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Health and Adult Social Care Overview and Scrutiny Committee

Agenda

Date:	**Thursday, 14th January, 2016**
Time:	**10.00 am**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Minutes of Previous meeting** (Pages 1 - 4)

   To approve the minutes of the meeting held on 26 November 2015

3. **Declarations of Interest**

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

4. **Declaration of Party Whip**

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

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

For requests for further information
Contact: James Morley
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A total period of 15 minutes is allocated for members of the public to make a statement(s) on any matter that falls within the remit of the Committee.

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

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

6. **Carers Task and Finish Group November 2013 - January 2015**

To consider a progress report on to the recommendations of the Carers Task and Finish Group which conducted a review between November 2013 and January 2015 and reported to Cabinet on 3 March 2015. To receive an update on the Caring for Carers Joint Strategy.

(report to follow)

7. **Winter Wellbeing and Winter Planning** (Pages 5 - 38)

To consider reports from the Council, NHS Eastern Cheshire CCG and NHS South Cheshire CCG regarding the work of the Winter Wellbeing Partnership to coordinate services to tackle excess winter deaths and deal with winter pressures.

8. **Hyper Acute Stroke Pathway for South Cheshire Patients** (Pages 39 - 44)

To consider a report from NHS South Cheshire Clinical Commissioning Group and Mid Cheshire Hospitals NHS Foundation Trust regarding proposed changes to hyper acute stroke services for patients in South Cheshire.

9. **Work Programme** (Pages 45 - 50)

To review the current Work Programme

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Adult Social Care Overview and Scrutiny Committee**
held on Thursday, 26th November, 2015 at Council Chamber - Town Hall, Macclesfield, SK10 1EA

PRESENT

Councillor J Saunders (Chairman)
Councillor L Wardlaw (Vice-Chairman)

Councillors Rhoda Bailey, B Dooley, L Jeuda, G Merry, A Moran and A Harewood (sub for D Bailey)

Apologies

Councillor D Bailey

ALSO PRESENT

Councillor J Clowes – Cabinet Member for Adults and Health in the Community
Brenda Smith – Director of Adult Social Care and Independent Living
Sarah Smith – Corporate Commissioning Manager,
Kate Philips – Commissioning Manager, Contracts Quality Assurance
Patrick Rhoden – Principal Accountant
James Morley – Scrutiny Officer

43 **MINUTES OF PREVIOUS MEETING**

RESOLVED – That the minutes of the meeting held on 5 November 2015 be approved as a correct record and signed by the Chairman

44 **DECLARATIONS OF INTEREST**

There were no declarations of interest

45 **DECLARATION OF PARTY WHIP**

There were no declarations of party whip

46 **PUBLIC SPEAKING TIME/OPEN SESSION**

Ms Kate Sibthorp spoke in relation to Item 6 of the Committee's Agenda. As the parent and carer of a adult daughter with learning difficulties she was concerned about the proposed fee rates for personal assistants which she purchased at an hourly rate using direct payments. She stated that there had not been a rise in fees paid to personal assistants for six years and that the proposed increase in the report by Red Quadrant was too low. She suggested that the process used to come up with the fees had been flawed and should have included more research

on the role of personal assistants and more consultation with service users groups should have taken place. She offered to provide a hard copy of her comments to the Committee and Officers and the Chairman requested that Ms Sibthorp be provided with a response.

47 IMPLEMENTING THE CARE ACT 2014 - MOVING TO A LOCAL AND PERSONALISED SYSTEM OF CARE AND SUPPORT

The Cabinet Member for Adults and Health in the Community provided an overview of report on Implementing the Care Act. The Council was required to comply with the Care Act 2014 which meant changes to the way services were provided need to be made. There were two phases to the Act, the first phase of which had started to be implemented from April 2015 and the second phase which had been delayed until 2019. The elements of the Act which the Council had implemented so far were working well however further implementation was required.

A report was due to be considered by Cabinet on 8 December 2015 for a decision and the Committee was requested to provide comments to be considered by Cabinet. Members asked questions and the following points arose:

- Members wanted to ensure that services continued to remain safe for users and employees as changes to the delivery of Care4CE were implanted.
- Members wanted to ensure that education and training was in place for all employees of private providers used to provide services. The Council could measure the levels of training as part of its contractual arrangements with commissioned providers.
- Members were pleased that there would be investment in Community Agents to support and advise users in their decisions about purchasing services and that social workers would continue to provide advice and support about the services that users would find useful.
- Members wanted to ensure good information about providers was available for services users to help them make informed decisions. A directory of services had been developed and the intension was to build on this.
- Members wanted to ensure that future services and ways of working helped to reduce social isolation. It was suggested that enabling people to chose they own packages and providing access to more local support would help to reduce isolation.
- Members believed that the Council needed to ensure that people acted in their own best interests when considering whether or not to purchase services.
- Members agreed that the implementation of the Integrated Care Teams was an essential part of the way services would be delivered in future. It was expected that the teams would be in place by April 2016.

