Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday 29th July 2014**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Declarations of Interest**

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

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

   To approve the minutes of the meeting held on 29 May 2014

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

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

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

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

5. **Appointment of Vice-Chairman**

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

6. **Introduction to the Care Plan for End of Life** (Pages 9 - 40)

To consider the approach taken by the End of Life Partnership in developing and implementing the Care Plan for End of Life

7. **Progress Report regarding the Local Safeguarding Adults Board** (Pages 41 - 44)

To receive the mid-year safeguarding up-date, which sets out the key goals and plans for the next 6 months

8. **Learning Disabilities Joint Health and Social Care Self-Assessment 2013 and Action Plan 2014/15** (Pages 45 - 54)

To consider the Learning Disability Action Plan

9. **Better Care Plan Update** (Pages 55 - 64)

To receive an update on the Better Care Plan

10. **Connecting Care in Cheshire Pioneer Programme** (Pages 65 - 68)

To receive a report on the programme governance and reporting arrangements

11. **Multi Agency Public Health Five Year Plan** (Pages 69 - 70)

To receive a briefing paper on Developing together a five year strategic plan for Cheshire, Warrington and Wirral

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Thursday, 29th May, 2014 at Committee Suite 1,2 & 3, Westfields,
Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor Janet Clowes (Chairman)

Councillor Alift Harewood, Cheshire East Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Dr Andrew Wilson, South Cheshire Clinical Commissioning Group
Tony Crane, Director of Children's Services
Brenda Smith, Director of Adult Social Care and Independent Living

Substitute
Caroline O'Brien, Healthwatch Cheshire East

Associate Non Voting Members
Lorraine Butcher, Executive Director Strategic Commissioning, Cheshire East Council
Tina Long, Director of Nursing and Quality, Cheshire Warrington and Wirral Area Team

Officers/others in attendance
Councillor Stewart Gardiner
Anita Bradley, Head of Legal and Monitoring Officer, Cheshire East Council
Guy Kilminster, Corporate Manager Health Improvement, Cheshire East Council
Kate Rose, Head of Integrated Safeguarding (items 16 and 17 only)
Dr Guy Hayhurst, Public Health Team (Items 8, 9 and 10 only)
Suzanne Austin, Local Pharmaceutical Council (Items 8, 9 and 10 only)
Rachel Graves, Democratic Services Officer

Councillors in Attendance
Councillor Margaret Simon
Councillor Jos Saunders
Councillor Brendan Murphy

1 APPOINTMENT OF CHAIRMAN

It was proposed and seconded that Councillor Janet Clowes be appointed as Chairman for the 2014/15 Municipal year.

RESOLVED

That Cllr Janet Clowes be appointed as Chairman for the 2014/15 Municipal year.

2 APPOINTMENT OF VICE CHAIRMAN

It was proposed and seconded that Mike O'Regan be appointed as Vice Chairman for the 2014/15 Municipal year.

As Mike O'Regan was not present at the meeting it was agreed that the appointment of Vice Chairman would be deferred until the next meeting.

RESOLVED:

That the appointment of Vice Chairman be deferred until the next meeting.

3 APOLOGIES FOR ABSENCE

Apologies were received from Councillor Rachel Bailey, Dr Paul Bowen, Heather Grimbaldeston, Mike O'Regan and Mike Suarez.

4 DECLARATIONS OF INTEREST

There were no declarations of interest.

5 MINUTES OF PREVIOUS MEETING

RESOLVED:

That the minutes of the meeting held on 25 March 2014 be approved as a correct record.

6 PUBLIC SPEAKING TIME/OPEN SESSION

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

7 HEALTH AND WELLBEING BOARD TERMS OF REFERENCE

Council, at its meeting on 14 May 2014, had approved the revised terms of reference for the Health and Wellbeing Board.

RESOLVED:

That the revised Terms of Reference for the Health and Wellbeing Board be noted.

8 PHARMACEUTICAL NEEDS ASSESSMENT PRE-CONSULTATION DRAFT

Consideration was given to a draft of the Pharmaceutical Needs Assessment.

Pharmaceutical Needs Assessments (PNAs) were carried out to assess the pharmacy needs of the local population. The PNA ensured that community pharmacy services were provided in the right place and met the needs of the communities they served. NHS England would use the PNA when making decisions on applications to open new pharmacies. Each Health and Wellbeing Board had to publish its first pharmaceutical needs assessment by 1 April 2015.

A survey of Community Pharmacists had been carried out and the Council's Research and Consultation Team would be sending out a survey via an online method to the Council's Citizen's Panel. Around 1,500 people would be sent the survey, which would ask about people's experiences when using a community pharmacy, what works well and what could be improved.

A pre consultation draft of the Assessment was attached to the report and the Board was asked to review it. The draft PNA had been prepared by a Steering Group led by Public Health and included 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.

Dr Guy Hayhurst of the Public Health Team spoke to the report and answered questions.

RESOLVED:

That the draft Pharmaceutical Needs Assessment be 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

Suzanne Austin, of the Local Pharmaceutical Council, briefly outlined the process for developing the Community Pharmacy Five Year Vision.

10 MINOR AILMENTS SCHEME

Suzanne Austin, of the Local Pharmaceutical Council, briefed the Board on Minor Aliments Scheme.

The Scheme allowed patients to visit a pharmacy for advice and treatment for several minor self-limiting conditions. Accredited pharmacists could supply some ‘prescription only’ medicines, which avoids the patients having to go to their GP for a prescription, saving time for the patient and GP.

The Scheme had been updated and extended and now included 20 Patient Group Directions, which enable community pharmacists to supply medicines to patients with defined conditions. Around 40 different medicines could e supplied by pharmacists to patients under the scheme.

New branding for the service had been considered and consultation with patient groups had taken place. “Think Pharmacy” would be the generic branding. Pharmacies would use posters, post cards and concertina cards to promote the service. Pharmacy contractors and GP surgeries were being asked to promote the service and raise awareness to patients and public

11 CONNECTING CARE - A TRANSFORMATIONAL APPROACH TO THE INTEGRATION OF HEALTH AND SOCIAL CARE IN CENTRAL CHESHIRE 2014 -2019

The Board considered a report and received a presentation from Diane Eden, Programme Director, on Connecting Care in Central Cheshire.

The Clinical Commissioning Groups were required to develop Five Year Strategies that included their plans for working with the local authority to integrate health and social care services.

The Central Cheshire Connecting Care Board had established a Strategy Task and Finish Group to develop the Connecting Care Strategy incorporating the Pioneer Integration Programme. The appendix to the Report represented the current working draft of the Strategy. The Task and Finish Group had resolved to ensure that individual partner boards and key stakeholders were offered the opportunity to shape the draft prior to the agreed draft being submitted to NHS England.

The draft Connecting Care Strategy provided details of the following:

- Vision and Ambition
- The national and local context for the Connecting Care Programme
- Challenges and opportunities in Central Cheshire
- Approach to integration and transformation
- Outline of current progress
- Outline of the overall programme and its composite elements

- Description of integrated health and social care model and its intended impact
- 6 key health and social care integration outcomes framework/foundation stones
- aspirations for transformation, approach and measures of success
- the plans for achieving a sustainable care system for the future

In line with NHS England requirements, an agreed strategy must be submitted by 20 June 2014.

RESOLVED:

(1) That the direction of travel and key themes outlined in the Connecting Care Document be supported;

(2) That it be noted that Central Cheshire Connecting Care Board will approve the submission to NHS England on 20 June 2014; and

(3) That further key stakeholder engagement will take place to shape the initial draft into a final strategy.

12 NHS SOUTH CHESHIRE CCG - QUALITY PREMIUM 2014-15

Consideration was given to a report on the NHS South Cheshire Clinical Commissioning Group (CCG) – Quality Premium 2014-15.

The quality premium was introduced in 2013-14 as a new mechanism to reward CCGs for improvements in the quality of services that they commission and for associated improvements in health outcomes and reducing inequalities.

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

The five national measures were

- Reducing potential years of lives lost through amenable mortality
- Improving access to psychological therapies
- Reducing avoidable emergency admissions
- Addressing issues identified in the 2013-14 Friends and Family Test, supporting roll out of Friends and Family Test in 2014-15 and showing improvement in a locally selected patient experience indicator
- Improving the reporting of mediation-related safety incidents based on a locally selected measure

The local quality measure was to continue the programme of work to appropriately manage patients with Atrial Fibrillation whilst promoting therapeutic optimisation in accordance with best practice

RESOLVED:

That the Quality Premium 2014-15 for NHS South Cheshire Clinical Commissioning Group and the local priority measure chosen be supported.

13 REVIEW AND REFRESH OF THE CHESHIRE EAST JOINT HEALTH AND WELLBEING STRATEGY

Consideration was given to a report on the review and refresh of the Cheshire East Joint Health and Wellbeing Strategy.

The Health and Social Care Act 2012 placed a duty upon the local authority and Clinical Commissioning Groups (CCGs) in Cheshire East, through the Health and Wellbeing Board, to develop a Joint Health and Wellbeing Strategy.

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 had 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 had been presented to the Council's Cabinet and the CCG's Governing Bodies. Comments from these bodies had been incorporated into the Strategy, which was attached as Appendix 1 to the Report.

RESOLVED:

That the refreshed Cheshire East Joint Health and Wellbeing Strategy be endorsed.

14 BETTER CARE FUND UPDATE

Consideration was given to a report which gave an update on the current position of the Better Care Fund (BCF).

All four Health and Wellbeing Boards across the Cheshire, Warrington and Wirral (CWW) area had signed-off BCF plans prior to the 4 April deadline. The CWW Area Team had provided an initial assessment of the Plans, which looked to RAG rate the plans across the agreed national metrics within it. Annex 1 to the Report gave details of the latest position of RAG rated matrices for the Plans.

The Area Team had chosen to look to address the RAG rated amber and red metrics for each Health and Wellbeing Board. It was felt that this would be a more constructive and coherent approach, offering not only a level of assurance but also would be better placed to develop relationships locally which would be more effective in addressing any potential underperformance in future.

Currently the national team had undertaken their own review of BCF plans submitted and were looking to understand any differences between the central and local assessment outcomes.

It was proposed that the CWW Area Team identify a lead Area team Director to work with the Health and Wellbeing Boards to develop an action plan to support the improvement of all metrics against the BCF assurance template which were amber or red, and to develop clear metrics for the for the BCF work stream with identified tolerances and triggers which would allow the Health and Wellbeing Board to be clear if a work stream was on track or required additional support or intervention.

RESOLVED:

That the Cheshire, Warrington and Wirral Area Team works, via a lead director, with the Health and Wellbeing Board Better Care Fund governance process locally to develop a robust and coherent action plan to improve the indices on the current Better Care Fund plan assurance template.

15 HEALTH AND WELLBEING PEER CHALLENGE

Consideration was given to a report on the Health and Wellbeing Peer Challenge being undertaken in 2014.

Peer Challenges were designed to support Health and Wellbeing Boards in implementing their health statutory responsibilities. A Peer Challenge for Cheshire East would be taking place from 18 to 22 November 2014, with a preliminary scoping meeting taking place on 10 June with the Peer Challenge Manager. Guidance on the Peer Challenge was attached to the Report.

It was noted that Peer Challenge Team would be observing the Health and Wellbeing Board on 18 November 2014.

RESOLVED: That

(1) the forthcoming Peer Challenge and the published Methodology and Guidance be noted.

(2) Nominations of lead officers to assist with the preparations for the Peer Challenge be forwarded to Corporate Manager Health Improvement.

16 MEMORANDUM OF UNDERSTANDING IN RESPECT OF SAFEGUARDING BETWEEN KEY STRATEGIC PUBLIC PROTECTION PARTNERSHIPS IN CHESHIRE EAST

Consideration was given to the draft Memorandum of Understanding in respect of safeguarding between key strategic public protection partnerships in Cheshire East.

The Head of Integrated Safeguarding was in attendance to answer questions.

It was agreed that the legal Appendix to the Memorandum of Understanding would be circulated to all members of the Board.

RESOLVED:

That the Memorandum of Understanding and Legal Appendix be circulated to Health and Wellbeing Board members for comments.

17 IMPLEMENTATION OF DOMESTIC VIOLENCE PREVENTION NOTICES AND DOMESTIC VIOLENCE PREVENTION ORDERS

Consideration was given to a report on the implementation of Domestic Violence Prevention Notices (DVPN) and Domestic Violence Protection Order (DVPO), prepared by Detective Chief Inspector Nigel Wenham, Strategic Public Protection Unit.

