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Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday, 27th January, 2015**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Declarations of Interest**

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

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

   To approve the minutes of the meeting held on 18 November 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. **Joining Strategy and Commissioning to Reduce the Scale and Impact of Domestic Abuse in Cheshire East** (Pages 9 - 72)

To consider a report relating to joining strategy and commissioning to reduce the scale and impact of domestic abuse in Cheshire East.

6. **Greater Manchester Healthier Together Consultation** (Pages 73 - 80)

To consider a report produced in response to a notice of motion submitted, relating to the Greater Manchester Healthier Together Consultation.

7. **Update on the Better Care Fund** (Pages 81 - 96)

To receive a report updating the Board on the Better Care Fund.

8. **S.256 Pilots - Progress Update** (Pages 97 - 112)

To consider a progress update report relating to S.256 Pilots.

9. **Family Focus Programme** (Pages 113 - 126)

To consider a report to inform the Board about the ending of the current programme and to begin discussion about the expanded programme.

10. **Co-commissioning of Primary Care Services** (Pages 127 - 136)

To consider a report relating to Co-commissioning of Primary Care Services.

11. **The NHS Five Year Forward View and NHS Planning for 2015/16** (Pages 137 - 140)

To consider a report to update the Board in respect of the NHS Five Year Forward View and NHS Planning for 2015/16.

12. **Winterbourne View/Transforming Care Update** (Pages 141 - 144)

To consider a report providing an update on progress with meeting the key requirements set out in “Transforming Care” and describing the newly introduced Care and Treatment Review process.

13. **Connecting Care Across Cheshire Pioneer Panel** (Pages 145 - 148)

To note the minutes of the Connecting Care Across Cheshire Pioneer Panel.

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 18th November, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

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

Cllr Rachel Bailey, CE Council
Cllr Alift Harewood, CE Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Tony Crane, Director of Children's Services, CE Council
Brenda Smith, Director of Adult Social Care and Independent Living, CE Council
Dr Heather Grimbaldeston, Director of Public Health, CE Council

Associate Non Voting Member
Lorraine Butcher, Executive Director Strategic Commissioning, CE Council

Officers/others in attendance
Anita Bradley/Susanne Antrobus, Legal Services, CE Council
Guy Kilminster, Corporate Manager Health Improvement, CE Council
Julie North, Democratic Services, CE Council
Alison Rylands – Deputy Medical Director, NHS England
Linda Devereux – NHS England
Ian Rush, Independent Chair of the Cheshire East Safeguarding Board
Inspector Kate Woods, Cheshire Police
Josie Norman - CE Council visitor

Observer
Cllr S Gardiner

Councillor in attendance
Cllr B Murphy, Cllr P Hoyland.

38 **APOLOGIES FOR ABSENCE**

Dr Andrew Wilson, Mike Suarez

39 **DECLARATIONS OF INTEREST**

There were no declarations of interest.

40 **MINUTES OF THE MEETING HELD ON 23 SEPTEMBER 2014**

RESOLVED

That the minutes be approved as a correct record, subject to an amendment to minute 33 to refer to Healthwatch having access to the data in respect of the JSNA consultation with the third sector and a correction to the start and finish time to refer to pm, rather than am.

41 **PUBLIC SPEAKING TIME/OPEN SESSION**

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

42 **CONSULTATION WITH GREATER MANCHESTER**

Alison Rylands and Linda Devereux gave a presentation to the Board relating to the consultation with Greater Manchester in respect of changes to some specialised cancer services. It was noted that plans had been developed to Improve outcomes of treatment and reduce health inequalities, ensure delivery of safe and sustainable services, improve patients' experience of their care and to ensure services met standards set out in national guidance.

It was reported that some specialised cancer services did not currently meet national guidance, namely Hepatobiliary and pancreas, Gynaecology, Urology and upper gastrointestinal cancers and this meant that these cancer services were not organised in the best possible way and it was considered that there needed to be a single specialist team working together, as this was known to affect the care patients received.

Details of what this would mean for patients were outlined. It was noted that the majority of cancer care would remain unchanged e.g diagnostic services, non specialist treatment, chemotherapy, radiotherapy and aftercare, but that better outcomes would be achieved, by concentrating complex diagnostic and surgical expertise and facilities for patients with rarer cancers. Safe and sustainable services would be provided by fewer specialist providers in centres of excellence and the scale of change would be minimal. Governance arrangements between GPs, local hospitals and specialist centres would ensure consistent high quality care irrespective of where patients lived.

With regard to consultation it was noted that there had been extensive engagement on the 'single service' model through the NHS Greater Manchester Clinical teams and hospital managers supported concentration of expertise on fewer sites and the plans were closely aligned with the CCGs Healthier Together Programme. Engagement had also taken place with GM and Cheshire Overview and Scrutiny Committees and GM Healthwatch and there were close links with the Strategic Clinical Network, to ensure engagement with patient groups. In addition, Clinical Reference Groups had patient representatives on the national patient panel and a South Cheshire/Vale Royal review of patient flows project group was to be established.

Following the presentation, members of the Board made comments and sought clarification on a number of issues.

RESOLVED

That the report be received

43 **NHS ENGLAND ACCOUNTABILITY REPORT**

NHS England provided a quarterly accountability report to each Health and Wellbeing Board. The Board received the latest report, which outlined national and regional context, together with a specific update on priorities that the Area Team was responsible for delivering and how these priorities were progressing. The report provided an update on co-commissioning, progress on the Two Year Operational Plans and introduction of the Commissioning Intentions & Planning Guidance for 2015/16.

In considering the report, Board members requested clarification with regard to the time frame for the work. Reference was also made to concerns nationally regarding conflicts of interest and it was suggested that the Board needed to consider this issue.

It was agreed that a report would be submitted to a future meeting of the Board in respect of the management of the risks and benefits associated with co-commissioning, particularly around some of the specialised services.

RESOLVED

That the NHS England Accountability Report be received and that a report be submitted to a future meeting of the Board in respect of the management of the risks and benefits associated with co-commissioning, particularly around some of the specialised services.

44 **CHESHIRE EAST SAFEGUARDING CHILDREN BOARD ANNUAL REPORT 2013-14**

Ian Rush, Independent Chair of the Cheshire East Safeguarding Board (CESCB) attended the meeting and presented the Cheshire East Safeguarding Children Board Annual Report 2013-14.

The work of CESCB over the past year had been to focus on the key issues identified by Ofsted. CESCB had reviewed its priorities and business plan for 2013-14, to align it to the Children's Improvement Plan and the requirements of the newly established Children's Improvement Board. Close work between the Improvement Board, the Children and Young People's Trust and other key partnerships had taken place, to provide a joined up strategic partnership approach to improvement. It was reported that there had been real improvements in quality of practice across the partnership, but there was still much more to do to achieve the challenging ambition set. The purpose of the report was to provide a detailed account of what the Board had done as a

Safeguarding Board, what impact it had made on improving arrangements to safeguard children and young people in Cheshire East and to clearly set out where it still had challenges and areas it was determined to improve. The annual report was intended to provide information for a wide ranging audience, including Cheshire East residents, staff in all agencies responsible for safeguarding children and promoting their welfare and those who were scrutinising the effectiveness of the CESCB's work.

In considering the report members of the Board raised a number of questions and issues, including the need for the inclusion of more detail regarding the level of partner provider care.

RESOLVED

That the report be received.

45 **DIRECTOR OF PUBLIC HEALTH ANNUAL REPORT**

The Director of Public Health (DPH) presented her independent annual report on the health of the local population, as required by law. This year's report focused on the health and wellbeing of children and young people and provided a current picture of how healthy the children and young people in Cheshire East were and what services they and their families used to support them. The report highlighted areas which were performing well and also made recommendations on ways to improve.

It was noted that, in her previous report, the DPH had drawn attention to proportionate universalism as an approach to reducing health inequalities across a community. In summary this meant that universal action was taken, but its scale and intensity was proportionate to the level of need in different areas. It was considered that proportionate universalism should be used to address the differences in need and reduce the gaps in health and that families were key to reducing ill health among children and families and children needed to be empowered to help keep children safe, healthy and happy. Commissioners needed to work together to reconfigure local preventive work, maximise the opportunities of the Healthy Child Programme and support children.

Reference was also made to the amount of fuel poverty in the Borough. Whilst it was important to identify the areas within the Borough with the highest levels of fuel poverty, it was also important to acknowledge that fuel poverty affected all geographies. This provided another example of how proportional universalism strategies needed to be applied within the Borough, to improve the health of children and young people. Chapter One of the report discussed the Cheshire East initiative to allow residents to buy their fuel through the Council at a competitively low price, which had been launched in October 2014.

The DPH gave a summary and overview of each chapter of her report.

RESOLVED

That the report be received.

46 **CHILDREN AND YOUNG PEOPLE PLAN**

Consideration was given to a report seeking the endorsement of the Children and Young People's Plan (CYPP) 2014 – 18 as the borough's "Starting Well" Plan.

The Children and Young People's Plan 2014–18 had been informed by a review of the Cheshire East CYPP 11-14, an analysis of available data and through consultation and engagement with children and young people, stakeholders and professionals. The Plan set out the key areas of focus which supported the "Starting Well" section of the Health and Wellbeing Strategy, providing a focus for the collective efforts of partner agencies on a small number of key priorities which limit the life chances of children and young people in Cheshire East.

RESOLVED

That the Children and Young People's Plan 2014–18 be ratified.

47 **MENTAL HEALTH STREET TRIAGE SCHEME**

Inspector Kate Woods, Cheshire Police, attended the meeting and gave a presentation in respect of the Operation Emblem, a mental health triage scheme which had been set up initially as a pilot in Warrington and Halton and had recently been introduced in Cheshire East, to help reduce the amount of people being arrested under the Mental Health Act or taken to A&E.

It was noted that there had been an increasing use of Section 136 of the Mental Health Act across Cheshire, resulting in poor experience for those needing support, significant inter-agency and political tension and resources being deployed in the wrong place for the wrong reason. Under the street triage scheme mental health nurses accompanied Cheshire Police officers out on patrol to offer advice and intervene at the earliest possible stage when someone was identified as having a mental illness. As well as better outcomes for the individuals with mental health issues, there were also cost.

Following receipt of the presentation it was suggested that Police Commissioner, John Dwyer, should be invited to a future meeting of the Board to discuss this matter. The Chairman explained that Mr Dwyer had a standing invitation to the Board's meetings and a representative from Cheshire Police was invited to attend each meeting. She undertook to invite Mr Dwyer to the next informal meeting of the Board.

RESOLVED

That the presentation be received.

48 **MENTAL HEALTH CRISIS CONCORDAT**

Consideration was given to a report relating to a Mental Health Crisis Concordat, which had been launched on 27 January 2014. This was a joint statement, written and agreed by a range of national organisations to describe what people experiencing mental health crisis should be able to expect in terms of service support. The high level principles within the document were to be underpinned at a local level by the formation of a local declaration statement and action plan setting out how agencies would deliver the commitments of the Concordat at a local level.

The Cheshire, Halton and Warrington area (Cheshire) Sub-Regional Leaders Board had agreed to the proposal from the Police and Crime Commissioner for Cheshire that he would take the lead and that the Pan-Cheshire Strategic Mental Health Board would oversee delivery. It was noted that the Pan Cheshire Strategic Mental Health Board comprised senior leaders from across the range of commissioner and provider agencies involved in mental health across the Cheshire sub-region.

In addition to supporting a single declaration work was underway to identify key actions across Cheshire that it was recommended should be undertaken on a combined basis. A list of potential joint actions was currently being considered and were attached as an appendix to the report, with the intention that, once agreed a Delivery Plan would be shaped for implementation. The Joint Action Plan would then complement identified actions agreed at the local level by Health and Well Being Boards. The report, therefore, sought to advise Health and Well Being Boards across Cheshire on the developing Pan-Cheshire approach to implementing the Mental Health Crisis Concordat.

In considering the report, the Chairman referred to the major improvements and large amount of progress already made in Cheshire East in this area and the Board noted this. It was suggested that further discussion would be needed in respect of this issue and it was agreed that a workshop should take place to consider this matter.

RESOLVED

1. That the adoption of the Cheshire, Halton and Warrington Declaration Statement be noted and the Sub Regional Leaders Board be recommended to endorse the Statement.

2. That the Health and Well Being Board support the development of the Joint Action Plan.

3. That the Health and Well Being Board notes and will monitor the development of local actions.

4. That future reports be received, updating the Board on progress towards implementation of the Pan Cheshire Plan.

49 **BETTER CARE FUND UPDATE**

Due to time constraints on the meeting, it was agreed that this item should be deferred to the next private meeting of the Board, in order to allow full and proper consideration of this matter.

The meeting commenced at 2.00 pm and concluded at 4.30 pm

Councillor J Clowes (Chairman)

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 27th January 2015
Report of: Kate Rose and Judith Gibson, Cheshire East Domestic Abuse Partnership
Subject/Title: Joining strategy and commissioning to reduce the scale and impact of domestic abuse in Cheshire East

1 Report Summary

1.1 Domestic abuse is widespread and damaging to individuals, families and communities. Cheshire East Domestic Abuse Partnership is implementing a strategy, following widespread consultation, to prevent as well as to respond which requires the engagement of all related partners and partnerships in promoting its aims and committing to its resourcing. The Health and Wellbeing Board has a significant role to play in this work.

In recognition of the above the Joint Leadership Group requested that this report be brought to the Board.

2 Recommendations

2.1 That the Health and Wellbeing Board should promote the priorities of Cheshire East Domestic Abuse Partnership Strategy within its own work.

In practice this means that Board members should be familiar with and incorporate the six priorities of prevention, protection, provision, partnership, participation and performance into related Board work

2.2 That the Health and Wellbeing Board should recognise the significance of and respond collaboratively to domestic abuse as a comorbid issue with mental ill health and substance misuse in all work streams

In practice this means that in every discussion or decision where issues or implications for those experiencing mental ill health and/or substance misuse are considered attention should be given to domestic abuse and where possible joint strategy and approaches should be implemented

2.3 That the Health and Wellbeing Board should seek assurance that partners are individually committed to CEDAP Strategy and Action Plan

In practice this means holding partners to account for their contribution of resources – financial and otherwise – to meeting local need

Reasons for Recommendations

3.1 The costs and consequences of domestic abuse and guidance on how to address it are widely documented and summarised for the health and wellbeing sector in two recent documents:

Violence and health and wellbeing boards: a practical guide for health and wellbeing boards
http://www.nhsconfed.org/Publications/Pages/Violence-health-wellbeing.aspx
Domestic Violence and Abuse: how health and social care services and the organisations they work with can respond effectively
http://www.nice.org.uk/guidance/ph50/resources/guidance-domestic-violence-and-abuse-how-health-services-social-care-and-the-organisations-they-work-with-can-respond-effectively-pdf

In summary these confirm that:

- People affected by violence and abuse are far more likely to experience poor physical and mental health than the general population.
- Early intervention is the most effective way to tackle the negative health and wellbeing impacts of violence and save local healthcare costs.
- Coordination across local services is necessary to address the complex needs of those at risk of causing violence, at risk of experiencing violence, and victims of violence.
- Effective joint strategic working between health and wellbeing boards and community safety partnerships will support improved local commissioning to achieve better health outcomes for those affected by violence

3.2 Cheshire East Domestic Abuse Partnership is the body with responsibility for the development and implementation of our local response. CEDAP is accountable to the Community Safety Partnership and its strategy and a report on its work to March 2014 can be found at
http://www.cheshireeast.gov.uk/social_care_and_health/domestic_abuse/domestic_abuse_partnership.aspx

Key data to note are:

Police domestic abuse incidents Jan to Nov 14	921 *In line with 13-14*	30% alcohol related 15% repeat victims
Police domestic incidents Jan to Nov 14	1763 *Significant reduction over 3 years*	
MARAC referrals Jan to Dec 2014	489 + 614 children *Significant increase*	29% repeats
Specialist service referrals April 2013- March14	1301 *Some duplication*	
Parental factors at case conference April 14 to Dec 15	Domestic abuse 229	Substance misuse 110 Mental health 115

3.3 Specialist services for victims and children have been established for some time and include:

- Independent Domestic Violence Advocacy and Multi-Agency Risk Assessment Conferencing for high risk victims
- Commissioned (and non-commissioned) provision of refuge and floating support including recovery and peer support
- Co-ordination of children's groupwork programmes

CEDAP Strategy aspires to treatment for the whole family and adequate support from crisis through safety to recovery. We have been able to offer a voluntary treatment programme for those who abuse since August 2013

More recent interventions include:

- Cheshire East Domestic Abuse Hub - one point of contact for professionals and the public for domestic abuse sitting alongside Cheshire East Consultation Service, the Police Referral Hub and other partners seeking greater integration in our response to families in need or at risk. This service is staffed collaboratively by all domestic abuse specialist services
- The placement of Independent Domestic Violence Advocates (domestic abuse professionals) in both hospitals and southern GP practices to increase earlier identification of and support to victims using health services
- The approval of funding to form an integrated team responding to families affected by mental ill health, substance misuse and domestic abuse including those who abuse

3. 4 The NICE Guidance above (PH50) recommends a joint commissioning approach to the funding of domestic abuse services. Cheshire East funding has developed historically and takes three main forms (see Appendix 1):

a. A partnership funding approach – some core commitment and some annual contribution – to high risk services (IDVA and MARAC) and the front door for all specialist services, the Domestic Abuse Hub
b. A three year commissioning cycle for refuge and floating support – funded through Council Adults and Children's Services
c. Applications to opportunities for enhancing services

3.5 CEDAP accepts funding approach 'c' will always be a part of its work and is a means by which innovation is driven.

Funding approach 'b' is being progressed through a joint commission of Adult and Children's Services.

This paper is expressly addressing funding approach 'a' in respect of placing core high risk services, the 'front door' for all services (the Domestic Abuse Hub) and partnership functions on a surer footing by agreeing a three year partnership agreement.
Commissioning is not possible as these services sit within the Council.
Service cost and existing committed funding are summarised below and set out in more detail in the paper to the Joint Leadership Group in November:

COSTS

Function	Cost
Domestic Abuse Family Safety Unit (IDVA, MARAC, Hub functions, training lead)	£325k
CEDAP business support, publicity, target hardening (Partnership manager post funded separately by Council)	£21k
TOTAL	£346k

RECURRENT CONTRIBUTIONS

Agency	Amount
Council – base budget	75,000
Police Strategic	9,750
2 CCGs	26,595
TOTAL	£111,345

OTHER SUBSTANTIAL BUT TIME LIMITED CONTRIBUTIONS

Community Safety Partnership	40,000	*Received since 2008 but notice given that not guaranteed for 2015*
Home Office	27,500	*Ends March 2016*
Council Housing and workforce development	13,000	*Not guaranteed*
Police and Crime Commissioner	35,000	*Ends March 2016*
Council Children's Services		*Significant contribution to sustain whole range of work 2014-15. Discussions re allocation to commissioned and council services ongoing*
TOTAL	115,500	

Due to partnership arrangements CEDAP is able to use carry forward to sustain annual provision. This will be in the region of £40k this year.

If all of the above funding is realised for 2015-16 and Children's Services agree a contribution to the Hub function in particular there may be a modest gap next financial year and significant shortfalls thereafter.

4 Impact on Health and Wellbeing Strategy Priorities

Achievement of CEDAP's 6 priorities of Prevention, Protection, Provision, Partnership, Performance and Participation contribute to the following priorities:

1. Children and young people have the best start in life – they and their family or carers are supported to feel health and safe (Children and young people feel and are kept safe, children and young people experience good emotional and mental health and wellbeing)

2. Driving out the causes of poor health – reducing the incidences of alcohol related harm and better needing the needs of people with mental health difficulties

3. Enabling older people to live active and healthier lives for longer

All CEDAP specialist provision has an agreed set of outcomes and measures and is scrutinised through its 'Board', the Commissioning and Development Group, which is accountable to the Community Safety Partnership.

Outcomes which span all provision are:

- Reduction of risk
- Improvement in health and wellbeing
- Enablement to cope/recover

5 Background and Options

5.1 CEDAP Commissioning Strategy

6 Access to Information

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

Name: Judith Gibson
Designation: Cheshire East Council Development Manager, Domestic Abuse and Sexual Violence and CEDAP Manager
Contact: 07818 002157 Judith.gibson@cheshireeast.gov.uk

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CHESHIRE EAST COUNCIL

REPORT TO: Joint Commissioning Group

Date of report: 21.11.14

Report of: Judith Gibson, CEC Development Manager

Subject/Title: Commissioning Paper – Domestic Abuse

1.0 Report Summary

The Report sets out the current funding streams for domestic abuse services and highlights how we can streamline funding to achieve a more integrated and easily accessible family model of provision as well as the risks which pertain if we do not re-model

2.0 Decision Requested

Approval of funding framework for next three years and permission to proceed to procurement

3.0 Reasons for Recommendations

3.1 A new model of provision has been agreed following extensive consultation based on a more integrated and innovative adults and children's model and simplifying service access

3.2 Strategic agreement to three year funding of this model is needed

3.3 There are significant risks in not procuring services which work to the new model in terms of value for money, quality assurance and partnership approaches to safeguarding

4.0 Wards Affected

4.1 ALL

5.0 Local Ward Members

5.1 ALL

5.0 Policy Implications

None

6.0 **Legal Implications**

None

COMMISSIONING PAPER FOR STRATEGIC COMMISSIONING MANAGER and ADULTS AND CHILDREN'S SERVICES DIRECTORS

BACKGROUND

CEDAP is the partnership body overseeing domestic abuse strategy and its implementation across the Borough. All relevant Council directorates and principle partners are represented on its 'Board' – the Commissioning and Development Group (CDG).

Following extensive consultation with all stakeholders a three year strategy was launched in March 2014. This set out key priorities and an Action Plan for their achievement.

One key priority is re-modelling and re-commissioning our service model to achieve an improved and innovative whole family offer and make the most of our combined resources. These resources include the Council based high risk services (Independent Domestic Violence Advocates and Multi Agency Risk Assessment Conferencing) as well as the commissioned and non-commissioned services in the voluntary sector (Barnardo's, Arch and Cheshire Without Abuse).

THE VISION

- **to offer individuals, families, communities and agencies what is needed to prevent domestic abuse or intervene early in households or relationships marked by domestic abuse to reduce both its scale and impact**

This means:

- Early identification
- Easier access to services (digital access and physical access via support centres as well as confident workforce)
- Engaging all those involved in support for the whole journey to safety, recovery and relationship change
- Putting service users at the heart of the service (real participation)
- Taking innovative approaches
- Offering a 'bespoke' service
- Improving interventions across the 'toxic trio'
- Systematic evaluation through an agreed outcomes framework

STEPS SO FAR

To date we have:

- Developed and signed off a **Commissioning Strategy** setting out in more detail the revised service model
- Worked in partnership with Adults and Children's Commissioning leads to develop a **Service Specification** for the services which have been historically funded through Supporting People and a small allocation of Children's Services funding (refuge, floating support and safety/recovery work with the children of these clients)
- Secured Public Health funding for developing our **'Safer and Healthier' families work** which engages those causing harm in families

- Written support for this model into the new Service Specification through **making partner and child support a function of the new service** as well as the capacity to undertake more bespoke work with those who harm where it is safe and appropriate to do so
- established a **Domestic Abuse Hub** which will provide a single point of information, advice, referral, triage and case allocation for all clients/services by end November as part of the multi-agency team based with ChECS
- Appointed a **Lead IDVA** to oversee this Hub through additional Children's Services funding
- Based **IDVAs in Child in Need/Child Protection teams** to provide direct support and consultation to Children's Services colleagues
- Planned and recruited to a short term **Young People's Abuse Prevention post** which will map provision and pathways and identify/resolve service gaps
- Secured IDVA provision in both **hospitals and GP practices** in the South
- Begun work to address the increasingly identified occurrence of **Child to Parent Violence**

NEXT STEP - PROCUREMENT

We need now to proceed to procurement of the commissioned elements of the agreed model if we are to reach our goal of implementation of the whole new model by 1/4/15.

This requires clarity about the funding available for the next three years and involves strengthening the current collaborative approach across Adults and Children's Services and other partners.

RISKS OF NOT PROCEEDING TO PROCUREMENT

1. **Failure to achieve our stakeholder agreed aim of providing a 'whole family' response**
   Our 3 year strategy and subsequent commissioning strategy sets out a clear direction of travel towards a more integrated family response, addressing the harm and needs present where domestic abuse affects families and communities. While our two commissioned services have sought to embrace developments towards this model they are working to (and around) a service specification which does not have this model at its core and so are not able to flex sufficiently to meet need

2. **Continued lack of certainty about service quality and effectiveness**
   The quality and effectiveness of current service provision is not easily ascertained as the Supporting People model focuses on a set of standards and objectives that do not capture the range of specialist support outcomes that apply across the domestic abuse sector. While the SP and Domestic Abuse managers have sought to harmonise requirements it has proved difficult to gain adequate data from services on quantity and quality of provision. Specific reporting and evaluation requirements would be firmly built in to a new service specification

3. **Failure to meet the demand anticipated from increased service access via the Hub/Health work**
   The work of the Domestic Abuse Hub and improved health service provision should result in increased referrals for those affected but as yet unknown and unsupported. Current SP contracts specify a prescribed number of clients and providers operate waiting lists for full service access. It is imperative that we move to a model where clients are triaged and prioritised in a consistent and equitable manner across the Borough so that we are confident that whatever resources we have are deployed in a way which meets safeguarding and support needs

CURRENT MODELS – FUNDING

There is currently an array of funding models to address domestic abuse in Cheshire East including:

1. Partnership contributions to the Council based high risk services (IDVA/MARAC) – Council, CCGs, PCC, Home Office…… These are renewed on an annual basis
2. A major three year Council commission for the two housing/floating support providers in Macclesfield and Crewe (largely former Supporting People Adults Services funding and a small amount of Children's Services funding for children of adult service users)
3. Smaller specific commissions for Children's Services or Health based work, most of which are short term
4. Significant contribution from the charitable sector largely through the work of Cheshire Without Abuse – national charities and local Business (300k p.a.)

COUNCIL FUNDING - ADULTS and CHILDREN'S

PROVISION	**ADULTS CONTRIBUTION**	**CHILDREN's CONTRIBUTION**
Refuge and Floating Support Bases Crewe and Macclesfield Providers Arch and Barnardo's	£620,499 (former Supporting People funding)	*It is my understanding that £36k of the £620k is a contribution from Children's Services but I am unable to confirm this via Finance. This was in the original service outline.*
IDVA/MARAC service		£75,632 core team *Base Budget* £60k (IDVA at ChECS/Hub and training) *additional CS funding via Director Children's Services*
Children and Young People's Group work Co-ordination Provider – Cheshire Without Abuse		£19k *funding via Director Children's Services additional funding*
Safer Families (Change work with perpetrators and their families) Provider – Cheshire Without Abuse and Barnardo's		£16,250 *(one off – additional CS funding via Director Children's Services)* *This covers the quarter from Aug – Oct spanning the end of the Health funding and the start of Public Health funding*
TOTAL	£620,499	£131,250

PROVISION FUNDED BY OTHER COUNCIL SOURCES

PROVISION	AMOUNT	COUNCIL SOURCE
Domestic Abuse Development Adviser/Partnership Manager	£54,795	this is described as 'Core Budget' – unsure if this is can be attributed to Children's or Adults
Core IDVA/MARAC Service	£40k	Community Safety Partnership *Ends this financial year – CSP say budget has transferred to PCC. Seeking confirmation of future contribution from PCC*
Target Hardening	£5k	Housing *Has been offered regularly but is not a core commitment*
Young People's Abuse Prevention Co-ordinator	£50k	Council Tax underspend *One off, one year*
Sexual Violence 'Aftercare	£48k	*Council contribution to sub regional commissioning model*
	£197,595	

PARTNER CONTRIBUTIONS

PROVISION	**AMOUNT**	**FUNDING SOURCE**	**COMMENT**
CORE IDVA/MARAC	£26,595	East and South CCGs	Annual commitment
CORE IDVA/MARAC	£27.500	Home Office	Ends March 16
CORE IDVA/MARAC	£9,750	Cheshire Constabulary	Annual commitment
CORE IDVA/MARAC	£40,000	Police and Crime Commissioner	£35k next year
CORE IDVA w/e hours	£8,624.75	Police and Crime Commissioner	Ends March 15
CORE IDVA/MARAC	£74,163	Partnership funding carry forward	
HEALTH IDVAs	£32,000 £16,000 £16,000 £51,000 £17,500	PCC (Macc DGH) East CCG (Macc DGH) PCC (Leighton DGH) South & VR CCG (Leighton DGH) South & VT CCG (GP practices Crewe/South)	ends March 16* " " April 15 onwards ends Jan 15* ends Sep 15
SAFER FAMILIES	£65k	South & VR CCG	Aug 13 –July 14
SAFER AND HEALTHIER FAMILIES	£95k	Public Health Transformation Fund Bid	Nov 14 - March 16
CHESHIRE WITHOUT ABUSE		Charitable funding - extends current provision significantly	

COMMISSIONING STRATEGY MODEL APRIL 2015

We hope to sustain and simplify Adult and Children's Services contributions for three years, including the re- commissioning of the two community support services, as follows:

PROVISION	**ADULTS**	**CHILDREN'S**	**ELEMENTS OF PROVISION**
REFUGE and COMMUNITY SUPPORT CREWE COMMUNITY SUPPORT MACCLESFIELD	£600k *Slightly reduced current contribution*	£120k *Includes current contributions to community and programmes work*	Secure refuge Dispersed housing Support Centre 1 to 1 adult and child victims Group work adult and child victims User groups Partner support for men on 'safer & healthier families' programme Peer support Volunteering
DOMESTIC ABUSE HUB *Access to all services- high risk IDVA/MARAC and community support*	*Staff seconded from above provision*	£50k *Lead IDVA and BSO*	Information, advice, referral, triage, allocation, participation in Children's 'MASH' type processes All cases, all pathways All DA cases held on a single database

STAFFING

HUB: 1 Lead IDVA, 1.5 staff seconded from commissioned community support, 0.5 Business Support based on 500 high risk referrals, 800 lower or unknown risk referrals + range of calls for advice and information

REFUGE 1.5 FTE added to and integrated with Service Provision for Crewe Community Provider

EACH OF CREWE AND MACCLESFIELD COMMUNITY BASES – NB it is not our intention to stipulate staffing levels but to indicate the size of the funding package and invite bidders to present their staffing and interventions model. However we expect to see a multi-skilled workforce including staff with specialisms in work with men, children and young people, group facilitation, training. We believe a team is likely to comprise:

1 manager

4-6 floating support staff including at least 1 male

2 child worker staff

1 Business Support Officer

CORE IDVA/MARAC SERVICES 2015-16

Core IDVA/MARAC provision remains a Council based service funded by partners and thus is not commissioned. We continue to work towards strengthening local multi-agency commitment which includes for 2015-16:

Adults	£75k
CCGs	£26.5k
Police	£9.75k
Children's	£20k
PCC	£35k
Home Office	£27,5k
Community Safety Partnership?	
TOTAL	£193.75k

We estimate that approximately 5 IDVAs, one manager and one Business Support Officer are required = £260k (plus the Lead IDVA at ChECS/Hub separately accounted for above). This is based on an anticipated 500 high risk referrals in this year.

