Public Document Pack

Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday, 23rd September, 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 the Previous meeting** (Pages 1 - 8)

   To approve the minutes of the meeting held on 29 July 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. **Joint Strategic Needs Assessment Consultation with the Third Sector** (Pages 9 - 46)

To receive a presentation on the Joint Strategic Needs Assessment consultation with the third sector.

6. **Strategy for Connecting Care in Central Cheshire 2014 -19** (Pages 47 - 114)

To receive the five year Strategy for Connecting Care in Central Cheshire.

7. **Update on Caring Together, Healthier Together and the South Sector Work**

Verbal report.

8. **Better Care Fund Update**

Verbal update.

9. **Health and Wellbeing Peer Challenge** (Pages 115 - 138)

To consider a report relating to the Health and Wellbeing Peer Challenge.

CHESHIRE EAST COUNCIL

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

PRESENT

Councillor J Clowes (Chairman)
Mike O'Regan, Healthwatch (Vice-Chairman)

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

Substitute
Mark Bayley, Cheshire East Council

Associate Non Voting Member

Lorraine Butcher, Executive Director Strategic Commissioning, Cheshire East Council

Observer

Cllr S Gardiner

Councillor in attendance:
Cllr B Murphy.

Officers/others in attendance:
Iolanda Puzio, Legal Team Manager - Children Families and Adults, Cheshire East Council
Guy Kilminster, Corporate Manager Health Improvement, Cheshire East Council
Brenda Smith, Director of Adult Social Care and Independent Living, Cheshire East Council
Annamarie Challinor, Head of Service Development (Macmillan)
Sinead Clarke , Medical Lead and Macmillan GP
Kathy McAteer - Local Safeguarding Adults Board
Jacqui Wilkes - Local Safeguarding Adults Board
Jon Wilkie - Local Safeguarding Adults Board
Ann Riley - Local Safeguarding Adults Board

Apologies

Tony Crane and Tina Long.

18 DECLARATIONS OF INTEREST

There were no declarations of interest.

19 MINUTES OF PREVIOUS MEETING

RESOLVED

That the minutes of the meeting held on 29 May 2014 be approved as a correct record.

20 PUBLIC SPEAKING TIME/OPEN SESSION

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

21 APPOINTMENT OF VICE-CHAIRMAN

At the previous meeting it had been proposed that Mike O'Regan be appointed as Vice Chairman for the 2014/15 Municipal year, but as he was not present at the meeting it had agreed that the appointment of Vice Chairman would be deferred until the next meeting.

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

RESOLVED

That Mike O'Regan be appointed as Vice-chairman for the 2014/15 municipal year.

22 INTRODUCTION TO THE CARE PLAN FOR END OF LIFE

Sinead Clarke, Medical Lead and Macmillan GP and Annamarie Challinor, Head of Service Development(Macmillan) attended the meeting and gave a presentation relating to the Care Plan for End of Life.

In June 2014 the Leadership Alliance for the Care of the Dying person (LACD) had produced five priorities for the care of the dying person, details of The needs of families and others identified as important to the dying person are actively explored, respected and met as far as possible.

These priorities were 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 had received widespread media attention and criticism over the last few years largely due to its 'tick box' approach.

The Care Plan for End of Life had been circulated as an appendix to a report to the board, relating to this matter and was presented as an example of an individualised care plan for end of life for use across the Cheshire East locality.

The Health and Wellbeing Board was requested to 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 and to then endorse this as being supportive of the delivery of high quality and individualised care of the dying person and their family.

In considering the report, members of the Board asked a number of detailed questions and requested that consideration be given to including reference to psychological issues and to engagement with A&E. The Chairman referred to the review processes which were in place and indicated that the Board would like to see examples of where these were working well and also where they were not working and well and what was in place counterbalance this. She also stressed the importance of wider training of professionals, particularly in Care Homes. This would tie in with the Council's quality assurance work.

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RESOLVED

That subject to the above comments, the Care Plan for End of Life be endorsed, as being supportive of the delivery of high quality and individualised care of the dying person and their family.

23 PROGRESS REPORT REGARDING THE LOCAL SAFEGUARDING ADULTS BOARD

Consideration was given to a progress report regarding the Local Safeguarding Adults Board. Since the previous report, presented to the Board on 26 November 2013, an Interim Chair of the Local Safeguarding Adults Board (LSAB) had been appointed in April 2014, following the resignation of the previous chair. The report was the mid-year safeguarding up-date and set 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.

It was noted that the Care Act 2014 set 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.

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. A considerable amount of work had been done on this and once complete the document would go out to consultation and following this would be submitted to the Board for consideration. The Board also requested information in respect of the risks and the priority areas of risk which were being focused on and sought assurance that local measures were in place and that a risk management framework would be developed.

At the LSAB had also reviewed its work programme and agreed the key priorities for 2014-15. This would 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 would be completed to establish how the performance of the LSAB will be measured to ensure it is effective and supports good partnership working.

The need for transparency in processes and public visibility was also highlighted.

RESOLVED

That the mid-year up-date as set out in the report be noted and that the Board receive the new Constitution as part of the next 6 monthly report.

24 LEARNING DISABILITIES JOINT HEALTH AND SOCIAL CARE SELF-ASSESSMENT 2013 AND ACTION PLAN 2014/15

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

The aim of the assessment was to provide a framework for a comprehensive local stock- take exercise. The self assessment was divided into two distinct sections. The first section was 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. The second section required each area to assess themselves against 27 measures using a RAG (Red Amber Green) 'Traffic Light' system. These were aligned to the outcome frameworks – Adult Social Care Outcomes Framework, Public Health Outcomes Framework, National Health Service Outcomes Framework 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.

Learning Disability Partnership Boards had been asked to rate provision in their area against a set of measures and the Cheshire East Learning Disability Partnership Board had contributed to the submission. 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 details of which were included in an appendix to the report. A joint programme of action had been devised in order to address the areas rated red and amber in the self-assessment and this also incorporated a number of drivers for action. The full detail of the action plan was also provided in the appendix.

A regional event had been 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 was now being progressed through a number of task and finish groups, sharing approaches and solutions across a wider footprint.

The Chairman referred to the work that the Public Health Team was carrying out in respect of the Joint Strategic Needs Assessment and suggested that learning disabilities was an area which could be targeted and piloted, specifically in relation to adults with learning difficulties not attending annual health checks.

It was noted that it was proposed to submit a report relating to the Winterbourne review to a future meeting of the Board.

RESOLVED

1. That the Learning Disability Action Plan be endorsed.

2. That the Board receive a further report setting out intentions and Performance Indicators, in 3 months time and a further progress report on outcomes, in 6 months.

25 BETTER CARE PLAN UPDATE

It was reported that two letters have been received outlining changes to the Better Care Fund and what would be required over the next couple of months. Each Health and Wellbeing Board was required to propose its 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 would be paid subject to achieving this target. The balance of the performance allocation would be paid up front and would need to be spent on out of hospital NHS commissioned services as agreed by the Board. Returns needed to be submitted by 19 September.

The Board was requested to receive the update and consider the most appropriate means of progressing the actions required.

A meeting was scheduled to take place in the following week where the guidance and its implications would be considered. It was agreed that, following this, an initial draft of the plan would be submitted to the 26 August meeting of the Board and that the final draft would then be circulated to members of the Board for comment before the 19 September submission date.

RESOLVED

That the above action be agreed and noted.

26 CONNECTING CARE IN CHESHIRE PIONEER PROGRAMME

Consideration was given to a report setting out the governance and reporting arrangements for the Connecting Care in Cheshire Pioneer Programme.

In May 2013, 13 national leaders of health and care and support had come together to help launch the 'Integrated Care and Support: Our Shared Commitment' publication, which recommended Integrated Care and Support Pioneers programme. The aim of the programme was to help local areas integrate services, so that individuals and families experienced consistent, high quality, personalised and non-fragmented care and support to meet their needs. Along with 13 other sites, Connecting Care in Cheshire had been selected to become ‘pioneers’ of the programme and now had a responsibility to act as exemplars, demonstrating the use of ambitious and innovative approaches to efficiently deliver integrated care and support. Pioneer partners across Cheshire were committed to a model of collaborative leadership, through which shared visions and outcomes would allow organisations to establish a common direction of travel and make joint decisions. A Pioneer Panel with representatives from both Health and Wellbeing Boards had been established to help coordinate activity across the Cheshire Pioneer areas where appropriate.

The report outlined and formalised the governance and programme reporting arrangements which had been put into place. A diagram outlining the relationship between the Programme, the two Health and Wellbeing Boards and the three locality integrated care programmes was also submitted.

It was noted that a Connecting Care in Cheshire Pioneer Programme Director would report progress monthly against the stated aims of the Connecting Care in Cheshire Programme to the Panel, using an agreed highlight report. Most of the work agreed by the Pioneer Panel was already underway and would continue to be monitored by the Panel, with regular reports back to the Board.

The Board thanked the outgoing Pioneer Director Carl Marsh for his work in establishing the pioneer programme.

RESOLVED

That the report be noted.

27 MULTI AGENCY PUBLIC HEALTH FIVE YEAR PLAN

Consideration was given to a briefing paper relating to developing together a five year strategic plan for Cheshire, Warrington and Wirral. The English health and social care system was facing significant and enduring operational pressure exerted, in part, by increased demand and financial constraints. NHS England had 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 was outlined in ‘EveryoneCounts’guidance,2014-19. Across England, health economies were being challenged to develop ‘strong, robust and ambitious five year plans with providers and partners in local government’. Innovation and transformation were considered important themes for providers and commissioners alike.

NHS England CWW had invited Health and Wellbeing Boards and Clinical Commissioning Groups to send representatives to a NHS England led Multi-Agency Strategy Planning workshop to take place at The Halliwell Jones Stadium, Winwick Road, Warrington, on 17 September and Board members were requested to note the date in their diaries. A preliminary discussion paper outlining the priority analysis undertaken would be available in advance of the workshop.

The meeting commenced at 2.00 pm and concluded at 3.50 pm

Councillor J Clowes (Chairman)

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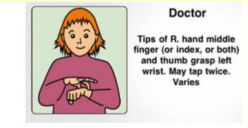

Health of D/deaf Communities Research

Background

As part of their ongoing research, the JSNA Project Team received a detailed response from staff at the Deafness Support Network in Macclesfield. The response highlighted the need for further research into the experience of D/deaf people when accessing health services.

This initial report documents personal experience and comments from 25 D/deaf people who communicated with project staff through a BSL interpreter. Over the coming months further research will be undertaken around sensory loss to include people with visual impairment and sight loss.

Sign Health, a national deaf charity, recently produced a report entitled ‘SICK OF IT’ in which they published findings from consultation with over 500 D/deaf people.

Based on its findings, the report asks challenging questions,

“Generally speaking, Deaf people are as active as hearing people, eat a similar amount of vegetables, drink less alcohol and smoke far fewer cigarettes. So, why are they more likely to be overweight, twice as likely to have high blood pressure, and four times as likely to be on the verge of diabetes? Why are so many unknowingly living with health issues which can lead to heart attacks, strokes and other serious conditions?” [1]

The ‘SICK Of IT’ findings suggest the answer is,

“…lack of information, poor communication, and unnecessary difficulties in getting to the doctor in the first place. All of that is outside the control of Deaf people themselves”.

The JSNA Consultation with the Third Sector Project research aims to determine if this is also the case within East Cheshire.

What does D/deaf mean?

The term D/deaf is used throughout higher education and research to describe students who are Deaf (British Sign Language users) and deaf (who are hard of hearing but who have English as their first language and may lip-read and/or use hearing aids).

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[1] http://www.signhealth.org.uk/health-information/sick-of-it-report/sick-of-it-in-english/

For the purpose of this document the term ‘Standard English’ has been used to describe the English language, spoken and written rather than ‘BSL’ British Sign Language.

Visit to Macclesfield Deafness Support Network (DSN)

Prior to conducting the focus group with the D/deaf community at Macclesfield’s DSN, the Project Team met with the Executive of Operations, the Health Coordinator, and a DSN Volunteer. They gave an insight into the key barriers the D/deaf community face, and also outlined two of their current projects, which are detailed below:

Life and Deaf Matters

The DSN has been awarded a grant from the Health and Social Care Volunteering Fund to support all GP surgeries in Cheshire to become more deaf- friendly and are conducting an audit of GP Practices.

D/deaf people have told DSN staff about a variety of problems they face when trying to access their GP. In order to overcome these barriers to health DSN will be offering free audits to GP surgeries throughout Cheshire, and offering free basic D/deaf Awareness training. As a result of this audit, and once any required changes have been made, the GP surgery will be presented with a D/deaf friendly award and DSN will publicly celebrate their achievement.

Health Awareness aNd Deafness, HaND Project

Following the success of the HaND project (Health Awareness aNd Deafness) that provided health information for deaf people, DSN has secured funding to expand the service this year.

As part of the project, Deaf people from across West Cheshire will benefit from ten health access awareness workshops, including a Health Provider Forum. Local service providers, including Cheshire West & Chester Council and Cheshire & Merseyside Commissioning Support Unit, will inform D/deaf people about health and wellbeing services available to them.

DSN Staff stressed,

“There are many barriers which can prevent D/deaf people from receiving the health care they need, with communication being a key problem.”

There is no ‘word of mouth’ within the Deaf community so people don’t tend to find out about health prevention issues as a hearing person would. And for individuals whose first language is BSL they are not able to read leaflets written in Standard English. As part of the HaND project, a breast cancer awareness session was provided. This resulted in a number of their service-users taking advantage of the screening service, and subsequently led to a diagnosis.

It would seem that this project could easily be replicated and provide benefits to the CCG areas in Cheshire East. Service-users within the D/deaf community express frustration that this service is not funded in Cheshire East

Key Findings

- Many Primary and Secondary health services do not provide a D/deaf friendly way to access services.
- D/deaf friendly technology is not used in many waiting rooms, i.e. Screens with subtitles or vibrating device.
- There is evidence of need for mandatory D/deaf awareness training for staff, and where appropriate basic sign language awareness.
- The Life & Deaf Matters audits will help to improve the quality of service for D/deaf community. It has been suggested however that there is a need for ongoing monitoring, as changes in staff may impact on the quality of service in the long- term
- Anecdotal evidence suggests that interpreter services are not being fully utilised, ie not booked in advance of appointments and/or not appropriate to the personal nature of the examination.
- There does not appear to be sufficient funding ring-fenced for the cost of interpreters.
- There is evidence of relatives and/or individuals with only basic awareness skills, being asked to interpret rather than providing qualified interpreters.

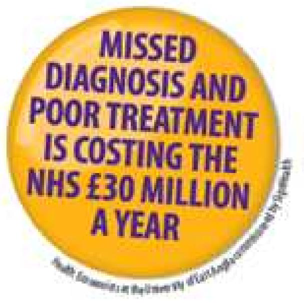
In addition to the above information gathered at the pre focus group meeting, the following points were highlighted by the staff at the Macclesfield Branch of the Deafness Support Network:

Making Appointments

Staff at the DSN informed us that the biggest issue the D/deaf community have is the first step of actually making a GP appointment.

“If you were to look at one of those thermometer- type charts which are used to decide which course of action to take …often the D/Deaf person can only take the top course of action which is go A & E!”

“D/deaf people require the same medical provision as each and every one of us ... BUT they require the services to be accessible, that means making adjustments to the one fits all policies. For example, to make a general GP appointment you have to telephone the surgery in the morning - some D/deaf people cannot use the telephone! Others find it extremely difficult - so how do they make a GP appointment?”
JSNA Questionnaire response



The 'SICK Of IT' findings state that missed diagnosis and poor treatment is costing the NHS £30 million a year.

The staff at the DSN highlighted that often when the D/deaf individual goes for a GP or hospital appointment and there has been a failure to book and interpreter, this can lead to a visit to A&E further down the line. In fact a D/deaf person is 8 times more likely to visit A& E than a hearing person.

It has been stated that A& E departments do not record if someone is D/deaf at the first point of entry, which then makes it difficult, once they get to see a doctor, to assess their need.

It has been reported that, where A& E departments have vibrating hand -held devices to alert D/deaf patients who are waiting to be called, these are being given to people who smoke and who leave the waiting room, rather than to D/deaf people for whom they were intended.

Interpreters

The staff at the DSN cited many cases, reported by their service-users, where an interpreter had not been booked for a D/deaf patient by their GP Practice. It was reported by clients that this often resulted in wasted appointments; misunderstanding regarding prescriptions, and in some cases the individual ending up at A & E. There were also examples of opposite gender interpreters being provided for intimate examinations. One Deaf lady at the focus group was so animated in sharing her experience that Project staff did not need an interpreter to understand her embarrassment.

DSN staff shared some harrowing case-studies including a gentleman who went into surgery not knowing he was to have his leg amputated. JSNA Project staff heard about a Deaf gentleman with a stockpile of many years' worth of medication for high blood pressure, but as he did not read 'Standard English', he didn't know what it was for. There were other stories where individuals had taken suppositories by mouth or tried to use capsules as suppositories. DSN staff support many clients by interpreting what their prescriptions are for and how to take them.

It was recognised that the cost of interpreters can be an issue. It was suggested that this should be examined against the cost to the Health Service of missed or wrong diagnosis, together with the need to provide equal access to services. It was also suggested that consideration be given to the cheaper option of annual contracts for interpreters.

The ‘Sick of It’ report published by Sign Health states,

“70% of Deaf people who haven’t been to their GP recently wanted to but didn’t go mainly because there was no interpreter” Sick of It http://www.signhealth.org.uk/health-information/sick-of-it-report/sick-of-it-in-english/

Deafness Support Network (DSN) – 3rd July 2014

Focus Group Findings

A BSL (British Sign Language) interpreter was booked for the focus group and paid for by the JSNA Project. The session started with the interpreter translating an introduction about the purpose of the focus group and about how feedback from the group would be fed into the JSNA and commissioners of services.

The session posed the following questions

What is happening now that works well for you when you go to see your GP or go to a hospital appointment?

What needs to change? How can we make it a better experience?”

Members of the focus group were very open and honest in their responses and keen to share their opinions. It was crucial to have the services of the interpreter to enable face-to-face communication. The responses are summarised below and have been grouped according to the themes that emerged.

Technology

- Booking on the internet is good.
- NHS Direct works for me, the internet chat function on NHS direct.
- Visual system when I arrive is great but this is not the case once I’ve checked in, and it’s difficult once you’re sat down.
- The internet is good.
- Have had to ask my neighbours to make me an appointment.
- If I book on the internet and don’t get confirmation then I tend to walk round anyway as I don’t know if it worked.
- In some surgeries there are TVs with health information on, preventative info but the subtitles are not switched on.
- We need a visual calling system or vibrating pager.

Staff & Training

- Good facial expressions and gestures are important
- Consistency, seeing the same GP is very important and in hospital.
- The receptionist left me waiting for 2 weeks to get an appointment.
- Bad attitudes from reception – my daughter said why are you ignoring my mum – so we just walked away
- The GP ignored me and talked to my daughter
- Staff in GP's need to be D/deaf aware.
- NHS Staff are not aware of even basic signs.
- Need D/deafness awareness in GP surgeries.
- Need basic sign language for reception staff, also staff tend to forget training so this would need to be refreshed?
- Some job descriptions within the Health Services should have sign language as criteria, or mandatory training.

Interpreters

- The GP used a pen and paper but I need an interpreter – I can't read what he wrote
- The glass is in the way, I can't use sign language through the glass or tiny speaking hole.
- Too many visual things to look at , all the leaflets are in 'Standard English'
- When they say, "Oh yes someone here can sign", and they have done a basic awareness course, not qualified, they should not be used.
- I have to take my family with me to hospital.
- Referrals must state communication needs and if a male or female interpreter is required.
- Interpreter not booked, waste of time.
- They need to check if we need a male or female interpreter.
- We need to have a good relationship with the interpreter.
- Sign is like a local dialect, basic level 1 training is not enough; we want to see the yellow badges.
- Posters in hospitals say they are available in all languages -but not BSL.
- Laws of diversity, BSL is always right at the bottom.

Waiting Times

- Had to wait 2 weeks for an appointment
- Having to wait a long time.
- I waited two weeks got to the hospital
- I went to the hospital, walk in centre

Making Complaints

- I tried to complain at Stepping Hill once and I had to complain to a social worker as they were the only person around who could sign.
- I know lots of people who don't have the confidence to complain
- It's very difficult to make a complaint

Other Issues

- My level of deafness and communication needs are not on medical records despite being requested to do so.
- I get worried that my local doctor knows I am Deaf but when I am referred on the doctors at the Heart Hospital that they won't know.
- I worry that if I was in an accident nobody would know that I am Deaf
- There was a lot of Campaigning in 2007/2010 but then we never saw them again it's the same every few years.
- If you are the only D/deaf child in a family your experiences can be very different from those who grow up in a D/deaf family, this is also the case for cared- for children.

Development of Health and Wellbeing Centre in Crewe

The focus group was asked what they would want to be included in the design of the new Wellbeing Centre in Crewe, specifically what would enable them to have equality of ease of access:

- Pictorial information
- Information in BSL
- Animations on a screen.
- Ramps
- Reception staff knowing some basic BSL
- Hand-held alert
- TVs with subtitles and BSL
- Internet booking
- Awareness- training for reception staff and GPs

Future Needs

The list below summarises what DSN staff and those attending the D/deaf focus group are saying is needed, to provide equality of access to health services by the D/deaf community

- *Alternative means to accessing services that don't rely on others or the telephone.*
- *Interpreters, for those who use BSL, at all appointments.*
- *Information in accessible formats.*
- *Deaf -Awareness Training to be mandatory for Medical staff and all front line staff.*
- *Future planning to include provision for D/deaf people*

Recommendations

- All health services to provide equality of ease of access to appointments and consultations for D/deaf people
- Technology to be used in waiting rooms, i.e. Screens with subtitles or vibrating device.
- D/deaf awareness training to be mandatory for staff to include the procedure for accessing interpreter services
- To consider training of health staff in core ‘signs’
- Fund a follow- up to the Life & Deaf Matters audits to ensure changes in staff don’t impact on the quality of service to the D/deaf community.
- To consider ring-fencing funds for the cost of interpreters and/or the taking out of annual contracts with interpreters.
- That only qualified interpreters (yellow badge) should be used for interpreting, not individuals with basic awareness skills.

Louise Daniels, Jayne Cunningham, August 2014
JSNA Consultation with the third Sector Project
networkteamdevelopment@cvsce.org.uk

This report has been read and commented on by the following organisations:

- Deafness Support Network Macclesfield
- To be completed once circulated
- To be completed once circulated

Health of Minority Communities Research

LGBT (Lesbian, Gay, Bisexual, Trans)

Background: “Part of the Picture” research 2009-11(14) carried out by LGF (Lesbian and Gay Foundation) provided a summary picture of alcohol and substance misuse that generated closely matching results with the national data set.

Although Cheshire East data could not be extrapolated, the assumption was made that findings for Cheshire East would also closely resemble the national sample. The report estimates 18,500 LGBT people live in Cheshire East.

Data highlighted four areas of concern:

1.Use of drugs compared to the general population – research suggested that drug use by LGB people is 7 times higher than in the general population

2.Problematic drinking patterns – available data suggested that binge drinking is about twice as common in gay and bisexual males and almost twice as common in lesbian gay and bisexual females when compared to the wider population

3.Substance dependency - research suggests that LGB people are not only more likely to take drugs or binge drink but are more likely to be dependent on these substances

4.Barriers to information, advice and help – Analysis of “Part of the Picture” research also indicated that LGB people are:

- Having difficulties accessing service where they feel comfortable and confident in the services provided
- Reporting both perceptual and structural barriers to accessing information, advice or help on substance use

The report concluded:

“The current relative lack of evidence reinforces LGB&T needs and experiences as being a low priority, which in turn further re-enforces the lack of LGB&T specific evidence. Therefore, it is essential that evidence is proactively sought out or produced in the development of JSNAs and Health and Wellbeing Strategies. ***This should be done in partnership with local LGB&T people, groups and organisations.”***

As part of the JSNA Project, staff at CVS Cheshire East surveyed LGBT people and VCFS support agencies in Cheshire East, to check out the findings against local experiences, and in particular real and perceived barriers to accessing information, advice and help.