Following a 15 month pilot in three police forces, DVPNs and DVPOs were being implemented nationally in June 2014. Cheshire Police had appointed dedicated resources to support this work and a DVPO Coordinator/Court Presentation Officer would be appointed. Multi agency working was critical to ensuring the success of these orders.

The report set out the key stages to issuing the DVPNs and DVPOs.

RESOLVED:

That the report be noted.

The meeting commenced at 2.00 pm and concluded at 4.00 pm

Councillor J Clowes (Chairman)

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting: 29th July 2014
Report of: The End of Life Partnership
Subject/Title: Introduction to the Care Plan for End of Life

1.0 Report Summary

1.1 In June 2014 the Leadership Alliance for the Care of the Dying person (LACD) produced **Five Priorities for the Care of the Dying Person**:

1. The possibility that the person may die within the next few days or hours is recognised and communicated clearly, decisions made and actions taken in accordance with the person's needs and wishes, and these are regularly reviewed and decisions revised accordingly.
2. Sensitive communication takes place between staff and the dying person, and those identified as important to them.
3. The dying person, and those identified as important to them, are involved in decisions about treatment and care to the extent that the dying person wants.
4. The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.
5. An individual plan of care, which includes food and drink, symptom control and psychological, social and spiritual support, is agreed, co-ordinated and delivered with compassion

The above priorities are intended to guide a more personalised approach to the care of the dying in contrast to more traditional approaches such as 'The Liverpool Care Pathway' which has received widespread media attention and criticism over the last few years largely due to its 'tick box' approach.

Individualised care planning during the last days and hours of life is of fundamental importance in order to meet the needs and preferences of a wide variety of people dying from a range of different conditions, and within a number of different care settings. These include people with conditions such as heart and respiratory diseases, dementia, cancer, neurological conditions and the frail elderly, who are being cared for in hospital, at home, within a hospice, or in a care home.

The Care Plan for End of Life, which is attached within **Appendix One,** is therefore presented as an example of an individualised care plan for end of life for use across the Cheshire East locality.

2.0 Recommendation

2.1 That the Health and Wellbeing Board consider the approach taken by the End of Life Partnership in developing, and implementing the Care Plan for End of Life as well as the plans being made to evaluate its effect in practice. That this approach is then endorsed as being supportive of the delivery of high quality and individualised care of the dying person and their family.

3.0 Reasons for Recommendations

3.1 To ensure local approaches to last days of life care are closely aligned to the **Five Priorities for the Care of the Dying Person** and that processes followed demonstrate appropriate levels of inclusivity and transparency.

4. Development of the Care Plan for End of Life

4.1 One of the key objectives of the End of Life Partnership is to coordinate a whole system approach to end of life care across Cheshire through promoting high quality care for the dying; regardless of disease type or place of care. In August 2013 a local group was formed to coordinate a locality response to the recommendations made within the Liverpool Care Pathway review with professional representation from organisations within the Eastern, South, and Vale Royal areas of Cheshire.

The group which was made up of 22 professionals and 1 member of the public, met between August and December 2013 to develop and to coordinate an action plan, and to agree a way forward in terms of supporting a more individualised approach to care of the dying across local organisations. In February 2014 a few of these group members were nominated to progress two key areas of work, this work resulted in:

1. The development of an Individualised Care Plan for End of Life
2. The development of Education and Training programmes and resources to support the use of the new care plan

A draft care plan was subsequently developed and informed by the recommendations made within the LCP review, alongside interim guidance provided by the LACD. This draft care plan was then made available for a consultation period of 3 weeks (1st April – 23rd April 2014) to local professionals, carers, members of the public, faith groups, and other community groups, with feedback facilitated via a survey monkey questionnaire.

The expertise and networks of the various patient engagement and communication leads from participating organisations were utilised in an attempt to gain feedback from a wide representation of local people. Media such as twitter, local press and patient user forums were therefore used to raise awareness of the consultation period and its purpose. Feedback was collated via a survey monkey questionnaire.

4.2 Emerging Themes

The survey monkey questionnaire was designed to facilitated constructive feedback that could then be used to inform the final version of the local care plan. Space was also provided for respondents' to feedback any qualitative comments that they had.

The main themes that emerged within the feedback received were as follows:

- A need for more explicit patient and family involvement at an early stage
- Named professionals involved in the decision making process needs to be clear
- The language used needs to be understood by patients and their loved ones
- Dislike of the term 'potential' to die- needs to be less ambiguous
- Details of the Lasting Power of Attorney for Health & Welfare (where relevant)
- More detailed and supportive information for both members of staff and for patients and their loved ones is needed
- Concern that elements of the care plan are duplicating information that is already recorded elsewhere within medical/nursing notes-
- Some suggestions that we do not need a care plan at all
- Too lengthy, needs less writing and more tick boxes/prompts
- General dislike of the daily assessment format
- Training was felt to be essential to ensure the care plan is used appropriately

4.3 Response to these emerging themes

- Names and roles of all professionals now detailed within initial assessment
- Term 'has the potential to die' replaced by 'the person's condition signifies that they are likely to die within hours or a small number of days'.
- Initial assessment requests specific information concerning the involvement of the patient and the family/significant others on initiation of the care plan.
- Where possible language has been simplified. Separate guidance notes and supportive information to be developed to assist understanding.
- Dedicated area included to record the contact details of the LPA
- It is believed that there are added advantages to having all the relevant information available in one place for quick reference, particularly if there is a need or desire for the person to change care settings during their final days e.g. Rapid Discharge.
- Unfortunately suggestions that we do not need a care plan are unfounded and go against recommendations made at a national level. Repeated clinical audits have demonstrated that without a framework used to guide the delivery and documentation of end of life care, many important elements can get unintentionally missed.

- One of the major criticisms of the Liverpool Care Pathway was the reliance upon tick boxes and therefore the inability to hold professionals accountable for precise elements of their decision making and care provision. The new care plan will therefore place an onus upon the individual who is providing the care and/or making the decisions to provide explicit documentation which will reduce the risk of misinterpretation of the plan of care. Inevitably this makes the care plan appear longer but the documentation within it becomes individualised to the person and their family/significant others. The complexity of the situation will inevitably dictate the amount of writing needed.
- The format of the ongoing assessment has completely changed in response to feedback. Now more in-keeping with familiar care planning documents.
- A comprehensive training programme is currently being planned and led by the End of Life Partnership. This includes the use of core training materials and resources to facilitate the consistent exchange of high quality information and advice concerning use of the care plan in practice.

4.4 Next Steps

June/July 2014 –The Care Plan for End of Life will go for formal ratification to various executive boards across the locality.

June-Dec 2014- Implementation of a comprehensive training strategy will begin across the locality. Extensive training will continue for the duration of 2014 and planning will take place for ongoing training into 2015 and beyond

September 2014- Reconvening of the group that has led the development of the care plan to begin the development of other supporting resources i.e. additional guidance notes for professionals/patients/carers, specialist one page inserts to the care plan for complex areas such as Intensive Care, Learning Disabilities etc Experts within these fields will be co-opted to guide this work.

January 2015- Spot audits of the care plan to take place across all care settings

June 2015- A comprehensive and robust evaluation of the care plan will take place, informed by the views of family/significant others, professionals and members of the public. The End of Life Partnership will be leading this evaluation and will begin planning how this will occur over coming months.

5.0 Access to Information

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

Name: Annamarie Challinor
Designation: Head of Service Development, the End of Life Partnership
Phone: 01270 758120
Email annamarie.challinor@nhs.net

Care Plan for End of Life

(A hospital label may be placed here where applicable)

Print Name________________________________ NHS No___________________

Hospital Number *(where applicable)*_________________ Date of Birth________________

Address____

Date of Birth__________________________ Ward/Place of Care________________

GP/Consultant___________________________ Contact ______________________

District Nurse/ Clinical Nurse Specialist _____________________________________

Role_________________________________ Contact Details___________________

Date started: ____________________ Time *(24hr clock):* _________________________

Doctor's name______________________________Signature_____________________

Role____________________________________ GMC No _____________________

Nurse's name ______________________________Signature_____________________

Role____________________________

Where to get further advice and support:

East Cheshire Clinical Commissioning Group	South & Vale Royal Clinical Commissioning Groups
Macmillan Specialist Palliative Care Team (*Mon-Fri 9-5)* Tel 01625 663177 **Macmillan Lung Cancer Team (*Mon-Fri 9-5*) Tel 01625 661997** **East Cheshire Hospice Helpline (24 hour advice available) Tel 01625 666999**	**Macmillan Specialist Palliative Care Team (*Mon-Fri 9-5)* Tel 01606 544155** **St Luke's Hospice Helpline (24 hour advice available) Tel 01606 555489**

Also refer to:

The Cheshire EPAIGE : www.cheshire-epaige.nhs.uk
GMC Guidance: Treatment & Care Towards the End of Life (London 2010)
Leadership Alliance for the Care of Dying People- Priorities for Care of the Dying Person; Duties & Responsibilities of Health & Care Staff (2014)

All personnel completing the care plan please sign below:

Name (print)	Full signature	Initials	Professional title	Date

To access:

- Separate guidance notes for professionals
- Separate guidance notes for members of the public
- Separate family documentation sheets/ continuation sheets/ assessment sheets/ review sheets
- Specialist care plan inserts for clinical areas such as Intensive Care Unit, Dementia Care

Please refer to www.cheshire-epaige.nhs.uk and click on ‘care plan for end of life’ on the homepage

Further advice concerning use of this care plan can be obtained by contacting the Service Development Team- End of Life Partnership Tel 01625 666996/ 01606 555698

ALL STAFF

Before commencing this care plan and during reassessment please refer to the __CRITERIA__ below. __Part 2__ to be completed on 1st initiation:

__Part 1__

The team caring for the person agree their condition is deteriorating, and death is likely within hours or a small number of days

1. Look for and treat reversible causes of symptoms if it would benefit the patient at this time
2. If uncertainty exists, or expertise is required, obtain specialist opinion from consultant team experienced in the person's condition
3. If complex and/or uncontrolled symptoms, obtain advice from the Specialist Palliative Care Team
4. Where applicable inform the individual's GP
5. Check for an Advance Care Plan or Advance Decision to Refuse Treatment, and use it to guide care appropriately
6. Check for a Lasting Power of Attorney (LPA) for health & welfare who has the right to make decisions relating to life-sustaining treatment (see page 9 for details of LPA). See www.cheshire-epaige.nhs.uk for further guidance on LPA's

__Part 2__

MULTIDISCIPLINARY TEAM INITIAL ASSESSMENT:

Date of initial assessment: ________________ Time *(24hr clock)* __________Place:________

Lead Clinician *(must be completed a Senior Doctor: ST3 or above)*

Name__________________________ Signature_____________________Role__________

Details of other clinicians involved in the initial assessment where a decision has been made to commence the Care Plan:

Name___________________________ Signature____________________Role____________

Name___________________________ Signature____________________Role____________

Name___________________________ Signature____________________Role____________

Name___________________________ Signature____________________Role____________

INVOLVEMENT OF THE INDIVIDUAL & THEIR FAMILY AND/OR SIGNIFICANT OTHERS DURING INITIATION OF THIS CARE PLAN:

Is the individual aware of this plan of care? Yes/ No *(if no explain reason. If the individual lacks capacity then this should be expanded upon in **Section 1**)*____________________________________

____

Are the family and/or significant others aware of the plan of care? Yes/No
(Details of conversations including names of people involved can be documented on page 12). Where the family/significant others have not been informed or involved, a clear rationale __MUST__ be given on page12.

MEDICAL & NURSING TEAM DAILY REVIEW

Review of this plan of care MUST take place on a DAILY basis (or before if an improvement in the person's condition /functional status is observed **OR** if any concerns are expressed regarding the current plan of care).

INSTRUCTIONS FOR THE DAILY REVIEW

- The daily review must be completed by a Senior Doctor (ST3 or above), **OR** by a competent clinician to whom responsibility has been delegated.
- The review should determine that the individual is still thought to be in the last hours or days of life and that the plan of care therefore remains appropriate
- The experience and opinions of the wider multidisciplinary team should be sought
- Goals of care should be clearly and sensitively discussed and agreed with the dying person (if conscious), and with their nominated family/significant others, (unless they have expressed a wish not to participate in such conversations)
- The observations and judgements of family members/significant others should be taken into account. A second opinion may be sought where disagreements occur or where additional reassurance is thought to be helpful
- Supporting documentation concerning the daily review should be written in the continuation notes on pages 16-20 (spare continuation sheets are also available)

NB: The senior clinician remains accountable, alongside their delegate, for decisions made on their behalf.

