to aid their improvement and learning. Peers are 'critical friends' or 'trusted advisors'. It is not an inspection. The process is based upon a view that organisations learn better from peers and are more open to challenge. Peers can challenge robustly and effectively.

5.4 There are three elements that the peer challenge focuses on, including the interconnectivity between the three:

- Operation of effective Health and Wellbeing Boards (HWB) as forums in which key leaders from the health and wellbeing system are coming together to improve the health and wellbeing of their local population and to promote more integrated services;

- Transfer and integration of the public health function into councils;

- Establishment and effective operation of a local healthwatch.

5.5 The Peer Challenge uses a set of headline questions from which to frame the preliminary review of materials, the interviews and the workshops that make up a peer challenge.

- Is there a clear, appropriate and achievable approach to improving the health and wellbeing of local residents?
- Is the HWB at the heart of an effective governance system? Does leadership work well across the local system?
- Are local resources, commitment and skills across the system maximised to achieve local health and wellbeing priorities?
- Are there effective arrangements for evaluating impacts of the health and wellbeing strategy?
- Are there effective arrangements for ensuring accountability to the public?

5.6 A scoping meeting is to take place on the 10th June to begin the process of planning for the Peer Challenge. This will allow some consideration as

to what to focus on and who needs to be involved. A further report will come to the Board after that meeting.

5.7 Appendix A includes the details of the methodology and guidance for the Peer Challenge.

6.0 Access to Information

This report was produced by Guy Kilminster – Corporate Manager Health Improvement

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Health and wellbeing system improvement

Health and wellbeing peer challenge

Methodology and guidance

14th June 2013

1. Supporting the new health and wellbeing system

From 1 April 2013, responsibility for public health and other health services was given to local agencies, including councils, clinical commissioning groups and the new health and wellbeing boards. The Local Government Association (LGA) has been convening national partners, including the Department of Health, NHS England, the NHS Confederation, Public Health England, Healthwatch England and the Association of Directors of Public Health, to provide a 'Health and Wellbeing System Improvement Programme' for health and wellbeing boards, local authorities, clinical commissioning groups and local Healthwatch organisations. This £1.8million programme includes support for local leadership on health through a health and wellbeing peer challenge, regional support to address collective issues, bringing together information on public health via the LGA's LG Inform tool, a self-assessment tool, support to council commissioners through the regionally based Healthwatch Implementation Team, online networking via the LGA's current Knowledge Hub tool and national learning events.

The core national elements of the LGA's offer are:

Peer challenge – this tried and tested LGA sector-led improvement tool is being developed collaboratively for health and wellbeing. Councils can commission the challenge to focus on local public health, health and wellbeing board and local Healthwatch priorities.

LG Inform – this LGA on-line data and benchmarking tool, part of the LGA's core offer, is developing a specific package to consolidate key benchmarking information on public health that health and wellbeing boards, councils, local people and voluntary organisations can use to facilitate monitoring trends and for benchmarking. Data and information is also being produced to inform the peer challenges.

Knowledge Hub - supports on-line networking and the LGA continues to support the existing National Learning Network for health and wellbeing boards.

Healthwatch Implementation Team - this small, expert team deployed in each region will continue, in the immediate term, to provide 'trouble shooting' capacity and to provide tailored support to local authority commissioners.

The LGA and Healthwatch England are currently co-producing a joint work programme, which will be framed around joint events, publications for local healthwatch and local authority commissioners, troubleshooting capacity and tailored support in response to Francis Review recommendations.

National Sharing learning events – two national events have been planned for June 2013 in London and Leeds for health and wellbeing boards and partners in public health to share experiences and learning.

Regional approach driven by local choices - this has focussed on identifying as much funding as possible to devolve to the regions throughout the year so the offer is responsive to local need and builds on local networks and capacity. Regional

funding will be made available as part of a grant agreement with clearly defined criteria to demonstrate value, share learning and regularly communicates.

For more information on the offer go to:

http://www.local.gov.uk/web/guest/health/-/journal_content/56/10171/3932121/ARTICLE-TEMPLATE

2. Purpose and scope of the health and wellbeing peer challenge

A peer challenge is a voluntary and flexible process commissioned by a council to aid their improvement and learning. It involves a team of between 4 - 6 peers from local government, health or the voluntary sector who spend time on-site at a council to reflect back and challenge its practice, in order to help it to reflect on and improve the way it works. The process involves a wide range of people working with the council in both statutory and partnership roles and the findings are delivered immediately.

Peers are working as 'critical friends' or 'trusted advisors', not professional consultants or experts. Peer challenge is not inspection. The process is based on a view that organisations learn better from peers and are open to challenge. Likewise it believes that peers, in their professional capacity, challenge robustly and effectively. While the process is voluntary it is not a 'soft option'.