Methodology:

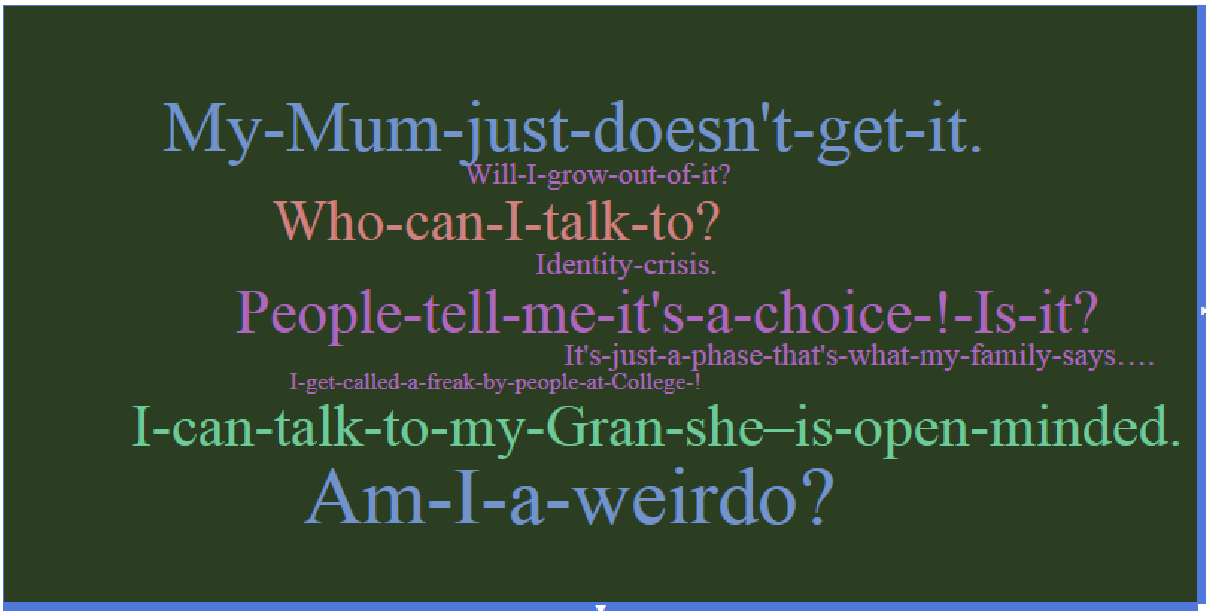
Individuals' questionnaires were distributed via VCFS organisations Body Positive (Cheshire Cheese), Gay Farmers, Lesbian and Gay Foundation and Utopia.

Organisations' questionnaires were sent out to VCFS organisations that support LGBT people

The research included work with focus groups to gather anecdotal evidence about:

- Real/perceived attitude of health providers
- Real/perceived barriers when accessing services
- Stigma, awareness, and changes over recent years
- Service provision for young people and LGBT people over 18
- Perceptions about health treatment/s
- Success stories about when things have gone well
- Difficult or negative experiences and how it could have been done better
- Assumptions/language/a safe space - LGB and T inclusion – how do we make it a reality?

- **Three focus groups were delivered**



My-Mum-just-doesn't-get-it.

Will-I-grow-out-of-it?

Who-can-I-talk-to?

Identity-crisis.

People-tell-me-it's-a-choice-!-Is-it?

It's-just-a-phase-that's-what-my-family-says….

I-get-called-a-freak-by-people-at-College-!

I-can-talk-to-my-Gran-she–is-open-minded.

Am-I-a-weirdo?

- Focus Group at Macclesfield Utopia- this was attended by approximately 16 young people under the age of 18 and two youth workers. Uptake on completing questionnaires was minimal but most young people talked with the research team regarding the questions raised and reported health and wellbeing issues they faced.

- Focus Group at Congleton Utopia, (Vision) - 3 attendees under the age of 18 and one youth worker, this session was run as a workshop where attendees wrote answers to the questionnaire on sheets and discussed issues as a group with the research team. The individuals also took their work to share with the Crewe group and reported back any additional insight.

- Focus Group for those over the age of 18. This was held at The Chappel Centre in Congleton with 3 attendees. Again, this session was run as a workshop where attendees wrote answers to the questionnaire on sheets and discussed issues as a group with the research team.

- The service managers from Body Positive and Agricultural Chaplaincy completed the ‘organisational questionnaire’.

- We received 13 questionnaires that had been completed by service users.

The total number of service- users consulted from the LGBT community in Cheshire East was 35 in addition to 3 Youth Workers and a service manager from Body Positive.

The Utopia groups are Youth Groups for LGBT people, the Macclesfield group is for those up to the age of 25, the Congleton group is for those up to the age of 19 and the Crewe group up to the age of 19.

Body Positive is based in Crewe and is a Health and Wellbeing service for LGBT people, young people and the general public, in particular MSM (Men who have sex with men). The Health and Wellbeing service is largely centred on providing advice and guidance on developing healthy relationships, practicing safe sex and improving their understanding of their own sexuality. There are currently 134 registered users of the service and 1800 Cheshire Cheese newsletter recipients. This does not include MSM outreach or public outreach numbers which would increase the total to over 4000. Of the 134 registered users 69.4% are heterosexual, 23.1% LGBT and 7.4% undecided or not fully completed their registration.

Key Findings – LGBT

- Language plays a large part in how LGBT people feel in a Health & Wellbeing environment, use of the term ‘partner’ for example.
- In Health & Wellbeing settings LGBT people feel that there is a presence of ‘heteronormativity’ i.e. assumptions made that the service user is ‘straight’ and there can be issues when identifying a same sex partner as a next of kin.
- The presence of the LGBT rainbow/flag on a leaflet or poster in a surgery window indicating that the staff there had had some awareness training would put an LGBT person at ease.
- The needs of the non-scene community are largely ignored in research unless looking at specifically rural populations.
- Most respondents in this research did not feel alcoholism and drug abuse were their main health needs.
- Isolation and loneliness around sexual orientation is an issue, and can lead to depression and the use of substances
- Early intervention is key to breaking into the cycle of isolation, depression, self-harm and possible suicide.
- VCFS support groups and services are clearly needed in Cheshire East where the social ‘scene’ for LGBT people is very limited.
- Gay farmers are a particularly vulnerable group in rural Cheshire East

Recommendations

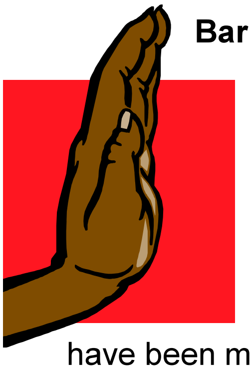
- As part of Health Professionals ‘Diversity’ training there should be a particular section focused on raising professional’s awareness particularly in terms of language and ‘heteronormativity’.

- Health & Wellbeing services should consider adopting a quality mark and include the rainbow flag on their marketing material/ websites and other service- facing material.

- Service-design for LGBT people should be based around providing healthy forms of exploring sexuality and not on the assumption that alcoholism and drug abuse is inevitable.

- Service-design should consider mental health provision for LGBT people and take into account how important VCFS groups are for the health and wellbeing of this minority community.

- Service-design should take into account the increased risk of suicide amongst gay farmers and continue to provide specific support



Barriers – Real or Perceived?

Research to date with the LGBT community has highlighted that there are still real barriers, in addition to perceived ones, in the health care environment. One of these highlighted was LGBT people feel that there is a presence of ‘heteronormativity’ i.e. assumptions made that the service user is ‘straight’. Some service users have reported that they have to ‘come out’ repeatedly and have been made feel uncomfortable about identifying their partner as next of kin.

In all of the focus groups, and some of the responses via questionnaire, education and training of Health Professionals was raised as something that should be further developed to benefit the needs of the LGBT Community. It has been suggested that the presence of the rainbow flag/mark in surgeries, leaflets would put service users at ease in addition to raised awareness in staff. Focus groups have highlighted that language used by professionals (other than those running LGBT groups) impacts greatly on the quality of service provided difference and how service- users react.

When respondents were asked “What Stops You Getting Advice or Support?” the responses were as follows:

- Worried about repercussions
- Don’t know other LGBT people
- Bad experiences

- Scared
- Not being out
- Isolation
- Getting that extra help with mental health and drug misuse
- The need for more accessible counselling

When respondents and focus groups were asked what was hard to talk about the following were reported by a large proportion of respondents;

- Mental Health Issues ,
- Sexual Health and STI's ,
- 'Hate Crime' verbal abuse /Homophobia and Transphobia

The following were reported by minimal respondents;

- Correctional rape and same sex rape.
- Suicide and the early prevention of such.

When respondents were asked what needs to happen to make things easier for you, responses included;

- "Doctors to know more about where to direct you to"
- "Have an LGBT support/health worker at doctors"
- "Accessible counselling"
- "Support worker at College" *
- "More advertised help groups and drop ins especially for under 18's"
- "Access to Sexual Health services at different times and at College"
- "Much education in schools and youth clubs"
- "I find it difficult having to correct health workers when they assume I am heterosexual. Once that barrier is overcome things generally get easier."
- Lesbians are unlikely to join or benefit from group work sessions with men, or to open up fully if it's mixture of women who are heterosexual – if cost is an issue should consider assistance with travel/child-care costs to allow LGBT people access to areas that can provide specific services."

**Body Positive provide drop-in services at South Cheshire College and Ellesmere Port and Hanbridge that include in-depth interventions to support LGBT people alongside general health services but are not available throughout Cheshire East*

Mental Health - Substance Misuse - the Scene

As part of the focus groups with young LGBT people, reference was made to some of the findings of the LGF (Lesbian and Gay foundation) research conducted in ‘The Village’ in Manchester between 2010 and 2012. During discussion around substance misuse amongst the LGBT community, the general consensus was that the issues highlighted in the study in ‘The Village’ in Manchester was not representative of the LGBT population in East Cheshire.

Respondents reported that meeting places for LGBT people tend to be places that encourage drinking alcohol and that for those not interested in the ‘Scene’ it is difficult to find other LGBT people to socialise with. Many of those completing the questionnaires said that there is not much of a ‘scene’ in East Cheshire, therefore the VCFS groups that are available are even more important for social interaction with other members of this community.

The LGF report stated that majority of respondents were not involved in any formal groups or support activities but would like to be.

One respondent referred to a VCFS group as a ‘Safe Haven’. Service users have commented:

“I think there should be more support groups for people in my community to use to that they can air their views and off load”

“Nowhere near enough groups and not fully advertised in public places”

“ We need non-scene/non-bar ways of socialising”

“Isolation is often a problem in rural, small towns. This caused strain on relationships and emotional health”

“Need more diverse social groups, networking occasions”

“What worked well? - Body Positive support workers when coming out about my status and when there was a youth group, not being so alone, incredible”

“What worked well? “Approaching Body Positive for general support, the very warm welcome and non-judgmental attitude I experienced”

Isolation and loneliness amongst this community has already been reported as an issue in terms of social activities, however Body Positive also reported that *“Isolation and loneliness around sexual orientation continues to be an issue whereby service users may take risks with their sexual health to secure emotional comfort.”*

One respondent stated;

“No problem with the NHS apart from Mental Health”

Body Positive also reported that;

"We reduce the isolation of MSMs (men who have sex with men) and by doing so improve their mental health and empowerment to act to protect their own health (Body Positive, Client Focus Group)"

Body Positive also described an emerging health priority,

"*The needs of the 'non-scene' community are largely ignored in research unless looking at specifically rural populations". Much more attention needs to be given in service-design to provide alternative healthier forms of exploring sexuality"*

It was noted that current health models seem to be based on the assumption that alcohol and drug abuse is inevitable. Body Positive reiterated that many of their service users/client groups are not representative of this, and that services–design needs to be based on local needs of LGBT people. This was also corroborated by many of the young people the research team spoke to at the focus groups.

There were only 2 respondents that felt the LGF research and findings reflected their own use of substances and binge drinking. One respondent cited a link between the use of substances and isolation, mental ill-health and poverty.

Staff at Body Positive found from one of their focus groups that receiving the 'Cheshire Cheese' led to feeling more empowered;

"The Cheshire Cheese has allowed recipients to make their first steps in coming-out and accessing service local to them as well as allowing them to feel they can be heard (Body Positive, Service User Feedback, Chester Pride 2013)"

Additional information

Agricultural Chaplaincy supports the farming community, including a service for gay farmers. They report on evidence that farmers and farm managers are the occupational group with the **fourth** highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights **gay farmers to be a particularly vulnerable group.**

Agricultural Chaplaincy provides a specialist support service via www.gayfarmer.co.uk .and provides a 24 hour helpline – this is thought to be the only one of its kind in the country.

Keith Ineson who manages Agricultural Chaplaincy says,

"Although the most significant impact of a suicide death remains the loss of a human life, there is evidence to suggest that the economic cost of this public health tragedy is also great. The Oxford Centre for Suicide studies estimates the average suicide costs £1,400,000 approximately to the economy. None of the clients with whom our service has worked have in fact been among these statistics.

Sexual Health

Body Positive reported that they,

"Increase the awareness, skills and access to resources around sexual health and provide opportunities for peer learning and support to normalise health-promotion practices (Body Positive, Student Evaluation Data).

Body Positive report on the need for the development and broader spread of targeted services for LGBT people. For example they deliver a drop-in service at South Cheshire college that includes sexual health, safe-sex and STI testing. Project workers have found that there is no equivalent service provided at Macclesfield college, so that although LGBT people needing pastoral care can access tutors and student counsellors they cannot access LGBT specific services on site.

Body Positive also report on the need for more innovative health promotion programmes. They say that sexual health maintenance remains patchy and that there is a need for more support groups and enhanced outreach and testing services. The need for 'LGBT friendly' testing services is backed up by responses from individuals taking part in this research.

Positive Outcomes :

JSNA Consultation with the Third Sector Project staff are responding to a need expressed through one of the focus groups in Congleton, and are facilitating the setting up of a new support group for lesbian and bisexual women in Congleton. Staff are liaising with Body Positive to provide ongoing support for the group and will provide governance, funding support and mentoring as required. One respondent said….

"I'm absolutely delighted at the news of a LGBT social group in Congleton……..
this is the BEST News that I've had in ages…."

Out In Cong
Poster.docx

Mental Health Update – April 2014

Introduction:

In June 2013 the JSNA research team at CVCSE submitted initial findings to the CEC team. It was identified that further community intelligence and evidence was required surrounding the provision of mental health services for communities in Cheshire East. It was therefore agreed that one of the thematic areas to re-visit in the last three months of the project 2013/2014 (Jan to March) would include Mental Health.

Background

The DOH Mental Health Strategy, No Health without Mental Health, stated that mental health must have equal priority with physical health. Closing the Gap: Priorities for Essential Change in Mental Health Feb 2014 sets out the challenges in its 25 point action plan.

The 2020 'Decade of Health and Wellbeing' also highlights the message that mental health and wellbeing is as important as physical health and that feeling good is an important part of being healthy:

Methodology

Information was gathered following the process below:

- Questionnaires emailed to relevant VCFS groups/organisations to determine if anything had changed since June 2013 and to hear from those who had not yet provided information.
- Phone contact and meetings with key groups/organisations
- Attendance at relevant events with Health Professionals, VCFS Organisations and members of the community, (BME Event organised by Pathways)
- Desktop research

JSNA Consultation with the Third Sector Project

JSNA Project staff took the 25 Point Action Plan for Mental Health to ‘Blue Sky Thinking ‘sessions with some VCFS organisations, with specific focus on:

- Services with an emphasis on recovery should be commissioned in all areas
- The need for an information revolution
- Tackling inequalities
- Improved access
- Gathering comments on experiences
- Change response to self-harm
- No one in mental health crisis should be turned away
- Support for schools to identify problems
- End the cliff-edge of lost support post 18

Key Findings:

- There is a requirement for clarity and honesty around lower threshold for referrals to CAMHS and NHS mental health services
- There is a requirement for ‘lower tier’ service provision for those deemed to not need NHS mental health services
- There is evidence of a need for mental health A&E service for those who regularly present in crisis
- A more structured approach to building resilience and emotional wellbeing is required
- There is a lack of research into funding group therapy as an alternative to more expensive one-to-one therapy
- There is evidence for a need for a robust system to be in place for those presenting with self-harm at A&E who do not meet CAMHS referral criteria
- There is no statutory mental health support for those using substances
- There is a substantial cost to Police and Ambulance services for attending to those who repeatedly present to A&E due to self-harm including substance use.
- Gay farmers are a particularly vulnerable group in rural Cheshire East

Recommendations:

- The development of a clear visual map of current service-provision across the sectors and a clear indication of who they can support
- A multi –tiered plan that at each level is underpinned with an outcome that reflects what that level of services is aiming to achieve
- Distribution of the plan to all agencies/services mentioned in the plan
- A series of 4 funded workshops for key agencies/partners to carry out the mapping at each tier
- Cross-sector support to ensure all contributors know how to keep service-users safe
- The development of a new A&E mental health service based on the VCFS organisation 'The Sanctuary' in Manchester
- More research into the cost effectiveness of funding group therapy as an alternative to more expensive one-to-one therapy
- Service-design should consider mental health provision for LGBT people and take into account how important VCFS groups are for the health and wellbeing of this minority community.
- Service-design should take into account the increased risk of suicide amongst gay farmers and continue to provide specific support

As part of the 'Blue Sky Thinking' session with the third sector it was agreed that in an ideal world we would be aiming for;

"Provision of information that allows for; signposting to other helping services at the appropriate level of need; reduced dependence on A&E services; access to recovery models of support; improved access to self-care models, and better use of community resources

Previous Findings – June 2013

The main findings from the June 2013 research are highlighted below and where further evidence has been collected it is either described below or referenced in another section of this report.

1. Mental Health services were being used well and in some cases over subscribed, service users said they felt less isolated due to the group they attend. The evidence submitted included positive feedback and reported benefits.

2. Service users reported satisfaction from the services they accessed but there was a concern about the lack of on-going support from statutory services for those with severe and enduring mental health problems

3. Service users would like more professional contact and support particularly when they are in crisis.

4. Coordination of service and long term planning were presenting issues

5. Direct referrals from Health professionals were being made to some services but not others, particularly the smaller and less well-known services were not getting direct referrals.

6. There were concerns around a gap in services for young people and children who don't access CAMHS services.

7. There were many important issues raised in the response from Friends for Leisure around services for young people and their families, particularly if they hit a crisis or when the young person is in transition to adulthood.

Questionnaires were emailed to relevant VCFS groups/organisations to determine if anything had changed since June 2013 and to hear from those who had not yet provided information.

The CAB Service (South and Central) updated the response from last June, confirming point 2 above – service-users reported satisfaction from the services they accessed but there was a **concern about the lack of on-going support from statutory services for those with severe and enduring mental health problems.**

Blue Sky Thinking sessions– April 2014

Access to NHS mental health services

It was reported that service-users may have to wait months to be seen for an assessment appointment only to find that a) They fall below the criteria for referring them for treatment (it has been suggested that unless an individual exhibits symptoms of, or has a history of, severe and enduring mental illness, they will not be accepted as needing NHS mental health services) or b) Because they are using substances (even small amounts) they will not be able to access treatment.

It was also reported that there are instances where young people who have self-harmed present at A&E and are assessed, but if they fall below the criteria for referral to CAMHS, they are sent away. It would seem that people of all ages can continue to present to A&E in crisis with anxiety and depression and that this is a repeating cycle. For example,

"When someone says, 'I want to slit my wrists'; we say 'You'd better go to A&E."

"If there is someone causing a disturbance, in shared accommodation for example, there is reluctance for emergency services to get involved – it can involve a 4 hour wait at the hospital waiting for an assessment just for the person to be given Librium and to do it all over again the next week."

"*We had an ex-offender threatening suicide – the police were out 4 times in one evening – they took him to A&E but nothing changed- he just came back to do it all over again."*

One organisation reported that getting young people assessed can take up to a year. If a young person is waiting for an ADHD assessment, parents must attend a parenting course for them to be seen.

"The courses are at Eagle Bridge at 0915 in the morning and parents say it's very difficult to get their other children to school - but if they don't attend there is no assessment."

There was some discussion around the need for joint assessments or at least some shared protocols that would save on resources. It was reported for example, that at present Housing will not accept Social Services assessments and vice versa. Service-users say that GPs are not interested in the content of the Social services reports and that mental health issues flagged up in these reports are not followed up and there is no signposting to helping services

Ideas for the way forward :

The Blue Sky Thinking sessions spent some time exploring how the issues highlighted could be addressed. Chris Whiley from Visyon shared her experience of a system that worked well in Gloucestershire. Public Health led on the initiative, but it was very much a multi-agency project. The results of the sessions are described below:

The Importance of Signposting

During the Blue Sky Thinking sessions it became clear that the following concept is key…..*There should be no wrong door!........if they don't hit our criteria we should be able to signpost them.*

Samaritans Crewe stated within their written response that "We signpost about 10 other agencies, e.g mental health charities, CAB, Childline…"

Middlewich Good Neighbours stated within their written response that, "We are hoping to link into as many agencies as possible to get referrals"

A Tiered Approach

It was suggested that Mental Health services could be divided into tiers, each tier detailing how to access a range of wide and diverse services available across the sectors. This visual map could then be used by every contributor to signpost individuals to where they could receive timely help. In addition cross-sector support would be required to ensure all contributors would have the basic tools to keep service-users safe.

The Reality is that to achieve the desired outcome as mentioned above a series of at least three funded workshops for key agencies/partners would be required to carry out the mapping at each tier. JSNA Project staff and key stakeholder/s recommend that the workshops are broken down as follows.

Workshop 1 – "What Does Emotional Wellbeing Look Like?"

JSNA project staff and key stakeholder/s recommend that resources be provided for up to 6 individuals from key VCFS mental health services, to meet with representatives from statutory services to produce a comprehensive map of support services. This tier would include services that help build emotional resilience including opportunities for group therapy, family therapy, youth services, church/faith groups, self-esteem building, anger management, working with addictions, peer mentors, recovery coaches, recovery colleges, volunteering, play groups, single-parent groups, counselling. The workshops would decide on the outcome descriptor that would sum up the difference these interventions would make

Workshop 2 – "What is Good Mental Health?"

Workshop 3 – "How to live well with a diagnosed mental illness."

Parents and Mental Health Issues

Parents of Children with ADHD

During the meeting with key representatives from the sector a discussion took place regarding parents of children with ADHD. In particular a discussion took place about ADHD assessments and parents having to attend parenting courses. It was reported that one of the key issues is that these are usually at Eagle Bridge at 09:15am which is very difficult for families with children at school to get to, but if parents don't attend these sessions there is no assessment undertaken for their child (this was reported by parents). These are undertaken by Community Paediatrics in Crewe.

Lone Parents' Needs

South Cheshire CLASP supported 95 adults and young people in 2013, and completed a questionnaire as part of this research. They state that their counsellors all now provide specialist support through continued professional development. Through the CORE evaluation process, they report that they can see positive results for almost all clients. Clients say things like "I feel more confident and able to deal with my anger". All of their clients experience some kind of progress.

In terms of barriers and gaps in service they report that, "*there are limited counselling appointments available through the GP service and the demand is increasing all the time…. "Our waiting list continues to grow".*

They also report that the barriers include waiting lists, and that, 'GPs that don't fully understand the complexity of parent's needs'. They stated that it would be useful if GPs were more aware of CLASP's services, but that alone would not solve the issue, as they cannot currently facilitate any more clients with their existing resources.

What Works For Parents

The SMILE Group

The SMILE Group (Supporting Mums in Living with Emotions) was set-up in January 2010, initially in Macclesfield, by two mums who both struggled with motherhood and needed someone to talk to about their feelings. The group meets every Friday from 10am to 12pm at Hurdsfield Children Centre. Since then the group has helped numerous women, some who attend regularly, some when they need, some only once. The SMILE Group was set up in response to a national demand for peer support, owing to the reported 1 in 7 cases of postnatal depression (PND) cited by the NHS.

However they have since expanded and now have a group in Congelton too. It opened its doors at Congleton's New Street Children's Centre last Autumn and has since received a grant from Congleton Town Council to contribute to its sustainability. They attract an average of 25 people per week to its sessions at Hurdsfield Children's Centre every Wednesday from 10am to 12pm. Parents in Congleton are benefitting from the opportunity to join sessions where they can take babies and toddlers, relax, chat and speak openly about their experience of Post Natal Depression.