It is estimated that Cheshire East has 600+ high risk victims and it may be that increased ease of service access at the Hub will enable us to identify those not known. This will increase demand on these high risk services.

ENHANCED PROVISION

We are working with CCGs and the PCC to secure long term funding for hospital IDVAs and to replicate the IRIS GP project in the north of the Borough. It is not envisaged that the IRIS GP work will require long term commitment but only the potential to refresh GPs on an annual basis. However we would like to see the extension of the IRIS GP work with GPs in the north of the Borough.

We also look forward to implementation of our 'toxic trio' model approach to addressing the harm associated with domestic abuse in families and particularly to engaging men in taking responsibility for their behaviour and improving the co-ordination of systems which hold them to account and support them in that challenge.

CONCLUSION

In short we believe that we can offer an improved service for more victims and offer better value for money for the Council and partners through consolidating funding to re-model commissioned provision as set out above and seek approval from budget holders to proceed on this basis.

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CHESHIRE EAST DOMESTIC ABUSE PARTNERSHIP

INTEGRATED COMMISSIONING STRATEGY

CONTENTS

1. INTRODUCTION AND AIM

This short strategy is based on the **Domestic Abuse Strategy 2014-16** agreed by Cheshire East Domestic Abuse Partnership in March 2014 which sets six priorities for our work together – prevention, protection, provision, performance, partnership and participation. The full document and associated action plan is attached:

The aims of this Commissioning Strategy are to set out in more detail the model we seek to fund for 3 years from April 2015, to give a rationale for proposed improvements to service provision, to outline the cost and provide a basis for agreement on how we can collectively fund it.

The Vision for our partnership is to:

> ***Reduce the human and service cost of domestic abuse through partnership and whole family work to prevent abuse from occurring, protect and support those affected and reduce the likelihood of further harm***

The significant links between domestic abuse and child and adult safeguarding and between domestic abuse and substance misuse and mental ill health create a challenging context for this work but also make it imperative that we succeed.

Such success will result both from improvements in public sector services and the provision of high quality specialist services. This makes our shared commissioning strategy a foundational document for keeping people safe and enabling them to recover and enjoy health and positive relationships.

This work will contribute to the achievement of priorities set in the following related strategies:

- Health and Wellbeing Strategy
- Children's Trust Priorities
- Local Safeguarding Adults and Children's Boards
- Safer Cheshire East Partnership
- Drug and Alcohol Strategy

- Clinical Commissioning Group programmes
- Police and Crime Commissioner Plan
- Vulnerable Persons Housing Strategy

2. THE MODEL

Building on what is already in place and evidence from national and local practice we seek to establish an improved and more integrated system from early identification and triage via a single 'hub' through support for medium risk clients using community based services in Macclesfield and Congleton to proactive safeguarding interventions for higher risk adults and the children in their care.

All of the work is informed by use of nationally agreed risk and needs assessments and includes services for those who harm so the risks they pose are better known and managed.

Victims – adult and child – will only come to our attention however if they and the professionals, families and communities who support them are confident to identify and name abuse which is why the strategy includes communications, awareness and training work. Our aim is to intervene as early as possible to prevent escalation and longer term impacts of harm to children, adults and families.

Please see Appendix 1 for a visual of the 'system' we plan to create which essentially involves

- A **Domestic Abuse 'Hub'** sitting alongside or within the increasingly integrated ChECS team at Dalton House to provide a point of information, referral and triage for service users and those formal or informal networks who support them i.e. agencies or friends/families/colleagues. This 'Hub' would be staffed in office hours by a member of the IDVA Service and supported and staffed out of hours on a rotational basis by all specialist services

- The provision of **two Community Based Support Services**, one in each of the north and south of the Borough serving families at 'medium' risk. These will provide services for both individuals and affected members of their family, including perpetrators of abuse and young people who harm, using a range of interventions including one to one and group based work. The services will work in a tailored way with service users to establish long term safety and recovery. The ethos of the work will be engagement and enablement to make choices which promote the safety, health and well being and positive contribution of all affected by domestic abuse

- The continuation of the core **IDVA** (Independent Domestic Violence Advocacy) service providing proactive short term support to reduce risk for victims at 'high risk'. This core service is currently enhanced through additional short term funding to implement health based best practice models of having an IDVA in GP practices and hospitals. This core team will be co-located in Macclesfield and Crewe with Children's Services, Police and substance misuse services to improve practice within and across these sectors

- The continuation of the **MARAC** (Multi Agency Risk Assessment Conferencing) administered by the manager and Business Support officer of the IDVA service and split into 'north' and

'south' meetings. This is a high risk information sharing and action planning arena for all agencies tasked with tackling domestic abuse

- The provision of a range of housing solutions for victims who have domestic abuse related accommodation needs. This includes provision of **dispersed and supported housing** in the community as well as the continuation of one high security **refuge**

- **Forming and supporting a skilled and knowledgeable workforce** which can identify individuals and families affected, use referral pathways to specialist services and make a safe and strong contribution to multi-agency interventions

- **Communication** of all the above to those who need it in the most appropriate format to get help to people at the earliest opportunity

- **Long term prevention** through schools healthy relationship work and social marketing campaigns

- **Continuous stakeholder participation** to inform and improve service delivery

3. REASONS FOR THIS MODEL

CEDAP has always sought to implement a 'co-ordinated community response' which is a longstanding best practice model promoted by government and leading specialist organisations and experts.

Nationally this model has been informed and refined by recent Guidance and Reports from:

- National Institute for Clinical Excellence Guidance March 2014 http://www.nice.org.uk/guidance/index.jsp?action=byID&o=14384
- Early Intervention Foundation Report http://www.eif.org.uk/publications/early-intervention-in-domestic-violence-and-abuse-full-report/
- Reports from CAADA (Co-ordinated Action Against Domestic Abuse) which is the leading national organisation developing and implementing new practice in tackling domestic abuse and which set up and quality assures MARAC and IDVA services around the country http://www.caada.org.uk/
- Learning from Serious Case Reviews and Domestic Homicides

Key features of the above are:

Early intervention and prevention
Focus on risk and recovery outcomes
Joint commissioning of high quality specialist services
Simplification and promotion of referral pathways
Adoption of a 'whole family' approach
Address the three issues which triply disadvantage individuals and families – mental ill health, substance misuse and domestic abuse

Workforce development to ensure practitioners are skilled and knowledgeable to provide safe and effective support
Tailoring interventions and approaches to individuals and minority groups

Locally we have been moving to a more integrated **'safer families'** approach over the past year with the commissioning of a perpetrator intervention package which uses a strategy of **'engage and enable'** rather than '**remove and separate'** where this is safe and possible. This promotion of responsibility for behaviour change is the result of practitioner and service user experience of the dynamic of intimate relationships and perpetrator behaviour which tells us that:

- Many perpetrators are 'serial' offenders so that when removed and separated from one family they move on to inflict harm in another thereby replicating harm and public sector cost
- Victims do not necessarily seek an end to their relationship but want the abuse to stop
- Children either want to or are required to remain in relationship with the separated party and it is our duty to ensure that this is safe and good for the child

The focus of this work remains the safety of those impacted by domestic abuse and in particular the children and any related vulnerable adult.

Early evidence from the programme is that the risk posed by perpetrators is better known, managed and where possible reduced and children are better protected and supported through bespoke work for them and their parent/carers.

Cost benefit analysis from the cohort receiving this intervention shows savings of xxxx (Saska)

4. SCALE of the PROBLEM

Domestic abuse is likely to be as underreported in Cheshire East as it is across the country though we have some evidence that high risk victims are accessing IDVA services earlier than the national average which may reflect a strong local tradition of domestic abuse awareness in partner agencies.

We also anticipate additional demand generated by:

- Promotion of one access point and number
- Domestic Violence Protection Notices and Orders
- 'Live' police and early help referrals
- Workforce development/'champions' role which should improve identification and referral
- Embedding of Young People's Violence Adviser function generating referrals for teenage victims and those who cause harm

Below is the picture from end year data March 2014 (more detail in CEDAP Annual Report xx):

a. POLICE

Domestic abuse incidents	1000	Domestic incidents	2617
Repeats	20%	Repeats	17%
Same sex	18		
Influenced by alcohol	305		
Influenced by drugs	58	Serial offenders	78

b. MARAC (high risk victims)

Adult victims	357
Children	455 (approx 50% under 5s)
Repeats	22%
% referrals from police	38%

MARAC numbers have fallen year on year over the last three years but are showing a rising trend since January 2014. It is estimated by CAADA that Cheshire East has approximately 600 high risk victims so a rise in referrals to MARAC may indicate improved identification of those in need of protection

c. SPECIALIST SERVICES

There are three key local providers of community support. Arch and Barnardo's are commissioned providers. CWA is a non-commissioned provider of refuge and community support but also has commissions for early intervention/troubled families, the co-ordination of children and young people's programmes and perpetrator interventions.

Some support is also provided by Victim Support which is commissioned at sub regional level.

There is only one commissioned refuge and this is provided by Arch, the provider in Crewe. Cheshire Without Abuse have secured four Wulvern Housing Trust properties to provide dispersed refuge accommodation, separating living and support functions by providing support at their support centre where one to one and group support are available.

The government is seeking to extend refuge provision and a bid has been submitted (Jan15) to mirror this dispersed model in Macclesfield and build the support element into the commission for the northern provider (currently Barnardo's).

April 13 – March 14

	ARCH	BARNARDO'S	Cheshire Without Abuse(CWA)	Domestic Abuse Family Safety Unit (DAFSU)	**TOTAL**
Referrals for Support in the Community	133	134	283	751	**1301** *(some duplication in this total)*
Service Users	106	100	147	357 high risk cases and 394 contact attempted and 'triaged' where possible	**710**
Refuge referrals (including out of area)	101		27		**128**
Refuge users	51 (90% non Cheshire East)		11 (90% Cheshire East)		**62**

April 14 onwards

Referrals have been rising as specialist services have been accepting live and medium risk police referrals, a function which has now been formally launched as Cheshire East Domestic Abuse Hub.

d. CHILD PROTECTION CONFERENCES – parental factors

	Domestic abuse	Substance misuse	Mental ill health
Quarters 1 – 3 2014-15	229	110	115

Unfortunately we cannot provide any data on domestic abuse as a factor at any other (i.e. earlier) stage of children's services interventions though the nationally recognised correlation between domestic abuse and physical abuse of children is borne out in the 80% of families in Q4 report where children come on to a plan for physical abuse and domestic abuse is a key feature.

5. COSTS

The costs associated have been managed in two ways:

1. Costs associated with Council based high risk services
    a. staff of the Domestic Abuse Family Safety Unit (IDVA and MARAC team, also now providing 'Hub' function) which is funded and governed via a Partnering Agreement
    b. Partnership costs (meetings, publicity & campaigns, target hardening)

2. Costs associated with Commissioned Providers of community services and one refuge which are managed via a Council contract and procured through the 'Chest'

The staffing levels below assume an average of:

800-1000 adult victim service users plus 300 child/YP victim service users

It is important to note that while we attempt to quantify staffing need in relation to individual family members there is an expectation that commissioned providers employ staff who can respond flexibly and holistically to family need

No. Service users p.a.	Length of time case open	Caseload per worker	Staffing required
4-500 High risk – IDVA/MARAC services	3 months	25	4 – 6 (5 to include Polish specialist across high/medium) 1 Lead IDVA for MARAC
4-800 Hub enquiries/referrals/triage cases including Early Help & Protect, all charged police cases...	Assessment only	n/a	1 lead IDVA office hours and supported by staff from commissioned services (+ out of office cover by all specialist services)
4 – 500 medium risk Commissioned services (includes partner support for men on programmes and group work co-ordination/delivery)	6 months	35	8 (supporting m/a 'hub') Cases allocated via hub Groupwork and peer support, volunteering….
300 child service users (children of clients, children on groups, children referred directly)	n/a	n/a	4 (implementing approved change and therapeutic programmes and building peer support and advocacy)

150 perpetrator service users	9 months	n/a	4

COST SCHEDULE

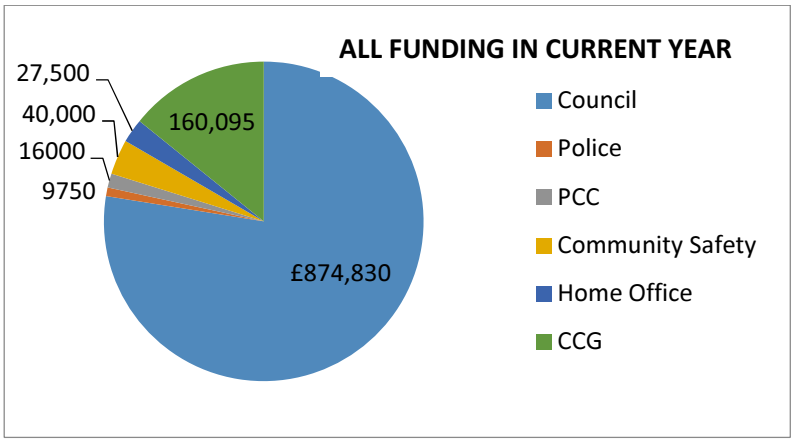
SERVICE or ITEM	DETAIL	COST or ESTIMATE
Domestic abuse and sexual violence Partnership (CEDAP)	Communications Meetings/workshops/conferences	**£5k**
Domestic Abuse Family Safety Unit (Council service)	HUB IDVA 1 IDVA leading on the 'Hub – Single Point of Contact' providing triage for clients, support for professionals and communities, Early Help and Protect process CORE SERVICE 4 core service IDVAs working on high risk cases (including 1 MARAC Lead IDVA) 1 Polish IDVA supporting clients across the risk spectrum 0.5 IDVA providing workforce development 1 DAFSU manager (IDVA and MARAC* co-ordinator) 1 DAFSU Business Support Officer (IDVA and MARAC administrator) TOTAL 6.5 IDVAs **There are clear efficiencies in funding MARAC costs in this way as otherwise it would have to be paid for separately* **ENHANCED PROVISION** *IDVA SERVICE ENHANCEMENTS BASED ON NATIONAL GOOD PRACTICE MODELS* *1 GP IDVA (as per national IRIS model to ensure victims and perpetrators are identified and directed to services* *2 HOSPITAL IDVAs (as per national THEMIS model* *These health based staff are matrix managed by health and the DAFSU so that the postholder benefits from support from both sectors*	**£300k** **Enhanced £100k – funding via CCG and PCC**
2 Community Bases	Flexible 'whole family' workforce - staff capable of delivering a co-ordinated and bespoke service for families referred for support via a range of 1 to 1 work and programmes: Expected need in each base: 6 adult case workers/including change & recovery programme co-ordinators 2 child case worker/including change & recovery programme co-ordinators 1 manager 1 Business Support Officer	**£600k**

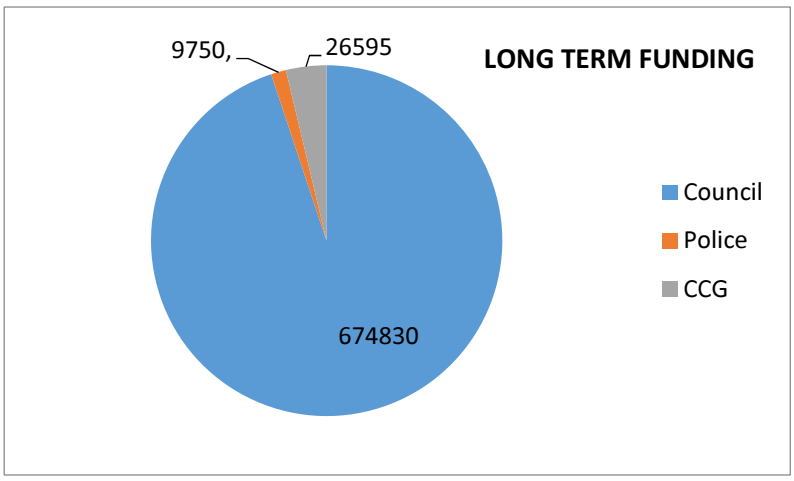
	It is expected that Voluntary Sector organisations will bring added value by attracting charitable funding *It is also recognised that the perpetrator aspects of this work may be part funded via other streams and that while we seek a whole family solution where funding is limited adult and child victims will always be the priority*	
1 High security refuge	This provision will be added to the commissioning specification for the providing of the Community Base in the 'south' of the Borough with an expectation of a shared workforce across both the accommodation and community support aspects of the contract Additional staffing of approximately 1.5 posts	**£50k**
Target hardening	Enhanced security measures - those not living in social housing	**£10k**
TOTAL		**£965k**

6. **COST SHARING**

It is important that commissioners appreciate that there is NO national or automatic funding stream for domestic abuse such is available to respond to the other two critical issues that negatively impact individuals and families – substance misuse and mental ill health. This means that although providers take advantage of new and one off funding streams there has historically been very little security for core services and provision has been patched together through some regular funding and short term allocations.

Currently the costs are disproportionately divided with the Council paying the greatest share (78% of in year funding and 95% of secure continuation funding) as the follow pie charts show:





A detailed breakdown is found in the spreadsheet attached.

And a table of current contributions is shown below

Current Contributor	Current Contribution	Contribution to provide
		CORE HIGH RISK SERVICES
Cheshire East Council Adults Services Base Budget	£75,632	Domestic Abuse Family Safety Unit (MARAC /IDVA)
Community Safety Partnership	£40k	Domestic Abuse Family Safety Unit (MARAC /IDVA)
East CCG	£13,595	Domestic Abuse Family Safety Unit (MARAC /IDVA)
South CCG	£13k	Domestic Abuse Family Safety Unit (MARAC /IDVA)
Cheshire Constabulary	£9,750	Domestic Abuse Family Safety Unit (MARAC /IDVA)
Cheshire East Council Children's Services	£55k (one year)	Domestic Abuse Family Safety Unit (MARAC /IDVA) (includes earlier intervention and training)
Home Office	£27.5k (p.a. to March 16)	Domestic Abuse Family Safety Unit (MARAC /IDVA)
Cheshire East Council Housing	£5k	Target hardening for all victims
		REFUGE AND FLOATING SUPPORT SERVICES (including children)
Cheshire East Council Adults/Supporting People Services	£550k	Refuge (Crewe) and outreach services in Macclesfield and Crewe
Cheshire East Council Children's Services	£60k	Direct support for children based with commissioned providers and co-ordination of programmes
		ENHANCED SERVICES – time limited funding
(South CCG)	£17.5k (sep 14- aug 15)	IRIS Project GP IDVA
(South CCG)	£51k (feb 14 – Jan 15)	Leighton Hospital IDVA
Police and Crime Commissioner	£16k (sep 14 – aug 15)	Macc Hospital IDVA
South and Vale Royal CCG	£65k (Aug 13 to July 14)	Perpetrator/safer families work
Children's Services	£45k	Continuation of safer families work
Cheshire East Council 'giveback' funding	£50k	'Giveback' one year funding for addressing abuse in young people's relationships (CWA working with Safeguarding Children in Education Team)
Cheshire Without Abuse	£300k	Charitable funding

7. OTHER POTENTIAL FUNDING SOURCES

PUBLIC HEALTH

NICE Guidelines recommend that a range of partners sit on the local Domestic Abuse Strategic Group and jointly commission services. The list (p9) includes Public Health but at present no contribution is received from this source. A Public Health Transformation Fund bid has been submitted in conjunction with Cheshire and Wirral Partnership to deliver Safer Families work in an integrated way which would cover Sept 14 to March 16.

TROUBLED FAMILIES/EARLY INTERVENTION

Another additional potential funding source is in relation to earlier intervention with families through the Troubled Families and/or Early Intervention programme. To date the national programme has not specifically included domestic abuse within its key criteria but from April 2015 this will be the case and we hope that local services might in future receive investment from this source and deliver the results which generate further remuneration.

Early Intervention monies are tied up until April 2016 but there may be some opportunity to work with fund holders to support families affected by domestic abuse via this stream.

SUB REGIONAL COMPLEX DEPENDENCY APPLICATION

Funding is being applied for through the Community Safety Sub Regional work stream to address complex dependency including domestic abuse perpetrators and victims. This may result in funding availability to pursue our integrated model.

8. OUTCOMES

Addressing domestic abuse and related factors results in a range of outcomes which meet the requirements of partners and plans including:

Children's Trust

- To help Children and Young People keep and feel safe;
- To support individuals and families as early as possible; and
- To help Children and Young People feel good about themselves and others

Public Health

- *Individuals are empowered to make healthy choices*
- *People are helped to live longer, healthier and more fulfilling lives*
- *the health of the poorest is improved'*

Cheshire East Council Outcome 5 - people are enabled to live well and for longer

GENERAL OUTCOMES

- Victims and children have earlier and Improved access to services through promotion of single Cheshire East DA 'hub'
- Victims and children are safer and better resourced to remain safe
- Risk posed by those harming others is reduced

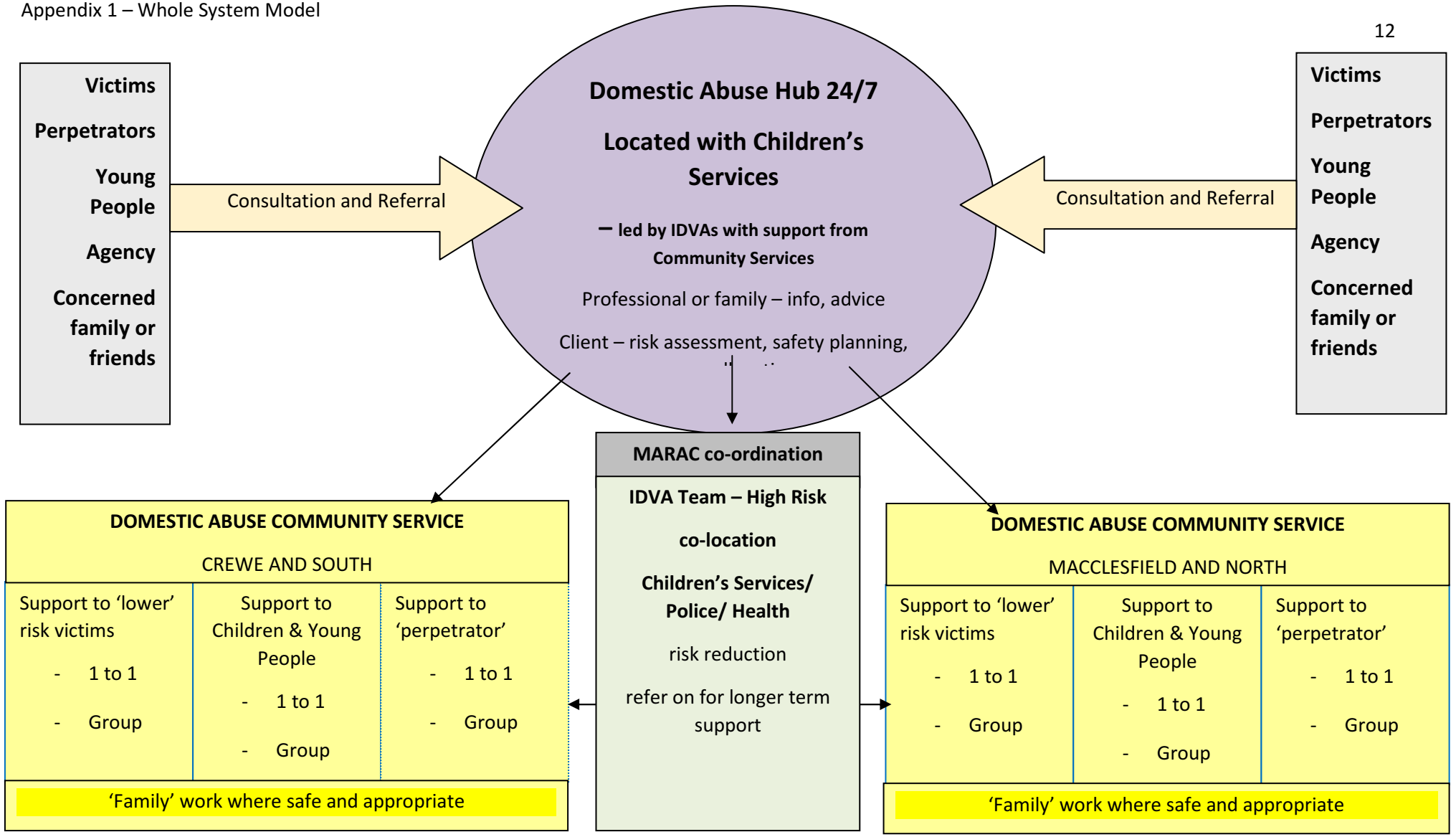
- Service users report improved health and quality of life thereby contributing to PH Outcomes Framework Objective 1 – Improvements against wider factors that affect health and wellbeing and health inequalities
- Parents, including perpetrators, are equipped better to support their children
- Where risk cannot be reduced or managed this information is known and used by other agencies involved or with a remit to be involved, including criminal justice agencies
- Criminal and civil justice systems are used to greater effect in safeguarding vulnerable victims and their children
- Agencies, family and friends who are concerned for others know where to get help
- Services are subject to continuous improvement through participation of stakeholders in shaping delivery
- Good practice in other agencies is more consistently implemented
- Service users are encouraged and enabled to support one another

9. SERVICE STANDARDS

- The safety of all involved, including staff, is the number one priority
- Through a strategy of engagement victims are empowered to take back control of their lives and accountability and responsibility on the part of those who harm is promoted
- Risk is systematically and continuously identified and reduced or managed in relation to individuals, premises and activities
- Interventions are tailored to individuals and families
- Groups who are currently underrepresented are proactively targeted e.g. people from LGBT community
- Group work will be offered where appropriate and agreed programmes will be used to provide consistency across Borough
- Accountability will be provided via a strong performance management system
- All agencies will be expected to work within a 'co-ordinated community response' which assumes strong and effective co-ordination of interventions
- The combined workforce provides specialisms in key related issues – substance misuse, mental ill health, sexual violence, disability, LGBT, honour based violence and forced marriage, young people experiencing Teenage Relationship Abuse
- Staff are safely recruited and supervised
- All referrals and case management are recorded on a shared database
- Longer term savings are evidenced through investment in earlier intervention and prevention

10. CONCLUSION

This is a key moment in our development towards a whole family risk and recovery model which will reduce the human and service cost of domestic abuse. Our aim to make Cheshire East a place where abuse is prevented or addressed at the earliest possible time is ambitious but we believe individuals, families and communities deserve no less. Through strong partnership work at local, borough and sub regional levels we believe we can achieve this goal and urge commissioners to consider their contribution to it.