The purpose of the health and wellbeing peer challenge is to support councils, their health and wellbeing boards and health partners in implementing their new statutory responsibilities in health from 1 April 2013, by way of a systematic challenge through sector peers in order to improve local practice. In this context, the peer challenge focuses on three elements in particular while at the same time exploring their interconnectivity – the:

- establishment of effective **health and wellbeing boards**
- operation **of the public health function** to councils
- establishment of an effective local **Healthwatch organisation.**

We appreciate that the new health and wellbeing system includes many organisations, representatives and stakeholders, who are engaged in the challenge process. However, for the purpose of this peer challenge the **client is the local council**.

3. Headline questions for the peer challenge

The peer challenge focuses on a set of headline questions and more detailed prompts, from which to frame the preliminary review of materials, the interviews, and the workshops that make up a peer challenge. They are discussed and tailored in the context of each council.

A list of headline questions and prompts are at **Appendix 2** but the main four questions are:

1. How well are the health and wellbeing challenges understood and how are they reflected in Joint Health and Wellbeing Strategies (JHWSs) and in commissioning?
2. How strong are governance, leadership, partnerships, voices, and relationships?
3. How well are mandated and discretionary public health functions delivered?
4. How well are the Director of Public Health (DPH) and team being used, and how strong is the mutual engagement between them and other council teams?

4. The peer challenge process

4.1 Preparation

The purpose of pre-site work is to prepare for an effective and high impact peer challenge. We are keen to avoid unnecessary burdens on councils and try to keep information requests to a minimum. However, our experience with peer challenges shows that a degree of pre-site analysis is required for the peer challenge team to be fully operational on day 1. Similarly, feedback from councils shows that encouraging them to reflect on the effectiveness of their practice before the peer challenge helps them to define a clear focus for the on-site work and ultimately provides them with a more tangible outcome of our work.

Preparatory work involves the following:

i. Position statement

We encourage councils to prepare a short position statement outlining how they are performing against the main themes of the peer challenge (see above) and the specific focus. We do not prescribe the format or style of position statements but we can provide examples of what these can look like.

ii. Pre-site reading

We ask the council to provide us with a number of documents, many of which are likely to be in the public domain already. Key documents are likely to be:

- a local stakeholder map of ‘who is who and who does what’ in the health and wellbeing system
- the council business plan
- a selection of service plans to ascertain how health and wellbeing permeates into services such as housing, licensing, planning
- Joint Strategic Needs Assessments (JSNAs)
- JHWSs
- background information about the health and wellbeing board (HWB), eg agendas, minutes and papers for past meetings, and terms of reference
- information about plans for joint commissioning and service transformation, eg a joint commissioning strategy, data on pooled budgets/resources
- the clinical commissioning group’s (CCG’s) commissioning plan
- NHS England Local Area Team plan or equivalent, outlining what they are commissioning to meet local need

- memorandum of understanding with CCG regarding public health advice
- latest NHS patient satisfaction surveys for the area
- information on arrangements for the local Healthwatch organisation
- information about arrangements for health scrutiny, including the forward plan
- summary description of arrangements for delivering statutory local PH functions
- Health Protection Plans.

iii. Pre-site analysis

Pre-site analysis is undertaken by the LGA and includes a high level analysis presentation and a number of datasets including:

- NHS outcomes benchmarking support pack
- Public Health England Health Profile
- Public Health England Local Health Profile
- Child Health Profile
- Community Mental Health Profile
- census data
- service data through LG Inform.

iv. Pre-site survey with members of the HWB

We conduct a short on-line survey with members of the HWB to obtain some baseline data on the effectiveness of working arrangements as well as the leadership and relationships of members. We have developed a standard survey which we discuss with you and adapt to include any specific questions of value for your local HWB. The survey is administered by the LGA.

v. Timetable of activities for the peer team

The team is on site at a council for a period of 4 days.

The council needs to arrange a timetable of activity organised in advance of the visit by the peer team. The timetable should enable meetings and discussion sessions (during the remainder of day 1, day 2 and day 3) with a range of officers, members and other stakeholders enabling the peer team to explore the issues relevant to the purpose, scope and suggested terms of reference for the peer challenge.

The peer team works in teams of two with three parallel interview streams each day. This allows for 40 - 50 activities.