*** Refer to page 8 for specific details of staff groups that have been delegated responsibility**
Clinicians must sign below following each daily review

Senior Clinician (*or person with delegated responsibility*): Print name________________________________
Signature_____________________ Role_________ Date/Time(24hr clock)__________ Place______________

Senior Clinician (*or person with delegated responsibility*): Print name________________________________
Signature_____________________ Role_________ Date/Time(24hr clock)__________ Place______________

Senior Clinician (*or person with delegated responsibility*): Print name________________________________
Signature_____________________ Role_________ Date/Time(24hr clock)__________ Place______________

Senior Clinician (*or person with delegated responsibility*): Print name________________________________
Signature_____________________ Role_________ Date/Time(24hr clock)__________ Place______________

Senior Clinician (*or person with delegated responsibility*): Print name________________________________
Signature_____________________ Role_________ Date/Time(24hr clock)__________ Place______________

If this care plan is discontinued please record below:
Date of discontinuation: ________________________________ Time__________________
Please provide rationale for discontinuing:
(*further supporting documentation can be provided using the continuation sheets p16-20- spare sheets also available*)

Section 1- Assessment & Communication

Where the team have identified that an individual under their care is deteriorating and likely to be dying, they must discuss and agree a care plan with the individual (where possible) and with their family/significant others. **Wherever possible this should be done in-hours and by the team that know the person best.** The **Doctor (ST3 or above) should take overall responsibility for the decision to commence this care plan.** The agreed plan of care should clarify the following:

- Recognition of deterioration and the rationale for the belief the individual is now dying
- Acknowledgement of the uncertainty that can exist concerning a person's prognosis
- The individual's understanding and wishes for their treatment and care
- Are there any concerns/ questions from the individual, and/or their family/significant others
- Proposed plan of care including discussion about;
    - Ceiling of care/CPR status
    - Risks and benefits of nutrition and hydration
    - Discontinuation of routine observations and tests
    - Symptom control and medications prescribed for pain, nausea and vomiting, dyspnoea, agitation and chest secretions – including the need to commence a syringe pump if required
- Any communication difficulties to consider e.g. deafness, speech difficulties. Is there a patient passport or is an interpreter required?
- For those who lack capacity and have no-one else to support them (other than paid staff), an **Independent Mental Capacity Advocate* (IMCA) MUST be consulted**

***The availability of an IMCA should not delay or preclude the delivery of good quality end of life care*

Date/Time of completion: *(24hr clock)*	
Place of Care:	

Notes	**Signature/Role**

INITIAL ASSESSMENT: DOCTORS & NURSES

Notes	Signature/Role

INITIAL ASSESSMENT: DOCTORS & NURSES

Section 2- Management Plan

To be completed by a Doctor

This **person is expected to die from natural causes and as a result of their advancing** *(insert relevant illness/condition)*……………………………………………………………………………………………

Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) has been discussed and recorded in the medical record. Please record communication below: (***NB: a DNACPR form is still required***)

Has the individual concerned been informed of the DNACPR decision? Yes/ No/ Unconscious

……

……

……………………………………Date/Time of discussion *(24hr clock)*……………………………………

For those who lack capacity and have no-one else to support them (other than paid staff), an *** IMCA MUST be consulted. ****The availability of an IMCA should not preclude making a DNACPR decision whereby the decision is unquestionably on medical grounds i.e. there are no benefits and burdens to weigh up*

This would be a suitable patient for Nurse Verification of expected death, if a suitably qualified nurse trained in 'Nurse Verification of Expected Death' is available Yes/ No

Doctor's Name (Print)…………………………………Signature……………………Role…………………

Date & Time *(24hr clock)* **of management plan completion:**		**Place of care**	
Does this person have an Implantable Cardioverter Defibrillator (ICD) in situ? *If yes, refer to local policy re deactivation, and contact the individual's cardiology team in hours*		**Yes**	**No**

Where applicable give details of actions taken to facilitate deactivation of ICD:

Signature________________________________ Role____

Insert details of medical and nursing interventions to be <u>discontinued</u>: *eg. blood tests, observations*

Notes:	**Signature/role**

Insert details of medical and nursing interventions to be <u>continued:</u> *e.g oxygen*

Notes:	**Signature/role**

INITIAL ASSESSMENT DOCTORS <u>ONLY</u>

PLEASE NOTE:

Food and drink should be continued for as long as the person can tolerate/ desires this.

- If the individual is having difficulty swallowing ordinary fluids, consider using a thickener and monitor for signs of aspiration (eg coughing, bubbly breathing). If the person is conscious and wishes to continue small sips of fluid although aware there is a risk of it going “the wrong way”, they should be supported in this.
- If a swallowing assessment is thought to be beneficial but there is likely to be a delay, alternative forms of hydration must be considered and discussed with the person.
- Decisions about clinically assisted hydration and nutrition must be in line with the General **Medical Council 2010 guidance *Treatment and Care towards the End of Life*** and relevant clinical guidelines
- For all cases nursing and medical records on the assessment of intake must be kept

Are there any specific instructions concerning the maintenance of appropriate hydration and nutrition for the person? *e.g. continuation or discontinuation of artificial fluids.* **If there are, please detail below:**

Notes:	Signature/Role

****DELEGATED RESPONSIBILITY***

Please detail below the staff members or staff groups to whom you are happy to delegate responsibility for the daily review i.e. District/Community Nurses, (for further information see pg 4).

PLEASE NOTE THAT IF THIS SECTION IN NOT COMPLETED STAFF WILL BE ADVISED TO REQUEST A SENIOR DOCTOR TO CARRY OUT THE DAILY REVIEW i.e. ST3 AND ABOVE

Notes	Signature/Role

INITIAL ASSESSEMENT DOCTORS ONLY

Section 3- Preferences and Choices

Where the person is able, **they should be given the opportunity to discuss what is important to them**. The choices available to the individual should be clearly explained. Examples of choices that the individual may wish to discuss include:

- **Nominating a person(s) to be involved in their plan of care and with whom they wish information to be shared concerning their condition**
- **Where they would like to die (preferred place of death)**
- **Religious and/or spiritual requests**
- **Organ and tissue donation**

If the person lacks capacity or is unconscious, check whether they have previously expressed a preference pertaining to their end of life care. This information may be contained within:

- **In an Advance Statement of Wishes e.g. Preferred Priorities for Care (PPC)**
- **In an Advanced Decision to Refuse Treatment (ADRT)**
- **Through a legally appointed Lasting Power of Attorney for Health & Welfare**
- **In a Patient Passport/ Person Centred Plan**

For individuals who are assessed to be lacking capacity and have no-one else to support them (other than paid staff), **please consider consulting with the IMCA service*.**

*****_The availability of an IMCA should not preclude the delivery of good quality end of life care_

What is most important to this person at this time? _(Continue overleaf if required)_

Date/Time/Place	Notes:	Signature/Role

Details of any Advance Statement of Wishes/expressed preferences e.g. _Preferred Priorities for Care_ and/or of any ADRT or Lasting Power of Attorney for Health & Welfare:

Date/Time/Place	Notes:	Signature/Role

Please sign below to confirm that relevant documentation has been seen, and is valid to support either an ADRT or LPA for Health & Welfare:

Signature__________________________ Role___________________ Date/time _(24hr clock)___________

NB: Please ensure that the ADRT or LPA is flagged/alerted to according to organisational procedures e.g. hospital notes, EMIS web template

Please indicate the Preferred Place of Death (PPoD):

Not established (please give reason)	Usual Place of Residence	Hospital	Hospice	Other (specify)

If the preferred Place of Death is somewhere other than their current place of care, please indicate below what has been done to facilitate achievement of this preference, and any reasons why achievement of PPoD is not possible:

Date/Time/Place	Notes:	Signature/Role

Has the individual and/or their family/significant others indicated any cultural/religious traditions that should be followed now or after death?

Notes
Religious tradition (if applicable):
Detail any expressed preferences concerning the support of the Chaplain or other religious or spiritual advisor:
Where applicable, contact details of religious or spiritual advisor:
Where applicable, identified cultural, spiritual, or religious needs immediate or after death:

Signature/role		Date/Time *(24hr clock)*	

Section 3- Continuation notes

Date/Time/Place	Notes:	Signature/Role

Section 4- Family/Significant Others

IDENTIFY THE SUPPORT NEEDS OF FAMILY/SIGNIFICANT OTHERS

- Address any concerns or information needs expressed by the family/significant others whilst observing patient confidentiality and consent
- Consider referral to other supportive services e.g. District Nurse, Crossroads, Hospice
- Early referral to bereavement services if appropriate
- Spiritual/religious needs (which may differ from those of the dying individual)

If the individual is not being cared for at home:

- Ensure contact numbers updated for key family members
- Explain facilities available e.g. parking permits, folding beds for relatives, open visiting
- Consider side room/ privacy of the environment- enable quality time together

Has the **"What to expect during the last days and hours"** leaflet been given to the family/significant others? *(Please circle)* **Yes** **No** **Offered but declined**

Reason for not using leaflet *(where applicable)*:……………………………………………………………...

Are there any specific communication needs to consider for family members/significant others? E.g. concerns, fears, interpreter required, deafness. *If yes please detail below*

Date/Time/Place	Notes:	Signature/Role

Next of Kin/ Nearest Relative Details	
Print Name	
Relationship	
Contact details *(address & Tel)*	
Conditions of contact	Contact anytime ☐ Do not contact during the night ☐ <u>ONLY</u> Contact 1st contact as detailed below ☐ Other directions (*please specify*):

1st Contact (if different from next of kin)	2nd contact
Print Name: Relationship: Address: Telephone: Contact: Anytime☐ Not during the Night☐	Print Name: Relationship: Address: Telephone: Contact: Anytime☐ Not during the Night☐

INITIAL ASSESSMENT: MULTIPROFESSIONAL TEAM

Date/Time of completion: *(24hr clock)*	
Place of Care:	

With whom have conversations taken place?

List all the names of family members and/or significant others involved in conversations	Signature/role

Please use this space to record details of specific conversations held with family members and/or significant others including dates & times (if different from the above).

Date/Time/Place *(if different from above)*	Notes:	Signature/Role

Section 5- Symptom Control

REVIEW CURRENT MEDICATION:

- Discuss and negotiate the management of symptoms including potential side effects
- Discontinuation of non-essential medications
- Anticipatory prescribing should be targeted at specific symptoms with a clear rationale provided for the starting dose
- Consider the most appropriate route for medication to be given
- Optimise the control of symptoms, seeking Specialist Palliative Care advice where initial measures have failed to provide adequate relief within at most 24 hours
- Review prescribed medications regularly and adjust as needed for effect

CONSIDER THE HOLISTIC MANAGEMENT OF SYMPTOMS i.e. psychological, spiritual, social as well as physical

- Consult with and involve the wider multi-disciplinary team in the management of symptoms
- Seek Specialist Palliative Care Advice where appropriate
- Refer to local guidelines available via **Cheshire EPAIGE** or on the intranet

PLEASE ENSURE THAT ANTICIPATORY MEDICATIONS ARE PRESCRIBED FOR ALL 5 OF THE MOST COMMONLY EXPERIENCED SYMPTOMS:

	Please tick when done
PAIN	
AGITATION	
RESPIRATORY TRACT SECRETIONS	
NAUSEA & VOMITING	
BREATHLESSNESS	
Also consider and prescribe for OTHER TREATABLE SYMPTOMS experienced or predicted	

A Syringe Driver may not always be required.
However, staff should ensure that a syringe driver is readily available should this be needed.
Conversations with both the individual and their family/significant others should also include information about when a syringe driver may or may not be indicated

Details of conversations held with the individual and their family and/or significant others concerning the management of symptoms at the end of life:

Date/Time of completion: *(24hr clock)*		
Place of Care:		
Date/Time/Place *(if different from above)*	**Notes**	**Signature/Role**

INITIAL ASSESSMENT: DOCTORS & NURSES

Patient Name……………………………Date of Birth……………………………NHS no…………………………

Section 5 Continuation notes

Date/Time/Place *(if different from above)*	**Notes**	**Signature/Role**

Section 6- Ongoing Assessment

Ongoing assessment should take place, wherever possible, within the persons preferred place of death. Assessment of the individual should be carried out holistically, and should consider the needs of both the person and their family/significant others. It should be ‘concerns led’ and flexible to respond to new circumstances.
The following principles should be used to guide the documentation of ongoing assessment:

1. Communication

Ensure compassionate person centred communication with the individual (where possible), and with family and/or significant others

Find out and respond to any concerns, preferences, or information needs

Ensure frequent updates are given to the family and/or significant others concerning the individual’s condition

Carefully document the details of any significant conversations with either the individual and/or their family/ significant others

Ensure effective handover of the individuals condition, including any changes in planned care to all relevant staff- document the named nurse at each handover period

Trigger and report to the senior clinician in charge of the individual’s care, the need for a daily review therefore prompting the completion of page 4

2. Symptom Control

Monitor (at least 4hrly in acute hospitals) for common symptoms and administer medication according to individual need, particularly:
Pain
Agitation
Respiratory Tract Secretions
Nausea/vomiting
Dyspnoea

Ensure the safe administration and recording of medications.