Victims
Perpetrators
Young People
Agency
Concerned family or friends
Consultation and Referral
Domestic Abuse Hub 24/7
Located with Children's Services
– led by IDVAs with support from Community Services
Professional or family – info, advice
Client – risk assessment, safety planning,
Consultation and Referral
Victims
Perpetrators
Young People
Agency
Concerned family or friends
MARAC co-ordination
IDVA Team – High Risk
co-location
Children's Services/ Police/ Health
risk reduction
refer on for longer term support
DOMESTIC ABUSE COMMUNITY SERVICE
CREWE AND SOUTH
Support to 'lower' risk victims
- 1 to 1
- Group
Support to Children & Young People
- 1 to 1
- Group
Support to 'perpetrator'
- 1 to 1
- Group
'Family' work where safe and appropriate
DOMESTIC ABUSE COMMUNITY SERVICE
MACCLESFIELD AND NORTH
Support to 'lower' risk victims
- 1 to 1
- Group
Support to Children & Young People
- 1 to 1
- Group
Support to 'perpetrator'
- 1 to 1
- Group
'Family' work where safe and appropriate

Cheshire East Domestic Abuse Partnership Strategy

2014-2016

They were very supportive. They provided me with information and phone nos. I could ring if needed. They told me how to keep me and my daughter safe and what to do if my ex partner kept on harassing me and also kept me informed of things before and after the trial of my ex partner. They were there for me if I needed to talk or was worried

They helped me make myself and my children safe in re-locating to a safer place and helping with other matters. The officer was very helpful and went out of her way to help myself and my children. She was very reassuring and understanding. We are very grateful for your help and are happy and safe in our new life now. Thank you

I think more women/men should know about this, information they can get by knowing they are not alone there is people who can listen and help them. I think there should be more advertising about, leaflets, bill boards, adverts, TV and more

Contents

Introduction

This strategy has been formulated to set out the priorities established by Cheshire East Domestic Abuse Partnership's (CEDAP's) Commissioning and Development Group as part of its work to re-design and re-commission all services involved in a co-ordinated community response to domestic abuse. It is informed by significant consultation with those who have experienced abuse and those who have sought to help them and is intended to ensure that strong partnership work is guided by strategic goals.

The strategy builds on an effective track record of partnership to tackle domestic abuse and sexual violence leading to key developments over previous few years including:

- effective delivery of Multi-Agency Risk Assessment Conferencing
- Leading Lights accredited Independent Domestic Violence Advocate Service (Domestic Abuse Family Safety Unit)

- Re-commissioning of refuge and floating support services
- Expansion of one of the decommissioned services to meet gaps in service provision and develop new models of provision
- Establishment of a Sexual Assault Referral Centre services at St Mary's Hospital Manchester
- Independent Sexual Violence Advisory service provided by RASASC (Rape & Sexual Abuse Support Centre)
- New services for men and for significant ethnic minority groups
- Commissioning of the co-ordination of children and young people's group work programmes
- Issuing of LSCB Guidance on safeguarding children from domestic abuse

Whilst CEDAP recognises the existing good practice within the Borough, it is also aware that without consolidating an early intervention and family focused approach our effectiveness will be limited. Therefore the strategy aspires to address not only the needs of victims of domestic abuse (both adults and children) but also to tackle the behaviour of perpetrators and to strengthen the many ways that friends, neighbours, colleagues and professionals can help to achieve prevention, partnership, protection, provision, performance and participation (the 6 'P's).

This strategy is intentionally brief so that all those commissioning or working in domestic abuse can absorb, articulate and play their part in delivery of its key objectives. More detail can be found at the Appendices from page 12 onwards.

Definition

The revised government definition of domestic violence and abuse (Sep 2012) now describes domestic abuse as:

Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse:

psychological *physical* *sexual* *financial* *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

Coercive behaviour is: an act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim."

This definition, which is not a legal definition, includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group.

Vision

The Government's vision within the National Violence Against Women and Girls Action Plan is to:

1. *Prevent violence from happening by challenging the attitudes and behaviours which foster it and intervening early where possible to prevent it*
2. *Provide adequate support where violence does occur*
3. *Work in partnership to obtain the best outcome for victims and their families*
4. *Take action to reduce the risk to women and girls (and men) who are victims of these crimes and ensure that perpetrators are brought to justice*

This ambition is reflected and enhanced under Cheshire East's ambition to

> ***Reduce the human and service cost of domestic abuse through partnership and whole family work to prevent abuse from occuring, protect and support those affected and reduce the likelihood of further harm***

This vision will be realised under 6 key priorities which are described on pp 6-8:

1. Prevention and Early Intervention
2. Protection
3. Provision
4. Partnership
5. Participation
6. Performance

Current Context

Data on the profile of domestic abuse nationally and locally can be found at Appendix 2. These combine with a geographic and social profile of Cheshire East and with local and sub regional priorities to frame CEDAP strategy in the context of the following needs and drivers:

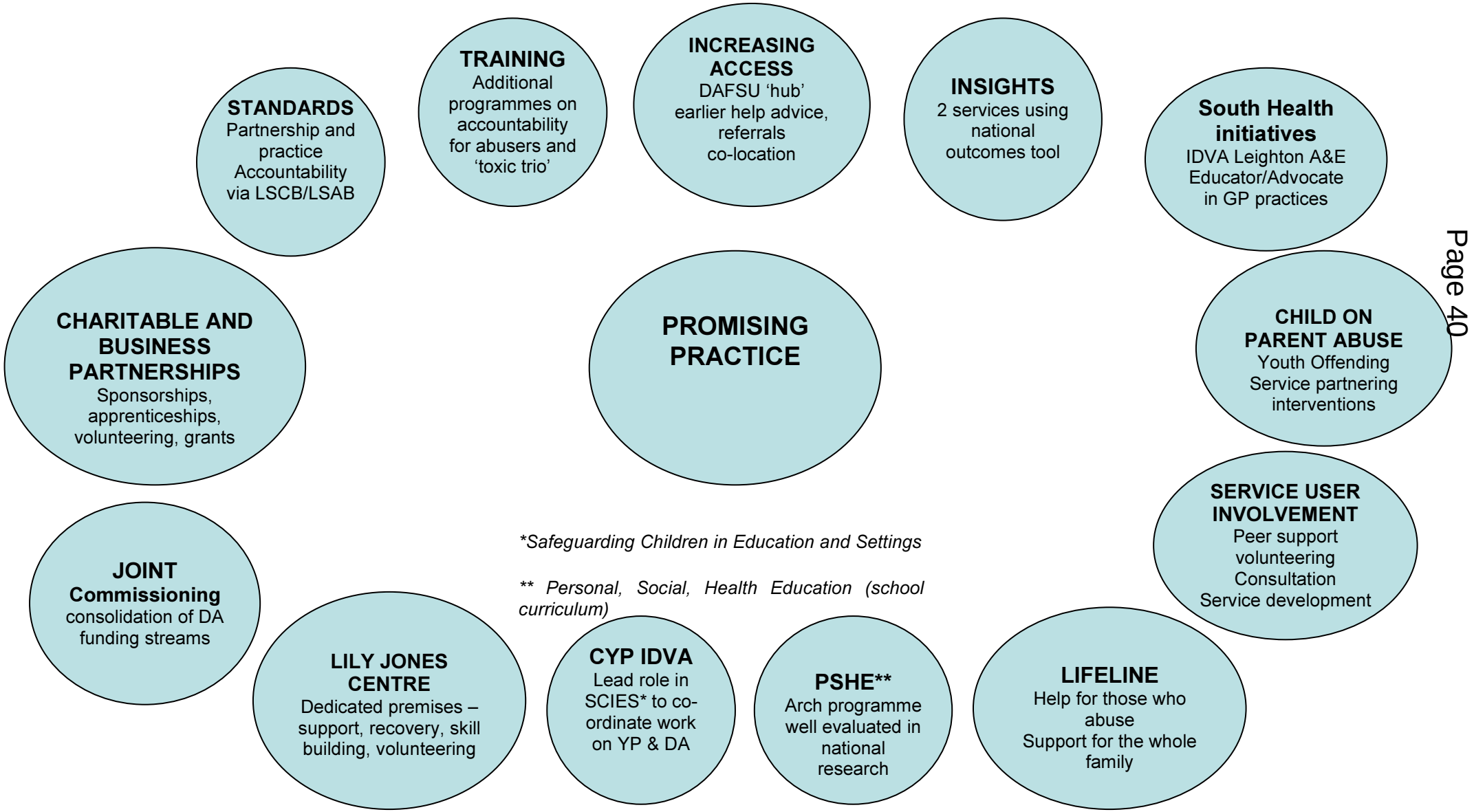
a. Increasing concern to deliver whole family work that involves assessing the risks and needs present within family relationships and delivers safety, accountability and recovery for all
b. More concerted work to address the three key parental issues that are known negatively to impact children and young people – domestic abuse, mental ill health, substance misuse
c. The importance of involving clients constantly in shaping their pathway to independence and to use that experience to drive service improvement
d. The need to address domestic abuse both as a criminal justice and safeguarding issue
e. A need to reach more clients at both ends of the age spectrum i.e. young people in teen relationships or with young children as well as older and vulnerable adults
f. The reality of having only two larger urban populations in Macclesfield and Crewe and needing to ensure access to services for those in more rural areas
g. A duty to address the continued underrepresentation of minority communities in the profile of reported domestic abuse
h. The integration of Health and Social Care and increased focus on joint commissioning
i. Major public sector re-organisation, shrinking resources and increased focus on value for money
j. Increasing opportunities to work more effectively at sub regional level i.e. Cheshire Constabulary footprint
k. Desirability of continued delivery of key work streams through participation in joint sub groups of the Local Safeguarding Children and Adults Boards

Current Provision

An outline of current provision is found at Appendix 4. It demonstrates that many elements of required provision in both specialist and public sectors are in place, albeit to varying degrees and with varying financial security. What is less clearly demonstrable is the effectiveness and efficiency of that provision. There are also some critical gaps and pressures in provision and co-ordination which would, if rectified, deliver improved outcomes for clients and services alike. Stakeholder feedback on what works and what needs to change can be found at Appendix 5.

Emerging Elements of More Effective and Efficient Practice

Neither service delivery nor commissioning are static and CEDAP continues to witness ambitious, creative and reflexive responses to identified need. Below are some very recent initiatives which offer promising developments on which the Partnership can build.



Safeguarding Children in Education and Settings

** Personal, Social, Health Education (school curriculum)

What do we want to achieve? The 6 'Ps'

A. PREVENTION & early intervention

i. Comprehensive publicity/campaigns work targeted at key audiences in appropriate formats

ii. Change work with those who abuse – children and young people's change programmes and adult perpetrator work

iii. Early intervention (asking the question as part of existing assessments or in response to cues from clients)

iv. Training of key professionals who come into contact with any family member affected by domestic abuse on practice standards

v. Ensuring 'early years settings' in particular are proactive in identifying, protecting and supporting children and families

vi. Healthy Relationships Programmes used routinely in Personal Social Health Education and the development of Young Person's advocacy work to ensure young people are supported in and challenged about current and future relationships

B. PROTECTION

i. Safety as the priority for intervention and particularly so for children and vulnerable adults

ii. Effective criminal and civil justice systems which afford protection

iii. Improved use of specialist courts

iv. Increased use and effectiveness of processes and resources to address perpetrator behaviour

C. PROVISION

i. Simplified access to support including one front door - single number/email/text

ii. Specialist services that include provision for all stages and types of adult and child journeys:

IDVA/ISVA – Refuge/safe housing – outreach support – recovery work - support groups – survivor forums - volunteering – skills building – change work where harmful behaviours are identified

iii. Good communication and joint working within and between statutory and third sector provision

iv. Bespoke provision for diverse needs

v. Base in Crewe and Macclesfield for above provision

vi. Use of appropriate media, networks and local services to reach those in rural settings

vii. Quality standards for all work

viii. Shared risk and needs assessment

ix. Programmes for recovery for adults and children

D. PARTNERSHIP

i. DA/SV partnership structure that is fit for purpose, transparent, accountable, properly linked to the work of related 'boards' and commissioning processes

ii. A partnership structure that encourages innovation and promotes best practice

iii. Interconnected and non-duplicating systems founded on shared aims and robust protocols/joint processes

iv. Institutional advocacy whereby agencies hold one another to account for the benefit of clients

E. PARTICIPATION

i. Service users of all ages and types involved in planning and delivery

ii. Communities (neighbourhoods, families, colleagues, friends, institutions, supportive individuals) empowered to take action on domestic abuse and sexual violence

F. PERFORMANCE

i. Monitoring, auditing and evaluation of all work

ii. Shared data/outcomes systems

iii. Shared survey work

iv. Use of analysis of outcomes to inform future service delivery

The Implications for Commissioning

To move from where we are now to where we want to be is a matter both for commissioning and development. Some change will come as a result of pooling monies to re-shape specialist services in line with the objectives above. Some will result from the commitment of partner agencies and Boards to align their own strategies and develop their provision to achieve a shared vision.

The commissioning process is underway. To date we have:

- Secured agreement from existing funding partners to pool funding with a target date of April 2015 for a re-shaped model of specialist service provision
- Consulted service users, providers and commissioners on priorities for change (see Appendix 5)
- Timetabled the key elements of the commissioning process for which Cheshire East Council is the accountable body
- Drawn up a set of practice standards which have been adopted by the bodies to which CEDAP is accountable – Local Safeguarding Children and Local Safeguarding Adults Boards (Appendix 6)
- Identified the main features of a re-commissioned service which are below:

- A 24/7 domestic abuse 'portal' which is a hub for information, advice, referral, assessment, documentation for both clients and those who support them professionally or informally. This 'portal' should link closely to and potentially be co-located with emerging Multi-Agency Safeguarding Hub (MASH) developments
- A single service with a base in both Macclesfield and Crewe or two services working closely together which can respond to all domestic abuse presentations whether from adult or child victim or perpetrator, across the whole spectrum of risk and complexity and from which services for families from protection to recovery and independence can be delivered
- Appropriate housing provision for those who cannot be safeguarded in their own homes in either a dedicated refuge space or through dispersed housing in the community or projects which address the complex needs of some victims
- Involvement in learning and development provision for the rest of the partnership
- Use of agreed monitoring and outcomes systems to evidence achievement and highlight further developments required

The following page sets out a visual of such an integrated service.

To fully establish the final model we plan to:

- Undertake further pathway mapping with service users, providers and other stakeholders to refine the model
- Consult on emerging models with the whole sector
- Agree on the implications of this model for sexual violence support services currently commissioned at sub regional level
- Establish the costs of the model
- Establish contributions for at least a 3 year period to support the model with existing and further partners
- Formulate an agreed Commissioning Strategy
- Undertake a full Equalities Impact Assessment

PREVENTION	PROTECTION	PROVISION	PARTNERSHIP	PARTICIPATION	PERFORMANCE

Campaigns

Publicity

PSHE

Communities aware & informed

Professionals Trained & Proactive

Asking the Q

↓

Think Risk Think Safety

Police call out

CJS process

Consideration Child or Vulnerable Adult Safeguarding

Use of Risk Indicator Checklist

Consideration of MARAC

Immediate safety planning

24/7 Domestic Abuse Service Portal

Advice Information Referral

Case and initial response logged

Risk and needs assessment

Immediate safety work

Case allocated to most appropriate person

BASE IN MACCLESFIELD

Housing if not safe to stay

One2one support for
adult victim
child victim
adult perpetrator

Liaison, joint working with agencies or processes required to address risks and needs

Change Group Work
Adults & Children

Recovery Group Work
Adults & Children

Family work – where safe and appropriate

Peer Support mechanisms

Survivor 'voice' group

Volunteering

Skill building

Service exit as service user

BASE IN CREWE

Quarterly Reports to CEDAP 'Board' including:

Insights (cases – risk management, needs, recovery)

All other activity not captured by Insights

Agency monitoring of DA in cases

Results from Criminal Justice Processes

CONCLUSION

Domestic Homicide Reviews and Serious Case Reviews continue, tragically, to underscore the importance of a robust statutory and voluntary sector partnership response to domestic abuse and sexual violence.

It is CEDAP's ambition to prevent or reduce the impact of such harm and its cost to the public purse and all those who sign up to this strategy are asked to consider their role - as an individual, a service, an agency, a community or a partnership - in making Cheshire East a safe place where everyone has the opportunity to live free from abuse and to realise their full potential.

APPENDIX 1 STRATEGY ACTION PLAN

CEDAP STRATEGY ACTION PLAN							
AIM - Reduce the human and service cost of domestic abuse through partnership and whole family work to prevent abuse from occuring, protect and support those affected and reduce the likelihood of further harm							
	OBJECTIVE	**ACTION**	**LEAD**	**TARGET DATE**	**OUTCOME**	**PROGRESS**	**RISK/ISSUES**
1	**Prevention and Early Intervention**	Produce publicity/campaigns plan in partnership with sub region and local Comms with agreed budget	Comms leads CEDAP manager/	Dec 14	Public and professionals aware/informed re access to help		
		Ensure funding for and reporting from change work with young people and adult	?	April 14	Current and future harm reduction		
		Deliver effective training in single and multi-agency settings, rural networks and minority groups in particular	CEDAP manager/Learning & Dev't Sub group	ongoing	People at risk are identified and supported		
		Ensure 'early years settings' in particular are proactive in identifying, protecting and supporting children and families	SCIES/CYP sub group Dec 2014	Sep 14	Safeguarding of young children		
		Ensure delivery of Healthy Relationships Programmes in Personal Social Health Education and the development of Young Person's advocacy work	SCIES service	ongoing	Children and young people know how to get help at early stages of harm		

	OBJECTIVE	ACTION	LEAD	TARGET DATE	OUTCOME	PROGRESS	RISK/ISSUES
2	**Protection**	Consider/ implement means of increasing accountability for perpetrators -'DV Protection Orders' and Domestic Violence Disclosure Schemes, Navigate Safer, new Probation Programme	Police, Probation	ongoing	Current and future victims safer		
		Evaluate LIFELINE voluntary perpetrator programme	Lifeline Steering Group	Sep 14	Informed decision making about spend on voluntary programmes		
		Work with police and survivor groups to establish a set of standards for police responses and a means of reporting on their achievement	Sub regional Community Safety Group	Jan15	Increased confidence in reporting		
		Resolve challenges of victims being systematically informed of court outcomes and prison releases	SDVC Ops and Strategic group	??	Increased victim safety and satisfaction		
		Work with police to establish 'live' referrals to IDVA service i.e. in immediate aftermath	DAFSU manager/PPU DI	June 14	Increased victim safety and use of CJS		

	OBJECTIVE	ACTION	LEAD	TARGET DATE	OUTCOME	PROGRESS	RISK/ISSUES
3	**Provision**	Establish a Commissioning Strategy that is based on evidence from local and national practice and consultation	CEDAP Commissioning & Development Group	June 14	Better use of pooled resources		
		For financial year 2014-5 sustain 'as is' provision and support developing practice	C&D Group	April 14	Retain adequate service		
		Embed agreed practice standards by carrying out first self assessment process	CEDAP manager	Sep 14	Agencies understand and implement good practice leading to better engagement with victims and restoration of safety and independence		
		Improve responses when domestic abuse, substance misuse and/or mental health are identified as issues for victims and/or perpetrators through training and more formal agreements on proactive prioritisation of clients	CWP/Specialist services	ongoing	Practitioners identify and are confident in dealing with complex needs		

	OBJECTIVE	ACTION	LEAD	TARGET DATE	OUTCOME	PROGRESS	RISK/ISSUES
4	**Partnership**	Ensure CEDAP groups function effectively through more rigorous use of Action Plans and their contribution to this Strategy Plan	Sub group leads	Jan 14	Maximise resources of partnership sector		
		Review co-location work in police stations, hospital, ChECS, GP practices	DAFSU manager/agency leads	ongoing	Increase ease of access and earlier support		
		Encourage shadowing/learning opportunities across agencies	Agency Leads	Ongoing	improved services from more confident and skilled practitioners		
		Promote and learn from identified good practice e.g. work of particular Children's Centres via workshops etc	CEDAP manager	Ongoing	Good practice is celebrated and promoted		
		Use LSCB and LSABs, sub groups, networks to ensure DA/SV considered in key strategies, policies, decisions	C&D Group members on Boards/subs	Ongoing	DA addressed more systematically		
		Ensure existing Protocols, MoUs and other Agreements are fit for purpose and develop others as needed	DAFSU manager, CEDAP manager	Dec 14	All work is framed by appropriate documentation and staff know expectations		

	OBJECTIVE	ACTION	LEAD	TARGET DATE	OUTCOME	PROGRESS	RISK/ISSUES
5	**Participation**	Strengthen the small survivors group in the north of the Borough and resource and consult more regularly the survivors group in Crewe	Specialist Services	Ongoing	Service delivery and planning is informed by the expertise of service users		
		Identify and use other service user mechanisms e.g. Adult Safeguarding Reference Group, Healthwatch	Partners with service user groups	Ongoing	Maximising opportunities to harness service user voice		
		Allocate small budget to service user groups for agreed priority activity	Spec Services Group	June 14	Groups have sense of autonomy in their work		
		Work with LAPs/other community groups to skill up local communities on key prevention activity	Head of Communities	ongoing	Communities take responsibility in prevention and early intervention		
6	**Performance**	Agree a shared performance framework	C&D Group	Jan 14 Onwards	Strengthen peer scrutiny and accountability regarding service delivery and quality		
		Analyse results to inform service planning	C&D Group	ongoing	Development informed by data		

APPENDIX 2

In addition the following national strategies, legislation and Case Reviews have influenced our priorities and actions towards our aim of reducing the harm caused by domestic abuse

Adoption and Children Act 2002 (amended 2005)
ADASS Guidance on Domestic Abuse and Vulnerable Adults
Adult Safeguarding and Domestic Abuse, ADASS 2013
Association of Chief Police Officers (ACPO) Guidelines
British Crime Surveys, 2000/09, Home Office, 2001 – 2010
Children Act, 1989 and 2004
Equality Acts of 2006 and 2010
Domestic Violence Crime and Victims Act, 2004
Domestic Violence Crime and Victims (Amendment) Act 2012
Every Child Matters, (Department for Education and Skills) 2004
Family Law Act, 1996
Female Genital Mutilation Act, 2003
Housing Act, 2003
Human Rights Act, 1998
Mainstreaming the commissioning of local services to address domestic abuse, HM Government, 2009
Mental Capacity Act, 2005
Multi agency practice guidelines: Handling cases of Forced Marriage 2009
National Violence Against Women and Girls Strategic Vision and Action Plan No Secrets (Department of Health) 2010
NICE Draft Clinical Guidance – domestic abuse 2013
Report from the Department of Health Taskforce on the health aspects of violence against women and children 2010
Sexual Offences Act, 2003
Serious Case Reviews of children who have died or been seriously harmed in circumstances involving domestic abuse
Statutory Guidance for Domestic Homicide Review, 2011
Working Together to Safeguard Children, DCSF, 2010 and 2013

APPENDIX 3 National and local incidence of Domestic Abuse

The National Profile of Domestic Abuse

Across England and Wales: -

- There were over 1 million victims of domestic abuse during 2009/10.
- One incident of domestic abuse is report to the police every minute
- Domestic abuse has the highest rate of repeat crime, 35% of all households will have had a second incident within 5 weeks of the first.
- On average 2 women every week are killed by a current or former partner
- 1 in 10 men (10.2%) and 1 in 5 women (19.9%) aged 16 or over have been victims of **stalking** in their lifetime. This equates to a gender-victim ratio of 1 in 3 victims of stalking are male.[1]
- In the UK, it is estimated that up to 24,000 girls under the age of 15 are at risk of **female genital mutilation**.[2]
- At least 12 "**honour**" killings per year in the UK[3] and 5,000 "honour killings" worldwide[4].
- In 2010 the **Forced Marriage** Unit (the joint initiative between Foreign & Commonwealth Office and Home Office), gave advice or support to 1735 cases. 86 percent of these cases involved females and 14 percent involved males. (These statistics reflect an upward trend).
- "In relationships where there is domestic violence, children witness about three-quarters of the abusive incidents." (Royal College of Psychiatrists, 2004). This comes to a total of at least 750,000 children in the UK per year. 5
- of 130 Serious Case Reviews since 2008 relating to children under 1yr old, domestic abuse was a factor in at least 60 cases, substance misuse was a factor in at least 46 cases and parental mental health in 34 cases (NSPCC 2011)
- Women who experience domestic violence are 15 times more likely to use alcohol and nine times more likely to use drugs than women that have not been abused (Barron, 2004).

The National Profile of Sexual Violence - Each year in England and Wales: Source: Supporting Survivors: The Value – A service review of the Rape and Sexual Abuse Support Centre

- 404,000 women survive a recent sexual offence (spectrum includes rape, sexual assault, indecent exposure and unwanted sexual touching)
- 72,000 men survive a recent sexual offence

- Around 90 per cent of survivors of the most serious sexual crimes knew the perpetrator
- Children under 16 account for 34 per cent of rapes reported to the police
- Sexual abuse in childhood (in children under age of 16) affects 16 per cent of children
- 24 in 100 recorded crimes of rape of a female result in a detection or a sanction
- 30 in 100 recorded crimes of rape of a male result in a detection or a sanction
- 30 in 100 recorded crimes of sexual assault of a female result in a detection or a sanction
- 30 in 100 recorded crimes of sexual assault of a male result in a detection or a sanction
- Each adult rape is estimated to cost over £96,000

The Profile of Domestic Abuse within Cheshire East

It is likely that domestic abuse and sexual violence are as underreported in Cheshire East as in other parts of the country. The reasons for this range from fear, shame and barriers to accessing service through a feeling of responsibility to hold the relationship and/or family together.
The British Crime Survey estimates that only ¼ of the worst incidents come to the attention of police so while we may ultimately seek a reduction in the harm caused by domestic abuse an increase in reporting may actually reflect positively on confidence in and access to services. This is particularly the case for some of our minority groups as detailed below.

The following is a summary of reported domestic abuse in Cheshire East:

- 1065 incidents of domestic abuse were reported to police during 2012-13 involving 22% repeat victims
- 3171 domestic incidents were also attended by police
- 387 high risk victims with 470 children were subject to Multi Agency Risk Assessment Conferencing (MARAC). These cases represent the top 10% of victims in terms of risk
- Children under 4 form the largest group and are least able of all children to protect themselves
- The MARAC repeat rate was 30% which is a rise of 8% on the previous year but at the lower end of the expected repeat range nationally. MARAC repeat rate Nov 2013 is 25%
- ¼ victims and perpetrators known to MARAC have some form of mental health problem
- Twice as many perpetrators as victims have problems with substance misuse
- Refuge provision is almost constantly full
- Support for victims to remain in their own homes (floating support) is also significantly stretched

Cheshire East Sexual Violence Referrals to the Rape and Sexual Abuse Support Centre 2012-13

- 172 referrals of which the 2 largest groups were came from the Sexual Assault Referral Centre (SARC) and victims (49 each)
- 84% were from adults aged 18 and over, 16% from 13 – 17 year olds
- 89% were female and 11% male
- 59 constitute 'domestic abuse' in that the perpetrator was a current or former partner or family member
- Only 18 perpetrators were strangers. The rest were known to the family or colleagues or acquaintances

EQUALITIES and LOCAL DEMOGRAPHIC PROFILE

Total Population	372,146	51% female 49% male
Aged 65+	75,300	20% of total population 41,300 females, 34,100 males
16 and 17 year old girls 16 and 17 year old boys	4229 4704	16 and 17 year olds are included in the definition of domestic abuse
Other than White British	6.4%	5.1% of CE residents were born outside the British Isles, with 2.7% born outside the EU. The most common non-British Isles countries for residents to have been born in are Poland and India
Have a disability where 'Day-to-Day Activities Limited a Lot'	29,200	(7.9%)
Have a disability where 'Day-to-Day Activities Limited a Little'	35,600	(9.6%)
Lesbian, Gay, Bi-sexual and Transgender	5-7% population	Source Healthwatch Cheshire East

There is evidence of underrepresentation across all minority groups other than those from the Polish community who have a specialist worker.

Wealth and Deprivation

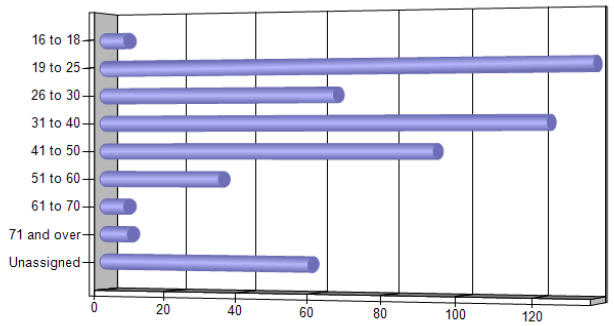
The table below shows significant variation in the rate of high risk victimisation across Local Area Partnerships in 2011-12 with Crewe experiencing the largest number and highest rate across areas and Macclesfield a close second:

LAP	No. High Risk Cases	Rate of victimisation per 1000 population - cases adjusted by LAP population
Crewe	158	2
Macclesfield	100	1.5
Congleton	78	1
Wilmslow	33	1
Nantwich	15	0.5
Knutsford	14	0.5
Poynton	6	0.2

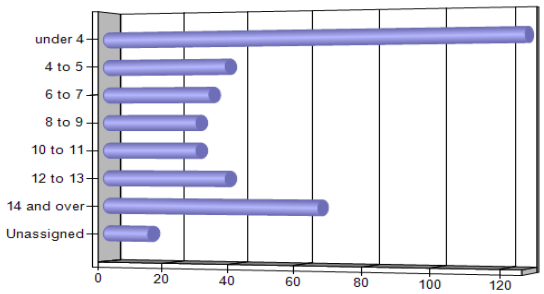
While this might indicate a need to target resources in more urban areas where there are areas of deprivation it is important to recognise that wealthier or rural victims may already be missing out on vital services due to a reluctance to report or opportunity to access services.

