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Eastern Cheshire Clinical Commissioning Group

South Cheshire Clinical Commissioning Group

Health and Wellbeing Board

Agenda

Date:	**Tuesday 15th September 2015**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Declarations of Interest**

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

3. **Minutes of Previous Meetings** (Pages 1 - 14)

   To approve the minutes of the meeting held on 24 March 2015 as a correct record and to note the minutes of the inquorate meeting held on 16 June 2015.

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

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

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

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

5. **Better Care Fund - Update** (Pages 15 - 32)

To receive an overview of 2015/16 BCF Quarter 1 performance and to provide an update on the overall implementation of the Better Care Fund plan

6. **Eastern Cheshire Clinical Commissioning Group 2015-16 Prospectus** (Pages 33 - 60)

The Board is asked to note the content of the Eastern Cheshire Clinical Commissioning Group Prospectus for 2015-16

7. **Local Transformation Plans for Children and Young People's Mental Health and Wellbeing** (Pages 61 - 66)

To note the requirement to develop and submit local Transformation Plans in relation to Children and Young People's Mental Health and Wellbeing and the requirement for local plans to be signed off by a representative of the Health and Wellbeing Board prior to submission in October 2015 and nominate a representative accordingly

8. **Care Act - Update** (Pages 67 - 70)

To note the impact of the Government's decision to delay implementation of the planned funding reforms on the Health and Wellbeing Priorities

9. **Update on Progress on the development of a Cheshire East Strategy for Carers** (Pages 71 - 76)

To note the concerns raised by the ECCCG Governing Body and the approach taken to address these concerns for the redrafted Strategy for Carers

10. **Ensuring and Improving Quality and Choice in Residential and Nursing Home Provision** (Pages 77 - 80)

To consider the proposal to establish a task and finish group to review residential and nursing home provision in Cheshire East

11. **Assistive Technology Task and Finish Group Recommendations** (Pages 81 - 100)

To consider the two recommendations of the Health and Adult Social Care Overview and Scrutiny Committee Task and Finish Group

12. **The NHS Healthy New Towns Programme - Expressing an Interest** (Pages 101 - 112)

To consider the Report on the submission of an expression of interest to join the Healthy New Towns Programme focussed upon the North Cheshire Growth Village at Handforth

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Agenda Item 3

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 24th March, 2015 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor J Clowes (Chairman)

Cllr Rachel Bailey, CE Council
Cllr Alift Harewood, CE Council
Mike Suarez, Chief Executive, CE Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Paul Bowen, Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Dr Heather Grimbaldeston, Director of Public Health, CE Council
Tony Crane, Director of Children's Services, CE Council
Brenda Smith, Director of Adult Social Care and Independent Living, CE Council
Kate Sibthorp, Healthwatch
Richard Freeman, NHS England local area team member

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

Officers/others in attendance
Deborah Nicholson, Legal Services, CE Council
Guy Kilminster, Corporate Manager Health Improvement, CE Council
Julie North, Democratic Services, CE Council
Dr Guy Hayhurst, Consultant of Public Health, CE Council
Ann Riley,Corporate Manager,Strategic Commissioning, CE Council
Louisa Ingham, Better Care Fund Finance Lead
Jon Wilkie, Commissioning Manager, CE Council
Karen Burton, Eastern Cheshire CCG
Julia Burgess, South Cheshire CCG
Jacki Wilkes, Eastern Cheshire CCG
Anne Higgins, Head of Transformation Adult Services, CE Council

63. **APOLOGIES FOR ABSENCE**

Apologies for Absence were received from Dr Andrew Wilson, Tina Long (Substitute Richard Freeman) and Anita Bradley (Substitute Deborah Nicholson).

64. **DECLARATIONS OF INTEREST**

There were no declarations of interest.

65. **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes of the meeting held on 27 January 2015 be approved as a correct record.

66. **PUBLIC SPEAKING TIME/OPEN SESSION**

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

67. **BETTER CARE FUND - SECTION 75 PARTNERSHIP AGREEMENTS**

Consideration was given to a report relating to Better Care Fund (BCF) Section 75 Partnership Agreements.

It was noted that the Board was responsible for the ongoing oversight of the delivery of the Better Care Fund (BCF) plan during 2015/16 and whilst not a signatory of the s75 partnership agreement it would have a role in gaining assurance that partners were collectively working together to deliver the plan.

The BCF was a national pooling of £3.8billion from a variety of existing funding sources within the health and social care system and would be utilised to deliver closer integration across health and social care. The BCF was a pooled budget held between Local Authorities and Clinical Commissioning Groups (CCG's) via a legal section 75 (s75) partnership agreement. The Fund provided a tool to enable local integration programmes. It would be spent on schemes that were integral to improving outcomes for local people. The BCF plans and allocations had been developed on the Cheshire East Health and Wellbeing Board basis and the pooled budget for Cheshire East would be £23.9m and consisted of Local Authority Capital funding of £1.8m, South Cheshire CCG funding of £10.5m and Eastern Cheshire CCG Funding of £11.6m.

On 27th January 2015, the Board had endorsed progressing with two separate s75 pooled budget agreements locally, to support the delivery of the Better Care Fund plan and to be aligned with the respective health integration programmes. The report provided the Board with an update on the implementation and delivery of the Cheshire East Better Care Fund, as approved by NHS England. It requested that the Board support and endorse the scheme specifications included within the s75 partnership agreement and the partnering of the Council and CCGs through two s75 Partnership Agreements from 1st April 2015 until 31st March 2016 and to continue post April 2016, so long as there was a national requirement to operate the Better Care Fund as a s75 pooled budget agreement.

It was reported that new operational guidance in respect of the BCF had been received from NHS England, the Department of Health and DCLG and this would need to be taken into account in the Better Care Section 75 agreement and that the timeframes for presenting a BCF update on performance, as set out at paragraph 4.6 of the report, may need to be revised.

It was reported that the figures in the chart at paragraph 5.1 of the report had been transposed and that the figure for the Eastern Cheshire CCG and CEC pooled budget should be £1,114.000 and the figure for South Cheshire CCG and CEC pooled budget £1,005,000.

RESOLVED

That the Health and Wellbeing Board(HWB):-

i) Supports and endorses that the s75 agreement is consistent with the Better Care Fund plan approved by the HWB on 25th March 2014 and recommends the Council and CCGs enter into two s75 partnership

agreements, with Eastern Cheshire Clinical Commissioning Group (for Caring Together Programme) and South Cheshire Clinical Commissioning Group (for Connecting Care Programme) to deliver the Better Care Fund Plan;

ii) Notes the lead commissioning arrangements for delivery of the Cheshire East Better Care Fund;

iii) Agrees that the Cheshire East Joint Commissioning Leadership Team is responsible for reviewing the delivery of the s75 agreement and the Better Care Fund plan (covering commissioning working arrangements and the monitoring arrangements for contract, performance, risk and finance) pending a review of existing governance arrangements and notes the arrangements for reporting progress back to the Health and Wellbeing Board;

iv) Agrees the indicative timeframe for reporting BCF plan updates to HWB as detailed in section 8.6;

v) Accepts that the Joint Commissioning Leadership Team are responsible for reviewing and maintaining the BCF risk register, including agreeing the level of risk and will provide regular updates to the HWB, so that they can gain assurance that risks, level of risk and issues are being managed appropriately;

Recognises the need to undertake further work in respect of the impacts of the non delivery of the pay for performance fund.

vi) Recognises the need to collectively develop data sharing arrangements across organisations which support the delivery of BCF and other wider initiatives;

vii) Accepts that the HWB should be notified of variations to scheme specifications included in the BCF plan, including funding arrangements and fundamental changes to scheme specifications.

68. **NHS SOCIAL CARE ALLOCATION 2014/15**

The NHS Social Care Allocation to Cheshire East Council for 2014/15 was an amount of funding, determined by the DH, that was to be transferred from the NHS (NHS England) to Councils (Gateway Reference 01597). The funds were to be used to "support adult social care services….. that also had a health benefit". The way the funds were spent has to be agreed with local health partners. The formal agreement was between NHS England and Cheshire East Council via a s.256 agreement. However the NHS England Cheshire, Warrington and Wirral Local Area Team were seeking support from the Clinical Commissioning Groups, Eastern Cheshire CCG and South Cheshire CCG, to the proposals for spending. Consideration was given to a report outlining the proposed spend areas that had been agreed locally. It also included the proposed governance arrangements. The overall areas of spending had been identified and were detailed in a table within the report, including continuations of existing spending, agreed in-year new spend and proposed carry forward of all underspends to 15/16 and onwards under BCF plans.

The total allocation from NHS England to CEC for 2014/15 was £6.649m. Locally there were unspent allocations from 2013/14 which had been carried forward and ring-fenced for agreed spending in 2014/15, or for future BCF plans. This had produced a total available budget for 2014/15 agreement of £8.42m.

In considering the report the Board considered that it was necessary to understand the reason for the underspend and felt that, in order to demonstrate best value, it would be useful to have a detailed breakdown of the figures. It was

noted that this information was already available and was reported to the JCLT on a monthly basis and it was agreed that the information should be passed onto the Board in order to provide reassurance.

The Board was requested to endorse the proposed spending of the allocation of social care funding and to regularly scrutinise performance against the agreed outcomes to ensure these contributed to the Health and Wellbeing Strategy outcomes.

RESOLVED

1. That the proposals for the spending areas and the governance arrangements be endorsed.

2. That it be noted that a review had taken place between CEC and the two CCGs of both current and future spend areas to ensure these proposals were agreed as the best ways of using this allocation for social care.

3. That the Board receive performance reports on this funding twice per annum at half-year and year-end.

4. That NHS England be recommended to release the funding allocation to CEC, based on the summary paragraph 1.2 of the report with any underspends ring -fenced for future years of BCF plans, as agreed.

69. **PHARMACEUTICAL NEEDS ASSESSMENT**

Consideration was given to a report relating to the final version of the Pharmaceutical Needs Assessment (PNA). The draft PNA had been consulted upon for 60 days between 19th November 2014 and 19th January 2015, with those specified in the Regulations. A total of 8 completed responses had been received and these comments had been incorporated where appropriate into the final version. No major changes to the PNA or to the Six Statements had been needed as a consequence of the consultation.

A new subsection 21.2 had been added to the PNA. It described the main new housing developments in Cheshire East, which should help to guide assessment of any new pharmaceutical provision. Three tables were included, covering dwellings currently under construction, those where development was likely to start or be completed within the next 3 to 5 years and also the main Strategic Sites which were identified within the Local Plan Strategy. The Board was requested to approve the PNA for publication.

RESOLVED

That the PNA be approved for publication.

70. **JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY SELF ASSESSMENT 2014 AND ACTION PLAN 2015/16**

Consideration was given to a report relating to the Joint Health and Social Care Learning Disability Self Assessment 2014 and Action Plan 2015/16.

The Learning Disability Health Self-Assessment Framework (LDSAF) had been an annual process since being used in England in 2007/8. 2013 had seen the

introduction of a revised Joint Health and Social Care Self-Assessment Framework to emphasise the need for a joint commissioning approach between health and social care. As part of this process all Local Authority areas had again been asked to complete the self-assessment in 2014, working with their local health partners and learning disability partnership boards. The aim of the self assessment was to provide a framework for a comprehensive local stock- take exercise.

The self assessment for 2014 required each area to assess themselves against 26 measures using a RAG (Red Amber Green) 'Traffic Light' system. These measures were divided into three broad areas in the self assessment, which were Staying Healthy, Being Safe and Living Well. Learning Disability Partnership Boards had been asked to rate provision in their area against this set of 26 measures. In Cheshire East, this had been undertaken by NHS and Local Authority colleagues, in collaboration with local care providers, self-advocates and family carers, through the Learning Disability Partnership Board.

An Action Plan had been devised with the Learning Disability Partnership Board to drive improvement in the areas where the rating was amber or red and to ensure that services continue to improve where they have been rated green. The full Action Plan was provided at appendix I of the report, with a summary of the actions to be taken included on the final 2 pages of the Plan.

With reference to Appendix 1 of the report – Actions Linked to SAF Section and 2014 Rating, it was noted that Action A2 had been recorded as been rated red and it should have been listed as amber.

The Board was requested to consider and endorse the Joint Health and Social Care Learning Disability Self Assessment Action Plan.

RESOLVED

That the Joint Health and Social Care Learning Disability Self Assessment Action Plan be endorsed.

71. **CONTINUOUS IMPROVEMENT IN COMMISSIONING FOR BETTER OUTCOMES**

Consideration was given to a report relating to Continuous improvement in commissioning for better outcomes.

It was reported that a single common commissioning model for all partners pan-Cheshire would support continuous improvement in commissioning for better outcomes. There were several commissioning models currently being used. Informed by learning from the Cabinet Office Commissioning Academy, the Commissioning Academy Cohort had offered to develop a single commissioning model for adoption across all partners.

The Commissioning Academy was a development programme for senior leaders from all parts of the public sector. It was designed to equip a cadre of professionals to deal with the challenges facing public services, to take up new opportunities and commission the right outcomes for their communities. The academy was supported by the Local Government Association, the Department for Communities and Local Government, the Ministry of Justice and the National Offender Management Service, the Department for Education, the Department of

Health, the Department for Work and Pensions and the Home Office. Two cohorts from Cheshire East had been participating in the Cabinet Office Commissioning Academy. The first cohort included representatives from Cheshire East Council, Eastern Cheshire CCG, South Cheshire CCG and the Office for the Police and Crime Commissioner. The cohort from Cheshire East was unique in terms of the partners represented, as all other area cohorts attended from a single organisation. This provided a unique opportunity to use the learning as a partnership.

RESOLVED

1. That Cheshire East Health and Wellbeing Board approach Cheshire West and Chester Health and Wellbeing Board to adopt the twelve standards described in 'Commissioning for Better Outcomes'

2. That the two Health and Wellbeing Boards adopt continuous improvement in commissioning for better outcomes as a joint project.

3. That the two Health and Wellbeing Boards (together or separately)complete the self assessment tool and establish a baseline of the quality of commissioning for better outcomes pan-Cheshire.

4. That the two Health and Wellbeing Boards establish a working group with appropriate representation to:-

    - Review the available commissioning models and propose a single common commissioning model for pan-Cheshire.
    - Review governance arrangements for commissioning decisions and propose a governance model to compliment the adopted commissioning model
    - Develop a communications strategy to embed the commissioning model and governance arrangements in all partner agencies across Cheshire.

5. As the Pioneer Project already works across Cheshire East and Cheshire West and Chester, the Health and Wellbeing Boards delegate oversight of the work group to the Pioneer Project steering group.

6. That the Health and Wellbeing Boards re-assess quality of commissioning for better outcomes in January 2016.

7. That an update report be submitted to the June meeting of the Board.

72. **CARING FOR CARERS: A JOINT STRATEGY FOR CARERS OF ALL AGED IN CHESHIRE EAST 2015 - 2018**

Consideration was given to a report relating to Caring for Carers: A Joint Strategy for Carers of all aged in Cheshire East 2015 – 2018.

Eastern Cheshire Clinical Commissioning Group had worked in partnership with carers, South Cheshire Clinical Commissioning Group and Cheshire East Council to develop a new three year strategy for carers. An evaluation of the previous strategy (2011-2015) showed that some progress has been made to improve the health and well-being of carers in Cheshire East. A number of engagement events had been held over a 12 month period to understand the stated needs of carers and review opportunities to meet those needs.

The publication of the 2014 Care Act outlined specific changes to the offer of support for carers and the impact of these changes had been assessed and included in the strategy. There were five priority areas outlined in the new strategy and an implementation plan would be developed for each area with a detailed set of actions to be undertaken in year one.

The implementation of the plan would be monitored by a Carers Reference group, which would look to develop a 'hub and spoke' approach to engagement, accessing existing carer groups within third sector organisations. An outcomes framework, with measures of success would be developed alongside the implementation plan and used to monitor progress. This would report to the Health and Wellbeing Board via the Joint Commissioning Leadership Team. It was reported that delivery of the strategy would require additional resources from across the three commissioning organisations and agreement was sought in principle for shared appointment of a project coordinator and associated costs.

The Strategy had been amended to include the development of a carer co-production charter and the detailed implementation plan would look at empowering carers.

RESOLVED

1. That the strategy for 2015-18 be agreed as a direction of travel in that it aligns to the Caring Together and Connecting Care vision and transformation agenda and as such is a key priority for Cheshire East Council, South Cheshire and Eastern Cheshire Clinical Commissioning Groups.

2. That the proposal to consider the implementation action plan and resource requirements via the partnership Executive Teams be approved.

3. That the proposal to monitor progress of delivering this strategy via the Joint Commissioning Leadership Team and report as required to the Health and Well Being Board be endorsed.

73. **NHS SOUTH CHESHIRE CCG DRAFT OPERATIONAL PLAN 2015-16**

The refreshed NHS South Cheshire CCG Draft Operational Plan 2015-16 was intended to inform local people, partners and staff about the healthcare services that would be commissioned during 2015-16 on behalf of the population covered by NHS South Cheshire Clinical Commissioning Group (CCG).

In the previous year the CCG had developed a 2 Year Operational Plan 2014-16. The CCG was now in the process of reviewing and refreshing the Operational Plan. *Forward View into Action: Planning for 2015-16* built on the direction of travel that all CCGs would have been following over the past year. Therefore, the refreshed Plan would not only reflect the progress that had been made against the stated plans and priorities from Year 1, but also realigned the narrative and focus in line with the *Five Year Forward View*.

Importantly the refreshed plan would reflect more fully on the Connecting Care Strategy and ensure that the programmes of work better reflected the CCGs clinical strategy, with greater focus on delivering the Priority Projects, whilst also remaining focused on the operational assurance of the NHS Constitution rand the NHS Mandate requirements.

As part of the NHS South Cheshire CCG Refresh Operational Plan the CCG had incorporated the work that had been undertaken as part of their Connecting Care Strategy, to bring all local providers together to improve the health and wellbeing of the local population. The Strategy was underpinned by 6 key integration outcomes/foundation stones created by the Connecting Care Board to provide a single framework for integration and transformation, which aligned directly to the exiting NHS Constitution, health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

Each stone identified the specific area of the Connecting Care programme plan and the relative plans, aspirations and measures of success that related directly to the 6 health and social care integration outcomes. The CCG had adopted the foundation stones from the Connecting Care Strategy, along with reviewing the top health inequalities for its locality. From this work the CCG had adopted Strategic Priorities and local ambitions that would support the delivery of the Connecting Care Strategy, details of which were set out in the report.

The NHS South Cheshire CCG Operational Plan Refresh 2015-16 had reflected what the CCG had achieved during 2014-15 to enable them to look at their commissioning intentions that needed to be delivered starting in 2015-16. The achievements had been categorised against the NHS Outcomes Framework Domains. A list identifying some of the key areas of the CCG's achievements was included in the report and further detail was contained within the plan, which was appended to the report.

It was noted that the full narrative detail of the CCGs refreshed Operational Plan would be made available locally, to be shared with partners and stakeholders, including NHS England following the final sign off form the Governing Body and NHS England, on 10th April 2015. The CCG had prepared a programme for sharing the Plan with stakeholders and members of the public.

Members of the Board were requested to submit any comments in respect of the Plan by the end of the current week.

RESOLVED

1. That the draft Operational Plan 2015-16 be noted.

2. That it be noted that the final version would be published on the CCG website, following approval by NHS England in April 2015.

74. **CARE ACT UPDATE**

The Board received a short presentation providing an update in respect of the Care Act 2014, which was the biggest change in Adult Social Care legislation for 60 years and included reforms in the law and funding regime relating to care and support for adults and carers. The new legal framework brought legislation together into one modern law and encompassed the whole population, not just those with eligible social care needs.

The key features of phase one were a duty to promote people's wellbeing and to prevent need for care and support; a duty to provide an information and advice service about care and support; a requirement to carry out an assessment of both individuals and carers wherever they had needs, including people who would be 'self-funders'; a duty to facilitate a vibrant, diverse and sustainable market of care

and support provision and to meet people's needs if a provider of care failed; a national minimum eligibility threshold for support, a minimum level of need which would always be met in every Council area; a requirement to offer a universal deferred payment scheme, where people could defer the costs of care and support set against the value of a home they owned; a duty in some cases to arrange independent advocacy to facilitate the involvement of an adult or carer in assessing needs and planning for care; a duty to provide social care support to people in prisons and bail hostels; a duty to strengthen Safeguarding Adults Boards and to make safeguarding 'personal'; embedding the right to choice through care plans and personal budgets.

The key features of phase two were the introduction of a revised upper and lower capital limits; a £72,000 cap for meeting eligible needs, care accounts; support after reaching the cap; free care for life (zero cap) for those born with an eligible need or who developed one in early life and an appeals process.

Everyone with eligible needs would be able to progress towards the cap, which would be set at £72,000. The rate at which they progressed would be based on what the cost was, or in the case of self-funders would be, to the local authority. This cost would be set out in a personal budget or an independent personal budget. Progress towards the cap would be recorded in a care account. The local authority would maintain the care account and provide people with annual statements so they were informed of their progress. There would be a different approach for adults of working age.

The cap only included the cost of care to meet a person's eligible needs.
Where a person was in a care home the local authority would deduct £230 per week for daily living costs to work out how much counted towards the cap. The rate included would be based on what the cost was, or in the case of self-funders would be to the local authority. This would not affect how much the provider received. Other costs which would not count included Top-up fees, NHS-funded care and only costs from April 2016 onwards would count.

Details of Cheshire East's approach to the act were reported. A new customer journey through adult social care was being designed and would be the foundation of all other developments. A new ICT system to support assessment and care management has been procured. The Care Act Project Board had overseen the implementation of the Care Act and task and finish groups, drawn from adult social care and corporate colleagues, had developed the detail of the changes. Public consultation on policy changes regarding fees had taken place and a detailed communications plan had been put in place.

RESOLVED

That the update be noted.