Consider non-pharmacological options to manage symptoms

Obtain Specialist Palliative Care Advice where needed

Monitor effectiveness of symptom management interventions

If a syringe driver pump is in situ ensure regular checks are made.

3. Privacy & Dignity

Support the hygiene needs of the individual based upon their comfort

Observe skin integrity and advise and support on appropriate positioning according to comfort

Consider the privacy of the environment e.g. noise levels, use of a side room. Allow quality time between the person and their family members/significant others

4. Hydration & Nutrition

Continue to support oral fluids where tolerated

Continually assess the individual to determine the appropriateness of artificial hydration and/or nutrition

Ensure regular and effective mouth care is given

Offer advice and support to the family/significant others to enable them to participate

Consider the use of thickened fluids

Maintain accurate fluid balance records

5. Spirituality

Enquire about, and respect any cultural or religious-specific requirements that are considered important to the individual and/or to their family/ significant others

Support timely involvement of chaplaincy/ spiritual leaders where this is requested

6. Other individualised

(*please enter details e.g. tracheostomy care)*

The above list is not exhaustive, therefore those providing care should consider the individual needs of the person and/or their family/significant others through ongoing holistic assessment.

ONGOING ASSESSMENT: MULTIPROFESSIONAL TEAM

Patient Name……………………………Date of Birth……………………………NHS no…………………………

Date/Time/Place	Ongoing Assessment Supportive Notes (see p15 for numbered principles)	Signature/Role

Patient Name……………………………Date of Birth……………………………NHS no…………………………

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Patient Name……………………………Date of Birth………………………………NHS no…………………………

Date/Time/Place	Ongoing Assessment Supportive Notes: (see p15 for numbered principles)	Signature/Role

Patient Name……………………………Date of Birth………………………………NHS no…………………………

Date/Time/Place	**Ongoing Assessment Supportive Notes:** **(see p15 for numbered principles)**	**Signature/Role**

Patient Name……………………………Date of Birth………………………………NHS no…………………………

Date/Time/Place	**Ongoing Assessment Supportive Notes:** (see p15 for numbered principles)	**Signature/Role**

Section 7: After Death Care

Verification of death

Date of death ………………………………Time of death *(24hr clock)* …………………………………Place………………………………

Persons present at time of death & relationship to the deceased………………………………………………………………………

………

Notes/Comments ……

If not present, has the individual's relative or significant other been informed?

Name of relative informed: ……………………………………………… Yes ☐ No ☐ No relative/carer ☐

Name of professional verifying death ………………………………………………… **Signature** ……………………………………

Role …………………………………………………………………… Time of verifying ……………………………………………………………

Is discussion with, or review by, the coroner required **Yes** ☐ **No** ☐

If a Doctor has agreed to Nurse Verification of Expected Death (see page 7) and a trained nurse is verifying death, this section needs to be completed by the nurse (as per the NVoED policy).

Vital signs checked:

• No response to painful stimuli (sternal rub)	**Yes** ☐ **No** ☐
• Carotid pulse absent for one minute	**Yes** ☐ **No** ☐
• Heart sounds absent for one minute	**Yes** ☐ **No** ☐
• Respirations absent for one minute	**Yes** ☐ **No** ☐
• Pupils fixed	**Yes** ☐ **No** ☐

Care after death notes: record relevant issues/communications (including feedback from relatives)

Date		**Name** *(print)*, **signature & role**

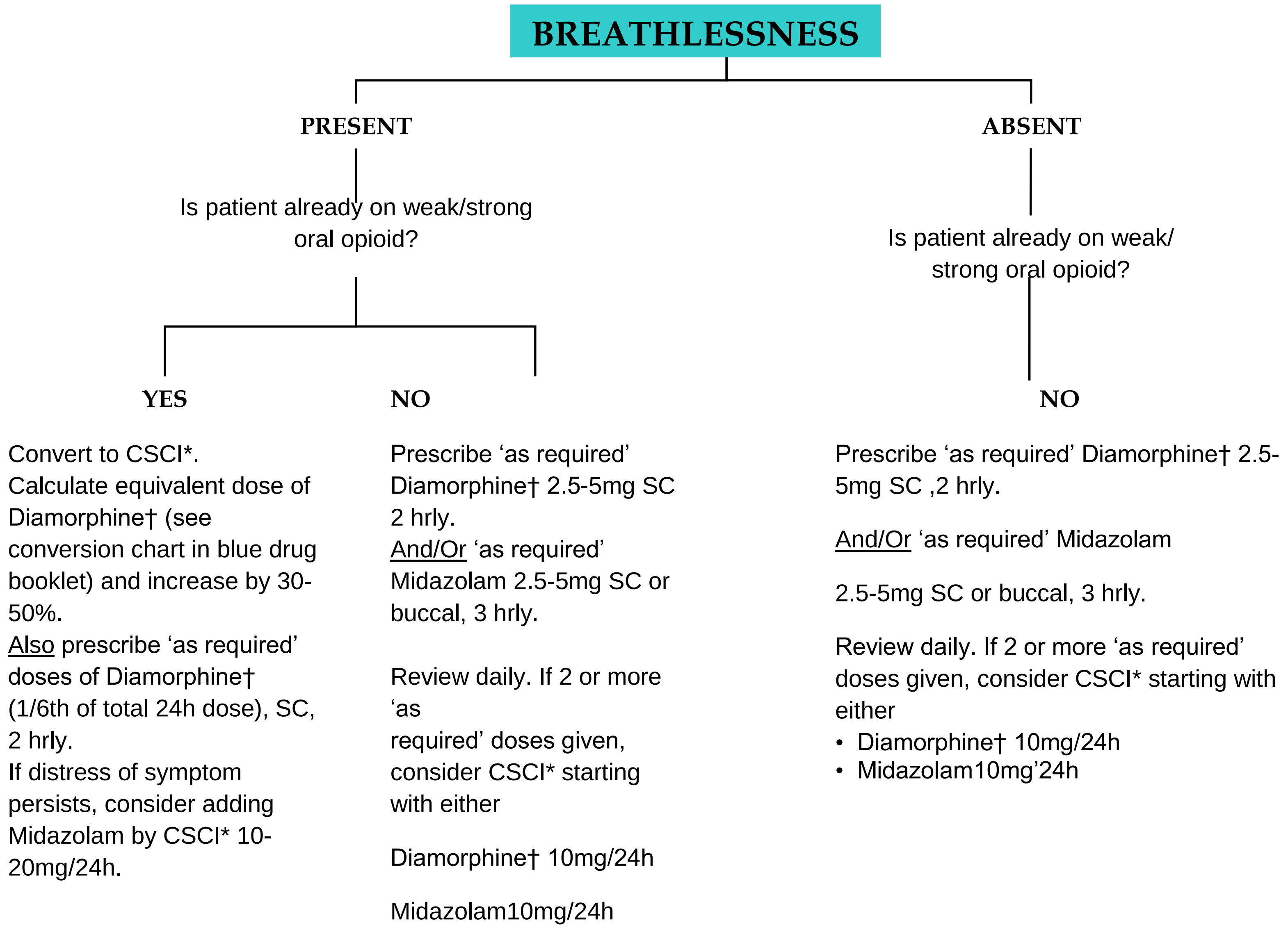
	Communication & support after death	***Name*** *(print)* ***Signature/role***
Care & Dignity	**Initial care after death is undertaken in accordance with policy** Consider: • Spiritual, religious, cultural rituals/needs met • The facilitation of quality time with the deceased as appropriate for the care setting and to meet the needs of the family/ significant others • Individual is treated with respect & dignity if any care is provided after death • Universal precautions & local policy/procedures including infection risk adhered to • If CSCI/Syringe Driver in use, following verification of death, it is removed & drug contents disposed of in accordance with policy.	
Relative /Carer/ Information	**The relative/carer understands what is required to do next & given relevant written information** Consider relative/carer information needs relating to the next steps, where appropriate: • Contacting a funeral director, how a death certificate will be issued, registering the death • Acting on patient's wishes regarding tissue/organ donation • Discuss as appropriate, the need for a post mortem, or removal of cardiac devices or when discussion with the coroner required • Bereavement support/services, including child bereavement services • Disposal of drugs & equipment • Provision of supportive leaflet/booklets: • Local bereavement booklet/services contacts/other bereavement information • DWP1027 (England & Wales) 'What to do after a death' booklet or equivalent	
Organisation Information	**The Primary Care Team/ GP Practice is notified of the patient's death**	Enter date/time of notification:
	Other services involved notified of patient's death	

Out of hour services (i.e. GPs, Nursing, other services)	Yes ☐	No ☐	N/A ☐
Hospice	Yes ☐	No ☐	N/A ☐
Macmillan Nurses	Yes ☐	No ☐	N/A ☐
Other Specialist Nurse	Yes ☐	No ☐	N/A ☐
Hospital	Yes ☐	No ☐	N/A ☐
Out Patient Services e.g. Chemotherapy, endoscopy	Yes ☐	No ☐	N/A ☐
Community Matron	Yes ☐	No ☐	N/A ☐
Allied Health Professionals (i.e. Physio, OT, Dietician)	Yes ☐	No ☐	N/A ☐
Social Services	Yes ☐	No ☐	N/A ☐
Continuing Health	Yes ☐	No ☐	N/A ☐
Other care agencies (i.e. Crossroads, Marie Curie)	Yes ☐	No ☐	N/A ☐
Continence	Yes ☐	No ☐	N/A ☐
Hospital Care at Home	Yes ☐	No ☐	N/A ☐
Community equipment	Yes ☐	No ☐	N/A ☐
Other, please state...	Yes ☐	No ☐	N/A ☐

When this section is complete. Healthcare professional name *(print)* ....

Signature .... **Role** ....**Date/Time**(24hr clock) ....

DOCTORS & NURSES



BREATHLESSNESS

PRESENT

Is patient already on weak/strong oral opioid?

YES

Convert to CSCI*.
Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet) and increase by 30-50%.
Also prescribe ‘as required’ doses of Diamorphine† (1/6th of total 24h dose), SC, 2 hrly.
If distress of symptom persists, consider adding Midazolam by CSCI* 10-20mg/24h.

NO

Prescribe ‘as required’ Diamorphine† 2.5-5mg SC 2 hrly.
And/Or ‘as required’ Midazolam 2.5-5mg SC or buccal, 3 hrly.

Review daily. If 2 or more ‘as required’ doses given, consider CSCI* starting with either

Diamorphine† 10mg/24h

Midazolam10mg/24h

ABSENT

Is patient already on weak/ strong oral opioid?

NO

Prescribe ‘as required’ Diamorphine† 2.5-5mg SC ,2 hrly.

And/Or ‘as required’ Midazolam

2.5-5mg SC or buccal, 3 hrly.

Review daily. If 2 or more ‘as required’ doses given, consider CSCI* starting with either

- Diamorphine† 10mg/24h
- Midazolam10mg’24h

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details

†- if Diamorphine not available, use equivalent dose of Morphine Sulphate for injection. *CSCI – continuous subcutaneous infusion via syringe driver

MOIST NOISY BREATHING/RESPIRATORY TRACT SECRETIONS

PRESENT

Prescribe stat dose of Glycopyronnium, 200 micrograms SC, repeated after 30mins if necessary

Prescribe ‘as required’ doses of Glycopyronnium 200 micrograms SC, 3 hrly (max 1200 micrograms/24h†)

Or

Prescribe stat dose of Hyoscine Butylbromide (buscopan) 20mgs, SC.

Prescribe ‘as required’ doses of Hyoscine Butylbromide 20mgs SC, 3 hrly (max 120mgs/24h†).

ABSENT

Prescribe ‘as required’ doses of Glycopyronnium 200 micrograms SC, 3 hrly (max 1200 micrograms/24h†)

Or

Prescribe ‘as required’ doses of Hyoscine Butylbromide 20mgs SC, 3 hrly (max 120mgs/24h†).