The Committee was requested to consider whether or not members would take part in the process to co-design the new service and delivery models of care as detailed in the report. Members expressed an interest in being involved in the piece of work and more detail on members' role would be developed in a scoping exercise.

RESOLVED:

(a) That the report be noted

(b) That the minutes of the meeting be submitted to Cabinet for consideration with the report on 8 December 2015.

(c) That a scoping exercise take place to define the role which members of the Committee will play in the co-design of the new service and delivery models of care.

48 ADULT SOCIAL CARE FEE RATES

The Cabinet Member for Adults and Health in the Community provided an overview of report on Adult Social Care Fee Rates. The Council had operated the same fee structure for adult social care external providers since 2009 and it was considered necessary to review the fees paid in future. Red Quadrant, a consultancy firm, had been commissioned to conduct an independent review of the adult social care fee structure which began in May 2015. Two reports were provided by Red Quadrant on Home Care costs and Care Home costs which were appended to the report.

A report was due to be considered by Cabinet on 8 December 2015 which recommended the adoption of the fee rates proposed by Red Quadrant. The Committee was requested to provide comments to be considered by Cabinet. Members asked questions and the following points arose:

- Members expressed concern about the delivery of 15 minute care visits and whether providers would be willing to provide 15 minute slots. Some providers were not geared up to provide personalised care packages. Changes in fees needed to come with changes in practices and attitudes.
- Members wanted to ensure that the Council had capacity to be agile to the changing needs of service user to ensure financial assessments were completed and fees were paid. 16 additional social workers had been employed in 2014 to increase the Council's capacity to deal with assessments.
- Members were concerned about whether self funders were subsidising Council customers based of the fees they were paying for residential care. This was something that needed to be considered in future.

The Committee was requested to consider whether or not members wished to be involved in the review of the delivery models of domiciliary care and residential care. Members expressed an interest in being involved in the piece of work and more detail on members' role would be developed in a scoping exercise.

RESOLVED:

(a) That the report be noted

(b) That the minutes of the meeting be submitted to Cabinet for consideration with the report on 8 December 2015

(c) That a scoping exercise take place to define the role which members of the Committee will play in the review of the delivery models of domiciliary care and residential care

49 WORK PROGRAMME

The Committee gave consideration to the work programme.

RESOLVED – That the work programme be noted

The meeting commenced at 2.10 pm and concluded at 3.35 pm

Councillor J Saunders (Chairman)

Agenda Item 7

CHESHIRE EAST COUNCIL

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

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Date of Meeting: 14th January 2016
Report of: Corporate Manager Health Improvement (on behalf of the Winter Wellbeing Partnership)
Subject/Title: Winter Wellbeing and Winter Planning
Portfolio Holder: Cllr Michael Jones / Cllr Janet Clowes

1.0 Report Summary

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

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

1.3 There is, however, still more to be done and the group continues to meet to both co-ordinate activity for this winter and to work on longer term issues. In addition there is now a recognition of the need to co-ordinate activity in relation to hot weather and this work has progressed during 2015 with effective partnership working to mitigate against the potential impacts of the mini heatwave at the beginning of July 2015.

2.0 Recommendation

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

3.0 Reasons for Recommendations

3.1 To ensure that Members of the Committee are aware of recent work to raise awareness of and mitigate against the dangers posed to health by extreme weather events.

4.0 Background

4.1 Excess winter deaths are defined by the Office of National Statistics as the difference between the number of deaths during the four winter months (December – March) and the average number of deaths during the preceding four months (August – November) and the following four months (April – July). Figures released by the Office for National Statistics (ONS) in November 2015 show a significant decrease in excess winter mortality in Cheshire East between 2012/13 and 2013/14, from 21.6 (Confidence Interval (CI) 18.9-24.3) to 9.1 (CI 7.3-10.9). Excess winter mortality in 2013/14 was significantly below the England rate.

4.2 However, provisional figures for 2014/15 highlight a significant increase at national level from an index of 11.3 (CI 11.1-11.5) in 2013/14 to an index of 27.4 (CI 27.1-27.6) in 2014/15. Analysis of local data suggests a similar picture in Cheshire East, with the Excess Winter Deaths Index (EWDI) significantly above the England rate. Initial investigation suggests that this is being driven by mortality rates in those aged 65 and over from respiratory disease (ICD10 J00-J99), and to a lesser extent Alzheimers Disease and Dementia (ICD 10 F01, F03 and G30). This effect is much more marked among females than males. Improvements in 2013/14 put Cheshire East in the second best quartile nationally. It is not yet possible to compare Cheshire East with other areas for 2014/15 but it is likely that the authority's relative position will slip to the worst quartile again. A trend diagram is attached as Appendix One.

4.3 It is likely that the increase last winter is attributable to an increase in the numbers of people getting flu, with last year's immunisation being less effective than had been intended.