The meeting commenced at 2.00 pm and concluded at 4.25 pm

Councillor J Clowes (Chairman)

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 16th June, 2015 in Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT
Councillor Janet Clowes – Cheshire East Council
Councillor Rachel Bailey – Cheshire East Council
Councillor Michael Jones – Cheshire East Council
Councillor Sam Corcoran – Cheshire East Council

Mike Suarez – Chief Executive Cheshire East Council
Dr Heather Grimbaldeston – Director of Public Health Cheshire East Council
Jerry Hawker – Eastern Cheshire Clinical Commissioning Group
Brenda Smith – Director of Adult Social Care and Independent Living Cheshire East Council
Simon Whitehouse – Southern Cheshire Clinical Commissioning Group
Dr Andrew Wilson – South Cheshire Clinical Commissioning Group

Councillors in attendance:
Councillors Rhoda Bailey, G Hayes J Saunders and L Wardlaw

Officers in attendance:
Anita Bradley – Head of Legal and Governance
Guy Kilminster – Corporate Manager Health Improvement
Nigel Moorhouse - Director of Childrens Services
Cherry Foreman – Democratic Services Cheshire East Council

1 APOLOGIES FOR ABSENCE

Apologies for absence were received from Dr Paul Bowen (Eastern Cheshire Clinical Commissioning Group, and Tina Long (NHS England).

2 APPOINTMENT OF CHAIRMAN AND VICE-CHAIRMAN

Councillor J Clowes opened the meeting. In considering the appointment of a Chairman and Vice-Chairman for the 2015/16 Municipal Year she reported that unfortunately there was a difference in the appointment process set out in the 2012 legislation and in the Health and Wellbeing Board Terms of Reference previously approved by the Council.

In accordance with legal advice it was, therefore, proposed that a Task and Finish Group be established to investigate this issue, and also to look at the Terms of Reference as a whole to ensure that they were fit for purpose, and that their findings be considered at the next meeting of the Council. In the meantime it was proposed that Councillor J Clowes be appointed interim Chairman.

In addition it was noted that the meeting was inquorate as no representatives from Healthwatch were present which meant that no formal decisions could be made.

RESOLVED

1. That a Task and Finish Group be established to look at the Terms of Reference of the Board, and that it include a representative from the Clinical Commissioning Group.

2. That, pending the outcome of the Task and Finish Group Councillor J Clowes be appointed interim Chairman of the Health and Wellbeing Board.

3. That the Corporate Manager Health Improvement discuss with Healthwatch the difficulties caused by their non-attendance.

3 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a personal interest by virtue of his wife being a GP and a member of the south Cheshire GPs Alliance Ltd.

4 **MINUTES OF PREVIOUS MEETING**

As the meeting was inquorate it was proposed that the approval of the Minutes be deferred until the next meeting.

AGREED

That approval of the minutes be deferred until the next meeting of the Board.

5 **PUBLIC SPEAKING TIME/OPEN SESSION**

No members of the public wished to speak.

6 **BETTER CARE FUND UPDATE (STANDING ITEM)**

Consideration was given to this report which provided the Health and Wellbeing Board (HWB) with an update on the progress of the Better Care Fund Section 75 Partnership Agreement; the Board being responsible for its oversight and delivery during 2015/16.

Revised delivery dates for signing the s75 Agreements had been agreed at the last meeting but as the timeframe for reporting to NHS England was not in line with the next meeting of the HWB (29th May v 16th June respectively) responsibility for sign-off of the NHS England return had been delegated to the Chairman of the HWB for this to be done electronically.

It was reported that both South Cheshire CCG and Eastern Cheshire CCG had signed their s75 agreements as of 29th May 2015 and these were executed by Cheshire East Council's Legal Services department on 1st June 2015.

The required report for NHS England had been submitted on 27th May 2015 following sign-off from the Chair of the HWB. This report was focussed on allocations, budgets and national conditions rather than the high level budgets which future returns are expected to focus upon, and a copy was attached to the report.

The report detailed the next steps and confirmed that the NHS England return would be formally presented for sign off at the next meeting of the Committee.

In response to a question from a member it was agreed that evidence in respect of the answers to whether or not the spending round conditions were on track be circulated to the HWB for information.

AGREED

That the report be noted.

7 **QUALITY PREMIUM 2015-16**

The Board considered an overview of the Quality Premium 2015/16 national measures and a summary of the national guidance, which had been published on 25 April 2015. The Board was asked to support the national measures and the two local priorities the NHS South Cheshire Clinical Commissioning Group had selected for 2015/16.

The quality premium to be paid to CCGs in 2016/17 would reflect the quality of the health services commissioned by them in 2015/16. The measures would be based on a combination of national and local priorities, these being reducing potential years of life lost, the urgent and emergency health care menu, the mental health menu and improving antibiotic prescribing. The two local measures identified were Lung Cancer – Record Stage at Diagnosis, and Estimated Diagnosis Rates of Dementia.

It was confirmed that whilst the health and wellbeing of children and young people was not set out specifically in any of the targets they were not precluded; it was agreed that the inclusion of this cohort be made more explicit in the documentation.

AGREED

That approval be given in principle to the CCG Quality Premium measures and local priorities for 2015/16 to be agreed at the next quorate meeting of the Board.

8 **FUTURE PRIORITIES**

(Cllr M Jones left the meeting during discussion of this item.)

Consideration was given to a report by the Director of Public Health on the progress made by the Health and Wellbeing Board over the last two years and to the areas on which it was proposed to focus in the future, these having been drawn from a workshop held earlier in the year.

The report listed ten priorities for future focus, including the development of a more robust work plan and also how best to engage with the public and stakeholders as there was a perception that communications needed to be improved. The success of similar schemes in Manchester, Northumbria and Tower Hamlets was cited and it was thought that there needed to be a smaller number of priorities.

Councillor S Corcoran circulated a further list of ideas for consideration by the Board and it was agreed that these be considered further; it was, however, noted

that some of these suggestions might/could be dealt with elsewhere such the Joint Strategic Needs Assessment (JSNA).

It was agreed that a Task and Finish Group, comprising Dr A Wilson, P Bowen (pending his agreement), H Grimbaldeston and J Hawker, be established to prepare a set o priorities and a work programme. In addition it was agreed that the JSNA Strategy Group be reconvened and refreshed and that it review the achievements to date.

AGREED

1. That a Task and Finish Group be set up to prepare a list of priorities and work programme for consideration at the next meeting of the Committee.

2. That the Joint Strategic Needs Assessment Strategy Group be reconvened to review its achievements to date.

The meeting commenced at 2.00 pm and concluded at 3.15 pm

Councillor J Clowes

Agenda Item 5

NHS South Cheshire Clinical Commissioning Group

Cheshire East Council

NHS Eastern Cheshire Clinical Commissioning Group

CHESHIRE EAST BETTER CARE FUND

Health and Wellbeing Board

Date of Meeting:	15th September 2015
Report of:	Brenda Smith, Director of Adult Social Care and Independent Living
Title:	Better Care Fund – Update Paper
Portfolio Holder:	Councillor Janet Clowes – Health and Social Care

1.0 Purpose of Report

1.1 The purpose of this report is to provide an overview of 2015/16 Better Care Fund (BCF) Quarter 1 performance and to provide an update on the overall implementation of the BCF plan.

1.2 The Better Care Fund was launched on the 1st April 2015 and there is a requirement to submit quarterly returns to NHS England. These quarterly returns should be reviewed and signed off by the Health and Wellbeing Board.

1.3 Cheshire East Health and Wellbeing Board (HwB) is responsible for the ongoing oversight of the delivery of the Better Care Fund plan during 2015/16 and whilst not a signatory of the s75 partnership agreement it has a role in gaining assurance that partners are collectively working together to deliver the plan, implement the national conditions and improve the associated performance measurements.

1.4 The Better Care Fund is a nationally driven initiative, encouraging health and social care systems to work collaboratively towards integration to develop more efficient, effective and pro-active services for the citizens of England. Locally the Better Care Fund plan is aligned to complement the local health and social care transformation programmes, Caring Together (covering the Eastern Cheshire geography) and Connecting Care (covering the South Cheshire geography).

2.0 Recommendation

2.1 Members of the Health and Wellbeing Board are asked to:

i) Acknowledge the progress with the implementation of the Cheshire East Better Care Fund plan

ii) Acknowledge the Cheshire East NHS England 2015/16 Quarter 1 performance report which was submitted to NHS England on 26th August 2015.

iii) Delegate responsibility to the Portfolio Holder for Adult Services and Health to provide the Health and Wellbeing Board sign off and oversight of the NHS England quarterly monitoring report for quarterly reporting deadlines that are not aligned with Health and Wellbeing Board meeting dates. The quarterly monitoring submission to NHS England will be reported to the next available meeting of the Health and Wellbeing Board

3.0 Reasons for Recommendation

3.1 Cheshire East Health and Wellbeing Board is responsible for the strategic oversight of the Better Care Fund plan and has significant influence in supporting partnership working across health and social care.

3.2 To provide the HwB with an update on the progress and implementation of schemes and the expected outcomes of schemes. To provide assurance to the HwB on the delivery of the Cheshire East BCF plan and the BCF national conditions.

3.3 NHS England will issue standard reports that will fulfil both local and national reporting obligations against the key requirements and conditions of the BCF Fund. The standard reports aim to fulfil both the quarterly reporting and annual reporting requirements to monitor the totality of the BCF at Health and Wellbeing Board level.

3.4 NHS England will be expecting quarterly updates on the progress of the Better Care Fund and the HwB is required to review and sign off of these quarterly returns in line with the published timescales.

3.5 The NHS England BCF quarterly reporting deadline is not always consistent with scheduled HwB meetings. It is recommended that the authority to sign off the quarterly reports is delegated to a HwB member (the Portfolio Holder for Adult Social Care and Health) and the HwB is provided with an update on the NHS England quarterly submission at the next available meeting following submission. This approach allows the flexibility for the NHS England deadlines quarterly deadlines being delivered with the involvement of a HwB member.

4.0 Progress of the implementation of Cheshire East BCF plan

4.1 Since the launch of the Cheshire East BCF plan on 1st April 2015, there has been a number of new schemes launched and existing schemes are being reviewed.

4.2 In particular, the Dementia Re-ablement scheme went live on 1st May 2015. This scheme offers support to people with an early dementia diagnosis who have been referred by the Memory Clinic. This scheme is a pilot scheme during 2015/16 and is being evaluated independently to measure the impact and outcomes of the scheme.

4.3 The Universal Outreach scheme was launched on 1st July 2015 and is focused on providing early intervention advice and support to residents in the community.

4.4 The creation of Integrated Community Teams whereby health and social care professionals will work together to provide integrated services is making good progress with the provider boards currently completing the design phase which will then lead to a phased implementation of the teams from late 2015 onwards.

4.5 Providers and commissioners are working together to review existing short term support services including intermediate care and re-ablement to develop improved co-ordinated services which are focused on early intervention.

4.6 Work is underway to understand the impact of the schemes and the expected outcomes as it is important to be able to understand the benefits of these schemes to be able to demonstrate the value for money to the public. Commissioning leads are completing monthly performance and financial monitoring reports and the Joint Commissioning Leadership Team will receive regular updates from the BCF Strategic Commissioning Manager.

4.7 Whilst there are signs of a reduction in non elective admissions across Cheshire East. The progress against the 3.5% reduction in non elective admissions is not progressing at the levels originally planned. The planned reduction by end of quarter 1 was 720 non elective admissions (covering Quarter 4 2014/15 and Quarter 1 2015/16), the actual reduction is 145. There are also some concerns that in areas where there are reductions in non elective admissions, the ability to release costs from the hospital cannot be achieved due to the complexity of those people are admitted (i.e. acuity).

5.0 BCF Quarter 1 2015/16 NHS England Return

5.1 The BCF Quarter 1 template was issued on Friday 7th August by NHS England and a copy of the report was circulated to HwB members for comment and approved by the Portfolio holder fro Adult Social Care and Health on behalf of the HwB on 25th August 2015. The template was submitted to NHS England on 26th August 2015 ahead of the 28th August 2015 deadline, information is currently being collated and the template will be presented directly as part of the HwB meeting on 25th August 2015.

5.2 The content of the BCF Quarter 1 is more detailed than the 2014/15 Quarter 4 report. The submission covers the following six key areas:

i. Budget arrangements – whether a section 75 agreement is in place, which it is in Cheshire East, executed on 1st June 2015;

ii. National Conditions – Nationally pre-determined conditions that are expected to be met as part of the implementation of BCF across local areas;

iii. Non-elective admissions and payment for performance calculations – This covers the latest quarter's non elective admissions rate and locally agreed payment for performance figures;

iv. Income and expenditure profile – The latest income and expenditure profiles;

v. Performance against local metrics – Local performance metrics were agreed at the beginning of the programme and progress is recorded here;

vi. Understanding support needs – This is a new section for this quarter's return and seeks the views of local areas on what type of support would be helpful from the national BCF team.

5.3 The primary aim of the submission is to provide assurance to the Department of Health, Local Government Association and NHS England that local areas have arrangements for managing joint budgets and improvements, as measured against the national conditions, and they are beginning to be delivered.

5.4 A copy of the completed Cheshire East Quarter 1, 2015/16 is enclosed as an appendix to this report.

National Conditions

5.5 The National Conditions were set at the beginning of the Better Care Fund process and all local areas across the country are measured against them. The submission provides insight into whether local areas have plans fully operational, in the progress of being developed or no plans in place to deliver the conditions.

5.6 Within Cheshire East we have made good progress in delivering against the National Conditions. Three of the conditions are now in place and there are five that are currently in the process of being developed, which are:

- Delivery of 7 day services to support discharge and prevent unnecessary admission, the implementation of the Integrated Community Teams is expected to support the delivery of this condition.
- Use of the NHS number as the primary identifier across all partner organisations, the implementation of the replacement Social Care Assessment System and the Cheshire Care Record will deliver this requirement.
- Appropriate information governance controls in place for information sharing. This is a fundamental requirement for the Cheshire Care Record and partners
- The development of a joint assessment and care planning approach with a lead accountable professional, will be developed as part of the design of the Integrated Community Teams.
- An agreement on the consequential impacts of changes in the acute sector.

Progress is being made against these conditions and they are planned to be met by the end of the calendar year.

Payment for Performance

5.7 The planned payment for performance of £2,175,400 is currently directly linked to the reduction in non elective admissions. The Cheshire East BCF plan reflected an ambition to reduce non elective admissions by 3.5% and this equates to a reduction of 1,459 non elective admissions for the period January 2015 to December 2016.

5.8 The payment for performance is **not** additional monies into the health and social care system and it is funded from the reduction in contract payments to the hospital (acute trusts) as activity levels should be lower. If the reduction in non electives is not achieved then the funding is retained by the CCG to support the funding of the unplanned activity in the hospital.

Non Elective Admissions

5.9 The actual non elective admission performance across Cheshire East HwB geographical footprint is showing a reduction of 121 covering the period of April 2015 to June 2015 (Quarter 1 2015/16) based on provisional released Monthly Average Return (MAR) data. The original plan for 2015/16 Quarter 1 had an expected reduction of 358 non elective admissions.

5.10 The breakdown of the Non Elective Admissions (NELs) across the CCG geographical areas is provided below:

Area	2015/16 Quarter 1 Plan NELs	2014/15 Quarter 1 Baseline NELs	2015/16 Quarter 1 Actuals NELs	Actuals vs Baseline NELs
Eastern Cheshire CCG	4,659	4,828	4,618	(210)
South Cheshire CCG	5,209	5,398	5,487	89
Total	**9,868**	**10,226**	**10,105**	**(121)**

Local Metrics

5.11 The Cheshire East local BCF metrics included in the BCF plan are:

- People who feel supported managing long term conditions (GP Survey) – updated data not available until January 2016
- Admissions to hospital, injuries due to falls aged 65 plus

5.12 The initial performance data for admissions to hospital, injuries due to falls aged 65 plus is indicating that there has been a reduction in the number of admissions against the expected plan. This data will be reviewed and verified as there are concerns about whether all the data has been captured.

Approval of future quarterly returns

5.13 The NHS England quarterly return deadlines are not always aligned with HwB meeting dates. It is recommended that the authority to sign off the quarterly reports is delegated to a HwB member (the Portfolio Holder for Adult Social Care and Health) and the HwB is provided with an update on the NHS England quarterly submission at the next available meeting following submission. This approach allows the flexibility for the NHS England deadlines quarterly deadlines being delivered with the involvement of a HwB member.

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

Name: Louisa Ingham

Designation: Better Care Fund Finance Lead

Tel No: 01270 686223

Email: louisa.ingham@cheshireeast.gov.uk

Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics and deliverables from the Health & Wellbeing Board Better Care Fund plan.

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by midday on 28th August 2015

This Excel data collection template for Q1 2015-16 focuses on budget arrangements, the national conditions, payment for performance, income and expenditure to and from the fund, and performance on local metrics. It also presents an opportunity for Health and Wellbeing Boards to register interest in support. Details on future data collection requirements and mechanisms will be announced ahead of the Q2 2015/16 data collection.

To accompany the quarterly data collection Health & Wellbeing Boards are required to provide a written narrative into the final tab to contextualise the information provided in this report and build on comments included elsewhere in the submission. This should include an explanation of any material variances against planned performance trajectories as part of a wider overview of progress with the delivery of plans for better care.

Content

The data collection template consists of 9 sheets:

Validations - This contains a matrix of responses to questions within the data collection template.
1) Cover Sheet - this includes basic details and tracks question completion.
2) Budget arrangements- this tracks whether Section 75 agreements are in place for pooling funds.
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Non-Elective and Payment for Performance - this tracks performance against NEL ambitions and associated P4P payments.
5) Income and Expenditure - this tracks income into, and expenditure from, pooled budgets over the course of the year.
6) Local metrics - this tracks performance against the locally set metric and locally defined patient experience metric in BCF plans.
7) Understanding support needs - this asks what the key barrier to integration is locally and what support might be required.
8) Narrative - this allows space for the description of overall progress on plan delivery and performance against key indicators.

Validations

This sheet contains all the validations for each question in the relevant sections.
All validations have been coloured so that if a value does not pass the validation criteria the cell will be Red and contain the word "No" and if they pass validation they will be coloured Green and contain the word "Yes".

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

Question completion tracks the number of questions that have been completed, when all the questions in each section of the template have been completed the cell will turn green. Only when all 8 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) Budget Arrangements

This plays back to you your response to the question regarding Section 75 agreements from the 2014-15 Q4 submission and requires 2 questions to be answered. Please answer as at the time of completion. If you answered 'Yes' previously you can selection 'Not Applicable' this time.
If your previous submission stated that the funds had not been pooled via a Section 75 agreement, can you now confirm that they have?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

This section requires the Health & Wellbeing Board to confirm whether the six national conditions detailed in the Better Care Fund Planning Guidance are still on track to be

It sets out the six conditions and requires the Health & Wellbeing Board to confirm 'Yes', 'No' and 'No - In Progress' that these are on track. If 'No' or 'No - In Progress' is selected please provide a target date when you expect the condition to be met. Please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

4) Non-Elective and Payment for Performance

This section tracks performance against NEL ambitions and associated P4P payments. The latest figures for planned activity and costs are provided along with a calculation of the payment for performance payment that should have been made for Q4. Three figures are required and one question needs to be answered:

Input actual Q1 2015-16 Non-Elective performance (i.e. number of NELs for that period) - Cell L12
Input actual value of P4P payment agreed locally - Cell D23
If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box
Input actual value of unreleased funds agreed locally

This section also requires indication of the area of spend that unreleased funds have been spent on for Q4 and Q1 using a drop-down list. If no funds were left unreleased then 'Not Applicable' should be selected.

5) Income and Expenditure

This tracks income into, and expenditure from, pooled budgets over the course of the year. This requires provision of the following information:
Planned and forecast income into the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual income into the pooled fund in Q1
Planned and forecast expenditure from the pooled fund for each quarter of the 2015-16 financial year
Confirmation of actual expenditure into the pooled fund in Q1

Figures should reflect the position by the end of each quarter. It is expected that planned income and planned expenditure figures for Q4 2015-16 should equal the total pooled budget for the Health and Wellbeing Board.

There is also an opportunity to provide a commentary on progress which should include reference to any deviation from plan.

6) Local metrics

This tab tracks performance against the locally set metric and locally defined patient experience metric submitted in approved BCF plans. In both cases the metric is set out as defined in the approved plan for the HWB and **the following information is required for each metric:**
Confirmation that this is the same metric that you wish to continue tracking locally
Confirmation of planned performance for each quarter of 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Confirmation of actual performance for Q1 2015-16 (against the metric being tracked locally - whether the same as within your plan or not)
Commentary on progress against the metric and details of any changes to the metric including reference to reasons for changing

7) Understanding Support Needs

This asks what the key barrier to integration is locally and what support might be required in delivering the six key aspects of integration set out previously. This section builds upon the information collected through the BCF Readiness Survey in March 2015. HWBs are asked to:
Confirm which aspect of integration they consider the biggest barrier or challenge to delivering their BCF plan
Confirm against each of the six themes whether they would welcome any support and if so what form they would prefer support to take

There is also an opportunity to provide comments and detail any other support needs you may have which the Better Care Support Team may be able to help with.

8) Narrative

In this section HWBs are asked to provide a brief narrative on overall progress in delivering their Better Care Fund plans at the current point in time with reference to the information provided within this return.

