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Health and Adult Social Care Overview and Scrutiny Committee

Agenda

Date:	**Thursday, 11th September, 2014**
Time:	**10.00 am**
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. **Minutes of Previous meeting** (Pages 1 - 4)

   To approve the minutes of the meeting held on 7 August 2014

3. **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.

4. **Declaration of Party Whip**

   To provide an opportunity for Members to declare the existence of a party whip in relation to any item on the Agenda

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

For requests for further information
Contact: James Morley
Tel: 01270 686458
E-Mail: james.morley@cheshireeast.gov.uk with any apologies

A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

Individual members of the public may speak for up to 5 minutes, but the Chairman will decide how the period of time allocated for public speaking will be apportioned, where there are a number of speakers.

Note: in order for officers to undertake and background research, it would be helpful if members of the public notified the Scrutiny Officer listed at the foot of the Agenda at least one working day before the meeting with brief details of the matter to be covered.

6. **Adult Social Care Commissioning Strategy** (Pages 5 - 38)

To examine the Adult Social Care Commissioning Strategy and make comments on proposals to be submitted to Cabinet for consideration.

7. **Winter Wellbeing** (Pages 39 - 76)

To review winter planning during 2013 and consider the multi-agency Winter Wellbeing activities planned for 2014.

8. **Work Programme** (Pages 77 - 82)

To review the current Work Programme

Agenda Item 2

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Overview and Scrutiny Committee**
held on Thursday, 7th August, 2014 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor M J Simon (Chairman)
Councillor J Saunders (Vice-Chairman)

Councillors C Andrew, R Domleo, L Jeuda, G Merry and A Moran

Apologies

Councillors S Jones

ALSO PRESENT

Councillor J Clowes – Cabinet Member for Care and Health in the Community
Councillor S Gardiner – Deputy Cabinet Member
Councillors D Flude, I Faseyi, S Hogben, B Murphy, D Newton

OFFICERS PRESENT

Brenda Smith – Director of Adult Social Care and Independent Living
Ann Riley – Corporate Commissioning Manager
Iolanda Puzio – Deputy Monitoring Officer
James Morley – Scrutiny Officer

20 **MINUTES OF PREVIOUS MEETING**

RESOLVED – That the minutes of the meeting held on 10 July 2014 be agreed as a correct record.

21 **DECLARATIONS OF INTEREST**

Councillor L Jeuda declared an interest as a signatory of the two Call-Ins

Councillors A Moran and C Andrew declared an interest as members of the task and finish group that conducted the Dementia and Older People Review 2010-2013

22 **DECLARATION OF PARTY WHIP**

There were no declarations of party whip

23 **PUBLIC SPEAKING TIME/OPEN SESSION**

Members of the public were provided with a total of 15 minutes to make a statement on any matter that fell within the Committee's remit.

Mrs C Peters-Rock representing Cheshire Action for Cheshire Area spoke about care for people with dementia. She suggested that loss of day care and respite centres for people with dementia would be detrimental to carers' ability to cope with their caring duties. She referred to the independent and private sector as the commercial sector and warned the Council that commissioning services from this sector may put services at risk of failure. She suggested that there were a lot of carers who did not have much in the way of support and this was a particular problem for elderly carers. She suggested that there would be hardly any support facilities in future unless something changed. She requested that the Committee needed to conduct a review of respite and day care facilities.

Mr E Clark representing service users in Congleton spoke about the respite facilities at Mountview. He suggested that there was very little provision of services for people in Congleton and closing Mountview would mean that there were no services in Congleton. He suggested that consultation which had been carried out was poor and with the wrong people. He asked where people in Congleton would go if Mountview closed and suggested that Crewe and Macclesfield were too far. He suggested that there was not currently enough capacity in Cheshire East to meet demand.

Mr M Card spoke about learning disabilities services provided at Lincoln House. His son used respite facilities there which needed upgrading. He suggested that promises to refurbish facilities had not been fulfilled sufficiently and that the budget for alterations had been underestimated. He was concerned that decisions whether or not to close or retain facilities were being made using inaccurate information.

Mr R Bradley, who was in his 80s, spoke about caring for his 57 year old son. He was new to caring and found Lincoln House had helped him with respite which he required as a full time carer because of his age. He suggested that respite facilities were the only difference between being able to care for his son at home and having to put him in residential care. He suggested that private respite facilities were not available when people really needed them so places like Mountview and Lincoln House should be kept open.

Mr J Cooper was a carer and suggested that Cheshire East Council was looking to put care out to the commercial sector. He suggested that the Council would be able to provide a better service than the private sector and should continue with its current facilities. He also suggested that there should be provision across the borough and not just in Crewe and Macclesfield.

The Chairman thanked each of the speakers and the Committee noted their comments.

24 CALL-IN OF THE DECISION OF CABINET DATED 1 JULY 2014 RELATING TO DEMENTIA COMMISSIONING PLAN

Before opening the discussion in respect of this matter the Chairman provided a brief overview of the extent to which the Committee could review the decision of Cabinet to clarify the procedure. The Chairman reminded the Committee that the decision regarding Dementia Commissioning Plan which was the subject of the

Call In did not involve any consideration of closure of facilities. The Committee was asked to consider whether or not to offer advice to Cabinet in response to the Call In, which suggested that no consultation with the public, carers or service users had taken place.

Councillor D Flude, lead Call In member, presented her reasons for the Call In. She suggested that proper consultation with the public, and service users and carers, had not taken place before this decision had been made. She expressed concern that the plan was not effective in addressing the issues people were raising and requested that the decision be properly reviewed by the Committee before going back to Cabinet for reconsideration.

Councillor J Clowes, Cabinet Member for Care and Health in the Community, presented the Cabinet's response to the Call In. She suggested that as this was simply a decision about the plan on Dementia Commissioning there was no requirement to consult the public before the decision was made. She also stated that during the development of the plan officers had consulted a variety of service users, community groups, organisations and charities on what their views were and what the plan should consist of. She believed that, whilst this wasn't formal consultation in the legal sense this was engagement of the public in the plan and was more than sufficient consultation in the circumstances. She also stated that during the implementation of the plan formal consultation with the public would be required and would take place as appropriate when decisions regarding facilities and operations were due to be taken.

At this point the meeting was adjourned for 10 minutes and reconvened at 14:50.

The Committee considered the information it had received regarding the reasons for Call In and the response from Cabinet.

It was concluded that the engagement that had taken place during the development of the plan gave the public the opportunity to influence the plan and have their say and therefore further consultation was not necessarily required.

Members also suggested that public concerns about the future of services may have developed because communication with the public about the process had not been effective and stressed the importance of communicating effectively with service users, carers, staff and the public during the decision making process to ensure all parties were clear about what was happening and why.

It was proposed that the Committee need not offer advice to the Cabinet on its decision in response to the Call In. The proposal was agreed by the Committee following a vote with five in favour and two against.

RESOLVED – That in response to the Call In the Committee offers no advice to Cabinet regarding its decision about the Dementia Commissioning Plan made on 1 July 2014.

25 CALL-IN OF CABINET DECISION DATED 1 JULY 2014 RELATING TO MOUNTVIEW SERVICES REVIEW

Before opening the discussion in response to this matter the Chairman provided a brief overview of what the Committee would be considering to clarify the procedure. The Chairman explained that the Committee was only able to

consider the decision made at the Cabinet meeting on 1 July 2014 and not the decision made on 24 June 2013 which was referred to in the 1 July 2014 decision, as the Call In period for that had expired five days after the decision notice had been published last year. Paragraph 9.7 of the cover report on page 28 confirmed the decision that was under consideration.

Councillor I Faseyi, on behalf of the Call In group, gave reasons for the Call In. She suggested that the Cabinet had not taken consultation responses which opposed the closure of Mountview into consideration when it made its decision in June 2013. She expressed concerns that the three beds for respite care which had been commissioned in the Cabinet's decision would not be sufficient to replace the 35 beds which were currently provided at Mountview. She also suggested that relevant information from the Coroner's report into a recent death at Mountview had not been taken into consideration when making the decision on 1 July 2014.

Councillor J Clowes, Cabinet Member for Care and Health in the Community, presented the Cabinet's response to the Call In. She stated that the decision in June 2013 was not under consideration as part of this Call In. She also suggested that the Coroner's report had no bearing on the decision taken on 1 July 2014. She stated that Mountview would remain open until alternative provision could provide and the three beds block purchased were not replacing all beds at Mountview.

The Committee considered the information it had received regarding the Call In and the response to the Call In. It was proposed that the Committee need not offer advice to the Cabinet on its decision as the decision was simply noting what had taken place in order to effect implementation of a previous decision.

RESOLVED – That in response to the Call In the Committee offers no advice to Cabinet regarding its decision about Mountview Services Review made on 1 July 2014.

The meeting commenced at 2.00 pm and concluded at 4.00 pm

Councillor M J Simon (Chairman)

Agenda Item 6

CHESHIRE EAST COUNCIL

REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting:	11 September 2014
Report of:	Director of Adult Social Care and Independent Living, Brenda Smith
Subject/Title:	Draft Adult Social Care Commissioning Strategy
Portfolio Holder:	Cllr Janet Clowes

1.0 Report Summary

1.1 The Council is putting residents first and intends to ensure that social care needs are a top priority in Cheshire East Council. This is a strong response to plan actions now that will make a real difference going forward. The commitment to residents first has resulted in a full consideration of the key changes that will make a difference to the outcomes of all people who may need social care support in future. This draft strategy outlines the key actions for 2014/15 that will improve outcomes. It recognises the challenge of an increasing older population and complex needs and will ensure that Council outcomes can be delivered into the future.

1.2 The Council intends to have a planned programme of further development of support to adults who may require social care, building on the current best practice locally. We will be seeking innovations and creativity to ensure that independence and choice and control for individuals continue to increase.

1.3 This report seeks input from the Committee to enhance the draft Adult Social Care Commissioning Strategy at Appendix 1.

1.4 The Adult Social Care Commissioning Strategy will be a working document that is revised regularly to reflect the progress of plans and identify further stages of these plans. This strategy will be the tool that the Council uses to ensure continuous improvements in support that will result in better outcomes.

2.0 Recommendation

2.1 That the Committee examine the draft Adult Social Care Commissioning Strategy as appended and agree any comments and recommendations it may have for Cabinet and/or Officers

3.0 Reasons for Recommendations

3.1 As part of the policy development process the Committee is being provided with the opportunity to submit comments and raise any issues

it feels need to be taken into consideration by Cabinet when it receives the draft Adult Social Care Commissioning Strategy.

3.2 The principal aims and benefits that the Commissioning Strategy will realise are to:

- Map the current picture of needs, available support and gaps in support
- Consider customer insights and feedback and ensure they are driving improvement in support
- Enable the identification of priority areas of joint commissioning with health, public health, children's services, housing and others
- Use this analysis to clarify and prioritise the adult social care commissioning annual delivery plan to improve support and address gaps.

4.0 Wards Affected

4,1 All Wards

5.0 Local Ward Members

5.1 All Ward members

6.0 Policy Implications

6.1 This Adult Social Care Commissioning Strategy supports The Strategic Direction of Travel for Adult Social Care Services – Promoting Open Choice as agreed at Cabinet of 4 February 2014 and the Strategic Direction of Travel – Informal Support as agreed at Cabinet of 4 February 2014. It will contribute to the delivery of the Cheshire East Council Three Year Plan outcomes:

Outcome 1: Our Local Communities are Strong and Supportive

Outcome 2: Cheshire East has a Growing and Resilient Economy

Outcome 5: Local People Live Well and for Longer

7.0 Financial Implications

7.1 None. Any key decisions will be taken through further Cabinet reports as necessary.

8.0 Legal Implications

8.1 None. Any key decisions will be taken through further Cabinet reports as necessary.

9.0 Risk Management

9.1 No identified risks in this overall strategy.

10.0 Access to Information

Name: Ann Riley
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Appendix 1 – Draft Adult Social Care Commissioning Strategy – 2014

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DRAFT Adult Social Care Commissioning Strategy

Commissioning to meet social care needs

April 2014

Executive Summary

Introduction

This is Cheshire East Council's Adult Social Care Commissioning Strategy. It is a working document that will be updated annually to reflect progress and provide for continuous improvement of all our support to adults. Adults in the context of this strategy mean adults in need of social care support. The priorities identified are based on our current understanding of customer needs and gaps but this understanding is work in progress; hence annual updates will refine this.

Its principal aims are to:

- Map the current picture of needs, available support and gaps in support
- Consider customer insights and feedback and ensure they are driving improvement in support
- Enable the identification of priority areas of joint commissioning with health, public health, children's services, housing and others
- Use this analysis to clarify and prioritise the adult social care commissioning annual delivery plan to improve support and address gaps

Scope

Adult social care services are the primary focus of this commissioning strategy. These services are targeted services that provide support to adults with social care needs who meet the eligibility criteria of the Council i.e. substantial and critical needs. In addition the service also seeks to provide advice and information and early help to those who are at risk of becoming more dependent so that they can maintain their independence for longer. Where there are key links or joint commissioning with health, public health, children's services or others these have been identified.

The strategy has many aspirations that relate to all adults but some particular groups require additional specialist focus, those groups include the following:

- Frail Older People
- Older People with Dementia
- Adults with Learning Disabilities
- People with Mental Health Problems
- People with Physical and Sensory Disabilities
- Carers of people with health and social care needs

This strategy is for all people with eligible social care needs, this includes those who fully fund their own care as well as those the Council support financially. The strategy recognises the new requirements of the Care Act 2014, which includes a new duty to provide personalised support to carers as well as carer assessments.