If 2 or more doses of ‘as required’ are needed

consider use of CSCI*

Glycopyrronium 1200micrograms/24h by CSCI*

Or

Hyoscine Butylbromide 60-120mgs/24h by CSCI*

Note:

- Drugs will not clear existing secretions.
- Treatment effective in 50-60% - more likely if noisy secretions due to unswallowed saliva, less likely if respiratory tract secretions.
- Many carers satisfied by explanation alone.
- A conscious patient treated with these drugs will be aware of an uncomfortably dry mouth

If symptoms persist or further advice required contact the Specialist Palliative Care Team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver † - maximums given as a guide. Seek Specialist palliative advice for further information if symptoms persist

NAUSEA & VOMITING

PRESENT

Give Cyclizine 50mgs SC as stat dose **<u>and</u>**
start Cyclizine 100-150mgs/24h by CSCI*
Or
Give Haloperidol 1.5-5mgs as stat dose **<u>and</u>**
start Haloperidol 2.5-10mgs/24h by CSCI*

Prescribe ‘as required’ doses:
Cyclizine – 50mgs SC, 4-6 hrly (max 200mgs/24h†)
Haloperidol – 1.5-5mgs SC, 4-6 hrly (max 15mgs/24h†)
If symptoms persist, see box below

If symptoms persist

Cyclizine and Haloperidol can be used together by CSCI*.
Or
Convert to Levomepromazine, 6.25-25mgs/24h by CSCI*
Prescribe ‘as required’ Levomepromazine 6.25-12.5mgs SC, 3 hrly
(max 75mgs/24h†)

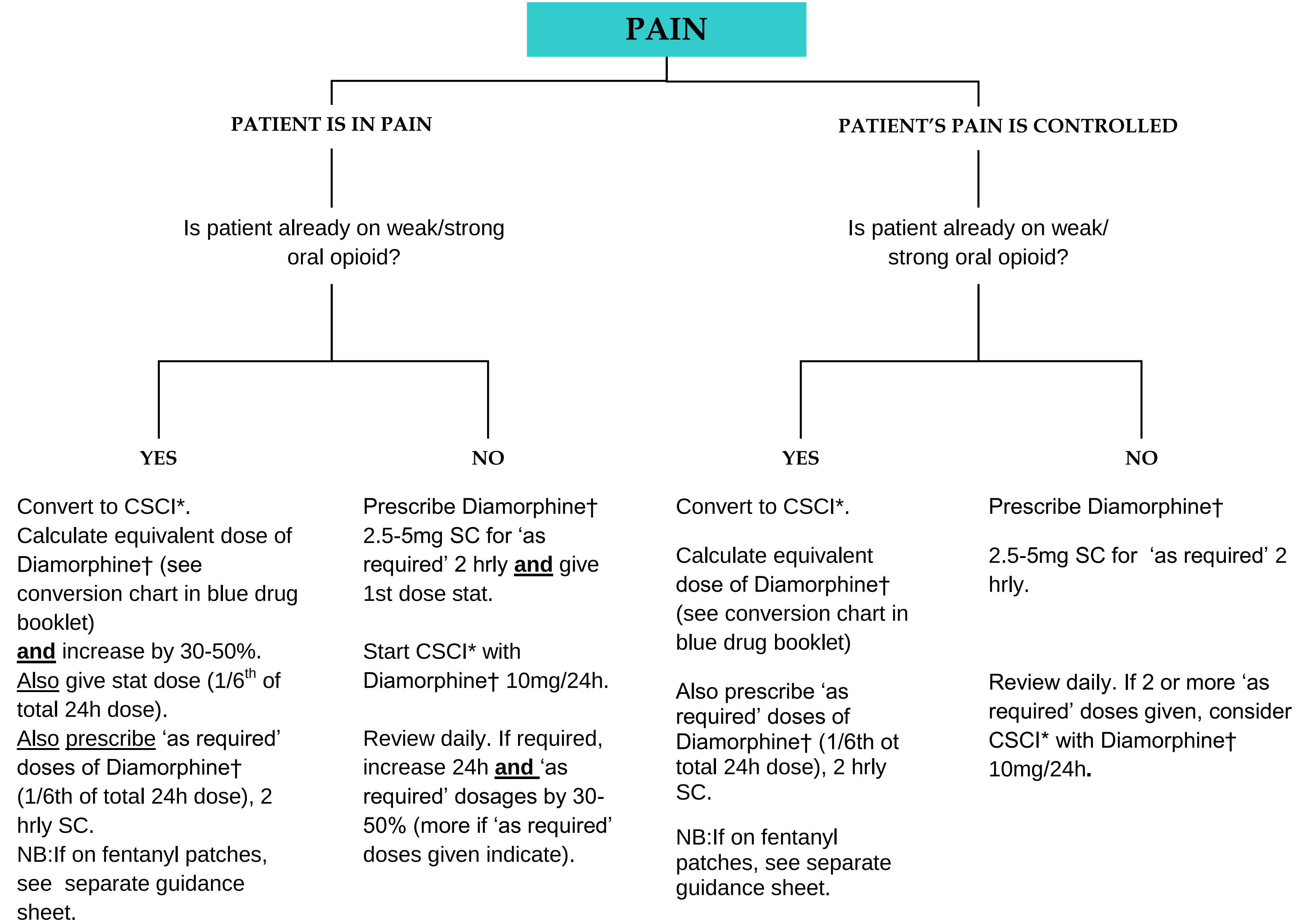
ABSENT

Prescribe Cyclizine 50mgs SC, 4-6 hrly
(max200mgs/24h†) ‘as required’
Or
Haloperidol 1.5-5mgs SC, 4-6 hrly (max 15mgs/24h†) ‘as required’.

Review daily. If 2 or more ‘as required’ doses given, consider converting to CSCI*

If symptoms persist, further advice required or patient has bowel obstruction, contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver.
† - maximums given as a guide. Seek Specialist palliative advice for further information if symptoms persist



PAIN

PATIENT IS IN PAIN

Is patient already on weak/strong oral opioid?

YES

Convert to CSCI*.
Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet)
and increase by 30-50%.
Also give stat dose (1/6th of total 24h dose).
Also prescribe ‘as required’ doses of Diamorphine† (1/6th of total 24h dose), 2 hrly SC.
NB:If on fentanyl patches, see separate guidance sheet.

NO

Prescribe Diamorphine† 2.5-5mg SC for ‘as required’ 2 hrly **and** give 1st dose stat.

Start CSCI* with Diamorphine† 10mg/24h.

Review daily. If required, increase 24h **and** ‘as required’ dosages by 30-50% (more if ‘as required’ doses given indicate).

PATIENT’S PAIN IS CONTROLLED

Is patient already on weak/ strong oral opioid?

YES

Convert to CSCI*.

Calculate equivalent dose of Diamorphine† (see conversion chart in blue drug booklet)

Also prescribe ‘as required’ doses of Diamorphine† (1/6th ot total 24h dose), 2 hrly SC.

NB:If on fentanyl patches, see separate guidance sheet.

NO

Prescribe Diamorphine†

2.5-5mg SC for ‘as required’ 2 hrly.

Review daily. If 2 or more ‘as required’ doses given, consider CSCI* with Diamorphine† 10mg/24h.

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

†- if Diamorphine not available, use equivalent dose of Morphine Sulphate for injection.
*CSCI – continuous subcutaneous infusion via syringe driver

RESTLESSNESS & AGITATION

PRESENT

Prescribe Midazolam 2.5-5mg SC stat dose, repeated after 30 mins if necessary
<u>And</u> prescribe Midazolam 10-20mg/24h by CSCI*
Prescribe ‘as required’ doses of Midazolam 2.5-10mg SC, 3 hrly (max 60mg/24h †)

ABSENT

Prescribe ‘as required’ doses of Midazolam 2.5-10mg SC, 3 hrly (max 60mg/24h †)

Review daily. If 2 or more ‘as required’ doses given, consider converting to CSCI*

If symptoms persist

Prescribe Levomepromazine 12.5-25mg SC to give as a stat dose <u>and</u> for ‘as required’ doses, 3 hrly.(max 150mg/24h†).

If effective, consider adding Levomepromazine 25-50mg\24h to the Midazolam in the CSCI*.

If symptoms persist or further advice required contact the Specialist Palliative care team or local Hospice – see front of Care Plan for contact details.

*CSCI – continuous subcutaneous infusion via syringe driver.
† - maximums given as a guide. Seek Specialist palliative advice for further information if symptoms persist

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting: 29th July 2014
Report of: Kathy McAteer, Independent Chair Local Safeguarding Adults Board
Subject/Title: Progress Report regarding the Local Safeguarding Adults Board

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1.0 Report Summary

1.1 Since the previous report presented to the Health and Wellbeing Board on 26th November 2013, an Interim Chair of the Local Safeguarding Adults Board (LSAB) was appointed in April 2014, following the resignation of the previous chair. This report is the mid-year safeguarding up-date and sets out the key goals and plans over the next 6 months, to develop the LSAB in line with the new legal framework set out in the Care Act 2014.

1.2 Care Act 2014

The Care Act 2014 sets out a new legal framework for the provision of care and support for adults, support for carers, safeguarding adults from abuse or neglect, and care standards. There are 2 key elements:

- Ensuring that key partners work together effectively to improve safeguarding, wellbeing and independence
- New duties and responsibilities for local authorities in how they provide this support.

The Care Act sets out a legal framework for how all agencies should protect adults at risk of abuse or neglect. There is a legal requirement for local authorities to set up a **Safeguarding Adults Board** in their area. Though adult safeguarding boards have been operating for many years, these have been on a voluntary basis. The Care Act aims to ensure that local organisations can make sure they are working together in the best way by giving these boards a clear basis in law for the first time. The Care Act says that Safeguarding Adults Boards must:

- Include the local authority, the NHS and the police, who should meet regularly to discuss and act on local safeguarding issues
- Develop a shared “safeguarding plan” for safeguarding, working with local people to decide how best to protect adults in vulnerable situations
- Publish this safeguarding plan and report to the public annually on its progress.

In addition to the legal requirement to establish a Safeguarding Adults Board, the Care Act also requires:

- Local authorities to make enquiries, or ask others to make enquiries, when they think an adult with care and support needs may be at risk of abuse or neglect in their area, and take any action that may be needed. This applies regardless of whether the authority is actually providing any care or not.

- The Safeguarding Adults Board to arrange a Safeguarding Adults Review in cases where there has been a failure in safeguarding – for example if an adult with care and support needs dies as a result of abuse or neglect and there is concern about how one of the safeguarding agencies acted or whether agencies acted together in the right way.
- The local authority must arrange for an independent advocate to represent and support someone who is subject to a Safeguarding Enquiry or Safeguarding Adult Review if they need help to understand and take part in the process.
- All organisations must share information related to abuse or neglect with the Board. This includes a legal requirement for organisations and individuals to respond and share any relevant information with the board, when asked to do so.

1.2 Review of Constitution

The LSAB has established a Business Management Group, chaired by the interim Chair and comprising the local authority, NHS, Police and the chair of the No Secrets Reference Group, who have been tasked with completing a review of the Constitution for the LSAB. The aim is to ensure clarity of definition, purpose and remit of the LSAB and ensure that this is in line with the new legal framework. This work will be completed over the next 6 months and will be subject to wider consultation in due course.

1.3 Business Plan and Work Programme

At the LSAB meeting held on 23rd July, the LSAB reviewed its work programme and agreed the key priorities for 2014-15. This will inform the development of a two year Business Plan and the new annual safeguarding plan required by the new legal framework. Linked to this, work will be completed to establish how the performance of the LSAB will be measured to ensure it is effective and supports good partnership working.

2.0 Decision Requested

2.1 That the HWBB notes the mid-year up-date as set out in this report and receives the new Constitution as part of the next 6 monthly report.

3.0 Reasons for Recommendations

3.1 The Health and Well-Being Board has a clear role in Adult Safeguarding. There is the need to formally recognise adult safeguarding and as a cross-cutting theme as set out in the previous report.

3.2 The HWBB also has a role in scrutinising and challenging the LSAB and in evaluating the performance of the LSAB in its contribution to the health and well-being agenda.

3.3 The review of the Constitution will ensure that the issues identified on 26th November 2013 are addressed. That is, the need to:

- Clearly locate each Board in an overall governance structure and agree inter-relationships
- Agree the basis of the relationship –mutual support, distinction of role, scrutiny and challenge
- Ensure the LSAB is not subordinate – It cannot compromise its separate identify and independent voice
- Identify the relationship with Healthwatch and Safeguarding

4.0 Access to Information

Any information regarding this report can be inspected by contacting the report writer:

Name: Katie Jones
Designation: LSAB Business Co-ordinator
Tel No: 71815
Email: katie.jones@cheshireeast.gov.uk

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting:	29th July 2014
Report of:	Brenda Smith, Director of Adult Social Services and Independent Living, Cheshire East Council; Karen Burton, NHS Eastern Cheshire CCG and Julia Burgess, NHS South Cheshire CCG
Subject/Title:	Learning Disabilities Joint Health and Social Care Self-Assessment 2013 and Action Plan 2014/15

1.0 Report Summary

1.1 The Learning Disability Health Self-Assessment Framework (LDSAF) has been an annual process since being used in England in 2007/8. 2013 saw the introduction of a revised Joint Health and Social Care Self-Assessment Framework to emphasise the need for a joint commissioning approach between health and social care. All Local Authority areas were asked to complete the self-assessment, working with their local health partners and learning disability partnership boards. The joint Cheshire East area submission was made in November 2013.