Suggestions (neither a prescriptive or exhaustive list) of whom the peer team need to meet with whilst on-site are:

1:1 discussions

- Leader or Elected Mayor
- Portfolio Holder for health and wellbeing and/or Adult or Children’s Services

- Chief Executive (CE)
- Director of Public Health
- Council Directors (either individually or as a focus group)
- Chair of the HWB (if different from above)
- Chair and Vice Chair of Health Scrutiny
- Leader(s) of the Opposition
- Accountable Officer and Chair of the local CCG(s)
- Director/senior manager of the local PHE centres
- Director/senior manager of the local NHS England Action/Area Teams
- CE or senior managers of other key health stakeholders, eg acute trusts, community trusts, mental health trusts, primary care and other local providers, including community pharmacy and other providers
- Research/intelligence officer (JSNAs)
- Head of Human Resources/Organisational Development within the council
- Operational lead for the HWB
- Public health professionals, including consultants
- CE of the local Healthwatch organisation
- Chair of the neighbouring HWB where the health economy has a significant sub-regional configuration
- District council representation where appropriate.

Focus Groups:

- external stakeholders (eg housing, economy, police, VCS, education, universities)
- remainder of Cabinet (as one focus group)
- Heads of Service, including planning, housing, leisure, highways
- CE/lead members for health of District Councils (where appropriate)
- front line public health staff who have been transferred to the council
- voluntary and community sector providers

4.2 On-site work

The on-site challenge takes place over four consecutive days when the peer team is at the council and undertakes a range of activities, including focus groups, observations, site visits and discussions with officers, elected members, partners and stakeholders.

The timetable can include workshops on a specific area of focus the council wishes the peer challenge to explore.

The timetable is designed on the focus of the peer challenge and local arrangements. However, there are two sessions which are common to all peer challenges:

- a **‘setting the scene’ meeting** in the morning of the first day of the peer challenge. This provides an opportunity for the peer challenge team to meet with key officers and elected members and to receive an introductory presentation about the council and how it embraces its new responsibilities in health, together

with key opportunities and challenges as well as successes. The team uses this session to re-state the focus for the peer challenge and to establish common ground in what a good outcome of the process will be. It is also an important part in 'starting the process together' and to build relationships and trust between the council and the peer challenge team

- the **feedback session** on the last day of the peer challenge. In addition to informal feedback at the end of each day, the peer challenge team provides two types of feedback on the last day:

    - an informal 'dry run' of the formal feedback to a small group of officers and elected members (normally including the Chief Executive and Leader or elected Mayor or lead Cabinet member). This allows a check on any sensitive issues

    - a formal roundtable feedback discussion on the final day on site at the council involving an audience of the council's choosing. The team shares its views and offers advice on the main focus of the challenge and key strategic and leadership issues.

4.3 Written feedback

The council receives written feedback within 2-3 weeks after the departure of the peer challenge team. Written feedback is normally in form of a letter addressed to the Chief Executive. It elaborates on the points made in the feedback presentation, outlining the main findings and conclusions and provides recommendations for improvement and innovation.

The council has an opportunity to comment on the draft letter before it is finalised by the review manager.

The feedback letter and presentation are the property of the council. They are not published on the LGA website. However, in the interest of openness and accountability we recommend making the feedback publicly available.

4.4 Follow-up work

The peer challenge includes an offer of follow-up support. This can involve all or part of the team engaging in an activity such as:

- holding an action planning workshop with the council
- organising a workshop on a specific theme or area, involving experts or other peers as appropriate
- arranging for a follow-up visit at a later time to challenge progress.

The review manager liaises with the council to scope and manage any follow-up activity.

The peer team provides continuous feedback throughout the peer challenge process. The intelligence gained is fed back into the LGA to inform the planning of

future support. It also contributes to our sector knowledge base, which we need to prove sector led improvement works for local government.

5. The Peer Team

Composition

Peer challenges are managed and delivered by the sector for the sector. Peers are at the heart of the peer challenge process. They provide a 'practitioner perspective' and 'critical friend' challenge. Peers help build capacity, confidence and sustainability by challenging practice and sharing knowledge and experience.

The peer team includes 6 - 7 peers, including the challenge manager, and reflects the focus of the peer challenge. The review manager discusses the composition of the challenge team with the council. All peers are approved by the council.

The core team normally consists of:

- a Council Chief Executive or Strategic Director
- an elected member, normally the Chair of the HWB in their area
- a Director of Public Health
- an NHS peer, for example an officer or member of a CCG or a national peer
- an LGA challenge manager.

In addition, the team includes one or two peers with a particular specialism or expertise such as a:

- specialist health peer
- peer with national perspective, eg Healthwatch England, NHS England, Public Health England
- representative from a local Healthwatch organisation
- representative from the voluntary and community sector
- district council peer (in two tier areas)
- a local authority officer peer.

Within each team, one officer is designated the lead peer, normally the Council Chief Executive or Strategic Director.