Better Care Fund Template Q1 2015/16

Data collection Question Completion Validations

Cover

Health and Well Being Board	completed by:	e-mail:	contact number:	Who has signed off the report on behalf of the Health and Well Being Board:
Yes	Yes	Yes	Yes	Yes

Budget Arrangements

S.75 pooled budget in the Q4 data collection? and all dates needed
Yes

National Conditions

	1) Are the plans still jointly agreed?	2) Are Social Care Services (not spending) being protected?	3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	i) Is the NHS Number being used as the primary identifier for health and care services?	ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	6) Is an agreement on the consequential impact of changes in the acute sector in place?
Please Select (Yes, No or No - In Progress)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
If the answer is "No" or "No - In Progress" estimated date if not already in place (DD/MM/YYYY)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Comment	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Non-Elective and P4P

Actual Q1 15/16	Actual payment locally agreed	Comments	Any unreleased funds were used for: Q4 14/15	Any unreleased funds were used for: Q1 15/16
Yes	Yes	Yes	Yes	Yes

I&E (2 parts)

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Please comment if there is a difference between the total yearly plan and the pooled fund
Income to	Plan	Yes	Yes	Yes	Yes	Yes
	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
Expenditure From	Plan	Yes	Yes	Yes	Yes	Yes
Expenditure From	Plan					
	Forecast	Yes	Yes	Yes	Yes	
	Forecast					
	Actual	Yes				
	Actual					
	Commentary	Yes				

Local Metrics

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local performance metric plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

	Same local performance metric in plan?	If the answer is No details				
	Yes	Yes				
	Plan	Plan	Plan	Plan	Actual	Actual
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16
Local patient experience plan and actual	Yes	Yes	Yes	Yes	Yes	Yes
Commentary	Yes					

Understanding Support Needs

Area of integration greatest challenge
Yes

	Interested in support?	Preferred support medium
1. Leading and Managing successful better care implementation	Yes	Yes
2. Delivering excellent on the ground care centred around the individual	Yes	Yes
3. Developing underpinning integrated datasets and information systems	Yes	Yes
4. Aligning systems and sharing benefits and risks	Yes	Yes
5. Measuring success	Yes	Yes
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Yes

Narrative

Brief Narrative
Yes

Cover and Basic Details

Q1 2015/16

Health and Well Being Board	Cheshire East

completed by:	Louisa Ingham / Caroline Baines
E-Mail:	louisa.ingham@cheshireeast.gov.uk /
Contact Number:	01270 686223 / 01270 686248
Who has signed off the report on behalf of the Health and Well Being Board:	Councillor Janet Clowes

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB' for example 'County Durham HWB'

	No. of questions answered
1. Cover	5
2. Budget Arrangements	1
3. National Conditions	24
4. Non-Elective and P4P	5
5. I&E	21
6. Local metrics	18
7. Understanding Support Needs	13
8. Narrative	1

Budget Arrangements

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q1 2015/16

Budget arrangements

Have the funds been pooled via a s.75 pooled budget?	No
If it has not been previously stated that the funds had been pooled can you now confirm that they have?	Yes
If the answer to the above is 'No' please indicate when this will happen (DD/MM/YYYY)	

Footnotes:

Source: For the S.75 pooled budget question which is pre-populated, the data is from the Q4 data collection previously filled in by the HWB.

National Conditions

Please select
Yes
No
No - In Progress

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q1 2015/16

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a date **and** a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	If the answer is "No" or "No - In Progress" please enter estimated date when condition will be met if not already in place (DD/MM/YYYY)	Comment			
1) Are the plans still jointly agreed?	Yes			1	1	1
2) Are Social Care Services (not spending) being protected?	Yes			1	1	1
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	31/10/15	A review of existing services is currently underway to support the delivery of seven day services and the Social Care Act. The reconfiguraiton of service delivery needs to be handled in a sensitive manner to support the workforce, internally and externally through this change. Integrated care teams will be become operational on a phased basis from	1	1	1
4) In respect of data sharing - confirm that:						
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	31/10/15	A new social care case management and care assessment IT system is being implemented in October 2015 and this will include an automated link to NHS number. The development of the Cheshire Care Record (Integrated Digital Care Record) to be used by health and social care professionals will use the NHS number as the primary identifier.	1	1	1
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes			1	1	1
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	31/12/15	All partners are in discussion about information governance arrangements and the implementation of the Cheshire Care Record will accelerate the need for a resoultion to any information governance issue.	1	1	1
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	31/12/15	A review is underway of existing services including the assessment process and integrated care teams and this would incorporate a joint approach to assessment and care planning.	1	1	1
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Dec-15	There is a high level of understanding of the potential consequential impact of changes in the acute sector locally and partners are working together to try to define/model what the impact is. NHS England, Monitor and NHS Trust Development Authority are also currently working to tri-angulate CCG operational plans and Provider Trust plans.	1	1	1

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Better Care Fund Revised Non-Elective and Payment for Performance Calculations

Selected Health and Well Being Board: Cheshire East

	Baseline				Plan				Actual				% change [negative values indicate the plan is larger than the baseline]	Absolute reduction in non elective performance	Total Performance Fund Available	Planned Absolute Reduction (cumulative) [negative values indicate the plan is larger than the baseline]				Maximum Quarterly Payment				Performance against baseline				Suggested Quarterly Payment				Total Performance fund	Total Performance and ringfenced funds	Q4 Payment locally agreed
	Q4 13/14	Q1 14/15	Q2 14/15	Q3 14/15	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16				Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16			
D. REVALIDATED: HWB version of plans to be used for future monitoring.	10,327	10,226	10,142	10,985	9,965	9,868	9,787	10,600	10,303	10,105			3.5%	1,460	£2,175,400	362	720	1075	1460	£539,380	£533,420	£528,950	£573,650	24	121			£35,760	£180,290			£2,175,400	£6,385,000	£35,760

Which data source are you using in section D? (MAR, SUS, Other)	MAR	If other please specify
Cost per non-elective activity	£1,490	

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Quarterly payment taken from above	£35,760	£180,290		
Actual payment locally agreed	£35,760	£180,290		

If the actual payment locally agreed is different from the quarterly payment taken from above please explain in the comments box (max 750 characters)	

	Total Payment Made			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Suggest amount of unreleased funds	£503,620	£353,130		
Actual amount of locally agreed unreleased funds	£503,620	£353,130		

	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Confirmation of what if any unreleased funds were used for (please use drop down to select):	acute care	acute care		

Footnotes:

Source: For the Baselines, Plans, data sources, locally agreed payment and cost per non-elective activity which are pre-populated, the data is from the Better Care Fund Revised Non-Elective Targets - Q4 Playback and Final Re-Validation of Baseline and Plans Collection previously filled in by the HWB. This includes all data received from HWBs as at 10am on 6th August 2015. Please note that the data has not been cleaned and limited validation has been undertaken.

Plan, forecast, and actual figures for total income into, and total expenditure from, the fund for each quarter to year end (in both cases the year-end figures should equal the total pooled fund)

Selected Health and Well Being Board: Cheshire East

Income

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total income into the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£6,791,555	£5,495,685	£5,778,785	£5,824,975	£23,891,000	£23,891,000
	Forecast	£6,791,555	£5,495,685	£5,778,785	£5,824,975		
	Actual*	£6,827,135					

Please comment if there is a difference between the total yearly plan and the pooled fund	N/A

Expenditure

		Q1 2015/16	Q2 2015/16	Q3 2015/16	Q4 2015/16	Total Yearly Plan	Pooled Fund
Please provide , plan , forecast, and actual of total expenditure from the fund for each quarter to year end (the year figures should equal the total pooled fund)	Plan	£5,166,055	£6,048,852	£6,257,952	£6,418,142	£23,891,001	£23,891,000
	Forecast	£5,166,055	£6,048,852	£6,257,952	£6,418,142		
	Actual*	£4,998,243					

Please comment if there is a difference between the total yearly plan and the pooled fund	N/A

Commentary on progress against financial plan:	The income in Quarter 1 is high due to the annual payments of the Disabled Facilities Grant and Capital Social Care Grant being transferred into the BCF fund as a lump sum rather than as quarterly income contributions into the BCF pooled budget. The income is higher than the planned budget due to the release of the Q4 performance payment fund into the pooled budget.

Footnote:

Actual figures should be based on the best available information held by Health and Wellbeing Boards.
Source: For the pooled fund which is pre-populated, the data is from a Q4 collection previously filled in by the HWB.

Local performance metric and local defined patient experience metric

Selected Health and Well Being Board:	Cheshire East
Local performance metric as described in your approved BCF plan	Injuries due to falls, persons 65+
Is this still the local performance metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local performance metric being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local performance metric plan and actual	579	553	553	553	373	344		

Please provide commentary on progress / changes:	There may be data issues as numerators are significantly lower than expected therefore potentially indicating an issue with data completeness. This will be examined over the next quarter and remedial action put into place.

Local defined patient experience metric as described in your approved BCF plan	People who feel supported managing long term conditions (GP Survey)
Is this still the local defined patient experience metric that you wish to use to track the impact of your BCF plan?	Yes
If the answer is no to the above question please give details of the local defined patient experience metric now being used (max 750 characters)	

	Plan				Actual			
	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16	Q4 14/15	Q1 15/16	Q2 15/16	Q3 15/16
Local defined patient experience metric plan and actual:	58	0	0	0	53	0		

Please provide commentary on progress / changes:	The figure above is a percentage. There is no data yet available for Q1 2015/16. The next publication of the GP Patient Survey will be on 7th January 2016 and will present the results of aggregated data collected from January to March and July to September 2015, representing the 2015 results. Zeros are entered in Inie with guidance where data is unavaialble for that quarter.

Source: For the local performance metric which is pre-populated, the data is from a local performance metric collection previously filled in by the HWB.
For the local defined patient experience metric which is pre-populated, the data is from a local patient experience previously filled in by the HWB.

Support requests

Selected Health and Well Being Board:	Cheshire East

Which area of integration do you see as the greatest challenge or barrier to the successful implementation of your Better Care plan (please select from dropdown)?	4.Aligning systems and sharing benefits and risks

Please use the below form to indicate whether you would welcome support with any particular area of integration, and what format that support might take.

Theme	Interested in support?	Preferred support medium	Comments - Please detail any other support needs you feel you have that you feel the Better Care Support Team may be able to help with.
1. Leading and Managing successful better care implementation	Yes	Central guidance or tools	
2. Delivering excellent on the ground care centred around the individual	Yes	Peers to peer learning / challenge opportunities	
3. Developing underpinning integrated datasets and information systems	Yes	Wider events, conferences and networking opportunities	Centralised guidance about the legislation or a recommended approach to developing integrated datasets would be useful. Learning from Scotland would also be beneficial.
4. Aligning systems and sharing benefits and risks	Yes	Case studies or examples of good practice	It would be useful to have national modeling tools/advice for areas such as modelling the impact on acute providers so that a consistent approach is being adopted (e.g. the NELs required to review the configuration and provision of beds within a hospital).
5. Measuring success	Yes	Central guidance or tools	
6. Developing organisations to enable effective collaborative health and social care working relationships	Yes	Peers to peer learning / challenge opportunities	

Narrative

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q1 2015/16

Narrative	Remaining Characters	32,292

Please provide a brief narrative on overall progress in delivering your Better Care Fund plan at the current point in time with reference to the information provided within this return where appropriate.
Overall work is progressing well with areas of excellent performance and areas of slippage. The metrics show a similar picture with some metrics improving (such as NELs) and others not so much (such as managing LTCs). Overall the system seems to be becoming more aligned across the complex organisational geography although further work is needed. Decisions still need to be formalised on use of released performance fund and a review of the cost of NELs needs to take place.

NHS
Eastern Cheshire
Clinical Commissioning Group

2015-16 PROSPECTUS

Contents

Inspiring Better Health and Wellbeing

Other key CCG documents:

Annual Report 2014/15

Five Year Strategic Plan 2014/15 to 2018/19

Caring Together: A Five-Year Forward View

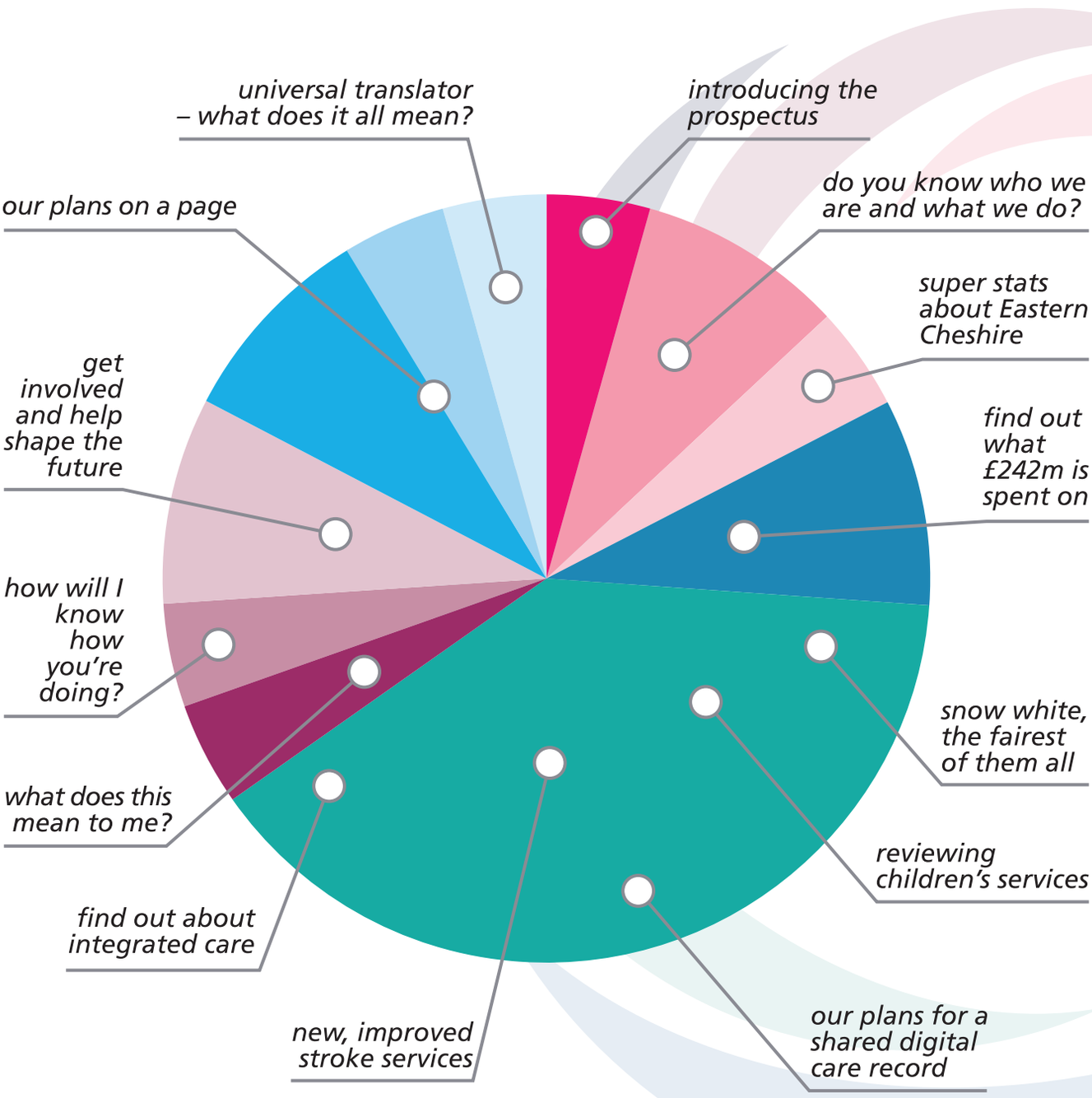
All available at : www.easterncheshireccg.nhs.uk/Publications

Published July 2015

Please note images are for illustrative purposes only.

www.easterncheshireccg.nhs.uk

Snapshot of Contents



1. Introduction

We are pleased to present our prospectus for 2015-16. This prospectus is intended to provide the public with an overview of our plans and priorities for year two of our Five Year Strategic Plan 2014/15 to 2018/19. Our performance in year one is described in our Annual Report and Accounts 2014-15 which can be found at www.easterncheshire.nhs.uk. Our plans will guide how we plan, buy (commission) and monitor health services in the year ahead.

At the heart of all our plans is a commitment to improve and transform care in Eastern Cheshire in partnership with our local communities, patients, carers and health and social care partners.

Local people and care professionals have helped us understand the community's needs and informed our plans, as expressed in our Five Strategic Year Plan.

Dr Paul Bowen

CCG Chair

Jerry Hawker

CCG Chief Officer

This year we have committed to further develop and integrate those teams of staff and volunteers working in the community to provide joined-up care for people living with long-term conditions. This will be facilitated by a real increase in investment in general practice, community services and mental health services. Technology will play an increasingly key role in our plans, with the introduction of a digital shared care record for all patients, increased electronic referrals and prescriptions and technologies to help better identify and more effectively manage people's care.

While we have set out ambitious plans to transform the way care is provided in the future, we will not fail to maintain a focus on today's services and needs.

For 2015-16 our plans therefore reflect more clearly both our work to transform services and continuously improve existing services.

2. Who we are

A Membership Organisation

We are a membership organisation of 23 GP practices in Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow.

Our practices are aligned to five GP locality areas:

- ***Alderley Edge, Chelford, Handforth and Wilmslow***
- ***Bollington, Disley and Poynton***
- ***Congleton and Holmes Chapel***
- ***Knutsford***
- ***Macclesfield.***

We employ more than 50 staff who work alongside the clinicians of the 23 practices to plan, buy and monitor health services for the 204,000 people of Eastern Cheshire.

The map below shows the location of the area's hospitals and GP practices.

The proximity of Eastern Cheshire to areas such as Greater Manchester and Staffordshire provides the people of Eastern Cheshire with significant access and choice of general acute hospital services and access to a range of specialist care providers.

What We Do

We are responsible for three main things:

- ***planning services based on the identified needs of our population***
- ***commissioning health services to meet those needs (from April 2015 this included co-commissioning of Primary General Medical Care Services)***
- ***monitoring the quality of services of providers contracted to deliver commissioned healthcare.***

We are a statutory member of the Cheshire East Health and Wellbeing Board. Through our membership, we have responsibility for producing and implementing the Cheshire East Joint Strategic Needs Assessment, the Cheshire East Health and Wellbeing Strategy and Better Care Fund Plans.

Our Vision, Values and Principles

Our vision of *"inspiring better health and wellbeing"* is embedded in all that we do, and underpins all the commissioning and business decisions we make for the people of Eastern Cheshire. Our way of working is also guided by and measured against our values and principles.

Values

- ***valuing people***
- ***working together***
- ***innovation***
- ***quality***
- ***investing responsibly.***

Principles

- ***clinical leadership***
- ***local experts in health needs and improving health outcomes***
- ***local leadership and community engagement***
- ***expertise in local provider relations and quality improvement***
- ***local assurance in finance, performance and governance.***

Our Partners

The area's hospital-based and community health services, including maternity and paediatric services, are provided by East Cheshire NHS Trust, which runs Macclesfield District General Hospital (MDGH), Congleton War Memorial Hospital and Knutsford and District Community Hospital. MDGH provides urgent and emergency care, and a wide range of elective surgery. Congleton War Memorial Hospital provides local health care to the residents of Congleton and surrounding areas. It has a specialist intermediate care unit and minor injuries unit.

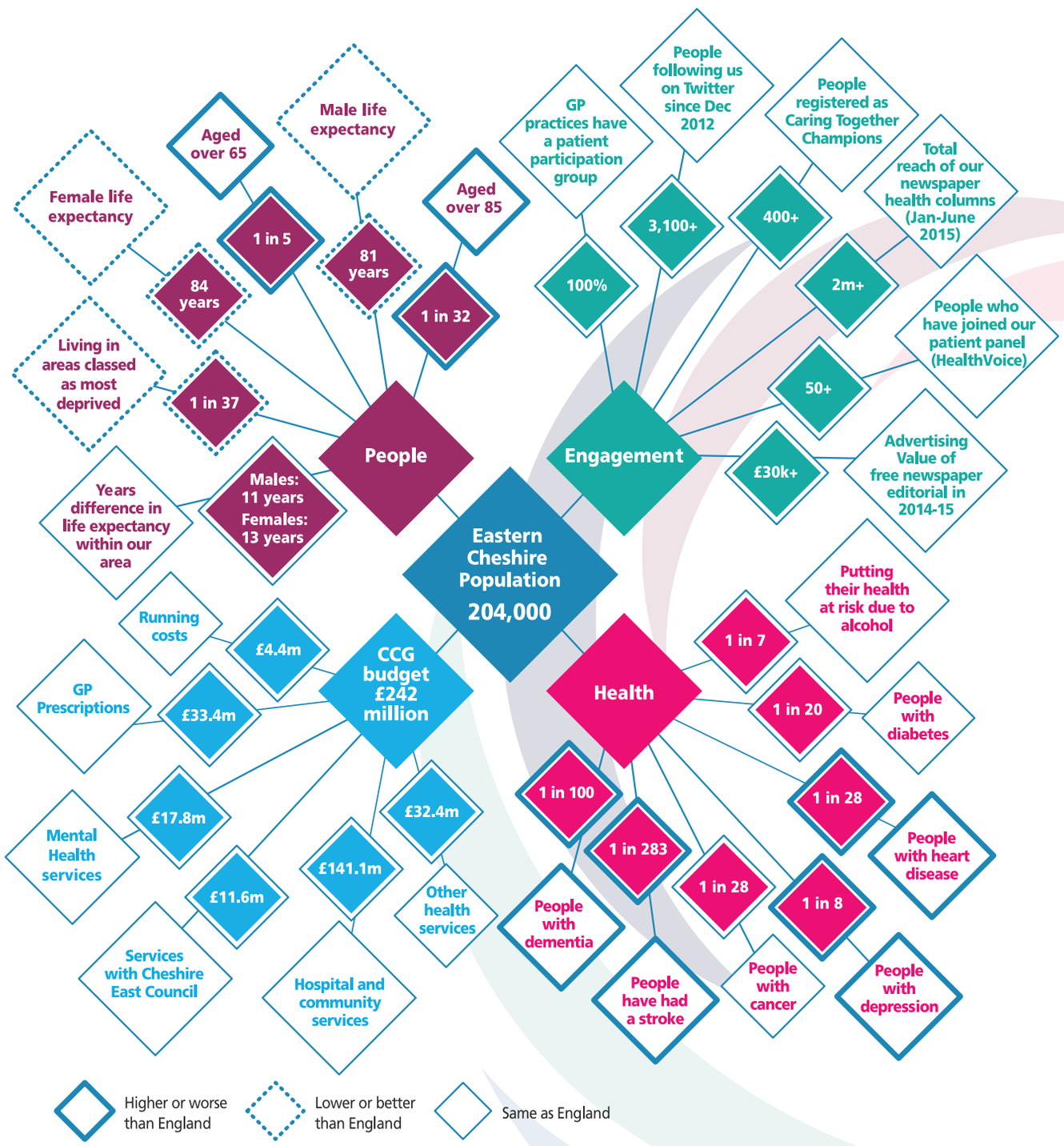
Knutsford and District Community Hospital offers a variety of outpatient services including blood tests and physiotherapy.