Commenting on the growing attendance at the Congleton SMILE sessions, one of the Co-founders said: *"Evidence suggests that peer support is a key element of recovery. A lot of parents battle on through this debilitating illness afraid to share their experience and seek the help they need. Mums and Dads who come to the group often experience a great sense of relief that they are not alone going through PND".* As a signposting service we provide information on how to seek help. Too many parents are still slipping through the net – the more people talk about it, the less stigma will be attached to it."

Macclesfield - Strong Mums from the Moss Estate on Macclesfield

As part of a multi-agency initiative 'Working Together on the Moss' where the aim of the project was to engage local people in decision making relating to delivery of their services, a group of local mums benefitted from training in confidence building and raising self-esteem. This has empowered them to take an active and dynamic role within their community.

The group have now got together, with support from Cheshire East Council and Peaks and Plains Housing Trust, to plan and deliver their own self- esteem course to support other women from their own and neighbouring estates. The women are planning their own fundraising events and are keen to set up and organise a family activity programme over summer, as well as other social and educational activities which have been identified by local residents.

LGBT People

As part of the JSNA Project, staff surveyed LGBT people and VCFS support agencies in Cheshire East, to check out local experiences, and in particular real and perceived barriers to accessing information, advice and help.

Body Positive reported that *"Isolation and loneliness around sexual orientation continues to be an issue whereby service users may take risks with their sexual health to secure emotional comfort."*

VCFS organisation Agricultural Chaplaincy supports the farming community, including a service for gay farmers. They report on evidence that farmers and farm managers are the occupational group with the **fourth** highest risk of suicide in England and Wales, and say that there is evidence to suggest this figure is much higher. Added to this is the statistic that one in four gay men will attempt suicide at some stage in their lives. This highlights **gay farmers to be a particularly vulnerable group.**

LGBT people who took part in the JSNA Project survey and the focus groups confirmed that Isolation and loneliness around sexual orientation is an issue, and can lead to depression and the use of substances.

Isolation and loneliness amongst this community is reported on more fully in a previous report.*

* JSNA Consultation with the Third Sector Project, Health of Minority Communities LGBT Report. March 2014, Louise Daniels and Jayne Cunningham**.**

Mental Health Crisis

The JSNA project team have heard anecdotal evidence at various Caring Together meetings and Local Area Partnership meetings that the emergency service are still being called out to attend individuals in mental health crisis and are in some cases not the most appropriate response to the situation. There is also anecdotal evidence that it is not clear to many professionals where to refer individuals in mental health crisis to and don't always get a positive result when contacting mental health teams.

The Cheshire Agricultural Chaplaincy team stated that, within the farming community they work with, "Stress levels are high and in many cases leading to severe depression". They also highlighted that in terms of gaps and future needs that social activities and groups specifically for the farming and rural veterinary profession suffering with depression are needed.

Samaritans Crewe responded,

"Increasingly mental health patients report limited availability of crisis care, and reductions in dedicated NHS services (anecdotal)"

Richmond Fellowship, supported by other VCFS organisations, has taken their concerns about individuals who are in crisis, to Healthwatch Cheshire East. Research has been undertaken with a diverse range of statutory agencies and a report is due to be released shortly.

Evidence of What Works – April 2014

Throughout this piece of research the JSNA project staff has collected insight on 'what works' from the 'Blue Sky Thinking' workshop, Questionnaire responses, attending events and verbal conversations.

"It works when we look at mental health and addiction together." Blue Sky Thinking workshop attendee.

"WRAP –Wellness Recovery Action Plans – what does it look like when you are well –what should we do when you deviate from this." Blue Sky Thinking workshop attendee.

"The development of a new A&E mental health service based on the VCFS organisation 'The Sanctuary' in Manchester." Blue Sky Thinking workshop attendee.

The Brightstone Clinic in Sandbach completed a questionnaire in which they described their service as, 'Low cost, person centred counselling which we provide to all members of the population, with the aim being for individuals to learn to effectively take care of their own needs…." They reported that they have supported over 40 clients since setting up and have received excellent feedback from Cheshire Carers' centre on the success of their services. They reported that that, "Continued access to talking therapies when required is currently a barrier" . They informed us that they have good feedback from the LIFT Project and Warrington and Cheshire Carers' centre.

Cheshire Constabulary is testing a new way of working in relation to mental health. Operation Emblem sees a mental health nurse attend incidents with a dedicated police officer (PC Mark Jenkins) to offer advice and reduce the amount of people arrested under the Mental Health Act or being taken to hospital unnecessarily for treatment. The pilot started in December in Warrington and Halton but, owing to its success, has now received funding for a further 12 months.

The Sanctuary Manchester

The Sanctuary Manchester offers Self Help Services. This VCFS organisation delivers a range of primary mental health care services and initiatives across the North West for people experiencing common mental health difficulties such as anxiety, depression and low mood. Some of the services they offer include; e-Therapy, Community Services, Psychological Therapies and CBT-Based and Psychological Well Being Services (IAPT)

The Sanctuary is an ‘overnight, every night’ service providing a place of safety and support to adults feeling at crisis point and living with difficulties such as panic attacks, depression and low mood. Experienced staff and volunteers with personal experience of mental health issues provide a range of support including managing panic attacks, offering a space to talk and assistance with coping after the initial crisis. The service provides high quality, non-clinical support in a non-stigmatising manner

The draft report was emailed to the following VCFS organisations for their comment:

East Cheshire Hospice
Friends For Leisure
Just Drop In
Knutsford GROW
Macclesfield United Reformed Church
Visyon
Breeze Foundation
WRVS Alsager Luncheon Club
Brusheads
Contact Cheshire Support Group
Survive (Abuse Counselling)
Lower Moss Wood Educational Nature Reserve & Wildlife Hospital
Home-Start East Cheshire
The Welcome (Knutsford)
Neuromuscular Centre
Macclesfield Community Garden Centre
Victim Support Scheme (Cheshire)
Cheshire Carers Centre
Relate - Cheshire & Merseyside
Friends of Waters Green Medical Centre
Seahorse Swimming Club

JSNA Consultation with the Third Sector Project

Age UK Cheshire East
Samaritans South Cheshire
Body Positive Cheshire & North Wales
Richmond Fellowship
SHARE
Shelter
The Joshua Tree
Crewe YMCA
Green Scape Vision
Central Cheshire Alcohol Services
Macclesfield & District Relief in Sickness Charity
Pathways CIC
IRIS Vision Resource Centre
Relate (Macclesfield)
Monks Coppenhall Primary School
Together Trust
The Circle Dancing Group
Plus Dane Group
CIC (Community Integrated Care)
Bridgend Centre
Bipolar UK
Arthritis Research UK, Macc & Congleton Branch
Reality Check
Macclesfield Bereavement Support service
Home-Start Central Cheshire
Macclesfield MIND
East Cheshire Housing Consortium
Lawton Memorial Hall
South Cheshire CLASP
New Life Community Church
Mind (Winsford)
Red Tent Women
South Cheshire Rural Minds
The Brightstone Clinic
Macclesfield Cancer Help Centre
The Donna Louise Children's Hospice
Arch
Adullam Homes Housing Association
Cheshire Advice Partnership
Alsager Community Theatre (ACT)
Mayfield Centre (Care4CE)
Addaction Cheshire
Cheshire Carers Centre - Macclesfield
B.I.R.D. (Brain Injury Rehab & Development)
Christian Concern
Addiction Dependency Solutions

Central and East Cheshire Mental Health Alliance
Alzheimer's Society Crewe & Nantwich
Lesbian and Gay Foundation
C.A.B. - Mental Health Advocacy Service (Nantwich)
Signhealth Counselling & Advocacy
SADS UK
Sportscape (NW) CIC
Chuff Chuff
Cheshire East Citizens Advice Bureau (CECAB)
The SMILE Group
Preparing for Work
Pettypool Trust College and Outdoor Centre
GO Project
Congleton Pentecostal Church
Agricultural Chaplaincy
You And Yours (Poynton) Counselling Service
Cheshire Probation Trust
Hope Street Centre
Great Places Housing Group Fundraising Co-ordinator
Chester Adult Phab
Keeping In Touch Network
Asist
LIFT PROJECT
Congleton Education Community Partnership Ltd
Down To Earth
Crewe Women's Aid
East Cheshire Mental Health Forum (Macclesfield)
Stammering Self- Empowerment Programme
Crossroads Care CMM
The Craft Shed
Xenzone
ADCA (Audlem and District Community Action)
Macclesfield Care & Concern Ltd
Scholar Green Art Group
Making Space
Changing Lanes
Macclesfield Music Centre
Alsager & District Food Bank
Lacey Green Centre
Open2autism
Chelford Tenants & Residents Association
Expert Patients Programme (Cheshire)
Live At Ease
North Staffs Mind

Rotary Club of Wilmslow Dean

**JSNA Consultation with the Third Sector Project
Mental Health, March 2014
Louise Daniels and Jayne Cunningham
networkdevelopmentteam@cvsce.org.uk 01270 763100**

The Systematic Process
To collect community data for the JSNA

The Process continues to develop as the Project grows, and has evolved into the following:

Research begins with a premise or statement reflecting current legislation, messages or trends

Key VCFS organisations are invited to:

discuss the statement,
provide evidence and challenges
offer potential solutions/improved ways of delivering services

Information is analysed to pull out messages, trends, challenges and solutions

Where appropriate a mapping of services is undertaken

Specific questions, together with the draft report are emailed to other VCFS organisations who haven't 'spoken' in order to:

check validity,
elicit 'expert opinion'
provide further comment
answer specific questions
provide additional evidence

The final report is sent to the JSNA Lead at CEC

VCFS organisations are encouraged to share reports, survey results, success stories etc., to be deposited in the JSNA 'Drop Box'

VCFS organisations are enabled to comment on 'refreshed' JSNA pages and contributions deposited in the JSNA 'Drop Box'

Information in the Drop Box is examined every few months by CEC Service Leads and processed as follows:

Information is graded according to a pre-determined scale
Contributors are informed about what has happened to their information eg it may be part of ongoing evidence collection around an issue, or it may represent the voice of a few people and needs further evidence before it is considered robust enough for inclusion on the JSNA pages
Every 6 months JSNA pages are 'refreshed' where there is new data available

Agenda Item 6

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

Version 1.6
18 June 2014

Document Control

Title	A Strategy for Connecting Care in Central Cheshire 2014 - 19
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Approver	Role
Connecting Care Board members	Multi-stakeholder consensus
Health & Wellbeing Board	Multi-stakeholder consensus
All partner organisations respective boards	Multi-stakeholder consensus

Change History			
Version	**Date**	**Author/Editor**	**Summary of Change**
1.1	26 Mar 2014	D Eden	Incorporation of feedback comments from Connecting Care Board
1.2	9 May 2014	D Eden	Inclusion of feedback from strategy group, stakeholders and NHSE peer review event
1.3	13 May 2014	D Eden	Feedback from wider stakeholder engagement, stakeholders and NHSE peer review event and reworking of document
1.4	23 May 2014	D Eden	Feedback from multiple presentations to partners boards and key stakeholder groups
1.5	9 June 2014	D Eden	Incorporation of feedback comments from multiple presentations to partners boards, key stakeholder groups by Strategy Task & Finish Group members
1.6	18 June 2014	D Eden	Additional sections on ambition and outcomes.

Contents

APPENDICES

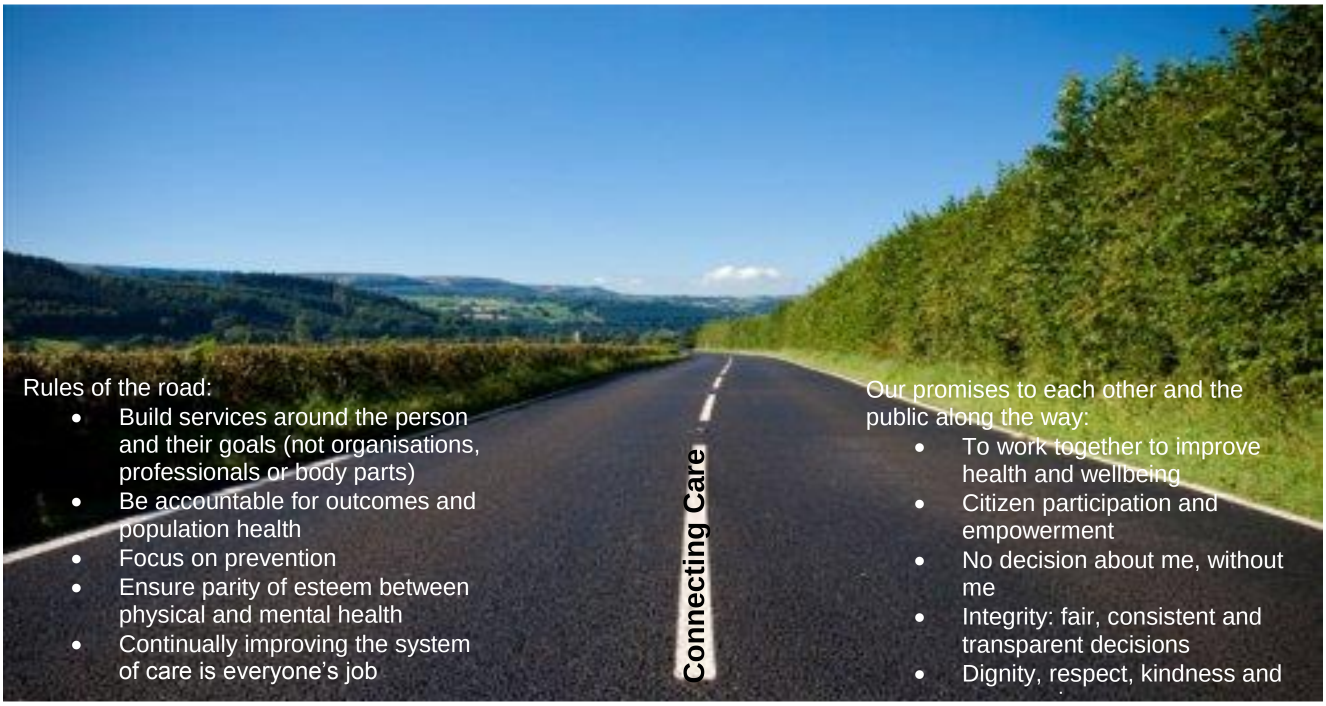
Vision

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

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

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

OUR DESTINATION



Rules of the road:

- Build services around the person and their goals (not organisations, professionals or body parts)
- Be accountable for outcomes and population health
- Focus on prevention
- Ensure parity of esteem between physical and mental health
- Continually improving the system of care is everyone’s job

Our promises to each other and the public along the way:

- To work together to improve health and wellbeing
- Citizen participation and empowerment
- No decision about me, without me
- Integrity: fair, consistent and transparent decisions
- Dignity, respect, kindness and

Our Transformational Journey

1. Our vision and ambition

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

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

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

- Centre all care around the individual, their goals, communities and carers
    - Have shared decision-making and supported self-care, family and community care as integral components to all care
    - Teams built around a persons needs and journeys, jointly accountable for outcomes and joint responsibility for continually improving care
- Focus its attention on health promotion, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities, the wider causes of ill-health and need for social care support e.g. poverty, isolation, housing problems and debt
- Have a strong clinically led primary care and community care system offering a comprehensive modern models of integrated care at scale
- Be delivering fully integrated and co-ordinated care, 7 days a week, close to home for populations of 20-40,000 with a focus on the frail elderly and those with complex care needs
- Provide care that is rated by our citizens as being the best in terms of quality, outcomes and experience
- Be an integrated 'Accountable Care System'.

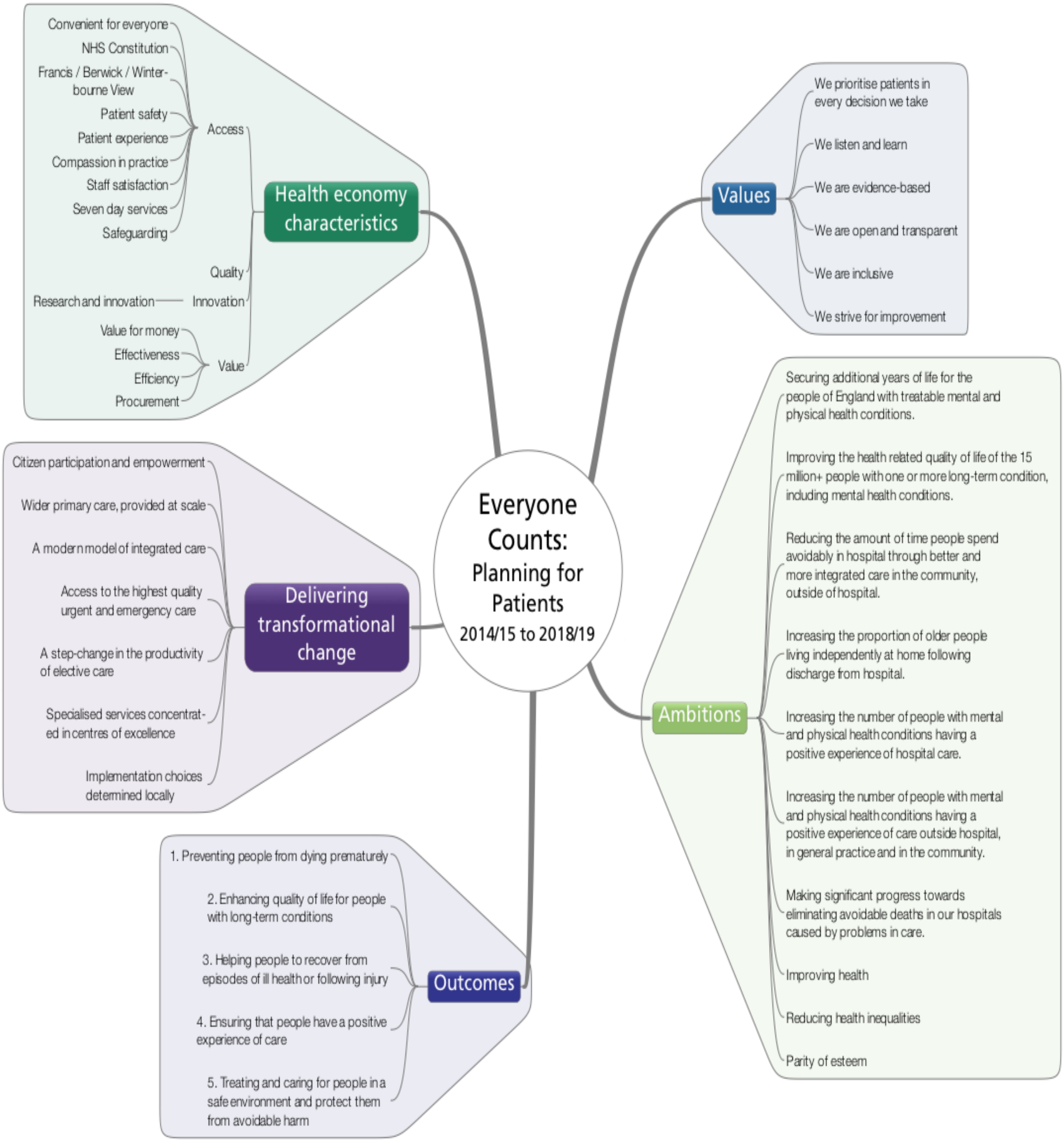
Supported by:

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

To achieve:

- Accountability for all health and social treatment and care to the public
- High quality, safe care and a robust system of continuous improvement
- Improved physical/mental health, wellbeing & independence of our citizens, those with chronic disease & those with long term/complex social care needs
- A sustainable and financially stable care system

- Ensure that people receive care in the most appropriate setting with a reported reduction of a fifth in avoidable hospital, care home admissions, delayed transfer of care in 2019 compared to 2014
- A transformed and integrated care system that realises continuous positive improvement on the following ‘everyone counts’ measures and outcomes:



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

The Connecting Care Programme

The Connecting Care Programme is based on both UK and international evidence of integrated care demonstrating its benefits e.g. Torbay, Kaiser Permanente and The Veterans Association. The Connecting Care Board is leading the programme, with oversight from our two Health and Wellbeing Boards.

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

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

National Voices & Making it Real 2013

The Programme comprises the following:

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

The Central Cheshire health and social care integration outcomes framework:

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

These integration outcomes have been created by our Central Cheshire Connecting Care Board members to provide a single framework for integration and transformation, which aligns directly to the existing NHS constitution, health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

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

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

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

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

2. The national and local context for Connecting Care

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

We have and continue to make significant advances in the prevention of ill-health, reducing inequalities, ensuring high quality care, shorter waiting times for advice, information, treatment and support, maintaining independent living and increasing life expectancy. However, we are aware that certain groups within our communities continue to fall behind these advances and continue to have large health inequalities e.g. people with mental health conditions.

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

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

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

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

There are long-standing fault lines in the current provision of care that result from historic divisions between budgets, between the major groups of healthcare providers and between health and local authority funders of care. Care is often fragmented and poor co-ordination can be a recurrent problem, resulting in frustration for the individual receiving care but also in delays, duplication, higher costs, waste, sub-optimal care and avoidable ill health. Many people accessing care feel that they must ‘slot into a number of services’ rather than the service being tailored to their own needs and situation. Current policy to address this is to provide ‘integrated care’ in a ‘personalised’ way, wrapping care around those who need it, provided by teams who work effectively together to improve outcomes.

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

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

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

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

A National Integration Pioneer site

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

In early 2013, partners in ‘care’ across Central Cheshire united behind a common purpose of transforming and integrating services to improve the health and wellbeing for local people during a period of austerity.

This resulted in the creation and initiation of the ‘Connecting Care’ Programme. In parallel to this, Cheshire was successfully selected as a national pioneer site for integration in December 2013.

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

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

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

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

‘Every One Counts: Planning for Patients’ places a focus on 7 areas for delivering transformational change:

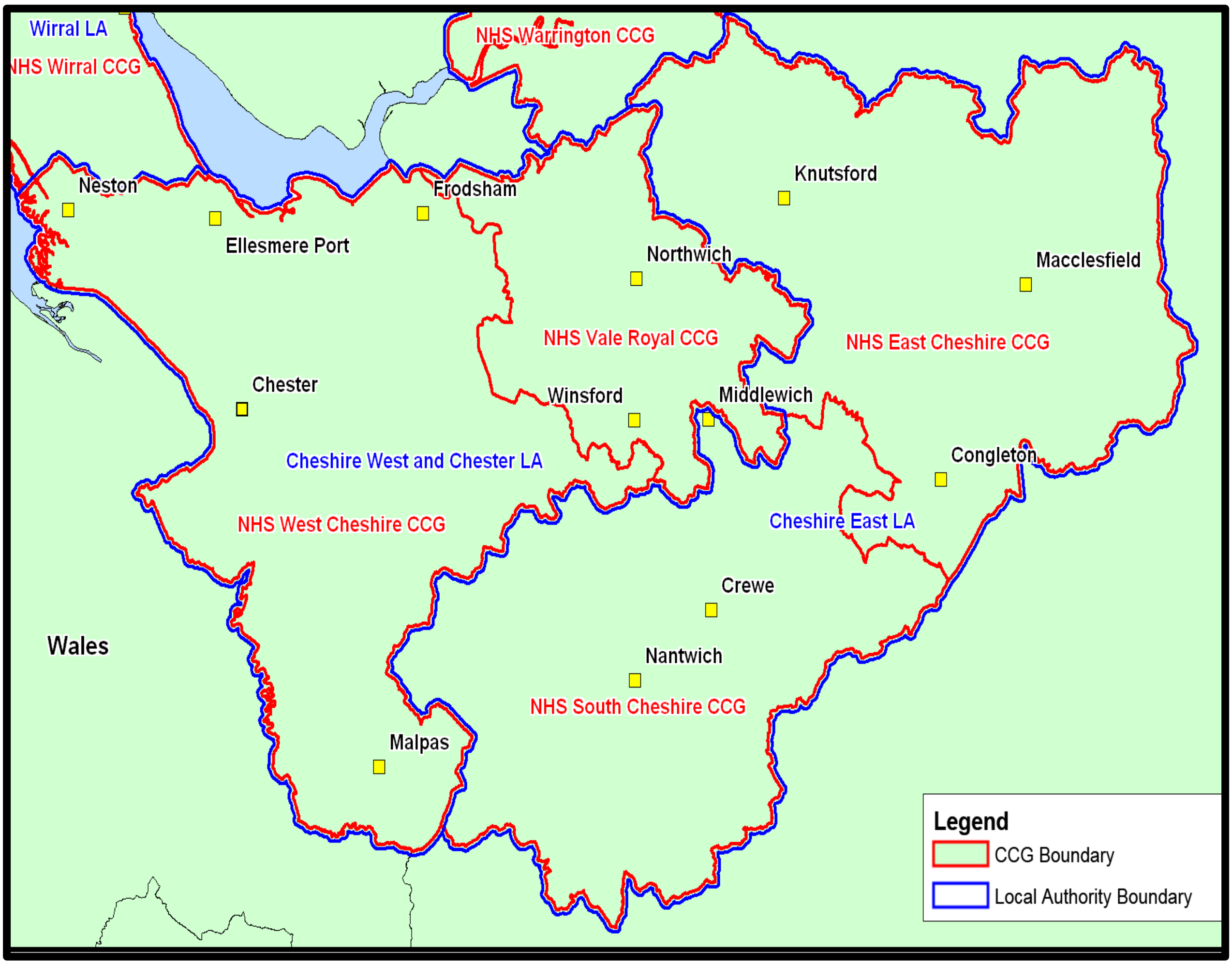
- Citizen participation and empowerment
- Wider primary care provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence
- Local transformational areas.