Roles and responsibilities

The role of peers is to:

- undertake pre-reading in advance of the peer challenge
- attend and participate in an initial peer team meeting
- facilitate interviews and discussion whilst on-site at the council and to gather information via these, record and share key findings with the peer team
- draw on their relevant skills, knowledge and experience
- analyse key messages throughout the process

- work with others in the peer team to develop and deliver a feedback presentation
- contribute to the draft feedback letter within agreed timescales
- participate in the evaluation of the peer challenge
- undertake additional or specialist roles on the peer team.

The role of the challenge manager is to:

- manage the overall peer challenge process and act as the first point of contact for the client
- work with the client to identify peers and compose the peer challenge team
- work with the client to scope and design the peer challenge process including a set up meeting and advice/guidance on developing the timetable and position statement
- during the on-site process, be a full part of the team and also act as facilitator and adviser to guide the rest of the team through the on-site process
- facilitate and support the preparation of the feedback presentation, including working with the team to determine points of judgement in the process
- write the written feedback and liaise with the team and the client to finalise it
- liaise with the client to agree follow-up support.

6. Peer team requirements during the on-site period

We ask the council to provide for the peer team requirements during the on-site period. These include:

- the provision of a room at the council to use as a base for the time the peer team are on site. This would ideally be located in the main headquarters of the council. The room is for the sole use of the team members, with all interviews and focus groups being held elsewhere
- equipment for the base room, including a whiteboard or PowerPoint projector, one computer with access to the intranet and internet, and a supply of basic stationery
- catering for the team, including a lunch to be held in the base room each day.

The review manager discusses these arrangements in detail with the council.

The LGA manages and covers all expenses related to accommodation and travel for the team.

Appendix 1: Sample timetable

Day 1

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Admin / Passes / set up in Team Room*		
09:00 - 09:45	**Setting the Scene - Committee Room 1**		
09:45 - 10:00			
10:00 - 10:45	**Margaret Smith, Chair of Health and Adults Select Committee, Room 127, Civic Hall** **Bill/Anne**	**Judith McDuffy** **Director of Public Health, Borchester Council** **Room 130, Civic Hall** **Abdul/Sam**	**Kieran Williams, Chief Executive, Borchester Council** **Chief Executive's Office, Civic Hall** **Tim//Martha**
10:45 - 11:00	***Break***		
11:00 - 11:45	**Sue McNally, Director Community Commissioning Borchester Council** **Room 127, Civic Hall** **Bill/Martha**	**Mike Thompson** **Director of Health and Social Care Commissioning, Borchester Council** **Room 130, Civic Hall** **Anne/Abdul**	**Brenda Tarbuck, Leader of Labour Group, Borchester Council, Room 104a, Civic Hall** **Tim/Sam**
11:45 - 12:00	***Break***		
12:00 - 1.30	**Local Healthwatch Focus Group** **Felpersham Room** **Edes Mansion** **Abdul/Martha**	**Senior Management Team Focus Group** **Committee Room 1, Civic Hall** **Tim/Bill**	**Heads of Service Focus Group - Youth Services, Road Safety, Learning and Education, and Economic Development)** **Halnaker Room, The Grange** **Sam/Anne**
13.30 - 14.00	***Break***		
14:00 - 14.45	**Jeannie Chesterman, Clinical Director Woman & Children, Borchester Health Trust, Room 127** **Tim/Sam**	**Claire Gregory, Head of Integrated Adult Care Commissioning, Borchester Council and Member of Health and Wellbeing Board** **Room 130, Civic Hall** **Abdul/Martha**	**Frances Abraham, Non Executive Director Health Watch Borchester (Chair) and Health & Wellbeing Board Member with David O'Donnelly, Regional Manager HealthWatch, Room 104a, Civic Hall** **Bill/Anne**
14:45 - 15:00	*Break*		
15:00-16:00	**Samantha Merton** **Head of Policy and Communications Borchester Council, Room 127, Civic Hall** **Abdul/Bill**	**Public Health Consultants Focus Group, Loxley Room, Edes Mansion** **Martha/Sam**	**Borchester All Party Elected Members Focus Group** **Gables Room, Edes Mansion** **Anne/Tim**
16:00-16:30	*Team working and feedback preparation*		
16:30-17:30	*Daily Feedback*		