Cheshire and Wirral Partnership NHS Foundation Trust (CWP) provides the area's mental health, learning disability, drug and alcohol support services.

Cheshire East Council provides the area's statutory social care services and local Public Health services, while various third sector organisations provide a wide range of services that enable people with long-term conditions to live independently at home.

3. Snapshot of Eastern Cheshire

The graphic below shows key facts about the Eastern Cheshire population and the operation of the CCG. The health figures indicate the number of people who have been diagnosed with a specific condition except that for alcohol as this number is a projected figure based on national information.
All the figures shown are calculated as a snapshot and is accurate for a single point in time.



4. How we spend your money

We receive our funding from NHS England. For the 2015-16 financial year, our allocation is £242 million. We spend this money in a number of ways to provide health care for our local population. ***Table One*** indicates how we plan to spend your money for the year. The CCG 2015-16 Financial Plan outlines in detail how we intend to spend our funding across a range of providers for services that are used by our population.

In our Five Year Strategic Plan 2014/15 to 2018/19 we highlighted some significant financial challenges between our predicted income (money in) and spend (money out). We have made positive steps to improve this by turning a planned deficit of £2m in 2014-15 into a small but healthy surplus of £0.2m as per ***Table Two***.

We received an uplift of 5.8 per cent on our income for 2015-16, which is higher than the minimum uplift awarded to all CCGs nationally of 1.4 per cent. This reflects NHS England policy to have all CCGs funded at a target level outlined within its revised CCG funding formula. We were 5.5 per cent below our target level and received an additional uplift to help reduce this gap.

Overall, our financial ambition and requirements for the 2015-16 financial year are to:

- ***deliver a surplus of £1.4m***
- ***support the Caring Together transformation programme as per year two of our Five Year Plan 2014-15 to 2018-19.***
- ***pay 95 per cent or above of all invoices within 30 days.***

Table One : How we spend your money - by service and equivalent cost per head of population

Services	£000s	%	Cost per head of population
Ambulance	6,857	3%	£33
Continuing Healthcare/Free Nursing	21,394	9%	£103
Hospital	122,502	51%	£589
Community	16,627	6%	£80
Better Care Fund (Community & Adult Social Care)	11,612	5%	£56
Mental Health	17,781	7%	£85
Other	3,259	1%	£16
Prescribing (Medications)	33,307	14%	£160
Running Costs	4,400	2%	£21
Transformation Fund	2,672	1%	£13
Surplus	1,413	1%	£7
ANNUAL SPEND	**241,824**	**100%**	**£1,163**

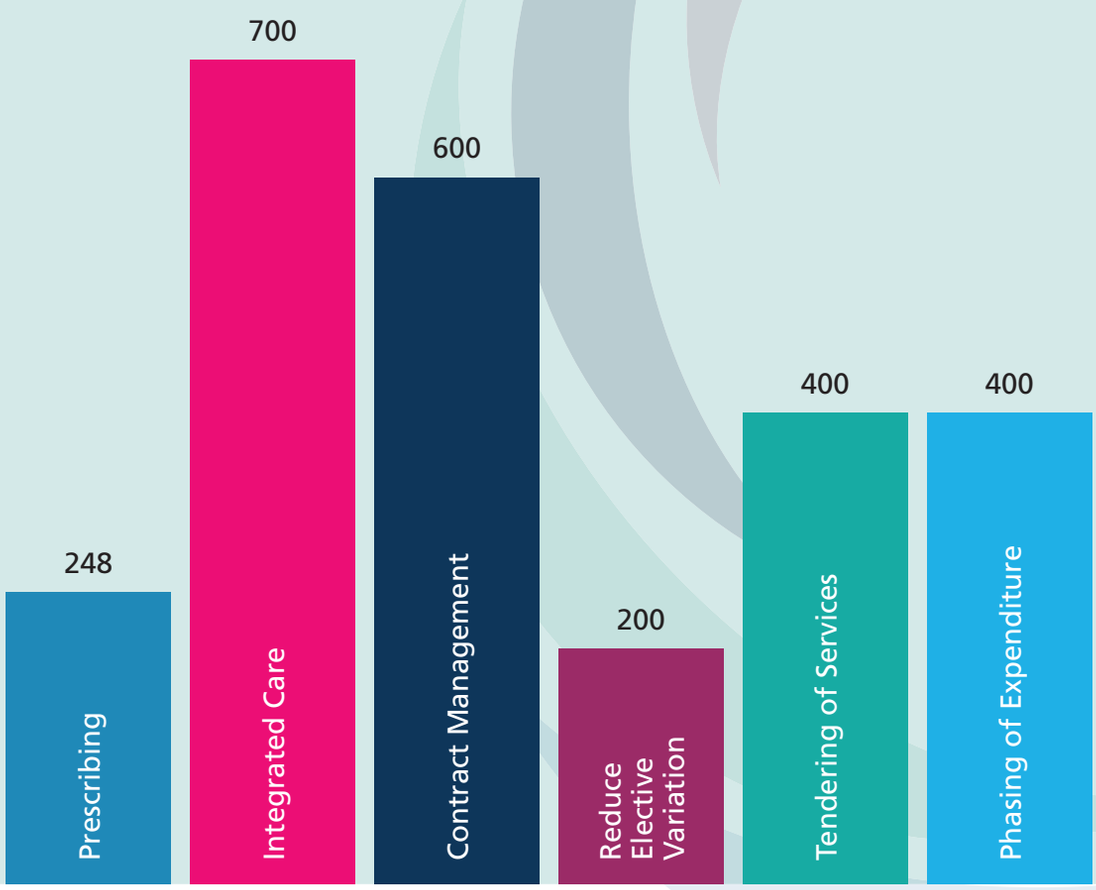
Table Two : Financial Overview from NHS Eastern Cheshire Clinical Commissioning Group

	2015-16 Plan £000	2014-15 Actual £000	Plan £000
Income	241,824	230,026	225,551
Spend	240,411	229,835	227,529
Surplus / (Deficit)	1,413	191	(1,978)

8.1 Quality, Innovation, Productivity and Prevention

This is a framework adopted by the NHS to help improve quality with the benefit of becoming more efficient (lower spend). For 2015-16, plans have been identified locally to deliver efficiencies of £2.5m. These savings will come from a wide range of initiatives as highlighted in the bar chart below.

Savings Target £000s



5. Our Plans for 2015-16

Our identified priorities and accompanying plan of programmes of work to deliver on these priorities have been informed by a detailed analysis of the health needs of the population of Eastern Cheshire. We have held consultation meetings in our five localities and have taken account of the views of Eastern Cheshire HealthVoice, members of the public and our health and social care partners.

Priorities

Our list of local priorities have been balanced against national priorities described in the document *"The Forward View into action: Planning for 2015-16"* produced by NHS England. This document provided mandatory guidance on what we should be focusing on in 2015-16. We have also incorporated in our priorities guidance from NHS England relating to the Quality Premium measures that CCGs should focus on commissioning services to deliver.

In preparing this prospectus we have taken the opportunity to refresh our *Five Year Strategic Plan on a Page 2014/15 to 2018/19 (Ref. Appendix One)* to reflect the progress made in 2014-15 and the latest national guidance and local intelligence.

Our plans are themed around five major programmes of work to deliver on our identified priorities:

- Integrated Care
- Specialist and Direct Care
- System Resilience
- Continuous Quality Improvement
- Duty of Care

Our plans for 2015-16 reflect the vision and values we hold as a membership organisation and our commitment to seeing real improvement in joined-up care for and in partnership with the people of Eastern Cheshire.

Our plans in each of these five areas are summarised in our *Operational Plan 2015-16 'Plan on a Page' (see Appendix Two)*. In the following narrative we will describe how service users, their carers and communities will see the improvements in the services they access and how it will benefit their health and wellbeing.

Integrated Care

The integration of care services is at the heart of our plans. During 2015-16 the Eastern Cheshire Caring Together Integrated Care transformation programme will be focusing on four main areas:

1. developing and investing in community teams
2. investing in enabling technologies to empower people
3. reviewing and supporting the development of General Practice
4. developing services in the community.

Developing and investing in community teams

Building on work started in 2014, we will continue to transform the way care is delivered in the community by further integrating health and social care teams and services to better meet people's needs. Through the pooling of resources (the Better Care Fund) we will work with Cheshire East Council to improve outcomes for people.

Working in partnership with local people we aim to provide better coordinated care within local communities, enabling more people to live well at home. This will also help to reduce unnecessary admissions to hospital and support the timely discharge for those patients who do need to be admitted.

In 2015-16 we will be prioritising the care of people with diabetes. This is because around one in 20 Eastern Cheshire people are living with this condition and there is lots more we can do to stop people developing the many complications associated with this illness. One of the ways in which we plan to do this is to help people better manage their diabetes through the use of technology.

We have also developed plans to better support people with other long-term conditions such as Chronic Obstructive Pulmonary Disease and heart failure.

Investing in enabling technologies to empower people

While recognising the value of face-to-face consultations where appropriate, we want to make best use of the latest information and communication technology to enable people to better manage their health and wellbeing at home.

In 2015-16 we have committed to a major investment in the development of a digital shared care record to be known as the Cheshire Integrated Digital Care Record (CIDCR). This investment is being made by all health and social care partners in Cheshire. The CIDCR is a key step to delivering integrated care and will greatly enhance the coordination of people's care.

Want to know more? Go to www.easterncheshirecc.nhs.uk and search for integrated digital care record.

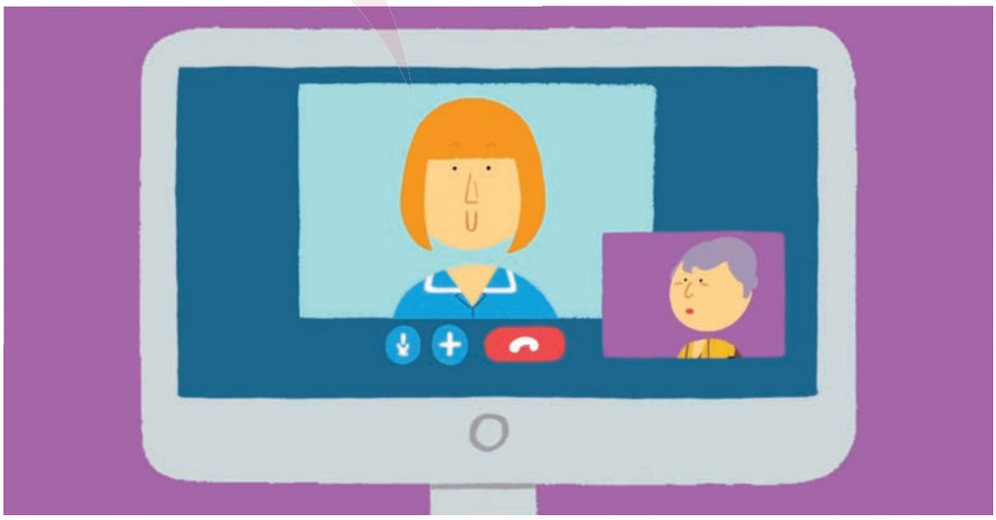
Enabling technologies will also help to improve access to services, support and information. We will work with members of the public and our partners to explore the options for making more use of technology, for example introducing remote physical health measurement and conducting consultations with a healthcare professional online. Linked to this we want to explore what tests and treatments can be delivered safely and effectively out of hospital in more community based settings.

An example of how enabling technologies can support the treatment and management of a long term condition in community and home settings was demonstrated in a recent animation that the CCG commissioned. Called Sheila's

Story, the animation was informed by real-life examples of how enabling technologies can support people with complex needs to continue to live independently at home.

Sheila's Story is available to view on the Caring Together website at www.caringtogether.info.

Screenshot of a scene from Sheila's Story.



Reviewing and supporting the development of General Practice

Working in collaboration with our 23 member practices and NHS England, we have embarked on a major project to review and improve the range of services available in your local GP practice. The aim is to make care more proactive to reduce the number of people falling ill and to help people get better more quickly. A wider range of services in general practice should help reduce pressure on urgent and emergency care, releasing resources for the people who need them most.

New services available in general practice during 2015-16 will include education to help people with diabetes to manage their condition more effectively.

Want to know more? Go to www.easterncheshireccg.nhs.uk and search for Diabetes

Developing services in the community

To support the shift in services from a hospital setting to the community, we will be specifically focussing on the development of community based services for deep vein thrombosis, pneumonia and people needing rehabilitation after a stroke.

Specialist and Direct Care

For 2015-16 we will be focusing on two key aspects of hospital based services, Maternity Services and Children's Services. We will also continue to participate in relevant transformation programmes to ensure equity of access to high quality services in neighbouring areas.

Review of Maternity Services

In March 2015 NHS England announced a national review of Maternity and Obstetric services. We will actively participate in the national review to ensure that consideration is given to the issues and challenges associated with delivering Maternity and Obstetric services in a small district general hospital setting such as Macclesfield.

If the review suggests that changes are needed to provide the best possible care, we will consult widely on proposals before any decisions are made.

Review of Children's Services

In 2015-16 we are planning to undertake a review of children's services to determine whether they meet best practice standards. Once completed, the

review findings will be shared with key stakeholders including the public, staff, Cheshire East Council, CWP and East Cheshire NHS Trust for consideration. If we do need to make any changes to the way in which services are provided we will ensure we consult widely on any proposals before changes are made.

Achieving the best standards and outcomes for hospital services

We and our key stakeholders in the Caring Together Integrated Care transformation programme have agreed a series of quality standards we expect our providers of care to adopt and the outcomes we expect them to achieve for our local population. This will help inform and determine what services for safety reasons can only be provided in a hospital setting and what can safely and effectively be provided in a community based setting. This work is being coordinated with the Healthier Together initiative in Greater Manchester to ensure that our population can access the same standard of care wherever they go.

System Resilience

The Eastern Cheshire System Resilience Group (SRG) comprises health and social care commissioners, providers, patient representatives and third sector colleagues. Its purpose is to ensure that there is sufficient resilience in our providers of care services to accommodate peaks in demand, not just during the winter but all year round.

Following a review of performance last winter, the SRG has identified a number of additional priority areas for ongoing development including:

- ***development of a system-wide capacity plan***
- ***further improving hospital discharge planning and processes***
- ***developing and implementing a local action plan to fulfil the local Mental Health Crisis Care Concordat***
- ***increasing seven day access to relevant services.***

We will build on successful initiatives introduced in 2014-15, such as our Acute GP Visiting Service, to include access

to a wider range of services in the community. This will support people with long-term conditions to live independently at home and will reduce avoidable hospital admissions.

We will use the intelligence generated by the recently developed system, 'snow white', to support future planning and monitor performance. The system provides a real-time view of pressures on urgent and emergency care, enabling demand to be managed effectively.

Want to know more? Visit www.easterncheshireccg.nhs.uk and search for snow white

Short-Term Assessment, Intervention, Response and Recovery Service

We will introduce a short-term assessment, intervention, response and recovery service (STAIRRS) during 2015-16. This will closely align social care reablement services and rapid response health services to provide a joined up approach to assessment of need and delivery of care and support. Over time the range of rapid response services will increase, networking with those services delivered by voluntary and faith sector services and other public sector partners. The STAIRRS initiative is a precursor to fully integrated services within the community which will mean that, for the first time, acute (rapid onset or short lived) episodes of illness can be managed and supported as part of an individual's ongoing care.

Want to know more? Email strategy and transformation director Fleur Blakeman: f.blakeman@nhs.net.

Implementation of a newly procured NHS 111 service

We will work with the recently awarded NHS 111 service led by North West Ambulance Service (NWAS) to integrate the service into our local health system. The five-year contract will start in October 2015. NWAS will provide the service in partnership with FCMS and Urgent Care 24, both providers of out-of-hours GP services in the North West. NHS 111 provides a triage, referral and support service for people needing urgent, non-emergency care.

Local GPs will continue to support the Eastern Cheshire out-of-hours service aligned with NHS 111. This recognises the exceptionally high regard in which our out-of-hours service is held.

Improving our response to those in mental health crisis, improving access to primary mental health services and improving physical health

Building on the successful work completed during 2014-15, our mental health programme of work will implement a range of nationally identified schemes for the year ahead to ensure mental health is accorded the same importance as physical health.

The focus will be on improving access and outcomes within Child and Adolescent Mental Health Services (CAMHS), neurodevelopmental services which support young people with autism and Attention Deficit Hyperactivity Disorder (ADHD), Improving Access to Psychological Therapies (IAPT), Psychiatric Liaison, Crisis Response and improving the diagnosis of dementia and subsequent access to older people's mental health services.

CAMHS are specialist NHS services offering assessment and treatment when children and young people have emotional, behavioural or mental health difficulties.

The IAPT programme supports the frontline NHS in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders.

Best practice stroke care

During 2014 - 15 we and East Cheshire NHS Trust worked with providers of specialist stroke services in Stockport, Salford and Stoke-on-Trent on a new hyper acute stroke pathway so as to ensure that the people of Eastern Cheshire had access to the best possible stroke care. The redesigned hyper acute stroke care pathway ensures that people have clot-busting treatment, called thrombolysis, within the first four hours of suffering a stroke. There is strong evidence that people having thrombolysis within this timeframe recover far more quickly and completely. During

2015-16 a new Integrated Stroke Rehabilitation Service will be commissioned to enable individuals to be discharged from hospital much earlier after thrombolysis because there will be specialist help and support available to them within the community.

Want to know more? Go to www.easterncheshireccg.nhs.uk and search for Stroke

Continuous Quality Improvement

We have developed a programme of work to achieve continuous quality improvement. This will not only ensure we meet our key statutory duties but will also provide the best possible services to our local population. The programme sits alongside our day to day operational work which monitors and develops the services we commission and the way our CCG workforce and internal processes operate.

During 2015-16 we will continue to incentivise our providers to deliver ongoing improvements in the quality, efficiency and productivity of the services they provide to patients and carers

Commissioning of Continuing Healthcare and Funded Nursing Care

To improve and further develop the NHS Continuing Healthcare and NHS Funded Nursing Care services, the CCGs of Cheshire and Wirral have developed a new shared service which went live in February 2015. During 2015-16 the CCGs will radically redesign and improve the way in which these services operate to improve service user and carer experience and to ensure that those who are entitled to funding receive it. This development work provides clinicians, service users and other interested stakeholders with an opportunity to shape the new person-centred service model.

Want to know more or get involved? Email Sally Rogers, Lead Nurse for Community and Safeguarding: sallyrogers1@nhs.net

Quality of care in care homes and a home based setting

In response to issues and concerns raised about the quality, standards and, on occasions, the safety of care, we will continue working with Cheshire East Council, to

strengthen quality assurance processes by:

- ***developing a framework to more effectively measure quality of care during visits***
- ***working with partners to develop workforce capability and capacity***
- ***supporting providers to implement small-scale service improvement and sharing of best practice.***

Learning from Patients and Professionals

In February 2015 we developed a new in-house team to manage complaints and compliments more effectively and to ensure we make best use of public feedback in shaping the way we work. Throughout 2015 this team will further develop its responsibility to include patient advisory and liaison services and will provide additional support to the Communications and Engagement approach of the CCG in actively engaging and acting on the feedback that we receive.

To make a compliment or raise a concern, please call the complaints team on 01625 663828 or email: complaints.nhseasterncheshireccg@nhs.net.

Ensure our population receives best practice cancer care

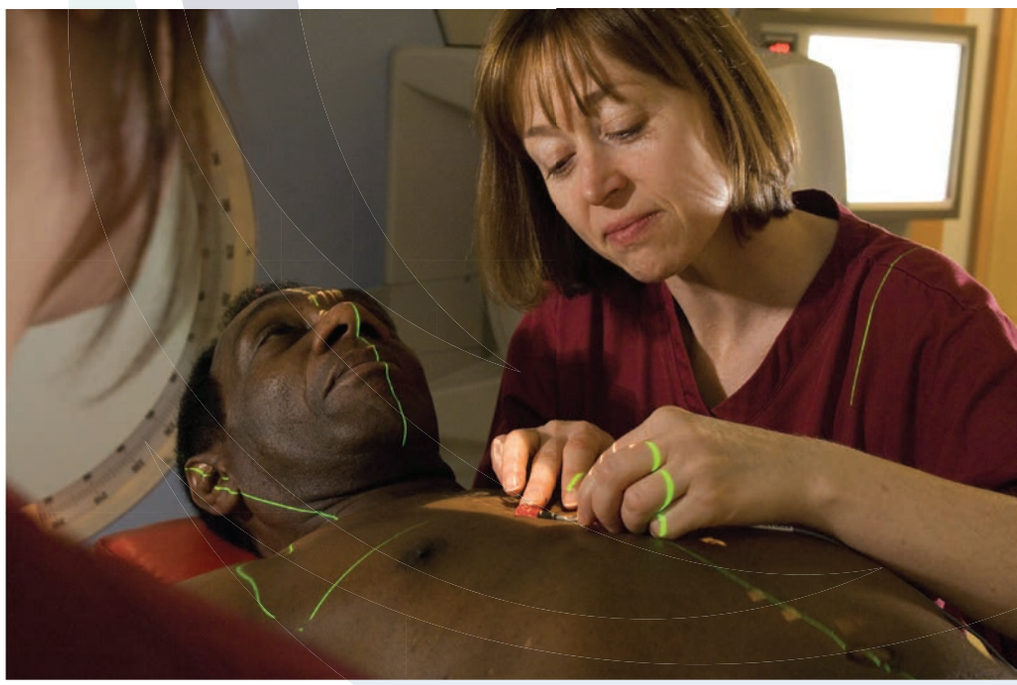
Working with Cheshire East Public Health, providers of cancer services and the voluntary sector, we will target our intervention and education efforts where local populations have a higher incidence of and mortality from cancer. Our approach will include introducing a range of training for practice nurses, public campaigns, implementation of best practice clinical guidance, assessment tools and care pathway improvements to support early detection, diagnosis and treatment.