Our task is to translate the above together with the political philosophy of integrated care into an actionable agenda designed to achieve quantifiable outcomes, and then execute that agenda effectively, measuring progress as we go.

3. An overview of Central Cheshire

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

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



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

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

The Central Cheshire area

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

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

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

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

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

A significant proportion of our population enjoys good health and seldom needs to seek care services or support. However, there are a range of different groups within our population that require episodic, intermittent or continuous care and support. These groups and the challenges they present to the capability and capacity of the existing care system are outlined in brief below:

- Increasing numbers of older people within our population is creating a continuing and spiraling higher level of need for care
- Due to the higher numbers of older people, the number of people with long term health conditions is rising e.g. heart disease, respiratory disease, dementia and depression
- There are wide variations in life expectancy among our population groups, with some being well below the national average
- There is a higher than national average number of people who live alone and increasing the incidence of social isolation and loneliness
- Inequalities in health persist creating gaps in access to care, life chances and wellbeing
- Inequalities in health between those with physical and mental health conditions

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

As a result of 'knowing' our population needs through the JSNA, there is a clear focus for our strategy on all of the above areas including prevention and early detection, reducing inequalities, taking local action and continuing to use the outcomes indicators to shape our plans to improve health and wellbeing.

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

4. Our challenges and our opportunities

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

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

Can our current care system address these challenges?

We have an outdated system

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

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

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

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

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

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

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

Can we meet our productivity and efficiency challenge?

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

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

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

Moving care ‘closer to home’ – in spirit and in geography

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

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

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

Technology

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

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

Fragmented and reactive care

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

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

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

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

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

Quality

There are wide variations in access to services, the quality of both health and social care provision and clinical outcomes across all care settings. Recent national publicity over the serious failings at Mid Staffordshire NHS Foundation Trust and Winterbourne View, underline the need for change in all parts of the system.

We currently work on a number of targeted areas to improve quality yet they tend to focus only on individual parts of the system and individual organisations. We need to consider quality from an individual's perspective, across pathways and the system of care.

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

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

Staff/workforce capacity and capability

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

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

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

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

The workforce has been changing slowly over recent years with new roles emerging and new ways of working. Roles will need to continue to change across a range of areas if we are to utilize our workforce differently to meet our challenges and to provide continuity of care and more in the community.

If the inappropriate use of hospital care is to be reduced and care closer to home is to be enhanced, then much more attention needs to be given to the work of GPs, nurses, allied health professionals, mental health and social care workers. Their separate systems of work need to move to an integrated care model across community services, social care, voluntary care and primary care teams. The engaged person, third sector support and community assets need to form a core part of the service offer.

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

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

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

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

Public expectations

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

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

Finance

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

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

In the short term, additional funds are being transferred through the NHS to local authorities to help tackle the shortfall with greater efficiencies achieved through integrated commissioning across health and social care. We will need to maximise the opportunities that the Better Care Fund offers. However, it is unlikely that this will be sufficient to cover the financial challenges within our local authorities. In addition to this the new Social Care Act 2014 streamlines the wide range of social care legislation in to a modern framework built around personal wellbeing, emphasising prevention and early support and the person being in control of their care. The Act will increase the number of people who will be eligible for social care support from April 2014.

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

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

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

5. Our level of ambition – what we want to achieve by 2018/19

The Cheshire partners are ambitious in their aspirations for transformation, integration and improving the health and wellbeing of our population. We recognise the opportunities before us and this strategy and our suppporting organisations operational, better care fund and financial plans have at their core initatives with associated ambitious timelines and outcomes in order to achieve this. Central to all our strategic development is the imperative to continuously improve at all levels, continue to provide safe, high quality care and to manage within our resources.

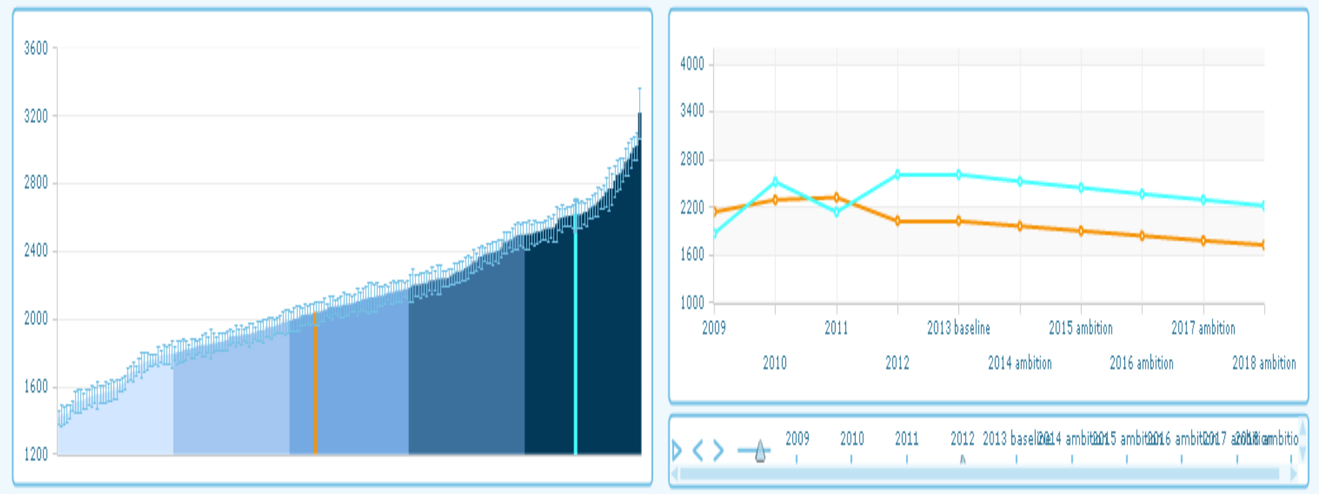
The following sets out our ambitions for both CCGs against 5 key outcomes indicators as illustrated on the NHS England 'Ambition Atlas', Data has been sourced at CCG level and is presented in quintiles and allows for comparisons with CCGs across England.

5.1 Securing additonal years of life for people, particularly those experiencing health inequalities, for conditions whose causes are amendable to healthcare

We hold an overarching ambition to reduce years of life lost for our population and preventing people from dying early from both physical and mental health conditions. This is an ambition which combines all aspects of health and social care commissioning, ill-health prevention, care delivery and citizen participation.

The extract below from the Ambition Atlas sourced from the Health and Social Care Information Centre (HSCIC) compares CCGs in relation to the number of years lost per 100,000 population from amenable causes. The data is directly age standardised to the England population. The tool makes predictions of suggested ambition up to 2018 for the population as a whole, and whilst it examines 2013 baseline data by gender it does not break the ambition data down by gender.

Chart 1: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Currently, Vale Royal CCG is placed in the highest quintile (worse) than most of its comparators and South Cheshire CCG is in the middle quintile.

Generally, CCGs across the country see a gradual improvement year on year and both CCGs share an objective to maintain this downward trend. Our levels of ambition for reducing years of life lost are detailed in the table below:

Table 1:

	Population wide			Males		Female	
CCG	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**	**Levels of ambition by 2018/19 (years of life lost per 100.000 population**	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**
Vale Royal	2610 (95% CI: 2515 – 2608)	Currently in highest fifth of CCGs i.e. highest number of years lost	2219 (15% reduction)	3308 (95% CI: 3157-3464)	Currently in highest fifth of CCGs i.e. highest number of years lost	1909 (95% CI: 1794 – 2030)	Currently in middle fifth i.e. average number of years lost
South Cheshire	2029 (95% CI: 1965-2094)	Currently in middle fifth i.e. average number of years lost	1724 (15% reduction)	2085 (95% CI: 1994 – 2180)	Currently in second lowest fifth i.e. lower than average number of years lost	1975 (95% CI: 1887 – 2066)	Currently in middle fifth i.e. average number of years lost
NHS England	2091	-	-	2267	-	1911	-

Reducing avoidable deaths

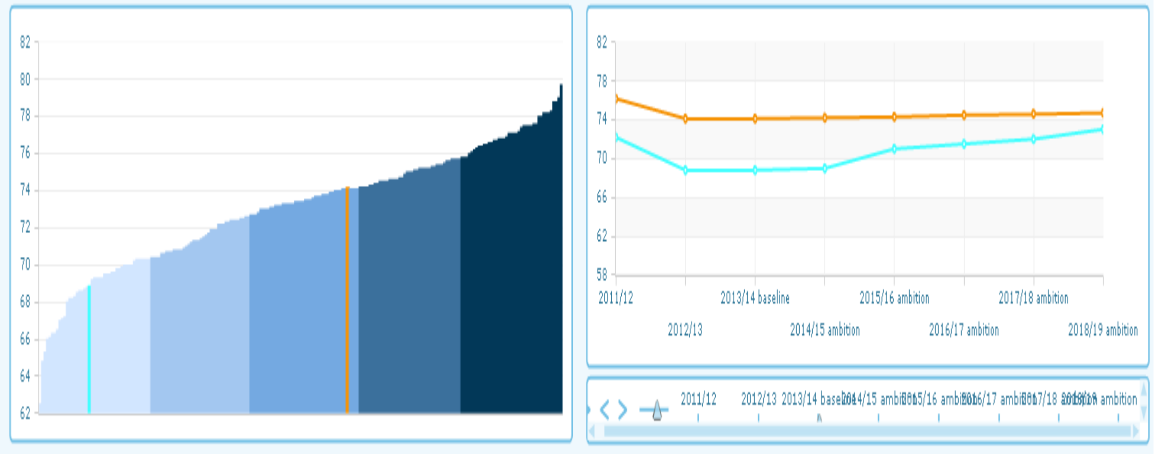
In additiona to reducing years of life lost, Central Cheshire partner organisations strongly support the national objective to eliminate avoidable deaths in hospitals caused by problems in care. Although there is no national indicator for this to date, both CCGs are constantly reviewing local rates in response to our main acute provider having higher than average mortality rates. There is an ongoing external review, triggered via our organisational quality assurance framework, which has produced a number of recommended areas for action and continuous monitoring of progress.

5.2 Improving the quality of life of people with a long term physical and/or mental health condition

Supporting people to lead their own health and wellbeing is a cetral foundation stone within this strategy based on evidence that people should and can be supported to self-care and self-manage their condition and that this will contribute to empowering the person and lead to improved quality of life over time.

This section looks at the 'quality of life' of people with a long term condition and uses data from the GP Patient Survey. The ED-5D is a standardised instrument used to measure quality of life is applicable to a wide range of health conditions and provides a single index value for health status. This tool uses the sum of the ED-5D scores for people with a long term condition, and divides this by the (weighted) count of all responses by people with a long term condition.

Chart 2: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is placed in the lowest quintile (worse) than most of its comparators and South Cheshire CCG is in the upper middle quintile. The trajectories for improvement reflect the different positions of the CCGs.

Our level of ambition for improving quality of life for those with long term conditions is set out in the table below:

Table 2:

CCG	Total EQ-5D score (per 100 people with a long term condition)	Ranking	Levels of ambition by 2018/19
Vale Royal	68.8	Currently in lowest quintile i.e. lower quality of life score	73.0 (6% improvement)
South Cheshire	74.1	Currently in middle quintile ie average quality of life score	74.7 (1% improvement)
NHS England	73.1	-	-

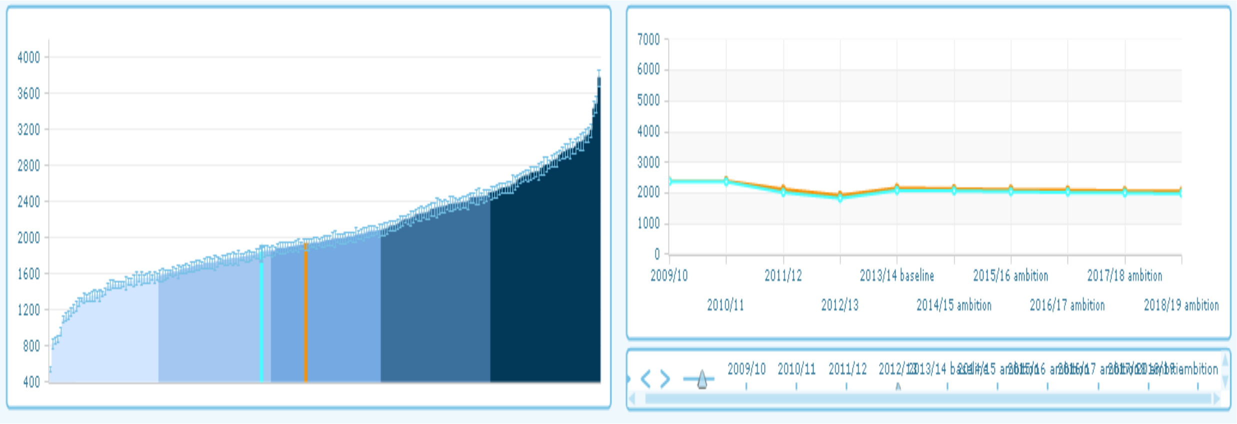
5.3 Reducing the amount of time people spend unnecessarily in hospital through better and more integrated care, more care outside hospital and to increase the people living independently at home following discharge

Our ambition is to significantly reduce emergency admissions for conditions considered avoidable by 15% by 2018/19. The measure by which we will assess our progress is a composit measure comprising the following 4 areas:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections.

The chart below measures the total emergency admissions for conditions considered avoidable compared to the total number of patients registered in the geographical area. Data is from hospital episode statistics and has been indirectly age and sex standardised to England rates.

Chart 3: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is placed in the second lowest quintile (better) than many of its comparators and South Cheshire CCG is in the lower middle quintile.

We believe that our plans to expand primary and community care and improve the range of services and support will have a significant impact on our ability to care for people in their own homes and communities.

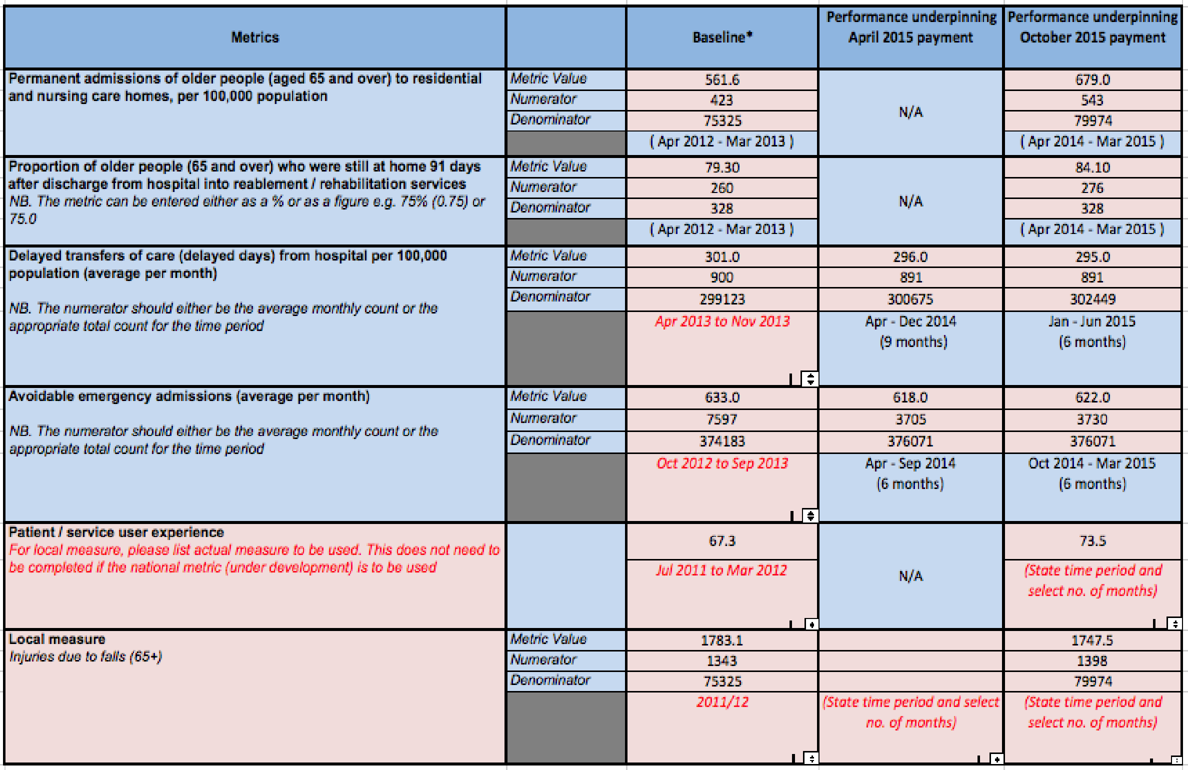
Our level of ambition for reducing avoidable stays in hospital is set out in the table below:

Table 3:

CCG	Admissions per 100,000 population – baseline 2013/14	Ranking	Levels of ambition by 2018/19
Vale Royal	2085.5	Currently in second lowest quintile of CCGs i.e. low number of avoidable emergency admissions	1772.5 (15% reduction)
South Cheshire	2159.2	Currently in middle fifth ie average number of avoidable emergency admissions	1735.2 (15% reduction)
NHS England	2096.9	-	-

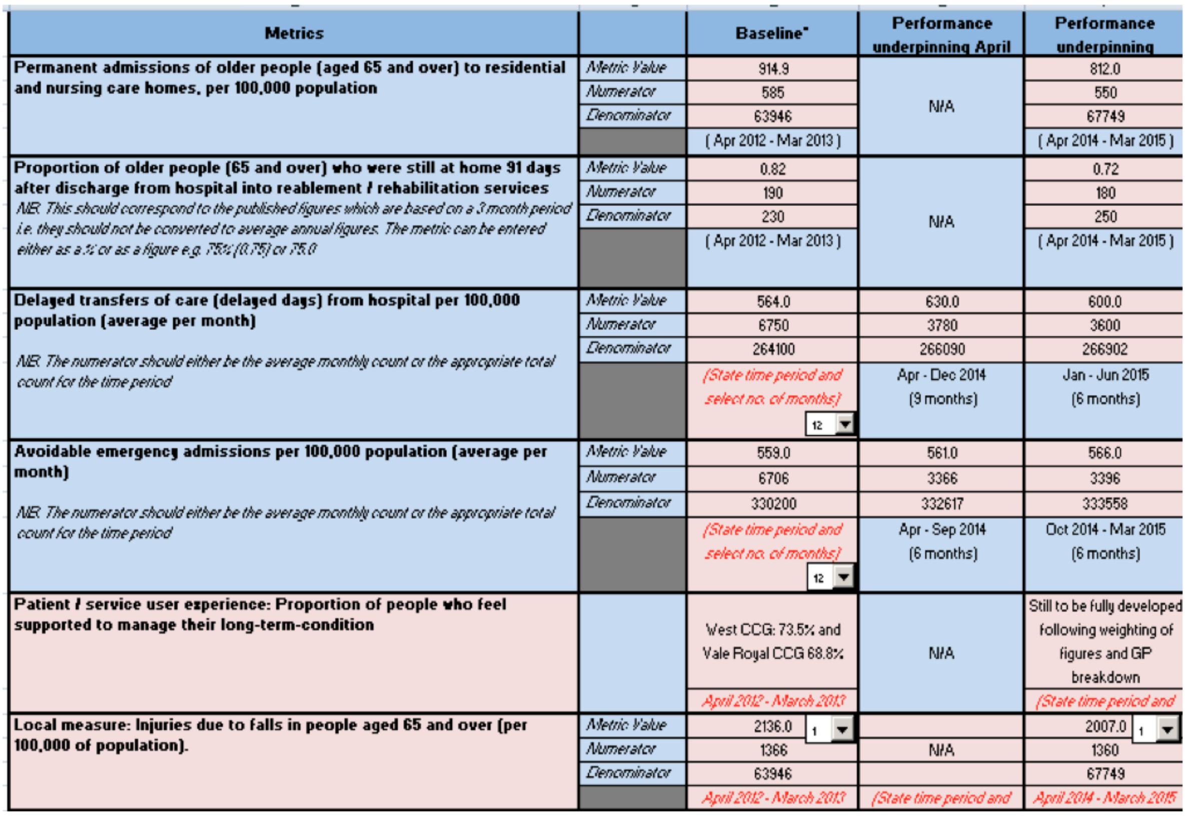
In addition to the above we have established plans and impact trajectories for delivery of our Better Care Fund integration programme, which augment the acheivement of the above.

Cheshire East Better Care Fund ambitions:



Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	561.6	N/A	679.0
	Numerator	423		543
	Denominator	75325		79974
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	79.30	N/A	84.10
	Numerator	260		276
	Denominator	328		328
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	301.0	296.0	295.0
	Numerator	900	891	891
	Denominator	299123	300675	302449
		Apr 2013 to Nov 2013	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	633.0	618.0	622.0
	Numerator	7597	3705	3730
	Denominator	374183	376071	376071
		Oct 2012 to Sep 2013	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		67.3	N/A	73.5
		Jul 2011 to Mar 2012		*(State time period and select no. of months)*
Local measure *Injuries due to falls (65+)*	*Metric Value*	1783.1		1747.5
	Numerator	1343		1398
	Denominator	75325		79974
		2011/12	*(State time period and select no. of months)*	*(State time period and select no. of months)*

Cheshire West Better Care Fund ambitions:



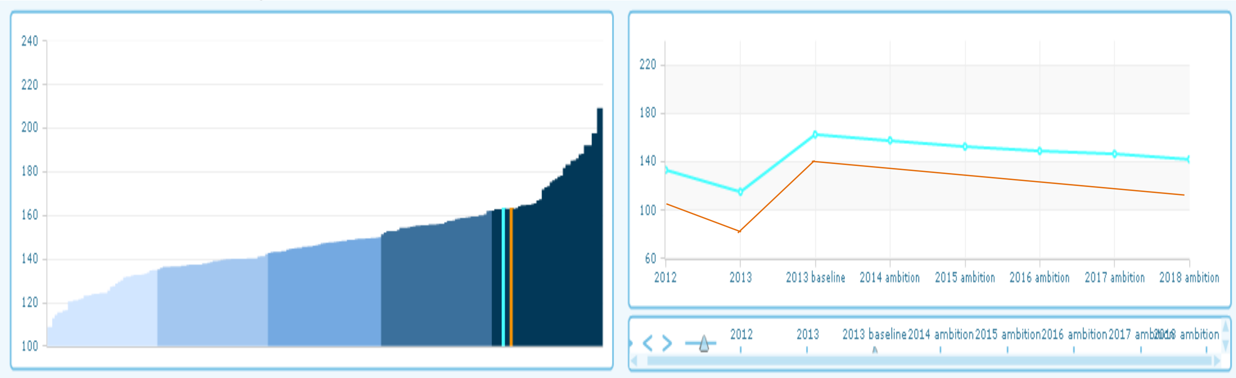
Metrics		Baseline*	Performance underpinning April	Performance underpinning
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	914.9	N/A	812.0
	Numerator	585		550
	Denominator	63946		67749
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	0.82	N/A	0.72
	Numerator	190		180
	Denominator	230		250
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	564.0	630.0	600.0
	Numerator	6750	3780	3600
	Denominator	264100	266090	266902
		(State time period and select no. of months) 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	559.0	561.0	566.0
	Numerator	6706	3366	3396
	Denominator	330200	332617	333558
		(State time period and select no. of months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience: Proportion of people who feel supported to manage their long-term-condition		West CCG: 73.5% and Vale Royal CCG 68.8%	N/A	Still to be fully developed following weighting of figures and GP breakdown
		April 2012 - March 2013		*(State time period and*
Local measure: Injuries due to falls in people aged 65 and over (per 100,000 of population).	*Metric Value*	2136.0 1		2007.0 1
	Numerator	1366	N/A	1360
	Denominator	63946		67749
		April 2012 - March 2013	*(State time period and*	*April 2014 - March 2015*

5.4 Improving a persons care experience both inside and outside hospital to be among the best in the country

Care in hospital

This tool looks at peoples experience of hospital care by reporting the average number of negative (“poor”) responses per 100 patients. The data has been collected from an acute hospital inpatient survey.