Day 2

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Team Time*		
09:00 - 9.45	**Dr Katie Bilbau, Accountable Officer, Brookfield Clinical Commissioning Group Telephone interview Peer to ring 02746 349672**	**Peter Samston, Cabinet Member for Children, Borchester Council Room 130, Civic Hall**	**Sean Matthews, Chief Fire Officer, Borchester Council Peer to call Sean on 07129 683641**
09.45 - 10.00	*Break*		
10:00 - 10:45	**Matthew Kershaw, Head of Legal Services, Borchester Council, Room 127 Civic Hall**	**Stuart Dawson, Director of Children's Services, Borchester Council, Room 130, Civic Hall**	**Christopher Macclesfield, Cabinet Member for Health and Community, Borchester Council, Member of Health and Wellbeing Board, Room 140**
10:45 - 11:00	*Break*		
11:00 - 12:30	**Dr James Partridge - Leader of Conservative Party, Borchester Council Room 127, Civic Hall**	**Christine Barnaby, East Gables Community and Voluntary Services (Voluntary Services Representative on Health and Wellbeing Board) and Martin Shoesmith, Room 130, Civic Hall**	**Service Leads Focus Group Martello Room, Edes Mansion**
12:30 - 13:30	*Team Lunch*		
13:30 - 14:45	**Patrick Orson, Head of Business Improvement, Martin Hammerstein, Business Change Programme Manager, Borchester Council, Room 127, Civic Hall**	**Jennifer Tatley, Head of Health and Social Care Practice, Borchester Council, Room 130, Civic Hall**	**Alan Jefferies, Head of Emergency Management, Borchester Council, Room 104a, Civic Hall**
14:45 - 15:00	*Break*		
15:00 - 16:00	**Hardeep Shah, Leader Borchester Council, Room 127, Civic Hall**	**Sarah Southill Director of Commissioning Borchester and Loxley Area Team (NHS England) Telephone interview. Peer (Room 130) to ring 07599 338561**	**Dr Parson Bilton Director of Local PHE Centre Peer to call 07227 485459**
16:00 - 17:00	*Team working and feedback preparation*		
17:00 - 17:30	*Daily Feedback*		

Day 3

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
08:30 - 09:00	*Team Time*		**TEAM TRAVELLING**
09:00 - 9.45	**Catherine Tilton & Tia Mistry, Borchester Council JSNA Lead Room 127, Civic Hall**	**Jamie Huntley, HR Business Partner & Jo Churchfield, Business Change Manager, Borchester Council, Room 130, Civic Hall**	**Travelling to Loxley (Abdul and Sam in Abdul's car)**
9.45 - 10.00			
10:00 - 10:45	**Loxley hub visit**		**Travelling to Gables**
10:45 - 11:00	*Break*		**Travelling to Gables**
11:00 - 12.30	**Public Health Focus Group Commissioning Bridge Room, Edes Mansion**	**Voluntary Sector Focus Group, Chief Executive's Board Room, Civic Hall**	**11.00 - 12.00 Dr Vishal Dhaliwal Clinical Chief Officer NHS Gables Clinical Commissioning Group, Vishal's Office, Gables Hospital** **then travel to Wellbeing Hub 12.00-12.30 - hub visit 12.30**
13.00 - 14.00			Gables Wellbeing hub visit - 12.30-13.30 Travel back to Gables hospital 13.30-14.00
14.00 - 14.45	**Justine Mitchell, Director of Nursing and Quality NHS England Borchester and Loxley Area Team), Member of Health and Wellbeing Board, Telephone Interview, Peer to call 07339 037362, Room 127, Civic Hall**	**Katie Butley, Commissioning Manager, Learning Disabilities, Borchester Council Phone interview, peer to call Katie on 07226 944626**	**Dr Agnieszka Laskowsa, Clinical Chairman Loxley CCG, Vice Chair of Health and Wellbeing Board Agnieszka's office, Gables Hospital**
14:45 - 15:00	*Break*		
15:00 - 16:00	**Detective Chief Inspector Pierre Lautrec, Borchester Police, telephone interview, peer to call 07394 339575**	**Public Health Staff (Other public health activities) Focus Group Leoni Room, Civic Hall**	**Travel back to Borchester for team working and feedback**
16:00 - 17:30	*Team working and feedback preparation*		
	No feedback session today		

Day 4

Time	Council Name		Day, Date, Month
	Workstream 1	Workstream 2	Workstream 3
09:00 - 12:30	Team prepares feedback		
12.30-13.30		**Dry run with Chief Executive, Leader and Director of Public Health, Committee Room 2, Civic Hall**	
13.30-14.30	*Lunch*		
14.30 - 15.30		**Feedback Committee Room 2, Civic Hall**	
15.30 - 16.00	*Team debrief and departure*		

Appendix 2: Headline questions for the peer challenge

The peer challenge focuses on a set of headline questions, and more detailed prompts, from which to frame the preliminary review of materials, the interviews, and the workshops that make up a peer challenge. They are discussed and tailored in the context of each council.