Patient Safety

We will continue to commission a wide range of local patient safety initiatives, such as prevention of falls and pressure ulcers. We will also be encouraging our care providers to improve the care for those with an acute kidney injury and those at risk of sepsis, as well as to reduce the incidence of Clostridium difficile, Methicillin-Resistant Staphylococcus Aureusis and community-acquired pneumonia.

We will work with our GPs and public to reduce unnecessary prescribing of broad spectrum antibiotics to minimise antimicrobial resistance.

Want to know more? Go to www.easterncheshireccg.nhs.uk and search for Antibiotics Guardian



Improve pathways for patient-chosen services

We have identified access challenges to Ophthalmology, Endoscopy and Dermatology services and will work with providers to improve access, including where necessary procuring additional provision and working to ensure equity of referral processes.

Promote appropriate access to emergency ambulance and patient transport services

Transport requirements are changing because of a greater emphasis on providing care closer to home and the need to sometimes travel further for best possible specialist treatment and care.

During 2015-16 we will continue with our main provider NWAS, Cheshire East Council, the voluntary sector, service users and the public to find innovative ways of meeting local needs for both emergency and non-emergency transport.

In addition, the Department for Transport has awarded £450,000 to Cheshire East Council to work with us and NHS South Cheshire CCG to improve integration of rural passenger transport services. The partners will spend the money from the Total Transport Pilot Fund on a feasibility study to improve the efficiency and effectiveness of passenger transport services commissioned by the public sector.

Want to know more? Go to: http://www.caringtogether.info/category/rural-transport/

Duty of Care

All public sector organisations have a legal duty to do everything in their power to guarantee the safety of service users and provide the best possible care.

Learning Disability

We will continue to work with service users, their carers and our NHS, local authority and third sector partners to improve outcomes and reduce health inequalities for people with learning disabilities. We will commission personalised, high quality services using evidence-based service specifications.

We will ensure that individuals are cared for in the most appropriate care setting, as close to home as possible whilst ensuring their care needs are met.

We will work with Cheshire East Council and other partners to meet the requirements of the new policy framework for Special Educational Needs and Disability to fully integrate health, education and social care services around the needs of individuals and their families.

We are currently evaluating an initiative introduced during 2014-15 to increase support to young people in transition from children's to adults' services. The aim of the approach is to ensure that providers of health, education and social care services work together to develop integrated pathways that are clear and accessible to young people and families. The intention is that each young person will have a transition co-ordinator.

We will continue to work with our partners to increase capacity and improve access to services for this very vulnerable group.

Giving people control over their care and associated resources

We are committed to developing Integrated Personal Commissioning, including extending the offer of a Personal Health Budget beyond just those individuals receiving NHS Continuing Healthcare. We will work with our partners from across Cheshire and Wirral and reflect on the experiences of the national pilot sites to develop a local approach.

Joint implementation of the Carers' Strategy

We acknowledge the invaluable contribution of carers who make it possible for people to be cared for in their own homes who may otherwise need to be admitted to a care facility. Accordingly, a key priority for us in 2015-16 will be implementing "Caring for Carers: A Joint Strategy for Carers of all ages in Cheshire East 2015-2018."

6. What our plans will mean

For our population:

- *Noticeable progress towards delivering the eight ambitions of Caring Together*
- *Better help and support for carers*
- *Improved access to a broad range of services*
- *Targeted interventions for specific conditions*
- *Avoiding unnecessary admissions to hospital and unnecessary testing.*

For quality and patient safety:

- *Access to good quality, evidence based, safe and effective services*
- *Access to specialist treatment and care when needed*
- *Benchmarked performance of our providers with areas of non-compliance, poor performance or poor quality being addressed*
- *Evidence that providers have acted on the feedback they receive and learn the lessons to avoid repeated failings*
- *Robust safeguarding arrangements are in place for adults and children alike.*

For our Practices:

- *Sharing best practice*
- *Reducing variation in services, treatment and care*
- *Primary Care teams with a wider set of skills and expertise*
- *Proactive case finding and case management.*

For our providers:

- *More integration of health and social care services*
- *More treatment and care provided out of hospital, in some cases supported by the transfer of resources*
- *Concentration of more specialist treatment and care in a smaller number of providers*
- *Integrated and innovative workforce planning to address the shortfall in staffing and to attract and retain the workforce of the future*
- *Resilience to accommodate peaks in demand*
- *Financially viable services.*

For our CCG:

- *Service users and the public have a voice and demonstrable influence*
- *Strong clinical leadership*
- *Effective Governing Body and governance arrangements*
- *Financial flexibility through the quality, innovation, productivity and prevention programme to reinvest in services*
- *Acting on the feedback we receive*
- *Having sufficient capacity and capability to deliver the scale and pace of transformation needed.*

7. How we will measure success

In line with our vision of *"inspiring better health and wellbeing"*, we are committed to improving our performance year on year and to securing the best possible performance from our providers.

We monitor the progress being made in delivering our plans through both quantitative and qualitative measurement of improved care and outcomes for our population. Regular updates on performance are presented to both our Quality and Performance Committee and our Governing Body to provide assurance as to the scale and pace of our progress in achieving our priorities.

The success of the CCG will also be measured by its performance against the NHS Constitution targets and NHS Outcomes Framework targets.

Here are some of the CCG's Quality Premium priorities for 2015-16.

- We will reduce by 10 per cent the number of potential years of life lost
- We will reduce avoidable emergency hospital admissions by 30 per cent
- We will reduce by 30 per cent the number of delayed transfers of care which are an NHS responsibility
- We will increase by 30 per cent the number of patients discharged from hospital at weekends or on bank holidays after being admitted for urgent or emergency reasons
- We will reduce by 30 per cent the number of patients with mental health issues who have to wait for more than four hours in A&E to be treated, discharged or admitted
- We will reduce by 30 per cent the number of people with severe mental illness who are smokers
- We will reduce the overall volume of antibiotic prescribing by one per cent
- We will reduce the number of pressure ulcers by 10 per cent
- We will improve physical healthcare of people with severe mental illness in order to reduce premature mortality by 10 per cent

8. Listening to and learning from our population

As an organisation rooted in the community it serves, we are committed to listening to and learning from patients, carers, the public and our partners in health and social care, ensuring that their needs, experience and views are taken fully into account when priorities are set. Accordingly, there are a number of mechanisms that have been put in place to enable Eastern Cheshire people, carers and staff to influence and get involved in the way we work.

Patient Participation Groups

Our 23 GP practices each has a Patient Participation Group (PPG) that recommends improvements to primary care services and supports its practice in communicating effectively with patients. You can find out more about the work of the PPG within your own GP practice from your practice manager or by visiting the Your Views section of our website at *www.easterncheshireccg.nhs.uk*

Eastern Cheshire
HealthVoice
***Your** health, **Your** voice.*

We support an independent, voluntary advisory committee called Eastern Cheshire HealthVoice. HealthVoice is a champion for and represents the interests of patients, carers and the public across Eastern Cheshire. It works with the CCG to ensure that the patient and carer perspective is fully represented and considered in all aspects of planning, prioritising and implementing health and care services.

HealthVoice reports to our Governing Body and its members participate in many CCG forums including our Systems Resilience Group and various Caring Together planning groups.

HealthVoice meets every eight weeks at various venues around Eastern Cheshire.

Attendance comprises PPG members, members of the public, representatives of third sector voluntary organisations and personnel from all levels within the CCG. Meetings are open to everyone to attend and details of these are widely available in advance.

You can find out more about HealthVoice by visiting its website at:
www.echealthvoice.info

or by calling CCG Engagement and Involvement Manager
Usman Nawaz
01625 663864;
usman.nawaz@nhs.net.

You can follow HealthVoice on Twitter @ECHealthVoice

Communication and Engagement

We run or attend many public engagement and stakeholder events throughout the year to help raise awareness of the services we commission and those of our partners, and to understand the needs of service users including young people, older people and those with complex needs or long-term conditions. A calendar of these events is published on our website.

Our Governing Body meets in public every month and hosts an informal question-and-answer session at the end of every second meeting. Details of the meetings can be found on our website at *www.easterncheshireccg.nhs.uk/Governing-Body.*

We provide an integrated communications service that makes full use of analogue and digital channels to raise awareness of the services we commission and to allow people to interact with us and get involved in shaping how we work. Our online channels include our website and the following social media accounts:

We regularly issue news releases to media serving Eastern Cheshire, and we publish health columns in the four weekly newspapers covering the area.

How to find out more or get involved

If you have seen any programme of work in this prospectus that you would like to find out more about or get involved with, please get in touch with us as follows:

Charles Malkin,
Communications Manager
01625 663824 or
c.malkin@nhs.net.

Usman Nawaz,
Engagement and Involvement Manager
on 01625 663864
usman.nawaz@nhs.net.

Kate Banks,
Communications and Engagement Officer
01625 663824 or
kate.banks1@nhs.net.

9. Appendix One
Five Year Strategic Plan 2014/15 to 2018/19

The Eastern Cheshire health economy is a system comprised of partners from across Eastern Cheshire who have come together to agree, refine and implement the Caring Together Programme over the next five years.

Our shared vision is to join up care, improve outcomes and our citizens' experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England.

To make affordable high value health services available to all to improve the health and wellbeing of our population.

System Ambition	Delivered through:	Overseen by the following governance arrangements:
System Ambition One Increase the number of people having a positive experience of care.	• Learning the lessons from the feedback from service users, carers and staff. • Giving people greater control over their care and the associated resources assigned to meeting their heath goals. • All those individuals with a long term condition will have a personalised care plan containing details of their agreed care outcomes and how they will be supported to achieve these. • All individuals within Eastern Cheshire will have access to their Integrated Digital Care Record.	• NHS Eastern Cheshire Clinical Commissioning Group • Cheshire East Health and Wellbeing Board • Caring Together Leadership Forum • Cheshire Pioneer Panel
System Ambition Two Reduce the inequalities in health and social care across Eastern Cheshire.	• Using the Joint Strategic Needs Assessment and the Health and Wellbeing Strategy and other relevant sources, to align resources more closely to meeting the needs of our population. • Using the latest tools and techniques to identify those individuals most at risk and ensure they have a designated care coordinator to ensure they receive the help and support they need.	
System Ambition Three Ensure our citizens access care to the highest standards and are protected from avoidable harm.	• Defining for our providers the evidence based standards of care and specifying the outcomes we want to achieve. • Undertaking specific service reviews to determine whether they meet best practice standards and act on the review findings. • Learning the lessons when things don't go to plan to avoid the same mistakes happening again. • Encouraging our staff, service users and carers to speak out when they have concerns.	

System Ambition Four

Ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services.

- Greater integration of health and social care services and better coordination of care so that people don't have to repeat their history and there is more continuity of care and care is better tailored to meeting their needs.
- Person centred care planning, care provided closer to home and designing services to be more flexible to meet the changing needs of individuals.
- Implementing an integrated health and social care record.
- Proactive case management of those individuals living with one or more long term conditions so that they can avoid being admitted to hospital unless absolutely necessary and they remain as fit and well as possible for as long as possible.

System Ambition Five

Increase the proportion of older people living independently at home and who feel supported to manage their condition.

- Implementation of assistive technology to help individuals manage their long term conditions themselves.
- Ensuring equal emphasis is placed on mental and physical health in the planning and delivery of health services to improve their quality of life and help avoid premature death.

System Ambition Six

Improve the health-related quality of life of people with one or more long term conditions, including, mental health conditions.

- Improving access to routine screening and improving uptake of immunisations, particularly for those individuals with a learning disability after routine screening and also after 'immunisations' to help those most at risk avoiding becoming unwell with preventable illnesses.
- Improving access to mental health services by reducing waiting times for initial assessment and treatment.
- Improving outcomes for those individuals suffering a mental illness to improve their quality of life and help avoid premature death.

System Ambition Seven

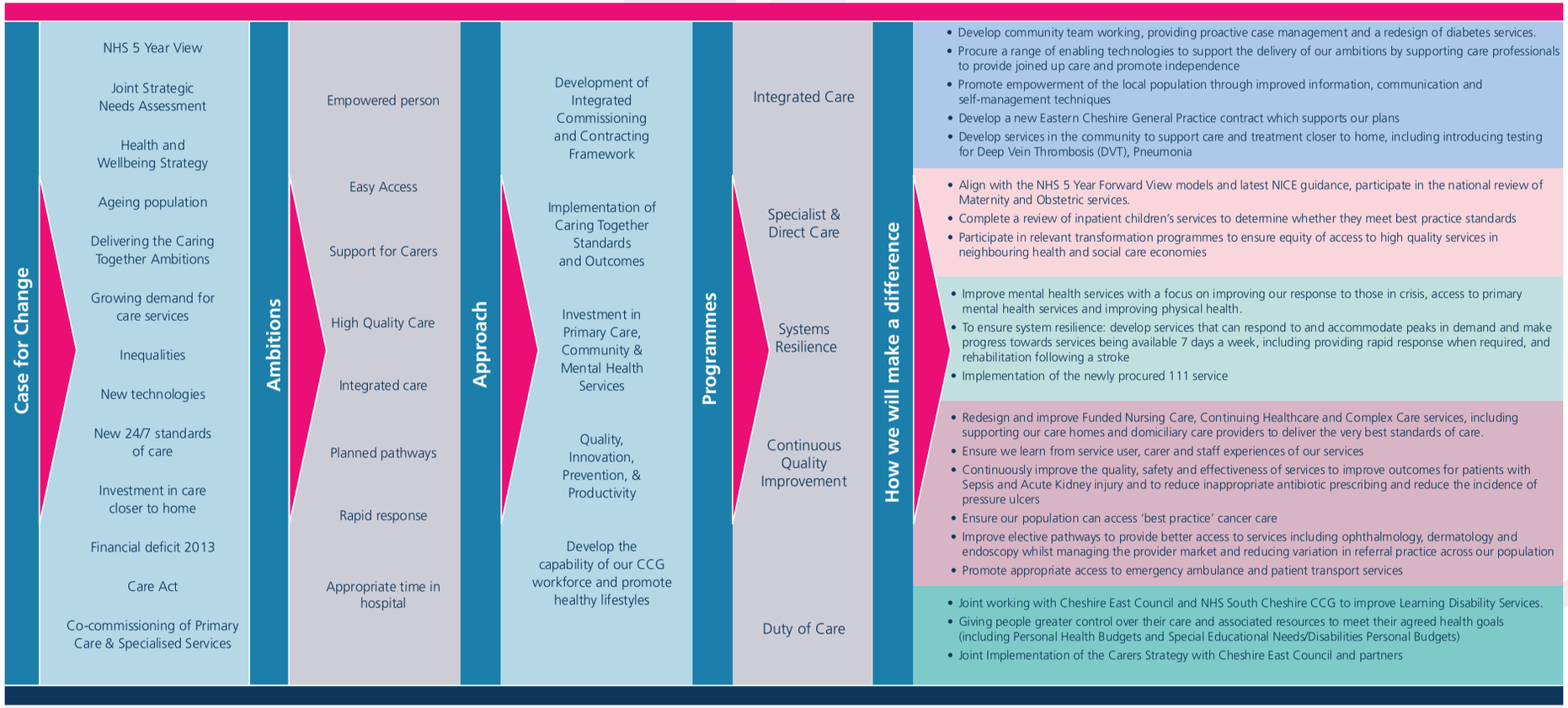
Secure additional years of life for the people of Eastern Cheshire with treatable mental and physical health conditions.

- Improved access to services to ensure early diagnosis and treatment to optimise treatment and recovery.
- Proactive case management so that health and social care professionals act on the early signs of changes in people's health and wellbeing.

Measured using the following success criteria

- Compliance against the emerging Caring Together and Healthier Together care standards and outcomes framework
- Delivery of the improvement metrics for each ECCCG ambition (Two Year Operational plan) and Caring Together ambitions
- All organisations within the health economy are clinically and financially sustainable by 2018/19
- NHS Constitution
- ECCCG Quality Premium metrics

Operational Plan 2015-16



Our Measures of Success

Quality Premium	NHS Constitution	Improving Outcomes
• Reducing potential years of life lost • Urgent and emergency care priorities • Mental health priorities • Improving antibiotic prescribing • Reduce ALL Pressure ulcer incidence by 10% • Improving Physical Healthcare, to reduce premature mortality, in people with Severe Mental Illness	• Maximum 18 weeks from referral to treatment • Maximum four hour waits in A&E departments-95% standard • Maximum 14 day wait from an urgent GP referral for suspected cancer-93% standard • Maximum 8 minutes responses for Category A (Red 1) ambulance calls-75% standard	• Outcome framework for monitoring Integrated Care System available on request • Corporate dashboards

11. Glossary of Terms

Better Care Fund: The £5.3bn Better Care Fund (formerly the Integration Transformation Fund) was announced by the Government in the June 2013 spending round to ensure a transformation in integrated health and social care.

Caring Together:
A programme to transform health and social care in Eastern Cheshire by developing an integrated care model that allows people with complex, long-term conditions to be cared for in the community where it is appropriate to do so. For more information visit *www.caringtogether.info*

Cheshire East Health and Wellbeing Board: Addresses the health and wellbeing needs of people in the Cheshire East local authority area to reduce unacceptable and avoidable variations in health and healthcare. Its membership comprises NHS commissioners and providers, local authority, police, fire and third sector representatives.
For more information, visit *www.cheshireeast.gov.uk*

Cheshire East Joint Health and Wellbeing Strategy:
A document written by the Health and Wellbeing Board. It provides an overarching framework that influences the commissioning plans of the local NHS, Cheshire East Council and other organisations in Cheshire East. For more information, visit *www.cheshireeast.gov.uk*

Cheshire East Joint Strategic Needs Assessment: A piece of research that every local authority has to carry out to tell the story of local people's needs. For more information, visit *www.cheshireeast.gov.uk*

Cheshire Integrated Digital Care Record (CIDCR): Will give Cheshire care professionals a common view of patient information which data subjects have consented to the sharing of. For more information, visit *www.local.gov.uk* and search for "Cheshire Integrated Digital Care Record."

Chronic obstructive pulmonary disease (COPD): The name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease.

Clostridium difficile: A bacterial infection that affects the digestive system. It most commonly affects people who have been treated with antibiotics.

Dermatology: The branch of medicine dealing with the hair, nails, skin and its diseases.

Endoscopy: A test that looks inside the body. The endoscope is a long flexible tube which has a tiny camera and light on the end of it. There are many types of endoscope used to look inside different parts of the body. The name of the test depends on which part of the body the doctor is looking at.

Five-Year Forward View:
The NHS Five-Year Forward View was published on 23 October 2014 and sets out a vision for the future of the NHS.
For more information, visit *www.england.nhs.uk*

Healthier Together:
A partnership between the NHS organisations and local authorities serving Greater Manchester. The aim is to take out variations in quality of care by joining up local authority and health services, improving standards in GP practices and reconfiguring hospital services. For more information, visit *www.healthiertogethergm.nhs.uk*

Integrated Personal Commissioning: A programme being led by health and social care leaders to build a new integrated and personalised commissioning approach which will, for the first time, blend comprehensive health and social care funding for individuals, and allow people to direct how it is used.

Mental Health Crisis Care Concordat: A national agreement between services and agencies involved in the care and support of people in crisis. It sets out how organisations will work together better to make sure that people get the help they need when they are having a mental health crisis.

Methicillin-Resistant Staphylococcus Aureusis (MRSA): A type of bacteria that is resistant to a number of widely used antibiotics. This means MRSA infections can be more difficult to treat than other bacterial infections.

NHS England: The NHS Commissioning Board was established in October 2012 as an executive non-departmental public body. Since April 2013, the NHS Commissioning Board has used the name, NHS England, for operational purposes. NHS England empowers and supports clinical leaders of the NHS through CCGs, networks and senates, in NHS England itself and in providers. NHS England helps commissioners and providers make informed decisions, spend taxpayers' money wisely and provide high quality services.
For more information, visit *www.england.nhs.uk*

Obstetrics: The field of medical practice that deals with pregnancy, childbirth and the care of mothers and infants in the immediate post-birth period.

Personal Health Budgets:
Personal health budgets are being introduced by the NHS to help people manage their care in a way that suits them.

Quality Premium:
Rewards CCGs for improvements in the quality of services they commission and for associated improvements in health outcomes and reducing inequalities.
For more information, visit *www.england.nhs.uk*

NHS
Eastern Cheshire
Clinical Commissioning Group

This publication is available on request in large print, braille, as a talking book and in languages other than English.

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easterncheshireccg

Eastern Cheshire

NHS Eastern Cheshire Clinical Commissioning Group
1st Floor West Wing, New Alderley Building
Macclesfield District General Hospital, Victoria Road,
Macclesfield, Cheshire SK10 3BL

T: 01625 663477

F: 01625 663285

Email: ecccg.generalenquiries@nhs.net

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015

Report of: Jerry Hawker - Chief Officer, NHS Eastern Cheshire CCG
Simon Whitehouse–Chief Executive, NHS South Cheshire CCG
Nigel Moorhouse –Interim Director of Children's Services, Cheshire East Council

Subject/Title: Local Transformation Plans for Children and Young People's Mental Health and Wellbeing

1 Report Summary

1.1 Additional funding is available to Clinical Commissioning Groups (CCGs) to support the delivery of transformation in relation to Children and Young People's Mental Health and Wellbeing**,** subject to the development, submission and assurance of Local Transformation Plans.

1.2 NHS Eastern Cheshire Clinical Commissioning Group and NHS South Cheshire Clinical Commissioning Group will be submitting their local Transformation Plans on 16th October 2015.

1.3 Development of Local Transformation Plans is currently in progress and sign-off of these plans is required by a representative of the Health and Wellbeing Board.

2 Recommendations

2.1 The Health and Wellbeing Board is asked to note the requirement to develop and submit local Transformation Plans in relation to Children and Young People's Mental Health and Wellbeing in October 2015.

2.2 The Health and Wellbeing Board is asked to note the requirement for local plans to be signed off by a representative of the Health and Wellbeing Board prior to submission in October 2015 and nominate a representative accordingly. This will follow a review of the plan at the Children and Young People's Commissioning Sub-group of the Joint Commissioning Leadership Team in September.