Key Strategic Outcomes

- Enable people to live well and for longer – (Council Outcome 5)
- *Enable people to live at home and as independently as possible – this is what people say they want*
- *Enable people to fully contribute to and be supported in strong and supportive communities – (Council Outcome 1)*
- *Enable people to access information, advice, early help and prevention so that they can help themselves and take responsibility for their well-being*
- *Enable carers of people to live well and be supported to fulfil their caring roles*

Specific Commissioning Intentions

Whilst all current support seeks to achieve the strategic outcomes above the analysis in this strategy indicates where commissioning plans are needed to improve on achieving these. Those areas are in summary:

For all adults:

- Provide support that informs, advises and encourages self-help and self-management to maintain healthy independence.

  For example: information and advice. Having a range of information easily available helps people to stay independent, customers tell us this needs to improve. (Appendix 1 - Think Local Act Personal (TLAP) report)

- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.

  For example: Community group support to provide stimulating recreational activities and low level counselling for older people, using volunteers.

- Greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support.

  For example: By developing a wide and diverse range of choices in support across geographical locations individuals can choose their preferences. This is particularly important for the rural communities in Cheshire East to ensure that people can continue to live well where they prefer.

- adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.

  For example: a wide range of community activities that people can enjoy as individuals, for daytime and social activity. This improves outcomes by helping people to choose how they prefer to meet their needs, not fit to a service that excludes them from the community. This area requires joint working with the Council's communities, housing and leisure functions and with the voluntary, community and business sectors. Customers tell us that some day activities offered now are not appropriate for them and that more opportunities in the community need to be available. (Appendix 1 - TLAP)

- Further develop support that helps people to gain or regain the capacity to live well independently.

  For example: specialist reablement support for older people and older people living with dementia. People who have had a fall and need help to recover their confidence and physical strength and avoid future falls.

- Enable access to support which affords adults protection from harm and safeguards them appropriately

- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.

  For example: the Care Bill requires and it is established good practice for assessment of young people with learning disabilities to commence from age 14 in order to ensure plans to prepare for adulthood begin as early as possible. Assessment and care management resources need to be designed to achieve this.

Frail Older People

- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.

For example: domiciliary care support that can be put in place very quickly the same day, any day of the week. This needs to be joint work with health as urgent health care in the community is a critical gap currently. (see Appendix ? Better Care Plan) Too often frail older people have to be taken to A&E as an urgent response when a community health response is not available quickly enough. Frail older people can deteriorate very rapidly and become seriously ill if treatment is delayed. Social care support to complement rapid health treatment in the community can allow the person to stay at home and recover from the illness. Hospital in-patient stays for this group can result in permanent loss of independence and capacity.

- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.

  For example: Community based services of social care and health need to be jointly commissioned to ensure that a suitable range of skilled support is co-ordinated around a frail older person. This could include for example: GP, district nurse, podiatry, mental health, occupational therapy, physiotherapy, domiciliary care (home care), reablement, intermediate health services (intermediate care), community equipment, assistive technology, housing adaptations.

- Ensure support is flexible and skilled to respond to people with complex and multiple needs.

Older People Living with Dementia

- Develop the range and coherence of the health, social care and community support for people with dementia and their carers.

  For example: Better information for carers about what to expect at diagnosis so that both the carer and the person living with Dementia can accept their diagnosis and plan for their future (see Appendix 2 - Dementia Event November 2013) When good information is not provided early this leads to greater anxiety and opportunities to mitigate the consequences for both the person and carer are lost.

- Support the need for early diagnosis and specialist interventions/treatment.

  For example: Dementia reablement and the use of assistive technology.

Learning Disabilities

- Develop a more effective joint health and social care approach to support adults with complex needs, including challenging behaviour. The complexity of needs is growing in the group of young adults who from children's services to adult social care and health support (often referred to as transition).

For example: specialist health input tailored to an individual in the community. At present some people with challenging behaviour are in residential provision rather than in community settings or their community accommodation is not stable. The aim would be to develop pro-active specialist community support that enables them to live sustainably in the community. This will require joint commissioning with health.

- Community inclusion to be developed further to ensure that day time and social opportunities encourage and enable access for adults with learning disabilities, including voluntary work and employment.

  For example: befriending schemes that help people with learning disability to find friends with similar interests. The particular needs of people with learning disability require a renewed focus. Encouraging more informal support from friends and communities needs to be a priority in commissioning strategy, it is key to community inclusion and often what individuals say they want.

- Clarify and plan for a suitable range of housing options for the future, under the Council's vulnerable people housing strategy.

Mental Health

- Develop the preventative support to people at risk of and experiencing poor mental health by working with Public Health and Health partners.

  For example: Lower level counselling support. Social care specialist support has to be targeted at those with serious mental illnesses yet there are opportunities to avoid the increase in this group by preventative commissioning by Public health and Health. Informal social support can be joined with those resources using stronger and supportive communities to mitigate against poor mental health; improving mental health and well-being is a priority in the Health and Well-being Strategy H&WB strategy.

- Ensure that informal support is developed and encouraged to provide better community and social inclusion for those recovering from serious mental illness.

  For example: befriending from the wider community can offer a key support to help someone on the path back to a successful and independent life. Often users of specialist mental health services are isolated from the community and their social contacts are those with similar difficulties.

- Focus on prevention by influencing in areas linked to wider determinants of health.

  For example: homelessness as a contributor to increased risk of poor mental health.

Physical and Sensory Disabilities

- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.

  For example: a new specialist stroke rehabilitation approach in the community. Some people who experience a stroke have not been achieving the maximum rehabilitation possible. Some individuals may be remaining physically and emotionally disabled when they could regain a much greater level of capacity and independence. The approach combines a different health response with community based social care support.

- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence.

  For example: the advent of the 'Apps' world is starting to provide innovative solutions that can enable independence. There is an app on the market that turns an android phone into a speech board to 'speak' for a person who has speech difficulties (e.g. motor neurone disease or stroke). Another provides fall detection via an android phone, there any many others developing. Many other solutions are available or being developed.

- Work with Housing through the Vulnerable People Housing Strategy to ensure housing supply and use enables those with physical disabilities to live as independently as possible.

  For example: the housing strategy seeks to promote general accessibility standards through planning processes, to ensure that as many new build homes as possible are suitable for people with physical disabilities.

Carers

- Increase the range of respite care choices available to ensure that carers can have periodic respite from their caring roles that meets their particular needs and preferences.

  For example: choices for respite for carers that are non-residential. The pre-dominant type of respite currently is residential and is focused on a small number of locations. A much wider choice can be provided by developing this market so that carers can select their preference. Other choices are needed to include non-residential options so that the cared for person does not need to be moved from their home environment.

- Increase the range of early advice, information and support to people new to the caring role.

  For example: carers knowing what help is available to them and the person they care for.

- Enable carers to develop skills and expertise to assist them in their caring role.

  For example: ensure health and social care services provide training and education for carers in relation to disease and condition specific interventions to help them care with confidence and know when to call in specialist help.

Commissioning Strategy

Introduction

Background and Aims

This is Cheshire East Council's Adult Social Care commissioning strategy. It is a working document that will be updated annually to reflect progress and provide for continuous improvement of all our support to adults. The priorities identified are based on our current understanding of customer needs and gaps but this understanding is work in progress, annual updates will refine this.

Its principal aims are to:

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The strategy has many aspirations that relate to all adults but some particular groups require additional specialist focus, those groups include the following:

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- Carers of people with social care needs

This strategy is for all people with eligible social care needs, this includes those who fully fund their own care as well as those the Council support financially.

Principles of Commissioning Approach

Listening to customers

Co-production/Co-design

Empowering people

Equity

Quality

Value for money

Longer-term cost-benefit

Targeting need/locality focus

Prioritisation

Affordability

Direction of Travel – How Social Care Support Needs to Be Different in Future

Cheshire East Council has set a new clear direction of travel to change how social care needs are supported; this underpins and directs this commissioning strategy. To be sustainable and meet the challenge of demographic change and complexity of need and still achieve good outcomes for the citizens of Cheshire East the way we support people needs to change. Hence this first iteration of a commissioning strategy in that new context will be the beginning of a journey of planned change, through effective commissioning, over the next 3-5 years.

The number of people aged 65 and older in Cheshire East Growth is forecast to increase by 49% in the next 16 years. The demographic growth will not be matched by public funding. To respond to these challenges the council recognises that we need to change the way we commission services and work with specialist social care providers. There are changes needed in the social care market to respond to the changing demographic and economic environment.

The direction of travel demonstrates how by 'doing things differently' we will:

- *do more for less* to meet the forecast growth in demand. We will encourage innovation and find new ways of delivering services so that people receive quality services which meet their care needs and deliver outcomes for individuals and for the council.
- *enable individuals to control their own care and support* and make open choices about how and when they are supported to live their lives.
- *increase opportunities for local businesses* to compete in the market and ensure that people have a varied care and support market to purchase from.

To complement our work with specialist regulated social care we need to shift the focus in commissioning to maximise the opportunities for self-reliance, independence and healthy lives. This will be done in conjunction with our commissioning colleagues, health, public health and communities.

The vision for the future is for the Council and partners to enable adults to be self-reliant and healthy for as much of their lives as possible. The goal is to make Cheshire East a place where strong empowered communities, including businesses, create that self-reliance.

In this context the informal support for adults and their carers needs to change to maximise the opportunities for self-reliance, independence, and healthy lives. The strategic direction of travel for informal support is to increase prevention and early intervention for people with social care eligible needs.

Quality informal support is needed that meets the objectives of:

encouraging the prevention of ill-health or dependency

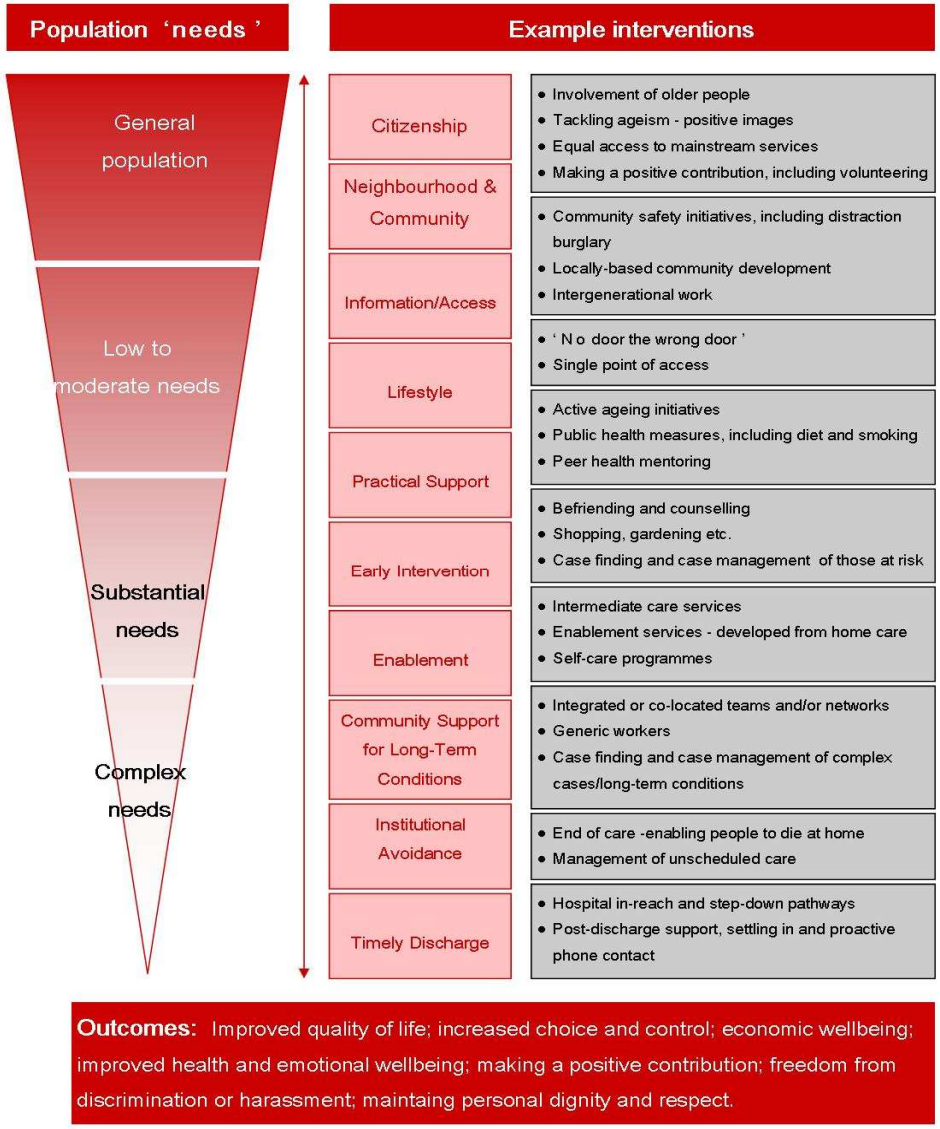
accessing early help and advice to maintain or regain health and independence

promoting self-reliance and community inclusion to increase well-being

personalisation and promoting open choice

How the Social Care and Health Economy Needs to Change – Working with Partners

Over time the resources in the local health and social care economy, including public health, need to be realigned to increase investment in prevention and early intervention. The current pattern of resource use is a high proportion invested at the bottom of the triangle below on the substantial and complex needs. This investment needs to decrease to allow more to be invested in the middle of the triangle where prevention can be maximised. The key and major shift required is in health investment, which social care can then support; without the health changes the goal of early help and prevention will be unachievable.