1. **How well are the health and wellbeing challenges understood and how are they reflected in JHWSs and in commissioning?**

- Is there a vision for the health and wellbeing of the local population? Is it shared between key partners in the local system?
- How strong are the analyses on which JSNAs are based? Do they reflect the population needs across health and care?
- Do JSNAs cover the wider-determinants of health?
- How well articulated and presented is the analysis?
- How clear are the priorities and timelines in JHWSs? Is there an appropriate balance between preventative and responsive interventions? Is there clarity over any areas of disinvestment from historic provision?
- How clearly are health inequalities, and their relationships with other inequalities, understood? Do JHWSs contain convincing strategies for closing gaps?
- How clearly are the delivery programmes related to available resources? How well are resources combined and pooled?
- Is there evidence of HWB members together finding the best uses of their collective spend across the system?
- How well are the potential contributions of the third sector and community structures reflected in strategies?
- How have local priorities been related to the national outcomes frameworks and strategies for public health, adult social care, children, and the NHS?
- How clear is the linkage through JSNAs, to JHWSs, and then to commissioning?
- How well combined are the analyses available from locality-based sources with those of the commissioning support unit?
- How clear is the relationship between JHWS and CCG commissioning plans and strategies?
- How well-used are national learning, benchmarking information, summaries of effective practice and value for money approaches, and the experiences of others responding to similar challenges?
- How clearly are health and wellbeing priorities reflected in broader community strategies and in the delivery strategies of individual agencies, including district council strategies in two-tier areas?
- How ambitious are the strategies and are they deliverable? To what extent is the balance of local service delivery being challenged?
- How well are actions, impacts and cost-effectiveness reviewed? To what effect? Is the local health system a learning system?

2. **How strong are governance, leadership, partnerships, voices, and relationships?**

- How well does the membership of the HWB reflect the need to align power and influence around the JHWS?
- How effective is the grip of the board on its programme and agenda? How well informed are its members? How effective are discussion, challenge, commitment and review? How is conflict managed?
- How strongly do members commit to the board and its actions? How well-shared is the core analysis to challenges and the commitment to priorities and actions?
- How well developed are relationships in the board? How effective has the development of the board been and a mutual understanding of how it can be most effective in achieving key impacts?
- What is the quality of the relationship between the HWB and the CCG(s)?
- What is the quality of the relationship between the local public health team and CCGs? Is it able to meet its statutory function in giving the CCG public health advice?
- How effective are relationships with Health Providers? The local schools system? Local housing agencies? Other public sector providers?
- How well is the council considering the impact of its services, plans and strategies on health and wellbeing (eg considering the impact of planning decisions on health and wellbeing)?
- How well engaged are local politicians, beyond those directly involved in the HWB? How strongly do health and wellbeing challenges influence political ambitions and vice versa? How strong is the commitment to JHWSs across the local political landscape?
- How effectively are local voluntary and community organisations engaged in advocacy, strategic direction, and delivery?
- How effective are the local Healthwatch arrangements?
- How well are the experiences of service users, patients and members of the public heard and reflected on, both through the local Healthwatch organisation and wider?
- How effective is the local Overview and Scrutiny function?
- How effective is collaboration with the Public Health England and NHS England regional and local teams?
- In two tier areas, how well are district authorities engaged in analysis and setting priorities? Do strategies make best use of the functions of both tiers?
- Are there shared arrangements for any element of the public health functions? How well do they work?

3. **How well are mandated and discretionary public health functions delivered?**

- How well are sexual health services commissioned and delivered?
- How effective are local arrangements for screening and immunisation?

- How well is the population healthcare advice service delivered locally? What is the quality of the relationship between the local public health team and the CCG(s)?
- How well is the local Health Check programme being commissioned and delivered?
- Is there a clear and appropriate Health Protection arrangements? Is there clarity over relative roles, responsibilities, and leadership arrangements in the context of an incident or outbreak?
- How effective are Emergency Preparedness, Resilience and Response relationships? How well are key roles understood? How strong are the connections to wider emergency planning and resilience arrangements?
- What discretionary functions, including drugs and alcohol interventions, are provided in the locality? On what rationale?
- How effectively has the Board encouraged integrated working between commissioners of health and social care services?

4. **How well are the DPH and team being used, and how strong is the mutual engagement between them and other council teams?**

- How has the organisational design of the council been adapted to make best use of the public health team?
- Do the local arrangements ensure that the DPH is able to fulfil the statutory functions of the role effectively?
- How well is the DPH able to contribute to the wider leadership of the place and council?
- How well are JHWS priorities reflected in service plans and change programmes across the council?
- How well are the strengths of the professional public health team used across the council and its partnerships?
- How is the public health team's use of evidence and analysis being incorporated with the place-based sensitivity of the councillors?
- How aware are key staff across the council of the contributions that the public health team can make?
- How aware is the public health team of the full range of the functions of the council, their spheres of influence, and their particular areas of expertise?
- How strong are the arrangements for the development of the public health profession, including continuous professional development and accreditation?
- How influential is the public health team across the wider local health system?