NHS South Cheshire Clinical Commissioning Group | NHS Eastern Cheshire Clinical Commissioning Group | Cheshire East Council

3 Reasons for Recommendations

3.1 Additional funding is available to Clinical Commissioning Groups from NHS England to support the delivery of transformation with respect to Children and Young People's Mental Health:

- **Roll-out the Children and Young People's Improving Access to Psychological Therapies programmes (CYP IAPT):** NHS Eastern Cheshire CCG £273k and NHS South Cheshire CCG £245k for 2015/16 when Transformation Plans are assured.

- **Develop evidence based community Eating Disorder services for children and young people** with an associated release in general capacity to improve self-harm and crisis services: NHS Eastern Cheshire CCG £109k and NHS South Cheshire CCG £98k for 2015/16 (funding also to support initial planning).

- **Improve perinatal care.** Allocation for this will be made separately and commissioning guidance will be published before the end of the financial year

3.2 However, release of funding is dependent on the development and assurance of Local Transformation Plans. Following assurance of plans, NHS Eastern Cheshire CCG could expect a minimum recurrent uplift for 2016/17 of £383k whilst for NHS South Cheshire this figure is £343k.

3.3 Local Transformation Plans are required to demonstrate that they:

- have been designed with, and are built around the needs of, children and young people and their families;
- are based on the mental health needs of children and young people within your local population;
- provide evidence of effective joint working both within and across all sectors including NHS, public health, local authorities, social care, youth justice, education and the voluntary sector;
- include reference to other improvement initiatives such as the Crisis Care Concordat;
- include evidence that plans have been developed collaboratively with NHS England Specialised and Health and Justice Commissioning teams;
- promote collaborative commissioning approaches within and between sectors
- clarify status within the children and young people Improving Access to Psychological Therapies programme

- include the level of investment by all local partners commissioning children and young people's mental health services for the period April 2014 to March 2015;
- include spend on services directly commissioned by NHS England on behalf of the CCG population;
- will be published on the websites for the CCG, Local Authority and any other local partners;
- are based on delivering evidence based practice and focused on demonstrating improved outcomes;
- make explicit how you are promoting equality and addressing health inequalities;
- will be monitored by multi-agency boards for delivery supported by local implementation / delivery groups to monitor progress against your plans, including risks;
- include baseline information for April 2014-March 2015 on referrals made, accepted, and waiting times;
- include workforce information, numbers of staff including whole time equivalents, skills and capabilities;
- include measurable, ambitious KPIs;
- have been costed and are aligned to the funding allocation that you will receive;
- take into account the existing different and previous funding streams including the MH resilience funding (Parity of Esteem).

3.4 Guidance for the development of the Transformation Plans was issued on the 3rd August 2015 and plans are required to be submitted by 16th October 2015. There are tight timescales around development of plans and Health and Wellbeing Board will not now formally meet again until after the closing submission date for Transformation Plans.

3.5 Draft Transformation Plans will be circulated to Health and Wellbeing Board members for information prior to submission and will be formally presented to Health and Wellbeing Board at the next meeting.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The development of a Local Transformation Plan for Children and Young People's Mental Health and Wellbeing provides an opportunity to improve the mental health and wellbeing of young people and their families in Cheshire East. Such plans will contribute to:

- Starting and Developing Well: Children and young people have the best

start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the service they receive.

- Working and living well: Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the borough. In particular, to better meet the needs of those with mental health issues.

4.2 The content of the plan will be reflective of priority needs as identified in a currently ongoing Pan-Cheshire Joint Strategic Needs Assessment with respect to mental health.

5 Background and Options

5.1 In March 2015, the Department of Health and NHS England published a report 'Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing'. This report outlined how to improve the way children's mental health services are organised, commissioned and provided and how to make it easier for young people to access help and support, including in schools, through voluntary organisations and online. The Children and Young People's Mental Health Taskforce made 45 recommendations across themes of:

- Promoting resilience, prevention and early intervention
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountability and transparency
- Developing the workforce

5.2 One of the key proposals in this report was that Local Transformation Plans for Children and Young People's Mental Health and Wellbeing should be developed and agreed to clearly articulate the local offer. It was stipulated that plans should cover the entire spectrum of relevant services from health promotion and prevention to support for those with mental health problems and include transitions between services.

5.3 Prior to the announcement of these plans, work had been underway on a needs assessment on a Cheshire-wide footprint as part of the Pioneer Mental Health Commissioning Review Panel. The elements of the Joint Strategic Needs Assessment pertaining to Children and Young People's Mental Health needs have been prioritised and will inform the development of these local transformation plans.

5.4 Cheshire East Children and Young People's Plan 2015-2018 is the overarching plan which sets out how partners across Cheshire East will work together to support children to get the best start in life. It is strategically aligned to the Health and Wellbeing Board and has six priority outcomes, one of which is Outcome 3: '*Children and young people experience good emotional and mental wellbeing'*. Themes within this current plan include:

- Prevention and early intervention for the mental wellbeing of children and young people
- Improving access to effective support – a system without tiers
- Care for the most vulnerable
- Accountable and transparent
- Developing the workforce
- Voice of the child

This plan is thus closely aligned to recommendations in 'Future in Mind'.

5.5 A project group with representation from both CCGs, Public Health and Children's Services is currently progressing the development of a Cheshire East Transformation Plan. Furthermore, opportunities for joint working on a wider footprint (e.g. in relation to Eating Disorder Services) are being actively pursued.

5.6 The Children and Young People's Commissioning Sub-group of the Joint Commissioning Leadership Team leads on the commissioning actions in the Children's and Young People's Plan. This sub-group also reports to the Children's Trust Board. The Joint Commissioning Leadership Team reports to the Health and Wellbeing Board. The draft Transformation Plans will be presented to and discussed at the Children and Young People's Commissioning Sub-group at the next meeting on the 24th September.

6 Access to Information

6.1 NHS England (2015). Local Transformation Plans for Children and Young People's Mental Health and Wellbeing. Guidance and Support for Local Areas. http://www.england.nhs.uk/2015/08/03/cyp-mh-prog-launch/

6.2 Department of Health and NHS England (2015). Future in Mind: Promoting, protecting and improving our children and young people's mental health and wellbeing'. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/414024/Childrens_Mental_Health.pdf

6.2 Cheshire East Children and Young Peoples Plan 2015-2018. Cheshire East Children and Young People's Trust. http://www.cheshireeast.gov.uk/children_and_families/childrens_trust/childrens_trust.aspx

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

Name:	Charlotte Simpson
Designation:	Public Health Consultant
Tel No:	01270 686883
Email:	charlotte.simpson@cheshireeast.gov.uk

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015
Report of: Brenda Smith, Director Adults Social Care
Subject/Title: Care Act Briefing

1 Report Summary

1.1 On 20 July 2015, in a Written Ministerial Statement, the Government set out its decision to delay implementation of the planned funding reforms - the cap on care costs system, including changes to the means test, set out in the Care Act 2014, until 2020.

1.2 The delay will allow time to be taken to ensure that everyone is ready to introduce the new system and to look at what more can be done to support people with the costs of care.

2 Recommendations

2.1 To note the report

3 Reasons for Recommendations

3.1 To be aware of the changes regarding the Care Act legislation.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The impact of this on each of the Health and Wellbeing Priorities are set out below:

- **Engaging effectively with the public**

  Communication with the public regarding the changes will be undertaken. Effective communication and engagement will remain a feature of the implementation of the remaining aspects within the Care Act phase 2 as well as reviewing and refining the implementation of phase 1.

- **Enabling people to be happier, healthier and independent for longer**

  There is no specific adverse impact on this priority because of the deferment of the funding reforms.

- **Supporting people to take personal responsibility and make good lifestyle choices**

  Both improving information and advice and the introducion of self – assessment remain in phase 2 of the implementation of the Care Act.

- **Achieving evidence-based outcomes within a holistic vision of health and wellbeing**

  There is no specific adverse impact on this priority because of the deferment of the funding reforms.

5 Background and Options

5.1 The Care Act 2014 came into force on 1 April 2014 and comprises of two phases. Cheshire East Council is fully compliant with the requirements and duties of the Act required under phase 1. Phase 2, due to come into effect on 01/04/2016, was mainly focused on funding reform.

5.2 On 17 July 2015, the Government announced that they had decided to delay the implementation to some of the funding reforms set out in the Care Act 2014 and that these would be deferred from April 2016 until April 2020 to both allow time to be taken to ensure that authorities are ready to introduce the new system and to look at what more can be done to support people with the costs of care. This has been confirmed in a Written Ministerial Statement on 25 July 2015. The reforms that are deferred are :

- **The cap on care costs**
  Currently anyone with assets of over £23,250 has to pay the full cost of their care. The Care Act (2014), set out that, from April 2016 the amount people over 65 needed to pay for care would be capped at £72,000, with no one having to sell their home to meet care costs. This has now been deferred until April 2020. The “nil cap” for people under has also been deferred until April 2020.

- **The extension to the Means Test Thresholds**
  This has been deferred until April 2020.

- **The introduction of an appeals system**
  The plan to introduce an appeals system has been deferred pending the next Comprehensive Spending Review to be published on 25 November 2015 when the timetable for appeals implementation will be confirmed. In the meantime, those using care and support will continue to be able to make use of the existing complaints system and ultimately, the Local Government Ombudsman.

- **Direct payments to people in residential care.**
  The Direct Payments in Residential Care trailblazer programme runs until October 2015 and the final evaluation report is expected in summer 2016. The Department of Health has decided to wait for the final evaluation before taking a decision about whether or not to roll out to all local authorities.

- **Early assessments of self-funders**.
  These are no longer required

- **Daily living costs**
  The principle of £230 as a daily living allowance has been deferred until April 2020.

- **First party top-ups**
  First party top-ups by service users are delayed until further notice.

- **Minimum income disregard**
  The equalisation of younger adults' disregard and those of pension credit age have also been delayed.

5.3 Care Act Funding

It is not clear what the position is with regard to the funding allocated to local authorities to implement the Care Act. The Department of Health will shortly advise local authorities on what will occur with the implementation funding.

5.4 Implications

There are number of implications, including:

1. Re-scoping the Care Act Project to focus on the areas still needing to be implemented in phase 2 of the Care Act 2014 implementation including:
   a. Embedding Prevention
   b. Building Community Capacity
   c. Information and Advice
   d. Self assessments
   e. Monitoring market impact

f. Ordinary residence, continuity of care and cross border placements

2. Re-scoping the Adult Financials Project as the work to develop Care Account systems is no longer required. This work was due to start in January 2016 and the resource allocated to this project can be redeployed.

3. In addition to the significant service and project management time invested to date in the Care Act projects, other costs have been incurred within the Adult Social Care, Business Support and Finance team which include:

   - The appointment of two Financial Co-ordinator posts (Fixed Term until 31/03/16) at a total cost of £58,842.
   - The appointment of two Administrators (Fixed Term until 31/03/16) at a total cost of £45,616.
   - Printing costs for Care Cap leaflets and posters amounting to £1,147

   This gives a total expenditure of £105,605 (excluding service management and project management time).

   The four Care Act specific posts are funded from the Care Act funding allocated to CEC, the positon of this funding is not clear and CEC needs to review whether the fixed term contracts can, or should, be ended early. If they are not ended early, funding will need to be found from elsewhere.

4. Contract Centre call staff and supervisors will not now be required on an ongoing basis and a stand down process has been invoked.

5. Updating external and internal communications to communicate the changes to CEC staff, partners and stakeholders

6 Access to Information

6.1 Further information can be accessed by following the link below http://www.local.gov.uk/care-support-reform/-/journal_content/56/10180/7399280/ARTICLE#sthash.5a8u6r1v.dpuf

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

Name: Heather Grove
Designation: Programme Manager
Tel No: 01270 685774
Email: heather.grove@cheshireeast.gov.uk

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015

Report of: Jacki Wilkes, Associate Director of Commissioning ECCCG and Joint Commissioning Team Lead for Carers

Subject/Title: Update on progress on the development of a Cheshire East Strategy for Carers

1 Report Summary

1.1 Cheshire East Health and Well Being Board recognise the need to support and protect the health and Well being of the 12,453 people in Cheshire East caring for 20 hours per week or more, and a further 27,481 caring between 1 and 19 hours per week. Altogether that is almost 11% of the population of Cheshire East. It is of great concern that 1,236 of the Carers who were caring for 20 hours or more per week (10%) report that they were in bad or very bad health

1.2 In April 2015 a Cheshire East Strategy for Carers was presented to accountable bodies and strategic leadership groups across the three health and social care commissioning organisations within the Cheshire East Council footprint. There was general agreement that this was the right approach and recognition that the engagement with carers was both representative and adequate however the Governing Body for Eastern Cheshire felt unable to support the strategy as it was presented, requiring assurance on a number of issues including clearer evidence on the benefits to carers, the resources identified to deliver these benefits and clearer governance arrangements for how the benefits will be delivered.

1.3 Officers from across health and social care, working in partnership with carers have 'reframed' the priority areas to give more focus to the strategy. Priorities are:

- Provision of respite
- Identification and assessment of need
- Information and signposting
- Power of Attorney
- Finance
- Ongoing and meaningful engagement – coproduction / Communication

Work continues and some of the priorities may merge. The intention is to add detail to each of the work areas including action plans, nominated accountabilities and timescales. The monitoring and evaluation framework will be developed further and included in the final document which will be presented to the commissioning accountable bodies and the health and Well Being Board for sign off.

2 Recommendations

2.1 Note concerns raised by the ECCCG Governing Body specifically in relation to resourcing and accountability.

2.2 Note progress made and approach taken to address concerns raised by Eastern Cheshire CCG Governing Body for the redrafted strategy for carers.

3 Reasons for Recommendations

3.1 To highlight concerns raised in relation to the joint ownership of the Carers strategy.

3.2 To recognise individual organisational accountability.

3.3 To agree robust governance arrangements for the implementation of plans.

3.4 To assure the Health and Well Being Board that progress is being made against a redrafted strategy which addresses concerns raised by Eastern Cheshire CCG.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 Cheshire East Health and Well Being Board have recognised that the health and wellbeing of carers is vital to enable them to carry out their caring role

4.2 There are 12,453 people in Cheshire East caring for 20 hours per week or more, with a further 27,481 caring between 1 and 19 hours per week. Altogether that is almost 11% of the population of Cheshire East.

4.3 In Cheshire East the number of people caring for 50 hours or over has increased by nearly a third since 2001 to 8,014, with over 42% of them aged 65 or over.

4.4 Unpaid care has increased at a faster pace than population growth between 2001 and 2011 and an ageing population and improved life expectancy for people with long term conditions or complex disabilities means more high level care provided for longer.

4.5 In Cheshire East, 1,236 of the Carers who were caring for 20 hours or more per week (10%) reported that they were in bad or very bad health.

4.6 By 2037 Carers UK[1] calculates that the number of carers in the UK will increase by 40%, which would equates to an estimated 56,000 carers in Cheshire East.

4.7 New government legislation, laid out in the 2014 Care Act sets out new standards for carers which include legal rights to assessment and support. It relates mostly to adult carers – people aged 18 and over who are caring for another adult, however young carers (aged under 18) and adults who care for disabled children can be assessed and supported under children's law.

5 Background and Options

5.1 In April 2015 a Cheshire East Strategy for Carers was presented to accountable bodies and strategic leadership groups across the three health and social care commissioning organisations within the Cheshire East Council footprint. There was general agreement that this was the right approach and recognition that the engagement with carers was both representative and adequate however the Governing Body for Eastern Cheshire felt unable to support the strategy, requiring assurance on a number of issues including clearer evidence on the benefits to carers, the resources identified to deliver these benefits and clearer governance arrangements for how the benefits will be delivered.

5.1.2 The ECCCG Governing body felt that the strategy recognises the “case for change”, and provides general supportive commentary as to future ambitions, but lacked clear and unequivocal commitments as to investment and additional resources. It was felt that the strategy needed to evidence much more clearly the current levels of investment and resources and how these will change (grow), specifically in relation to Cheshire East Council as the principle commissioner.

5.1.3 There were concerns that the strategy also lacked clear and credible evidence about investment in the required infrastructure to support implementation specifically no clear commitment to and clarity of availability and investment in respite facilities, day centres or modern equivalents taking advantage of community assets, all of which have been consistently raised by carers and their families in engagement events held through the Caring Together programme.

5.1.4 The Governing Body wished to see included, additional measures against which meaningful difference can be demonstrated e.g. a description of a carer support currently and what their support would look like in two years’ time. This carer focused approach should be complimented with explicit and

[1] http://www.carersuk.org/

measureable outcomes and outputs to reflect progress and provide assurance to the Health & Wellbeing Board.

5.1.5 Finally the governance structure for delivery of the carer's strategy needs to be clearer including accountability arrangements and milestones. The health economy leadership of this work will be revisited once the redraft strategy has been completed and will be explored at a future health and Well Being Board

5.2 Representatives from the CCGs and Council, working with the carers reference group have 'reframed' the priority areas giving it more focus. In addition Carers have advised on what needs to happen to deliver the tangible difference and who is responsible. The evaluation and measurement of progress will be mixed method but will include the ongoing feedback from five 'carer sponsors' who have agreed to work with us on a continuous basis to feedback how things are changing for them. Each of the carers are from very different situations such as a mum caring for two disabled children, an older person caring for a loved one with dementia, and a working son caring for an older relative living alone with multiple long term conditions. This will ensure the strategy addresses the needs of all carers and not favour one group over another

5.3 Listed below are the reframed priority areas alongside initial thoughts relating to what needs to be dome and what success would look like to someone in a caring role:

<u>Provision of Respite</u>

- Respite planning should be personalised
- A clear respite plan should be put together and agreed
- Respite should be carer rather than finance/provider lead
- The tendering process should be transparent
- Assess current capacity and stimulate the market to produce more options
- Pre-procurement checks should be carried out on suppliers re: workforce, stability
- Financial projection – demand/capacity lead
- A range of respite services acceptable to carers and logged in a directory
- Planned and unplanned access – flexibility

<u>Identification and assessment of need</u>

- Single point of contact
- Information collected in a secure manner and in line with data protection
- More avenues for people to be referred for carer assessments
- GP involvement – use carer coding's to extract useful information

- Agree Crisis support plan with Carer
- Plan for finding carers not on the radar
- Local guidance on eligibility – target groups each year
- Agreed process including documents and data protection

Information and sign posting

- Financial support for carer networks to hold events and share information
- Support to ensure the Local Offer website is updated and maintained (pay a carer to do this?)
- Create an image/brand for the Carers Reference Group
- Understand what terminology we can use to attract the attention of those who do not identify themselves as carers.
- Multiple modes of communicating information (internet, posters, leaflets, communication & engagement)
- Bounty packs (goody bags) for carers including information & essentials

Power of attorney

- Power of attorney should be included on the carer assessment form
- Pre-emptive explanation to carers about power of attorney and early warnings about the cost and timings.
- Funding and support for power of attorney due to the expense and length of the process.
- Choices available to carers
- Clear plan for crisis support in case of emergency with one point of contact

Ongoing and meaningful engagement – coproduction / Communication

- Agree common aims and goals
- Single point of contact and consistency

Finance

- Financial plan based on demand for respite and carer breaks (testing and assuring on affordability

5.4 Work continues and some of the priorities may merge. The intention is to add detail to each of the work areas including action plans, nominated accountabilities and timescales. The monitoring and evaluation framework will developed further and included in the final document which will be presented to the commissioning accountable bodies and the health and Well Being Board for sign off.

NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

6 Access to Information

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

Name: Jacki Wilkes
Designation: Associate Director of Commissioning
Tel No:01625 663350
Email:jackiwilkes@nhs.net

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015

Report of: Brenda Smith Director of Adult Social Care and Independent Living (Cheshire East Council)
Sally Rogers Lead Nurse Community and Safeguarding/Registered Nurse, Governing Body Member (NHS Eastern Cheshire Clinical Commissioning Group)
Judith Thorley, Chief Nurse and Director of Quality & safeguarding (NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups)

Subject/Title: Ensuring and Improving Quality and Choice in Residential and Nursing Home Provision.

1 Report Summary

1.1 Cheshire East Council and the Eastern Cheshire and South Cheshire Clinical Commissioning Groups, all have an interest in and responsibility for people living in residential or nursing homes. Although the strategic priority is to support people to live independently for as long as possible, we know that there are approximately 3,500 older people living in residential or nursing homes in Cheshire East. It is anticipated that by 2030 this number will have increased to 5,500[1]. In addition there are about 250 people with learning disabilities receiving services in residential or nursing care, 91 of whom are in long term accommodation.

1.2 Ensuring that the available capacity and quality of provision is appropriate is therefore a concern for all parties. It is proposed that a task and finish group is established, under the auspices of the Health and Wellbeing Board, to review current provision and consider what might be required to ensure that it is fit for purpose in the future.

2 Recommendations

2.1 That the Health and Wellbeing Board support the proposal to establish a task and finish group to review residential and nursing home provision in Cheshire East, release capacity to contribute to the work of the Group and receive an update report in three months' time.

[1] Cheshire East Council 'Vulnerable and Older People's Housing Strategy 2014'

3 Reasons for Recommendations

3.1 To assure delivery of high quality, effective services, led by demand, needs and the desired outcomes of the people of Cheshire East.

3.2 To align existing single agency plans, reducing duplication, providing a clear vision for the future of care home provision.

3.3 To improve the robustness of contracts, setting clear expectations for continuous improvement of quality and safety, enabling partners to jointly hold Providers to account.

3.4 To enhance the joint scrutiny of providers and action plans.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The 'Ageing Well' priority within the Health and Wellbeing Strategy is focussed upon enabling older people to live healthier and more active lives for longer. This includes when circumstances require them to move into a care environment. The outcomes of the task and finish group would help to ensure that people in care are kept healthy and active with a good quality of life for as long as possible.

5 Background and Options

5.1 In May 2014 the Cheshire East Council Vulnerable and Older People's Housing Strategy was published. This identified the need to focus on the avoidance of admission to residential or nursing home accommodation and to help people live independently or in supported accommodation for as long as possible. This was both to reduce costs to the Council and Health service, but also to improve the quality of life of the people concerned, with permanent admission to residential or nursing care being seen as a temporary or final phase in their accommodation pathway, only when absolutely necessary.