Chart 4: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Both Vale Royal and South Cheshire CCGs are in the highest quintile (worse) and we recognise that there is significant room for improvement here. Our ambitious targets is for a 15% reduction in patient reported ‘poor’ responses per 100 patients by 2018/19.

Table 4:

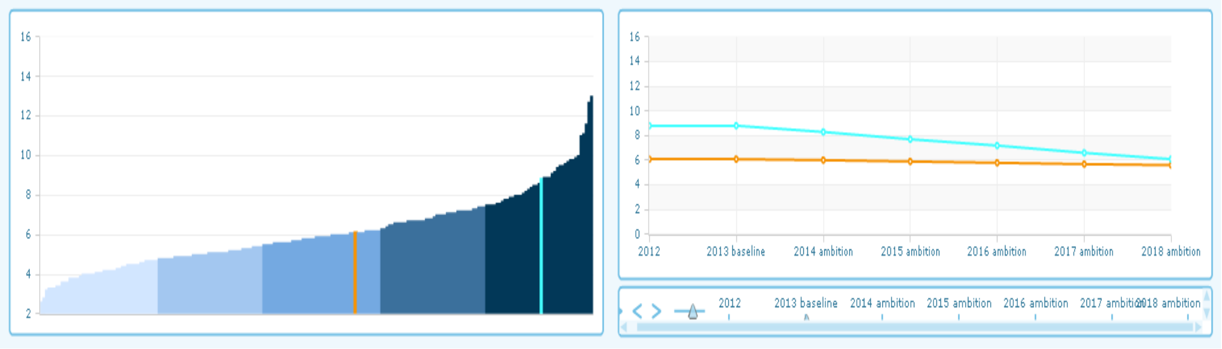
CCG	Number of poor responses – 2013 baseline data per 100	Ranking	Levels of ambition by 2018/19
Vale Royal	162.0	Currently in highest quintile of CCGs i.e. high number of poor responses	138 (15% reduction)
South Cheshire	162.7	Currently in highest quintile of CCGs i.e. high number of poor responses	138 (15% reduction)
NHS England	148.4	-	-

In addition to this, we will continue to roll-out Compassion in Practice (6Cs).

Care outside hospital – GP, out of hours and dentistry

This tool looks at peoples experience of primary care by reporting the average number of negative ("poor") responses per 100 patients. The data has been collected from the GP patient survey.

Chart 5: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is ranked in the highest quintile (worse) and South Cheshire CCG is in the middle quintile.

The respective ambitions of each CCG are in the table below:

CCG	Number of poor responses – 2013 baseline data	Ranking	Levels of ambition by 2018/19
Vale Royal	8.8	Currently in highest fifth of CCGs i.e. high number of patients reporting poor care	6.1 (30% reduction)
South Cheshire	6.1	Currently in middle fifth ie average number of people reporting poor care	5.6 (8% reduction)
NHS England	6.1	-	-

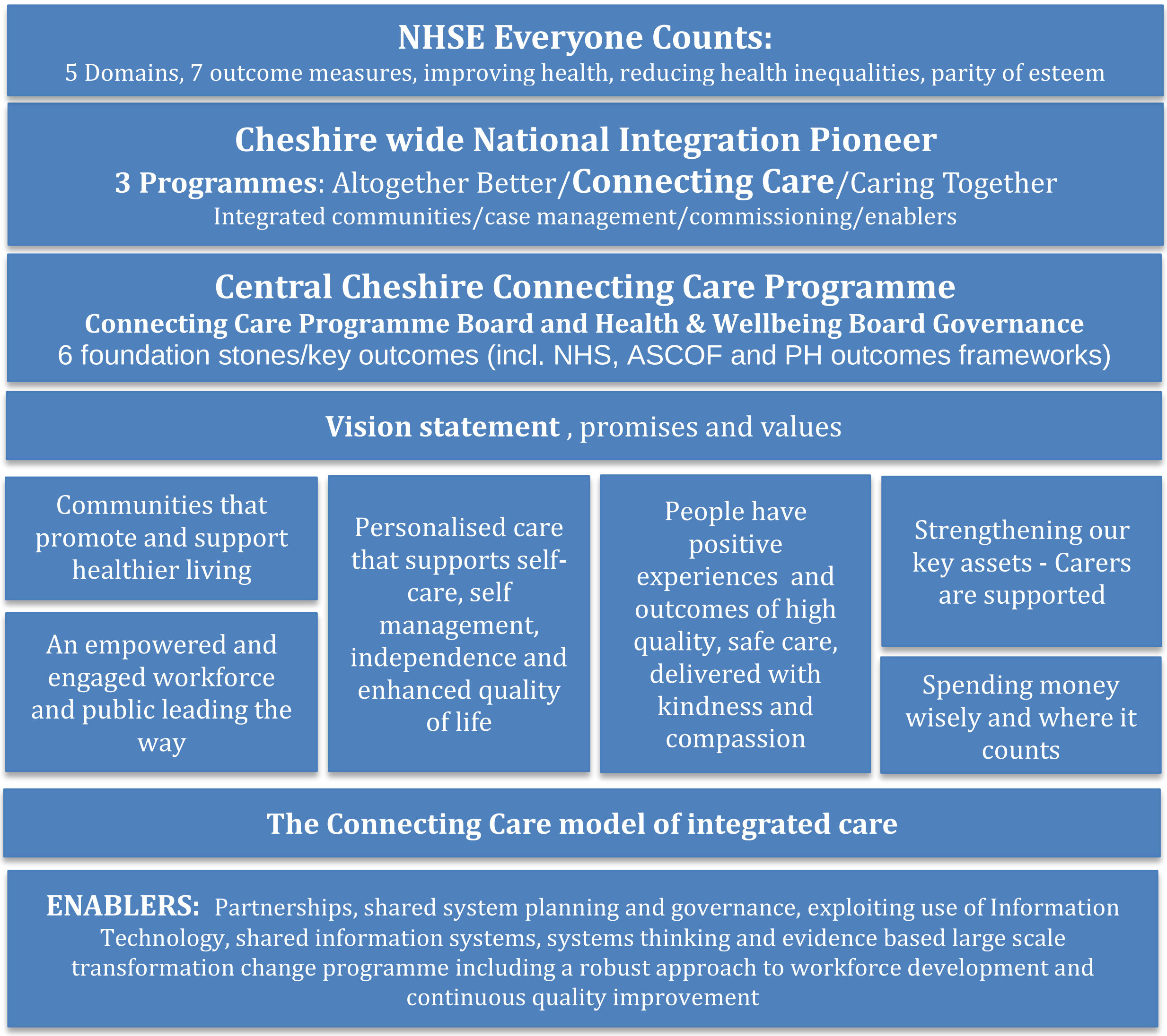
Our ambition for all other NHS, Public Health, Adult Social Care and NHS Constitutional measures can be viewed wihtin our finance, activity and operational plans that support this strategy.

The following chapters outline how the above ambitions will be realised through tranformational change initiatives over the lifespand of this strategy.

6. Transforming, integrating and connecting care

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

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



NHSE Everyone Counts:
5 Domains, 7 outcome measures, improving health, reducing health inequalities, parity of esteem

Cheshire wide National Integration Pioneer
3 Programmes: Altogether Better/**Connecting Care**/Caring Together
Integrated communities/case management/commissioning/enablers

Central Cheshire Connecting Care Programme
Connecting Care Programme Board and Health & Wellbeing Board Governance
6 foundation stones/key outcomes (incl. NHS, ASCOF and PH outcomes frameworks)

Vision statement , promises and values

Communities that promote and support healthier living

An empowered and engaged workforce and public leading the way

Personalised care that supports self-care, self management, independence and enhanced quality of life

People have positive experiences and outcomes of high quality, safe care, delivered with kindness and compassion

Strengthening our key assets - Carers are supported

Spending money wisely and where it counts

The Connecting Care model of integrated care

ENABLERS: Partnerships, shared system planning and governance, exploiting use of Information Technology, shared information systems, systems thinking and evidence based large scale transformation change programme including a robust approach to workforce development and continuous quality improvement

Our vision and our promises

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

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

What is 'integrated' or 'connected' care?

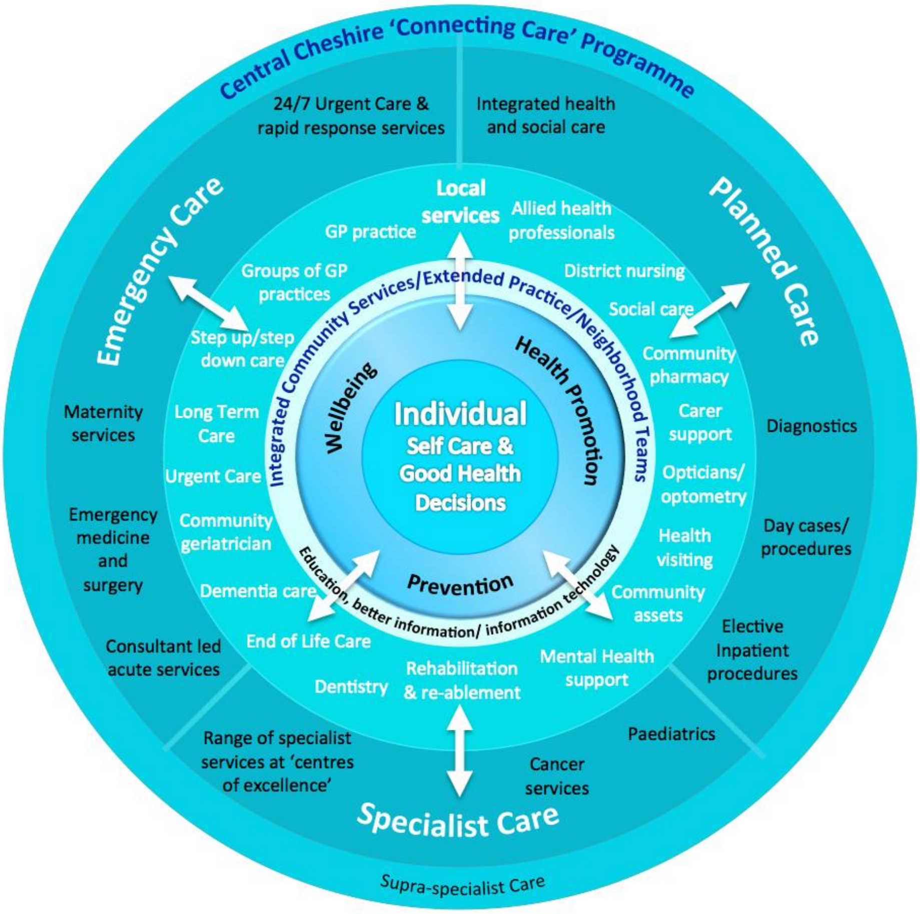
There is no single definition of integrated care. It can be defined as an approach that seeks to improve the quality of care for service users and carers by ensuring that services are well co-ordinated around their needs regardless of professional, team, service or organisational boundaries. The citizen's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

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

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

The Connecting Care integrated heatlh and social care model –in 2019

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



A modern model of integrated care – 'Connecting Care' key components:

- The person is at the centre of all care – 'no decision about me, without me' with all care services and resources wrapped around them for when they are in need
- People will get the right care, quality, safe care delivered in new ways that support empowerment and shared decision making and people will receive only the care that they need
- Integrated care teams will provide physical, mental, psychological, emotional and social care to their communities and will focus on supporting people to remain in their own homes/out of hospital or institutional care wherever possible
- More care will be organised and delivered outside of traditional hospital settings, in local communities with closer collaboration across teams, 7 days a week
- People will use services differently with more provided in primary care/community and less in the hospital:
    - With integrated extended GP practice/neighbourhood teams and integrated community services delivering integrated care and support 'closer to home' incorporating physical & mental health, social care & the voluntary sector
    - Traditional 5 day per week community services will be extended to offer support, when needed 7 days a week
    - With a smaller, more flexible community facing hospital delivering planned, emergency and specialist care and
    - Regional specialist hospitals continuing to deliver supra specialist and specialist care, some of which will be in the community setting
- Asking people what they want - Personalised care planning with embedded shared decision making and the individual's identified goals driving care
- Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
    - Supported self care and self management through targeted programmes and 'making every contact count' approaches
- Much more cross organisational planning, commissioning and provision of care, that reduces duplication and achieves the best use of resources
    - A focus on prevention, and early detection and interventions/support through risk stratification, care co-ordination & proactive case management
    - Building of community assets and resilience
    - Targeting care where it delivers the greatest benefits, thus avoiding the need for rescue or repair care because prevention or good long-term care is lacking
- Be accountable to our citizens for outcomes and population health through the establishment over time of accountable care teams, which will have the following characteristics:

  2014/15

    - Multi-organisational teams with a responsibility to a population and working to shared objectives and outcomes for that population

  - Meaningful measurement related to patient defined purpose (objectives and outcomes) that is freely available to all team members & used frequently.
  - The use of quality improvement and systems approaches to improvement to continually improve the care delivered.

2015/16

  - The development of 'care panels' at locality level (town based) with membership from:
    - Patients
    - Patients representatives
    - Local political leadership
    - Commissioners
    - Health & social care staff

- Focus on the multiple determinants of physical and mental ill-health and creating innovative solutions across partners
  - Supporting 'enablers' of integrationWorkforce – development of CLIA – 'Cheshire Learning & Improvement Academy' to support cultural change, workforce education and development, leadership capacity and capability within individuals and teams across the lifespan of the programme to support the new model of care and developing new roles e.g. interface geriatrician, generic care roles, roles that can assess both mental and physical health needs
  - Information Technology – Creating shared information systems and exploiting the use of technology to support care
  - Public and workforce Engagement, Communications and Participation using range of techniques/approaches e.g. campaign methodology.

Citizen participation and Empowerment

Over the next 5 years we will make a significant step change in our engagement activity so that individuals, families, carers and communities feel supported and empowered to achieve more control over their health and to work in partnership with care professionals to improve health and wellbeing. We will achieve this through creation of a culture of partnership and knowledge sharing, effective partnerships, clear and ongoing communication and engagement and utilisation of a full range of digital support/media.

Increasing the capacity and capability of primary/community care

The development of the neighbourhood and expended practice teams will bring additional capacity within primary and community care which will broaden their ability to respond to the health and social care needs of our population. Our integrated care model incorporates expansion of primary care teams across the entire patch covering a population of over 200,00 and includes a full range of disciplines, functions and roles to support primary care. The planned investment in primary/community care is in excess of £3m for 2014-2016. Resources have been made available within our financial plan to support the £5 per head investment.

Both CCGs have also expressed their interest to NHS England in relation to exploring the opportunity of co-commissioning primary care.

Access to the highest quality urgent and emergency care: 'The Urgent Care Project'

All partners are working collaboratively to transform urgent and emergency care services, so that people have easy access to a consistently high quality service, seven days a week, which is part of the wider model of integrated health and social care and an integral part of a sustainable care system.

The new approach will see the introduction of a 'health-point', utilising an approach similar to NHS 111 to identify when additional effective support and health advice in an alternative setting is better for a person rather than waiting in an Emergency Department. We believe that, by providing this additional support, by 2015 the number of patients with a long term condition who say, when asked, that they feel better supported to effectively self-manage their conditions will increase by 6.2% from our current baseline.

Patients requiring further clinical assessment will be transferred to a 'care-hub' where by 2015 97% of patients will be seen by a member of the multi-disciplinary team dependent upon their symptoms within 4 hours. Where patients require an admission to hospital we want them to experience shorter hospital stays. Patients will be discharged to the comfort of their own home for mobility and activity assessment, rather than being kept in hospital to be assessed. Our ambition is that, these changes will by 2015 reduce the number of delayed transfer of care including those attributeable to social care by 4% from our baseline.

If patients require additional support on discharge, a member of the multi-disciplinary team will liaise with the Integrated Care Teams to ensure services are provided enabling the patient to live independently at home more easily.

All the above changes will reduce spend in the acute sector and this will be re-invested into the expansion of primary/community services. It is anticipated that these changes will reduce acute activity related to emergency admission by 3% in 2014-15 and by 15% by 2019. Our Connecting Care Board has developed an innovative solution to enable this to be delivered. The board has established a 'Provider Board' which brings together multiple acute, mental health, community and primary care providers. An 'Innovation Fund' of £3.2m has been created from a range of sources e.g. tariff deflator, multi-partner contributions and this has created the resource to contract for outcomes via an 'Alliance contract' to achieve our ambitions for the care system inclusive of the shift of activity and resources from the acute to the community setting. As patients move out at scale and the providers can realise a reduction in costs e.g. close wards, there is an iterative cycle created to continually shift monies and invest where needed to support community care.

7 day working - 10 Clinical standards

National evidence and campaigns links poor patient outcomes, including a higher risk of death for patients admitted to hospital at weekends to a lack of a seven-day service.

Our transformational agenda aims to make better use of expensive diagnostic equipment and improve clinical outcomes by providing a more patient focused service, available seven days of the week. We want people to be actively involved in making choices about their health care seven days a week and see this being achieved by giving people timely access to services, results and reports so that treatment can be start as early as possible from a convenient location close to their home.

This will be achieved by adopting the 10 clinical standards recommended by Sir Bruce Keogh in the NHS Services, Seven Days publication and by partnership working to embed these standards across each organisation.

A step change in the productivity of elective care

There is a current challenge in terms of our current growth in elective activity and all partners are working collaboratively to understand the demand, the activity and agree how and where capacity should be sourced in the most efficient way possible. We are developing plans to reduce the current 8-13% annual growth down to an average annual growth of 3%.

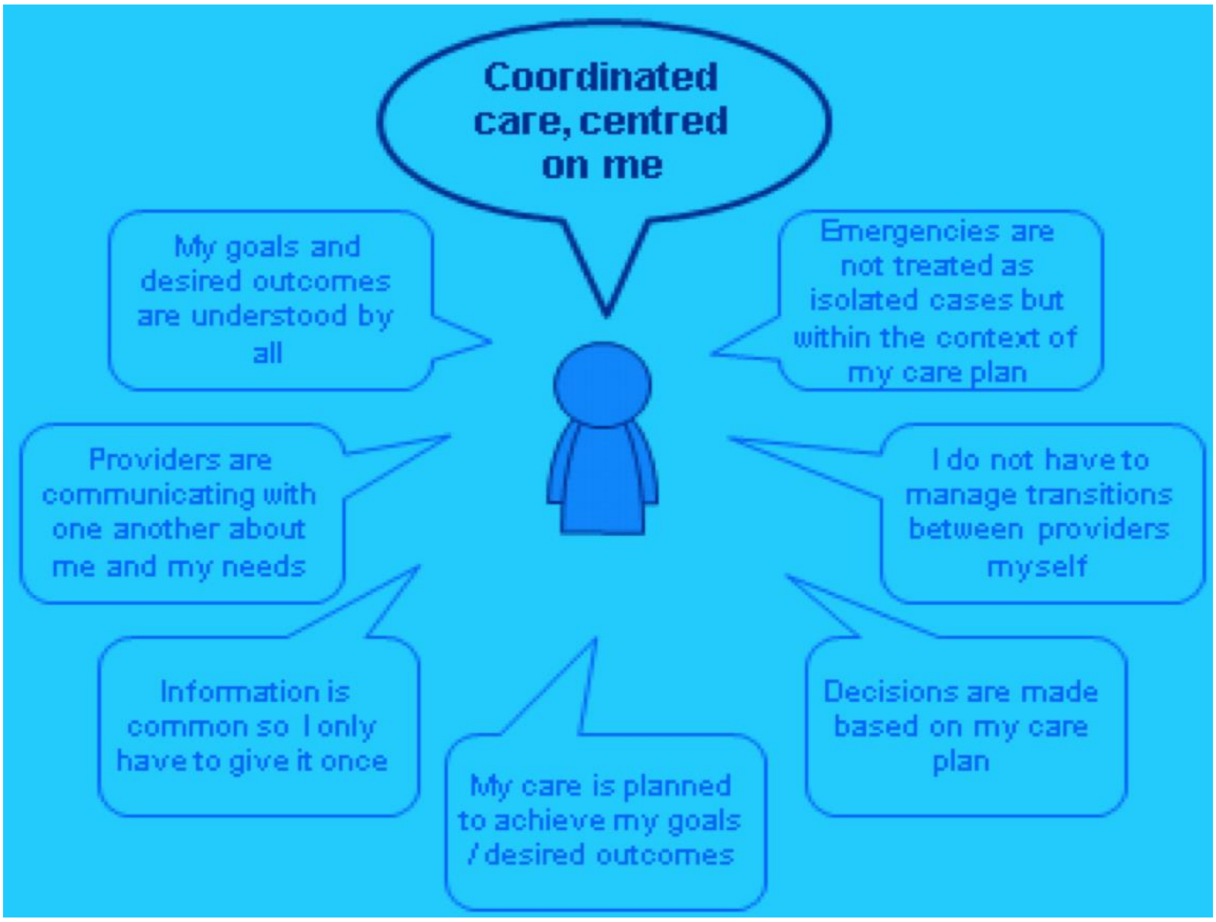
High quality elective care will be provided by centres undertaking sufficient volumes to maintain expertise, using modern equipment and evidence-based techniques. Our elective care services will continue to be concentrated within a small number of providers and we are committed to driving up productivity in line with international benchmarks, treating more patients at a lower cost.

Our drive to reduce referrals and follow up attendances will continue, developing shared care pathways, fuller work-ups/optimization of patients in primary care and avoiding unnecessary visits to hospitals. Efficiencies gained in reducing out-patients will be redirected to increase productivity in elective care.

Specialised services concentrated in centres of excellence

There is recognition of the transformation agenda at specialised services level, outlined in the Specialised Services Strategy, to ensure that people requiring specialised services receive the best quality clinical care and outcomes. We are committed to working with our partners, clinical networks e.g. Cancer, Vascular, Major Trauma and specialist commissioners to understand the impact of national standards and the national strategy for specialised services. We will work collaboratively to align these with the local system development. We are committed to securing services in line with national footprints, specifications and guidance and will work hard to reduce avoidable referrals and activity at specialised services e.g. Neurology.

Impact of the Connecting Care integrated care model



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

Key to the new model is the formation of Integrated Extended Practice and Neighbourhood Teams. The GP will be the accountable professional, supported by the wider teams with the aim of supporting the individual to maintain/improve their health and wellbeing. The core component of the approach is scaling up access to generalist services and scaling down unnecessary access to more specialist services. These are multi-disciplinary teams comprising GPs, geriatricians, nurses, palliative care, allied health professionals across physical and mental health disciplines, social workers and social care support workers and voluntary sector support workers, working together in a specific geographical area. Effective co-ordination of the multi-disciplinary team surround the person/patient and their authority to access efficiently broader health and social care substantially improves pro-activity of care, consistency and access. The population covered by each team is planned for between 15-50,000. Services will be planned on the basis of each defined population and timely response is a key factor.

Populations will be risk stratified using formal and informal methods and by aligning health, social care and voluntary sector teams and resources, we will be better able to work together around our population's needs, share information and combine experience to provide a positive experience of care for our citizens and shape continuous improvement.

Initially, the newly established primary care/community teams will focus their attention on those aged over 60, the frail elderly and those with the most complex health and social care needs. Primary and community care will be expanded and strengthened and will work with new models of person centred primary care e.g. The B Starfield principles – first contact care, comprehensive care, person-focused care over time and care-co-ordination. Incrementally the teams will be expanded to cover all needs of their relevant populations and teams will focus support on the individuals own goals. There will be embedded systems of quality improvement within the teams.