Age

The tables below show that young families form the highest proportion of high risk clients while older people are not coming to the attention of services as frequently as they ought to.



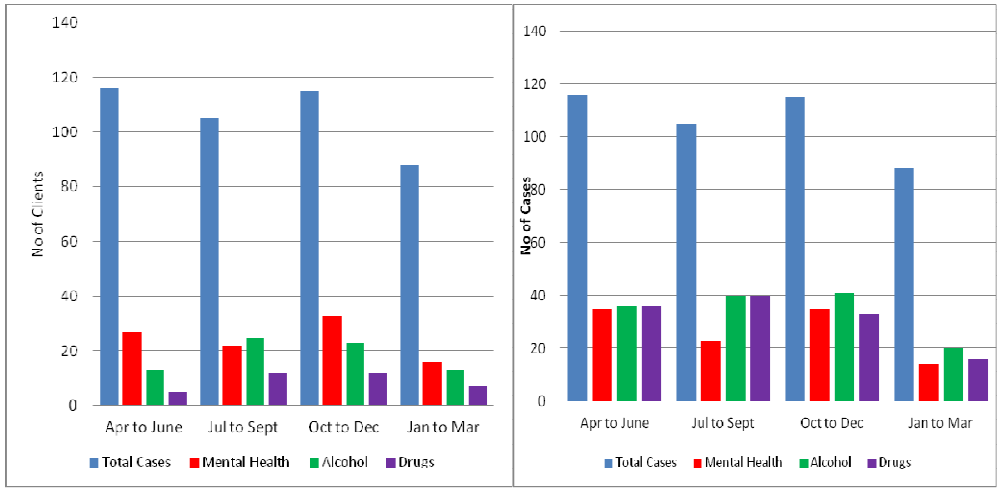
Age of clients of the IDVA (Independent Domestic violence Advocacy) Service



Age of children of IDVA clients

Additional Factors

Substance misuse and mental ill health are frequently related to domestic abuse and while their interrelationship is complex and not causative it is important to address these issues together at a strategic and operational level in order to minimise the harm that is often associated with co-presentation.



Age of clients of the IDVA (Independent Domestic violence Advocacy) Service

MARAC Victims Additional Factors MARAC Perpetrators

Data from the parental factors recorded at child protection conferences confirms the importance of addressing these issues effectively.

Appendix 4 Current Provision

CURRENT PROVISION – Domestic Abuse and Sexual Violence

Perpetrator		Adult Victim	Child Victim
Criminal Justice: incl'g SDVC (Specialist Court) & Community Domestic Violence Programme (CDVP) Multi-agency systems: MARAC, MAPPA, PDP Priority and Prolific Offenders	**Tier 4 (top 10%)** Risk of murder or serious harm (approx 4 - 500 p.a)	MARAC and MARAC + 2 x Refuges (both Crewe + dispersed housing) SARC, RASASC 5 IDVAs + 1 Hospital IDVA + 1 ISVA Criminal & Civil Court (SDVC) Probation Women's Safety Work and SAFE disposal	Children's Social Care MARAC Refuge Spec Services Children's Workers CAMHS RASASC
Voluntary Perpetrator Programme (start summer 13) MH and substance misuse services Troubled Families	**Tier 3** Seriously affected – complex needs Substance misuse; mental ill health	Target Hardening Cheshire Fire and Rescue Service Community Support (Arch, Barnardo's, CWA, RASASC, Victim Support, Survive, NSPCC) IAPT Range Stat'y & 3rd Sector Services Self Neglect meetings (Adults) Troubled Families	Youth Offending Service (YOS) Troubled Families Safeguarding Children In Education and Settings (SCIES) Cheshire East Family Service (CEFS) Youth Services – staty & 3rd Sector
?	**Tier 2** Vulnerable – abuse occurring Not actively seeking help or recovering	Local 24 hour helpline - *(CWA – not commissioned)* Housing Support Recovery programmes Question asked routinely in assessments by some providers 'Screening' e.g midwifery DA info in some key settings Training L1 & 2	NSPCC under 13 SV support & other CAF CE Consultation Service (ChECS) CYP recovery programme (Jigsaw) CYP Prevention programme (Acorns/Changing Places) *(CWA co-ordination-m/a delivery + schools delivery)* Some PSHE Training L1 & 2
Some public campaigns especially at key times Training re new VPP Training L1 & 2	**Tier 1** Prevention – universal (public info)		

APPENDIX 5 SUMMARY OF CONSULTATION FINDINGS 2013

DOMESTIC ABUSE AND SEXUAL VIOLENCE PROVISION

SOURCES OF DATA:

1. End year data from key providers
2. Subregional Community Safety Commission
3. Survivor voices on film
4. Survivor and professional views at Joint Safeguarding Conference May 2013
5. Partnership Surveys
6. Commissioning Workshop June 2013

SUBREGIONAL COMMISSION DA WORKSHOP OUTPUTS - PRIORITIES

A useful summary report is available covering the views of a wide range of agencies across the 4 Local Authority areas covered by Cheshire Constabulary.

• The provision of a ***holistic domestic abuse services for victims,*** survivors, perpetrators and families.
• A focus on ***early intervention to reduce the long term demand for*** domestic abuse services.
• Compulsory ***education on healthy relationships in schools, colleges*** and universities.
• ***Ease of access to domestic abuse services. Every agency to provide the*** opportunity to discuss domestic abuse so that there is no wrong door
• ***Consistent service provision achieved by all agencies committing to*** best practice and implementing current procedures.
• ***Improved skill sets across agencies so that practitioners are able to ask*** the right questions, listen to victims and perpetrators, and recognise risk.
• The provision of ***voluntary perpetrator programmes across the*** Cheshire sub region.

SURVIVOR VOICES ON FILM

Survivors reflect their experience of some very good joint work to address their immediate and long term needs and some inadequacies, including:

- Not being believed or taken seriously
- Waits for access to services required immediately (particularly mental health, DA floating support)
- Failure to identify, record and risk manage the reality of domestic abuse
- Having to repeat their story many times, at some personal cost
- Inappropriate interventions for perpetrators

Many of the survivors of domestic abuse had experienced very serious levels of sexual abuse while others were already vulnerable due to abuse in their childhood

VIEWS FROM THE SAFEGUARDING CONFERENCE WORKSHOP

60 attendees – survivors, commissioners, managers and practitioners - were asked to highlight what problems and what solutions they were aware of in addressing domestic and sexual violence.

PROBLEMS	SOLUTIONS (not correlating to individual problems)
- Not being believed or taken seriously	more training, publicity, getting OUT to providers, community
- telling story many times, passed between services -	single talk to children point of contact
- Treating symptoms, not cause	adult CAF
- Welfare changes making life even harder	consistency from service providers
- Lack of IT infrastructure spanning services	information recorded and shared appropriately
- Wait for services/processes	every door an entry point to services needed/ASK the ?
- No help for or understanding of perpetrator (risks)	Multi-Agency Safeguarding Hub (MASH
- FEAR (of agencies, stigma, perpetrator…..)	walk-in services
	more survivor voices
	more openness about the issue

PARTNERSHIP SURVEYS
'blue skies'

- Continued commissioning /maintaining Sexual Violence provision that is a seamless and consistent service from initial contactOne stop shop
- 24 hour helpline
- Well promoted easily accessible range of services that are all available regardless of postcode
- Greater attention to the needs of young people involved in domestic abuse
- The pay for support workers should also be improved
- All staff and services working on the empowerment model basis

COMMISSIONING WORKSHOP ACTIVITIES
Outcomes Summary

Community	Recognition of and commitment to unacceptability of DA and SV
	Feel confident and equipped to address issues locally
Family	Goals/needs more achievable by co-ordination of early and speedy bespoke service provision
	Service provision easily accessed
Adult Victim	Able to report earlier
	Supported to recover
	Safe
	Health and wellbeing improved
Adult Perpetrator	Challenged and supported to change
Child/Young Person	Understand what a healthy relationship is
	Confident to access support when relationships unhealthy
	Safer and healthier in their family life
Services	Funding stability More confident workforce (own practice and knowing who can help and how to work tog)

Processes that can be changed

- Communicate more
- Ensure SV offers opportunity to reflect on practice and get support for improvement
- Train
- Document concerns
- Give/receive feedback re cases
- Listen to service users
- Raise profile of own service (partic. 3rd sector)
- Keep asking the Q

STOP	CONTINUE	START
- Duplication of services - Working in isolation - Excluding key providers in cases from information or meetings - Requiring service users to repeat their story - 'referring on' without dealing with issues - Making access to services difficult	- Being victim/service user focused - Prevention and early help - Joined up strategic approach - Key elements of specialist provision across risk spectrum - Ask the question - Perpetrator work - Training to support confident professionals - Multi-agency work	- Community response - Comprehensive preventive work in schools - Joint commissioning (across sectors/geog. Boundaries) - Focus on outcomes not outputs - Single Point of Contact - One stop shop - Shared data analysis

	- Sharing information/communicating to keep people safe - Professional challenge - Valuing and involving 3rd Sector	

SUMMARY - RECURRENT PRIORITIES

RE-DESIGN/RE-INFORCE (development rather than commissioning)	PREVENTION/ EARLY HELP	PROVISION	PROTECTION	PARTNERSHIP	PARTICIPATION
CYP awareness strategy	X			X	
Ask the Q/screening	X	X	X	X	
Involve survivors					x
Speedy responses to need	X	X	X		
Single referral form/case documentation		X	X	X	X
Community resourced to protect and be resilient	X			X	X
Focus on empowerment	X	X	X	X	X
Improved volume and quality of communication between providers	X	X	X	X	
Training for those who support – professional & community	X	X	X	X	
Value and involve 3rd Sector	X	X	X	X	X
Data provision – outputs and outcomes					
RE-COMMISSION (things that will need financial resourcing)	PREVENTION	PROVISION	PROTECTION	PARTNERSHIP	PARTICIPATION
Single Point of Contact/Access/24-7 helpline	x	x	x	x	
Family case co-ordination across risk spectrum	X	X	X	X	
Recovery as well as crisis support	X	X			X
Challenge and support to perpetrators	X	X	X	X	X

Shared outcomes systems				x	
Appropriate accommodation – refuge/resettlement		x	x		
Support Centre in Crewe & Macc		x		x	x
Target hardening	x		x		

APPENDIX 6 CHESHIRE EAST DOMESTIC ABUSE PARTNERSHIP – PRACTICE STANDARDS

Name of Agency date of completion name of person completing Audit

			STANDARD	EVIDENCE	ACTION REQUIRED	RATING
A	PREVENTION and EARLY INTERVENTION	1	Posters, leaflets are available in our public and office spaces, including in appropriate language or accessible formats			
		2	Signposting to help, including the Partnership website, is on our agency website			
		3	We get involved in shared campaigns such as White Ribbon			
		3	Where there are indicators of domestic abuse staff make further enquiries in a safe way			
		4	Where domestic abuse is disclosed and there are indications that it is of a serious nature staff undertake the shared Risk Indicator Checklist and make a referral to MARAC if necessary			
		5	We provide or support awareness/education programmes in local community settings, early years, schools, colleges			
B	PROTECTION	1	The safety of clients and related children and vulnerable adults is assessed when domestic abuse is identified and appropriate action is taken according to internal and partnership procedures			
		2	We respect client confidentiality but know and use our responsibilities to share information about risk of harm			
		3	Risk to all affected is identified and reviewed at key stages of intervention			
		4	We support clients to use the criminal and civil justice systems to achieve safety and justice			
C	PROVISION	1	Staff are trained on internal and shared procedures according to their level of responsibility			

		2	Staff work to empower people to take responsibility for their lives and know how to motivate, support and challenge people			
		3	A whole family approach is adopted and referrals are made to appropriate services including programmes for children and young people, adult survivors and perpetrators			
		4	Staff focus on recovery as well as safety as a means of preventing further harm or vulnerability			
		5	Staff recognise that each case is unique and are competent to address the issues that people experiencing less frequently encountered forms of domestic abuse might experience e.g. honour based violence, female on male abuse....			
D	PARTICIPATION	1	An ethos of empowerment is employed at all times to enable service users to take responsibility for decision making appropriate to their individual situation			
		2	Service users' views are proactively sought at every stage of service delivery			
		3	The views of service users are systematically captured and influence service delivery and future planning			
E	PARTNERSHIP	1	Our strategy/policy/procedures recognise that safeguarding is everybody's business and that domestic abuse is a key safeguarding issue which can only be addressed in partnership			
		2	We engage in partnership discussions and arrangements for funding domestic abuse specialist provision			
		3	There is a nominated lead for domestic abuse who takes part in CEDAP work at an appropriate level and raises CEDAP business within our organisation			
		4	There is an up to date Human Resources/Employers Domestic Abuse Policy			

		5	Staff seek and give advice on best practice and undertake and undertake/receive institutional advocacy where there is concern regarding partners' approach or practice			
F	PERFORMANCE	1	Agreed monitoring and outcomes data are supplied in a timely way			

Appendix 7 CEDAP Governance and Structure

COMMISSIONING and DEVELOPMENT SUBGROUP TERMS OF REFERENCE

AIM

To safeguard and strengthen adults, children and communities through establishing and overseeing the implementation of a domestic abuse strategy which is aligned to partnership priorities and commissioning structures in the local authority area, sub region and government.

OBJECTIVES

1. Secure Domestic Abuse Family Safety Unit funding for financial year 2013-14
2. Oversee a performance framework that enables informed decision making about need, provision and outcomes
3. Develop a commissioning strategy which maximises the resources of all budgets, services and partnerships and promotes early and holistic help
4. Determine a CEDAP substructure which can carry out the range of tasks required to fulfil the Group's aim
5. Strengthen stakeholder involvement mechanisms to ensure that partnership work is informed by the experience and views of citizens and agencies
6. Report (jointly) to each Adults and Children's Safeguarding Board
7. Establish an Action Plan to achieve these aims and objectives
8. Determine appropriate links and representation within the range of other Boards and Partnerships connected to domestic (and sexual) abuse
9. Consider options and implications of including sexual violence in the remit of this group

VALUES and PRINCIPLES STATEMENT

The Commissioning & Development Group will exemplify a commitment to:

- equal opportunities and valuing diversity
- reducing inequality and social exclusion
- openness and transparency in its decision making and communications
- non-judgementalism
- working together to maximise safety for all

GOVERNANCE

The group is accountable to the Local Safeguarding Children and Local Safeguarding Adults Boards and will provide a written report to each meeting, highlighting issues requiring decision making or direction.
This report will also be forwarded to the Safer Cheshire East Partnership in recognition of the fact that domestic abuse remains one of their priorities.

MEMBERSHIP

Membership will comprise all funding partners including:

Cheshire East Council Children, Families and Adults
Cheshire East Council Safer Cheshire East Partnership (SCEP)
Clinicial Commissioning Groups
Cheshire Police – local and strategic Public Protection Units
Office of the Police Crime Commissioner

Representation from the following sectors is also needed to inform service planning and delivery

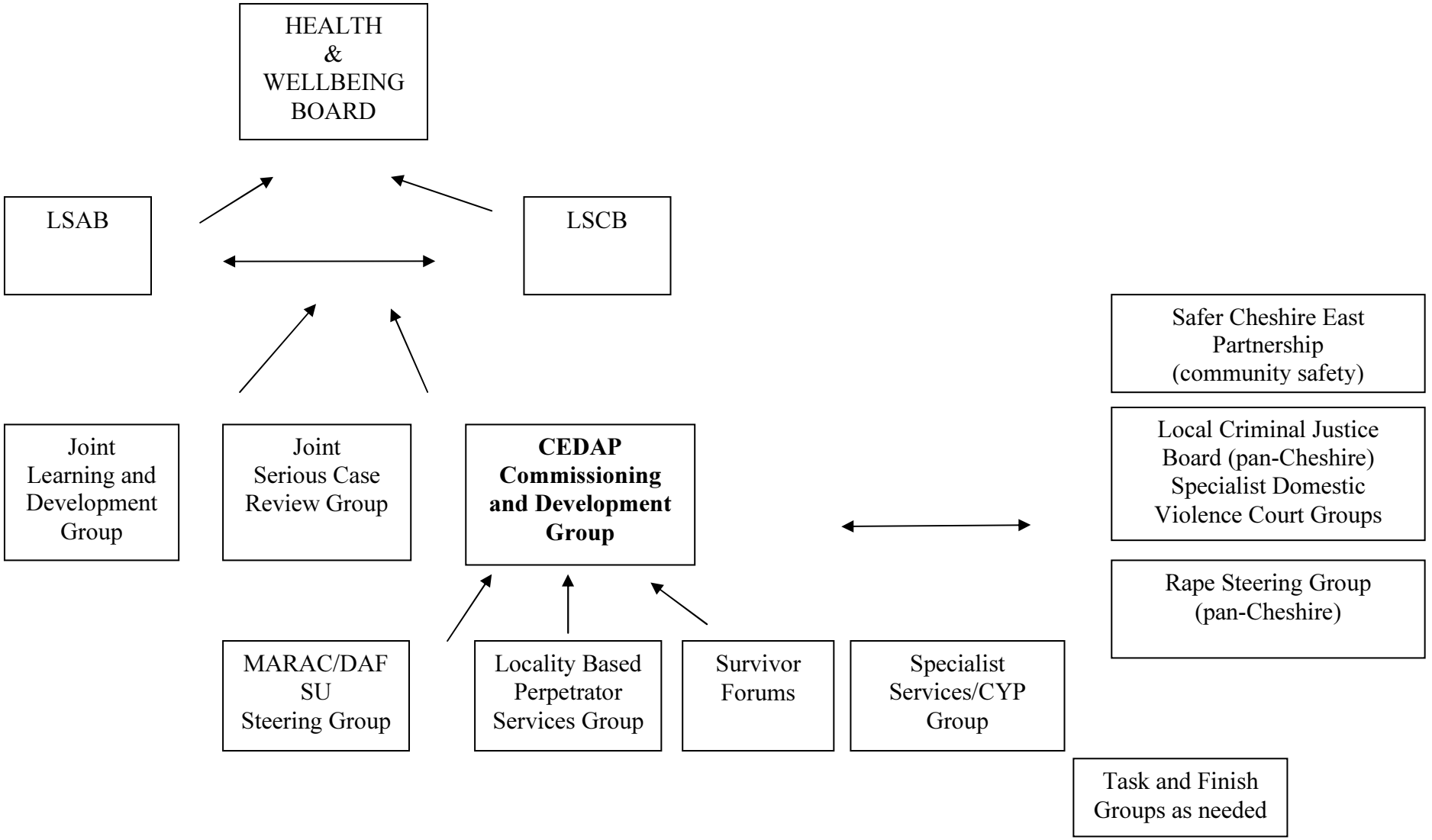
Providers of specialist services representing the voice of service users
Public Health
Mental Health Sector
Drug and Alcohol Sector
Probation
Housing

All Group members are expected to lead on at least one of the Group's objectives

MEETINGS

Meetings will take place approximately 2 weeks before Safeguarding Board meetings in order that a report on progress is available to the Board meetings and agenda items tabled.

SUBSTRUCTURE (see diagram below)



DOMESTIC ABUSE FUNDING - elements of a whole family model

ADULT VICTIM	**Pre April**	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**April 15 onwards**
IDVA SERVICE		**£75,632**		**Council (Adults)**										ongoing commitment
high risk victims,		**£15,000**		**Council (Children - regular)**										ongoing commitment
front door/hub,				**Council (Children - additional)**			£40,000							ends Aug 15
training, MARAC		**£27,500**		**Home Office**										ends March 16
		£13,595		**East CCG**										ongoing commitment
		£13,000		**South CCG**										ongoing commitment
		£9,750		**Police (strategic)**										ongoing commitment
		40,000		**Community Safety**										*advised by CS this is now PCC money*
		74,163		**Underspend**										
GP IDVA				**South &VR CCG GP IDVA**			£17,500							ends Aug 15
Hospital IDVA				**PCC Macclesfield Hospital IDVA**			16,000							
Hospital IDVA	start Feb 14	£51,000		**South &VR CCG Leighton Hospital IDVA**										*post with Leighton Trust*
TARGET HARDENING		**5,000**		**Council (Housing)**										
COMMISSIONED VICTIM SERVICES														
ARCH (South)														
floating support		**£ 234,954.15**		**Council (Adults)**										ongoing commitment
refuge		**£ 52,221.54**		**Council (Adults)**										ongoing commitment
BARNARDO's (South)														
floating support		**£ 261,021.93**		**Council (Adults)**										ongoing commitment
includes Partner Support work for families in Lifeline														
NON COMMISSIONED VICTIM SERVICES														
Cheshire Without Abuse		**£XXX**		**CWA charitable funding & Early Intervention Commission**										
refuge, floating support, 24/7 helpline														
CHILDREN and YOUNG PEOPLE														
prevention/intervention YP abuse				**Council 'Giveback'**			£50,000							ends Aug 15 (CWA/SCIES)
Commissioned Services		**£36,000**		**Council (Children's Services)**										
support for children of clients				**Council (Children's Services)**			£40,000							ends Aug 15
and referrals from CSC/CEFS														
co-ordination of CYP groupwork		**20,000**		**Council (Children's Services)**										
WORK WITH PERPETRATORS														
Lifeline Intervention	start aug 13	**£65,000**		South & VR CCG			£45,000	**Council (Children's Services)**						
							bid to PH Transformation Fund Sep 14 to March 16							
TOTAL		**£993,838**					**£208,500**							

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 27th January 2015
Report of: John Wilbraham, Chief Executive, East Cheshire NHS Trust
Subject/Title: Greater Manchester Healthier Together Consultation

1 Report Summary

1.1 The report has been produced in response to a motion proposed by Councillor Brendan Murphy and seconded by Councillor Lloyd Roberts:

"In the light of plans for the development of sub-regional Specialist Hospitals and the consequent downgrading of other Hospitals in the Greater Manchester conurbation, the Council requests the Health and Wellbeing Board to consider the impact that such developments *could* have on the future of Macclesfield General Hospital and, in particular, to ensure that the wellbeing of North East Cheshire residents will not be adversely affected in the event of Stepping Hill Hospital being downgraded as result the changes being currently considered"

2 Purpose of the Report

2.1 The Board is asked to note the contents of this report and the work being undertaken by East Cheshire NHS Trust (ECT) with its partners in primary and acute care.

2.2 The Board is asked to note the Healthier Together consultation period has ended but no decisions have been made and none are likely until the summer.

2.3 The Board is asked to note that the Caring Together Board, of which Cheshire East Council is a member, will have more influence over service provision locally than the Healthier Together consultation as Healthier Together is looking only at 3 service areas.

2.4 The Board is asked to note that East Cheshire Trust has close working relationships with Stockport Foundation Trust and University Hospital of South Manchester (UHSM) before the Healthier Together consultation commenced and will continue to work together where necessary for the continued provision of safe and high quality care for patients. This relationship is known as the Southern Sector.

2.5 The Board is asked to note that NHS Eastern Cheshire CCG already commissions services from sub-regional specialist hospitals for the population of Eastern Cheshire, including Central Manchester Foundation Trust, Salford Royal Foundation Trust and University hospital of West Midlands in-line with national clinical standards and to ensure access to specialist services 24/7. Services are provided at these specialist centres (eg Neurology and Spinal surgery at Salford Royal) or by the specialist centres at the Macclesfield site in partnership with ECT.

3 Background To Healthier Together

3.1 Greater Manchester Clinical Commissioning Groups have jointly undertaken a consultation about future service delivery given increasing clinical standards and the challenging financial position. This consultation was entitled Healthier Together and was undertaken during the period July 2014 to September 2014.

3.2 East Cheshire NHS Trust and NHS Eastern Cheshire are not formally part of the programme of work, however given the clinical flows of residents into Greater Manchester it is clear that the work could impact on future service provision for patients and as such both organisations have kept close to the work.

3.3 The consultation posed 5 questions to the public and the majority of these questions are in line with questions being posed through the NHS Eastern Cheshire Caring Together programme in terms of changes in primary care, more care out of hospital and meeting clinical standards.

3.4 The issue raised in the motion refers to possible consequences to Cheshire East residents and East Cheshire Trust should there be changes to services at Stepping Hill. In this regard the 5th question is the relevant one for further discussion. It should however be noted that there are possible changes to UHSM where local residents also currently access services.

3.5 The 5 questions posed in the Healthier Together consultation were:

1. **<u>Why Health in Greater Manchester needs to Change</u>**

   We believe health and care services should be provided to a reliable, high standard every time for you and your family. This requires a change to the way services are provided.

   Do you agree or disagree that change is needed.

2. **How Primary Care is Changing**

Our key aims for primary care include:

- Same day access to primary care services, supported by diagnostics test, seven days a week
- People with long term, complex or multiple conditions cared for in the community where possible
- Community based care focusing on joining up care with social care and hospitals and sharing records
- Residents being able to see how well GP practices perform against local and national measures

Do you agree or disagree that change is needed.

3. **How we are joining up Care**

Do you agree or disagree with our proposals for a joined up health and care system, delivered in the community where clinically appropriate?

4. **How we are joining up Care**

Do you agree or disagree that children and young people should be cared for closer to home where appropriate

5. **How Hospital services could change**

We have already changed the way we treat some specialist conditions such as stroke and major trauma and there is evidence that this has saved lives and improved patient care. We want to do more of this as our senior doctors believe that providing specialist care at a smaller number of hospitals in Greater Manchester will raise standards and save more lives.

Do you agree or disagree that:

- Hospital services need to change to meet the quality and safety standards and provide the best care for you and your family
- Providing specialist care at a smaller number of hospitals will raise standards of care to achieve the quality and safety standards
- Doctors and nurses should work in teams that provide care across specialist and local general hospitals as part of a single service

3.6 There could be either 4 or 5 specialist hospitals and members of the public were asked to rank their top three from:

Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital and Royal Bolton hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital and Royal Albert Edward Infirmary (Wigan)
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital and Wythenshawe Hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital and Stepping Hill Hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Albert Edward Infirmary (Wigan) and Stepping Hill hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Albert Edward Infirmary (Wigan) and Wythenshawe Hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Bolton hospital and Wythenshawe hospital
Manchester Royal Infirmary, Salford Royal Hospital, Royal Oldham Hospital, Royal Bolton hospital and Stepping Hill hospital

3.7 Of the 8 options therefore:

Stockport is included as a specialist hospital in 3,
UHSM is a specialist hospital in 3, and
2 options have no specialist hospital in the South of Greater Manchester

4.0 **Impact on Residents of North East Cheshire**

4.1 The impact of the Healthier Together programme on local residents is clearly dependent upon any decision made through the healthier together process.

4.2 There are 2 options, which if implemented, would result in their being no “specialist Trusts” in the south sector of Manchester and would therefore have the biggest impact on East Cheshire residents as they would need to travel further for some specialised services (most likely to Central Manchester FT). It is important to understand that neither option would however affect the main general hospital services provided by Stepping Hill or Wythenshawe for which eastern Cheshire residents predominantly access (including A&E, Out-patients, etc).

4.3 ECT and NHS Eastern Cheshire have highlighted the issue of travel times in their response to the consultation, however both organisations have confirmed their support for the Healthier Together intentions with respect to the raising of clinical standards and improving health outcomes.

4.4 The other options would mean residents travelling either to Wythenshawe or Stepping Hill. These Trusts currently serve residents of Eastern Cheshire.

4.5 NHS Eastern Cheshire will be ensuring that the Caring Together programme of work oversees any recommendations from the Healthier Together programme and ensure that the best interests of the residents are served.

5.0 **Impact on East Cheshire Trust**

5.1 ECT wishes to provide the best care in the right place and it oversees service delivery in 4 tiers. ECT will aim to firstly:

- Provide local services independently where it can meet the required clinical standards and do so within available finance.

- Where this is not possible, it will provide local services in partnership with other providers (this currently happens in the ENT service with support from UHSMT, cancer services with The Christie).

- Where this second option is not possible it will work with commissioners to allow other providers to operate locally for the benefit of residents (This currently happens with the provision of Renal Dialysis provided by a private sector organisation through Central Manchester Foundation Trust)

- Only where all the above options are not possible would we expect patients to travel for their care (for example major trauma services)

5.2 The Trust is not a formal member of the Healthier Together consultation nor is its major commissioner NHS Eastern Cheshire. In this regard the consultation has no formal mandate to impose solutions upon the Trust.

5.3 The Trust does however wish to continue to provide safe, high quality services and recognises that changes may be required for this position to be sustained given increasing clinical and other standards required by bodies such as commissioners, royal colleges and indeed the public themselves.

5.4 NHS Eastern Cheshire will set these clinical standards and ECT will need to deliver against them.

5.5 East Cheshire Trust uses its £180m of financial resources to provide a wide range of acute and community services whereas the Healthier Together consultation is looking at only 3 areas of hospital work, namely:

Accident and Emergency
Acute Medicine
General Surgery

5.6 It is important to recognise that periodically there have been concerns about sustainability of the A&E department at ECT and it should reassure Board members that the Healthier Together documentation states that every local general hospital will have:

- *an A&E department and only the sickest patients will go to a specialist hospital*
- *an acute medical unit caring for adults who need to receive care from hospital teams*
- *general surgery operations for adults (high risk surgery will be provided at specialist hospitals"*

5.7 In terms of high risk surgery very small numbers of this activity currently take place at East Cheshire Trust reinforcing the point that the services being reviewed under the Healthier Together consultation are only a small proportion of the organisations overall service portfolio.