5.2 However, the Strategy also identified that there were already some 3,500 older people living in residential or nursing homes and this figure was projected to rise over the next fifteen years to 5,500. Additionally 91 people with learning disabilities lived in residential or nursing homes with another 159 receiving services from such homes.

5.3 Many of the people living in these types of accommodation are paid for wholly or in part by the Local Authority or through the Clinical Commissioning Groups and there is a duty of care in relation to self funders. In addition the Council is

required to provide appropriate advice and guidance to people and their carers in relation to the accommodation provision available locally.

5.4 With these responsibilities it is necessary to ensure that the capacity and quality of care available in Cheshire East is appropriate and fit for purpose. There are a number of elements that might be considered:

- The purpose and function of care homes;
- The routes into care, how do people get there, are alternatives considered?
- The quality of care and ability to provide the increasingly complex levels of care required to meet individual needs (in particular in relation to dementia and fragility, behaviour that challenges and complex needs that might involve a range of issues);
- The skills and experience of staff, their training and development needs;
- The experience of the residents, are they empowered to live well, exercise choice and control and how are their voices heard?
- The holistic, person centred approach of the support offered/delivered by the care home;
- The apparent low levels of expectation from residents;
- The role of and support for carers/families;
- The outcomes that are delivered, are these defined and measured?
- The capacity (numbers of homes/beds, too much, too little);
- The high levels of agency staff use in the absence of stable recruitment;
- The high levels of attrition;
- The poor public perception of care homes and care home staff;
- End of life care;
- Costs and fees;
- The contractual arrangements;
- Workforce development, recruitment, profile, turnover, cultural transformation and effective leadership;
- The type of resident eg those with a learning disability; MND; acquired brain injury; younger person with long term condition

5.5 It is proposed that a joint task and finish group be established to review the residential and nursing care provision, to consider the adequacy of current arrangements and the requirements for the future. This would include the current commissioning arrangements, the impact of individual commissioning, and market management.

5.6 The Joint Strategic Needs assessment will be reviewed to determine what information it might provide to assist with the review.

5.7 The ongoing work being undertaken by Red Quadrant, to review the fair price of care and make recommendations for future costs, will also be considered.

5.8 It is envisaged that the Group would provide an initial report back in three months with a final report within six months making recommendations for the Health and Wellbeing Board's consideration.

6 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 01270 686560
Email: guy.kilminster@cheshireeast.gov.uk

NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015

Report of: Brenda Smith, Director of Adult Social Care and Independent Living

Subject/Title: Assistive Technology Task and Finish Group Recommendations

1 Report Summary

1.1 The Health and Adult Social Care Overview and Scrutiny Committee, through a task and finish group, completed a review of Assistive Technology and how its use could be developed through adult social care services to help people remain independent and healthy in their own homes for longer. Amongst the recommendations were two for consideration by the Health and Wellbeing Board and they are the focus of this report. However the broader recommendations will be of interest too. The Task and Finish Report is attached as Appendix One.

2 Recommendations

2.1 That the Board consider the two recommendations of the Health and Adult Social Care Overview and Scrutiny Committee Task and Finish Group.

3 Reasons for Recommendations

3.1 To allow a response to be given to the Health and Adult Social Care Overview and Scrutiny Committee.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The use of Assistive Technology can play a significant part in enabling older people to live healthier and more active lives for longer.

5 Background and Options

5.1 Prior to Council agreeing changes to its decision making and governance arrangements in May 2014, the Adult Social Care Policy Development Group (PDG) set up a sub group to look at Assistive Technology (AT) and how its use could be developed throughout adult social care services to help people remain independent and healthy in their own homes for longer. The sub group was set up following a PDG meeting in February 2014 where a report about

the potential to develop the use of assistive technology in adult social care was received. The Sub Group had the following membership:

· Councillor Jos Saunders (Chairman)
· Councillor Janet Jackson
· Councillor Brendan Murphy

5.2 At the Council's Annual Meeting on 14 May 2014 the Council decided to replace the previous scrutiny committee and policy development group system with a new Overview and Scrutiny Committee system. The responsibilities of the Adult Social Care PDG were taken up by the Health and Adult Social Care Overview and Scrutiny Committee; the Committee decided to continue the work of the PDG's sub group by setting up a task and finish group with a new membership:

· Councillor Jos Saunders (Chairman)
· Councillor Carolyn Andrew
· Councillor Laura Jeuda

5.3 The PDG sub group which subsequently became the Overview and Scrutiny Task and Finish Group (the Group) held several meetings and site visits over the course of the review including:

· A site visit to Liverpool Museum to see the 'Mi Smarthouse' Exhibit to discover more about the types of AT that are currently available and how they work to help people live independently or assist carers with caring duties.
· A visit to Peaks and Plains Housing Trust to discuss the provision of the Council's Telecare service and the additional services provided by P&P to their tenants and other private customers.
· Meeting with officers to discuss financial aspect of Assistive Technology.

5.4 During the review the Group considered three policy areas suggested in the original report to the PDG which are:

· Effectiveness: - how effective is assistive technology in achieving good outcomes for prevention and early intervention of illness to help maintain independence?
· Universal Accessibility: - how accessible should the Council make AT? Should it be reserved for the few with critical and substantial needs or should it be made available to everyone who could benefit from it?
· Charging: - Who should pay and how much; what is financially sustainable for the Council and what are the cost benefits of providing AT?

5.5 The Task and Finish Group's report was presented to the Health and Adult Social Care Overview and Scrutiny Committee in February 2015.

5.5 Two recommendations of the Task and Finish Group's Report are directed to the Health and Wellbeing Board:

- That the Health and Wellbeing Board be requested to encourage health service providers and commissioners to promote the benefits of assistive technology to patients and service users in order to increase its use as part of early intervention and prevention initiatives.

- That the Health and Wellbeing Board be requested to consider how funding for assistive technology projects can be increased through contributions from health and social care commissioners.

5.6 The Board is asked to consider and discuss these two issues (in the light of the broader report) so that a response can be provided to the Overview and Scrutiny Committee.

6 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement
Tel No: 01270 686560
Email: guy.kilminster@cheshireeast.gov.uk

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APPENDIX ONE

Health and Adult Social Care Overview and Scrutiny Committee

Assistive Technology Task and Finish Group

March 2014 – January 2015

APPENDIX ONE

Chairman's Foreword

Cheshire East has an older age profile than the UK as a whole and this is set to increase. Obviously having a higher life expectancy and ageing community is something to celebrate, but we also need to be aware of the challenges that these figures bring. We are aware that the majority of older people wish to remain independent in their own homes but we are still in a situation whereby many people are entering residential care prematurely. This attracts costs, both to the users (and their families), as well as the Council. Assistive Technology is a tool that can be utilised to enable people to remain independent for longer, as well as supporting the principle of the Empowered Person.

We believe that the recommendations contained in this report underpin and support the Council's objectives of maximising our older resident's opportunity to live independent, safe and fulfilling lives. We believe that the recommendations would increase the usage of Assistive Technology and that with appropriate charges the service would also be financially sustainable.

I would like to thank my two Councillor Colleagues, Carolyn Andrew and Laura Jeuda, who worked with me in compiling this report. We would all like to thank the officers and the members of outside bodies who gave us so much valuable information.

Councillor Jos Saunders

Chairman of the Assistive Technology Task and Finish Group

Task Group Membership



Cllr Jos Saunders, Cllr Carolyn Andrew and Cllr Laura Jeuda

APPENDIX ONE

Introduction and Background

1.1 Prior to Council agreeing changes to its decision making and governance arrangements in May 2014, the Adult Social Care Policy Development Group (PDG) set up a sub group to look at Assistive Technology (AT) and how its use could be developed throughout adult social care services to help people remain independent and healthy in their own homes for longer. The sub group was set up following a PDG meeting in February 2014 where a report about the potential to develop the use of assistive technology in adult social care was received. The Sub Group had the following membership:

- Councillor Jos Saunders (Chairman)
- Councillor Janet Jackson
- Councillor Brendan Murphy

1.2 At the Council's Annual Meeting on 14 May 2014 the Council decided to replace the previous scrutiny committee and policy development group system with a new Overview and Scrutiny Committee system. The responsibilities of the Adult Social Care PDG were taken up by the Health and Adult Social Care Overview and Scrutiny Committee; the Committee decided to continue the work of the PDG's sub group by setting up a task and finish group with a new membership:

- Councillor Jos Saunders (Chairman)
- Councillor Carolyn Andrew
- Councillor Laura Jeuda

2.0 Methodology

2.1 The PDG sub group which subsequently became the Overview and Scrutiny Task and Finish Group (the Group) has held several meetings and site visits over the course of the review including:

- A site visit to Liverpool Museum to see the Mi Smarthouse Exhibit to discover more about the types of AT that are currently available and how they work to help people live independently or assist carers with caring duties.
- A visit to Peaks and Plains Housing Trust to discuss the provision of the Council's Telecare service and the additional services provided by P&P to their tenants and other private customers.
- Meeting with officers to discuss financial aspect of Assistive Technology.

2.2 During the review the Group considered three policy areas suggested in the original report to the PDG which are:

- Effectiveness: - how effective is assistive technology in achieving good outcomes for prevention and early intervention of illness to help maintain independence?

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- Universal Accessibility: - how accessible should the Council make AT? Should it be reserved for the few with critical and substantial needs or should it be made available to everyone who could benefit from it?
- Charging: - Who should pay and how much; what is financially sustainable for the Council and what are the cost benefits of providing AT?

3.0 Background

3.1 British Assistive Technology Association definition of assistive technology: Assistive technology is any product or service that maintains or improves the ability of individuals with disabilities or impairments to communicate, learn and live independent, fulfilling and productive lives.

3.2 Telecare Services Association definition of telecare: Telecare is support and assistance provided at a distance using information and communication technology. It is the continuous, automatic and remote monitoring of users by means of sensors to enable them to continue living in their own home, while minimising risks such as a fall, gas and flood detection and relate to other real time emergencies and lifestyle changes over time.

3.3 Nationally it is felt that AT should be used a lot more than is currently the case as AT can support individuals to retain or regain independence which in turn reduces the costs of social care support for individuals and to local authorities as commissioners. AT takes many forms and provides a variety of benefits to people with diverse ranges of need.

3.4 Assistive Technology can help people to live more independently but it is also valuable to making people safe. For example; a woman living on her own with a diagnosis of dementia had some telecare fitted to manage a number of identified risks in her home. She had a heat rise detector fitted in her kitchen, flood detectors in her bathroom and kitchen where she also had a heat rise detector. Weeks after the equipment was installed there was an alert from her heat rise detector in the kitchen followed by an alert from the smoke detector. Staff at her local call centre received the alert and tried to speak to her via the loud speaker on her lifeline unit but received no reply. They contacted the fire service who attended and put out a fire in the kitchen which had started in the cooker. The woman herself had been distressed and confused by the incident and had stayed in the kitchen trying to stop the smoke alarm from beeping. She was rescued from her home uninjured with only cosmetic damage to her property. Without the telecare being fitted, the need to manage the risks to her health and safety meant that she would have been assessed as needing to go into permanent care which she (supported by her family) was anxious to avoid.

3.5 Another example; a woman living on her own and receiving daily domiciliary support had reported having two night time falls in a short period of time. There was no obvious cause for these falls and support workers had also reported that she was reluctant to eat when they assisted her to prepare a meal at tea time. A reassessment led to consideration of

whether this woman needed to move on to permanent care. The woman herself expressed her wish in the strongest terms to remain in her own home. She had a bed sensor placed under her mattress which produced an alert if she was out of bed for more than 15 minutes at night time which managed the risk of a night time fall. She also had a lifestyle monitoring system installed as part of the reassessment which showed that she was moving around in the kitchen half an hour before the daily support called to assist with her tea time meal. It became clear that she was able to prepare food for herself and was doing so before the support worker arrived. Her reluctance to eat was not an indicator of a general increase in needs as had been assumed. Three years later the woman was still living independently in her own home with support tailored to her needs.

3.6 Fire Authorities have done a lot of work over the past few years in the community, particularly elderly people living alone, to ensure that homes have the appropriate safety equipment (e.g. fire alarms) properly installed and maintained.

4.0 Findings

Mi Smarthouse Exhibit, Museum of Liverpool

4.1 The exhibition included technology for all rooms in a normal home, kitchen, bathroom, living area, bedroom and front door. Technology displayed in the exhibit included:

- Outside key safes for front door keys,
- Fingerprint recognition locks on doors,
- intercom with video link,
- alarms to alert when front door is left open,
- easy to use kettles and stoves,
- talking microwave,
- electronic adjustable beds and arm chairs,
- wifi light controls,
- remote power outlet controls,
- colour coded remote buttons that link to various appliances,
- large print home phones with pictures of people on speed dial.

4.2 There were examples of technology, such as front door sensors, that could be added to the range of items that the Council supplied to service users. However some of the equipment wasn't seen as essential to independent living or was too expensive to be a viable option to supply as part of a social care package (e.g. easy to use kettles and talking microwave). The Council is also unlikely to fund big capital expenses such as special adjustable beds or chairs.

4.3 Nonetheless, the Council could provide a signposting service to those service users who want to purchase such equipment. Anything that service users are able to do for themselves would assist the Council in reducing the level of assistance it needed to provide whilst maintaining their own living standards.

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4.4 As well as the list of technologies above, the exhibit demonstrated the use of the internet, linked to the television or computer, to communicate with health and care services. This enables users to contact their GP or Nurse to discuss illnesses and treatment without them having to leave their home. Technology also enabled users to submit vital statistics such as blood pressure, weight and heart rate etc. online.

Council's Telecare Service

4.5 The Council's Telecare Service is provided through a service contract by Peaks and Plains Housing Trust. The Trust provides 24/7 monitoring on telecare.

4.6 The basic service comes with one control box which was used for communication between the resident and the monitoring team. Service users living in a two story house can find it difficult to get to the box quickly from a different floor. The Group was informed that additional boxes connected to the original can be installed with an additional cost.

4.7 All technologies used are linked to a control unit in the home which is connected to the P&P contact centre. If any of the devises are activated the contact centre will make a call to the control box to check in with the resident. If no response is received then a call is made to the house phone which will be followed by response staff attending the home if required.

4.8 Customers are given a comprehensive assessment with the installation of equipment to ensure its suitability. This is when the Trust will also identify the most appropriate responder e.g. family member, neighbour or Peaks and Plains staff.

4.9 The Council's customers (i.e. C+S eligible) are currently charged £1.14 per week for monitoring and response but not for renting equipment. A person's family is able to purchase top ups through P&P if desired on a flexible basis (i.e. they were able to increase or decrease level of service at any time which was useful when away on holiday and required extra assistance).

4.10 The Telecare contract allows new technologies to be added as and when they are introduced.

Financial Implications for Council

4.11 The Council's Telecare customers receive the service at a heavily subsidised rate and some customers do not pay for the service having been financially assessed as being eligible for support.

4.12 The cost of maintaining care plans and carrying out financial assessments is inefficient to keep up with the demand of reviewing 2000 assessments to reclaim £1.14 per week which makes the current situation unsustainable. Telecare has also developed since this charge

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was originally but in place and much more options are available. The Council also needs to consider that service users require different levels of support which incur different costs. Therefore there is a need to examine how Telecare can be changed.

4.13 At the time of writing this report the Council is conducting public consultation on a new adult social care charging policy. Most of the proposed changes to the old policy are necessitated by the Care Act 2014 but there are also proposed changes to the Telecare charging structure.

4.14 The Council is proposing three levels of Telecare service with associated charges.

(1) The first level was proposed to be similar to the current basic level. This would involve a standard charge that all service users would be liable for; this removes need for financial assessments at low levels.

(2) Level two would include more equipment such as fall sensors and property exit sensors. This would require a higher level of response from the provider therefore incurring a greater cost. This level would involve a financial assessment of the service user.

(3) The third level would be something that the Council does not currently provide through its current Telecare contract. This would involve more complex cover and more technology e.g. GPS trackers.

4.15 Evidence from elsewhere shows that there is some price elasticity in the demand for AT and people are likely to accept charges knowing the value of the service. In developing its charges, the Council will benchmark against comparator authorities and the private sector to ensure charges are competitive. The table below shows what some other authorities in the North West are currently charging.

4.16 Table 1

Halton Borough Council	Service Level 1 – Community alarm emergency response - £5.64/week Service Level 2 – Telecare service environmental monitoring response service - £6.76/week Service Level 3 - Telecare lifestyle/environmental monitoring response service - £9.00/week	http://www3.halton.gov.uk/Pages/adultsocialcare/pdf/CommunityAlarmLeaflet(new).pdf
Knowsley Council	Level 1 Lifeline unit Pendant or wristband You pay £1.09 per week for Level 1 package Level 2 Lifeline unit Pendant or wristband Environmental sensors (e.g. bogus caller alarm, smoke detector, flood detector) You pay £1.09 per week plus 33p per week for	http://www.knowsley.gov.uk/residents/care/telecare-alarms/telecare-monitoring-charges.aspx

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	each environmental sensor Level 3 Lifeline Unit Pendant & wristband Lifestyle sensors (e.g. wandering alarm, bed sensors, chair sensors) You pay £1.09 per week plus 75p per week for each lifestyle sensor Level 4 Lifeline unit Pendant or wristband Combination of environmental and lifestyle sensors from levels 2 and 3 You pay £1.09 per week plus 33p per week for each environmental sensor and 75p per week for each lifestyle sensor	
Sefton Council	Based on assessment equipment can be fitted to individual needs Lifeline - £11.22/month Lifeline with falls/sensors fitted - £21.70/month Cost is means tested	http://carehomeguides.com/sefton

4.17 The Council's Top Up Policy (family members paying to enhance a service users care package) also applied to AT services.

4.18 The charging policy for people with Learning Disabilities (LD) is the same as that for the Elderly and Infirm and AT is used as part of the overall support package for people with LD.

Registered Social Landlords

4.19 Registered Social Landlords in the Borough all provide an AT service to its residents and private customers. Peaks and Plains, Wulvern Housing and Plus Dane Cheshire are all providers of AT and could be encouraged to market their services beyond just their residents. The Group has learned about the services RSLs can provide during a visit to Peaks and Plains (P&P).

4.20 P&P used to provide a standardised service for all customers but has developed a "5 star" service which offers five different levels depending on the clients requirements.
The basic package of a pendent alert button and control unit for the private sector is £4.01.The top rate is £15.93 per week followed by £12.37, £10.02 and £7.68. Costs are based on a 1 to 5 star rating which prescribes the number of house calls per week the customer is entitled to. The cost includes a fee for renting the equipment and cost of monitoring and response and additional pieces of technology costs extra.

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4.21 RSLs provide a variety of technologies including: smoke detectors, temperature gauges/alarms, flood detectors, door sensors, emergency pull cords, fall detectors, pill dispensers, pressure sensors for beds/chairs and pagers for carers (linked to the control unit). As well as providing assistive technology inside the home RSLs may potentially be able to support people outside the home, enabling people to be more active and avoid isolation in the home.

4.22 There is unlimited capacity to increase the number of Telecare and private customers RSLs serve and many of them are keen to develop their services further. RSLs can play a key role in supporting the Council and Health Commissioners to increase the use of assistive technology and telecare across the Borough.

Case Study (How AT enables a man with Alzheimer's disease and his wife [carer])

4.23 During its visit to P&P the Group met with one of the Council's customers who had volunteered to share her story. She was the carer for her husband who had Alzheimer's. The husband enjoyed getting out of the house and travelling on the bus to various locations. This often caused difficulties for his carer as he would sometimes become lost or not return home for long periods meaning that the Police were sometimes called to help bring him home.

4.24 To enable him to continue enjoying his trips outside yet enable the carer to keep track of him at the same time they were provided with a GPS tracker. The supplier taught the carer to use the technology on a computer and it enables her to work with the supplier to track down her husband should he wander out of his "safe zones" (familiar areas he usually goes to). The tracker gives the carer peace of mind, enables her to find her husband quickly when he needs assistance and enables the husband to enjoy his time out and about which is very important to his wellbeing.

Involvement of Health Care Providers

4.25 The Group believes that AT is able to support hospitals and social care services to get patients discharged quicker, reducing costs of hospital stays. RSLs work with the discharges programme board (consisting of hospital and social care managers) to install technology in patients homes were needed to enable people to be discharged into their own homes when they would otherwise have been kept in hospital or admitted to residential care. Below are further examples of how health care providers may be able to contribute to, and benefit from, AT services.

4.26 The Group has learnt that P&P recently took part in a pilot with North West Ambulance Service (NWAS) to help reduce hospital admissions when ambulances were called to tenants/service users. Using "Winter Pressure Funding" the pilot ran for 9 weeks. If NWAS was called out to a tenant for a fall or something that did not necessarily require hospital treatment, rather than take tenant to hospital, the paramedics would inform the Trust who

would then check in on the tenant and provide support to stabilize them. The pilot worked well with reduced admissions to hospital, meaning reduced costs for NWAS and the Hospital Trusts. P&P is currently working with Eastern Cheshire CCG to consider running the scheme again, this time for a six month period.

4.27 Pharmacists can play a role in increasing the use of pill dispensers, as they reduce the risks of users forgetting to take pills or taking too many/wrong pills. There is a cost to users for pharmacists' services to fill dispensers, as well as the cost of the equipment itself which might discourage some people from using them. However promoting the benefits of the technology and looking at ways to reduce the cost may encourage wide spread use.

4.28 There may also be a role for GP surgeries to play in promoting the use of AT. GPs could contribute to the identification of people who may be close to crisis or might benefit from some support as part of early intervention and prevention.

Assessments and Signposting

4.29 There are requirements in the Care Act 2014 which entitle anyone to a Needs Assessment. This means that the Council is likely to be approached by a number of people who will not be assessed as having critical or substantial needs. Whilst the Council is only required to support people with critical and substantial needs it is still in a position to be able to help those at low and medium risk avoid becoming critical and substantial by providing signposting and advice about the various AT and other services that people would be able to purchase for themselves. The Council's website would be a useful place to have a directory/portal where people can get access to information about available products and services in the area.