The Spectrum of Prevention

(Reference: 'Improving care and saving money: learning the lessons on prevention and early intervention for older people' DH, January 2010)

Council Duties and Policy Framework

This commissioning strategy is guided by the requirements of legislation and national policy drivers. (see Appendix...? Social Care Legislation and Policy for details). The key legislation and policy includes:

- The Care Act 2014
- Health and Social Care Act 2012
- Equality Act 2010
- Autism Act 2009
- Valuing People (2001) and Valuing People Now: A New Strategy for People with Learning Disabilities 2007
- Aging Well 2010 – 2012
- National Dementia Strategy 2010
- National Autism Strategy
- Mental Health Act 1983
- Mental Capacity Act 2005

Cheshire East – Characteristics and Demographics

Cheshire East has a population of 372,000 and an area of 116,638 hectares. In addition to Cheshire West and Chester on the west side, Cheshire East is bounded by the Manchester conurbation to the north and east, and Stoke-on Trent to the south. It contains the major towns of Crewe, Macclesfield, Congleton and the commuter town of Wilmslow (population above 20,000). There are also a number of other significant centres of population (over 10,000) in Sandbach, Poynton, Nantwich, Middlewich, Knutsford and Alsager. With few large conurbations the borough otherwise comprises a mixture of smaller market towns and more isolated rural villages. This mixture of rural/urban presents particular challenges in delivering cost-effective services close to individuals and their neighbourhoods.

In 2010 there were 83,300 older people aged 65+ in Cheshire East (Office for National Statistics indicative population estimates 2010). Estimates suggest that in 2012 5,234 (6%) older people were living with dementia and 33,154 (40%) with a limiting long term illness. The population of Cheshire East is forecast to grow modestly over the next 30 years rising from 362,700 in 2009 to 384,000 in 2029, however, the age structure of the population is forecast to change significantly with a 8% reduction in young people (0-15), a 12% reduction in working age people (16-59 Female, 16-64 Male) and a 42% increase in people of retirement age

(60/65+), with the number of older people (85+) increasing by around 92%. As the prevalence of dementia increases with age, the number of older people with dementia is anticipated to increase by 28% by 2020. The significant changes in demographic in Cheshire East will have direct implications for adult social care.

Current Market Analysis and What Is Needed in Future

This section of the strategy provides a summary of the current market analysis and future requirements, with a focus on key priorities for 2014/15. Further detail providing the intelligence and background that underpins this summary is in Appendix....? ('Detailed Commissioning Intelligence and Background')

Information and Advice/Self-Help

Service Mapping and Need:

There are many sources of information but no simple route for customers and carers to get the information they need quickly and easily. Information is offered by many different organisations but the quality is variable; customers say that some of the best sources are from the voluntary sector. The Council's website is not easy to navigate and does not provide a comprehensive set of information on community support available. Adult Social Care has commissioned a number of services from the independent sector that provide information and advice; these will be in place from 1st April 2014.

It is not yet easy for customers to know how to access these services. The Care Bill requires the development of effective advice and information as a key to helping people to help themselves to be independent and healthy.

What we will do in 2014/15:

Develop joint community, health, public health and social care advice and information services including the development of a Resource Directory, both on-line and other easily accessible ways
Develop easy access routes to this advice and information, including but not exclusively the internet.

Prevention and Early Intervention

Service Mapping and Need

Prevention and early intervention in Cheshire East has been developing over the last 18 months with a move to contracting these services based on priority outcomes rather than the grants that had previously been in place. This is providing for a better market fit with the direction of travel and increased coherence of support.

Adult Social Care has recently commissioned a number of services from the independent sector that provide prevention and early intervention; these will be in place from 1st April 2014. These services include for example:

- Carers support services
- Peer support for older people to remain independent
- Early help for those starting to develop deafness to avoid deterioration and dependence
- Community agents in isolated/rural communities to target social isolation and other needs
- Advocacy support to help people access universal services
- Specialist support and advice to people with visual impairment

This market development needs to be embedded and closely monitored to ensure it is meeting desired outcomes. There is also a need to seek innovative ways to encourage and help customers, carers to self-help earlier to avoid future dependency. There is also a role for local businesses to develop support and services that people can buy themselves.

Through the Health and Well-being Strategy and with public health and health there is a recognition that universal health promotion activities must develop greater impact on the ability of people to avoid ill-health and retain independence. Adult social care will need to play a part in that development. (Appendix .... Health and Well-being Strategy). There is also a need to ensure that informal community facilities and groups play a part in helping people to access them. This is a substantial resource in Cheshire East which is not yet fully understood or maximised strategically to achieve the outcome of living well and for longer. Over the next 3-5 years this area of investment needs to be enhanced through all possible routes, including local businesses.

The commissioning intentions driving developments in this area are:

- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.

- people should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this.

What we will do in 2014/15

Closely monitor the impact of the adult social care newly commissioned services from 1st April 2014.

Launch a second year opportunity for the third sector and community groups to gain seed-funding to establish sustainable prevention and early help work (through the 'Innovation Fund')

Pilot an innovative approach to promoting universal access to assistive technology and aids to living (equipment).

Commission jointly with the Head of Communities and the Director Public Health to ensure all potential resources are contributing effectively to prevention and early intervention

Commission jointly with health to ensure all potential resources for prevention and early help are identified, maximised and increased over time.

Community Based Services

Community based services are designed to support or reable people to live independently at home and avoid the need for admission into long-term residential or nursing care. These areas of service will need to be continuously reviewed to ensure they can meet the future direction of travel. There are priority changes needed and these will be the focus of this year's commissioning work.

These services include:

Domiciliary Care (Home Care)

Service Mapping and Need

In 2011/12 995,000 hours of domiciliary care were delivered to 764 service users at a cost of £16.5 million. 97% of these hours were provided by the independent sector. In response to customer demand the Council are committed to developing this type of care provision as an alternative to residential based care services. As at December 2013 2,464 older people are being supported by 71 domiciliary care providers; of these the council directly commission the care for 1,414 older people. A further 1,050 people currently receive cash payments to organise their own support, the majority of which are spending their personal budgets on traditional social care services, particularly domiciliary care. The Council has already removed the domiciliary care block contract arrangements to widen the available supply. The uptake of domiciliary care has increased through the current financial year. To continue this trend the Council wants to make it easier for existing and new providers to enter the market and work with us via framework agreements. We also expect the amount Cheshire East spends via cash payments to increase together with the demand for a more personalised service offer as the market expands and expectations of future generations change and they move away from traditional care services.

The commissioning intentions driving developments in this area of support are:

- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.
- Greatly increase the choices of support available for social care needs so that it can be tailored to particular needs and individual's preferences – personalising support.
- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.

What we will do in 2014/15

Procure a new framework for providers of this care to widen the choice of supply and provide for developments of the range of support
create a new quality assurance service to monitor all domiciliary care
review the use of this market during 2013/14 to identify any further developments needed
consider the potential impact on this market's development of a need for 7 day care responses across the health and social care system
promote personalised care including flexibility, choice and control for customers

Daytime Activities (including Day Care)

Service Mapping and Need

There is a range of services that provide for daytime activity, this includes some specialist day care commissioned by adult social care, but also a wider range of community activities that can also be accessed. The specialist day care is in a limited number of locations and it can have the unintended consequence of excluding people from the community. Because this specialist day care is whole group based it is difficult to tailor activity to individual needs and preferences. Customers tell us that some activities offered now are not appropriate for them and that more opportunities in the community need to be available. (Appendix 1 - TLAP).

The commissioning intentions driving developments in this area of support are:

- people should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this.
- Greatly increase the choices of support available for social care needs so that it can be tailored to particular needs and individual's preferences – personalising support.

What we will do in 2014/15

map the current opportunities in the community for social/recreational activities
publish a Resource Directory of all opportunities so that people can choose their preferences
stimulate informal support, working with the Council's Head of Communities and other partners

Community Based Reablement

Service Mapping and Need

Cheshire East has increased the use of reablement services to help people learn or relearn the skills necessary for daily living which may have been lost through deterioration in health and/or social abilities of daily living which has led to increased support needs. Reablement is offered to individuals who can benefit and is delivered for up to 6 weeks within the persons own home to restore people's ability to perform usual activities and improve their perceived quality of life. Over

1,123 older people completed a period of reablement in 2012/13, of which 40% achieved a positive outcome of either needing no on-going support, or having reduced care needs on completion. We believe the success of telecare and reablement has contributed to the reduced demand for lower level home care services.

Currently the reablement services respond well to a range of needs. However there are potential specialist skills that could be enhanced so that the particular needs of those with dementia or stroke patients have even better outcomes.

There is a specialist reablement team for those recovering from serious mental illness. The customers of the service have good outcomes and the approach is viewed as best practice and there is an opportunity to consider how to enhance this approach.

The commissioning intentions driving developments are:

- Further develop support that helps people to gain or regain the capacity to live well independently
- Develop the range and coherence of the health, social care and community support for people with dementia and their carers.
- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.

What we will do in 2014/15

A pilot dementia reablement approach will be trialled

Potential new stroke rehabilitation approach will be considered with health partners.

Existing support will be targeted and managed to ensure those who can most benefit receive the service they need

An interim review of reablement will commence and begin to consider the future models including Intermediate care (health)

Supported accommodation

Service Mapping and Need

Under the development of the Vulnerable People Housing Strategy a range of services have been mapped (see details in Appendix 3 - Detailed Intelligence and Background). There is currently sufficient to meet current demand but future demand both in scale and type means plans need to predict further. As of July 2013, Cheshire East has the capacity to house 409 people with a varied range of learning disabilities in supported accommodation across the borough. Support in is provided through a range of providers. A large proportion of accommodation in Cheshire East for people with learning disabilities is in shared houses (48%). Whilst an option that works for some people to work effectively resident composition must be carefully matched; this does not always sustain. There is a need to consider whether the mix of options needs to include more single occupancy accommodation in a supported setting. This increases privacy and independence and avoids potential mismatches of individuals. Currently accommodation is unevenly distributed, with Poynton, Wilmslow, Nantwich, and Knutsford possessing significantly less supported accommodation for people with learning disabilities than the major population centres of Macclesfield, Crewe, and Congleton.

The commissioning intentions driving this area are:

- Work with CEC housing through the vulnerable people strategy to ensure housing supply and use enables those with disabilities to live as independently as possible.

What we will do in 2014/15:

with CEC housing colleagues consider the feedback of customers and carers to the strategy to inform future planning
ensure through the Learning Disability Lifecourse commissioning review that innovative ideas for the future are developed to offer a range of choices for living in the community, including Shared Lives adult placements with families.
ensure sustainability of accommodation for vulnerable groups as a key preventative measure.

Assistive Technology

The Council have increased the use of assistive technology each year for the last three years as a means to increase independence, provide safety for customers and reassurance for carers. The range of opportunities presented by assistive technologies is expanding.

The commissioning intentions driving this area are:

- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence
- Stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes.
- Consider option of increasing choice and control as a safe means to access to suppory whilst promoting privacy and independence

What we will do in 2014/15:

pilot an innovative approach to raising awareness and access to assistive technology and equipment in the wider population to enable self-help and self management for prevention and early help

pilot the use of assistive technologies for people with learning disabilities to increase independence

focus on increasing use of assistive technology as part of new and future contractual arrangements

Long-term Residential and Nursing Care

Service Mapping and Need

Cheshire East has a large market supply of residential and nursing care for older people, overall there is sufficient current capacity which enables choice for customers. The direction of travel seeks to increase the proportion of older people who can stay living at home rather than enter long-term residential care. However there will always be a need for good quality residential and nursing care.

The demographic trends and their associated increase in the prevalence of dementia will mean that the future need for this type of care needs careful planning. It is clear that the complexity of need will grow, including the need for specialist dementia care, and this is likely to require some growth in the nursing home market to meet the needs in 2020.

The commissioning intentions driving this area:

- Greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support.

- Develop the range and coherence of the health, social care and community support for people with dementia and their carers.

What we will do in 2014/15

create a new quality assurance service to monitor all regulated care provision
monitor the use of this market during 2013/14 to identify any developments needed, particularly in nursing home provision
consider the potential impact on this market of a need to develop 7 day care responses across the health and social care system
ensure personalised care is available within residential and nursing home settings

Assessment and Care Management

Assessment and care management is the service which ensures that individuals needs are understood and allocates resources to meet their eligible needs. The assessment and care management processes and procedures need to reflect the future requirements of the Care Bill.

The commissioning intention driving this area:

- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.

- Ensure assessment and care management response is focused on independence and self-management within overall context of positive risk taking and safeguarding

What we will do in 2014/15:

options for the assessment and care management arrangements will be developed that ensure appropriate customer responses including:

providing support to people who fund their own social care

providing effective advice and information to enable independence

ensuring those with complex needs receive specialist responses

ensuring people can access financial planning support

Current Customer Grouped Support and What is Needed in Future

As well as understanding the current markets for provision of various types of support as above it is important to understand particular groups of customer needs. Bringing these together in this strategy ensures that all developments deliver the necessary range of support to meet the differing aspects of meeting individual needs.

- All adults
- Frail Older People
- Older People with Dementia
- Adults with Learning Disabilities
- People with Mental Health Problems
- People with Physical and Sensory Disabilities
- Carers of people with social care needs

All adults*:*

Ensuring all adults are supported to have fulfilled and healthy lives is the core goal of social care. This Commissioning Strategy identifies areas where support may need to change or where there are gaps that need to be addressed to continue to meet that goal effectively.

There are some common aspirations for all adults that this strategy has identified as commissioning intentions as below

- provide support that informs, advises and encourages self-help and self-management to maintain healthy independence
- stimulate and enable a range of early help and prevention activity and informal support that prevents the need for more specialist social care support and improves outcomes

- greatly increase the choices of support available for social care need so that it can be tailored to particular needs and individual's preferences – personalising support
- adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.
- Further develop support that helps people to gain or regain the capacity to live well independently.
- Enable access to support which affords adults protection from harm and safeguards them appropriately

Additional specialist developments are required for some groups as follows:

Frail Older People

Service mapping and need

The complexity and frailty of older people is increasing as people live longer with multiple health conditions. This changing level of complexity is resulting in the increased risk of people entering residential or nursing care rather than being able to live at home. To address this services need to be redesigned and shaped to ensure deterioration is prevented and hospital admissions are avoided as this lead to a greater risk of loss of independence. Many of the existing services are the appropriate services, what needs to change is the speed with which they can be accessed in a crisis and the coherence of the options for a support package that is comprehensive. In addition resources currently invested in hospital care need to be reinvested into community support which will be more preventative and keep people at home.