These integrated extended practice/neighbourhood teams will pro-actively manage their population groups, offering higher levels of support than is possible at present, innovating support, care pathways and processes that will maximise care provision in the home or community, providing self-care support and education, manage down the existing growth in avoidable hospital and care home admissions, implement admission avoidance plans and incrementally increase the numbers of people being supported to live independently in their community. People will have their own care co-ordinator/key worker and they will know how and where to access information, care and support when it is needed. There will be improved access to information and support in all care/support settings to improve health and wellbeing. The aim is to help people with their individual need before it becomes a problem and to support learning, to share skills and knowledge and promote self-care.

The current cycle of reactive interventions and subsequent hospital admissions will be broken, through the above model, which incorporates an integrated urgent care/rapid response service, spanning primary, community and secondary care. This will reduce hospital attendances and admissions. Our local district hospital will shrink over the next 5 years and will begin to utilise their buildings and staff in different ways to support more community based care. They will become community-facing organisations taking direct referrals from the extended practice/neighbourhood teams, supporting those with complex needs until they can be returned into their community. In 5 years time, there will be significantly less of our population attending or staying in hospital as is today. We plan to close one or two wards at our local hospital in the next 12 months as a result of this integration model, increased community support and shifting care provision into the community.

People will only be admitted to hospital for emergency care or when it is absolutely necessary and where it would not be possible or safe to provide that care in the community setting. Both the hospital and community will begin to offer a wider range of services on 7 days of the week.

When a hospital admission is necessary, the stay will be much shorter. Community in-reach and hospital team outreach will support the individual to return to their own home/community.

The lines between primary and secondary care will become blurred with specialists working in the community e.g. community geriatrician, dementia, mental health specialists and GPs/ generalists and community teams working in an in-reach way with secondary care teams and all working collaboratively as part of an 'accountable care team'. It will be a truly integrated care system for those with physical, mental, psychological and emotional needs.

The new care system will require closer, smarter, working, between organisations and the development of new relationships between care professionals and between care professionals and those people using services.

It means strengthening community and generalist based services and developing the workforce to ensure they have the right balance of skills and knowledge and can deliver the new ways of working. Teams will be formulated differently, based on a persons needs and their journey rather than on buildings and organisations. The Cheshire Learning and Improvement Academy will support this transition through learning and development e.g. leadership skills, quality improvement approaches, clinical skill, working effectively to achieve citizen participation.

Specialised services will be accessed at centres of excellence and local pathways will develop in line with these changes.

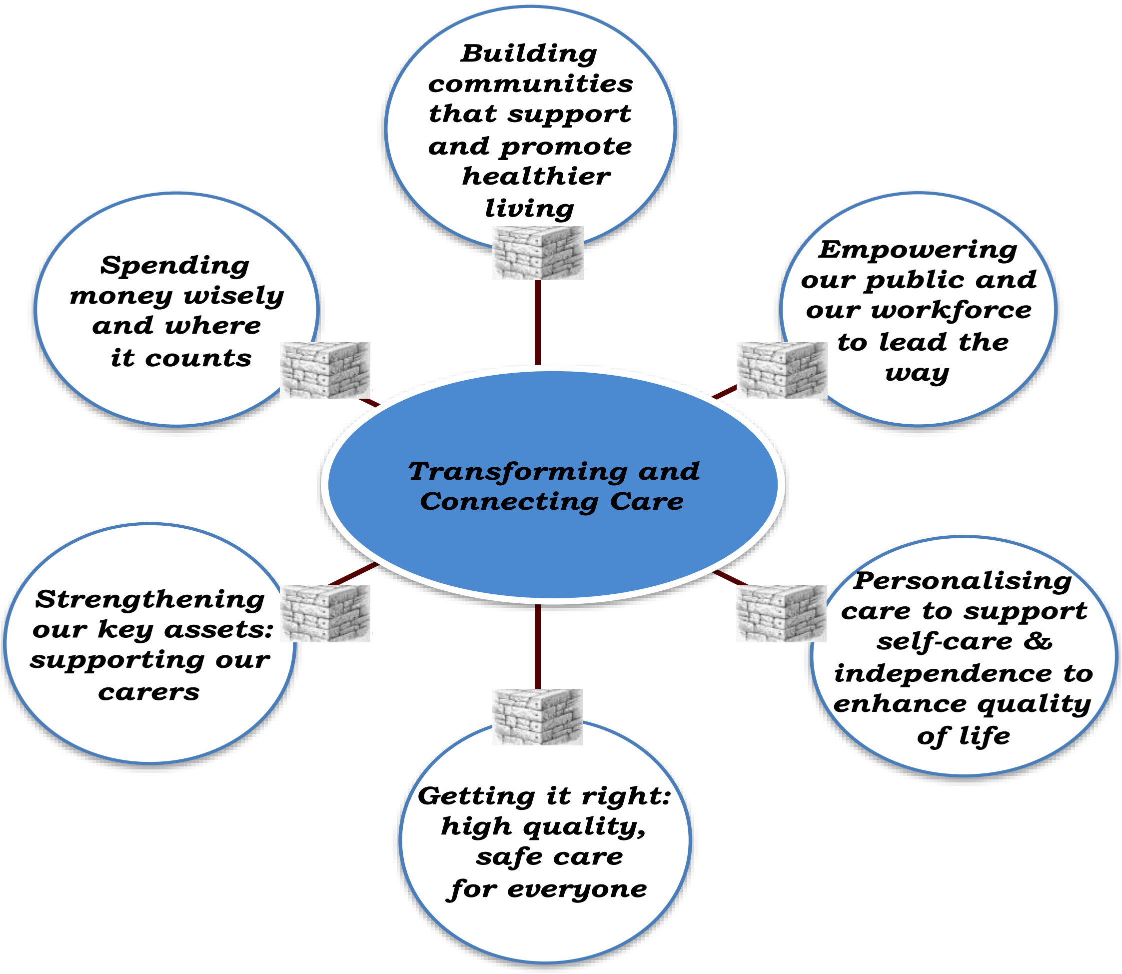
The model will use the defined outcomes, metrics and quality evidence to support ongoing development, shared learning and evaluation of impact at key stages over the lifespan of the programme. Learning will no doubt lead to recommended changes. Connecting Care is part of an international study to evaluate integration models which will report findings in 2017.

Together all the elements described above will develop into a locality 'accountable care team'. They together take responsibility for the outcomes for their population, frequently come together to examine quality, delivery of outcomes, patient journeys and experience. This quality improvement work will be supported by the 'Cheshire Leadership and Improvement Academy, that will be formed to lead continuous quality improvement in the area.

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

7. Laying the six foundation stones for success

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



Transforming and Connecting Care

Building communities that support and promote healthier living

Empowering our public and our workforce to lead the way

Personalising care to support self-care & independence to enhance quality of life

Getting it right: high quality, safe care for everyone

Strengthening our key assets: supporting our carers

Spending money wisely and where it counts

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

Work will be undertaken to establish baselines across all the key measures of success and the composite metrics for each foundation stone. These will be translated into a 'dashboard' for monthly review by the Connecting Care Board.

A high level summary outline of the planned interventions planned to deliver the vision is provided in Appendix 3.

7.1 Building communities that promote & support healthier living

Our strategic objective

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

Our key measure of success

Locally designed questions asked via the local authority quarterly citizens panel survey.

Our plans

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

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

Plans and initiatives:

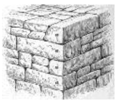
- New approaches and scaling up of existing self-care support and education programmes
- Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term acute and specialist services
- A new third sector strategy jointly agreed across partner agencies, setting out an investment plan for voluntary and community sector support
- Implementing a joint information and advice strategy and the supporting information to help individuals make informed choices about their care
- Jointly commission prevention services across all partner organisations to effectively align prevention and treatment services in order to improve health
- Roll-out of personal health and social care budgets to enhance local choice, independence and local microenterprises
- Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation

- Integrated support for carers across health and social care
- A suite of interventions that tackle the causes of ill-health, links with unhealthy lifestyles, housing, debt or increasing levels of stress including the public, employers and voluntary agencies
- Rolling out time-banks to attract volunteers and mutual support networks
- The Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models
- Implementation of integrated extended practice/neighbourhood teams
- Extend existing models of and implement new approaches to increase levels of self care and supported self management
- Investment in time banking models to foster community delivery and create a closer link between residents and their neighbourhoods
- Extension of schemes such as Street Safe, Anti-bullying programmes and Nominated Neighbourhoods that promote social inclusion, supporting older people to feel safe within their communities.
- Deliver Falls Awareness training to all frontline staff through online learning
- Develop and implement a new approach to Community Transport Grants that support local transport initiatives
- Extension of telecare and telehealth to support residents to be safely supported to live independently in their own homes for longer.

Our aspirations and metrics to measures our progress

- Increasing numbers of people and carers accessing personal budgets that empowers them to take responsibility for improving their own outcomes
- Increasing numbers of people utilising assistive technologies, telehealth and telecare support that supports healthier living
- Decreasing percentage of people experiencing poverty of all types (fuel, economic etc.) adult social care users who have as much social contract as measured in the Public Health outcomes framework
- Increasing improvements in health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks
    - PHOF 1.18 Measure of social isolation – percentage of adult social care users that have as much social contact as they would like
    - PHOF 1.19 Older people's perception of community
    - PHOF 1.17 Fuel Poverty - percentage of households that experience fuel poverty
    - PHOF 0.1i Healthy life expectancy at birth for both males and females
    - PHOF 4.03 Mortality rate from causes considered preventable

  - ASCOF - 1c People receiving self directed support - what percentage of people using community services receive self directed support e.g. personal budgets
  - PHOF 2.12 Excess weight in adults
  - PHOF 2.13 Percentage of physically active adults
  - PHOF 2.14 Smoking prevalence
  - PHOF 2.18 Alcohol related admissions.



7.2 Empowering our public and our workforce to lead the way

Our strategic objective

People who work in health and social care across all sectors are positive about their role, are supported to improve the care and support they provide and are empowered at a local level to lead change and develop new ways of working.

Our citizens of all ages, in schools, in the workplace, as members of communities are fully engaged in the shaping the development and re-design of health and care services and supported to make positive choices about their own health and wellbeing.

Our key measures of success

Increasing levels of communications and engagement ‘listening events’, increasing evidence of public co-production using ‘Think Local, Act Personal (TLAP) – Markers for Change’ and improvements in feedback via staff surveys.

Our plans

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

Our challenge is to ensure that our communication, involvement and engagement is honest, meaningful and effective. We are further challenged by the sheer scale of the numbers of people involved and want to avoid a system of involvement and engagement that becomes tokenistic. We recognise that the people using our services and the staff within them are experts in their own right and clearly have intimate knowledge and views of the world from their own perspective.

Our challenge is to ensure that we seek as many expert opinions as possible to ensure we have a balanced and representative view. It is acknowledged that the meaningful involvement and engagement of all key stakeholders takes skill, planning, time and effort. In a climate of time pressures and deadlines this is often an area of compromise. It is our clear intention that this will not be the case within the Connecting Care Programme. We need to recognise that communication and engagement are not the same things and that we cannot reassure ourselves that because we have told people what is happening that we have engaged them.

We will therefore:

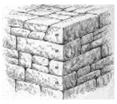
- Utilise a joint Communication and Engagement Group representing the partner organisations to establish explicit principles regarding our approach to communication and engagement with all stakeholders
- Establish a joint Communication and Engagement Strategy which all partner organisation will sign up to which will govern all activity whether routine business or planned service design
- Ensure that all existing patient/user/carer groups are identified and linked into Connecting Care with effective two-way communication systems and opportunities for direct involvement
- Identify gaps where specific groups are not represented and establish mechanisms to ensure their voices are heard and their involvement is active
- Develop varied systems of engagement with the workforce to facilitate effective two way communication and allow staff to contribute, influence, design and be creative in their individual services and across the whole system of care
- Develop a culture where staff can feel confident in sharing their views and suggestions with an understanding they will be heard and listened to
- Establish mechanisms to have regular evaluation points to include all key stakeholders in our service design, service delivery and service improvement
- Ensure that any service design group has representation from the public and workforce groups and that representation is meaningful and effective
- Ensure that services establish service monitoring and evaluation forums with public and workforce representation to ensure on-going engagement with key stakeholders to ensure their contribution and influence is present

in measuring the effectiveness and quality of services and taking an active role in determining continuous service improvements

- Develop a system of regular communication to key stakeholders with the opportunity for feedback and ensure that all means of communication are utilised including social media
- Commission a range of person empowerment and self-management courses e.g. expert patient, diabetes
- Utilise local Health Watch teams together with wider third sector partners through a newly established Cheshire wide communications and engagement network
- Deliver training programmes for our workforce to ensure that they understand and effectively apply the principles of effective communication and engagement with customers on an individual, service and whole system level
- Utilise the broad range of information already being collected from people and staff and ensure these are constantly referenced and utilised to inform service design and service improvement
- Establish the Cheshire Learning and Improvement Academy to support workforce development inclusive of citizen participation.

Our aspirations and metrics to measures our progress

- Evidence of co-production on care system redesign with the public utilising the local authority 'TLAP' markers of change
- Evidence of co-production with staff in the whole system design
- 100% citizen participation on all change projects by March 2015
- Feedback and evaluation from public and staff of how engaged and involved they have been in the design of the whole system
- Review of consultation feedback using both qualitative/quantative measures
- Evidence of CCG 'You said' 'We Did' communications with public and staff
- Evidence of promotional materials for involvement and engagement opportunities and evidence of take up
- Evidence of Connecting Care Communication and Engagement Strategy
- Evidence of delivery and application of staff training in involvement and engagement skills
- Evidence of staff and public involvement/membership of key design, development and service evaluation groups
- Achievement of 'Dementia Friendly' communities.



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

Our strategic objective

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

Our key measure of success

The percentage of people on the GP survey who 'feel supported to manage their long term condition' will increase year on year.

Our plans

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

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

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

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

- Developing a robust self-management strategy which will promote, encourage and support self-care and independence
- Providing advice, information and educational support to the individual to facilitate self-care e.g. test results, pro-active approaches to prevent crises
- Commission self-management education programmes and utilise new models of support, helping individuals/patients monitor their symptoms and know when to take appropriate action and in managing the social, psychological, emotional and physical impacts of their conditions
- Motivating individuals using targeted approaches and structured support e.g. health coaches, expert patient programme or befriending services

- Helping people to monitor symptoms and know when to take appropriate action e.g. Minor ailments schemes, telehealth
- Shared decision making: Involving the person in all care decision-making at every level
- Developing holistic, whole person 'personalised' care plans as a partnership between the individual and the person providing support and or care
- Individual will tell their own story, set their own care agenda, goals and actions and will lead problem solving discussions supported by their identified key workers/case manager/co-ordinator
- Setting goals with the individual, development of action/care plans with pro-active follow up on achievements
- Implementing new modern models of care, our primary care strategy, with support wrapped around the individual at neighbourhood or locality level via integrated community teams using care co-ordination and case management approaches
- Utilise technology and telehealth/telecare to support self-care and self management of a range of long term conditions
- Proactively maximise all care 'contacts' to promote healthy lifestyles and wellbeing
- Working together across partners to tackle the wider determinants of ill-health and social care need
- Create and support an environment for proactive personalised care, self-care/self management and shared decision-making are a reality across our system
- Development of the Cheshire Learning and Improvement Academy to provide a vehicle for learning and improvement over the lifetime of the Connecting Care Programme.

Our aspirations and metrics to measures our progress

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

- Increasing improvements in health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks
    - PHOF 0.1i Healthy life expectancy at birth for both males and females
    - PHOF 4.03 Mortality rate from causes considered preventable with annual decline in avoidable deaths
    - ASCOF - 1c People receiving self directed support - what percentage of people using community services receive self directed support e.g. personal budgets
    - PHOF 2.12 Excess weight in adults
    - PHOF 2.13 Percentage of physically active adults
    - PHOF 2.14 Smoking prevalence
    - Decrease premature mortality from Cancer, Respiratory Disease, Mental Health related conditions, Heart Disease and Gastro-intestinal conditions
    - Improve quality of life for people with Learning Disabilities
    - Earlier diagnosis rates for Dementia
    - Meeting the health needs of the Armed Forces through implementation of the single management model and plans, increasing identification in primary care and offering veterans priority services
    - Increasing numbers of people with life limiting conditions e.g. dementia or other long-term conditions who express their care requirements via advance statements or preferred priorities for care

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

Our strategic objective

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

Our key measures of success

The NHS 'Friends and Family Test, the 'NHS/Mental Health Safety Thermometer', together with the local authority annual survey.

Our plans

For our citizens accessing care, the programme will:

- Deliver person centred care without service gaps, so users will experience a single service of continuous care with no joins visible to the service user or their family/carer when crossing service or organisational boundaries
- Deliver more care and support in a local setting wherever it is safe and appropriate to do so including the development of new roles and new additional capacity to deliver new models of care
- Development and implementation of our primary care strategy
- Implementation, awareness and continuous training on protection and safeguarding
- Parity of esteem of physical, emotional and mental health across health and social care
- Ensure 'care' is defined by its ability to meet the needs of the individuals rather than being defined by its organisation and service
- Implementation of the 6 C's framework
- Robustly evaluate the key programme workstreams
- Measure care experience by asking those who receive the care, support and information, with the aim of demonstrating a high proportion of service users are experiencing a good standard of care.
- Build incrementally engagement with service users, their carers and families, as well as wider public representatives, so they are able to actively support and influence the design of the programme
- Act swiftly and professionally in pro-actively seeking information on, dealing with and resolving any quality and safety issues within established governance frameworks
- Only approve service developments where service users, carers and citizen participation is evidenced
- Implementation of CQUiNs and Quality Premium.

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

- Securing additional years of life for in your local population with treatable conditions
- Improving the health related quality of life of people with one or more long term conditions, with parity of esteem of physical and mental health
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital

- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people having a positive experience of hospital care
- Increasing the number of people having a positive experience of care outside of the hospital, in general practice and in the community
- Eliminate avoidable deaths in our hospitals caused by problems in healthcare.

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

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

Our aspirations and metrics to measures our progress

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

- **Reporting performance against the national outcome frameworks**: NHS, Public Health and Social Care as a measure of our success, which can then be compared with other care economies and national standards. We will aim for continuous improvement towards the best
- **Achievement of the 'Better Care Fund'** outcome measures in 2015/16
- **Achievement of the 7-day service, 10 clinical standards** by 2016/17
- **Programme evaluation via triangulating national and local data**:. Analysis of primary care, hospital care, public health and social care activity, financial and service user experience data
- **Feedback from service users**, their families and the public: via engagement events, focus groups and citizen participation approaches.

7.5 Strengthening our key assets – supporting our carers

Our strategic objective

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

Our key measure of success

Locally devised questions via the bi-annual Carers Survey and an increase in the number of carers of all ages receiving assessments and support.

Our plans

There is no single definition of a ‘carer’. In general, when a health or social services member is planning what services to provide for a person in need e.g. a disabled person, they need to consider the views of significant people in that person’s life. This will include people who provide some form of care for that person (usually family members or friends or neighbours), be that physical care or emotional support, advice or advocacy support etc.

Carers experiencing inequalities in health and social care and our carers have told us that having access to a short break, respite services or employment opportunities can make a significant difference to their ability to cope with and maintain their caring role. Our work will focus on a community based assets approach and building of social capital.

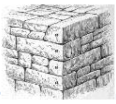
Our vision is to ‘Enable Carers to experience and have a life outside of caring’ and our commitment is to:

- Enable Carers to be respected as Equal Care Partners who are treated with Dignity and Respect
- Enabling Carers to live full and meaningful lives in their own right
- Enable Carers to feel supported by offering them a range of support and practical help
- Enable Carers to feel empowered through positive engagements and interactions with service providers and professionals, having positive experience of services
- Identify “hidden” carers and supporting them to access services and information appropriate to their needs
- Enable Carers to access Information and Advice – including practical and emotional support in a timely way to support them in their caring role

- Enable Carers to access services and support through their GP and practice staff which supports their health and wellbeing
- Support Carers to access training and learning which helps to maintain or access employment opportunities
- Enable and support Carers of all ages to feel safeguarded from abuse within their caring role, family and local communities
- Consider how we will support on-going involvement by people who are in caring roles where respite is required to support that engagement.

Our aspirations and metrics to measures our progress

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



7.6 Spending money wisely and where it counts

Our strategic objective

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

Our key measure of success

All partner meet their statutory and regulatory requirements and achieve the outcomes identified within the 6 foundation stones initiatives.

Our plans

We will spend wisely, on the right things that meet our population's needs and that will have the highest impact and ensuring best value for money.

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

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

Initiatives and plans:

- Commission, target and deliver care in line with JSNA identified priority areas, with a focus on prevention and self-care
- Increase investment in evidence based prevention, self-care approaches and high impact interventions e.g. early diagnosis of Dementia, mental health, rapid response, carer support, medications to reduce high blood pressure and high cholesterol
- Targeting care at the most appropriate level including those most in need through risk stratification and those for who preventative and pro-active approaches can have the most impact e.g. upstream approaches
- Increased levels of joint working, joint commissioning, planning and integration

- Work towards the establishment of a population wide, citizen led and governed 'Accountable Care System' working to shared objectives and outcomes for that population
- Collaborative working by providers of care and support across all care settings and in participation with our citizens
- Collective approaches to care, redesign to increase efficiency and productivity within both existing and new services/care approaches whilst still maintaining a focus on quality
- Transforming community and primary care services and maximise the capability & capacity of our workforce via development and support
- Innovate with new collaborative provider models to support integrated care
- Implementation of our Better Care Fund plans and integrated initiatives to support care provision in the most appropriate setting
- Implementation of the 'commissioning for prevention' 5-step framework and priority areas within 'commissioning for value' packs
- Test out new contracting approaches – Provider Board/Alliance contract/Innovation Fund – working differently and closing wards to re-invest in community services – £3.2m
- Increasingly using Information Technology to support care processes and systems and linking data across organisations e.g. digital front door for people with long term conditions and a single shared integrated care record
- Sustainability plans – QIPP, CIPs, bridging the financial gap
- Alignment of resources to priorities to deliver on agreed objectives and outcomes identified in all 6 foundation stones.

Our aspirations and metrics to measures our progress

- Achieve Better Care Fund metrics
- Achieve health, public health and social care system wide outcome measures/quality benchmarks/markers and constitutional targets
- All partner organisations meet their statutory and regulatory requirements
- Development of a transformational model for moving from existing system to future model through robust financial, activity and impact modeling
- Integrated neighbourhood/extended practice teams – all metrics
- Internal organisational CIPs/savings – NHS 4%
- Reduce variances in referral rates
- Redesign of urgent care/rapid response
- Agree shared risk contract – Non-PbR for Non-elective work at MCHT
- 3-5% reduction in avoidable hospital and care home admissions annually.

8. The Connecting Care Transformational Roadmap

How are we and how will we Transform Care

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

The Connecting Care Board is dedicated to achieving the above transformation and existing and new resources have be aligned/redesigned to facilitate this. A dedicated Programme Director for Connection Care was appointed jointly across the 7 partner organisations in October 2013 and is leading the programme development, implementation and evaluation on behalf of and in partnership with the members of the Connecting Care Board. Programme governance is detailed in Appendix 1.

The Groundwork

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

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

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

In progress

- Building integrated care from the bottom up as well as top down through the implementation of a single point of access and integrated multi-disciplinary community teams that wrap around the service user and provide whole person care
- Increasing pooled resources to reduce duplication and maximize the available resources through joint commissioning and the Better Care Fund
- Testing of new innovative collaborative contracting approaches including a new 'innovation fund', a collaborative provider contract and an outcomes based contracting model
- Exploration of ways to support and empower more users to take more control of their own health and wellbeing
- Exploration of ways to increase the sharing of information about service users with the support of appropriate information governance
- Bringing challenge to all plans and proposed initiatives in respect of 'do they offer parity of esteem across physical and mental health'
- Reviews of existing services and key work areas in readiness for redesign and transformation in line with the Connecting Care Programme, e.g. Emergency Care, Intermediate Care, Mental Health, Specialist Commissioning and Community Services.
- Build a robust case for change from a detailed analysis of service utilisation and cost across health and social care in order to define our system 'roadmap' to move all partners from the 'here and now' to the 'future system'

In the planning stage

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

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

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

We envisage our approach to have a number of phases:

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

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

The key initial projects for Phase two delivery are those we have identified as being most critical to delivering benefits for all service users of partner organisations' services, and where those organisations will see most initial benefit.