4.30 The Group asked how the Council might encourage people with low to moderate needs to invest in AT as part of early intervention and prevention. There is potential for a website promoting the benefits of AT that would also include a questionnaire for people to fill out, identifying potential needs and then signposting them to potential services. Officers were also working with GPs to encourage their patients to take on AT (where beneficial) ensuring they are aware of their needs.

4.31 As a private provider, anyone can refer a family member or themselves to an RSL for private assistive technology services. If it transpires that a person referred to an RSL is identified as possibly having critical or substantial (C+S) needs they will be referred on to the Council for assessment.

4.32 As well as providing the AT services the RSLs can signpost users to other services, activities and groups they may be interested in, and some proactively assess people for falls and social isolation to help prevent injury and illness. For example, P&P assesses it's none C+S customers on a six monthly basis to see if their conditions have degenerated to establish

whether they needed any additional services. This helps to avoid potential crisis points resulting in hospital admissions.

4.33 The Group considered ways of reaching out to people who were not yet C+S but would benefit from AT and avoid becoming C+S and maintain independence for longer. Ways identified include:

- accessing applicants for blue badges,
- those who receive council tax credits,
- through GPs and Hospitals,
- through the fire authorities community home safety scheme,
- through Age UK, Healthwatch and other sign posting organisations,

Private Service Users

4.34 The Council is aware that some private customers are choosing to go into residential care unnecessarily i.e. when they are not in critical or substantial need. This is difficult for the Council to monitor and discourage because it does not have any contact with these people therefore they can not be identified. Private providers tend not to question whether an individual is genuinely in need of residential care when they come to them (it is not in a providers interests to turn potential customers away).

4.35 These private customers will often be in residential care for a long time due to their relatively good health (the average length of stay for Council service users with C+S is three years). This often results in privately funded customers reaching the capital thresholds for eligibility for Council funding or reaching the care cost cap because residential care is expensive (The Care Act makes the Council responsible for anyone who reaches the care cost cap of £72,000).Those individuals who reach the capital threshold would then become eligible for Council funding, which results in a cost to the Council that could be avoided by those individuals living independently in their own home longer and only going into long term care when necessary.

4.36 The Council is trying to encourage private providers to do more to ensure potential customers are in need of their services and that they can afford to fund their care for at least three years.

Extra Care Housing

4.37 Before the Council admits people into residential care it explores all alternative options, including AT and Extra Care Housing.

4.38 Extra Care Housing offers a positive alternative to residential care in the same way as AT. ECH is a communal estate where care is provided to all residents, enabling them to maintain independence, support each other (also providing a social element) and provides economies for care services by having a number of service users in close proximity.

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4.39 ECH has AT integrated into the property as standard and the control boxes are linked to an onsite monitoring service. Oakmere in Handforth, Beachmere in Crewe and Willowmere in Middlewich are all examples of ECH developments in Cheshire East however it is felt that more sites are needed to cope with the Borough's growing older population.

Cost Benefit of Keeping People out of Residential Care

4.40 The Group wanted to establish whether it was possible to illustrate the assumption that investing in AT and other alternative services to residential care and domiciliary care would result in an overall cost saving. The Group was informed that it is difficult to calculate precise figures because of the complexity of care services, the needs of each individual and the size of the cohort.

4.41 There are a number of factors that contributed towards someone remaining independent at home for longer (e.g. AT, support from a carer, individual needs both mental and physical, personal preference etc). If one element of support was missing from an individuals care package there is a likelihood that they would not be able to live independently and would require residential care.

5.0 Conclusions

5.1 Based on the three policy areas considered during the review, namely effectiveness, universal accessibility and charging, the Group has developed the following conclusions.

Effectiveness

5.2 The Group believes that assistive technology is very effective in helping people live independently in their own homes for longer. By avoiding the need for residential care and promoting independence, not only does it provide people with better quality of life but it also reduces costs to the Council and service users (and their families).

5.3 In certain situations AT could reduce the demands on care staff or family carers, reducing the costs to Council and reducing the burden on family members. In some instances AT can be used to support service users in carrying out tasks independently however it is noted that AT cannot replace the need for human interaction and socialising that is so important to a person's wellbeing. There are some examples of how AT can facilitate social interaction, such as Skype being linked to the television which enabled users to video chat with friends and family or easy to use mobile phones users could call friends on.

5.4 As well as helping people to socialise using AT in their homes the Council needed to enable service users, particularly some elderly people who were socially isolated, to have opportunities to get out and socialise with others in community settings. Linking the use of a

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variety of services, including AT, to create a full package of support for service users would meet more of their needs and improve their overall health and wellbeing to a greater extent.

5.5 Regarding Carers the suggestion was made that as well as helping service users AT can support Carers to help reduce the demands on them and maintain their own independence. It was suggested that if Carers were to be given personal budgets then perhaps they would be able to use some of it to fund AT in their cared for person's home to assist them with their caring duties.

5.6 The Group agreed that the benefits of AT from an early intervention and prevention perspective, helping to reduce accidents and incidents of ill health, that result in reduced demand for health services, mean that Health Commissioners should also consider supporting the use of AT to help reduce their overall costs.

5.7 The Group believes that there is a need to engage CCG's, GPs, Pharmacies etc. to involve them in the use of AT in people's homes and to help people access services. The technology demonstrated by the Mi Smarthouse Exhibit shows how users can interact with their GP or Nurse without having to leave the home. Having access to your GP via email would also help users to share the health queries easier and might enable GPs to deal with more people quicker and easier than during a visit to the surgery.

5.8 Health care providers need to have a knowledge and understanding of AT and the benefits it can bring. Health providers should be encouraging the use of AT by signposting patients to particular items in the interest of early intervention and prevention.

5.9 The Group is interested in the impact of the innovative approach to handling ambulance call outs piloted by P&P and NWAS and was keen to explore extending this to the South of the Borough.

5.10 The Group believes that Extra Care Housing (ECH) with AT integrated into it is an effective option for people who want to maintain their independence but require close monitoring to ensure they are safe and secure. The Group agreed that the Borough needed more ECH in the future to cope with increased need.

Universally Accessibility

5.11 The Group suggests that there were two areas of work for the Council:
(1) to provide services for those with critical and substantial needs; and
(2) to assist people currently at low to medium risk with early intervention and prevention.

5.12 As well as increasing the use of telecare in the care packages of people with critical and substantial needs the Council should also encourage these services users to expand their use of assistive technology by purchasing additional items that are available in the private market that they feel would benefit them and support their independence.

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5.13 The Group does not believe that the Council should be providing direct access to AT to those who are not eligible because of limited capacity and budgets. However the Council can support these low to medium risk residents with information and advice regarding the benefits of AT increase the accessibility of AT by having effective signposting. The Council should be encouraging people to support themselves and think about their needs at an earlier stage in order to maintain their health and independence for longer.

Charging

5.14 The Group is keen to see the use of assistive technology expanded and promoted but wants to ensure it was done in a sustainable and effective way.

5.15 The Group believes that the current pricing of Council Telecare is not sustainable and that changes to the charging policy are needed. It is understood that this may lead to service users being charged more however it will be necessary to ensure the Council can continue to provide effective services.

5.16 Whilst there may be a need to increase charges for some services to ensure they are sustainable, the Group emphasises the need to ensure charges are set at a level that avoids service users opting out of Telecare services. If a person with critical or substantial needs chose not to use Telecare, the chances of incidents that cause harm are raised which could lead to the need for residential care, therefore resulting in additional cost to the Council.

5.17 Whatever charges are chosen the Group advises that the Council will have to be clear with residents about the needs to increase charges to avoid a negative reaction.

6.0 Recommendations

6.1 That the development of Extra Care Housing be prioritised to ensure that there is sufficient supply in the Borough to meet the rising demand from the growing older population.

6.2 That the use/provision of assistive technology is included in all of the Council's contracts with care providers that it commissions.

6.3 That the Council with its CCG Partners, the North West Ambulance Service and Housing Associations give consideration to funding to implement the initiative piloted by Peaks & Plains and NWAS to reduce the number of hospital admissions across the Borough.

6.4 That the three levels model of Telecare service proposed in the Charing Policy public consultation be adopted.

6.5 That charges for the three levels of Telecare service be set at a level that ensures the service is financially sustainable without deterring potential service users.

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6.6 That the need to implement new charges for assistive technology and rationale for the charges chosen be effectively communicated to service users.

6.7 That when residents request an assessment and are assessed as being low to medium risk they are provided with information and advice about assistive technology, and the benefits of early intervention and prevention, to enable them to access products and services privately.

6.8 That service users in receipt of Telecare service also be provided with information and advice about additional assistive technology to enable them to access products and services to further support their needs privately.

6.9 That the Health and Wellbeing Board be requested to encourage health service providers and commissioners to promote the benefits of assistive technology to patients and service users in order to increase its use as part of early intervention and prevention initiatives.

6.10 That the Health and Wellbeing Board be requested to consider how funding for assistive technology projects can be increased through contributions from health and care commissioners.

6.11 That officers be requested to explore the possibility of providing telecare services free of charge to over 85s who live alone and whether this would be financially sustainable and effective in maintaining independence.

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NHS South Cheshire Clinical Commissioning Group

NHS Eastern Cheshire Clinical Commissioning Group

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 15th September 2015

Report of: Guy Kilminster, Corporate Manager Health Improvement

Subject/Title: The NHS Healthy New Towns Programme – Expressing an Interest

1 Report Summary

1.1 An opportunity has arisen to express an interest in a new scheme from NHS England. As part of the 'Forward View into Action' initiative, the Healthy New Towns Programme has been launched (see Appendix One).

1.2 Expressions of interest are sought from areas to develop new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent. This requires an appropriate development site to be selected as our chosen location. The deadline for submission is 30th September.

2 Recommendations

2.1 That the Board consider the Report and support the submission of an expression of interest to join the Healthy New Towns Programme focussed upon the North Cheshire Growth Village at Handforth.

3 Reasons for Recommendations

3.1 The Healthy New Towns Programme, builds upon discussions that have taken place in Cheshire East to incorporate health and wellbeing into the Local Plan and planning considerations more effectively. It offers an opportunity to bring a focus upon a development site to demonstrate the potential to design in health and wellbeing in the broadest sense and to rethink how health and care services could be delivered, with support from NHS England to do things differently.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The proposals outlined in the Healthy New Towns Programme, align with the three priorities of the Health and Wellbeing Strategy.

5 Background and Options

5.1 Many areas already promote health and wellbeing through 'place-shaping', including through better housing and urban design and access to well-designed public spaces and facilities. The ambition of the Healthy New Towns Programme is to develop new and creative approaches that contribute to the priorities of the Five Year Forward View (focussing on prevention, integration of health and care and establishing a financially viable and sustainable system).

5.2 Building strong communities and healthy places to live can contribute to these priorities. Good urban and housing design promotes healthy lifestyles and can help prevent illness. It also helps keep older people independent and healthy, supported by the latest technology to live in their own homes rather than in care. New developments also offer opportunities to radically reshape health and care services, testing what can be achieved with fewer legacy constraints.

5.3 There are three core objectives to the Programme:

- To develop new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent;
- To show what is possible when we radically rethink how health and care services could be delivered, freed from the legacy constraints (i.e. existing services) that operate in other areas. This will support the New Models of Care programme by adding to the learning about how health and care services could be integrated to provide better outcomes at the same or lower cost;
- To accomplish the first two objectives in a way that can be replicated elsewhere, making learning available to other national programmes as well as other local areas.

5.4 The NHS is seeking to establish up to five ambitious, long-term partnerships with local areas through which to develop healthier neighbourhoods and towns. Expressions of interest are invited from sites across England that are considering developments at different scales. Larger sites (for example, around 10,000 homes) are able to think radically about future health 'operating systems' and fundamental aspects of healthy place-making, such as transport infrastructure, housing or access to open space. Smaller sites, down to neighbourhoods of 250 homes, might focus on meeting the needs of particular groups or experiment with particular design features; for example, the use of 'behavioural nudges' to encourage healthy behaviours.

5.5 Further detail regarding the offer to interested sites is outlined in the Prospectus (Appendix One). Following discussions with the Planning Department and Head of Assets in Cheshire East Council, the site that is

thought to offer the most potential in relation to a successful expression of interest is the North Cheshire Growth Village site at Handforth.

5.6 **The North Cheshire Growth Village, Handforth East (extract from Draft Local Plan)**

The development of the North Cheshire Growth Village site over the Local Plan Strategy period will deliver a new exemplar 'Sustainable Community' in line with the principles of sustainable development, including:

i. Phased provision of 1,650 new homes (excluding 237 units on the land to the west of the A34 for which permissions have already been granted /granted subject to S106);

ii. Up to 12 hectares of employment land, primarily for B1 uses;

iii. New mixed-use local centre(s) potentially including:
- Retail provision to meet local needs;
- Contributions to local health infrastructure;
- Public house / take away / restaurant;
- Sports and leisure facilities;
- Community centre;
- Children's day nursery;
- Extra care housing; and
- Hotel.

iv. New one and a half form entry primary school and potential additional secondary school facilities;

v. The incorporation of Green Infrastructure including:

- Green corridors
- A country-park style open space
- Public open space including formal sports pitches;
- Allotments and / or community orchard.

vi. Appropriate contributions towards highways and transport, education, health, open space and community facilities.

5.7 Following submission of an expression of interest, follow up face-to-face discussions will be held to look in more detail at the proposed sites and to help NHS England form a view on their preferred partners. This would offer an opportunity to explore an option to have a second site included within our proposal. Knutsford and Basford have been suggested for example.

5.8 The Health and Wellbeing Board is asked to consider the Healthy New Towns Prospectus and to support an expression of interest, initially focussed upon the North Cheshire Growth Village at Handforth.

6 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health improvement
Tel No: 01270 686560
Email: guy.kilminster@cheshireeast.gov.uk

THE *FORWARD VIEW* INTO ACTION:

Registering interest to join the healthy new towns programme

July 2015

Introduction

1. The *NHS Five Year Forward View* published in October 2014, set out three gaps the health service must close in order to be sustainable into the future. Firstly, we must close the health gap, by radically upgrading our prevention efforts. Secondly, through the New Models of Care programme, the NHS and its partners are already taking the first steps towards closing the care gap by redesigning how we deliver health and social care services. Thirdly, by 2020/21 we must close a financial gap by delivering efficiencies of 2-3% across the NHS's entire funding base.

2. Building strong communities and healthy places to live can contribute to each of these three gaps. Good urban and housing design promotes healthy lifestyles and can help prevent illness. It can also keep older people independent and healthy, supported by the latest technology to live in their own homes rather than in care homes. New developments also give us the opportunity to radically reshape health and care services, testing what can be achieved with fewer legacy constraints. By keeping people well and providing services in better, more productive ways, healthy places to live can also contribute to the long term financial sustainability of the NHS.

> ***"New town developments and the refurbishment of some urban areas offer the opportunity to design modern services from scratch, with fewer legacy constraints - integrating not only health and social care, but also other public services such as welfare, education and affordable housing."*** *NHS Five Year Forward View* (October 2014)

Objectives of the programme

3. Many areas already promote health and wellbeing through "place-shaping", including through better housing and urban design, and access to well-designed public spaces and facilities. The ambition of this programme is to go beyond existing good practice, developing new and creative approaches that offer the potential to make a substantial contribution to closing the three gaps. It is also to drive closer collaboration between local authorities, planners, developers and the NHS. In our early discussions, we have heard that this collaboration is often lacking or comes too late in the process.

4. More specifically, the programme has three core objectives:

   a. To develop new and more effective ways of shaping new towns, neighbourhoods and strong communities that promote health and wellbeing, prevent illness and keep people independent;
   b. To show what is possible when we radically rethink how health and care services could be delivered, freed from the legacy constraints (i.e. existing services) that operate in other areas. This will support the New Models of Care programme by adding to the learning about how health and care services could be integrated to provide better outcomes at the same or lower cost;
   c. To accomplish the first two objectives in a way that can be replicated elsewhere, making learning available to other national programmes as well as other local areas.

5. Of course the NHS can't accomplish these objectives alone. So we are inviting areas with future population growth and housing needs to work with us to develop these radical new approaches to shaping the built environment. This may include but won't be limited to:

   - Building healthier homes and environments that support independence at all stages of life. We would like to explore new ways of integrating housing, care and communities to keep people independent and in their own homes. For those who do need support, more innovative residential care facilities may be combined with flexible housing options and step-up or respite care.
   - Tackling unhealthy (and "obesogenic") environments by creating walkable neighbourhoods, delivering radically improved infrastructure for safe active travel and more accessible public transport, and by providing easy access to healthy and affordable food in the local area.
   - Implementing a new 'operating system' for health and care that achieves "triple integration" between primary and secondary care, mental and physical health, and health and social care. This means developing a flexible health and care infrastructure that is linked to specialist care when needed, but provides many more services in the home, in primary care and alongside other public services. This infrastructure would also provide a strong platform for people to manage their own health and care, together with their peers and the voluntary sector, by making the most of mobile and digital channels.
   - Creating connected neighbourhoods, strong communities and inclusive public spaces that enable people of all ages and abilities from all backgrounds to mix. Examples include 'dementia-friendly' design or ensuring that public spaces include features such as public toilets or benches that can make the difference between people being able to get out and about and being confined to their homes.
   - Designing healthy workplaces, schools and leisure facilities that make the most of opportunities to encourage physical activity, healthy eating and positive mental health and wellbeing.

6. The potential of this programme stretches beyond the health and care sector. Digitally-enabled 'smart' towns and neighbourhoods, supported by integrated and effective public services, are attractive places to live and work. They are also attractive to businesses and entrepreneurs, offering to encourage innovation and economic growth.

Our offer to interested sites

7. The NHS is seeking to establish up to five ambitious, long-term partnerships with local areas through which to develop healthier neighbourhoods and towns.

8. We invite expressions of interest from sites across England that are considering developments at different scales. Larger sites (for example, around 10,000 homes) are able to think radically about future health 'operating systems' and fundamental aspects of healthy place-making, such as transport infrastructure, housing or access to open space. Smaller sites, down to neighbourhoods of 250 homes, might focus on meeting the

needs of particular groups or experiment with particular design features; for example, the use of 'behavioural nudges' to encourage healthy behaviours.

9. We are particularly interested in hearing from partnerships that include NHS organisations considering how to make better use of underutilised estate. Some NHS organisations have large asset holdings that could be suitable for neighbourhood level developments including supported housing. Rather than disposing of these assets, it may make more sense to partner with local authorities and developers to create a longer term revenue stream that also contributes new housing.

10. We will develop a national offer of support with the aim of helping to reduce barriers to progress and accelerate healthy developments. Although we want to develop this offer alongside our partner sites, we envisage a package that could include the following:

    - Convening expertise such as national policymakers, global leaders in healthy built environments, cutting-edge designers, behavioural economists and leading academics, technologists and other innovators.
    - Removing barriers at the national level, by coordinating between government departments and escalating problems to the right decision-makers.
    - Specialist input into design of local health and care services, drawing on the New Models of Care programme, national clinical leaders and other global experts.
    - Working with local experts in public health to ensure that we maximise opportunities for health promotion and disease prevention.
    - Helping to bring enterprise and innovators to the table with tangible offers of assistance and investment.
    - National sponsorship including assistance with problem-solving and opportunities for national and international showcasing.
    - Supporting the design of technology-enabled 'smart' developments that support digital and mobile health.
    - Supporting planning by providing capacity and expertise at key points in the process, and supporting alignment between planners and developers. Where necessary, this may involve some funding support to local government partners.
    - Identifying viable methods for evaluating impact on health, wellbeing and other outcomes.

What are we looking for in our partners?

11. We are seeking to partner with local partners that are ambitious as us about developing radical new approaches to developing new healthy neighbourhoods and towns. We are particularly looking for areas that:

    - Have ambitious ideas about how to collaborate with the NHS to promote healthy environments – and would benefit from closer engagement both nationally and locally from NHS organisations.

- Are in areas identified for future population growth or housing need (e.g. in regional or local plans).
- Are in the pre-application, pre-masterplanning or masterplanning phase.
- Are planning schemes of at least 250 homes (with no upper limit on the size of a development).
- Have the active backing of the relevant local authorities even if subsequent planning decisions are outstanding.
- Are keen to engage the expertise of globally recognised designers, clinical experts, public health specialists, technologists and from other innovators.
- Are interested in working with other sites with similar ambitions to solve common problems.

12. Additionally, we want to engage with a diverse set of schemes, including:

- Different types of communities or contexts (e.g. rural and urban areas);
- Different types of developments (e.g. urban extensions, regeneration projects);
- Developments of different scales and at stages of development that offer both shorter and longer term benefits realisation. We aim to partner with at least one site of 10,000 homes or more, but will consider neighbourhood schemes as small as 250 homes.

How to express interest

13. Expressions of interest (EoIs) should be sent to england.fiveyearview@nhs.net by 30th September at 1700 BST. The EoI form is two pages long in order to minimise the burden.

14. Interested sites are asked briefly to outline their development plans, with reference to paragraph 11 and 12. They are also asked to describe the size, type, location and stage of their development, with information about build-out time and scheme trajectory.

15. EoIs should identify a lead partner for the proposal, as well as other key stakeholders who could form a broader coalition or partnership, including the Local Planning Authority. Where lead partners are not local authorities or other statutory planning bodies (e.g. Development Corporations), they may be housing associations and registered social landlords, NHS Trusts and Foundation Trusts with land they wish to develop, or private developers and land owners.

16. Following submission of the EoIs we would like to have face-to-face discussions with interested sites to better understand their plans. We aim to announce our partners in the Autumn.

Forward View into Action

Registration of interest for healthy new towns programme

Q1. Who is making the application? Who is the lead partner and who are the other organisations involved in the partnership? Interested areas may want to list wider partnerships in place. Please include the name and contact details of a single CEO best able to field queries about the application.
Q2. Please provide a brief description of the site. (500 words max.) Please outline the name, location, total planned size (in housing units) as well as naming the local planning authority for the site. Please also outline the phase of the planning process, expected build-out rate and completion date for this site.

Q3. How would your scheme promote health and wellbeing through the built environment? How could the NHS support you to deliver your ambition?
Q4. What opportunities are there to redesign how health and social care is delivered in your development? How could the NHS support you in delivering this?


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