1.2 The new framework replaces and combines the previous Valuing People Now Self- Assessment and the NHS Learning Disability Health Self - Assessment, becoming a comprehensive needs assessment. The information collected supports action that improves outcomes for people with learning disabilities and their families.

1.3 The aim of the assessment is to provide a framework for a comprehensive local stock- take exercise. This is intended primarily to support Learning Disability Partnership Boards, Health and Wellbeing Boards, Clinical Commissioning Groups and Local Authorities identify the priorities, levers and opportunities to improve care and tackle health and social care inequalities in their areas. It is expected that local findings will be considered by local Health and Wellbeing Boards as well as Learning Disability Partnership Boards.

1.4 The self assessment is divided into two distinct sections. The first section is data collection with 149 questions under 59 domains. The data was collected from a range of sources including Public Health, CCGs, Children's Services and Adult Social Care.

1.5 The second section required each area to assess themselves against 27 measures using a RAG (Red Amber Green) 'Traffic Light' system. These are aligned to the outcome frameworks – Adult Social Care Outcomes Framework (ASCOF), Public Health Outcomes Framework (PHOF), National Health Service Outcomes Framework (NHSOF), and key policy documents such as the Winterbourne View Concordat. These nationally set outcome frameworks and policies were used as the evidence base for the three broad areas in the LDSAF, which are Staying Healthy, Being Safe and Living Well.

1.6 Learning Disability Partnership Boards were asked to rate provision in their area against a set of measures. This aspect of the assessment was undertaken by NHS and Local Authority colleagues in collaboration with local care providers, self-advocates and family carers.

1.7 The Cheshire East Learning Disability Partnership Board contributed to the submission. Evidence was also gathered at 2 engagement events: "My Health, My Say" held in Crewe and Macclesfield. The self assessment was followed by a validation process conducted by the NHS Local Area Team. A final version of the results, RAG rated, is included in the appendix attached.

1.8 The validated outcome of the self assessment was that 8 areas were rated as red, 13 were rated as amber and 6 were rated as green (see appendix for details).

1.9 To address the areas rated red and amber in the self-assessment and also incorporate a number of drivers for action a joint programme of action was devised. The partners involved are: Cheshire East Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG, East Cheshire NHS Trust (ECT) Mid Cheshire Hospitals Foundation Trust (MCHT) and Cheshire & Wirral Partnership Foundation Trust (CWP).

1.10 The additional drivers for action addressed include: Transforming Care: A national response to Winterbourne View, the Confidential Inquiry into premature deaths among people with learning disabilities and the Challenging Behaviour National Strategy Group Charter. The Winterbourne View action plan has been recently submitted to the adult safeguarding board.

The full detail of the action plan is provided in the appendix. The delivery of the action plan is aligned with the learning disability life course review.

1.11 A regional event was held in February 2014 which enabled commissioners of learning disabilities services to come together and agree what were the common challenges across the North West. An outcome of this event was to identify areas of work which would benefit from a regional approach. This is now being progressed through a number of task and finish groups, sharing approaches and solutions across a wider footprint.

2.0 Recommendation

2.1 That the Health and Wellbeing Board consider and endorse the Learning Disability Action Plan.

2.2. That the Health and Well-being Board receive six monthly report to monitor the progress of this action plan.

3.0 Reasons for Recommendations

3.1 As part of the governance arrangements, requested by Public Health England - Improving Health and Lives (IHAL), there is a requirement to report to the Health and Wellbeing Board in respect of the Learning Disability Self Assessment Action Plan.

3.2 Reporting to Health and Well-being board will provide an opportunity to ensure progress is being made on the agreed actions.

4. The Learning Disability Self Assessment Action Plan

4.1 The action plan contained in the appendix has been approved by the NHS England Local Area Team and submitted, in line with the governance arrangements.

5.0 Access to Information

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

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Appendix – Joint Learning Disability Self Assessment and Winterbourne View Action Plan; including the summary of validated self-assessment ratings

Appendix to Health and Wellbeing Report (29th July 2014)
Learning Disabilities Implementation Group
Programme of Action 2014 -15

- This is a Joint Programme of Action between;
    - Cheshire East Council (CEC)
    - NHS Eastern Cheshire Clinical Commissioning Group (ECCCG)
    - NHS South Cheshire Clinical Commissioning Group (SCCCG)
    - East Cheshire NHS Trust (ECT)
    - Mid Cheshire Hospitals Foundation Trust (MCHT)
    - Cheshire & Wirral Partnership Foundation Trust (CWP)

  All of these organisations are represented at the Learning Disabilities Implementation Group

- The Learning Disabilities Implementation Group (LDIG) meets bi-monthly and is chaired by the Clinical Commissioning Groups.

- This work programme reflects the requirements and priorities set out in a number of key policy documents including:

    - Transforming Care: A national response to Winterbourne View (WV)
    - Confidential Inquiry into premature deaths among people with learning disabilities
    - Challenging Behaviour National Strategy Group Charter
    - 2013 Joint Health and Social Care Self-Assessment Framework for Learning Disabilities

- The LDIG will not deliver all of the actions relating to these policy documents as there are a number of other groups working on the Learning Disabilities agenda. In particular, this programme needs to be seen in the context of the Cheshire East Council Learning Disabilities Life Course Review and the work on Learning Disabilities that is being co-ordinated by the NHS England area team. Key areas of work being undertaken by other groups are summarised below in order to clarify which groups are leading on which actions.

- The LD Implementation Group will consider those areas of the LDSAF that have scored amber to ensure a positive direction of travel towards green. The group will also evaluate the areas scored green to ensure that the positive position is sustained and any lessons learnt in achieving a green status are transferred to other areas of the assessment.

Learning Disabilities Implementation Group Programme of Action 2014 -15

Action (High Level)	Local Response/Action	LEAD	Due for completion	Commentary	Source[i]
Conduct an audit of deaths among our population with Learning Disabilities and identify lessons to be learned		CEC CWP MCHFT ECCCG SCCCG	September 2014	Work in progress	LDSAF Confidential inquiry
Use commissioning "levers" to ensure that providers meet their obligations in relation to reasonable adjustments	Audit of reasonable adjustments proposed as a CQUIN for acute trust.	ECCCG SCCCG	June 2014	Completed - CQUIN in place Scored Red in SAF A8	CI2 CI7 LDSAF A8, B5
Improve communication about a person's Learning Disability Status and their needs. This includes flagging systems in primary care as well as secondary care.	Improve the quality and uptake of communication tools that support people to access health services (Health Action Plans, Patient Passports)	CWP SCCCG ECCCG MCHFT ECT	March 2015	Complements work being undertaken by NHS Area Team (See below) Scored Red in SAF (A4 & A6)	CI5 CI6 LDSAF A4 & A6 LCR
Re-assessment of individual clients to ensure person centred care plans continue to meet need and improve outcomes. Improve quality of commissioned services and ensure that robust monitoring processes are in place	Ensure that individuals receiving care packages commissioned by health and/or social care are reviewed annually. CEC is currently reviewing the staff complement required to improve the timeliness of client reviews	CEC ECCCG SCCCG	March 2015	Scored Red in SAF B1	WV LDSAF B1
Increase the involvement of service users and carers in training and recruitment of staff	Re-affirm service standards for all LD commissioned services via service specifications, quality assurance processes and provider forum	CWP SCCCG ECCCG MCHFT ECT	October 2014	Scored Red in SAF B5. Reference to Driving Up Quality	LD SAF B5
MCA and DOLS	Implementation of latest guidance – to be discussed by LDIG. Actions may fall to other groups e.g. Safeguarding	CEC ECCCG SCCCG CWP	TBC		

Summary of Key actions being undertaken by other groups:

The LD Life Course Review is a major change project for the Council, 2 CCGs, Community & Voluntary sector and other key partners. The LD Life Course Review is a whole system / whole life course approach to improving the outcomes for individuals with a learning disability, their parent and carers. A life course approach is recognised as a best practice response to the WV improvement agenda. The review is looking at the long term and therefore is planned to take up to 2 years and has been split into three workstreams as follows:

a) Life Course Review - Commissioning work stream

- Ensure that the needs of people with Learning Disabilities are taken into account when planning and delivering commissioning strategies that are joined up across key partners
- Develop local, community based services that offer an alternative to out of area placements and that can meet the needs of clients with challenging behaviours. This work is based on the vision set out in the Challenging Behaviour – National Strategy Group Charter

b) Life Course Review – Children & Families Act work stream

- Develop opportunities for joint commissioning
- Accessible and effective approach to improving choice and control through Personal Budgets
- Develop Single Plans for Education, Health and Care
- Develop a comprehensive Local Offer

c) Life Course Review – Integration work stream

- Implement integrated teams across adult social care and health in the first instance
- Consider and develop integrated teams for transition and children's social care and health

NHS England Local Area Team

- Address health inequalities by improving both the number and quality of health checks provided within primary care.
- Increase the uptake of national screening programmes, in particular cancer, among people with Learning Disabilities (Scored Red in SAF A2 & A5).
- Clear identification of people with learning disabilities on the NHS central registration system and in all healthcare record systems

CEC and CCG service teams

- Develop and maintain a register of all people with learning disabilities or autism who have mental health conditions or challenging behaviour in NHS funded placements
- Review of all out of area hospital placements to provide assurance in relation to safety and quality and to ensure that they meet the requirements set out in the Winterbourne Concordat and Confidential Inquiry

- Ensure that clients are in the least restrictive setting
- Review existing contracts to ensure they include an appropriate specification, clear individual outcomes and sufficient resources to meet the needs of the individual
- CCGs and the local authority will set out a joint strategic plan to commission the range of local health, housing and care support services to meet the needs of people with challenging behaviour in their area.
- Review of the LD Pooled Budget 2013-14 and development of an equitable / sustainable agreement (including the governance and accountability structures).
- Develop a consultation and engagement plan incorporating the principles of co-production.

Carers Strategy Group

- Implementation of the joint Carers Strategy for Cheshire East, ensuring that the needs of people caring for those with learning disabilities are reflected (Scored Red in SAF C9)

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[i] WV: Winterbourne View Concordat
CI: Confidential Inquiry
LD SAF: Joint Health and Social Care Self-Assessment Framework for Learning Disabilities
LCR: Cheshire East Learning Disabilities Life Course Review
NHS LAT: NHS Local Area Team
CSU – Commissioning Support Unit
JIP – Winterbourne View Joint Improvement Programme

Joint Health and Social Care Self Assessment Framework for Learning Disabilities 2013

Validated RAG ratings for Cheshire East Council (including NHS Eastern Cheshire and NHS South Cheshire CCGs)

Section A Staying Healthy									
🟧 A1 LD QOF Register	🟥 A2 Screening	🟧 A3 Annual Health Checks	🟥 A4 Health Action Plans	🟥 A5 Screening (Cancers)	🟥 A6 Communication of LD status	🟧 A7 LD Liaison Function	🟥 A8 Primary and Community Care	🟧 A9 Offender Health	🟥 Overall
Section B Being Safe									
🟥 B1 Regular Care Reviews	🟧 B2 Contract compliance assurance	🟧 B3 Assurance of Monitor Compliance	🟩 B4 Safeguarding	🟥 B5 Involvement in Training and Recruitment	🟩 B6 Value Based Culture	🟩 B7 Support, Care and Housing Strategies	🟧 B8 Change of practice in response to feedback	🟧 B9 MCA and DoLS	🟧 Overall
Section C Living Well									
🟩 C1 Effective Joint Working	🟧 C2 Transport and amenities	🟧 C3 Arts and Culture	🟩 C4 Sport and Leisure	🟧 C5 Employment	🟩 C6 Transitions	🟧 C7 Community Inclusion and Citizenship	🟧 C8 Involvement	🟥 C9 Family Carers	🟧 Overall

Updated 2014-04-23

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CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting: 29th July 2014
Report of: Guy Kilminster
Subject/Title: Better Care Plan Update

1.0 Report Summary

1.1 Two letters have been received outlining changes to the Better Care Fund and what will be required over the next couple of months. Each Health and Wellbeing Board is required to '…propose their own performance pot based on their level of ambition for reducing emergency admissions, with a guideline reduction of at least 3.5%'. Part of the funding allocation will be paid subject to achieving this target.