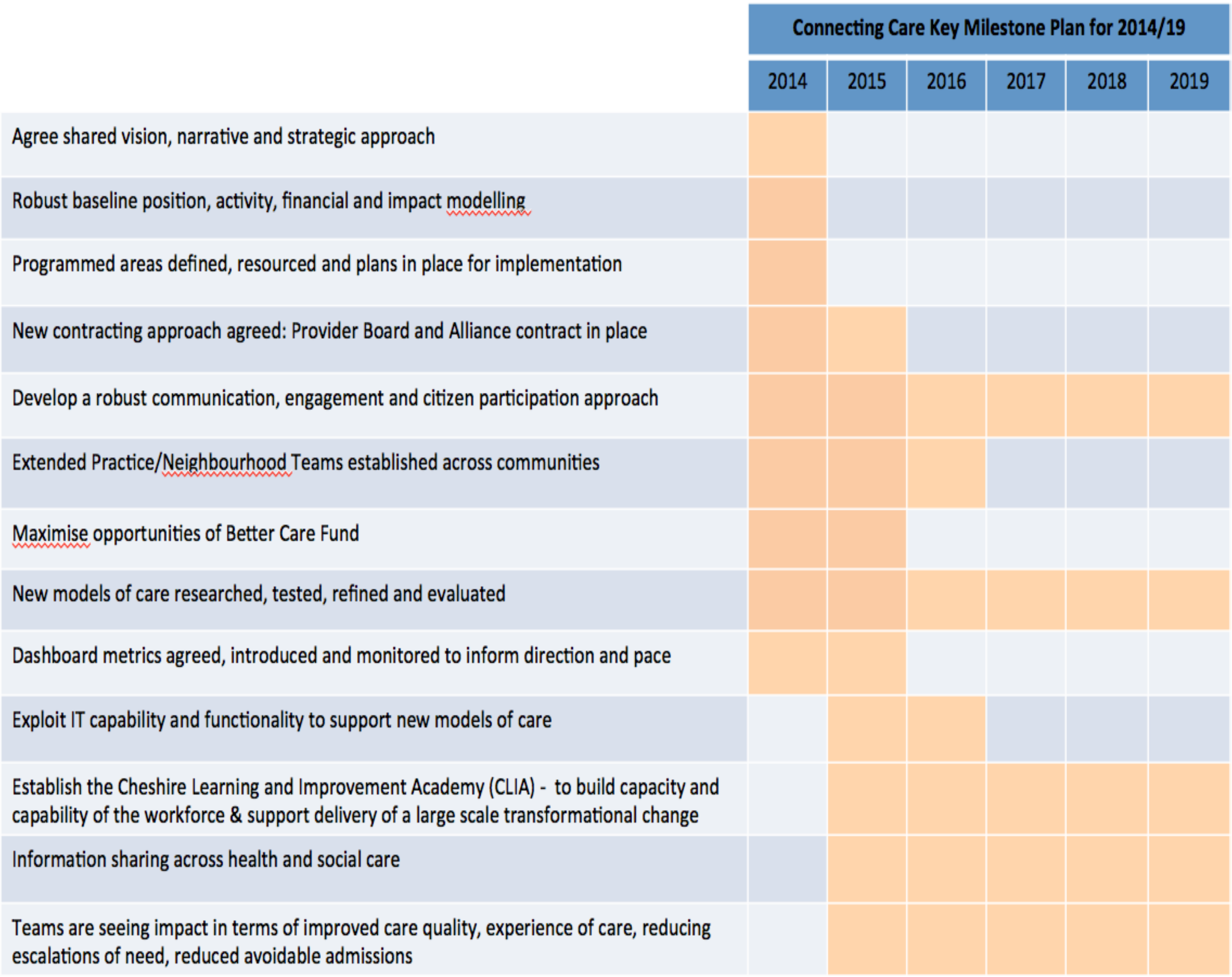
These changes are seen as delivering real benefits and as 'totemic' in communicating our seriousness about securing transformational change.

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

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

Connecting Care key milestones

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



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

Box = Milestone achieved

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

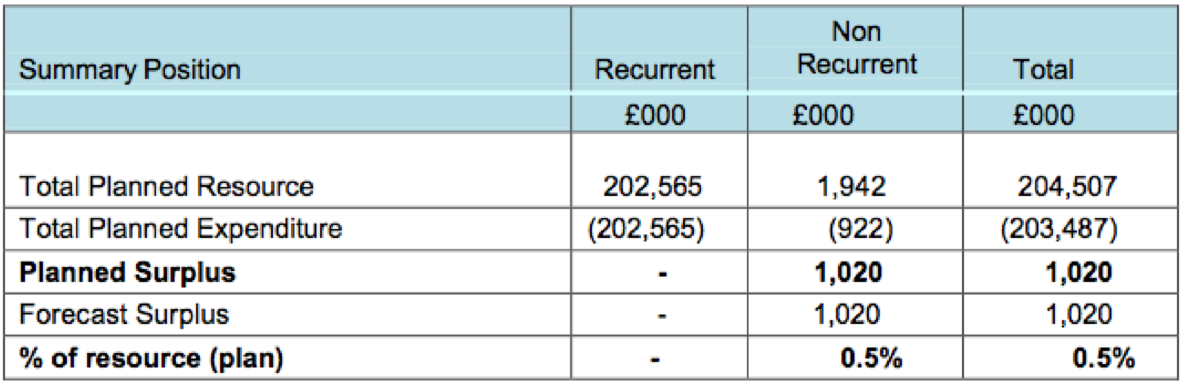
The challenge and complexity of delivering this programme can not be underestimated. We know that this strategy will be outdated almost as soon as it is written but it is our first step on a pathway of complex and chaotic change. The Connecting Care Programme is a key driver for delivering a sustainable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

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

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

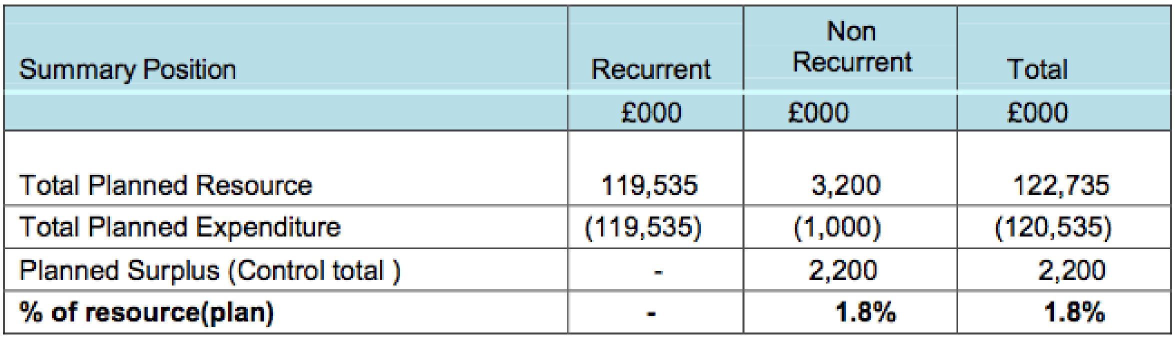
This gap and the impact that the initiatives within this strategy and detailed within our financial and operational plans will have in terms of narrowing it is yet to be defined with clarity. This will be established as part of our planned modelling work, which is currently 'paused' due to national Information Governance issues. Current month 1 financial positions for both CCGs are provided below:

South Cheshire CCG:



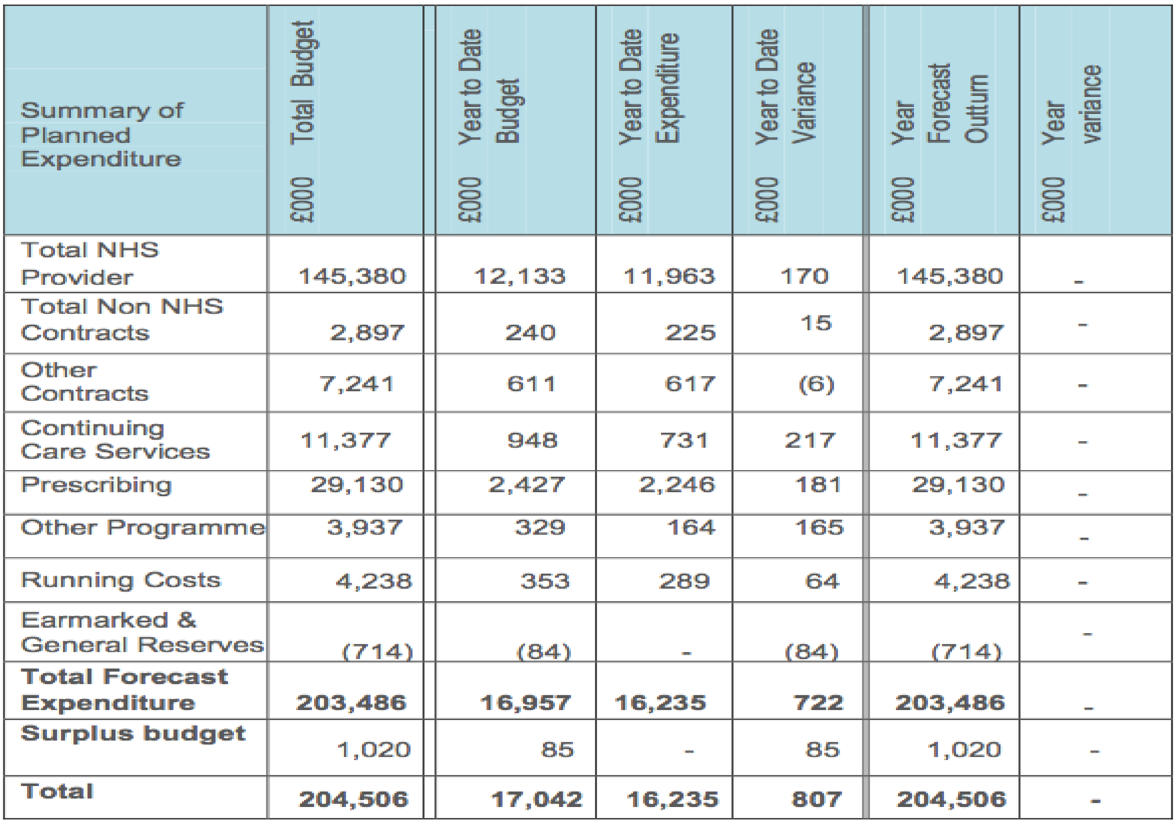
Summary Position	Recurrent	Non Recurrent	Total
	£000	£000	£000
Total Planned Resource	202,565	1,942	204,507
Total Planned Expenditure	(202,565)	(922)	(203,487)
Planned Surplus	**-**	**1,020**	**1,020**
Forecast Surplus	-	1,020	1,020
% of resource (plan)	**-**	**0.5%**	**0.5%**

Vale Royal CCG:



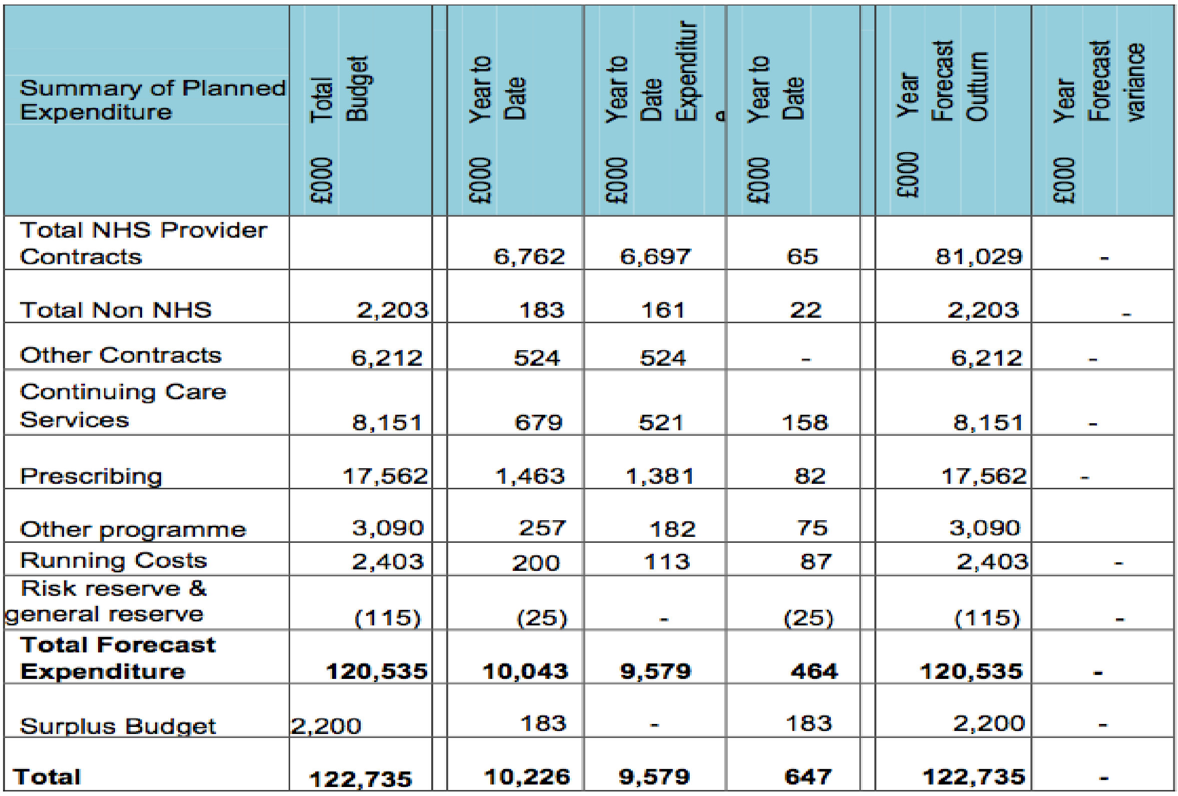
Summary Position	Recurrent	Non Recurrent	Total
	£000	£000	£000
Total Planned Resource	119,535	3,200	122,735
Total Planned Expenditure	(119,535)	(1,000)	(120,535)
Planned Surplus (Control total)	-	2,200	2,200
% of resource(plan)	**-**	**1.8%**	**1.8%**

South Cheshire CCG:



Summary of Planned Expenditure	£000 Total Budget	£000 Year to Date Budget	£000 Year to Date Expenditure	£000 Year to Date Variance	£000 Year Forecast Outturn	£000 Year variance
Total NHS Provider	145,380	12,133	11,963	170	145,380	-
Total Non NHS Contracts	2,897	240	225	15	2,897	-
Other Contracts	7,241	611	617	(6)	7,241	-
Continuing Care Services	11,377	948	731	217	11,377	-
Prescribing	29,130	2,427	2,246	181	29,130	-
Other Programme	3,937	329	164	165	3,937	-
Running Costs	4,238	353	289	64	4,238	-
Earmarked & General Reserves	(714)	(84)	-	(84)	(714)	-
Total Forecast Expenditure	**203,486**	**16,957**	**16,235**	**722**	**203,486**	-
Surplus budget	1,020	85	-	85	1,020	-
Total	**204,506**	**17,042**	**16,235**	**807**	**204,506**	**-**

Vale Royal CCG:



Summary of Planned Expenditure	£000 Total Budget	£000 Year to Date	£000 Year to Date Expenditure	£000 Year to Date	£000 Year Forecast Outturn	£000 Year Forecast variance
Total NHS Provider Contracts		6,762	6,697	65	81,029	-
Total Non NHS	2,203	183	161	22	2,203	-
Other Contracts	6,212	524	524	-	6,212	-
Continuing Care Services	8,151	679	521	158	8,151	-
Prescribing	17,562	1,463	1,381	82	17,562	-
Other programme	3,090	257	182	75	3,090	
Running Costs	2,403	200	113	87	2,403	-
Risk reserve & general reserve	(115)	(25)	-	(25)	(115)	-
Total Forecast Expenditure	**120,535**	**10,043**	**9,579**	**464**	**120,535**	**-**
Surplus Budget	2,200	183	-	183	2,200	-
Total	**122,735**	**10,226**	**9,579**	**647**	**122,735**	**-**

The interventions within our strategy are being resources from within existing baselines, through efficiencies and increased productivity across the care system and from new models of contracting including the Better Care Fund and the Alliance Contract.

The Better Care Fund plans include joint investment levels of £47m across both Central Cheshire.

The key risks for delivery are summarised below and will need to be monitored closely:

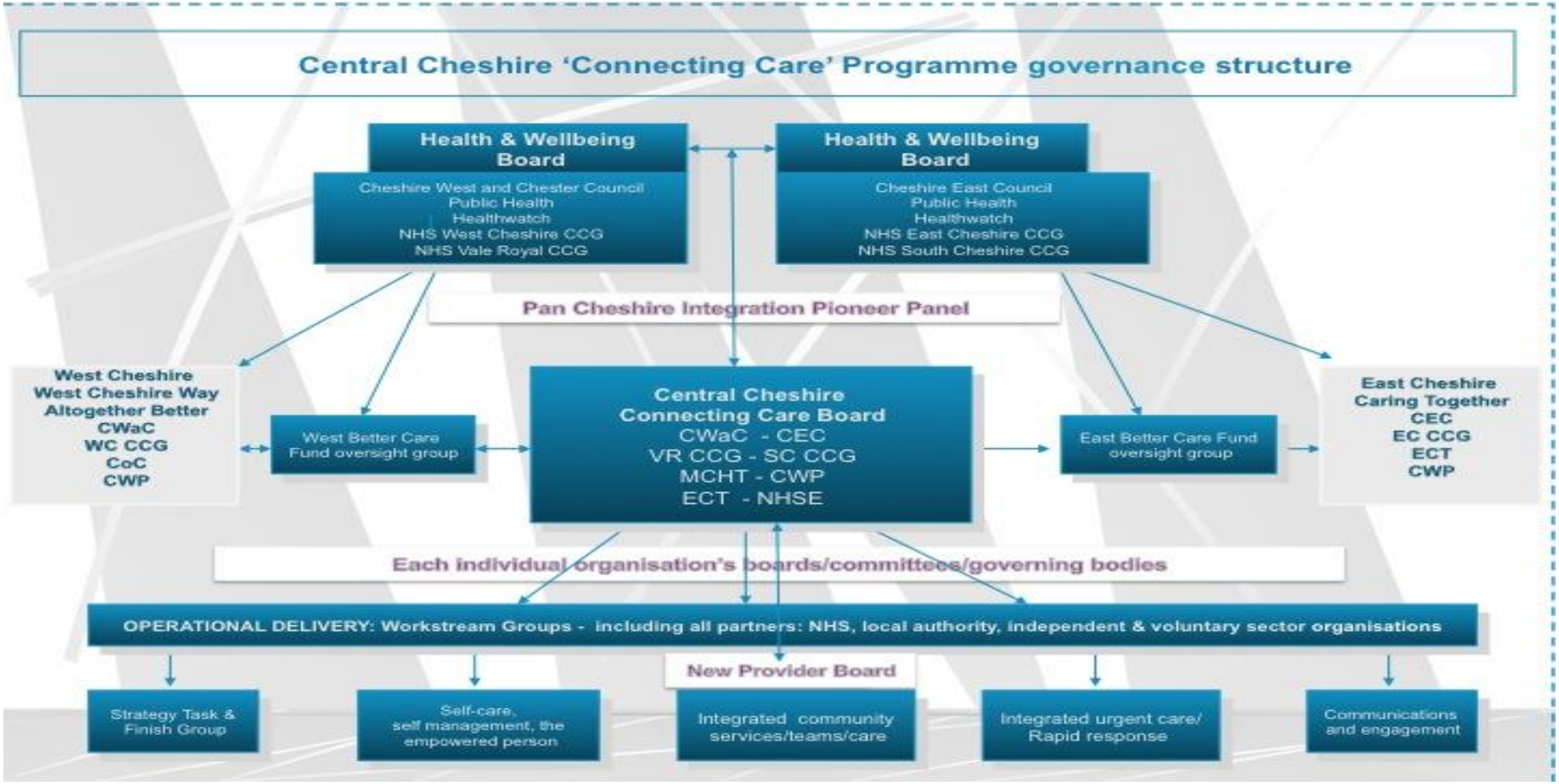
- Delivering the integration agenda within existing resources
- Over performance of activity within secondary care
- Continuing healthcare assessments and complex claims relating to Learning Disabilities
- Impact of NHS England adjustments including primary care information technology, the national shortfall relating to NHS Property services and the national risk pool for CHC legacy claims
- Increasing demand due to demographic changes.

Our strategy is based on the above assumptions and that our plans will narrow the financial gap and ensure viability and sustainability of the care system.

Delivering financial stability and sustainability will be a significant challenge yet with a system wide approach and partnership working as outlined in this strategy, our aim is to achieve transformation that will shift resources across the care system, at scale without the need for significant pump prime funding.

2014/15 is a critical year for our health and social care economy and it is essential that our interventions outlined in this document deliver on their intended outcomes.