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Memorandum Of Understanding in respect of safeguarding between key strategic public protection partnerships in Cheshire East

Introduction:

This document makes explicit the key responsibilities and accountabilities relating to safeguarding for all the key strategic public service partnerships in CE, namely:

- Cheshire East Health and Well-being Board (HWBB)
- Safer Cheshire East Partnership (SCEP)
- Cheshire East Safeguarding Children Board (CESCB)
- Cheshire East Safeguarding Adults Board (CESAB)
- Cheshire East Children's Trust (CECT)

This document will also reference the key role of the Cheshire East Councils Corporate Scrutiny Committee. The legislation and guidance that underpins the status and remit of these partnerships is set out in Appendix 1.

Principles:

- The key accountability and responsibility for safeguarding lies with the two Safeguarding Boards (CESCB, CESAB);
    - CESCB in relation to children and young people up to their 18th birthday
    - CESAB in relation to safeguarding adults 18 years and over and domestic violence and sexual assault strategy and commissioning
- However the other bodies referenced in this document all have significant roles in safeguarding;

Cheshire East Health and Well-being Board - HWBB

- HWBB is responsible for producing the Joint Strategic Needs Assessment (JSNA), which will identify and set the commissioning priorities for our vulnerable population.
- The Annual Report from both Safeguarding Boards will set out how the commissioning plans from the JSNA are promoting effective safeguarding in Cheshire East. The annual reports of both Boards will be presented to the HWBB.

Safer Cheshire East Partnership - SCEP

- SCEP is responsible for the commissioning of Domestic Homicide Reviews (DHR's), which are undertaken on its behalf by the CESAB
- It also receives bi-annual reports on domestic abuse and sexual violence partnership working
- The SCEP has a role in ensuring that it maintains and supports partnership awareness and effective response to domestic abuse and sexual violence in Cheshire East.

Cheshire East Children's Trust - CECT

- CECT will set out the strategic priorities for children and young people in Cheshire East. Within this, explicit priorities in respect of prevention and early help, will be identified.
- This will influence the priorities set by CESCB and their published levels of need.
- CESCB annual report will be scrutinised by CECT

<u>Additional responsibilities for safeguarding vulnerable people in Cheshire East</u>

- The two Safeguarding Boards are independent of each other but need to ensure that they take a whole family approach to setting their priorities and reporting performance where warranted, for example:
  - Transition of vulnerable young people to adulthood
  - Domestic and peer abuse
  - Sexual Exploitation
  - Transfer of learning from case reviews
- Cheshire East Corporate Scrutiny Committee will scrutinise the annual reports of both safeguarding Boards and receive performance updates. Their role is to provide scrutiny and challenge to the work of the Boards.
- The Local Authority Chief Executive is responsible for the appointment and performance of the Independent Chairs to the safeguarding Boards. (this is a requirement for the CESB). Each Chair will meet with the Chief Executive (and the respective Strategic Director) on a regular basis.

REPORT TO:	Cheshire: Local Safeguarding Children Boards (LSCB) Local Safeguarding Adults Boards (LSAB) Domestic Abuse Strategic Partnerships Community Safety Partnerships (CSP) Health and Wellbeing Boards
DATE:	22nd April 2014
REPORTING OFFICER:	Detective Chief Inspector Nigel Wenham Strategic Public Protection Unit
SUBJECT:	Implementation of: Domestic Violence Prevention Notices (DVPN) Domestic Violence Prevention Orders (DVPO)

1.0 Purpose of Report

1.1 The purpose of this report is to provide members of the respective Strategic Boards across Cheshire an overview of the implementation of Domestic Violence Prevention Notices (DVPN) and Domestic Violence Prevention Orders (DVPO)

1.2 The report has been forwarded to be presented at the following Strategic Boards:

Local Safeguarding Children Boards (LSCB)
Local Safeguarding Adults Boards (LSAB)
Domestic Abuse Strategic Partnerships
Community Safety Partnerships (CSP)
Health and Wellbeing Boards

2.0 Action Required

2.1 The paper is circulated to all members of the respective boards and the contents acknowledged.

2.1 Members of the respective boards ensure that this briefing is further communicated and disseminated across strategic and senior leaders within each of their own agencies.

2.2 Any questions raised are sent to DCI Nigel Wenham who will respond appropriately.

3.0 Background

3.1 The implementation of DVPN's and DVPO's are legislated through the provisions of Sections 24-33 Crime and Security Act 2010.