1.2 The balance of the performance allocation will be paid up front and will need to be spent on out of hospital NHS commissioned services as agreed by the Board.

2.0 Recommendation

2.1 That the Board receive the update and consider the most appropriate means of progressing the actions required.

3.0 Reasons for Recommendations

3.1 To ensure that The Health and Wellbeing Board has in place the appropriate plans to satisfy the requirements of the Better Care Fund and to make the most effective use of the resource available.

4. Letter from Jon Rouse and Helen Edwards (Appendix 1)

4.1 This letter '…sets out how you will be continued to be supported to get the plans ready for implementation in 2015'.

4.2 The first key element of the letter relates to the Pay for Performance and Risk Sharing. This sets the need for the plans to demonstrate how they will reduce emergency admissions. Each Health and Wellbeing Board is required to propose its own performance pot, based on the level of ambition for reducing emergency admissions, but with a guideline reduction of at least 3.5% specified. A proportion of the current performance allocation (our share of the national £1bn performance element of the fund) will be paid on delivery of this target. The proportion paid will depend on the level of ambition of the target. If an area does not achieve the target the money retained will be available to the CCGs, to be used to pay for the unbudgeted acute activity.

4.3 The balance of the performance allocation (the amount not set against the target for reduced admissions), will be available upfront. It will need to be spent on out-of hospital NHS commissioned services that have been agreed locally by the Health and Wellbeing Board.

4.4 It is acknowledged that much of the funding will be used for joint services and '…a simple way to account for that investment…' will be found.

4.5 The need to strengthen certain aspects of local plans is referred to and that new guidance from NHS England and the Local Government Association will be shortly issued. Exemplar plans from a small number of areas will also be published.

4.6 A new plan template will also be issued which will require additional financial data around metrics, planned spend and projected savings. This will be required to be submitted at the end of the summer.

4.7 The final part of the letter refers to the newly expanded Better Care Fund Programme Team, to be headed up by Andrew Ridley as the new BCF Programme Director.

5. Letter from Andrew Ridley (Appendix 2)

5.1 The new team's role is outlined in this letter, '…to ensure we drive forward progress and provide local areas with the support they need'. Priorities for the Programme Director are:

- Establishing a programme management office;
- Developing an effective offer of support to local areas;
- Clarifying a revised, consistent and robust assurance process;
- Strengthening communications and stakeholder engagement to ensure clear and consistent communication.

5.2 A weekly communication is planned and those wanting to receive this can sign up by emailing bettercarefund@dh.gsi.gov.uk

5.3 The letter also refers to the 'fast-track' process for a sample of the best draft plans. These will be 'exemplar' plans that others can use to improve their own Plan.

5.4 Finally he refers to the detailed guidance that will be published shortly and the need to wait for this '…to fully understand the implications of the BCF planning process'.

5.0 Access to Information

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

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Department of Health

Department for Communities and Local Government

Dear Health and Wellbeing Board Chair

11 July 2014

BETTER CARE FUND

Thank you for the progress you have made so far with your preparations to implement the Better Care Fund. We know that local plans contain a clear commitment to ensure more people receive joined-up, personalised care closer to home. This letter sets out how you will continue to be supported to get the plans ready for implementation from April 2015. Following the recent announcement on the Better Care Fund, we also want to tell you about some changes we are making to further develop the programme.

We remain convinced that the shift to integrated care is the right way to deliver a sustainable health and social care system that can provide better quality care and improve outcomes for individuals. That is the way we can preserve people's dignity by enabling them to stay in their own homes, and to receive care and support when and where they want and need it. That is why the Government remains fully committed to the Better Care Fund and are clear that pooled health and care budgets will be an enduring feature of future settlements.

The Better Care Fund is deliberately ambitious. The majority of local draft plans submitted in April showed that same ambition. We recognise the scale of the task of transforming local services and the plans show how significant progress has been made in bringing together organisations and moving to a new and more collective way of working. We were particularly pleased to learn that most of the plans were addressing key conditions such as a commitment to seven day working, better sharing of information and protection of social care services.

We know that we need to shift as quickly as possible from improving and assuring the plans to letting local areas get on with delivery. However, we believe there is more to do over the next few months to ensure a strong first year.

Pay for Performance and Risk Sharing

First, as announced earlier in the month we are finalising arrangements for the pay for performance element of the fund and, as part of that, putting in place a clear framework for local risk sharing.

We know that unplanned admissions are by far the biggest driver of cost in the health service that the Better Care Fund can affect. We need the plans to demonstrate clearly how they will reduce emergency admissions, as a clear indicator of the effectiveness of local health and care services in working better together to support people's health and independence in the community.

We are therefore asking each Health and Wellbeing Board to propose their own performance pot based on their level of ambition for reducing emergency admissions – with a guideline reduction of at least 3.5 per cent. A proportion of your current performance allocation (i.e. your area's share of the national £1bn performance element of the fund) will be paid for delivery of this target. That proportion will depend on the level of ambition of your target. Where local areas do not achieve their targets the money not released will be available to the CCGs, principally to pay for the unbudgeted acute activity.

The balance of your area's current performance allocation (i.e. the amount not set against the target for reduced admissions) will be available upfront to areas and not dependent on performance. Under the new framework, it will need to be spent on out-of hospital NHS commissioned services, as agreed locally by Health and Wellbeing Boards.

In reality we know of course that a lot of the investment from the Fund will be in joint services. We welcome that and will find a simple way to account for that investment.

This change will mean that while it is likely that local authorities will continue to receive the large majority of the Better Care Fund, the NHS will have the assurance that plans will include a strong focus on reducing pressures arising from unplanned admissions.

This change also means that, because of its importance in terms of driving wider savings, reductions in unplanned admissions will now be the sole indicator underpinning the pay for performance element of the BCF. Performance against the other existing metrics will no longer be linked to payment. However, we will still want to see evidence of strong local ambition against them as part of the assurance of plans.

Plan Improvement and Assurance

Second, certain aspects of local plans need to be strengthened to ensure we are ready to deliver from April 2015. NHS England and the LGA will shortly be issuing guidance on what a good final plan should look like. NHS England will also be publishing exemplar plans from a small number of areas to help the process.

In addition, NHS England will issue a revised plan template which will request additional financial data around metrics, planned spend and projected savings. They will also provide further detailed guidance on the revised pay for performance and risk sharing arrangements.

We expect that areas will be asked to submit revised plans and any further information at the end of the summer. NHS England, supported by the LGA, will also set out the assurance and moderation process. Where localities need support to complete their plans NHS England, supported by the LGA, will discuss how best to provide this.

The plans will be further reviewed by DCLG Permanent Secretary Sir Bob Kerslake and NHS Chief Executive Simon Stevens in the autumn prior to submission to Ministers to ensure they are ambitious enough to achieve improvements in care and that every area is on track to begin in April next year.

Better Care Fund Programme Team

Third, in order to drive this through at pace an expanded joint Better Care Fund programme team has been established, working across Whitehall, local government and the NHS. Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, will take on overall responsibility for delivery through this team. The expanded team is headed by Andrew Ridley as the new BCF Programme Director. A key priority for the new team will be ensuring that, given the fast-moving nature of the programme, you are kept fully up to date and provided with the support you need to deliver effective plans and move into implementation. Andrew will be writing to you shortly to outline his plans for doing this, and to begin a regular programme of communication with local areas.

We recognise that in order to make integrated services a reality, you have achieved a lot already over a short space of time. We would like to thank you again for your hard work, and to reiterate that the Government remains absolutely committed to making the Better Care Fund and integrated services a success. We know that you share our ambition to transform local services for the benefit of all who use them.

J Rouse

Helen Edwards

JON ROUSE

HELEN EDWARDS

Department of Health
Department for Communities and Local Government
Local Government Association
NHS England

11 July 2014

Dear Health and Wellbeing Board Chair

BETTER CARE FUND PROGRAMME TEAM

Helen Edwards and Jon Rouse have written to confirm a number of important developments on the Better Care Fund. This included my appointment as the new Better Care Fund Programme Director, and the establishment of an expanded joint programme team. I am writing now to begin a regular programme of communication, and to set out my plans for working with you to help make a success of the BCF. I would encourage you to share my thoughts with colleagues and partners working on BCF plans locally.

As set out in Helen and Jon's letter, I am heading up an expanded joint team that includes colleagues from NHS England, the LGA, DH and DCLG, working under the leadership of Dame Barbara Hakin, National Director: Commissioning Operations, NHS England, who will take on overall responsibility for the programme. The team, reporting to me, has been brought together to ensure we drive forward progress and provide local areas with the support they need. I have prioritised a number of work areas, in order to take the programme forward with clarity and purpose:

- Establishing a programme management office, which will work to quickly ensure a shared understanding of key deliverables and deadlines – when we have clear dates and deadlines we will share them
- Developing an effective offer of support to local areas to ensure they are fully supported to develop the best plans possible – including how the plans of 'fast track' areas can act as exemplars
- Clarifying a revised, nationally consistent and robust assurance process, including being clear on what is being asked from local areas
- Strengthening communications and stakeholder engagement to ensure that all partners and stakeholders communicate clearly and consistently across the programme

This is a fast-moving programme working to challenging deadlines and I recognise the fluidity recent events have created in the system. To ensure you are kept fully up to date going forward, I am planning to issue a weekly communication to all areas. This will begin next week. If it would be helpful for any colleagues in your area to be included in this communication, please email bettercarefund@dh.gsi.gov.uk with their details.

The recent letter from Helen and Jon confirmed that a revised plan template and guidance will be issued to support the further improvement of plans locally and to underpin the strengthened pay for performance and risk sharing arrangements. I recognise that this will mean additional work and that we will need to review current timescales, and in this context I am clear that we also need to ensure areas have the time necessary to adequately prepare for implementation from next April.

I also recognise the need to ensure local areas are fully supported to agree and implement ambitious, deliverable plans. I will communicate the next steps on this as soon as I can and in any case before the end of the month. In the meantime, I would like to clarify a couple of specific points that have been brought to my attention.

First, I wanted to clarify arrangements around the areas subject to a “fast-track” process, as announced last week. The aim of this process, which is underway, is to take a sample of the best draft plans and support those areas to further improve the plans ahead of publication of refreshed guidance. These plans have not been approved but have been identified as ones which exhibit strong potential, and which we envisage can provide ‘exemplar’ plans for other areas to use as part of improving their own plans.

Second, I would like reassure you that we will be issuing refreshed guidance that includes further detail on the changes to the risk sharing and pay for performance framework outlined in the letter from Helen and Jon Rouse. This will include more detail on the full range of performance metrics. I appreciate there is a degree of uncertainty over the details of these changes, so I would encourage you to wait for this detailed guidance to fully understand the implications for the BCF planning process.

I look forward to working with you.

A Ridley

Andrew Ridley
BCF Programme Director

Connecting Care Across Cheshire

Three localities, one ambition

| NHS Eastern Cheshire CCG | NHS South Cheshire CCG | NHS Vale Royal CCG
| NHS West Cheshire CCG | Cheshire East Council | Cheshire West and Chester Council

CONNECTING CARE IN CHESHIRE PIONEER PROGRAMME

A Report on Programme Governance and Reporting Arrangements

1. Purpose

1.1. The purpose of this report is to set out the governance and reporting arrangements for the Connecting Care in Cheshire Pioneer Programme.

2. Background

2.1 In May 2013, 13 national leaders of health and care and support came together to help launch the 'Integrated Care and Support: Our Shared Commitment' publication, which recommended Integrated Care and Support Pioneers programme.

2.2 The aim of the programme is to help local areas integrate services, so that individuals and families experience consistent, high quality, personalised and non-fragmented care and support to meet their needs.

2.3 Along with 13 other sites Connecting Care in Cheshire was selected to become 'pioneers' of the programme and now has a responsibility to act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver integrated care and support. The organisations comprising Connecting Care in Cheshire Pioneer Programme are reflected in the Figure 1 below.