Appendix 1: Connecting Care Programme Governance



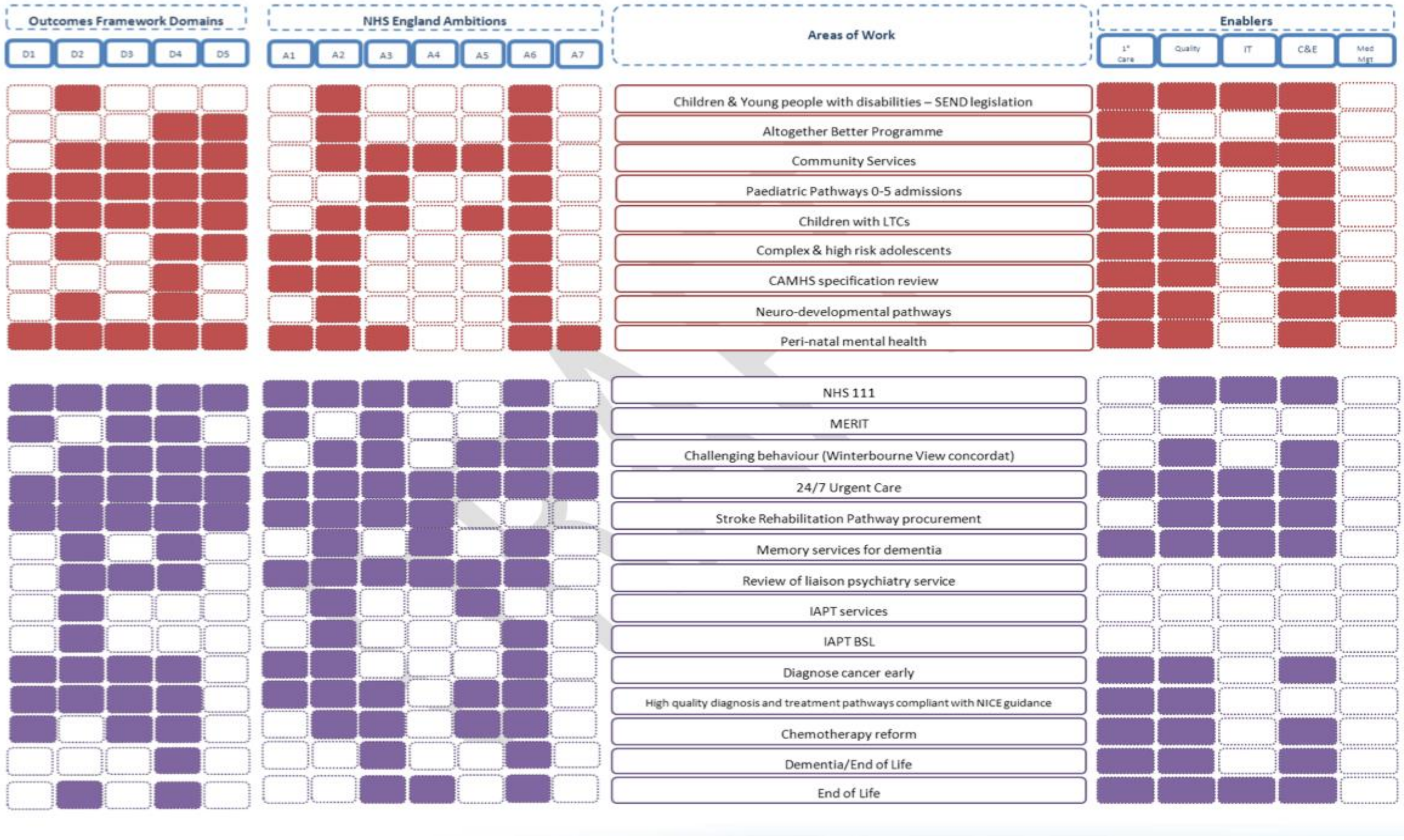
Appendix 2: The Cheshire wide 'Pioneer' Plan

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

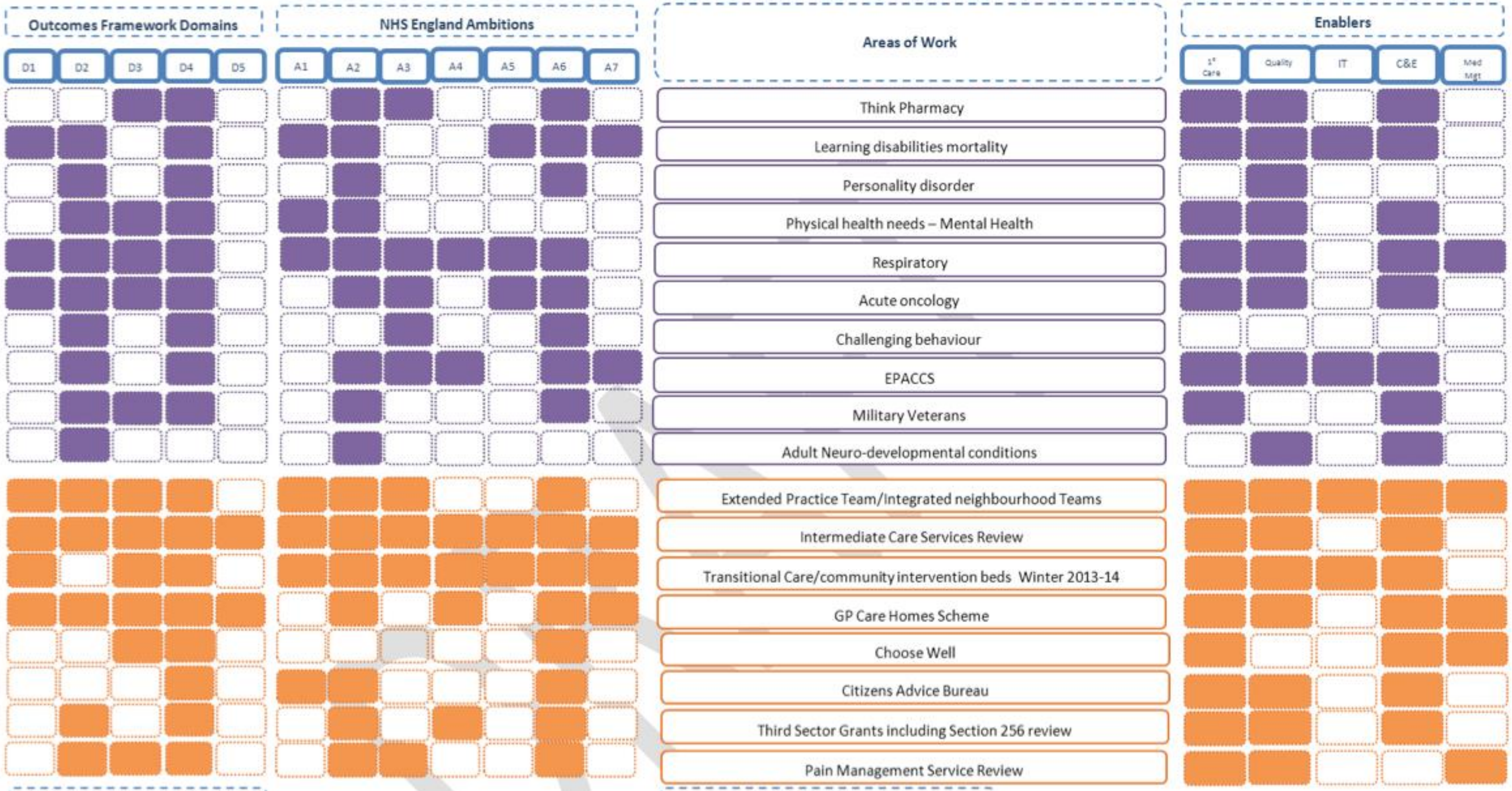
Pan-Cheshire

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

Appendix 3: Improvement interventions summary and impact ambition – for South Cheshire CCG



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



Outcomes Framework Domains					NHS England Ambitions							Areas of Work	Enablers				
D1	D2	D3	D4	D5	A1	A2	A3	A4	A5	A6	A7		1st Care	Quality	IT	C&E	Med Mgt
		🟪	🟪			🟪	🟪			🟪		Think Pharmacy	🟪	🟪		🟪	
🟪	🟪		🟪		🟪	🟪			🟪	🟪	🟪	Learning disabilities mortality	🟪	🟪	🟪	🟪	
	🟪		🟪			🟪				🟪		Personality disorder		🟪			
	🟪	🟪	🟪		🟪	🟪						Physical health needs – Mental Health	🟪	🟪		🟪	
🟪	🟪	🟪	🟪		🟪	🟪	🟪	🟪	🟪	🟪		Respiratory	🟪	🟪		🟪	🟪
🟪	🟪	🟪	🟪			🟪	🟪		🟪	🟪		Acute oncology	🟪	🟪		🟪	
	🟪		🟪				🟪			🟪		Challenging behaviour					
	🟪		🟪			🟪	🟪	🟪		🟪	🟪	EPACCS	🟪	🟪	🟪	🟪	
	🟪	🟪	🟪			🟪				🟪		Military Veterans	🟪			🟪	
	🟪					🟪						Adult Neuro-developmental conditions		🟪		🟪	
🟧	🟧	🟧	🟧		🟧	🟧	🟧			🟧		Extended Practice Team/Integrated neighbourhood Teams	🟧	🟧	🟧	🟧	🟧
🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	🟧	Intermediate Care Services Review	🟧	🟧		🟧	
🟧		🟧	🟧		🟧	🟧	🟧	🟧	🟧	🟧	🟧	Transitional Care/community intervention beds Winter 2013-14	🟧	🟧	🟧	🟧	
🟧	🟧	🟧	🟧	🟧		🟧		🟧		🟧	🟧	GP Care Homes Scheme	🟧	🟧		🟧	🟧
		🟧	🟧							🟧		Choose Well	🟧			🟧	🟧
			🟧		🟧	🟧				🟧		Citizens Advice Bureau	🟧	🟧		🟧	
	🟧		🟧			🟧		🟧		🟧		Third Sector Grants including Section 256 review	🟧	🟧		🟧	
	🟧	🟧	🟧			🟧	🟧			🟧		Pain Management Service Review	🟧	🟧			🟧

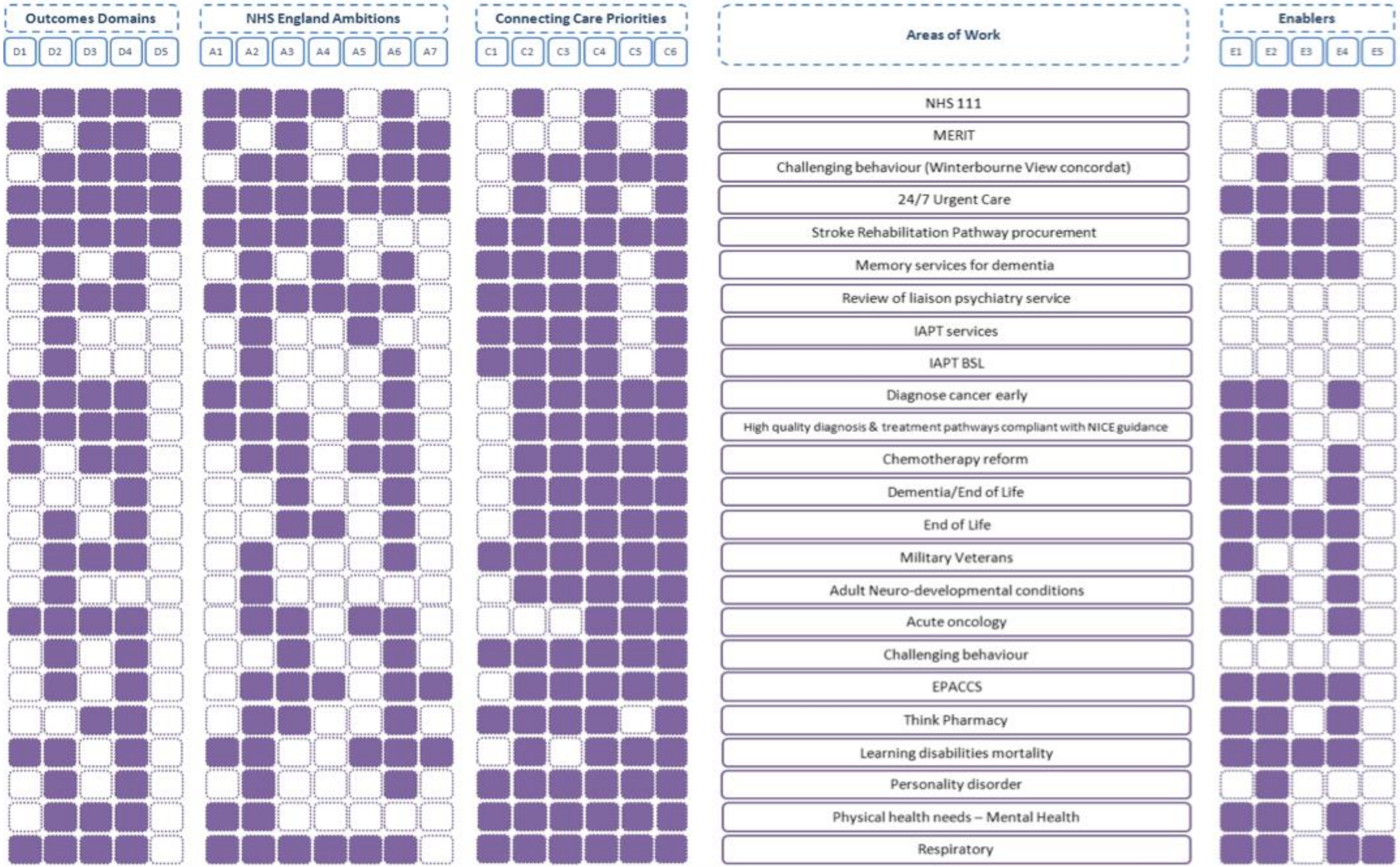
Outcomes Framework Domains

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

NHS England Ambitions

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

Appendix 3: Improvement interventions summary and impact ambition – for Vale Royal CCG



Outcomes Domains					NHS England Ambitions							Connecting Care Priorities						Areas of Work	Enablers				
D1	D2	D3	D4	D5	A1	A2	A3	A4	A5	A6	A7	C1	C2	C3	C4	C5	C6		E1	E2	E3	E4	E5
■	■	■	■	■	■	■	■	■	□	■	□	□	■	□	■	□	■	NHS 111	□	■	■	■	□
■	□	■	■	□	■	□	■	□	□	■	■	□	□	□	■	□	■	MERIT	□	□	□	□	□
□	■	■	■	■	□	■	■	□	■	■	■	□	■	■	■	■	■	Challenging behaviour (Winterbourne View concordat)	□	■	□	■	□
■	■	■	■	■	■	■	■	■	■	■	■	□	■	□	■	□	■	24/7 Urgent Care	■	■	■	■	□
■	■	■	■	■	■	■	■	■	□	□	□	■	■	■	■	■	■	Stroke Rehabilitation Pathway procurement	□	■	■	■	□
□	■	□	■	□	□	■	□	■	□	■	□	■	■	■	■	□	■	Memory services for dementia	■	■	■	■	□
□	■	■	■	□	■	■	■	■	■	■	□	■	■	■	■	□	■	Review of liaison psychiatry service	□	□	□	□	□
□	■	□	□	□	□	■	□	□	■	□	□	■	■	■	■	□	■	IAPT services	□	□	□	□	□
□	■	□	□	□	□	■	□	□	□	■	□	■	■	■	■	□	■	IAPT BSL	□	□	□	□	□
■	■	■	■	□	■	■	□	□	□	■	□	□	■	■	■	■	■	Diagnose cancer early	■	■	□	■	□
■	■	■	■	□	■	■	■	□	■	■	□	□	■	■	■	■	■	High quality diagnosis & treatment pathways compliant with NICE guidance	■	■	□	□	□
■	□	■	■	□	□	■	■	□	■	■	□	□	■	■	■	■	■	Chemotherapy reform	■	■	□	■	□
□	□	□	■	□	□	□	■	□	□	■	□	□	■	■	■	■	■	Dementia/End of Life	■	■	□	■	□
□	■	□	■	□	□	□	■	■	□	■	□	□	■	■	■	■	■	End of Life	■	■	■	■	□
□	■	■	■	□	□	■	□	□	□	■	□	■	■	■	■	■	■	Military Veterans	■	□	□	■	□
□	■	□	□	□	□	■	□	□	□	□	□	□	■	■	■	■	■	Adult Neuro-developmental conditions	□	■	□	■	□
■	■	■	■	□	□	■	■	□	■	■	□	□	□	□	■	■	■	Acute oncology	■	■	□	■	□
□	■	□	■	□	□	□	■	□	□	■	□	■	■	■	■	■	■	Challenging behaviour	□	□	□	□	□
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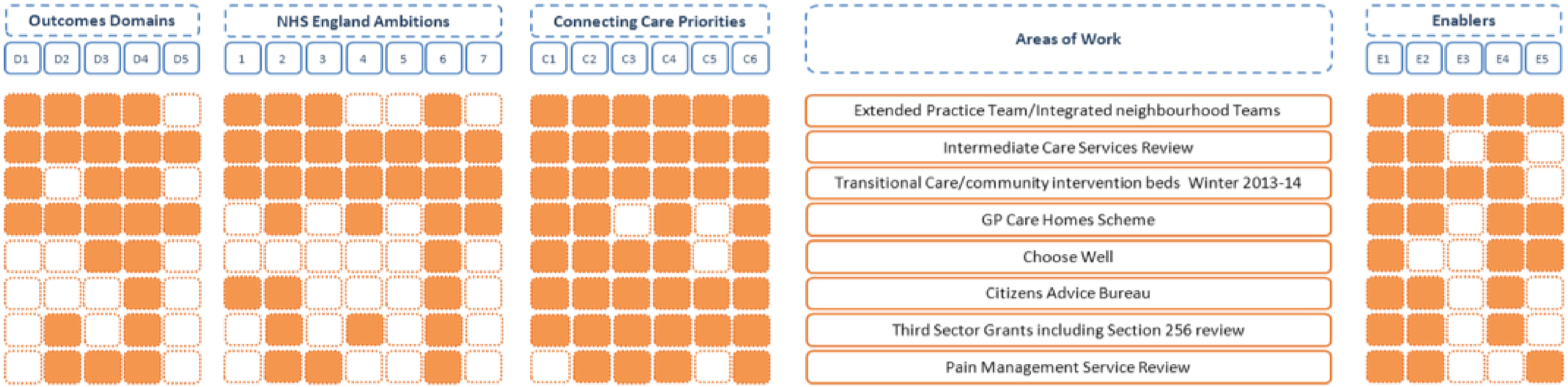
■	■	□	■	□	■	■	□	□	■	■	■	□	■	□	■	■	■	Learning disabilities mortality	■	■	■	■	□
□	■	□	■	□	□	■	□	□	□	■	□	■	■	■	■	■	■	Personality disorder	□	■	□	□	□
□	■	■	■	□	■	■	□	□	□	□	□	■	■	■	■	■	■	Physical health needs – Mental Health	■	■	□	■	□
■	■	■	■	□	■	■	■	■	■	■	□	■	■	■	■	■	■	Respiratory	■	■	□	■	■



Outcomes Domains					NHS England Ambitions							Connecting Care Priorities						Areas of Work	Enablers				
D1	D2	D3	D4	D5	1	2	3	4	5	6	7	C1	C2	C3	C4	C5	C6		E1	E2	E3	E4	E5
■	■	■	■	□	■	■	■	□	□	■	□	■	■	■	■	■	■	Extended Practice Team/Integrated neighbourhood Teams	■	■	■	■	■
■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	Intermediate Care Services Review	■	■	□	■	□
■	□	■	■	□	■	■	■	■	■	■	■	■	■	■	■	■	■	Transitional Care/community intervention beds Winter 2013-14	■	■	■	■	□
■	■	■	■	■	□	■	□	■	□	■	■	■	■	□	■	□	■	GP Care Homes Scheme	■	■	□	■	■
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□	■	□	■	□	□	■	□	■	□	■	□	■	■	■	■	■	■	Third Sector Grants including Section 256 review	■	■	□	■	□
□	■	■	■	□	□	■	■	□	□	■	□	□	■	■	■	□	■	Pain Management Service Review	■	■	□	□	■

Outcomes Framework Domains

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

Enablers

E1	Primary Care
E2	Quality
E3	Information Technology
E4	Communications and Engagement
E5	Medicines Management

NHS England Ambitions

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

Connecting Care Priorities

C1	Communities that promote and support healthier living
C2	An empowered and engaged workforce and public
C3	Personalised care that supports self-management and independence and enhances quality of life
C4	Individuals will have positive experiences and outcomes of safe services
C5	Carers are supported
C6	Effective resource use

Agenda Item 9

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 23rd September 2014
Report of: Guy Kilminster
Subject/Title: Health and Wellbeing Peer Challenge

1.0 Report Summary

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

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

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

2.0 Recommendations

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

2.2 That the Board consider the establishment of a task and finish group to manage the Peer Challenge.

3.0 Reasons for Recommendations

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

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

4.0 Financial Implications

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

5 Background

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

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

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

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

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

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

- Establishment and effective operation of a local healthwatch.

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

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

5.6 A scoping meeting took place on the 10th June beginning the process of planning for the Peer Challenge. This provided the opportunity to discuss what to focus on and who needs to be involved. The CCG business managers have been involved in preliminary discussion with the Corporate manager health Improvement to prepare for the Challenge. This work will begin in earnest now, with the drafting of the position statement that is to be submitted at the beginning of October.

5.7 It is suggested that a task and finish group be established to manage the Peer Challenge and if this is agreed nominations are sought for this group.

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

5.9 Appendix B is a leaflet produced by the LGA summarising the purpose of the Challenge and listing the Challenge Team members.

Access to Information

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

Appendix A

Peer challenge
methodology.pdf

Appendix B

What's it all about
leaflet - Cheshire eas

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Health and wellbeing system improvement

Health and wellbeing peer challenge

Methodology and guidance

14th June 2013

1. Supporting the new health and wellbeing system

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

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

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

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

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

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

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

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

Regional approach driven by local choices - this has focussed on identifying as much funding as possible to devolve to the regions throughout the year so the offer is responsive to local need and builds on local networks and capacity. Regional funding will be made available as part of a grant agreement with clearly defined criteria to demonstrate value, share learning and regularly communicates.

For more information on the offer go to:

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

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

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

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

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

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

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

3. Headline questions for the peer challenge

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

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

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

4. The peer challenge process

4.1 Preparation

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

Preparatory work involves the following:

i. Position statement

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

ii. Pre-site reading

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

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

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

iii. Pre-site analysis

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

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

iv. Pre-site survey with members of the HWB

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

v. Timetable of activities for the peer team

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

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

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

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

1:1 discussions

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

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

Focus Groups:

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

4.2 On-site work

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

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

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

- a **‘setting the scene’ meeting** in the morning of the first day of the peer challenge. This provides an opportunity for the peer challenge team to meet with key officers and elected members and to receive an introductory presentation about the council and how it embraces its new responsibilities in health, together with key opportunities and challenges as well as successes. The team uses this session to re-state the focus for the peer challenge and to establish common ground in what a good outcome of the process will be. It is also an important part in ‘starting the process together’ and to build relationships and trust between the council and the peer challenge team

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

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

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

4.3 Written feedback

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

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

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

4.4 Follow-up work

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

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

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

The peer team provides continuous feedback throughout the peer challenge process. The intelligence gained is fed back into the LGA to inform the planning of future support. It also contributes to our sector knowledge base, which we need to prove sector led improvement works for local government.

5. The Peer Team

Composition

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

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

The core team normally consists of:

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

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

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

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

Roles and responsibilities

The role of peers is to:

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

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

The role of the challenge manager is to:

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

6. Peer team requirements during the on-site period

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

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

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

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

Appendix 1: Sample timetable

Day 1

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

Day 2

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

Day 3

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

Day 4

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

Appendix 2: Headline questions for the peer challenge

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

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

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

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

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

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

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

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

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

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

What's it all about leaflet

Cheshire East
Health and Wellbeing Peer Challenge
November 18 – 21 2014

Between the 18th and 21st November 2014, Cheshire East Council is hosting a visit by an external health and wellbeing peer challenge team. The team will be here at the invitation of Cheshire East Council

The members of the team are:

Timothy Wheedon
Chief Executive
Bracknell Forest Council

Cllr. Joanna Spicer
Chair of Suffolk Health & Wellbeing Board
Suffolk County Council

Roz Jervis
Director of Public Health
Wolverhampton Council

Saba Raj
Senior Commissioning Manager
Sandwell and West Birmingham CCG

Dawn Wickham
Director of Operations and Delivery NHS
England (Shropshire and Staffordshire Area)

Caroline Bosdet
Peer Challenge Manager, LGA

why?

Peer Challenge is the cornerstone of the DH funded Health and Wellbeing Systems Improvement Programme, applying the LGA's tried and tested approach of sector-led improvement and peer challenge to health and wellbeing.

The team explores how Cheshire East is working together to deliver successful health outcomes through their Health and Wellbeing Board (HWB), their public health and local Healthwatch responsibilities. Through a comprehensive programme of discussions, observations, workshops, focus groups and visits, the peer team develops and feedbacks its findings and recommendations at the end of the four days, enabling the HWB to focus on key issues to take their agenda forward.

how?

The health and wellbeing peer challenge is improvement focused and involves bespoke teams of peers from a range of organisations working on site with the council and HWB. The emphasis is agreed with the client council and their HWB at the earliest stage. It is tailored to reflect their local needs and specific requirements. The peer team chosen will help councils and their HWBs respond to local priorities and issues in their own way to greatest effect. To get the maximum benefit out of the challenge, it needs to be based on open and honest information. So the peer challenge team gathers a range of information before and during their visit to the area for four days. Before the challenge visit, this information includes background documents, data and analysis of local needs and progress, a financial position and position statement, a summary of local stakeholders and a self-assessment by HWB members. During the challenge visit, the peer team talks to a range of people, local partners and stakeholders, via interviews, focus groups and other meetings. These discussions enable the peer team to explore local context and progress further, using a framework of initial questions to help probe into how the key elements below are progressing:

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

Cheshire East Health and Wellbeing Peer Challenge

what will happen?

The peer challenge team will undertake a four day on-site peer challenge. This is not an inspection. Through peer challenge, the sector is taking responsibility for its own improvement. The team will seek to help Cheshire East HWB recognise and celebrate its strengths as much as identifying areas to explore. Members of the team are knowledgeable about, and experienced in, health and wellbeing, from council and health perspectives. They are visiting as friends, albeit 'critical friends', enabling an open and honest exchange to drive improvements forward that are owned by Cheshire East HWB.

During the four day visit, members of the challenge team will meet and talk with a cross-section of staff within Cheshire East Council, elected members and representatives of partner organisations, especially those represented on the HWB. The team will feed back their conclusions and recommendations on the fourth day. This will be followed by a written report that Cheshire East Council and partners on the HWB will have the opportunity to consider and respond to.

Contact for more information?

If you would like more information or the opportunity to speak to the peer challenge team, please contact:

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Peer Challenge Manager, LGA
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Email: caroline.bosdet@local.gov.uk

Guy Kilminster
Corporate Manager - Health Improvement
Cheshire East Council
Telephone: 01270 686560
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find out more at
www.local.gov.uk/peer-challenge