5.8 ECT, UHSM, Stockport and Tameside have been working together for a number of years identifying how they can best work together to support each other in the delivery of high quality care.

5.9 The Trusts are working together to seek to identify how specialist services can be delivered in the South of Manchester/East Cheshire and it is important that this work continues such that any outcome of the Healthier Together work can be delivered collaboratively across the south sector such that the most local provision of services can be maintained.

6 Access to Information

6.1 The Healthier Together programme has a website:
www.healthiertogethergm.nhs.uk

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

Name: John Wilbraham
Designation: Chief Executive, East Cheshire NHS Trust
Tel No: 01625 661500
Email: john.wilbraham@nhs.net

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REPORT TO: Cheshire East Health and Wellbeing Board:

Date of Meeting: Tuesday 27 January 2015

Report of: Lorraine Butcher

Title: Update on the Better Care Fund (BCF)

1.0 Report Summary:

1.1 This Report has been jointly developed by Officers from across both the Cheshire West and Chester, and Cheshire East Health and Wellbeing Boards, with the intention being that the issues raised will be discussed at both meetings.

1.2 Due to a number of issues emerging from both respective BCF submissions, there are some matters which will have an impact across the pan-Cheshire geography. Therefore, it is essential that consistent information is presented to both bodies.

1.3 The purpose of this report is to provide an update on the latest developments regarding the Better Care Fund, and enable discussion and debate on the proposed way forwards for the governance, delivery and monitoring of the schemes associated.

1.4 Both, the Cheshire East, and Cheshire West and Chester BCF plans were submitted to the Department of Health on 19 September. Following the national assurance process both plans were rated as 'Approved with Support'.

1.5 Since the last meeting of the Health and Wellbeing Board, both plans have been upgraded to 'Approved' following dialogue with the Local Area Team, and the submission of an Action Plan.

1.6 The next area of focus is the implementation and delivery of the plans and how this is incorporated into the existing health and social care transformation programmes along with meeting the national reporting expectations. This includes getting into place the required Section 75 agreements (as covered in Appendix One).

2.0 Recommendations:

2.1 These papers are structured to inform Health and Wellbeing Board Members regarding:

a) **Approval of Plans:** Both Health and Wellbeing Boards received letters from Dame Barbara Hakin on 22 December, informing us that our BCF plans had been 'approved'.
This included the statement that: *"We are confident that there are no areas of high risk in your plan and as such you should progress with your plans for implementation."*

b) **Update in National Context:** A number of areas that have submitted large amounts of additional pooling, have revised plans to reflect their minimum allocation (e.g. Dorset moving from over £300million to £60million).

The Planning Process was also reviewed by the Public Accounts Committee (Chaired by Margaret Hodge). This meeting was attended by Simon Stevens, Bob Kerslake, Jon Rouse and others to discuss the process to-date on BCF planning. This included specific lines of enquiry relating to: use of consultants, achievability of 3.5% reduction, and the lack of upfront investment to support plans.

2.2 Beyond the information noted above, these papers have been structured to enable an appropriate discussion and decision making regarding the following issues:

a) **Section 75 Development:** The approval of both BCF plans is subject to an appropriate S75 agreement being put in place. There are a number of options that exist for the approach to this with a range of merits for each. This information is covered in full in the supporting document Appendix 1.0.

b) **Ambition of 3.5% Admission Target:** In the letter of approval received by both Health and Wellbeing Boards, there was a paragraph included by Barbara Hakin that related to the potential to 'revisit' the ambition relating to non-elected admissions, and partners need to be mindful of the potential impact of this target in 2015/16. (Further information in section 8.2).

c) **Wider / Joint Governance of BCF:** Given the potential links between BCF proposals across Cheshire, there is a need to note the Governance arrangements relating to the three transformation programme Boards, and the respective organisation bodies. This also requires input regarding any potential relationship with the Pioneer Panel.

d) **Potential need for a pan-Cheshire group/ BCF Management Group:** The alignment of plans / development of S75 agreements is currently being progressed through informal or existing meetings. It may be required that a dedicated group is established to own these issues.

e) **Contracting approach for 2015/16:** There needs to be due consideration given to the contracting approach for 2015/16 in-light of these new arrangements.

3.0 Reasons for Recommendation(s):

3.1 There is a need for clarity regarding the management, oversight, and delivery of the BCF schemes, and these issues require cross-partner discussion and agreement before full arrangements can be put in place.

3.2 Nationally there is significant focus on the impact of the BCF particularly on the impact on reducing non elective admissions (as established at 3.5%). Locally,

there is an expectation that BCF schemes will be implemented and operational from April 2015.

3.3 Furthermore, the need to clarify partner's positions on the structure of S75 agreements, and the level of ambition regarding non-elective admissions has illustrated the challenges presented by existing governance arrangements, especially in relation to any potential to operationalise BCF proposals on a pan-Cheshire basis.

4.0 Policy Implications:

4.1 The integration of Health and Social Care services is a key area of public sector reform, and has been subject to significant press-coverage and academic analysis. The Better Care Fund as launched through the Comprehensive Spending Review of 2013 formalises joint initiatives throughout 2015/2016.

4.2 There is significant cross-party support for the integration of services amongst national political parties. However, there is little clarity regarding the medium- term commitment to the Better Care Fund as a process post April 2016. This creates a number of risks to the plans already developed by areas, whilst also presenting an opportunity for areas to significantly shape their own longer-term proposals.

4.3 However, significant elements of the BCF are linked with the implication of the Social Care Act and other areas of long-term statute. This includes specific issues relating to eligibility criteria, and safeguarding boards.

5.0 Financial Implications

5.1 The BCF has a total value of £23.8million for Cheshire East partners; the equivalent figure for the Cheshire West and Chester Health and Wellbeing Board is £24.3million. Within these financial envelopes funding has been allocated to individual schemes and areas as agreed within our final submissions.

5.2 Finance officers from across both Health and Wellbeing Boards have met on a number of occasions to progress the work, and this information is covered in more detail in Appendix One. However, there remain fundamental questions regarding the following financial issues:

a) How many S75 agreements will be put in place?
b) Who will host each of the pooled-budgets?
c) The time period covering the pooled-budgets?
d) Risk sharing agreements relating to the non-delivery of schemes?
e) Framework for the monitoring, delivery and reporting of schemes?

5.3 It is the aim of all partner organisations to limit exposure to the risk of financial pressures as part of the delivery of the BCF and robust financial management and monitoring will be essential. Therefore, and in-line with the guidance issued to date, it is being recommended that each of the schemes funded through the BCF will be underpinned by a specific S75 agreement (a Tier-Two Agreement).

6.0 Legal Implications:

6.1 The BCF is a nationally mandated process for Health and Wellbeing Boards to comply. The next phase of implementation requires the development of a S75 agreement (National Health Service Act 2006 Partnership Agreement) to support any pooled budget arrangements.

6.2 The BCF also incorporates some statutory duties relating to the Social Care Act, in particular; Carer's Assessments, Information and Advice, and the eligibility criteria of local residents.

7.0 Risks:

7.1 Both BCF plans included risk-registers. Dependent upon the geography on which S75 agreements are operationalised, there will be a need to further align or distinguish these registers.

7.2 There is a need to refresh this risk-register, both in-light of the further development of the schemes contained within the BCF, but to also reflect the current context of services, and existing performance levels.

7.3 Finally, a decision needs to be made regarding the reporting of exceptions against these issues.

8.0 Area's for Discussion and Decisions Required:

8.1 Governance and Commissioning Arrangements:

The planning process associated with the BCF has been valuable in strengthening relationships across health and social care, leading to constructive challenge, widespread sharing of information, and significant amounts of collective planning. The process has also exposed some opportunities to clarify commissioning and governance arrangements to ensure that services are developed to support the local community.

Consideration needs to be given to how BCF governance is either incorporated into existing governance arrangements or amendments are made to ensure that governance arrangements exist for BCF. The role of both Health and Wellbeing Boards should also be considered as part of any discussion about governance arrangements as the recently released CIPFA, 'Pooled Budgets for the BCF' guidance advises considering operating the pooled budget through a sub-committee of the HWB.

All partners are mindful that there is risk that a poor alignment of governance and commissioning arrangements would lead to both gaps in service provision and inconsistent quality. Furthermore, there is an inverse risk that poor alignment will result in significant duplication and repetition of information and reports to boards.

8.2 Section S75 Development: (Covered in Appendix One):

8.3 Potential to Revisit the 3.5% Non-Elected Admissions Target:

In the letter of approval received by both Health and Wellbeing Boards, there was a paragraph included by Barbara Hakin that related to the potential to 'revisit' the ambition relating to non-elected admissions:

"We recognise that some areas may want to revisit their ambitions for the level of reduction of non-elective admissions, in light of their experience of actual performance over the winter, and as they become more confident of the 2014/15 outturn, and firm-up their plans to inform the 2015/16 contracting round. Any such review should include appropriate involvement from local authorities and be approved by HWBs. NHS England will assess the extent to which any proposed change has been locally agreed in line with BCF requirements, as well as the risk to delivery of the ambition, as part of its assurance of CCGs' operational plans."

Further information contained within this letter provids more clarity regarding the full value of the element of the fund linked to non-elected admissions being paid over to the CCGs at the start of the financial year, only to be released in full upon the achievement of results. Moreover, if this target is not achieved the CCG(s) may release only part into to pool that is proportionate to the completion of the target. Any part of the funding that is 'held-back' or not released into the local BCF pool must be dealt with in-line with NHS England requirements.

In addition it must also be noted that within the 'Supplementary information for commissioner planning 2015/16' from NHS England

'Through the review CCGs will need to be confident, together with Councils and providers, that they have translated their initial ambition to firm and deliverable planning assumptions on which NHS acute capacity provision can be safely based'

This creates a significant challenge to partners as the current level of performance is above the baseline included within the BCF. Therefore, there is a need to ensure that there is a collective view across partners to ensure that any revision of ambition reflects this guidance.

8.4 Implementation and Delivery:

There are approximately 9 weeks or 45 working days until the BCF is officially in operation on 1 April 2015.

The oversight of the development of the BCF plan has been undertaken within each Authority through existing structures, for example the Joint Commissioning Leadership Team in Cheshire East and the BCF Working Group in Cheshire West and Chester. In the coming weeks the implementation of plans has to pick-up pace, therefore requiring light-touch decisions, advice and guidance on a regular basis. Whilst much of this is linked directly to activity that is already underway as part of the respective transformation programmes, there will be ongoing issues requiring input.

8.5 There are on-going discussions relating to the governance and reporting structures in relation to the Better Care Fund. The arrangements relating to project management and routes of escalation for issues need to be identified.

Clearly as relationships mature and difficulties arise due to culture and organisational priorities, the development of these structures and implementation of schemes will identify a number of issues which will need to be resolved.

9.0 Access to information

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REPORT TO: CHESHIRE EAST HEALTH AND WELLBEING BOARD

Date of Meeting: Tuesday 27th January 2015

Report Of: Lorraine Butcher

Title: Update on the Better Care Fund: Appendix One: Section 75 Development

1.0 Report Summary:

1.1 It is a statutory requirement for a Section 75 pooled budget agreement to be developed to support the delivery of the Better Care Fund plan from 1 April 2015. The Better Care Fund is a national initiative to encourage integrated Health and Social care working at a local level and to improve outcomes for patients, service users and carers. To date, the BCF plans and allocations have been developed on a Health and Wellbeing geographic and organisational footprint, with both submissions containing the expectation that any S75 agreement would reflect this geography. Further guidance has now been issued in respect of the formation of a S75 fund agreement and it has become apparent that there will be a pooled fund for each scheme with a host partner allocated for each pool. This gives the opportunity to more closely reflect the current strategic footprints of the West Cheshire Way, Connecting Care and Caring Together.

1.2 This paper outlines a number of options for the potential structure of the s75 agreements, the partners involved, the financial value of the schemes in the BCF applications and prospective merits of each. A collective Strategic decision from all partners is required to agree and confirm which proposed S75 option to progress and develop so that a pooled budget arrangement can be operational from 1 April 2015.

1.3 Consideration also needs to be given to the General Election which is due to take place in May 2015 and this may lead to further changes to the Better Care Fund. A local ambition and ongoing support for an arrangement for integrated care regardless of the national direction will provide a more stable platform for developing the s75 agreement locally.

1.4 Given that there are potentially six partners, this paper does not provide an overarching recommendation as all partners are assumed to be equal for the purposes of this decision. A consensus decision will need to be reached in order to facilitate working relationships across the Cheshire Area and to truly embed the principles of integrated working.

2.0 Recommendation

2.1 A Strategic decision is required on the following matters:

i) The S75 option and structure to be used to support the BCF. The preferred option is option four (as agreed by the Cheshire West and Chester Health and Wellbeing Board on 14th January 2015).

ii) The local ambition to support ongoing pooled-budget arrangements in-light of the lack of clarity for medium-term for the BCF due to the general election.

3.0 Options for BCF s75 Pooled Budget Agreement

Local discussions across partners have taken place throughout November and December regarding the potential approaches to the S75 agreement. During these discussions a number of issues for consideration have been raised:

- Existing proposals and plans have been developed on a Health and Wellbeing Board footprint.
- The ability to develop and implement proposed S75 by 1 April 2015.
- The BCF is currently only covering the financial year of 2015/16 so there is input needed regarding the longer-term intentions locally.
- The governance and reporting arrangements that are required for the Health and Wellbeing board, the CCG Governing Bodies and NHS England

The governance arrangements supporting the s75 Better Care Fund pooled budget arrangement are fundamental to the smooth delivery and implementation of the BCF plan and ensuring the level of risk both financial and non-financial the council, CCGs, partner organisations and providers are exposed to. This has been supported through the publication of CIPFA guidance, and the 'mock' templates issued by NHS England and produced by Beavan Brittan.

The following options exist for the structure of S75 agreements across Cheshire, and each will be presented in more detail:

Option 1: Pan-Cheshire	One over-arching S75 agreement on a pioneer geography, including all six partners.
Option 2: Bi-Cheshire	Two over-arching S75 agreements on Health and Wellbeing footprint, with three signatories to each.
Option 3: Tri-Cheshire	Three over-arching S75 agreements reflecting the geography of existing transformation programmes. (See below)*
Option 4: Four separate agreements	Four over-arching S75 agreements reflecting the geography of the Clinical Commissioning Groups with the ability for reporting to be consolidated on a transformation programme basis and a Health and Wellbeing Board basis.

Option 3 Structure of S75 agreements:

Transformation Programme Locally:	***No. partners***	***Named Partners:***
Connecting Care in Central Cheshire.	*4*	*NHS South Cheshire CCG;* *NHS Vale Royal CCG;* *Cheshire West and Chester Council* *Cheshire East Council*
Cheshire West Way	*2*	*NHS West Cheshire CCG* *Cheshire West and Chester Council*
Caring Together in East Cheshire.	*2*	*NHS Eastern Cheshire CCG* *Cheshire East Council*

Further information on each of these options is presented below.

3.1 Option One: Pan-Cheshire Section 75 Agreement:

This financial mechanism would operate across Cheshire (including both Health and Wellbeing Boards). This would reflect the Pioneer footprint, therefore including all four CCGs and both Local Authorities. This would reflect the ambition of partners to integrate across the Cheshire geography, and inform planning better aligned to the flow of patients.

This option would propose combining the BCF budgets of £24.3m and £23.9m respectively across the County. Indicatively, this would be structured as illustrated below:

Oversight of the BCF	Pioneer Panel / or a Pan Cheshire HWBB.
No. of S75 agreements	One overarching
Number of partners	6
Geographic Area	Pan Cheshire
Value of Pooled Budget	£48.2m
Number of schemes	24
Pooled Budget Hosts	*TBC*

Potential Strengths of this approach:

a) This approach demonstrates the ambition of partners and aligns with the wider pioneer ambition over coming years.
b) This approach provides an opportunity to develop integrated health and social care services across Cheshire
c) Reduces duplication and provides a platform to share risk across a greater number of organisations.
d) This provides an opportunity for the provision of more consistent services across Cheshire, and for us to better align services to patient flows.

Potential Weakness of this approach:

a) It would become more challenging to get quick decisions across partners due to the breath of organisations involved.
b) Except for the Pioneer Panel there are no pan-Cheshire governance arrangements in place, and there would be a need to ensure that this did not hinder or hamper the wider pioneer work.
c) This would not be aligned with the BCF proposals submitted by partners in September.
d) Performance and financial monitoring needs to be transparent to provide confidence to partners.
e) Performance and monitoring would need to be disaggregated to a CCG and HWB level.
f) This decision has not yet been approved by organisation's governing bodies
g) There is a risk that this would create some politically sensitivities across partners, especially with the uncertainty on issues following the general election.

3.2 Option Two: Bi-Cheshire Section 75 Agreements:

This financial mechanism would operate on the individual geography of each Health and Wellbeing Board. This would therefore require two S75 agreements with three partners acting as signatories to each, as reflecting the organisations which approved each submission. These two S.75 agreements would be worth £24.3m and £23.9m.

This reflects the partners that have developed and approved the plans to date, and the assumption for S75 operations as submitted in plans. This is also the current expectation of partners following our Nationally Consistent Review process.

However, the emerging issue with this approach is the overview of the Connecting Care in Central Cheshire Programme (South, Vale Royal, CWAC, and CEC). The CCGs in this programme are currently making progress across social care boundaries, but are divided by the HWBB geographies.

Oversight of the BCF	Cheshire East Health and Wellbeing Board	Cheshire West Health and Wellbeing Board
No. S75 Agreements	One for Cheshire East	One for Cheshire West
Number of partners	3	3
Area Covered	Cheshire East	Cheshire West
Total Value	£23.891m	£24.3m
Number of schemes	11	13
Pooled Budget Hosts	TBC	TBC

Potential Strengths of this approach:

a) Aligned with BCF plans that have been submitted nationally and that have already been approved and quality assured.
b) BCF plans Signed off by statutory bodies co-terminus with the geography of the plans.
c) Furthermore, the existing governance structures of partners have the potential to be aligned to include updates on these issues.
d) Provides an opportunity for consistent services across respective local authority social care provision
e) More realistic workload for implementation by the 1 April 2015.
f) The partners that have approved each plan are naturally well informed regarding its content. This approach keeps organisations closely linked to plans that they have jointly-designed, rather than expanding interest across new plans that they have had little involvement in.

Potential Weaknesses of this approach:

a) The proposal does not reflect the strategic direction of West Cheshire Way, Connecting Care or Caring Together, causing a lack of alignment for all areas.
b) There will need to be disaggregation in all reporting to an individual CCG basis as reporting will be required to the CCG Governing Bodies as the Statutory Bodies responsible for these funds.
c) Differing approaches by the two councils will not be highlighted using this approach leading to confusion for patients and carers within Central

Cheshire as they will be potentially dealing with disparate social service systems..

d) Using 2 S75s will ensure that Social Services partners remain only informed about the plans which they have been previously involved in producing, it is imperative that both social services partners understand the impact on patients of lack of consistency for Vale Royal and South Cheshire CCG patients when accessing social services provision from local health services.
e) The approach does not reflect patient flows.
f) There is a potential weakness for Central Cheshire partners regarding both the double reporting of progress to both health and wellbeing boards, and the wider alignment of plans to the Connecting Care in Central Cheshire programme.
g) Different approaches across the Health and Wellbeing might lead to inconsistencies in approach to Central Cheshire
h) Finally, this does not reflect the patient flows across the Borough or our larger ambition as a Pioneer area.
i) This decision for 2 S75s has not yet been approved by organisation's governing bodies

3.3 Option Three: Tri-Cheshire S75 Agreements:

To support the existing health transformation programmes the BCF plan could be aligned to the health locality geography and the existing transformation programmes.

The emerging issue with structuring the S75 agreements on a health and wellbeing board footprint is the issue of consistency for Central Cheshire partners, as highlighted above. The CCG are currently working across social-care boundaries, and therefore, across BCF geographies. This would require dividing the BCF schemes, and assigning them to the appropriate locality level. Under the guidance each scheme represents an individual pool with a designated pool manager for all of the S75 options so this should not be an issue for health.

	Caring Together:	**Connecting Care in Central Cheshire**	**West Cheshire Way**
Oversight of the BCF	Cheshire East Health and Wellbeing Board	Cheshire East Health and Wellbeing Board Cheshire West Health and Wellbeing Board	Cheshire West Health and Wellbeing Board
Three s75 agreements	Caring Together	Connecting Care	West Cheshire Way
Number of partners	2	4	2
Area Covered	Eastern Cheshire	South Cheshire and Vale Royal	Western Cheshire
Value of Pooled Budget	£11.612m (CCG) £0.953m (Council) *£12.565m*	£10.481m (South CCG) £0.845m (CEC)	

		£11.326	
Pooled Budget Hosts	To be decided	To be decided	To be decided

Potential Strengths of this approach:

a) Aligned with health localities, therefore strengthening the oversight and BCF schemes on the ground.
b) This would also help to align financial and performance reporting is to locality areas.
c) Existing governance structures have the potential to be aligned (for example the Provider Board, and Connecting Care in Cheshire Partnership Board).
d) There are strong existing working relationships across partners involved in each of these areas.
e) Supports required reporting to both CCGs and HWB
f) Reflects patient flows across health areas and will allow greater patient focus.

Potential Weaknesses of this approach:

a) Performance information from the Council is not reported on a health locality basis.
b) Whilst this does provide some more consistency for Central Cheshire partners, it does not alleviate the need to report to two Health and Wellbeing Boards.
c) This model does not reflect the patient flows across the whole of Cheshire or the ambition stated in our Pioneer Programme.
d) Health and social care is not integrated across a Health and Wellbeing board basis, and it does not reflect the geography on which plans were approved.

3.4 Option Four: Bi-Cheshire Section 75 Agreements:

This financial mechanism can be consolidated to operate on the individual geography of each Health and Wellbeing Board and can reflect the health transformation programmes. There would be four separate s75 agreements which are aligned with the CCG boundaries and there would be two signatories.

This reflects the partners that have developed and approved the plans to date, and the assumption for S75 operations as submitted in plans. This is also the current expectation of partners following our Nationally Consistent Review process.

	Eastern Cheshire	**South Cheshire**	**Vale Royal**	**Western Cheshire**
Oversight of the BCF	Cheshire East Health and Wellbeing Board	Cheshire East Health and Wellbeing Board	Cheshire West Health and Wellbeing Board	Cheshire West and Chester Health and Wellbeing Board
Four s75 agreements	Eastern Cheshire	South Cheshire	Vale Royal	Western Cheshire

Number of partners	2	2	2	2
Area Covered	Eastern Cheshire	South Cheshire	Vale Royal	Western Cheshire
Value of Pooled Budget	£11.612m (CCG) £0.953m (Council) £12.565m	£10.481m (South CCG) £0.845m (CEC) £11.326		
Pooled Budget Hosts	To be decided	To be decided	To be decided	

Potential Strengths of this approach:

a) Aligned with health localities, therefore strengthening the oversight and BCF schemes on the ground.
b) This would also help to align financial and performance reporting to locality areas.
c) Existing governance structures have the potential to be aligned (for example the Provider Board, and Connecting Care in Cheshire Partnership Board).
d) There are strong existing working relationships across partners involved in each of these areas.
e) Flexibility to report at a local CCG level and options to consolidate at a health transformation programme basis; local HwB and on a Pan Cheshire basis if required
f) Opportunity to introduce standardised performance and finance reporting to assist with consolidation of information
g) Opportunity to progress schemes on a local basis whilst also developing an overarching strategic commissioning approach

Potential Weaknesses of this approach:

a) Performance information from the Council is not reported on a health locality basis.
b) Whilst this does provide some more consistency for Central Cheshire partners, it does not alleviate the need to report to two Health and Wellbeing Boards.
c) Differing approaches by the two councils might not be highlighted using this approach leading to confusion for patients and carers within Central Cheshire as they will be potentially dealing with disparate social service systems.
d) Information would need to be consolidated to report to respective health and wellbeing boards and there would need to be adequate resources identified to support this

4.0 Feedback from the Local Area Team:

Contact has been made with NHS England colleagues through the Local Area Team to gain their insight into this subject. These emails answered some questions put forward on behalf of the officers that developed this paper.

As noted above NHS England was not in favour of a single pioneer wide S75 arrangement for Cheshire as there is not a single HWB across Cheshire although they supported cross Cheshire working.

NHS England was clear that reporting is required at both individual CCG and HWB level.

NHS England was not specifically asked if the arrangements for 3 or 4 s75s, noted above with strong and focussed governance and reporting would be acceptable.

5.0 Potential Option for discussion:

The feedback from the LAT and the guidance issued to date seemingly promotes the use of a bi-Cheshire approach, structuring the S75 agreement in-line with the HWBB geography. However, this does not reflect the wider ambition of partners and the needs of specific geographic areas within Cheshire.

Therefore, following discussion at the Pioneer Panel it has been suggested that we could use a phased approach to move towards a more appropriate framework. This would include a tiered model of schemes to an appropriate level, with S75 agreements developed to reflect the geography, scope and appropriateness of these initiatives.

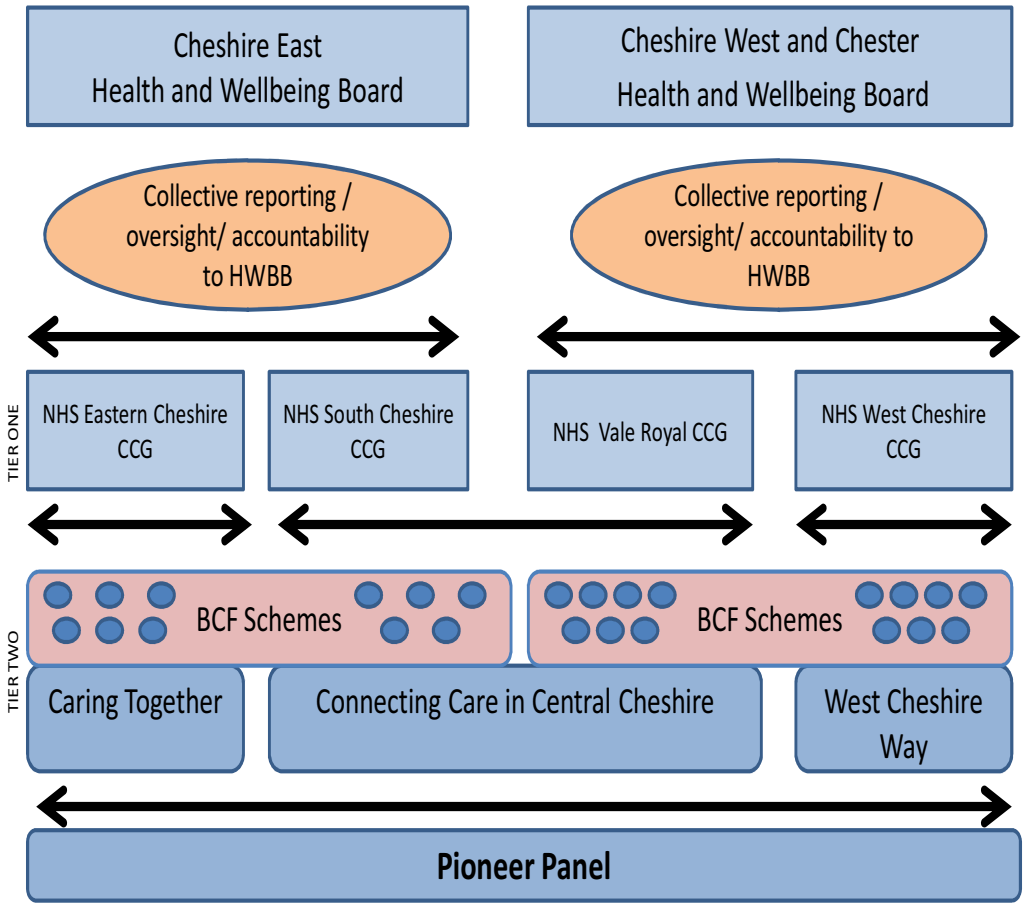
- **Tier One:** Initiatives that are legally required or mandated to operate at a HWBB footprint and would therefore be unable to operate at a Pioneer level, and would be uniform at a locality level within the Borough (e.g. Social Isolation and the Care Act).
- **Tier Two:** The initiatives that would vary across CCG areas and would be better informed through local oversight and delivery (e.g. integrated teams).
- **Tier Three:** Pan Cheshire Initiatives: The common schemes within the BCF that could be extended a Pioneer level, and would be appropriate for this geography (e.g. Carers and Equipment).

Establishing the most appropriate option in relation to the creation of the Section 75 agreements is now necessary.

For information the Cheshire West and Chester Health and Wellbeing Board agreed at its meeting on 14th January:

- That each of the BCF schemes would be supported through an individual S75 (tier two agreement).
- That these schemes would be grouped / collated at a Transformation Programme level (West Cheshire Way) and (Connecting Care).
- Vale Royal and South CCG would hold their individual schemes separately (two tier one agreements) as this enables reporting up to the HWBB, and also allows them to collectively manage the operationalization.
- CWAC would act as ‘host’ due to the practical benefits of VAT/ carry forward issues.