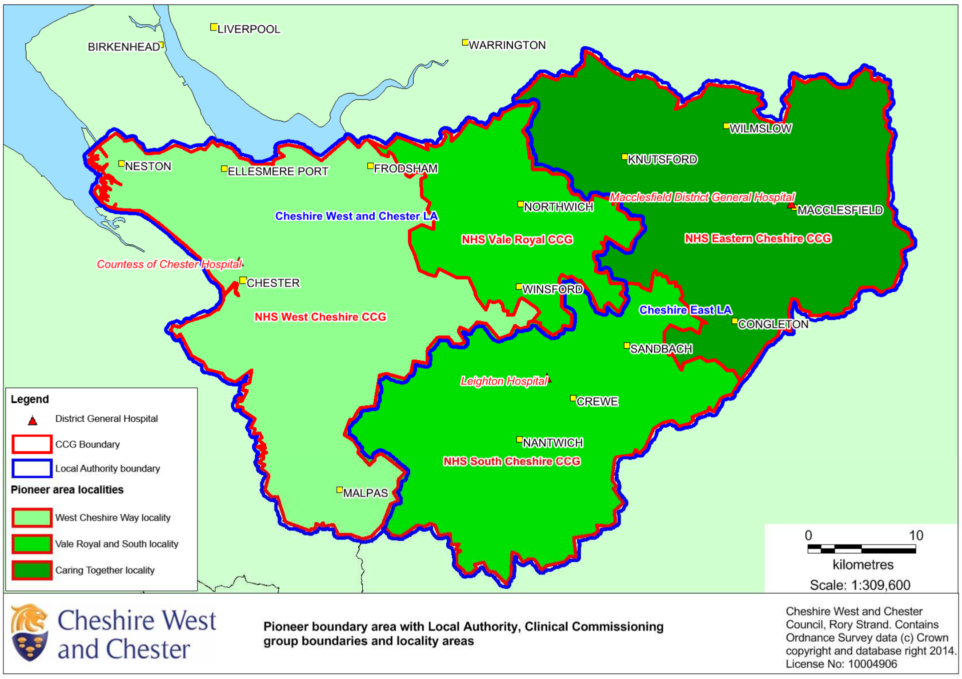

Figure 1 Connecting Care in Cheshire Pioneer Programme boundaries

3. Governance Arrangements

3.1 Pioneer partners across Cheshire are committed to a model of collaborative leadership, through which shared visions and outcomes will allow organisations to establish a common direction of travel and make joint decisions. A Pioneer Panel with representatives from both Health and Wellbeing Boards has been established to help coordinate activity across the Cheshire Pioneer areas where appropriate.

3.3 The relationship between the Programme, the two Health and Wellbeing Boards, and the three locality integrated care programmes is outlined in Figure 2.

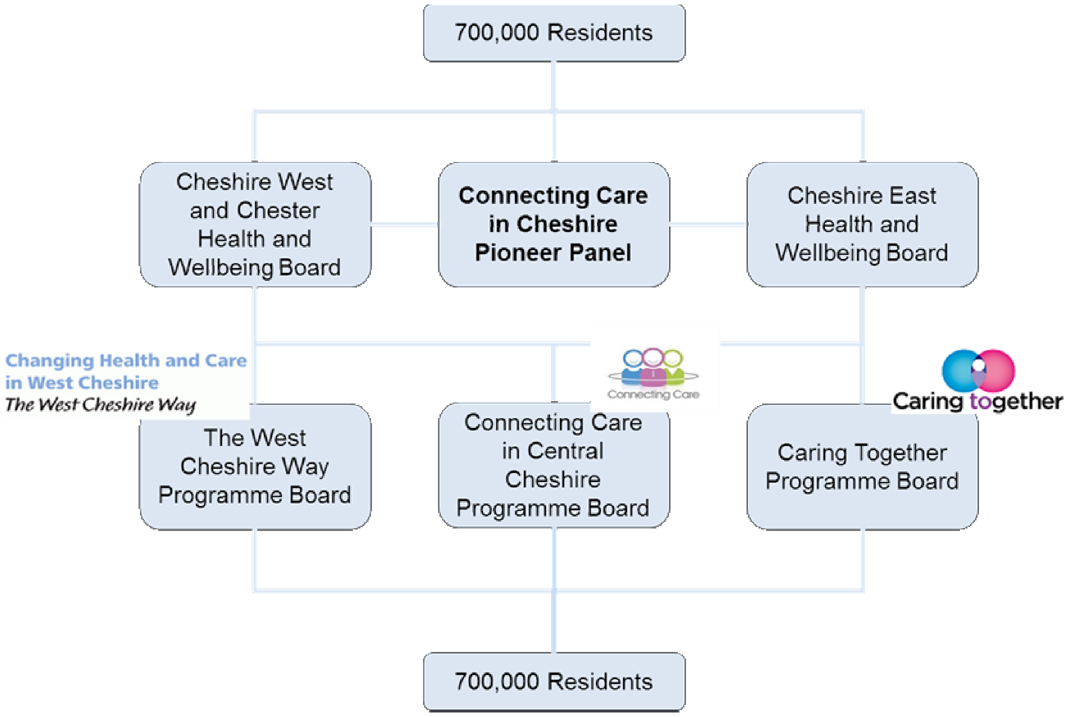

Figure 2 Connecting Care in Cheshire Pioneer Programme Governance Structure

3.2 It is recognised that that all local organisations and partnerships will maintain their governance processes and structures to ensure continuity of existing sovereignty to stability. The role of service users and their carers is vitally important and will feed in via Health Watch and other local arrangements such as the Older Peoples Network, Health Voice, the Parent Partnership, and Patient Participation Groups.

4. Programme Reporting Arrangements

4.1 The Connecting Care in Cheshire Pioneer Programme Director will report progress monthly against the stated aims of the Connecting Care in Cheshire Programme to the Panel using an agreed highlight report.

4.2 Although still evolving, the Connecting Care in Cheshire delivery structure is outlined in Figure 3. The ‘enablers’ chime with those set out in national Pioneer programme and the workstreams reflect those common areas of integration that all three locality programmes have committed to collaborate on across the Cheshire Pioneer area.

4.3 As workstreams progress it may become necessary to establish a steering group between the Pioneer Panel and the portfolio of workstreams.

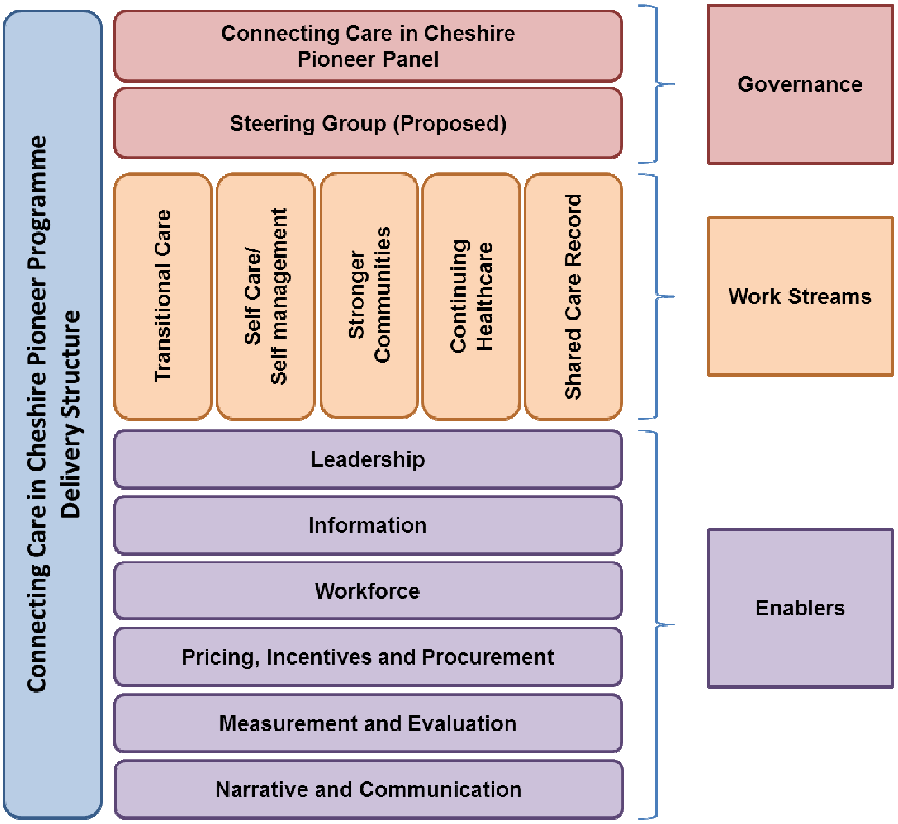

Figure 2 Connecting Care in Cheshire Pioneer Delivery Structure

5. Conclusion

5.1 The Connecting Care in Cheshire Pioneer Panel believes the collaborative governance and reporting arrangements outlined above will help partners in Cheshire deliver better outcomes for our citizens, many of which are vulnerable, at both scale and pace. It will also lead to a transformational reduction in demand and the ability to meet needs with reducing resources.

Briefing Paper

Developing together a five year strategic plan for Cheshire, Warrington and Wirral

Background

The English health and social care system is facing significant and enduring operational pressure exerted, in part, by increased demand and financial constraints. NHS England has a systems management role for health services, promoting the culture and conditions necessary to deliver the highest standard of care whilst ensuring efficient use of public resources. Its ambitious vision for outcomes-based transformation of services is outlined in 'Everyone Counts' guidance, 2014-19 [http://www.england.nhs.uk/everyonecounts/]. Across England, health economies are being challenged to develop 'strong, robust and ambitious five year plans with providers and partners in local government'. Innovation and transformation are important themes for providers and commissioners alike.

Increased collaboration not only strengthens our strategic plans but is also a potential mechanism by which transformation can be encouraged. The Public Health Team within Cheshire, Warrington and Wirral Area Team for NHS England (CWW) is leading on the development of its five-year plan by seeking the input of all commissioners across the geographical footprint. Whole disease pathways are rarely commissioned by one organisation and this is particularly the case where the goal is to improve public health outcomes (for example, in services for obesity or alcohol). We believe that fostering the involvement of our key partners will ensure a more robust strategic plan and will identify opportunities for further ambitious approaches that could be achieved through collaboration across agencies and borders.

Planned approach

We aim to build a consensus between partners around the key priority pathways for the CWW region that would benefit from a more collaborative approach. The findings of a desktop review of existing plans, strategies and JSNA data will be used to help shape the discussion. We are hosting a short-day stakeholder workshop on the 17th of September 2014. This event will be a crucial opportunity to shape the NHS England CWW five-year strategy and a move towards a more collaborative approach to commissioning within the region.

We want to explore with partners the potential priorities and the opportunities for collaboration and commissioning of integrated care across whole pathways (from prevention to end of life). It is therefore vital that the relevant agencies and localities are represented at this event. The outcome of the workshop will be to agree two or three priority pathways that localities and partners decide to explore further, agreeing frameworks for collaboration and key milestones. This new work stream will be a central part of the NHS England CWW five-year strategy.

Action requested

NHS England CWW invites Health and Wellbeing Boards and Clinical Commissioning Groups to send representatives to the 17th September workshop (see save the date flyer overleaf). Representatives from each locality should include leads/commissioners covering primary care, secondary care, public health and social care. A preliminary discussion paper outlining the priority analysis undertaken will be available in advance of the workshop.

This work is being supported by the Cheshire and Mersey Public Health Collaborative Service. If you have not already done so, we would be grateful if you could please nominate your representatives directly to Helen Unsworth at helenunsworth@wirral.gov.uk, 0151 666 5123.

DATE FOR YOUR DIARY

Developing together a five year strategic plan for Cheshire, Warrington and Wirral

NHS England led Multi-Agency Strategy Planning Workshop

Wednesday 17th September 2014

9:30am to 2:30pm
The Halliwell Jones Stadium, Winwick Road, Warrington, Cheshire, WA2 7NE

Aim

The aim of this workshop is to bring together key stakeholders to shape the CWW multiagency five year strategic plan and agree a partnership approach with key milestones. In preparation for the workshop, work is being undertaken to review the shared health needs and priorities and a discussion paper will be circulated prior to the workshop.

Demands for services continue to grow faster than funding, meaning we have to innovate and transform the way we deliver high quality services. Across England, health economies are being challenged to develop strong, robust and ambitious five year plans with providers and partners in local government. Fundamental to such plans is a shared outcomes based approach that aims to maximise health gains and value for money. This can only be achieved by working together.

The Public Health Team in NHS England Cheshire, Warrington and Wirral Area Team (CWW) are therefore approaching their strategic planning as an opportunity to build consensus and partnership across the region, focussed on shared priority pathways. CWW have commissioned the public health collaborative service to support this work.

It is planned that the outcomes of the workshop will be fed back to the local Health and Wellbeing Boards, CCGs and other local partners.

Who should attend?

Clinical Commissioning Group Chairs, Local Councillors, Local Authority Directors of Public Health, Public Health England, NHS England, Specialised Commissioning, Probation, Police

For more details please contact helenunsworth@wirral.gov.uk; 0151 666 5123.