The additional commissioning intentions driving this area are:

- Develop rapid response 7 day support in the community to avoid health deterioration and the risk of an emergency admission to hospital.
- Develop further the range and scale of community based wrap-around support to keep people living well at home and avoid the risk of needing long-term residential or nursing home care.
- Ensure support is flexible and skilled to respond to people with complex and multiple needs.

What we will do in 2014/15:

Develop service specifications and commissioning with health to enable changes to the system to begin the necessary changes. Changes are required that can lead to the release and re-direction of current investments to increase effective community wrap around and 7 day working in future.

Develop specifications for rapid response services to avoid health deterioration and possible admissions to hospital.

Community based services of social care and health need to be jointly commissioned to ensure that a suitable range of skilled support is co-ordinated around a frail older person. This could include for example: GP, district nurse, podiatry, mental health, occupational therapy, physiotherapy, domiciliary care (home care), reablement, intermediate health services (intermediate care), community equipment, assistive technology, housing adaptations

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Older People with Dementia

The predicted increase in dementia is already emerging but as yet is not fully understood locally as diagnosis levels appear lower than comparators. The local Dementia Strategy is being further developed by social care and health with customers central to that work. This then needs to be used to influence commissioning priorities. There are already some key things that customers want us to do better and these are informing this commissioning strategy.

The commissioning intentions driving this area are:

- Further develop support that helps people to gain or regain the capacity to live well independently.
- Develop the range and coherence of the health, social care and community support for people with dementia and their carers.
- Support the need for early diagnosis and specialist interventions/treatment.

What we will do in 2014/15:

Update and publish a new local Dementia Strategy together with our health partners

Cheshire East to become a member of the Dementia Alliance – with the aim of making Cheshire East dementia friendly

Pilot a dementia reablement approach to seek ways to mitigate against the impact of dementia

Commission respite support to enable carers to have regular breaks from their caring role

Adults with Learning Disabilities

The Commissioning intentions driving this area are:

- Develop a more effective joint health and social care approach to support adults with complex needs, including challenging behaviour. The complexity of needs is growing in the group of young adults who transition from children's services
- Community inclusion to be developed further to ensure that day time and social opportunities encourage and enable access for adults with learning disabilities, including voluntary work and employment.
- Clarify and plan for a suitable range of housing options for the future, with strategic housing in the Council.

What we will do in 2014/15:

the Council, in partnership with health, has established a commissioning review of support for people with a Learning Disability to consider how support from birth to end of life needs to be re-designed for the future. This review is on-going in 2014/15 and will provide a longer-term vision by summer 2015 to inform future investment choices and direct commissioning intentions.

a joint commissioning plan for challenging behaviour will be developed between social care and health.

map the current opportunities in the community for social/recreational activities

publish a Resource Directory of all opportunities so that people can choose their preferences

stimulate informal support, working with the Council's Head of Communities and other partners

Mental Health (not dementia)

Service Mapping and Need

Cheshire East social care services provides support at any one time to around 600 people with a substantial or severe mental health issue (based on Oct 13 data).

Social care work in partnership with health services to provide multi-disciplinary community mental health specialist teams. There is a specialist reablement team for those recovering from serious mental illness. The customers of the service have good outcomes, the approach is viewed as best practice and there is an opportunity to consider how to enhance this approach. There is also a need to consider how to ensure that recovery is sustained by developing community inclusion and networks that enable this. Some supported housing is provided for those with lower level support needs.

The Director of Public Health's report 2012 – 2013 has identified that Cheshire East has one of the highest excess mortality rates for adults under 75 with a serious mental illness.

The Commissioning intentions driving this area:

- Adults should access the same opportunities to enjoy social/recreational activities in the community as others; strong and supportive communities enable this. Social isolation and loneliness blights lives and must be addressed urgently.
- Develop the preventative support to people at risk of and experiencing mental health issues by working with Public Health and Health.
- Ensure that informal support is developed and encouraged to provide better community and social inclusion for those recovering from serious mental illness.
- Focus on prevention by influencing in areas linked to wider determinants of health.

What we will do in 2014/15:

Work with health and public health to better meet the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness (Health and Well-being Strategy)

map the current opportunities in the community for social/recreational activities

publish a Resource Directory of all opportunities so that people can choose their preferences

stimulate informal support, working with the Council's Head of Communities and other partners

Physical and Sensory Disabilities

Social care provides support to around 400 people with a physical or sensory disability aged 18 -64 (based on data at Oct 13). Census projections anticipate only a small rise in the overall numbers of adults aged up to 64 with a moderate or severe physical disability by 2030. However the over 65s with disabilities which are considered in other parts of this strategy also will grow in line with the demographic changes predicted for older people. This will increase need but is likely to be complex need because of the growing numbers of people with multiple conditions. There are opportunities to provide a different health and social care response to illnesses that can result in disability, such as stroke and COPD.

The commissioning intentions driving this area:

- Improve the outcomes of the rehabilitation/reablement of those affected by specific conditions to ensure individuals live well for longer.
- Expand awareness of and access to assistive technology to ensure those with disabilities can maximise their personal independence.
- Work with Housing through the vulnerable people housing strategy to ensure housing supply and use enables those with physical disabilities to live as independently as possible.

What we will do in 2014/15

Pilot/experiment with innovative outreach to better understand how we can enable people to self-help using assistive technologies and equipment.
This pilot evaluation will inform a commissioning review in 2015/16 to commission a model for the future
Potential new stroke rehabilitation approach will be considered with health partners
Work with housing to ensure that housing and complementary support are coherent

Carers

Adult social care currently support carers in a number of ways including carers assessments, respite for carers to have a break from caring and early help and prevention support in the community. Some carers say that they are not always receiving the focus and support they need (Appendix ? TLAP). The role of carers is a critical one that adult social care recognises should be well supported. It is difficult to estimate the true number of carers in Cheshire East as many are not in contact with social care services. It is also difficult to estimate how many carers access informal support. One of the key messages from the carers survey (Appendix? Carers Survey) is that many carers (around 60%) do feel reasonably satisfied with their support; but this leaves 40% who do not feel satisfied. There are some elements of the current support that have been identified as needing to change. There will be further developments in future years as commissioning intelligence and review increases our understanding of what is needed.

The commissioning intentions driving this area are:

- Increase the range of respite care choices available to ensure that carers can have periodic respite from their caring roles that meets their particular needs and preferences.
- Redesign assessment and care management processes and systems to ensure customers receive a timely, effective, outcome- focused service.
- Increase the range of early advice, information and support to people new to the caring role.
- Enable carers to develop skills and expertise to assist them in their caring role.

What we will do in 2014/15:

Increase the range of respite choices available

Review carers assessments and support to develop a service model to improve outcomes and deliver the Care Act requirements including information, advice and training to be confident to care and know when to call on specialist help.

Update and publish a new Strategy for Carers in conjunction with health partners

CHESHIRE EAST COUNCIL

REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

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Date of Meeting: 11th September 2014
Report of: Corporate Manager Health Improvement (on behalf of the Winter Wellbeing Partnership)
Subject/Title: Winter Wellbeing and Winter Planning
Portfolio Holder: Cllr Janet Clowes

1.0 Report Summary

1.1 The multi-agency Winter Wellbeing working group was formed in October 2012. This followed a workshop that had highlighted that Cheshire East had higher than average numbers of excess winter deaths and a recognition that an effective partnership approach was required to try and improve this situation. Putting the health and wellbeing of residents first is a priority for the Council and the Winter Wellbeing Group is working towards this.

1.2 There has been significantly improved partnership working as a result of the Winter Wellbeing working group and a raising of awareness in relation to the risks associated with cold weather. In addition we are better placed to identify those who are most vulnerable to the impacts of colder weather.

1.3 There is, however, still more to be done and the group continues to meet to both co-ordinate activity for this winter and to work on longer term issues. In addition there is now a recognition of the need to co-ordinate activity in relation to hot weather and this work is just getting underway.

2.0 Recommendation

2.1 That Members consider the report and the arrangements for co-ordinated Winter Wellbeing currently in place.

3.0 Reasons for Recommendations

3.1 To ensure that Members of the Committee are aware of recent work to raise awareness of and prevent excess winter deaths.

4.0 Background

4.1 Excess winter deaths are defined by the Office of National Statistics as the difference between the number of deaths during the four winter months (December – March) and the average number of deaths during the preceding four months (August – November) and the following four months (April – July). In November 2012 the figures published for 2010 – 2011 indicated that Cheshire East had worse than average excess winter deaths (221 deaths). Winter deaths in Cheshire East were 26% higher among people over the age of 85 compared to 17.2% for those aged 65 to 84 and 9.8% for those aged under 65. The equivalent figures for England were 24.4% for people over the age of 85, 15.1% for those aged 65 to 84, and 7.1% for under 65's. Although there was a slight improvement in 2011 - 2012, the CEC figures were still worst quartile. Appendix One is the JSNA page on Excess winter Deaths.

4.2 There is strong evidence that a large number of these deaths are preventable. The evidence also suggests that isolated elderly people are particularly vulnerable, whatever their social background. Poverty/fuel poverty, poor quality or un-insulated housing, chronic disease and multiple long term conditions are all relevant factors as well.

4.3 Research has established that for every £1.00 spent on tackling fuel poverty, the health service saved 42p as a by-product. By working to address fuel poverty through achieving affordable warmth, local partnerships can help to:

- Achieve safer, warmer and better insulated homes;
- Support the local carbon reduction targets
- Address child poverty
- Support older people to live at home for longer

4.4 In March 2010 the Department of Health's Health Inequalities National Support Team (HINST) published best practice guidance on 'How to reduce the risk of seasonal excess deaths…' Three stages were key:

- Preparation – understanding the local situation, developing a shared understanding, engaging appropriate partners and initiating joint working.
- Identifying vulnerable people – developing a register of key workers who know who their vulnerable clients are (a list of lists) and criteria for prioritisation.
- Systematically offer interventions

4.5 Age UK has published a number of reports related to Excess Winter Deaths including 'The Cost of Cold' and 'Excess Winter Deaths - Preventing an avoidable tragedy'. They calculate the cost to the NHS of cold homes as being in the region of £1.3 billion. Social Services costs will also be significant.

4.6 The impacts of cold on the health of older people are:

- Exposure to cold through the hands, feet, face or head can rapidly lead to a drop in core body temperature;
- Cold air can narrow airways, making it harder to breathe;
- Cold air increases the risk of respiratory infection;
- Cold lowers heart rate but raises blood pressure much more;
- In older people raised blood pressure may last many hours;
- Cold increases the risk of blood clotting;
- Blood clotting and raised blood pressure both increase the risk of heart attack or stroke;
- The longer someone is exposed to cold, the more at risk they are of all these effects.

4.7 Knowing the risks is important and raising awareness of these impacts and the risks of being cold is a priority. There is also evidence that during the winter months older people feel more isolated and lonely due to a variety of factors including reduced day light hours which has an effect on their contact with neighbours and their willingness to drive in the evening, and anxiety about falling during icy weather.

4.8 Age UK recommended five areas in which local authorities can take action:

- Map the extent of the problem and identify those at risk
- Plan for cold weather each winter
- Prioritise excess winter deaths and associated ill health as a public health concern;
- Improve the energy efficiency of vulnerable older people's homes;
- Work in partnership with local older people's groups to protect the health of older people in winter.

5. Progress to date

5.1 The Winter Wellbeing partnership was initiated in October 2012. It is led by Cheshire East Council, but has representation from a wide range of Council services, public sector and community, voluntary and faith sector partners. This includes amongst others, Adult Social Services, Public Health, Partnerships and Communities, Highways, Strategic Housing, housing providers, the Fire and Rescue Service, Cheshire Emergency Planning Team, Snow Angels CIC, Cheshire Community Action, Age UK Cheshire East, the NHS Clinical Commissioning Groups and NW Ambulance Service. A full list forms Appendix Two.

5.2 For Winter 2012 / 2013 the Group was able to co-ordinate a successful funding bid for resources to help keep people warm and begin the more effective co-ordination of on the ground activity. However the work to follow the HINST best practice and Age UK recommended areas for action got underway at the same time which significantly improved the planning for Winter 2013 / 2014.

5.3 An early decision made, was that the Group needed to meet throughout the year to really build understanding and momentum. The Joint Strategic Needs

Assessment was used to map occurrences of winter deaths and areas of fuel poverty (September 2012 information). This was cross referenced to information from housing about properties that were energy inefficient and off the main gas supply system. The results demonstrated a correlation between the different sets of data that highlighted the rural areas around Nantwich as being an area where excess winter deaths and fuel poverty appeared closely linked. Crewe and Knutsford LAP areas demonstrated higher level of fuel poverty and Nantwich, Wilmslow and Poynton were where the levels of excess winter deaths were higher than the CEC average. Interestingly the November 2013 update (information for 2011 – 2012) showed a shift, with Wilmslow, Macclesfield and Congleton being the three areas with the highest levels of excess winter deaths.

5.4 Identifying the more vulnerable people was a priority and the initial mapping allowed more targeted activity to take place. In addition the Assisted Bin Lift List was used to identify households that might contain vulnerable individuals and a mail out was sent to those households inviting the householders to get in touch if more information was required on keeping warm, energy efficiency and insulation or other aspects of coping with colder weather.

5.5 Colleagues in Adult Social Care initiated a pilot piece of work cross – referencing and data matching information from the Council's databases and Mid Cheshire Hospitals NHS Foundation Trust in relation to individuals over 75 with respiratory or heart conditions admitted to A&E between 1st November 2012 and 30th April 2013.