Better Care Fund Oversight



6.0 Access to information

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

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 27 January 2015
Report of: Director of Adult Social Care CEC, Brenda Smith
Subject/Title: s.256 Pilots – Progress Update

1.0 Report Summary

1.1 The NHS Social Care Allocation to Cheshire East Council for 2013/14 is an amount of funding, determined by the Department of Health, that is to be transferred from the NHS (NHS England) to Councils (Gateway Reference 18568). The funds are to be spent on social care support that also has health benefits. The way the funds are spent has to be agreed with local health partners. The formal agreement is between NHS England and Cheshire East Council via a s.256 agreement. However the NHS England Cheshire, Warrington and Wirral Local Area Team seek support from the Clinical Commissioning Groups to the proposals for spending. This support is to be based upon plans that are robust.

1.2 The s.256 agreement was endorsed at the Health and Wellbeing Board on 27 August 2013. This paper provides an update on the agreed proposals for this fund.

1.3 Five areas of spending were agreed (table below). The first two areas below are continuations of existing spending. The three new areas of spend are: a pilot of the expansion of the existing Assistive Technology and Occupational Therapy (OT) service - £552,000 (c/f ringfence from 13/14); a pilot of the use of assistive technology for adults with learning disability - £246,500 (c/f ringfence from 13/14); and a pilot dementia reablement service - £637574 (c/f ringfence from 13/14).

Service	Allocation £	Launch Date
1. Community Reablement	£2,826,000	Ongoing
2. Assistive Technology and Occupational Therapy support:	£ 930,000	Ongoing
3. Pilot of Dementia Reablement service as an early intervention initiative	£637,574	1st May 2015
4. Pilot of Assistive Technology and Occupational Therapy Universal Outreach (now known as 'Lifelinks')	£ 552,000	1st June 2015
5. Pilot of the use of Assistive Technology for adults with Learning Disability	£246,500	Dec. 2014

1.4 The project plans on these three pilots were circulated for discussion at the Joint Commissioning Leadership Team (JCLT) meeting of 21 November 2014. At that meeting the pilots were well received and JCLT were assured that good

progress was now being made. This report provides the latest highlights of progress against the project plans since that report to JCLT.

1.5 Appendices 1, 2 and 3 attached provide that progress update.

2.0 Outline of the Objectives of the three Pilot projects

The pilots are all aimed at increasing the independence and self reliance of adults who are at risk of losing their independence and wellbeing. They will run for 12 months to test their impact on that objective. Each will be fully evaluated to consider what the benefits are, to customers and to agencies and what the funding options for continuation are (including self-sustainability).

2.1 Pilot of Dementia Reablement service as an early intervention initiative.

This service will be targeted at those who have received an early diagnosis of dementia. The outcomes sought from this innovative and experimental approach is for those in an early stage of dementia to increase their ability to continue to live independent lives and improve quality of life for them and their carers.

2.2 Pilot of Assistive Technology and Occupational Therapy Universal Outreach (now known as 'Lifelinks')

This service will be targeted at the universal population to seek to inform and advise at a much earlier stage about the assistive technologies and equipment that can prevent loss of independence.

2.3 Pilot of the use of Assistive Technology for adults with Learning Disability

There are an expanding range of technologies available, including everything from apps on mobile devices to sophisticated monitoring equipment. This pilot will seek to explore how that range of technologies can be used to help adults with learning disabilities to be more independent.

2.0 Recommendation

2.1 That the Health and Wellbeing Board note the progress of the three pilots.

3.0 Reasons for Recommendations

3.1 For Health and Wellbeing Board to monitor the delivery of the pilots.

4.0 Background summary

4.1 Background is provided in Appendices attached as follows:
Appendix 1 - Dementia Reablement,
Appendix 2 –' Lifelinks'
Appendix 3 – The use of Assistive Technology for adults with Learning Disability.

5.0 Access to Information

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

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Health and Wellbeing Board

27th January 2015

s256 Pilot: Appendix One

Dementia Reablement Service- Project Update

Following the Dementia Project Implementation Group meeting on the 14th January, this document provides an update on the progress of the project to date.

Service specification

Signed off by CEC Joint Commissioning Leadership Team; the spec will be used by Workforce Development and Care4ce in the recruitment of the Resource Manager, Outcomes Coordinator and Admin Assistant posts following the application process. The 12-month pilot is due to be launched on 1st May 2015.

Service Level Agreement

A detailed SLA has been drafted with the input of our Legal department; this will be reviewed in the New Year by the Commissioning Manager and Care4ce Resource Manager, before going to the Director of Adult Services for sign off. The Service Level Agreement along with the Service Specification will then be used by the PIG to implement and then evaluate the pilot programme.

Service Pathway

Mapping of existing dementia resources and coverage/capacity in Cheshire East reviewed and agreed at Dementia Project Implementation Group, and the Service Pathway has been updated to reflect these. Catherine Mills (S CCG) is to circulate to a small group of GPs for comment, before it is ready for circulation to all partners. GPs will need contact details for the service.

Stakeholder Engagement

Met in person with 30+ service users and carers of people at early dementia cafés. Initial feedback was extremely positive, all qualitative feedback has been collated which will support the implementation, in particular the training and induction along with the toolkit used by the Dementia Reablement Team.

Partner engagement

The Dementia Project Implementation Group has engaged with the following partners to ensure that the new pilot is targeted at gaps in existing support for people with dementia and compliments rather than duplicating existing support:

- The Memory Clinic service from both South and East CCG area; received extremely positive feedback from consultants, they identified a gap in post diagnostic support for people with dementia as a major area for improvement;
- Community Mental Health Teams- representatives from both South and East Teams on the Dementia Project Implementation Group;

- GPs- Established a shared script to communicate details of the service, together with the Service pathway, through an identified lead GP; agreed with Jean Jenkins;
- CCG Commissioned services- South and East CCG Clinical commissioning leads are represented on the Dementia Project Implementation Group.

Evaluation of the pilot

Thorough evaluation of the pilot programme will support the Council's evidence based approach to commissioning of services, ensuring best possible value for money for the Council and residents.

The evidence gathered from this process will support future commissioning of dementia support services.

The pilot programme will be evaluated by a third party; three research organisations have been approached. Currently procuring the Evaluation of the pilot with the aim of the external partner in place by the end of February.

The submissions for evaluation will be reviewed in January, ready for the appointed organisation to commence work in April.

Recruitment

Resource Manager posts (2 posts), Outcomes Coordinator posts (3.5 fte equivalent) and Administration posts (2 posts) were agreed at the December Recruitment Watch, however still waiting for final approval. The Resource Manager and Outcome Coordinator posts were advertised in late December and early January and there has been a huge mount of interest. Currently shortlisting with a view to interviewing in February. The Administration posts are to be advertised once final approval gained. All posts to be in place by 13th – 20th April.

Training & Induction

Workforce Development have been briefed and are already starting to shape the training and induction programme for the new team.
Training and induction will take place in April to ensure the team are bedded in before the 1st May.

Communications Plan

This is well underway, however the rep from the Comms Team who was a member of the Dementia Project Implementation Group has now left and we are liaising with the Comms Team to identify a replacement.
We have had some initial design work done for a logo for the service and we are currently working to finalise this. The Comms rep is essential to ensure that the communication and marketing of the Reablement Service will support the existing Dementia Strategy communication.

Implementation

Data/ Info protocol: Details of the new service to be added to PARIS/ Liquid Logic – Suzanne James and Tom Hewitt meeting with Lesley Hall (Adult Services lead for Liquid Logic) in January.

The required data recording and reports are identified in the service specification, and work is currently being undertaken to identify how this compares to the existing data and

information recording by the Mental Health Reablement team. Further data and information will be recorded as part of the service evaluation, the external research institution to advise.

Toolkit resources: a number of existing resources have been identified including the Warwickshire Dementia Portal, as a template for the CEC toolkit resource. Further work is being undertaken to develop the toolkit.

Dementia App: Meeting with Citrus Suite Developers in the New Year to discuss how Cheshire East can be part of the pilot of their innovative app to help people live well with dementia and their carers.

Project Plan
(Attached)

Jill Greenwood, Commissioning Manager
Tom Hewitt, Senior Contracts Officer
Lindsey Taylor, Project & Performance Manager
Kim Purkis, Project & Performance Manager

15 January 2015

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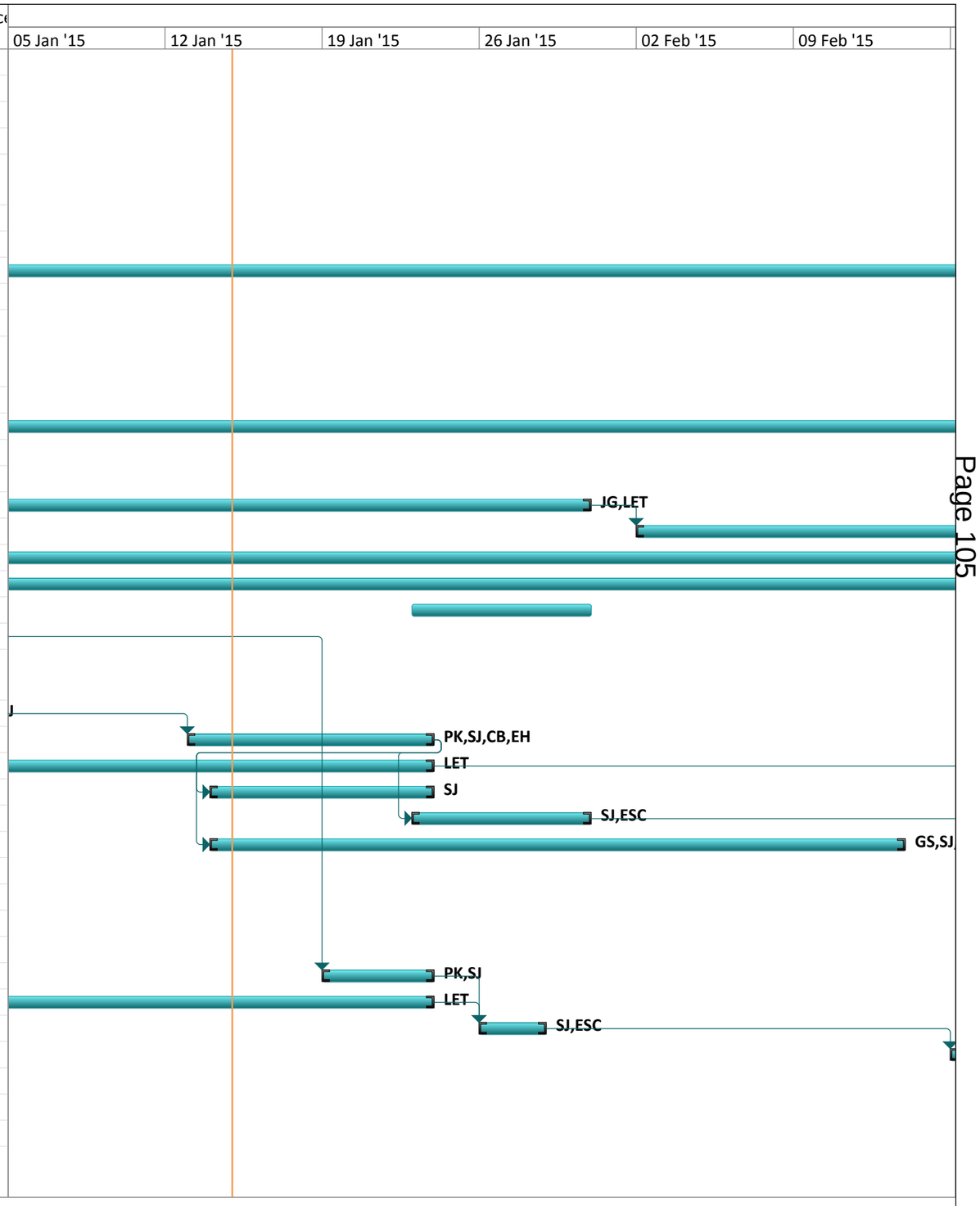
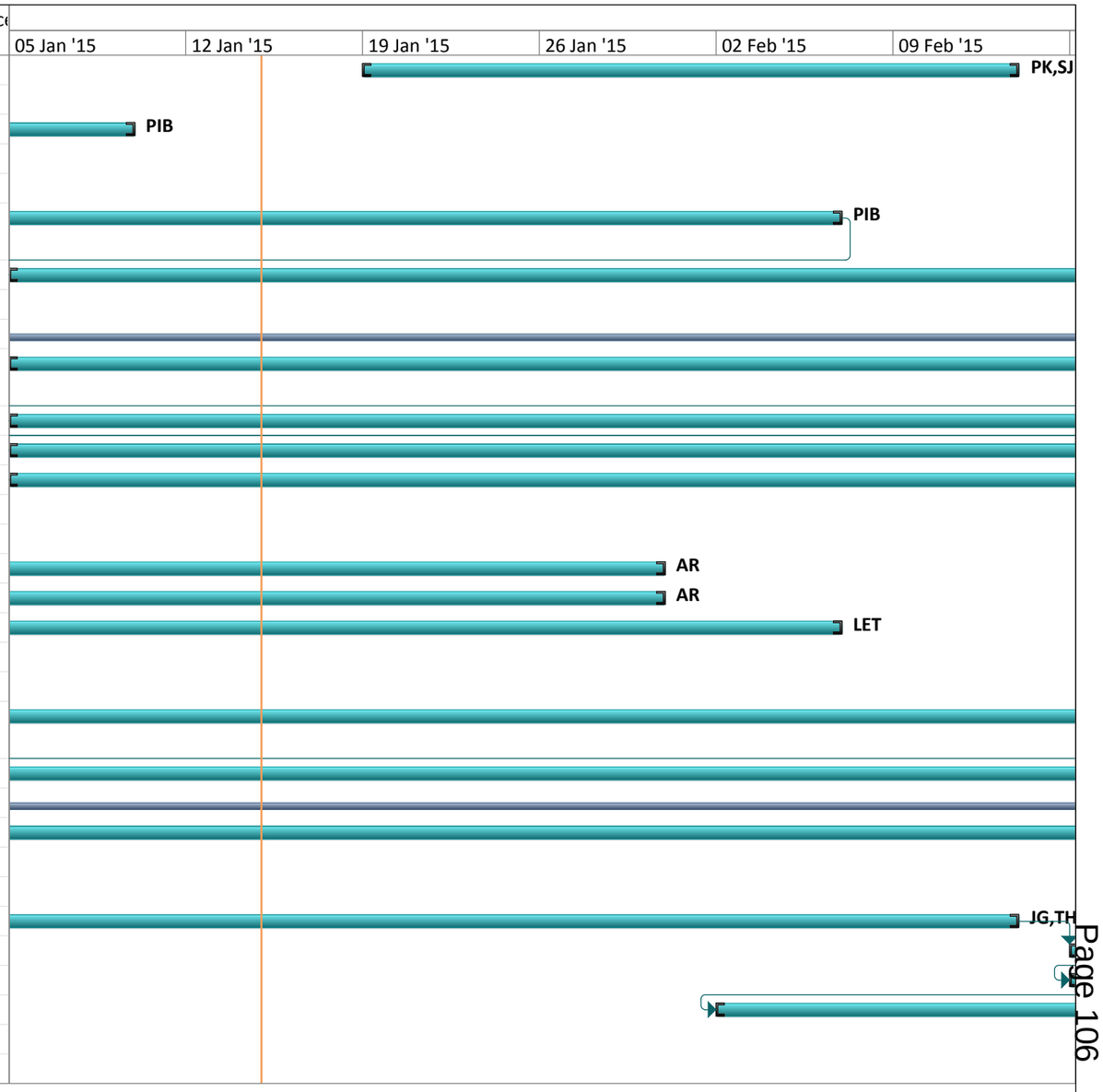
ID	Task Name	Duration	Start	Finish	Resource Names	Predec
1	**Project Governance and Management of Pilot**					
2	Initial Project Plan	0 days	Mon 29/09/14	Mon 29/09/14	AR	
3	Project Plan developed and Milestones agreed	44 days	Mon 29/09/14	Thu 27/11/14	PIB	
4	Leads agreed for each area	19 days	Fri 07/11/14	Wed 03/12/14	PIB	
5	Identify other agencies providing Dementia Services in CEC and invite to PIB Meetings	13 days	Tue 21/10/14	Thu 06/11/14	JG	
6	Length of Pilot agreed	1 day	Tue 21/10/14	Tue 21/10/14	BS	
7	Project Implementation Board Membership agreed	17 days	Tue 21/10/14	Wed 12/11/14	PIB	
8	Budget Allocation and Monitoring	395 days	Mon 13/10/14	Fri 15/04/16	JG	
9	Produce Interim Evaluation Report	0 days	Fri 14/08/15	Fri 14/08/15	JG	
10	Produce Final Evaluation Report	0 days	Fri 14/08/15	Fri 14/08/15	JG	9
11	Secure Approval for BAU or to Commission the service externally	1 day	Fri 14/08/15	Fri 14/08/15	JG	10
12	Risks and Issues Identified	29 days	Tue 14/10/14	Fri 21/11/14	PIB	
13	Risks and Issues Monitored	135 days	Mon 24/11/14	Fri 29/05/15	PIB	
14	**Specification**					
15	Confirm scope	34 days	Tue 14/10/14	Fri 28/11/14	JG	
16	Develop specification	83 days	Wed 08/10/14	Fri 30/01/15	JG,LET	
17	Development & sign off of SLA for Care4CE	40 days	Mon 02/02/15	Fri 27/03/15	JG,TH	16
18	Estimate Demand for Service	57 days	Thu 11/12/14	Fri 27/02/15	TH	
19	Establish KPIs	97 days	Mon 17/11/14	Tue 31/03/15	JG,TH,external	
20	**New Team Structure**					
21	Structure and Grades for new team agreed	40 days	Mon 06/10/14	Fri 28/11/14	PK,SJ,BS,JG	
22	Job Descriptions and Person Specs updated - Grade 8s x 2, Grade 7s x 10	5 days	Mon 01/12/14	Fri 05/12/14	PK,SJ	21
23	Posts advertised (internally & externally)	19 days	Mon 08/12/14	Thu 01/01/15	PK,HR,SJ	22
24	Shortlisting	9 days	Tue 13/01/15	Fri 23/01/15	PK,SJ,CB,EH	23
25	Confirmation of Approval to Appoint from RW	27 days	Thu 18/12/14	Fri 23/01/15	LET	
26	Book rooms for interviews and Assessment Centre	8 days	Wed 14/01/15	Fri 23/01/15	SJ	24
27	Send Invites for Interviews Grade 8s and 6s	6 days	Fri 23/01/15	Fri 30/01/15	SJ,ESC	24
28	Develop Assessment Centre tasks and prep for interviews	23 days	Wed 14/01/15	Fri 13/02/15	GS,SJ,PK	24
29	Grade 8s and 6s Interviews & Assessment Centre 2 or 3 days	5 days	Mon 23/02/15	Fri 27/02/15	HR,LB,PK,SJ	27
30	Appoint 2 x Grade 8s and 10 x Grade 6s	1 day	Fri 27/02/15	Fri 27/02/15	HR,LB,PK,SJ	25,29
31	Grade 8s in post (assume 4 week notice + 2 week appts letters)	0 days	Mon 13/04/15	Mon 13/04/15		30
32	Grade 6s in post (assume 4 week notice + 2 week appts letters)	0 days	Mon 13/04/15	Mon 13/04/15		30
33	Job Descriptions and Person Specs updated - Grade 4 posts x 2	5 days	Mon 19/01/15	Fri 23/01/15	PK,SJ	21
34	Approval to advertise Grade 4s from RW	27 days	Thu 18/12/14	Fri 23/01/15	LET	
35	Posts advertised (internally & externally) closing date 13/2	3 days	Mon 26/01/15	Wed 28/01/15	SJ,ESC	33,34
36	Shortlisting, book rooms	3 days	Mon 16/02/15	Wed 18/02/15	SJ,EH,CB	35
37	Send Invites for Interviews Grade 4s	3 days	Wed 18/02/15	Fri 20/02/15	SJ,ESC	36
38	Grades 4 Interviews	2 days	Thu 05/03/15	Fri 06/03/15	SJ,GS,EH,CB	37
39	Appoint Grade 4 posts	0 days	Fri 06/03/15	Fri 06/03/15	RM?,SJ,LB	38
40	Grades 4s in post (assume 4 week notice + 2 week appts letters)	0 days	Mon 13/04/15	Mon 13/04/15		39



Project: Dementia Pilot Project Pla
Date: Thu 15/01/15

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline	
Split	External Tasks	Inactive Summary	Manual Summary	Progress	
Milestone	External Milestone	Manual Task	Start-only		
Summary	Inactive Task	Duration-only	Finish-only		

ID	Task Name	Duration	Start	Finish	Resource Names	Predec
41	Confirm location of new teams	20 days	Mon 19/01/15	Fri 13/02/15	PK,SJ	
42	**Toolkit, Research & Training**					
43	Map Existing Dementia Services in Cheshire East	50 days	Mon 03/11/14	Fri 09/01/15	PIB	
44	Research into academic studies on Dementia services	20 days	Mon 03/11/14	Fri 28/11/14	TH	
45	Research other Dementia services in the UK and Europe	20 days	Mon 03/11/14	Fri 28/11/14	TH	
46	Research innovative solutions, technology & AT to support clients	81 days	Fri 17/10/14	Fri 06/02/15	PIB	
47	Development of Toolkit for Team to use with clients	55 days	Mon 05/01/15	Fri 20/03/15	TH,SJ,EH,CB	46
48	Training Programme developed	15 days	Mon 23/03/15	Fri 10/04/15	GS,SJ,TH	47
49	**Client Data Recording**					
50	Development of Questionnaires/baseline info for service users (individuals and families/carers)	40 days	Mon 05/01/15	Fri 27/02/15	SJ,TH,external	
51	Development of Format of Client's 'Action Plan' record	50 days	Mon 05/01/15	Fri 13/03/15	CB,EH,SJ,TH	50
52	Agree Recording Method prior to Liquid Logic	50 days	Mon 05/01/15	Fri 13/03/15	CB,EH,SJ,TH	51
53	Develop Recording System in Liquid Logic	50 days	Mon 05/01/15	Fri 13/03/15	CB,EH,SJ,TH	51
54	**Communications**					
55	Initial Comms Plan produced	16 days	Mon 01/12/14	Mon 22/12/14	AR	
56	Logo Developed	22 days	Thu 01/01/15	Fri 30/01/15	AR	
57	Final Comms Plan	29 days	Tue 23/12/14	Fri 30/01/15	AR	55
58	Provide Info & Advice for the new ASC Webpages (Care Act)	27 days	Thu 01/01/15	Fri 06/02/15	LET	
59	Launch Of Pilot	0 days	Fri 01/05/15	Fri 01/05/15	AR	
60	**Information Governance**					
61	Julie Gibbs and Kate to confirm Restrictions for Data Collection for pilot	65 days	Mon 01/12/14	Fri 27/02/15	SJ	
62	Develop Data Sharing Protocol (for clients & other agencies)	65 days	Mon 01/12/14	Fri 27/02/15	SJ	61
63	**IT Equipment**					
64	Obtain advice from IT for best kit for staff	56 days	Mon 01/12/14	Mon 16/02/15	TH,SJ	
65	Order IT equipment and phones	1 day	Tue 17/02/15	Tue 17/02/15	SJ	64
66	**Performance Monitoring and Evaluation**					
67	Procurement of External Partner for Advice & Evaluation	50 days	Mon 08/12/14	Fri 13/02/15	JG,TH	
68	Explore & develop Evaluation options with external partner	20 days	Mon 16/02/15	Fri 13/03/15	TH,JG,external	67
69	Develop Monitoring system for KPIs	20 days	Mon 16/02/15	Fri 13/03/15	TH,SJ	68
70	Establish Baseline information	30 days	Mon 02/02/15	Fri 13/03/15	TH,external	69
71	Collate data and produce monthly reports	262 days	Fri 01/05/15	Mon 02/05/16	Tbc	69
72						

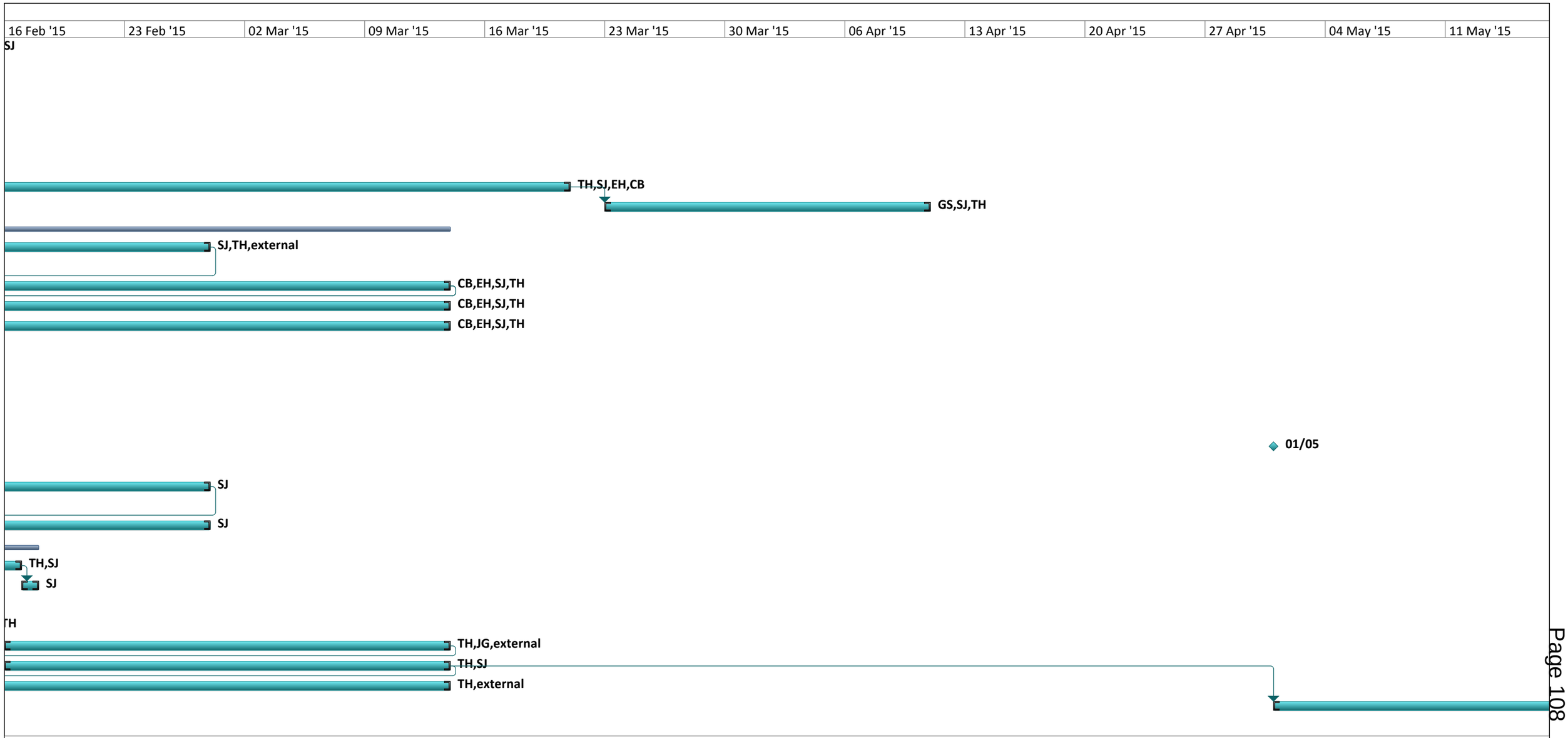


Project: Dementia Pilot Project Pla
Date: Thu 15/01/15

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline
Split	External Tasks	Inactive Summary	Manual Summary	Progress
Milestone	External Milestone	Manual Task	Start-only	
Summary	Inactive Task	Duration-only	Finish-only	

Project: Dementia Pilot Project Pla
Date: Thu 15/01/15

Task	Project Summary	Inactive Milestone	Manual Summary Rollup	Deadline			
Split	External Tasks	Inactive Summary	Manual Summary	Progress			
Milestone	External Milestone	Manual Task	Start-only				
Summary	Inactive Task	Duration-only	Finish-only				



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Project: Dementia Pilot Project Pla Date: Thu 15/01/15	Task		Project Summary		Inactive Milestone		Manual Summary Rollup		Deadline	
	Split		External Tasks		Inactive Summary		Manual Summary		Progress	
	Milestone		External Milestone		Manual Task		Start-only			
	Summary		Inactive Task		Duration-only		Finish-only			

Section 256 Report
Appendix 2

Background

The Council, along with our Health and Wellbeing partners has made a substantial investment in prevention and early intervention services and support. This is to support people to be as well as they can be and to have a good quality of life. It is also to prevent and delay people needing specialist care services.
Cheshire East places prevention and early intervention at its heart. This will ensure:

- availability of comprehensive information, advice and guidance to support people to have a good quality of life;
- services and support are available, some for all adults, some for targeted groups of people, to prevent ill health and maintain physical, emotional, financial, and social wellbeing;
- preventative services and support are available to make the new arrangements around co-funding and eligibility for personal social care possible

Public spending is coming under increasing pressure. This means that health and social care services must be even more rigorously targeted on those people at greatest need and risk, and that enhanced approaches to supporting people with lower levels of need, in order to maintain their wellbeing and independence and avoid premature escalation in dependency, must be rapidly advanced.