3.2 2011/12, a 15 month pilot took place in three police force areas (Greater Manchester, West Mercia and Wiltshire) to test a new civil provision, Domestic Violence Protection Orders (DVPOs). DVPOs were designed to provide immediate protection for victim-survivors following a domestic violence incident in circumstances where, in the view of the police,

there are no other enforceable restrictions that can be placed upon the perpetrator

3.3 DVPOs aim to give victim-survivors time, space and support to consider their options by placing conditions on perpetrators, including restricting / removing perpetrators from households, and preventing contact with, or molestation of, victim-survivors. The Home Office published an Evaluation of the pilot and sanctioned **(1)** the national roll out of the DVPO's, with a target date of June 2014.

3.4 There are a number of key stages to issuing of DVPN's and DVPO's;

- Following arrest of a subject and a decision made to take No Further Action (NFA) in custody, an application is made to a Superintendent for a DVPN to be issued. If granted this will contain a range of prohibitions and result in multi-agency referral and support
- Within 48 hours of issuing a DVPN, an oral application must be made to Magistrates Court for a DVPO
- The legislation allows for the application to be made by police officers, police staff and lawyers
- Following the granting of a DVPO a range of activity will be progressed including, multi-agency referral and liaison, risk assessment and intelligence/data systems management
- DVPO can last between 14 and 28 days
- Strategies must be in place to 'Police' the DVPO's and enforce breaches
- A breach of DVPO will result in arrest and appearance at Magistrates Court for a civil offence (within 24 hours)
- In line with the application for the order, the breach can be presented to the court by the same categories of people

3.5 There is provision to issue a DNPN any time, outside of the custody process. It is likely that our procedure will allow for this under limited conditions

3.6 Prohibitions – The DVPN/O must contain a non-molestation prohibition and can include additional prohibitions that include exclusion from their home address (hence the media referring to these as 'Go Orders')

3.7 The non-molestation may be explicit in referring to particular acts of molestation, to molestation in general, or to both.

The terms 'molestation' and 'particular acts of molestation' are not defined in the CSA 2010. The dictionary definition of molestation is 'the act of disturbing, annoying or tormenting someone with persistent behavior and to pester in a hostile way'. Therefore it could also include using or threatening violence, intimidating and harassing.

3.8 If 'P' lives in the same premises as the person for whose protection the DVPN/O is issued, the DVPN/O may also: (P refers to Perpetrator and V refers to Victim)

3.9 prohibit 'P' from evicting or excluding from the premises the person for whose protection the DVPN is issued;

- prohibit 'P' from entering the premises; An exception should be considered that, on one occasion, P will need to enter the property, in the presence of officers, to collect necessary possessions, (see 5.3.13);

- require 'P' to leave the premises; or

- prohibit 'P' from coming within such distance of the premises as may be specified in the DVPN.

4.0 Cheshire Implementation

4.1 The implementation is being led by DCI Nigel Wenham and managed in accordance with the current guidance (2) issued by the Home Office. Revised guidance may be published in the near future; this could impact on the implementation strategy.

4.2 A strategic multi agency implementation group has been established that includes strategic leads and relevant representation from Her Majesty Court Service (HMCTS), Police Operational Staff, Public Protection Unit, Domestic Abuse Coordinators, Cheshire Police Legal Services, Custody, Criminal Justice, Strategic Public Protection Unit and Training.

4.3 A number of task and finish groups have been established to lead on various strands of the implementation, including, court processes, IT issues, training, multi-agency safeguarding, referral, procedures and communication.

4.4 Cheshire Police have committed to appoint dedicated resources to support this work. A newly developed Police Staff role, DVPO Coordinator/Court Presentation Officer has been established. The recruitment process will commence at the end of April.

4.5 The application for a DVPO is a civil order; each application incurs court cost of £200 and £500 for a contested case and a breach.

4.6 Based on the pilot and force data it is estimated between 180 – 220 new applications per year and 15 – 20 breaches per year. However the actual number may vary considerably.

4.7 Cheshire Police are allocating approximately 80k to fund the implementation for the first year.

4.8 The force will go live with the orders on Monday 2nd June 2014.

4.9 A communication strategy is being developed, that will include communication with partners and the public.

5.0 Conclusion

5.1 The implementation of the DVPN's and DVPO's provide an opportunity to build on established multi-agency working and strategies to intervene in domestic abuse by providing additional measures to safeguard victims and their children.

5.2 Effective multi-agency working is critical to ensuring the success of these orders.

5.3 An evaluation will be carried out and reported to the four Domestic Abuse Strategic Groups. Performance data will also be reported to these groups.

Nigel Wenham (Detective Chief Inspector)
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(1) https://www.gov.uk/domestic-violence-and-abuse
(2) https://www.gov.uk/domestic-violence-and-abuse

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