5.6 This work identified 5069 admissions (10% of all A&E admissions) at an estimated cost to the Trust of £9.5 million. 3791 patients were involved in these admissions with 925 being admitted at least twice in the six month period (71 individuals were admitted five or more times). 1200 of the people were living alone. Mapping of address data identified admission hotspots.

5.7 This analysis has provided a lot of information that can now be used to help inform the integration work underway through the Caring Together and Connecting Care Programmes to more effectively join up services. It also provides information to assist with targeting preventative activity.

5.8 A Winter Wellbeing Plan was prepared for 2013 – 2014 to help co-ordinate the activity of the Council and partners. A Winter Wellbeing portal was also developed as an information hub.

5.9 In preparing this report I asked partners for their thoughts on what the Winter Wellbeing partnership has achieved and what still needs to be improved. A summary of responses is below:

Achievements -

- Better co-ordinated approach to tackling excess winter deaths / cold homes and vastly improved partnership working;

- Engagement with a significant number of vulnerable households to be able to talk to them about how to improve their energy efficiency;
- Better understanding in CCG of the Partners' work and opportunities to work together;
- Under the weather Conference organised and held for partners;
- Identification of vulnerable people now more clearly understood;
- Partnership development and co-ordination of plans;
- Encouraged partnership funding bids that would otherwise not have happened;
- Raised awareness of who does what and contacts within the different organisations;

Further improvement needed:

- Continue to improve data sharing;
- Further develop the research in relation to admissions and vulnerability;
- Being able to act quickly when a vulnerable person is identified at a time of crisis;
- Improved joint communications and engagement to ensure key messages are co-ordinated;
- Overcoming data protection issues relating to sharing data about individuals if that data sharing is in their best interest;
- Ensure robust plans are in place in case of severe weather events.

5.10 So although much has been achieved there is still more to be done. The 'Under the Weather' Conference held in July was designed to provide a direction of travel for future work and the summary of the Conference is attached as Appendix Three for information. The Working group will now use this to focus its activity for Winter 2014 – 2015 and beyond and for the warm weather and flood risk planning.

6.0 Access to Information

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

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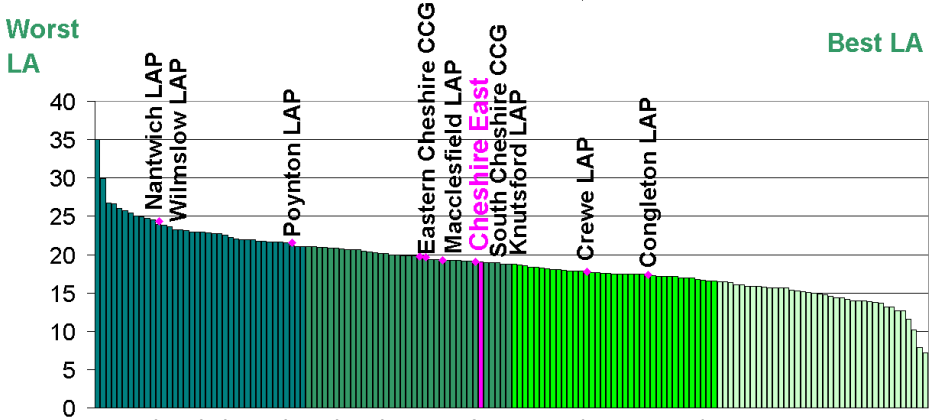
Excess Winter Deaths PH 4.15

Fuel poverty PH1.17
Flu vaccination coverage PH 3.3

Cheshire East JSNA

4.15 Excess Winter Deaths Index: The ratio of extra deaths from all causes that occur in the winter months compared to the expected number of deaths, based on the average of the number of non-winter deaths, 2007-2010



LAP data is based on the six years from 2004/05 to 2009/10

Excess Winter Deaths	Annual excess winter deaths	Excess risk of winter death	Change needed to achieve		
			England average	Best quarter	England best
Congleton LAP	48	17.4%	-	2 less	28 less
Crewe LAP	44	17.8%	-	3 less	26 less
Knutsford LAP	16	19.1%	-	2 less	10 less
Macclesfield LAP	40	19.7%	2 less	7 less	26 less
Nantwich LAP	28	24.3%	6 less	9 less	19 less
Poynton LAP	18	21.5%	2 less	4 less	12 less
Wilmslow LAP	27	24.1%	6 less	9 less	19 less
NHS Eastern Cheshire CCG	119	19.8%	10 less	23 less	81 less
NHS South Cheshire CCG	102	19.3%	6 less	13 less	59 less
Cheshire East	**221**	**19.7%**	16 less	36 less	140 less

The comparable excess risk of winter death for England is 17.6%

Suggested Actions

- A local Cold Weather Plan that prevents and deals with the health consequences of cold weather
- Increasing the uptake of influenza vaccinations
- The Local Authority and the Clinical Commissioning Groups should work together to develop fuel poverty referral mechanisms (for insulation and better heating) aimed at those people who are clinically at greatest risk
- During periods of cold weather, shops could offer free home deliveries of groceries to vulnerable people

Evidence Of What Works

- Annual flu vaccination is an important free protective measure
- Keeping warm during cold weather, both indoors and outdoors
- Planning ahead so there is a clear response to a cold spell

Asset Map

- The Marmot Review
- The Chief Medical Officer's Annual Report for 2009
- Reducing Excess Winter Deaths is a key outcome measure in the Cold Weather Plan for England

Interpreting the Data

Winter deaths in Cheshire East are 26% higher among people over the age of 85 compared to 17.2% for those aged 65 to 84 and 9.8% for those aged under 65. The equivalent figures for England are 24.4% for people over the age of 85, 15.1% for those aged 65 to 84, and 7.1% for under 65's. The risk is 55.9% higher locally for people who have respiratory disease and 22.3% higher for cardiovascular disease

Winter has an important influence on people's risk of illness and death. Cold weather causes a rise in blood pressure which can lead to a heart attack. It also makes the blood thicken and this can lead to a thrombosis (blood clot) which causes death from heart attack or stroke. Cold weather also lowers people's resistance to chest infections, particularly influenza.

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Appendix Two

The Winter Wellbeing partners

CEC Services
Health Improvement Team
Benefits
Partnerships & Communities
Highways
Care & Repair Team
Emergency Planning Team
Flood Risk Team
Business Intelligence
Public Health
Safeguarding Team (children's)
Communications
Commissioning
Libraries
Housing
Adults Social Care & Independent Living
Trading Standards
Environmental Services
Community Safety Team
LAP Teams

External Partners
Cheshire Fire & Rescue Service
Wulvern Housing
Cheshire Community Action
AgeUK
North West Ambulance Service
CCG's
NHS (including Community and District Nurses)
Faith Sector
Peaks & Plains Housing Association
Plus Dane Housing Association
Poynton Town Council
Energy Projects Plus
Middlewich Vision
Snow Angels
ChALC (Cheshire Association of Local Councils)
CVSCE (Cheshire Voluntary Service Cheshire East)Groundwork Cheshire
Riverside Housing Association
SPEN

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Under the Weather in Cheshire East

Workshop 2014

Contents

Introduction

Following the publication of figures for excess winter deaths for 2010/2011, where Cheshire East was identified as having the largest number of excess winter deaths nationally, Cheshire East Council formed a group of officers and partners to better understand and look to address the situation.

Excess winter deaths are related to cold weather and the health problems, particularly heart attacks, strokes and respiratory difficulties, which can be exacerbated by being cold. It has been shown that this leads to an increase in winter hospital admissions and GP consultations as well as the increase in deaths. A significantly linked issue is that of fuel poverty, where households are unable to afford the cost of adequately heating their home.

Due to changes to our climate, there are also issues regarding the effects on health caused by warmer weather and flooding and the working group has now recognised the need to consider these as well.

On Thursday 17th July 2014 the group, represented by a range of council services, housing associations, charitable organisations and multi-agency partners, held an event to address the impact of extreme weather on health.

The following document sets out the problems and solutions discussed. The document also covers action planning, future work together with results taken from the evaluation forms.

Members from the Under the Weather planning group

Paul Reeves, Flood Response Management Team
Guy Kilminster, Health Improvement
Dominic Anderson - AgeUK
Matt Tandy, Flood Response Management Team
Cathy Boyd, Snow Angels
Carole Weaver, Community Action
Jane Kavanagh, Partnerships and Communities
Ruth Stevens, Joint Cheshire Emergency Planning Team

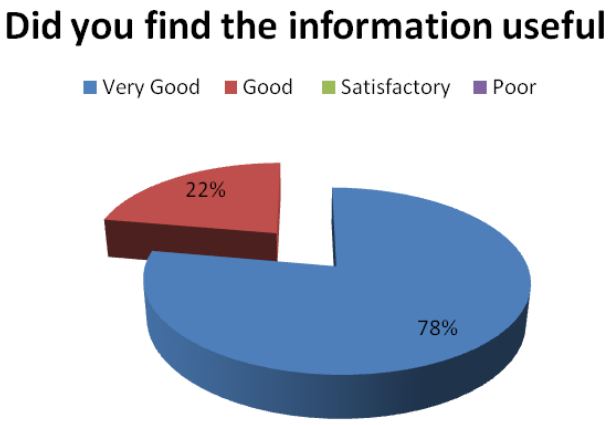
Attendance and Event Feedback

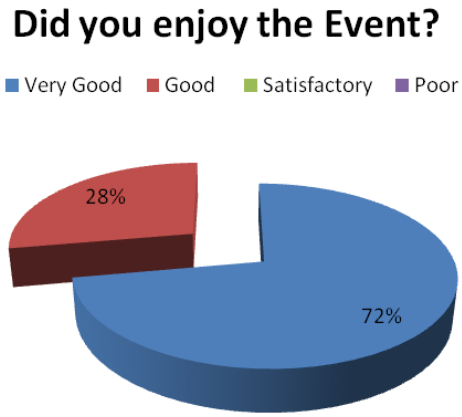
Name	Organisation/Service
Alison Ainsworth	Cheshire East Council - Benefits
Zoe Ahearne	Community Matron – East Cheshire NHS Trust
Dominic Anderson	Age UK
Usman Ashiq	Health and Wellbeing Officer – Plus Dane Housing Group
Aimee Bentley	CEC Partnerships and Communities
Cathy Boyd	Snow Angels
Dave Caldwell	Cheshire East Council
Nicola Cooker	CVS CE
Lynne Cullens	Faith Sector
Sally Davies	CVS CE
Phillip Goodwin	NHS
Dr Guy Hayhurst	Cheshire East Council Public Health
Carol Hill	Cheshire East Council Partnerships and Communities
Margaret Hopley	Cheshire East Council Regulatory Services and Health
Katie Jones	Cheshire East Council Adults and Children
Jane Kavanagh	Cheshire East Council Partnerships and Communities
Guy Kilminster	Cheshire East Council Health Improvement
Margaret Leonard	Cheshire East Council
Dr Keith Malone	NHS
Catherine Mills	NHS
Mike Moore	North West Ambulance
Eleanor Morris	Carers Trust
Lorraine Page	Cheshire Fire and Rescue
Norman Powell	Joint Cheshire Emergency Planning Team
Paul Reeves	Flood Response Management Team
Liz Rimmer	Cheshire East Council Benefits
Elenor Rowlands	Age UK
Tania Sayer	Energy Plus
Carole Stynes	Wulvern Housing

Joanne Shannon	Cheshire East Council
Peter Smith	Cheshire East Council
Ruth Stevens	Joint Cheshire Emergency Planning Team
Matt Tandy	Flood Response Management Team
Jenny Underwood	NHS
Carole Weaver	Cheshire Community Action
Karen Whitehead	Cheshire East Council Private Sector Housing
Donna Williamson	Cheshire East Council Health Improvement Team
Britta Wright	Cheshire East Council Health Improvement Team

The event generated positive feedback with facilitators briefing that they had received engagement from all participants throughout the workshop.

Overall all practitioners enjoyed the event and found the information useful and we fulfilled a high percentage of expectations.





All practitioners are now more aware of the impact of climate changes to health and feel better informed/prepared to start looking at these issues within their communities. The majority of those who came to the event said that they would be interested in attending future events.