Summary of service

To proactively provide an outreach service which targets people who may be on the brink of physical dependence or social isolation, and to ensure that they receive the lower level support and advice they need to prevent them from requiring intensive, expensive health and social care services

Progress

Draft Service Specification completed and awaiting sign off.

Milestones

Sign off pilot specification	Mid - Feb-15
Governance, regular reporting & evaluation process established	End Feb - 15
Explore & develop Evaluation options with MMU	Mar-15
Develop ITT with procurement	Feb-15
Go out to market	Mar-15
Award contract	May-15
Contract start date	1st June -15
Service launch date	Jul-15
Receive and review 3 month highlight report	Nov-15
Receive and review 6 month highlight report	Feb-16
Interim external evaluation report	May-16

Appendix 3

Assistive Technology for People with Learning Disabilities Project Plan Update Jan 2015

Background: This is a pilot to explore the use of Assistive Technology (AT) options within 24 hour supported tenancy based schemes and individuals living in their own homes as part of the Care Fund Calculator review work.

The pilot will link with AT suppliers and developers to consider new and innovative solutions that can be tested within environments where staff or family carers continue to be available to observe, oversee support and reassure. The service is targeted at adults with a Learning Disability who have extensive levels of support and supervision.

The service will be provided concurrently, alongside traditional methods of support in the pilot phase.

Update:

- The Social Workers for the project are in place and the Care Fund Calculator reassessment programme started ahead of schedule in December 2014 with AT as an integral part of the work with individuals who are receiving support
- The AT lifestyle assessment systems have been acquired and training session is booked in January 2015 to support the implementation of the systems
- The recruitment of the AT Social Care Assessor will now take place in January following consideration of a number of redeployment candidates. Specialist AT support is provided by the existing AT SCA until the learning disability specialist is in place

Milestones & Progress (including Evaluation):

Key milestones	Due date:	RAG rating:
1) Assistive technology Social Care Assessor and Social workers appointed	Dec 2014	A –Social Workers appointed, AT worker to be recruited in Jan 2015
2) CFC reassessment programme commences	Jan 2015	Achieved – commenced in Dec 2014
3) Monthly Performance Reporting Commences	Mar 2015	G
4) 3 month highlight report	June 2015	G
5) Start of Benefits Realisation	May 2015	G

6) 6 month evaluation	Sept 2015	G

CHESHIRE EAST COUNCIL

Health and Wellbeing Board

Date of Meeting: 27th January 2015
Report of: Jonathan Potter, Principal Manager Early Help
Subject/Title: Family Focus Programme

1.0 Report Summary

1.1 This report is presented to the Health and Wellbeing Board to inform the Board about the ending of the current programme and to begin discussion about the expanded programme. The expanded programme will place greater demands on the Local Authority and its partners, specifically Health providers both in operational provision and through data requirements.

1.2 The National Troubled Families Programme has been operating in Cheshire East since early 2011 and during the spring of 2014 it was rebranded as the Cheshire East Family Focus Programme

1.3 The expanded programme will have a national roll out date of April 2015 and will be a 5 year programme – thus ending in 2020.

1.4 Key features of the expanded programme are:

- Increased eligibility criteria
- the development of a local Outcomes Plan to define and measure significant and sustained progress,
- greater understanding of the fiscal benefits achieved through the programme and by stimulating ongoing service transformation, by use of the cost savings calculator,

2.0 Recommendation

2.1 That this report is for discussion, but there is a consensus about the need for improved information sharing between partners, and that the mechanisms for that will be defined; additionally that all partners including both Health commissioners and Health providers are sufficiently represented on the Family Focus Executive Board, and the Youth Management Board.

3.0 Reasons for Recommendations

3.1 The principles of the expanded programme are defined by the Department for Communities and Local Government (DCLG) as Trust, Transformation and Transparency. It is expected that there will be a focus on service transformation by:

- increased investment in, and increased expectations of, local co-ordination, analysis and oversight across partner agencies,
- which will be demonstrated through family monitoring and costs data for representative sample of all families,
- some of the funding will be dependent upon incrementally increased expectations of quality and comprehensiveness of data and analysis.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 All

6.0 Policy Implications

6.1 Information Sharing

7.0 Financial Implications (Authorised by the Director of Finance and Business Services)

7.1 This is a payment by results programme and successful participation will result in significant income generation.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 None

9.0 Risk Management

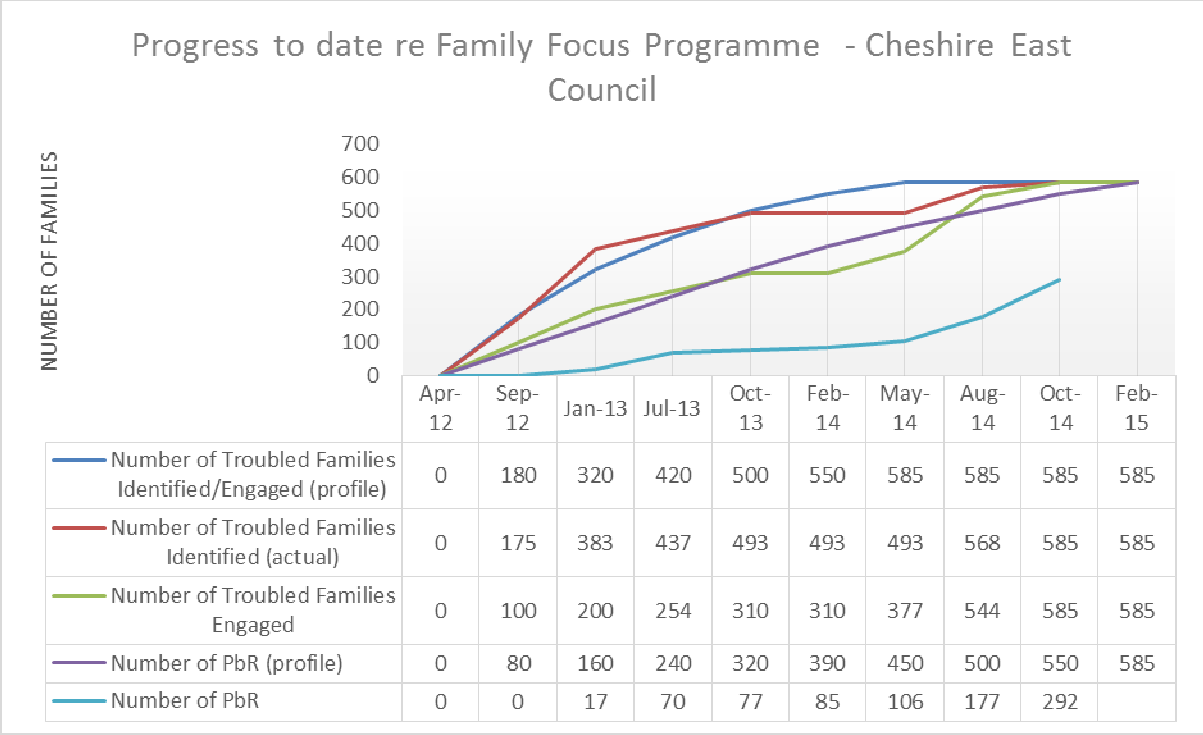
9.1 There are risks that Cheshire East will not be able to feed information into the cost savings calculator and therefore not identify fiscal savings to ourselves and our partners and without that knowledge, will be less likely to achieve service transformation.

9.2 There is a risk to the reputation of the Local Authority if gaps in partnership working are evident to various inspection regimes such as CQC and Ofsted.

10.0 Background and Options

10.1 The current programme:

10.1.1 The current three year programme will end in May 2015, and it is expected that all Local Authorities will have achieved success with all of its identified numbers of families and, in anticipation of that it is expected that we will have turned around 75% of our cohort numbers by February 2015 in order to progress into the expanded programme. The table below shows the current position i.e. that Cheshire East has currently turned around 49% of its cohort.



	Apr-12	Sep-12	Jan-13	Jul-13	Oct-13	Feb-14	May-14	Aug-14	Oct-14	Feb-15
Number of Troubled Families Identified/Engaged (profile)	0	180	320	420	500	550	585	585	585	585
Number of Troubled Families Identified (actual)	0	175	383	437	493	493	493	568	585	585
Number of Troubled Families Engaged	0	100	200	254	310	310	377	544	585	585
Number of PbR (profile)	0	80	160	240	320	390	450	500	550	585
Number of PbR	0	0	17	70	77	85	106	177	292	

10.1.2 To this end we have received and acted upon advice from the DCLG and from other more successful Local Authorities. It has been acknowledged by the DCLG that despite a slow start, progress is now being made, and there is an action plan in place to ensure that we achieve as high a figure as possible in the February claim to ensure our involvement beyond May 2015.

10.1.3 Under the current phase, Cheshire East has supported additional data requirements of the programme such as the Family Monitoring data returns – which give more information about issues other than the main eligibility criteria that affect many of the families worked with. This data from all LAs has influenced the development of the expanded programme as the research has identified that the majority of families worked with under this programme have numerous other issues affecting their lives and these have been brought into the criteria for Phase 2.

10.2.1 The expanded programme:

10.2.2. Phase 2 has now been confirmed by DCLG and 52 Authorities became early starters for Phase 2 in September and another group joined them in January 2015. It is hoped the remainder will join in April 2015 – once the figures described above have been achieved. An Interim Financial Framework issued in September 2014 was updated on 14th November and there will be a further iteration early in 2015. However we do know that cohort numbers will increase by approximately 3.3 times, making the Cheshire East cohort 1931, although this actual figure is yet to be confirmed in writing.

10.2.3 The expanded eligibility programme will cover six 'headline' eligibility criteria, of which families will have to meet 2 in order to move into the programme. The headlines are shown below.

Headline Criteria	Comment
Parents and children involved in crime or anti-social behaviour.	Now includes adult crime
Children who have not been attending school regularly.	As before
Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan.	This was previously included within locally defined criteria.
Adults out of work or at risk of financial exclusion or young people at risk of worklessness.	Now includes NEET and at risk of financial exclusion (debt)
Families affected by domestic violence and abuse.	New criteria
Parents and children with a range of health problems.	New criteria

10.2.4 The financial structure will change; the money paid as results payments will reduce from £4,000 per family to £1,800 per family. However the monies for coordination costs will double and this reflects the increased emphasis on the data collection and analysis to evidence success and financial savings.

10.2.5 Based on the cohort numbers being 1931, the potential value in terms of payment by results is £3,475,800 over the five years of the programme and coordination grant will be doubled to £200,000 per year. This is equivalent to £895,160 per year.

10.2.6 It is expected that there will be a focus on service transformation by:

- increased investment in, and increased expectations of, local co-ordination, analysis and oversight across partner agencies,
- which will be demonstrated through family monitoring and costs data for representative sample of all families,
- some of the funding will be dependent upon incrementally increased expectations of quality and comprehensiveness of data and analysis.

10.2.7 The broader eligibility criteria will make identification of families' in Cheshire East easier as only 2 of the 6 criteria will have to be met (rather than 3 of 4), but ways of monitoring success will change considerably.

10.3.1 Fiscal benefits:

10.3.2 There will be a much better understanding of the fiscal benefits achieved through the programme and by stimulating ongoing service transformation through transparent local accountability for these benefits. Details of the fiscal benefits being looked at have been agreed between the DCLG and the Treasury and a cost savings calculator (CSC) has been developed. Completing this will be a significant development in terms of data collection as the relevant data will need to be gathered in respect of each

person within each family. Relevant costs built in to the calculator are based on economic research undertaken by New Economy Manchester.

10.3.3 Costs during the 12 months prior to the programme will need to be included so figures can be compared to costs within the programme – and savings calculated.

10.3.4 The Family Monitoring Data (FMD) will become Family Progress data and how this is gathered and used is under consideration by DCLG at the moment in light of discussions in regional meetings with coordinators, but it is likely that these will on the whole correlate with the CSC.

10.3.5 A review of information sharing agreements with partners will be required in order to access all the required data.

10.4.1 Information/Data sharing:

10.4.2 During November a Health Leadership Statement was issued by the Dept. of Health, the Local Government Association, NHS England and Public Health England, along with data sharing guidance and a training and skills document were issued to facilitate the level of engagement required to meet the expectations of the programme.

10.4.3 Discussions have begun with current partners about the expanded programme through the Family Focus Executive Board and the Youth Management Board. They also need to begin with new potential partners such as Health providers, the Probation service, Cheshire without abuse to prepare for information and data sharing as well as service delivery and associated pathways and processes.

10.5.1 Outcomes Plan:

10.5.2 Each LA will create a Troubled Families Outcomes Plan - guidance on this is currently being developed by DCLG and examples will be issued based on examples from the early starter LAs. This will describe the outcomes that are expected and will form the basis of measuring success. There will be merit in having some outcomes agreed with LAs who share the same partnerships across the region.

10.5.3 The outcomes plan will reflect strategic plans such as the Children and Young Peoples Plan and the Health and Wellbeing plan and draw on national frameworks.

10.5.4 The plan will define how success is measured. The financial framework states that Payment by Results may be claimed when there is ‘significant and sustained progress’ in areas that have been identified as relevant to each family and/or a move into continuous employment.

10.5.5 A draft Outcomes Plan is attached for consideration. It should be noted that this is a first draft and is a work in progress. This has been prepared in consultation with the Family Focus Executive Board. Further development is needed alongside regional Local Authorities namely Halton, Cheshire West and Cheshire and Warrington with whom we share partner services. DCLG anticipate sharing some outcomes plans

developed and agreed with Early Starter Authorities to assist development. The final version will need to be approved by DCLG.

Next steps

11.1 Continue preparation for entry into the expanded programme by finalising the outcomes plan and information sharing strategies so that all partners aware of and committed to the requirements of the financial framework.

11.0 Access to Information

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

Name: Jonathan Potter
Designation: Principal Manager, Early Help
Tel No: 01606 275891
Email: jonathan.potter@cheshireeast.gov.uk

Cheshire East Council

Family Focus Outcomes Plan

2015 – 2020

Introduction and Purpose of the plan

Cheshire East Council will join the expanded national Troubled Families Programme in April 2015. This will continue to be known locally as the Cheshire East Family Focus Programme. Whilst the programme remains focussed on trying to change the lives of families who face multiple difficulties and will continue to include families affected by poor school attendance, youth crime and anti-social behaviour and unemployment; it will also now include families with a broader range of problems, including those affected by domestic violence and abuse, younger children who need help, where crime and anti social problems may become intergenerational and with a range of physical and mental health problems.

The programme will continue to operate on a Payment by results (PbR) basis to the Local Authority, and each LA has been given a number of families which for results may be able to be claimed – in Cheshire East this will be just under 2,000 (approx.1930) – but is yet to be confirmed.

Broader eligibility criteria may make it easier to verify eligibility, but it makes progress harder to monitor and success more difficult to establish. To this end the DCLG have made 2 definitive statements with regard to success i.e.

A results payment can be claimed by a local authority if it can demonstrate that a family who was eligible for the Troubled Families Programme has either:

*1. Achieved **significant and sustained progress**, compared with all the family's problems.*
OR

2. An adult in the family has moved off benefits and into continuous employment.

The definition of significant and sustained progress is to be defined by each Local Authority and the outcomes and measures that constitute and demonstrate this are to be set out in this Outcomes Plan.

DCLG Principles on which the plan is based:

1) Outcomes should focus on measurable changes that can be achieved by families.
2) Outcomes for families should be set once a full picture of the family is known (see p 26 Financial Framework for the expanded programme Nov 2014).

3) If some aspects are not relevant to the family, at the point of engagement significant and sustained progress does not need to be demonstrated against that aspect, but the LA must ensure that the position has not regressed.
4) All school age children in families for whom significant and sustained progress is claimed must be achieving at least 85% attendance of possible sessions across three consecutive terms.
5) Outcomes should be developed and agreed with local partners and have reference to relevant outcomes frameworks and other objectives those organisations may have.
6) Where unemployment an issue for the family on entry to the programme, significant and sustained progress towards work is not necessarily continuous employment, but may be achieving a recognised vocational qualification or undertaking work experience over a period of time.
7) It will be helpful to refer to the Family Monitoring Data and cost savings calculator within the outcomes plan to recue data collection.
8) The outcomes plan should be simple and not too complex.

This plan therefore sets out:

1. What Cheshire East aims to achieve in regard to the six issues the programme aims to tackle, and how this supports our wider service transformation objectives (e.g. how these 'per family' outcomes support broader, area wide goals in terms of demand reduction for services or fiscal savings);

2. To provide a basis against which we can determine when significant and sustained progress has been achieved and, therefore, a results claim may be made for the family.

3. To provide a framework against which internal auditors (and the TFT's 'spot checks') may establish whether a result is valid.

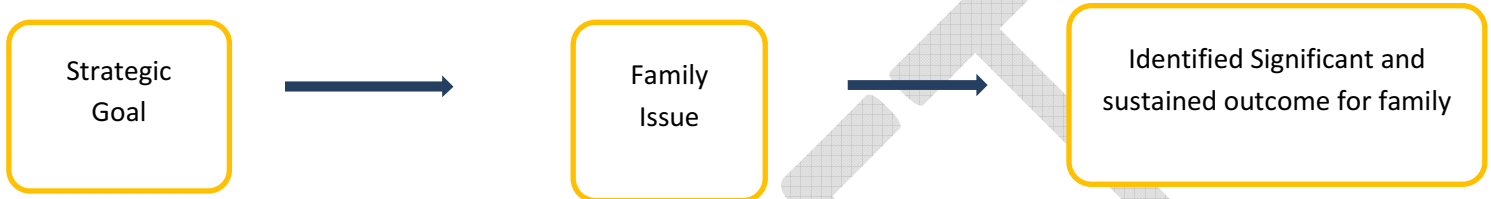
4. Show links where relevant to other local plans primarily:

- The Children and Young Peoples Plan 2014 – 2017
- The Health and Well Being Strategy 2014 -2016
- The Public Health Outcomes Framework 2014
- Family Monitoring Data
- Troubled Families cost savings calculator

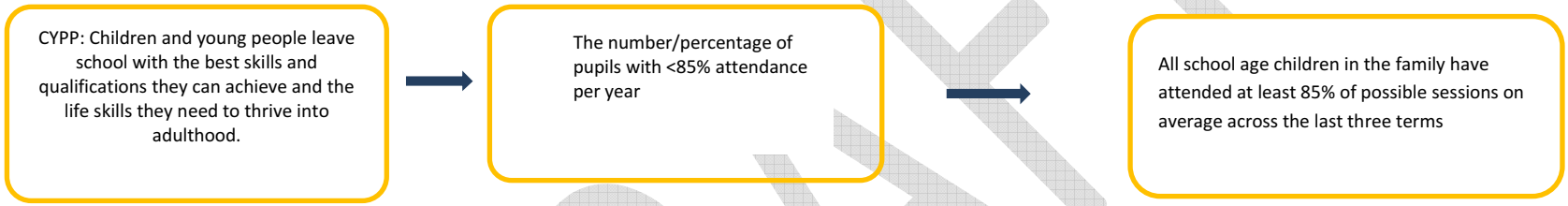
Measurable Outcomes:

The Troubled Family Outcomes Plan will provide a set of success measures applicable to all families, from which the outcomes and measures relevant to each family may then be drawn. For example, if a family has a debt problem, domestic violence problem and is unemployed at the point of engagement, then relevant outcomes would be

drawn from the area's Troubled Family Outcomes Plan and form the goals against which significant and sustained progress would be judged for this family. An example of this is shown below:



For example:



Appendix 1 shows the links between the relevant local plans and it will be necessary for operational staff to show these links when establishing goals and action plans in their work with families - thus establishing a 'golden thread' between the work the are doing and the successes achieved for and with the families and those available to be claimed under the PbR system.

Family outcomes should be identified following assessment and recorded in relation to overarching (strategic) goals within assessments and headlines for these will be included in the assessments used.

The breadth of the programme means that there are numerous possible outcome measures, but those identified here are those that are consider to

- Fall within the remit of the strategic plans previously referred to,
- Are already captured and readily available,
- Are within the cost savings calculator and therefore need to be captured for the whole cohort (as far as possible). The Cost savings calculator benefits along with potential data sources are shown at *Appendix 2*

The key areas for monitoring to evidence significant and sustained progress are still being considered, but those suggested to date are shown below and will be added to before this plan is finalised:

Suggested measurable outcome	**Potential data source**
The number/percentage of pupils with <85% attendance per year	Cheshire East Council Education systems
The number/percentage of pupils with Fixed Term Exclusions per year	Cheshire East Council Education systems
The number of DV incidents	Police
a reduction in the number of children DNA vaccination	Child Health system
a reduction in the number of children DNA developmental checks	Child Health system
an increase in the uptake of attendance for cervical smear screening	Patient administration system (PAS)
The number of those on cohort who have registration and engagement in Children's Centres	Cheshire East Council - Estart
The number on the cohort making good progress along the parenting track	Parenting track data

Appendix 1: Links between the relevant local plans

Family Focus Main Eligibility Criteria		1. Parents and children involved in crime or anti-social behaviour	2. Children who have not been attending school regularly	3. Children who need help: children of all ages, who need help, are identified as in need or are subject to a Child Protection Plan	4. Adults out of work or at risk of financial exclusion or young people at risk of worklessness	5.Families affected by domestic violence and abuse	6. Parents and children with a range of health problems
Children and Young Peoples Plan Priorities 2014-17							
1. Children and young people will be actively involved in decisions that affect their lives and communities	This spans all of the work areas and will be supported in the Family Focus Programme through involvement of the children and young people in the whole process from assessment to action planning and agreeing outcomes.						
2. Children and young people are kept safe							
3. Children and young people experience good emotional and mental health and well being							
4. Children and young people are healthy and make positive choices.							
5. Children and young people leave school with the best skills and qualifications they can achieve and the life skills they need to thrive into adulthood.							

6. The life chances of children, young people and young adults with additional needs are improved.							
Health and Well Being Board Priorities 2014-16							
1. Starting and developing well…							
Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive	Children and young people feel and are kept safe						
	Children and young people experience good emotional and mental health and wellbeing						
	Reduce the levels of alcohol use / misuse by Children and Young People						
	Reduce the numbers of children and young people self harming.						
	Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met						
	Targeted prevention interventions to reduce children and young people's obesity						
2. Working and living well…							

Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.	Reducing the incidence of alcohol related harm.						
	Reducing the incidence of cancer.						
	Reducing the incidence of cardiovascular disease.						
	Ensuring the health and wellbeing of carers to enable them to carry out their caring role						
	Better meeting the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness						

Appendix 2: Cost Savings Calculator Benefits:

Cost Savings Calculator benefits	Suggested Data source	Cost Savings Calculator benefits	Suggested Data source
No. of incidents of common assault	Police	No. of Accident and Emergency attendances resulting in investigation and subsequent tr	Patient Administration System (PAS)
No. of incidents of criminal damage	Police	No. of Accident &Emergency attendances resulting in no investigation and no significant	PAS
No. of incidents of shoplifting	Police	No. of ambulance call-outs	NWAS
No. of anti-social behaviour incidents where further action is neces	Police	No. of hospital inpatient admissions	PAS
No. of anti-social behaviour incidents where no action is taken	Police	No. of hospital outpatient admissions	PAS
No. of domestic violence incidents	Police	No. of general practitioner (GP) visits	GPs
No. of adults in prison	Police	No. of practice nurse visits	GPs
No. of arrests where individual is detained	Police	No. of adults suffering from depression/anxiety disorders (per year)	GPs
No. of arrests where no further action is taken	Police	No. of children suffering from mental health disorders (per year)	GPs
No. of first time entrants to the criminal justice system aged under	YES	No. of evictions	Registered Social Landlords
No. of months served by under 18s in prison	YES	No. of repossessions	Registered Social Landlords
No. of children permanently excluded from school	CEC Education systems	No. of homelessness applications	CEC - Housing Team
No. of children missing at least five weeks of school (per year)	CEC Education systems	No. of weeks of homelessness	CEC - Housing Team
No. of adults claiming Employment and Support Allowance	DWP	No. of Common Assessment Frameworks undertaken	CEC systems
No. of adults claiming Job Seeker's Allowance	DWP	No. of social worker visits	CEC systems
No. of adults claiming Lone Parent Income Support	DWP	No. of children in need cases	CEC systems
No. of 18-24 year old not in education, employment or training (pe	DWP	No. of children taken into care	CEC systems
No. of deliberate fire incidents	Fire Service	No. of weeks children were in local authority foster care	CEC systems
No. of individuals engaging in alcohol misuse (per year)	CWP	No. of weeks children were in local authority residential care home	CEC systems
No. of individuals engaging in drugs misuse (per year)	CWP		

REPORT TO: Health and Wellbeing Board

Date of Meeting: 27th January 2015
Report of: Jerry Hawker, Chief Officer, NHS Eastern Cheshire CCG
Subject/Title: Co-commissioning of Primary Care Services

1 Report Summary

1.1 All Clinical Commissioning Groups (CCGs) in England have been asked to indicate to NHS England by January 2015 which option they wish to proceed with in regards to the model of co-commissioning of primary medical care services in 2015/16. The three models which CCG's have a choice to take forward are:

- Model A: greater involvement in primary care decision making
- Model B: joint commissioning arrangements
- Model C: delegated commissioning arrangements

1.2 **Appendix A** provides a summary of the three model options and what adopting a model would mean for a CCG.

1.3 For 2015/16 NHS Eastern Cheshire CCG and NHS South Cheshire CCG have chosen to proceed with joint commissioning arrangements.

1.4 This paper provides additional detail around these models of co-commissioning and the intended benefits and opportunities

1.5 This paper also provides a brief overview of the actions that need to be completed and points to consider ahead of 1 April 2015.

2 Recommendations

2.1 Members of the Cheshire East Health and Wellbeing Board are asked to note the following:

- the model option chosen by both CCGs
- the governance arrangement requirements for joint commissioning and implications of membership of joint committees

3 Reasons for Recommendations

3.1 Guidance for the development of joint committees to oversee joint commissioning decisions indicates that its membership should include other statutory members of the Health and Wellbeing Board.

3.2 Co-commissioning local primary medical care services provides further opportunity to improve quality of services delivered, experience and outcomes for Cheshire East residents and its communities through improving the quality of general practice for patients.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 Co-commissioning could potentially lead to a range of benefits for the public and patients, including:

- improved access to primary care and wider out-of-hospitals services, with more services available closer to home;
- high quality out-of-hospitals care;
- improved health outcomes, equity of access, reduced inequalities; and
- a better patient experience through more joined up services.

4.2 Co-commissioning is seen as a way to:

- promoting greater Integration of health and care services
- shaping investment to increase primary care capacity
- designing and negotiating contracts to better meet local care system, patient needs as well as enhancing clinical engagement in primary care contracting
- enable better management contractual delivery, improving performance
- strengthen the quality improvement agenda, ensuring needs are locally defined rather than nationally, galvanising membership engagement
- enable greater consistency between outcome measures and incentives used in primary care services and wider out-of-hospital services
- improve the quality markers around patient experience, satisfaction and access through enhanced local provision and reduced unwarranted variation in care
- enable a more collaborative approach to designing local solutions for workforce, premises and IM&T challenges.

5 Background and Options

5.1 On 1st May 2014 Simon Stevens at the Annual NHS Clinical Commissioners Conference in London announced that CCGs would have the opportunity to co-commission primary care. CCGs received on the 9th May 2014 correspondence from NHS England outlining the detail behind this opportunity.

5.2 CCGs were asked to submit expressions of interest to develop new arrangements for co-commissioning of primary care services to NHS England by the 20th June 2014.

5.3 Further correspondence was received by NHS England on the 27th June 2014 and on 1st September 2014 providing an update on co-commissioning. 196 CCGs expressed an interest in co-commissioning. Notification was also given about the establishment of a national primary care co-commissioning oversight group to take the co-commissioning agenda foreword and which was to be co-chaired by Ian Dodge – national Director for Commissioning Strategy, and Dr Amanda Doyle – Chief Clinical Officer for NHS Blackpool CCG. This group has been tasked to oversee co-commissioning policy development and the publication of guidance setting out the steps that CCGs need to undertake towards taking on co-commissioning responsibilities.

5.4 On the 29th September 2014 CCGs received further correspondence from NHS England which presented for comment and review the slide deck, 'Proposed next steps towards primary care co-commissioning: an overview', which provided for discussion further detail around the proposed models for co-commissioning and key questions related to the implementation of these models. The three models which CCG's had a choice to take forward are:

- Model A: greater involvement in primary care decision making
- Model B: joint commissioning arrangements
- Model C: delegated commissioning arrangements

Appendix A provides further detail on what adopting a particular model of co-commissioning would mean for a CCG.

5.5 On the 10th November 2014 CCGs received final guidance around co-commissioning. The document entitled *'Next Steps towards primary care co-commissioning'* provided additional detail to CCGs with regards the models of co-commissioning, the steps required to submit the preferred approach and detail around conflicts of interest.

5.6 This document confirmed that for the 2015/16 period the commissioning of primary care services that include dentistry, optometry and community pharmacy services would remain the responsibility of NHS England, however CCGs would still have the opportunity to discuss these areas with their NHS England area team but have no formal decision making role.

5.7 *'Next Steps towards primary care co-commissioning'* was accompanied by a suite of supporting documents providing tools and resources to support CCGs in the process of submitting their proposals, namely:

- submission proforma for joint commissioning or delegated commissioning
- model wording for amendments to CCG Constitutions. This is required due to the passing of the Legislative Reform Order (LRO) in Parliament allowing CCGs to form joint committees with one or more CCG and to form joint committees with NHS England. Further detail has been provided in a briefing letter to CCG's. It is important to note that the LRO does not allow CCGs to form joint committees with Local Authorities. It is not the intention that joint committees will replace other important strategic decision making fora such as Health and Wellbeing Boards. Amendments to the individual constitutions of both NHS Eastern Cheshire CCG and NHS South Cheshire CCG have been made to reflect the model wording within the guidance and approved / ratified by the membership of each CCG and Governing Body.
- model Terms of Reference for joint commissioning arrangements and delegated commissioning arrangements.

5.8 On the 19th December 2014 NHS England released an updated version of 'Managing Conflicts of Interest: Statutory Guidance for CCG's – which incorporated additional guidance on how to manage conflicts with the advent of co-commissioning.

5.9 **Models of Co-commissioning.** For all forms of primary care co-commissioning, there has been clear feedback from CCGs that it would not

be appropriate for CCGs to take on certain specific pseudo-employer responsibilities around co-commissioning of primary medical care. Whilst CCGs must assist and support NHS England in discharging its duty under section 13E of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) so far as relating to securing continuous improvement in the quality of primary medical services, it has been agreed that NHS England will retain the following responsibilities regardless of what model option is chosen by a CCG:

- functions relating to individual GP performance management (medical performers' list for GPs, appraisal and revalidation)
- the administration of payments and list management
- setting the terms of General Medical Service (GMS) contracts – and any nationally determined elements of Primary Medical Services (PMS) and Additional Primary Medical Services (APMS) contracts. These terms will continue to be set out in the respective regulations and directions and cannot be varied by CCGs or joint committees. For the avoidance of doubt, CCGs will be required to adopt the findings of the national PMS and Minimum Practice Income Guarantee (MPIG) reviews, and any locally agreed schemes will need to reflect the changes agreed as part of the reviews.

5.10 With the freedoms of co-commissioning arises the need for mitigation of the potential risks of inconsistency of approach in areas where national consistency is clearly desirable. There is already an ability to set out core national requirements in GMS, PMS and APMS contracts through regulations. In line with this, NHS England reserves the right to set national standing rules, as needed, to be reviewed annually. NHS England will work with CCGs to agree rules for areas such as the collection of data for national data sets and IT intra-operability. The standing rules would become part of a binding agreement underpinning the delegation of functions and budgets from NHS England to CCGs.

5.11 Consistent with the NHS Five Year Forward View and working with CCGs, NHS England reserves the right to establish new national approaches and rules on expanding primary care provision – for example to tackle health inequalities. This applies to joint and delegated arrangements.

5.12 Throughout November 2014 both CCGs engaged with their member practices, governing body and clinical leadership seeking their views and agreement as to which model of co-commissioning to indicate to NHS England. Both CCGs agreed that for 2015/16 joint commissioning would be the option of choice.

5.13 In joint commissioning arrangements, individual CCGs and NHS England always remain accountable for meeting their own statutory duties, for instance in relation to quality, financial resources, equality, health inequalities and public participation. This means that in this arrangement, NHS England retains accountability for the discharge of its statutory duties in relation to primary care commissioning. CCGs and NHS England will need to ensure that any governance arrangement they put in place does not compromise their

respective ability to fulfil their duties, and ensure that they are able to meaningfully engage patients and the public in decision making. Arrangements should also comply with the conflicts of interest guidance.

5.14 For joint commissioning arrangements a joint committee structure has been the recommended governance structure as this allows a more efficient and effective way of working together than a committees-in-common approach. A joint committee is a single committee to which multiple bodies delegate decision-making on particular matters. The joint committee then considers the issues in question and makes a single decision. In contrast, under a committees-in-common approach, each committee must still make its own decision on the issues in question.

5.15 A model terms of reference for joint commissioning arrangements, including scheme of delegation, has been provided to CCGs and it being encouraged to be used as the framework for a local terms of reference, adapted to reflect local arrangements and to ensure consistency with the CCGs particular governance structures. Both CCGs are currently adapting the model terms of reference.

5.16 **Membership of joint committees.** It is for the area team and CCGs to agree the full membership, but the membership of the committee should be constituted so as to ensure that the majority is held by lay and executive members. The Chair and Vice Chair of the committee must always be lay members. Guidance indicates that GP representatives from other CCG areas and non-GP clinical representatives (such as CCGs secondary care specialist and/or Governing Body nurse lead can be invited to sit on the committee. Lay members not currently employed/contracted by a CCG can be co-opted onto this committee.

5.17 A standing invite must be made to Healthwatch Cheshire East and the Cheshire East Health and Wellbeing Board to appoint representatives to attend the committee meeting as non-voting attendees.

5.18 It is vital that membership of their committees retains clinical leadership for commissioning.

5.19 Meetings of the Joint Committee are expected to be held in public, unless the CCG has concluded it is appropriate to exclude the public.

5.20 It is not the intention that joint committees will replace other important strategic decision making fora such as Health and Wellbeing Boards.

5.21 **Resources and support.** Under joint commissioning arrangements there will be no direct transfer of dedicated staff resources from the NHS England area teams primary care commissioning staff, and there is no possibility of additional administrative resources being deployed on these services at this time due to running cost restraints. Therefore conversations are ongoing with the area team and neighbouring CCGs with regards identifying a pragmatic and flexible local solution to accessing and pooling support through the

existing area team primary care team and primary care expertise within CCGs.

5.22 It has been recognised by NHS England that it will be challenging for some CCGs to implement co-commissioning arrangements without an increase in running costs. Whilst NHS England has indicated that an increase is not possible in 2015/16, they will keep this situation under review.

5.23 **Approval process.** Both CCGs are required to submit their individual proforma to NHS England by 30th January 2015. The proposal will be agreed by the area team via regional moderation panels that will convene in February 2015, and if they are assured that arrangements comply with the legal governance framework and constitution amendments have been approved. Once approved, the CCG and NHS England will be required to sign a legally binding agreement to confirm how both parties will operate under joint arrangements, with a view to arrangements being implemented by 1 April 2015.

5.24 Unless a CCG:

- Serious governance issues; or
- Is in a state akin to 'special measures'

then NHS England will support a CCG to move towards joint commissioning

5.25 In the event the CCG proposal in not recommended for approval, regional teams will work with the CCG and the area team to support the development of joint arrangements.

5.26 It is anticipated that many CCGs across England intend to enter into joint commissioning arrangements for 2015/16 to see how the agenda develops, before deciding to take on delegated responsibilities from 2016/17.

5.27 **Assurance.** The on-going assurance of primary care co-commissioning arrangements would be managed as part of the wider CCG quarterly assurance process, adapted according to the commissioning function that the CCG is undertaking. NHS England is currently working with CCGs to co-develop a revised approach to the current CCG assurance framework for 2015/16.

5.28 As primary medical care co-commissioning has implications for Local Authorities and Health Wellbeing Boards, NHS England has provided updates to both Local Authority CEOs and HWB Chairs. The last update was sent on 18th December 2014.

6 Access to Information

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

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Designation: Chief Officer
Tel No: 01625 663764
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Appendix A Model Options for Co-Commissioning

Model A: Greater Involvement in Primary Care decision making Aims to deliver greater CCG involvement in influencing commissioning decisions made by NHS England area teams; this requires no formal governance process and Area Teams will be expected to put the appropriate arrangements in place. This option **does not** change the existing relationship and responsibilities of the CCG. Furthermore, there are no requirements for the CCG to enter into new governance arrangements and it is unlikely that CCGs will encounter increased conflicts of interest.	Advisory role for the planning of wider Primary Care services (not medical): • Assessing needs • Co-designing services/models • Developing strategic direction for services • Liaison with other service partners Advisory role for strategic planning of General Practice • With HEE of workforce • Premises, including Prioritisation of investment via joint SYB wide governance • arrangements • Reducing unacceptable variation in quality of provision • The CCG would have the opportunity

	to invest in Primary Medical Care services in line with current arrangements.
Model B: Joint Commissioning Arrangements Joint commissioning arrangements; requires appropriate governance arrangements and the creation of a Joint Committee across NHS England and the CCG(s). NHS England's scheme of delegation is being reviewed and will be revised as appropriate to enable to formation of joint committees between NHS England and CCGs. Funding under this option will remain on the NHS England financial ledger, and NHS England will remain party to all decision making.	Jointly designing, reviewing and making contract decisions: • GMS/PMS/APMS contracts • Jointly deciding appropriate arrangements for practice splits/mergers/replacements • Joint decisions and setting priorities for discretionary spend on premises and how to increase workforce capacity • Joint approach to decisions on reinvestment of any released primary care medical spend, based on agreed strategic place based strategy • Jointly reviewing practice and deciding strategic direction and scope • Jointly managing enhanced services not delegated to the CCG • Working collectively together on Primary Care Education & Training • Joint decision making in establishment of new GP practices, and approving practice mergers • Joint decision making on "discretionary payments" • Pooling of funding for investment in primary medical care services.

Model C: delegated commissioning arrangements: Requires a comprehensive assurance process to satisfy NHS England that the CCG(s) has the capacity and capability to undertake this additional role, that the evidence of expected benefits to patients is clear, and that CCG governance arrangements, particularly in relation to conflict of interest, are robust. An assurance process, coordinated and managed in line with the broader CCG assurance	Offers an opportunity for CCGs to assume full responsibility for commissioning general practice services. However, legally, NHS England retains the residual liability for the performance of primary medical care commissioning. A standardised model of delegated commissioning responsibilities has been agreed and includes; • GMS, PMS, APMS contracts • Newly designed enhanced services ("Local Enhanced Services" (LES) and "Directed Enhanced Services" (DES)) • Design of local incentive schemes as an alternative to the Quality and Outcomes Framework (QOF) • Ability to establish new GP practices in an area. • Approving practice mergers • Making decisions on discretionary payments (e.g. returner / retainer schemes) • Pooling of funding for investment in primary medical care services

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Cheshire East Health and Wellbeing Board
27th January 2015

The NHS Five Year Forward View and NHS Planning for 2015/16

The NHS Five Year Forward View was published in October 2014 and represented a significant shift in the way the NHS in England is managed and organised, setting a new direction for the NHS based on four key themes;

1. **Why the NHS needs to change**
2. **What will the future look like? A new relationship with patients and communities**…..
    a. Getting serious about prevention…..
    b. Empowering patients…..
    c. Engaging communities…..
    d. The NHS as a social movement…..
3. **What will the future look like? New models of care**
    a. Emerging models
    b. New care models
    c. How we will support local co-design and implementation
4. **How will the NHS get there?**
    a. support for diverse solutions and local leadership
    b. aligning national NHS leadership
    c. creating a modern workforce
    d. exploiting the information revolution
    e. accelerate useful health innovation
    f. drive efficiency and productive investment

Following publication of the NHS 5 year Forward View, NHS England, Monitor, the NHS Trust Development Authority, the Care Quality Commission, Public Health England and Health Education England have come together to issue the joint guidance called **The Forward View into action: planning for 2015/16,** coordinating and establishing a firm foundation for longer term transformation of the NHS.

The guidance is backed by the recently-announced £1.98 billion of additional funding, and also a significant shift in the way funding for healthcare commissioners are allocated.

2015/16 Planning Guidance

In late December, NHS England published the 2015/16 planning guidance titled and information regarding 2015/16 CCG allocations.

In the main, it is less bureaucratic than in recent years, and focuses on implementing the NHS Forward View. CCG's are required to produce new 2 year operational plans with an option (not mandatory) to refresh their 5 year plans published in 2014/15

The key new requirements and initiatives set out in the guidance which affect clinical commissioning groups are summarized in bullet point below:

- A process to identify and appoint new **"vanguard" sites** to lead the development and implementation of the new NHS care models
- Clinical commissioning groups must increase their **spend on mental health** by at least as much as the increase in their allocation
- New commissioning for quality and innovation payments for treatment of **sepsis and acute kidney injury**
- A new CQUIN on improving urgent and emergency care
- A requirement to increase and accelerate plans to progress towards **seven day working**
- CCGs and providers to agree plans to **improve antibiotics prescribing**
- Introduction of **two new mental health access targets** *(By April 2016, 50% of people experiencing a first episode of psychosis to receive treatment within 2 weeks and at least 75% of adults should have had their first treatment session within 6 weeks of referral, with a minimum of 95% treated within 18 weeks*
- Requirement for CCGs to work closer with Local Authority partners to **establish quantifiable ambitions to reduce inequalities**, specifically around behaviour interventions related to smoking, alcohol and obesity.
- Requirement for all NHS Organisations to implement actions to **improve staff health & wellbeing**
- **Expansion of personal health budgets**
- Requirement for CCGs to review choices available to women accessing **maternity care**
- Requirement for CCGs to draw up plans with Local Authority partners to **identify and support carers** (link to 2013 Care act)
- Confirmation of the £1bn fund available over 4 years to **improve primary care** premises and infrastructure
- 60% of practices to **process prescriptions electronically** and 80% of elective referrals to be completed electronically by March 2016
- Reconfirmed that CCGs must **reduce running costs** by 10%
- "Winter pressures funding" now included within CCG baselines

In the guidance, NHS England has made a significant step towards addressing the historical underfunding in some geographic areas, and an increasing recognition of the need to reflect ageing populations in CCG allocations. Both NHS South Cheshire CCG and NHS Eastern Cheshire CCG have seen improved allocations above the National average and have moved closer to their target allocations.

Perhaps the most significant section of the guidance relates to the development of new types of care models, recognising that the existing care system is not sustainable, the need to invest and improve primary care, the move to community integrate care models and the need for some treatments to move to specialist centres to improve health outcomes.

Cheshire East Council, NHS South Cheshire CCG, and NHS Eastern Cheshire and partner organisations are already moving forward exploring new models of care through both Caring Together and Connecting Care programmes.

NHS England has confirmed in the guidance that it wants to set up a cohort of health economies that can develop “prototypes” of new care models such as primary and acute care systems, and multispecialty community providers.

In summary the guidance presents both significant opportunities and challenges for both commissioners and providers of health and social care services. Many of the initiatives will require close collaboration of partners and a commitment to prevention and engagement with local communities.

The Health and Wellbeing Board will play a pivotal role in providing local leadership and ensuring the commitments in the guidance are delivered.

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Wellbeing Board

Date of Meeting: 27 January 2015

Report of: The Director of Adult Social Services and Independent Living, Brenda Smith, Cheshire East Council; Karen Burton, NHS Eastern Cheshire CCG and Julia Burgess, NHS South Cheshire CCG

Subject/Title: Winterbourne View/Transforming Care Update

1.0 Report Summary

1.1 This report provides an update on progress with meeting the key requirements set out in "Transforming Care" and describes the newly introduced Care and Treatment Review process.

1.2 Transforming Care set out four key recommendations in relation to people with LD or autism in NHS funded inpatient settings;

1.2.1 By end of March 2013, CCGs to put in place a register of people with LD or autism funded by the NHS for their care needs.

All Cheshire East residents who meet the criteria for the register were identified and included on this register within the required timescales. The register continues to be updated and in line with subsequent data reporting requirements, the two CCGs submit regular updates on numbers and progress towards discharge via the NHS England Area Team to the national team.

1.2.2 By June 1st 2013, review the care of all those included on the register and agree a care plan for each individual based on their and their families' needs.

Both CCGs met, and continue to meet, this requirement for all clients.

1.2.3 By June 1st 2013, all current placements will be reviewed and everyone in hospital inappropriately will move to community based support as quickly as possible, and no later than June 2014.

In June 2014, 14 Cheshire East residents were placed in inpatient settings, eight from NHS Eastern Cheshire CCG and six from NHS South Cheshire CCG. Since June, two Eastern Cheshire and one South Cheshire patient have been discharged to community settings[1].

The individuals who remain in hospital are considered to have needs that cannot currently be met in a community setting (although it is acknowledged that the decision to deem a

[1] One South Cheshire patient has also been removed from the register as it transpired that he did not have a learning disability and had been included on the register due to an error in reporting which has now been resolved.

placement as appropriate may be due in part to the absence of any realistic alternatives). These patients are now required to have an independent Care and Treatment Review (CTR), unless they have a discharge date prior to 31 March 2015 and or do not give consent.

The focus of CTRs is on;

- Whether the individual feels safe in their current placement
- How their care is progressing
- What plans are in place for future care

Consent is gained via the provider with which the patient is currently resident. If a patient lacks capacity to consent then the best interests of the patient are determined as to whether a review would be beneficial. Reviews are not be undertaken if the patient does not lack capacity and declines to consent.

CTRs are being undertaken by independent panels with the purpose of reviewing the care of all of the patients who were in hospital before and up to 31 March 2014. Once this cohort of patients has been completed those patients in services as of 1 April 2014 will also be reviewed.

As a minimum each independent panel consists of a local commissioner, a clinical reviewer, an expert by experience and a local authority representative. The CCGs are working closely with NHS England to carry out the reviews as the Area Team have been tasked with providing independent clinical reviewers and experts by experience to support the CTR process. Patients and family members are supported to contribute to the review process where they wish to do so.

At the time of writing, the nine clients (three for South Cheshire CCG and 6 from Eastern Cheshire) who meet the criteria for a CTR have been contacted to ask for their consent to the process. Of the nine, one from South Cheshire CCG and to date 5 from Eastern Cheshire CCG have given this consent. All but one of these six individuals (who is from Eastern Cheshire CCG) has now had their CTR. Two further (Eastern Cheshire CCG) CTRs are planned for 23rd January although consent is still pending from one individual which will determine if a CTR will be held.

CTRs are part of the government's response to the national target of 50% patients being discharged from hospital settings into community care services not being achieved as quickly as the government would like.

The expectation nationally is that 50% of LD patients currently in receipt of hospital services as of 31 March 2014 will be discharged to a community setting before 31 March 2015. However it has been acknowledged that in order to achieve the 50% discharge target we should plan for 70% as patients may deteriorate prior to discharge and there may be difficulties with Ministry of Justice approval for some individuals including those with forensic needs and those in secure placements.

1.2.4 By April 2014 CCGs and their local authorities will have a locally agreed joint plan to ensure high quality care and support services for all people with learning disabilities or autism and mental health conditions or behaviour described as challenging.

Cheshire and Wirral Partnership NHSFT are leading on a piece of work to integrate clients who have been placed out of the local area back into their local communities, if appropriate, in a person centred way with their agreement and family involvement.

A joint commissioning plan has been drafted between the local authority and the two CCGs.

Within Cheshire East, there are currently very limited community alternatives to inpatient services; therefore this type of provision will need to be developed to meet the needs of individuals as identified through the CWP inpatient review, CTR process and ongoing care planning approaches for clients. The North West Commissioning Support Unit have been alerted to this as an area of work for the coming months and have advised the CCG that a Framework approach would be the most appropriate commissioning model.

2.0 Recommendation

2.1 That the Health and Well-being Board is informed of and comments on progress that is being made in relation to both the review of individuals in inpatient settings, and the development of alternative models of care within the local area.

2.2. That the Local Adult Safeguarding Board receives quarterly updates to provide the routine monitoring of the progress of this area of work and the LASB is required to escalate any concerns that require further strategic scrutiny to the Health and Wellbeing Board.

2.3 That the Health and Well-being Board receives an annual report in January each year

3.0 Reasons for Recommendations

3.1 The level of scrutiny placed on the small number of remaining inpatient placements has increased significantly. An appropriate body should monitor local progress with meeting the requirements set out by NHS England.

5.0 Access to Information

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

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Connecting Care Across Cheshire
Three localities, one ambition
NHS Eastern Cheshire CCG | NHS South Cheshire CCG | NHS Vale Royal CCG
NHS West Cheshire CCG | Cheshire East Council | Cheshire West and Chester Council

Connecting Care Across Cheshire Pioneer Panel

Minutes of Meeting held on 13th November 2014, Wyvern House, Winsford

Present: Cllr Brenda Dowding, (Chair) Cheshire West and Chester Council
Mark Palethorpe, Cheshire West and Chester Council
Lorraine Butcher, Cheshire East Council
Dr Jonathan Griffiths, Chair, NHS Vale Royal CCG
Alison Lee, NHS West Cheshire CCG
Jerry Hawker, NHS East Cheshire CCG
Simon Whitehouse, NHS Vale Royal and NHS South Cheshire CCGs
Amanda Lonsdale, Cheshire Pioneer Programme Director

Ref	Minute	Action
1.	**Apologies, Introductions and Welcome** Apologies were received from Cllr Janet Clowes, Dr Andrew Wilson, Dr Paul Bowen, Dr Huw Charles-Jones, and Belinda Dooley. Cllr Brenda Dowding extended a warm welcome to all members.	
2.	**Notes of Last Meeting and Matters Arising** The notes of the previous meeting were accepted as an accurate record. **Matters Arising** **Twilight meetings** – noted that arrangements for future Cheshire Pioneer Panel meetings are being progressed and the option of twilight meetings will not be explored due to commitments of panel members. **PIRU baseline assessment** – outstanding interviews have taken place and a final report is expected in early 2015. **Terms of reference** – the group discussed the value of the current joint clinical and senior management leadership representation on the panel which enables learning and synergy across the systems leaders in Cheshire. To ensure clear lines of accountability, it was agreed that the Cheshire Pioneer Panel minutes would be sent to the two Health and Wellbeing Boards for information along with a 6 monthly update report. **Action – Amanda Lonsdale to circulate minutes to Health and Wellbeing Boards.** **Cheshire Pioneer Learning Event/Conference –** Jonathan Griffiths highlighted an opportunity to be involved in a conference with the NHS Leadership Academy in order to share the Cheshire Pioneer experience and it was agreed that Jonathan Griffiths and Amanda Lonsdale would explore this opportunity further. **Action – update next meeting.**	Amanda Lonsdale Jonathan Griffiths/ Amanda Lonsdale

	Transformation Challenge Award – the group noted 2 separate applications for Transformation Challenge Award funding had been submitted, namely Transitional Care and Complex Dependency (troubled families). **Integrated Personal Commissioning (IPC) Initiative** – an application for learning disabilities has been submitted for this initiative which will focus on implementation of personal health budgets for individuals with learning disabilities. If the application is successful, the project would commence in Cheshire West with roll out across the remaining footprint following early learning. **Action – update next meeting.**	Amanda Lonsdale
3.	**Cheshire Pioneer Workstream Updates** **Self-Empowered Person** – Guy Kilminster presented background information to the Empowered Person work-stream within the Caring Together' Programme. The group discussed how this initiative would be suitable to be scoped across the Cheshire footprint and acknowledged that empowering patients has been recognised as a key part of the NHS Five Year Forward Plan launched in October. It was agreed that Heather Grimbledeston, Director of Public Health in Cheshire East Council will undertake a scoping exercise with Fiona Reynolds, Acting Director of Public Health in Cheshire West and Chester Council. **Action – update on scoping exercise next meeting.** **Cheshire Pioneer Integrated Digital Shared Care Record** – an implementation group has been set up in order to introduce the West Cheshire record across the remaining Cheshire footprint. A business case will be produced which will require approval across partners due to the ongoing financial commitments associated with this project. The outcome of the Techfund2 bid supported by all partners for national funding for the introduction of the integrated digital shared care record is awaited. **Action – update next meeting.** **Transitional Healthcare** – it was noted that transitional care is included within each of the Better Care Fund submissions. The West Cheshire Way programme currently has a project to introduce the Care Category Framework which will be a service delivery framework for transitional care and the STAIRRs project is a concept which has been discussed via the Caring Together and Connecting Care in Central Cheshire programmes with a workshop taking place on 7th November 2014. It was recognised that whilst there are 2 separate projects running for transitional care, there will be a common outcome for individuals across Cheshire. **Action – update next meeting.** **Continuing healthcare** – panel members noted the concept of a new 'operating model' to drive a change in the provision of Continuing Health Care commissioning support services. The intended outcome of this initiative is to ensure the services that are commissioned are safe for service users and that service users and their families are fully involved with decision making. It was noted that the patient and their family are at the heart of this redesign process. The panel noted that both Cheshire East and Cheshire West and Chester Councils are key stakeholders in this area of work due to their role in the assessment process. Opportunities exist to utilize the business redesign teams within Councils to support this area of work. **Action – update next meeting.**	Guy Kilminster Amanda Lonsdale/ John Glover Amanda Lonsdale Amanda Lonsdale

4.	**Pioneer Assembly 6th November 2014** Three representatives from Cheshire attended the Pioneer Assembly on 6th November and the following issues were highlighted: Ian Dodge is now the Pioneers lead within NHS England and there is an expectation that Pioneers take an active part at responding to the new models of care referenced in the 5yearforward view. The Pioneer programme will be expanded to include an additional 10 sites which will be announced at the Year End conference on 27th January 2015. Pioneer sites will be requested to contribute to a Pioneer Annual Report and further information regarding this request is awaited. Feedback from the 4 national Pioneer sub-groups was noted: **Information Sharing and Informatics** – there are 8 work streams included within this group. Kevin Highfield is the key Cheshire representative on this group but the Panel agreed that it would be helpful to have representation on the informatics group. **Leadership and workforce** –expectation that Pioneers will really address systems leadership. A Synthesis paper – Exceptional leadership for exceptional times from the Staff college identifies what works in system leadership for integration. Claire Henderson from Islington shared their experience; avoided difficult conversations, didn't talk money or difficult issues which were all under the surface; Shared vision same words different intent. They worked with Jo Clearly their enabler and now have a real focus on shared vision with distributed leadership. **Pricing and contracting – Jyrki Kolsi, MONITOR** – this small technical group are discussing prototypes of capitation. Caroline Bailey from North West London shared experience – using capitated approach, shadow running in 15/16 using a segmentation framework **Provider development -** John Wardell, Waltham Forest, East London and City Site outlined the provider event on 22nd October 2014. This was an interactive event hosted by WELC Care Collaborative learning from a number of leading provider organisations and discussed the opportunities for stimulating service development and provider engagement to support the integrated care programme. The Panel discussed the importance of having a full picture of all ongoing sub-group work and how this is communicated across the 3 integration programmes. **Action – to produce a summary of national Pioneer sub-groups.**	Amanda Lonsdale
5.	**National Pioneer Support Group** Ian Dodge, National Director Commissioning Strategy, NHS England has invited representation from Pioneer sites to become involved in a Pioneers Support Group which is designed to assist the pioneers in making progress with the integration agenda, bringing coordination and opportunities for shared learning within and beyond the programme. The first meeting of this support group is planned for 28th November 2014 and Simon Whitehouse will attend this first meeting to represent the Cheshire Pioneer Programme. **Action – feedback next meeting**.	Simon Whitehouse

6.	**Cheshire Pioneer Programme website** Panel members noted that a dedicated Cheshire Pioneer website is now operational which will be used to share learning and good practice across Cheshire and across other areas. Amanda Lonsdale will be liaising with the Transformation Directors of the three programmes to agree a timetable for including information on the website.	
7.	**Age UK Integrated Care Partnership Initiative** The panel noted an application from Age UK Cheshire, the West Cheshire Way and Connecting Care in Central Cheshire programmes would be submitted. The application related to further implementation of third sector wellbeing coordinators, community navigators and care coordinators.	
8.	**Any Other Business** **Challenge Sessions -** a proposal to host a session with NHS England and MONITOR to discuss the challenges that both provider and commissioning partners are facing was discussed. It was agreed that this would be a good opportunity to discuss with regulatory bodies the barriers that are faced when undertaking integration programmes. It was agreed that it would be useful to include representation from Department of Communities and Local Government. **Action – arrange session with relevant senior representatives from NHS England, MONITOR and Department of Communities and Local Government.** **Systems Leadership** - the opportunity to access systems leadership support to the panel was discussed and it was agreed that this opportunity could focus on the panel as the leadership group across the borough. **Action – initial discussions to take place regarding systems leadership support.** **Mental Health Concordat** - Lorraine Butcher highlighted to the panel that the Mental Health Concordat across Cheshire, Halton and Warrington has been signed off. **Better Care Fund Governance** - as part of the Better Care Fund submissions, there is a requirement to have in place section 75 agreements which will support clear governance and accountability for delivery of schemes which are recognised as the delivery mechanisms for the transformation programmes. Lorraine Butcher agreed to produce a working paper, following discussions with panel partners, that would be discussed at the next panel meeting. **Action – working paper regarding section 75 agreements to be produced and discussed at next meeting.** **Data Challenge Session** - The panel noted the offer that had been made through North West Coast Academic Health Science Network from Aridhia Informatics Ltd to undertake a data challenge event for the Cheshire Pioneer footprint. A similar event had taken place with Waltham Forest, East London and City Pioneer site which supported the development of local analysts and clinicians to work with joined up data sets and with each other to develop local skills in the evaluation of integrated care. **Action – feedback next meeting on this offer.**	Amanda Lonsdale Amanda Lonsdale Lorraine Butcher Amanda Lonsdale
9.	**Date and time of next meeting** Monday 12th January 2015, 11 am, Kim Ryley Room, Cheshire East Council, Westfields, Sandbach, CW11 1HZ	