Exhibition Stands

The workshop had a number of exhibition stands displayed for the practitioners to gather further information on the following areas:-

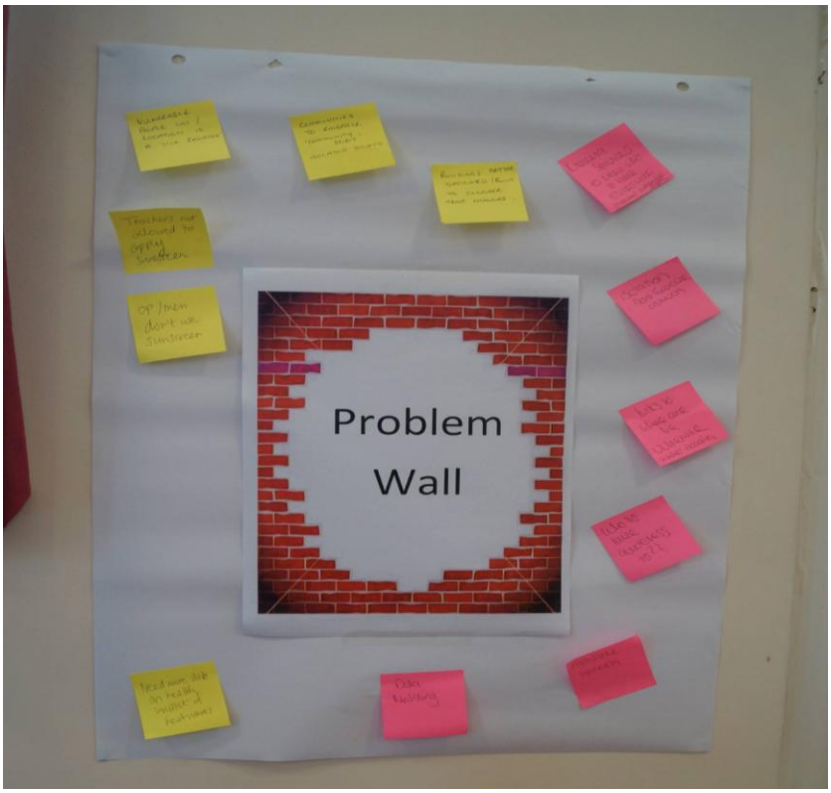
- Be Steady Be Safe
- Care and Repair
- Cheshire Community Action
- Community Resilience, Joint Cheshire Emergency Planning Team
- CVS
- Dementia Friendly Communities
- Flood Preventions and Highways, Flood Response Management Team
- CVSCE
- AgeUK

Information Gathering

A number of techniques used to gather key information including ‘Problem Wall’ and ‘Solution Tree’ posters that were displayed around the room. The posters provided the groups with the opportunity throughout the event to write their comments on post-it notes and place on the appropriate poster,

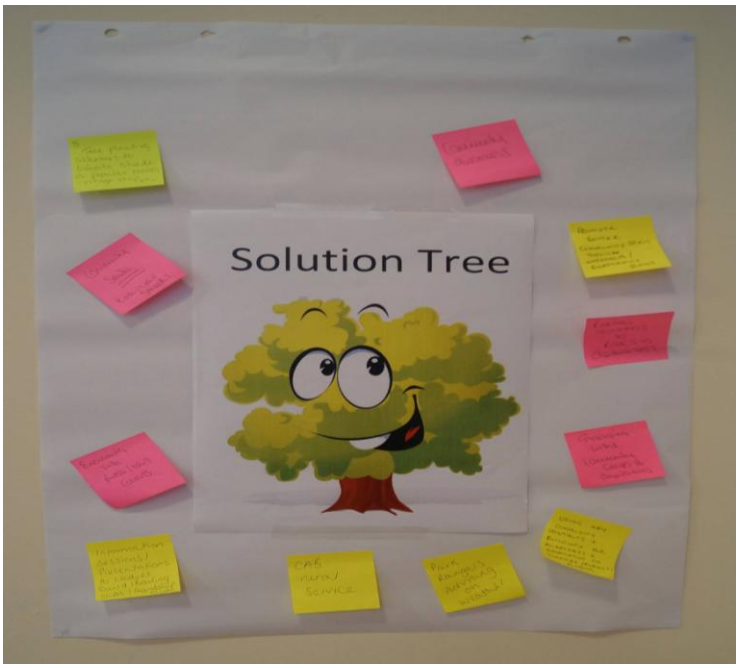
Examples from the ‘Problem Wall’

- Data-matching hurdles
- Teachers not allowed to apply sunscreen to students
- Communities need to embrace community sprit
- Loneliness escalates during the long winter nights
- Need more data on health impacts during heat waves
- Short term funding means front line professional and customers are not always aware of what services are available from month to month
- Homeless people - what do we do for them when the temperature drops?
- Sun bed monitoring – Dangerous level of UV being used
- Isolation issues and people not exercising as much
- Identify where vulnerable people are
- Buildings to be better designed to deal with temperature changes
- Speed of devastation and raising awareness
- Who should raise awareness?



Examples from the 'Solution Tree'

- Match data to Council Tax records and get band of property A-H which Indicates size of property
- Check Emergency Assistance – claims from pensioners
- Flu Angels (volunteers) to promote VAC in areas with low take-up
- Commitment to provide emergency advice services, interdependent, trustworthy
- Shutters and black-out blinds
- Develop data sharing agreement in declaration so customers can agree to proactive support/sharing
- Cold weather or warm weather champions who spread the word on good practice
- Promote better Community Sprit through Workshops/Emergency plans
- Information sessions/ presentations to Ladies Guild/Bowling Clubs/Friendship Clubs etc
- Publicise the presentation slides showing impacts to health over period of days – people look to help on cold days – press coverage
- Raise awareness of risks in Cheshire East
- Engaging with Parish and Town Councils
- Sun screen in pump dispensers at parks, leisure centres etc - free of charge
- Extreme weather toolkits in Town/Parish hubs
- Tree planting schemes to create shade on popular walk ways – e.g. near village shop
- Raising Community Sprit
- Flu jabs in smaller venues, homes, drop-in centres
- One stop central coordination of services for people to refer to – navigate customers to the right services
- Handing out bottles of water during heat waves
- Heat safety messages in pharmacies
- Heat wave and cold weather booklet/thermometer
- Commissioners thinking longer-term about the problem (rather than short-term funding)
- Free ice packs
- Engaging with community groups and organisations
- Using key community contact and building awareness and information on schemes/events/funding



Information Gathering of Wish Lists and Evaluation Forms

As a result of attending the workshop we asked the practitioners “what might their organisation do differently?” and gave them the opportunity to feedback any additional comments. We provided the practitioners with a ‘Wish List’ to capture any further suggestions they may have in relation to future planning.

- Closer links for liaising with other agencies/groups
- Consider advice regarding warm weather
- Certainly be more aware of impacts of hot weather
- Look at how integrated data solution could help with ‘Under the Weather’ campaign
- Be more aware of need to spread news, warnings, information to the voluntary and community sectors of Cheshire East.
- Work with partners to continue to raise awareness
- Ask questions relating to effects of weather, provide information and support available
- Look at Summer Initiatives
- Identify relevant flood risk areas
- Hold cold weather themed coffee mornings in local area
- Seasonal team meetings for front staff
- Consider more factors around impacts of bad weather
- From the perspective of Environmental Health it’s more a case of knowing who to notify of any concerns that we may come across through involvement with individuals
- More joined up working, use libraries for promotion
- Plan more for summer heat and be aware of impacts of temperatures that may not be very extreme - being aware of the impacts they can have

Additional comments

- Learned a lot about the health impact of hot and cold weather which I didn’t really know before
- Would have been good to have Parish Councils and Food banks represented *(all Parish Councils were invited)*
- Learnt lots of information and very well organised
- Very useful would like to be part of this work going forward
- If winter warmth events are planned for 2014/15 they should be held out in the community for a good impact and engagement with the public

Wish List – I would like to make the following suggestion:-

- Look at making ‘Under the Weather’ being seen as ‘business as usual’ rather than an emergency response e.g. ask contractors how they incorporate warm/cold weather planning, or part of evaluation criteria or business case criteria
- Use of funds = issue free cool packs to school children for use in lunch boxes
- Information/Training regarding the effects of heat and sun
- Please use libraries and mobile libraries to promote this agenda

Syndicate Workshop 1 – Cold Weather

Question 1: What do you feel are the key risks facing your community in relation to cold weather? For example, isolation, poverty.

- Old housing structure, poor insulation
- Rural aspect, isolations
- Hard to find properties in rural areas
- People not known to services
- Older people independent and don't want to ask for help
- Universal Credit, lack of budgeting skills
- Older people not taking up benefit entitlement
- Can't share data
- Environmental Health – Opportunities to network with services to identify problems in homes during bad weather
- Community is the whole of the borough
- Raise awareness to the risks to target effective response
- Lack of resources (staffing) to deal with making contacts
- Quick repair service for young tenants
- People getting organised prior to cold snaps i.e. medications, food etc.
- Hearing aid batteries
- Government funding has slowed down
- Energy improvement measures for RSL's for older housing stock
- Lack of money to pay bills
- Community engagement
- Language barriers
- Fuel poverty
- Inform people of long term risks
- Indentify fuel poverty, education to use of fuel energy effectively
- A role for front line workers as they are more likely to be in a position of trust
- Carers bringing coughs and colds into homes of patients

Question 2: In what ways do you think that your community may have already considered cold weather planning?

- Plus Dane – Gave put winter packs and hot water bottles
- Ensuring that carers are supported and any problems recognised
- Making sure communities are dementia aware
- Provided analysed data, MET office alerts distributed
- Grant funding availability
- Emergency assistance scheme – food parcels
- Cheshire Fire Service engage in events
- Winter wellbeing Events
- Community venues in bad weather doesn't work need to go out where older people are people who can't get out
- GPs being asked to identify vulnerable people but not around fuel poverty. Need to share data
- Need engagement, buy in
- How to communicate? People don't know neighbours
- Lack of community spirit

Question 3: What do you see as being the potential challenges/barriers to making a community more prepared for cold weather? What do you see as being the potential solutions to overcome those barriers?

- Schemes don't necessarily benefit e.g. emergency switching
- Rural, wide and diverse areas
- Need to get to other areas like Parish/Town Councils
- Need publicity
- Need vehicles
- Need something more substantial than information packs
- People with wider network, do better in cold weather than those with smaller network
- Get more information out to the public – potential risks to health during cold weather, it's not just about slipping on ice/hypothermia
- Who are the best people to get on board - parishes? not necessarily
- Lack of support from utility companies, charitable debts
- Money, correctly target
- Data protection, communication/information/adverts/communication between departments
- Overcomplicated schemes
- Public and private sector engagement, greater joined up working
- Why people are having repeat visits in hospitals? Does discharge work correctly? Are the right organisations involved?
- Advertising things such as flu jabs on milk bottles
- Trust
- Good neighbourhood schemes
- More trained front line staff to access properties and assess need
- Opening communication with neighbours and family members to assess and support change to attitudes

Question 4: What types of help and support do you think communities/organisations will need to progress this type of initiative?

- People buy their fuel in summer when cheaper
- Engage with people who aren't buying fuel
- Take 'bull by the horn' and get senior persons to make decisions
- Can nominate street safe areas
- Take kit out to people, blankets, thermometers
- Education
- Community hubs
- Health Centres, process of engagement
- Being kept informed of any schemers or initiatives
- Partnership working
- Use of flu clinic to deliver literature on winter wellbeing
- Use supermarkets to give fuel advice
- Training front line staff
- Use of timers on boilers

Syndicate Workshop 2 – Warm Weather

Question 1: What do you feel are the key risks facing your community in relation to warm weather? For example, isolation, poverty.

- Opening windows at night
- Risks on older people, very young and disabled
- Impacts of hay-fever and asthma
- Humidity effects and chest issues
- Suppressing appetite, buying salads, fruits etc
- Medications exposed to sunlight deteriorate
- Lack of awareness about importance of taking enough fluids
- Seeing more events during warm weather to raise awareness of hard ground and flood risks
- Monitoring air quality
- How does environmental health get air quality messages out to the public?
- Target certain areas know to have poor air quality
- Skin cancer awareness for people who work outside e.g. farmers
- Lack of knowledge and education e.g. shelf life of sun screens
- Water loss from perspiration vs. hydration knowledge of skin types
- Knowledge of factors in sunscreen
- Alcohol consumption vs. dehydration
- Teachers not allowed to apply sunscreen
- Poor air quality in town centres

Question 2: In what ways do you think that your community may have already considered warm weather planning?

- Care homes distributing water, sun cream etc.
- Have areas of shade
- Tree planting schemes to create shade on popular walks to local shops and water for pets
- GP's should make patients aware that their medication deteriorates during prolonged spells of hot weather
- Children's groups give advice regarding safety in the sun but parents don't always adhere to requests
- DEFRA – Strategic level plans are in place but this information is not getting through to lower levels
- Cost to families – sun cream

Question 3: What do you see as being potential challenges/barriers to making a community more prepared for warm weather? What do you see as being potential solutions to overcome those barriers?

- Barriers – money to afford sun creams
- People don't see warm weather as a risk
- Solution change perceptions of tanning ' pale is beautiful'
- Raising awareness of dehydration with alcohol consumption
- Provide easy access to water in public buildings
- Should schools be able to provide and apply sunscreen?
- Awareness raising
- Do water companies know where the vulnerable people are?

- Do vulnerable people have fans?, Cold Flannels
- Warm weather packs
- Gardening/allotment users - risk of skin cancer, important to wear hat etc
- Different attitudes to different ages
- Lack of knowledge and understanding of UV levels for example we prepare for holidays abroad but don't necessarily think it's a need in this country
- Security at night if leaving windows open
- Emergency fans
- Information to minimise risk
- Water fountains
- Build a better environment

Question 4: What types of help and support do you think communities/organisations will need to progress this type of initiative?

- Education about the affects of heat
- Dehydration leading to urine infections, constipation and falls
- Particular effects on heart patients on diuretic medication
- Cataracts and lights
- Sun glasses
- Stock cupboards with fruit and water
- Information and partnership working
- Access into organisations to deliver initiatives
- Financial restraints - resource bags for families in need
- Hydration awareness in pubs/clubs
- More information in retail outlets about skin types and effective factors
- Accessibility to get moles checked at pharmacies
- Have people ready to deliver/prepare for extreme weather
- Education replicates what happens for winter warmth
- Get into schools, educate teachers
- Build hats into school uniforms
- Community hubs and toolkits
- Free ice packs
- Heat wave and cold weather booklet
- Reduce temperature in care homes and circulation of air
- More shutters and curtains
- Need more data on impact of warm weather

Action Planning

What needs to happen?	Who would be involved
Cold – Education with regards to the importance of keeping warm and affects of cold weather on physical well being Good neighbours Boiler education Resources for most vulnerable (not necessary elderly)	Key Organisations Local Community Care and Repair British Gas Local Council Housing
The existing Winter Wellbeing group to continue working on both winter and summer planning to avoid inconsistency Use of wider ways to raise awareness	
Communication and incident planning	Local Authority Environmental health
Education of public – awareness raising	Local Authority Public Health NHS Third Sector
Community action planning	Parish Councils Village-organisations
Get packs of sunscreen that can be distributed at schools	Cheshire East
Get people to take advantage of free offers e.g. insulation campaign	
Disseminate information – GPS, Faith sector	
Plan environment	Planning Emergency Services Parish Councils Community Hubs
Have a wish list ready if funding opportunities arise	
Raise public awareness of heat waves – campaign	
Greater awareness of dehydration e.g. falls and infections etc	Home visiting services
Encourage store cupboards for warm weather	
Quick repair service	
Preparation for cold/warm whether via packs	
Target certain groups – gardeners, garden centres, carer agencies – passing on correct information	
Use Libraries as a community venue to promote this agenda	All libraries and mobile libraries

Work with Town and Parish councils to push this awareness	
Families to get assistance with insulation etc who don't access benefits and therefore should get financial help	
Warm weather packs – hand held fans, water beakers, flannels etc. sunglasses	
Try empower communities to show old fashioned community spirit, look in and check on neighbours and elderly for need of warmth, food, water etc	All agencies
Stop granting planning permission for green space, flood plans and vulnerable areas at risk of flooding	Cheshire East Council
Winter/Summer checklists for older people – check if one exists already- send out with prescriptions for relevant symptoms	Third sector? Funding from public health
Work with specialist groups e.g. mental health as clients are affected by hot and cold weather Share practical advice	CCGs/ Public Health
Continued dialog between Cheshire East Council and Wulvern Housing in relation to planning/preparation for cold, warm weather events and flooding	Relevant Staff
Joined-up thinking in terms of funding available to ensure best use of resources	Local Authority – HA/RSLs
Consider packs for those at risk	
Ensure discussions result in actions	All
Make flood risk information more relevant to the particular area – more specific and up to date with information on action being taken in terms of prevention	Flood Response Team

Conclusion

The Under the Weather workshop was a successful event. The information within this document has identified some of the problems, which practitioners face regarding raising awareness on health issues during severe weather conditions.

Sufficient information has been pulled together from this event to help steer future working for the planning group. It has helped to identify key priorities, such as raising awareness about the impact of cold weather and also the effects of warm weather and sunlight to health.

The focus for the immediate future will be the establishment of a number of task and finish groups. These will be working on:

- Communications and engagement, we need to raise awareness of the issues and provide advice and guidance;
- Identification of vulnerable people - we need to continue the work to better connect information from different organisations about those individuals who may be most vulnerable to extremes of weather;
- How we can facilitate moving people from fuel poverty into affordable warmth;
- Preparing the Winter Plan;
- Preparing the Warm Weather Plan.

The event raised awareness on the increase of local flooding incidents, due to climate changes. Also, it raised the importance of implementing flood prevention schemes in high risk areas.

The event highlighted the importance of the Flood Management Team and Joint Cheshire Emergency Planning Team to work with Parish and Town Councils, to implement Community Emergency Plans.

NHS
Eastern Cheshire
Clinical Commissioning Group

REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting: 11 September 2014
Report of: Head of Clinical Developments and Health Outcomes
Subject/Title: Eastern Cheshire Operational Resilience: planning process and assurance 2014 - 2015
Portfolio Holder: Councillor Janet Clowes

1.0 Report Summary

1.1 This report outlines the Eastern Cheshire Clinical Commissioning Group's approach to operational resilience planning.

2.0 Recommendation

2.1 That Members consider the report and the arrangements for operational resilience.

3.0 Reasons for Recommendation

3.1 To ensure that members are aware of the CCG's operational resilience process.

4.0 Background

4.1 Eastern Cheshire has one of the fastest ageing populations in England. Approximately half of hospital expenditure and around half of spending on adult social care is used to support people aged over 65, who represent one fifth of the overall population.

4.2 Over the next 20 years the number of people aged over 85 is expected to significantly increase, leading to an exponential growth in care needs for people living alone and in nursing homes locally.

4.3 Over the last 18-months local commissioners, providers and patients have developed a shared vision for how health and social care services will transform and work together to provide support at home and earlier treatment in the community. This will prevent people needing emergency care in hospital, or care homes, and to deliver new opportunities to live as independently as possible.

4.4 Work has also been completed to design and implement a system-wide monitoring tool; 'Snow White', which utilises hard and soft data from a number of organisations to present a visual picture of system performance. It uses

colour codes to highlight specific pressure points and real-time assessment of whole system performance. Resulting actions taken are then targeted and monitored.

5.0 System Resilience

5.1 Delivering operational resilience during 2014-15 moves beyond planning for urgent care over the winter, and includes planned care for system wide, year round resilience. This is overseen by a System Resilience Group (SRG) with representatives from across health; social care, the third sector and patient representatives

5.2 The objective of the SRG is to ensure that the health and social care system has an understanding of urgent and planned care capacity and performance across all providers. The members hold each other to account for performance but provide an opportunity for partnership working.

6.0 Operational Resilience Planning

6.1 NHS Eastern Cheshire CCG wishes to secure £1.2M non-recurrent NHS England, system resilience funding to address whole system resilience. The CCG has implemented a robust 5-step process, to ensure effective investment of this funding on behalf of our population. This process was open to all providers and partners, including voluntary, community and faith sector (VCFS) organisations, with an extended deadline offered to VCFS to support wider discussion and involvement.

6.2 ***The 5 Steps***

6.2.1 ***Step 1;***

Statutory sector bids were considered by the SRG on 19th July 2014. Bids were assessed using a scenario-based approach utilising 'Snow White' to ensure the bids would have the intended effect. A notional sum was ring fenced for future VCFS bids

6.2.2 ***Step 2;***

Prioritisation by the SRG members based on the output of the scenario testing. The initial bids were scored from 1-3; 1 being of the lowest priority and 3 being the highest priority.

6.2.3 ***Step 3;***

With delegated responsibility of the SRG, the Chair of the group and SRG Project Manager, approved, shortlisted submissions based on the results of step 2. Bidders were informed of the decision. Those shortlisted to the next stage were invited to attend a Panel on the 19th August 2014.

6.2.4 ***Step 4;***

The Panel, (commissioners, clinical and patient representatives) used an agreed set of criteria to evaluate bids to ensure the process was consistent and transparent. Panel proposals will be presented to the ECCCG Executive team on September 3rd 2014 for formal approval to proceed.

6.2.5 *Step 5;*

Third sector organisations were required to submit bids by 15th August 2014. The bids were shared with the SRG on the 21st August 2014 and following a process of prioritisation, successful bidders will attend a panel on the 8th September 2014. Recommendations will go to the ECCCG executive team for final approval

6.3 Successful bidders will be expected to work closely with the SRG to ensure the additional resources are implemented successfully providing coherent and responsive interventions for patients with the greatest level of need. Providers will need to work effectively with existing services and contractual arrangements. The SRG will monitor KPIs and performance on a monthly basis.

7.0 Clinical Models

7.1 In line with the national evidence base and operational resilience guidance, prioritisation has been given to initiatives which support the following areas:

7.2 ***1. Rapid assessment and treatment (RAT)***

Definition: Having consultant-led rapid assessment and treatment systems (or similar models) within emergency departments and acute medical units during hours of peak demand to ensure swift, sound clinical decision-making and effective use of staffing and other resources.

Evidence of assurance: Proposed new initiatives to deliver this model:

- additional Emergency Medicine Physician and estates work, to improve integration and patient flow within ED. ***This will be funded internally by Eastern Cheshire Trust.***
- system resilience funding has been requested for an Advanced Nurse Practitioner to stream appropriate medical presentations in ED.

7.3 ***2. RAID***

Definition: Delivering rapid response to mental health crises 24/7, via a single point of contact, with team fully integrated into acute hospitals

Evidence of assurance: Proposed new initiatives to deliver this model:

- extended Psychiatric Liaison Services to a 7-day service within ED.
- extended and increased capacity within Hospital Alcohol Liaison Services to a 7-day service within ED linking with community-based follow-up support.

7.4 ***3. Hear & Treat and See & Treat***

Definition: Reducing the need to despatch ambulances to patient and the need for ambulances to convey patients to hospital respectively.

Evidence of Assurance: There is existing CCG funding for this model and therefore no additional system resilience funding has been agreed. Existing initiatives are as follows:

- continued investment in the GP Acute Visiting Service, to support the NWAS pathfinder scheme, ensuring an urgent 2 hour response for GP assessment and treatment.

- the CCG is part of a team working across Cheshire Warrington and Wirral with NWAS to address factors affecting performance and identify solutions to support achievement of the targets in 2014/15.

- the CCG quality incentive plans will support an increase in 'Hear and Treat' and 'See and Treat' and to reduce the need for people to be taken to hospital.

- community care plans / patient passports are being completed for patients with complex health and social care needs. This will describe the patients preferences and agreed crisis plan and will be available for all partners to use

7.5 ***4. Primary care in A&E***

Definition: Co-location of primary care and A&E so patients can be signposted after assessment.
Evidence of Assurance: Existing initiatives are as follows:

- GP Out-of-Hours is co-located within ED and supports partnership working

Proposed new initiatives to deliver this model:

- The 'Think Pharmacy Minor Ailments' service to enable more patients to access NHS funded medicines without requiring a GP or A&E appointment to provide a prescription. Supporting 7-day working, whilst also freeing up appointments elsewhere in the system.

7.6 ***5. 7-day cross-system working***

Definition: Providing more responsive and patient-centred delivery seven days a week, including arrangements to facilitate hospital discharge, and in line with Better Care Fund principles.

Evidence of Assurance: All initiatives which support 7-day working have been prioritised including:

- therapy services
- social care
- hospital pharmacy
- liaison psychiatry
- range of VCFS services to support patients with complex health and social care needs

7.7 ***6. Facilitating and minimising delayed discharges***

Definition: Processes to minimise delayed discharge and good practice on discharge across organisations to support patients with complex needs.

Evidence of Assurance: Proposed new initiatives are as follows additional:

- stretcher transport to facilitate timely discharge hospital to home.
- Occupational Therapy and Physiotherapy in-reach service over 7-days
- Social Worker service over 7-days to support rapid assessment.
- bed-based rehabilitation services to support step-up and step-down patients.
- VCFS proposals prioritised to support discharge of people back home

7.8 ***7. Alternatives for high risk patients and data-sharing***

Definition: using software tools to gain identify people with complex needs and commission appropriate alternatives to hospital care.

Evidence of Assurance: Existing initiatives are as follows:

- agreements in place with all local GP Practices to share data within protection guidelines.
- interim software solution in place which uses primary and secondary care data.
- multi-disciplinary neighbourhood teams in place and aligned with GP Peer Groups.
- primary and community care plans for complex care patients.

Evidence of Assurance: Proposed new initiatives are as follows:

- procure software tool (iRIS) which incorporate a range of social indicators that impact upon a person's level of need and risk. This will enable care professionals to identify people prior to crisis and support the implementation of a more proactive model of care.
- additional therapy and community services support, including the third sector will be aligned to neighbourhood teams to ensure targeted support is available to enable people to remain safely at home during times of increased need.

7.9 ***8. Preventing admissions from residential and nursing homes***

Definition: Planning for regular health surveillance of care home residents (especially those with chronic conditions) to decrease the risk of hospital admission.
Evidence of Assurance: Prioritisation has been given to initiatives which focus on community services. The outcome will be proactive management of patients in residential and nursing homes and an increase in the proportion of older people who remain in their care home 91 days after discharge from hospital:

- Additional capacity for Speech and Language Therapy in-reach service over 7-days to support rapid assessment and follow-up of patients with swallowing difficulties.

- A proactive care model to ensure continuity of care for all care home residents. The service will provide management of long-term conditions, mental health and dementia care, ambulatory care sensitive conditions and support for end of life care.

- The GP Acute Visiting Service provides additional urgent care to care home residents.

- The CCG is also working with South Cheshire & Vale Royal CCGs to improve quality in care homes

8.0 Conclusion

8.1 The plans contained in this paper will be monitored via the system resilience group, specifically to evaluate their impact across the whole urgent care system. Initiatives which support a shift from hospital to home will inform our local integration programme which in turn will inform future commissioning for services.

8.2 Final proposals will be presented to the ECCCG executive committee for authorisation ahead of the final submission deadline of 23 September 2014 to NHS England.

9.0 Access to Information

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

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NHS
South Cheshire
Clinical Commissioning Group

REPORT TO: Health and Adult Social Care Overview and Scrutiny Committee

Date of Meeting: 11th September 2014
Report of: NHS South Cheshire Clinical Commissioning Group
Subject/Title: Preparing for Winter in the Health Service
Portfolio Holder: Cllr Janet Clowes

1.0 Report Summary

1.1 There is a marked growth in the need for urgent and emergency services across the winter months (November – March), which increases pressure on already struggling resources. To ensure timely access and patient safety Government scrutiny and performance monitoring increases and is led locally through the Urgent Care Working Group.

1.2 The Urgent Care Working Group involves a range of organisations across health and social care including NHS South Cheshire Clinical Commissioning Group, NHS Vale Royal Clinical Commissioning Group, Cheshire East Council, Cheshire West & Chester Council, NHS Mid Cheshire Hospital Trust, NHS East Cheshire Trust, Cheshire and Wirral Partnership, North West Ambulance Service and NHS England. There are also two Patient Representatives on the Group.

1.3 The Urgent Care Working Group will soon be changing to the System Resilience Group and will be covering planned and non-elective care.

1.4 For the last two years non recurrent funding has been allocated to NHS South Cheshire Clinical Commissioning Group to help to alleviate this pressure. Allocation of the fund is undertaken through the Urgent Care Working Group. This year NHS England has allocated an additional £1.7m to our local health economy, with £1,077,705 being allocated to NHS South Cheshire Clinical Commissioning Group and £636,496 to NHS Vale Royal Clinical Commissioning Group.

1.5 An Operational Resilience and Capacity Plan (ORC Plan) was produced, approved and submitted to NHS England on the 30th July 2014. The Plan was extremely well received by NHS England who indicated they felt Medium Assured with the 2014/15 winter planning arrangement and identified the following main areas of concern:

- Primary care resilience
- Mental health resilience

NHS
South Cheshire
Clinical Commissioning Group

2.0 Recommendation

2.1 To receive the contents of this report.

3.0 Reasons for Recommendations

3.1 This information provides a wider understanding on how the health and social care economy manages increased pressures during the winter months (November – March).

4.0 Background

4.1 There is national recognition of increased urgent and emergency services across the winter months, which officially run from November to March. During this time central government scrutiny and performance monitoring increases to ensure patient demand for timely access to safe and appropriate services are met.

4.2 This scrutiny involves the assessment of local health economy winter planning preparations by NHS England and considers:

- how robust preparations have been undertaken
- how pressures will be monitored daily
- how effective action will be undertaken to address growing pressure

4.3 For the last 2 years Government has released non-recurrent winter funding to help local economies address this increasing pressure.

5. The 13-14 Winter Planning Period

5.1 NHS England assessed NHS South Cheshire Clinical Commissioning Group's winter planning approach and plans as Medium Assured identifying the following three main areas of concern:

- Impact on elective activity
- Delayed transfer of care
- Changes to working practices that may create a need for 7 days social care support

5.2 Anticipated pressures were monitored regularly through the Urgent Care Working Group who helped to develop, create and test winter planning arrangements for the local economy. The monitoring process utilised a red, amber yellow and green escalation matrix and a performance report, which was published 3 times a day on a portal.

5.3 In November 2013, NHS England allocated £1.088m non-recurrent winter investment money to NHS South Cheshire Clinical Commissioning Group as lead commissioner of urgent and emergency

services at Mid Cheshire Hospital Trust, to help the local economy address increasing pressures.

5.4 Alongside the £1.088m NHS Vale Royal Clinical Commissioning Group underwrote an additional £203,000 bringing the total available to local providers to £1,291m. The funding required investment by 31st March 2014 and came with the caveat that it was to be invested towards:

- Improving other services away from A&E
- Reducing unnecessary visits and avoidable emergency admissions
- Boosting individual A&E departments

5.5 NHS South Cheshire Clinical Commissioning Group implemented a robust and challenging process, overseen by the Urgent Care Working Group. All partners and third sector organisations were given the opportunity to apply for some of the funding and 41 applications were received.

5.6 Evaluation was facilitated in December through the Urgent Care Working Group where 21 of the bids were supported, with organisations receiving between £2 - £316K. Supported applications included:

- Additional social work support within the hospital with Local Authorities
- Urgent Care Centre Sunday opening with the hospital
- Disabled family support with Cheshire Buddies
- Additional psychiatric liaison support with Cheshire and Wirral Partnership

6. 13-14 Health Economy Pressures

6.1 Although there was little activity relating to pandemic flu or major severe weather, the winter continued to present challenges to NHS Mid Cheshire Hospital Foundation Trust as it experienced bottlenecks in processing patients at the front (A&E) and back (patient discharge) doors and experienced a number of infection control issues relating to diarrhoea and vomiting (D&V) outbreaks.

6.2 NHS England's late notification of funding in 2013 did create some challenges for the supported applications to have the desired impact on the local health economy, particularly in respect of recruiting professionally trained staff. These issues impacted the availability of bed capacity within the hospital and affected performance of the 4 hour standard.

6.3 NHS Mid Cheshire Hospital Foundation Trust's Emergency Department achieved the 4 hour standard in the first two quarters of the year,

struggled in quarter 3 and failed the standard in quarter 4, compared to the Urgent Care Centre which achieved the standard for all 4 quarters. On a positive note, the performance of the Urgent Care Centre did mean that the standard was achieved at Trust level. The failure of quarter 4 was down to a virulent strain of D&V , which re-infected patients just before the 72 hour all clear timeline.

7 Changes for 14-15

7.1 In the summer of 2014, NHS England notified Clinical Commissioning Groups that Urgent Care Working Groups were to be developed into System Resilience Groups (SRG) and be responsible for elective and non-elective performance.

7.2 An Operational Resilience and Capacity Plan (ORC Plan) was produced, approved and submitted to NHS England on the 30th July 2014.

7.3 The ORC Plan was extremely well received by NHS England who indicated they felt Medium Assured with the 2014/15 winter planning arrangement and identified the following main areas of concern:

- Primary care resilience
- Mental health resilience

8. 14-15 Winter Pressures Investment

8.1 In May 2014 the Urgent Care Working Group undertook a review of the 2013/14 process and outcomes, identifying that in 2014/15 winter funding would be best utilised to deliver:

- Provision of services in the community (Primary Care, Third sector, Social Care and Community Services) to reduce A&E attendances, admissions and readmissions.
- Within Secondary care to reduce average length of stay and improve patient flow.
- Additional workforce around the discharge team to reduce Delayed Transfers of Care and improve the hospital discharge processes.

8.2 To help alleviate the recruitment pressures felt last winter, this years' announcement was made in June. For this year, NHS England allocated £1,077,705 to NHS South Cheshire Clinical Commissioning Group and £636,496 NHS Vale Royal Clinical Commissioning Group (total £1.7m).

8.3 NHS England also announced an additional £250m fund to address pressures in delivery of the 18 Referral to Treatment (RTT) target. This funding is in additional to current Trust contract levels and has enabled

hospitals to undertake additional elective activity between July – September in preparation for the non-elective winter increase on resources.

8.4 In preparation for this winter, the 2013/14 winter investment approach was developed further and approved in June by the Urgent Care Working Group. The new process utilised national and local priorities in a two tier evaluation process; with Phase One taking place in July and Phase Two in August/September. The following outcomes were used to evaluate the applications:

- Reduce A&E attendances
- Reduce A&E Non Elective Admissions
- Reduce the Number of Patients Experiencing Delays in Discharge
- Reduce the Average Length of Stay for Admitted Patients
- Increase the Number of Patients Signposted to more appropriate services from A&E and UCC
- Increase the Number of Telephone Calls to NHS 111

8.5 This winter funding process was promoted to all partners and the third sector in June 2014 and on the 4th July 58 applications were received. Submitted applications were considered at the July Urgent Care Working Group and were categorised as fully supported, supported in principle or not supported. 44 of the submitted applications went through to Phase Two.

8.6 Organisations were requested to further develop their applications (sometimes in partnership), strengthening their funding requests and submitting revised application by the 8th August. 34 revised applications were received and Phase Two evaluation is taking place through the Urgent Care Working Group during August and September.

9.0 Access to Information

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

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Adults in the Community Scrutiny Committee

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Date of Meeting: 2 September 2014
Report of: Democratic Services
Subject/Title: Work Programme update

1.0 Report Summary

1.1 To review items in the 2014 Work Programme, to consider the efficacy of existing items listed in the schedule attached, together with any other items suggested by Committee Members.

2.0 Recommendations

2.1 That the work programme be received and noted.

3.0 Reasons for Recommendations

3.1 It is good practice to agree and review the Work Programme to enable effective management of the Committee's business.

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 Not applicable.

6.0 Policy Implications including - Climate change
- Health

6.1 Not known at this stage.

7.0 Financial Implications for Transition Costs

7.1 None identified at the moment.

8.0 Legal Implications (Authorised by the Borough Solicitor)

8.1 None.

9.0 Risk Management

9.1 There are no identifiable risks.

10.0 Background and Options

10.1 In reviewing the work programme, Members must pay close attention to the Corporate Priorities and Forward Plan.

10.2 The schedule attached, has been updated in line with the Committees recommendations on 10 July 2014. Following this meeting the document will be updated so that all the appropriate targets will be included within the schedule.

10.3 In reviewing the work programme, Members must have regard to the general criteria which should be applied to all potential items, including Task and Finish reviews, when considering whether any Scrutiny activity is appropriate. Matters should be assessed against the following criteria:

- Does the issue fall within a corporate priority
- Is the issue of key interest to the public
- Does the matter relate to a poor or declining performing service for which there is no obvious explanation
- Is there a pattern of budgetary overspends
- Is it a matter raised by external audit management letters and or audit reports?
- Is there a high level of dissatisfaction with the service

10.4 If during the assessment process any of the following emerge, then the topic should be rejected:

- The topic is already being addressed elsewhere
- The matter is subjudice
- Scrutiny cannot add value or is unlikely to be able to conclude an investigation within the specified timescale

11.0 *Access to Information*

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

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Health and Adult Social Care Overview and Scrutiny Committee Work Programme – 2 September 2014

Topic	Description /Comments	Responsible Organisation /Officer	Suggested by	Corporate Priority	Current Position (G/A/R)	Next Key Date
Better Care Fund and Integrated Care	Briefing for members to provide understanding to allow monitoring of the Better Care Fund	Lorraine Butcher	Lorraine Butcher	Outcome 5 – People live well and for longer	Briefing for members to be arranged.	Deferred from July, new date TBC
Adult Social Care Commissioning Strategy	To examine the Strategy and make comment on proposals before Cabinet decision	Brenda Smith	Brenda Smith	Outcome 5 - People live well and for longer	Strategy to be examined at Sept meeting before Cabinet decision	Agenda Deadline 3 September Meeting 11 September
Winter Wellbeing	To Review of Winter Planning 2013 – encompassing the CCG's Winter Planning and the multi-agency Winter Wellbeing activities 2014.	Council, Eastern CCG, South CCG/ Guy Kilminster	Committee	Outcome 5 - People live well and for longer	Reports from multiple agencies to be received at Committee meeting.	Agenda Deadline 3 September Meeting 11 September
Stroke Pathway – Eastern Cheshire	To consider an update on proposals to alter Stroke Pathways for patients in Eastern Cheshire CCG area	Jacki Wilkes Eastern Cheshire CCG	Jacki Wilkes	Outcome 5 - People live well and for longer	Update on proposals for changes to Stroke Pathways to be considered at Committee meeting. Previously discussed in Dec 2013.	Deferred from September Requested: Meeting 9 October
Eastern Cheshire 5 Year Strategic Plan	To review the CCG's 5 year plan	Matthew Cunningham	Matthew Cunningham	Outcome 5 - People live well and for longer	Confirm with Chairman whether item to be considered at Committee meeting	Possible item for 9 October meeting
CCGs Commissioning Policy Review	To examine the final consultation report of the Cheshire and Merseyside CCGs'	Julia Curtis	Matthew Cunningham	Outcome 5 - People live well and for longer	Consider whether item to be considered at Committee meeting or alternative method.	TBA

Health and Adult Social Care Overview and Scrutiny Committee Work Programme – 2 September 2014

	Commissioning Policy Review. Extra focus on IVF Funding requested				Previously considered draft and submitted comments in Feb 2014	
ESAR – Leisure Trust 6 Month Review	To examine report on Leisure Trust activity over previous 6 months	Mark Wheelton Commissioner of service	Mark Wheelton	Outcome 5 - People live well and for longer	Confirm with Chairman	Possible item for 6 November meeting

Task and Finish Groups						
Assistive Technology	To develop the use of assistive technology in Social Care Services and to maintain people's independent living	Jon Wilkie Ann Riley	Health and Adults PDG	Outcome 5 – People live well and for longer	Information about technology available gathered during a site visit. Meeting to discuss next steps to be arranged	Latest meeting 19 August, next meeting TBC
Carers Strategy	To develop a strategy to assist carers in their caring roles and ensure they are	Rob Walker	Health and Adults PDG	Outcome 5 – People live well and for longer	Arrangements to be made for the next meeting mid August.	Next meeting mid Sept

Joint Health Scrutiny Activity						
Whole System Review of Mortality Rates at Mid Cheshire Hospitals NHS Foundation Trust	To request a detailed report on mortality rates following concerns raised during consideration of Quality Account	Mid Cheshire Trust, South CCCG, Vale Royal CCG NHS England Both Councils	Committee	Outcome 5 - People live well and for longer	Joint Scrutiny Committee formed with CWAC and considered reports on MCHFT. Cttee to review again in February 2015	Meeting held on 23 July Update in Feb 2015 TBA

Possible Items to Monitor or consider at future Meetings

- Integrated Care – Caring Together and Connecting Care
- CCG two year plans
- Family Nurse Partnership
- Future of local hospitals

Health and Adult Social Care Overview and Scrutiny Committee Work Programme – 2 September 2014

- Rape and Sexual Abuse Support Centre Annual Report
- Impact of Social Landlords on Health and Wellbeing
- Better Care Fund – Briefing
- Public Health Services
- Mental Health
- Health and Wellbeing Strategy
- NHS England – Specialist Commissioning
- Health Impact Assessments for the Local Plan
- Travel plans (i.e. patients, family and friends travelling to health services)
- Shifting services from hospitals to communities
- Quality of health and care services
- Integration and connecting budgets for health and social care
- Early Intervention and Prevention of illness and deterioration
- Clinical Pathways for Obesity – NHS England
- Planning – consultation of Public Health on developments
- Leisure and Sport
- Ambulance Services – NWAS Response Times, First Responders and Co-responders
- Screening – Cancer and other health screening, take up and promotion by Public Health
- Health Impact Assessments in planning applications
- Health and Wellbeing Board performance review
- Director of Public Health Annual Report
- Annual Report on Residential Care Commissioning
- Access to GPs and increasing GP services
- Co-Commissioning
- Future of Care4CE
- Quality Assurance
- Cessastion of the Empower Care – referred by Corporate Scrutiny

Dates of Future Committee Meetings

11 September, 9 October, 6 November, 4 December, 8 January 2015, 5 February 2015, 5 March 2015, 2 April 2015

Dates of Future Cabinet Meetings

16 September, 14 October, 11 November, 9 December, 6 January 2015, 3 February 2015, 3 March 2015, 31 March 2015, 28 April 2015

Dates of Future Health and Wellbeing Board Meetings

23 September, 18 November, 27 January 2015, 24 March 2015

Dates of Future Council Meetings

16 October, 11 December, 26 February 2015, 20 May 2015

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