4.4 There is strong evidence that the majority of excess winter deaths are preventable. The evidence also suggests that isolated elderly people may be particularly vulnerable, whatever their social background. Poverty/fuel poverty, poor quality or un-insulated housing, chronic disease and multiple long term conditions are all relevant factors as well.

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

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

4.6 In March 2015 the national Institute for Health and Care Excellence (NICE) published its guidance on 'Excess winter deaths and morbidity and the health risks associated with cold homes'. It identified that the health problems

associated with cold homes are experienced during 'normal' winter temperatures, not just extremely cold weather.

There were a number of recommendations:

- Develop a strategy to address the health consequences of living in a cold home;
- Ensure there is a single point of contact health and housing referral service for people living in cold homes;
- Provide tailored solutions via the single point of contact health and housing referral service for people living in cold homes;
- Identify people at risk of ill-health from living in a cold home;
- Make every contact count by assessing the heating needs of people who use primary health and home care services;
- Non-health and social care workers who visit people at home should assess their heating needs;
- Discharge vulnerable people from health or social care settings to a warm home;
- Train health and social care practitioners to help people whose homes may be too cold;
- Training housing professionals and faith and voluntary sector workers to help people whose homes may be too cold for their health and wellbeing;
- Train heating engineers, meter installers and those providing insulation to help vulnerable people at home.

To move towards achieving these recommendations requires some preparation – understanding the local situation, developing a shared understanding, engaging appropriate partners and initiating joint working.

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

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

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

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

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

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

5. Progress to date

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

- The Winter Preparedness Plan
- Identifying Vulnerable People
- Warm Homes and energy efficiency
- Communications

5.2 For Winter 2014 / 2015 there was a £10,000 investment in resources to help keep people warm, with these being distributed in a targeted manner. Funding was made available to purchase bedding, clothing, hot water bottles, heaters, slow cookers etc. Excellent partnership working ensured that items could be stored and distributed widely, enabling easy access at short notice for frontline services and local neighbourhood groups, who were able to identify those in need and begin the more effective co-ordination of on the ground activity.

5.3 For 2015 – 2016 Cheshire East Council has secured funding to help vulnerable people heat their homes this winter.

A total of £380,340 has been sourced from Department of Energy and Climate Change (£180,340), Warm Zones (£100,000) with match funding from Cheshire East Council strategic housing budgets (£50,000) and Public Health (£50,000)

Residents who are eligible can apply for grants to help with:

- First time central heating systems, particularly in rural off gas areas
- Boiler repairs
- Boiler replacements

Energy Projects Plus, a charity working across Cheshire East, is working in partnership with the Council to advise residents on the grants available. The charity are handling public enquiries and carrying out a direct mailing exercise to targeted areas.

5.4 Peaks and Plains have established a Smart Energy Project to help their customers keep their homes warmer in a cost effective way. One of the main challenges that has been faced has been the high cost of energy for customers who have prepayment meters installed. With the majority of those people being on a low income, it is perverse that they have to pay more for their gas and electricity.

5.5 Another major challenge has been the number of customers supported who are off-gas and rely solely on electricity for their heating. This is obviously a more expensive option and limits the support that can be offered (in terms of energy saving devices that can be installed) Many of these customers are on an Economy 7 or 10 tariffs which only a few energy companies are now supporting, making it hard to shop around for the best deal on electricity.

5.6 The Smart Energy Team have had a number of achievements, including successful applications to Energy Funds, which have either reduced or written off customers' outstanding energy debt. They have also been able to save people hundreds of pounds by switching them to cheaper energy providers. So far customers have saved nearly £20,000 since going live with the project in May. Cheshire East's Care and Repair team have also been really helpful in assisting customers who have needed repairs to their properties, their boilers or central heating systems as a whole.

5.7 Another partner, Citizens Advice Bureau (North) promoted and publicised awareness around better deals for domestic fuel in November and for all face to face clients aim to carry out assessments of cost and usage around domestic fuel and with that information help clients shop around for better deals. They are also promoting "Energy Efficiency is the Cheapest Fuel" and are currently compiling a single reference point for use with clients on identifying grants and other funding options for insulation, heating system upgrades and advice on best use of fuel.

5.8 The CAB are working with Knutsford Lions on a scheme that sees some elderly people in Knutsford gifting their Winter Fuel Allowance payment from the Government to the Lions so that it can be pooled with other similar donations and then redistributed to CAB clients, who are struggling to meet the additional costs of domestic fuel during the winter months. They are also involved in supporting the WHAM project running in Macclesfield providing weekend shelter for street homeless people via the churches in the town. They meet all clients who need advice and explore their housing options.

5.9 TrustLink (also a Peaks and Plains initiative) have been delivering a Falls prevention Project since November 2014 – funded by CCG resilience monies. This has continued throughout the year, with funding in place until at least the end of March 2016. Clients are referred direct from North West Ambulance Service (NWAS) when they respond to patients who have fallen but there is also a dedicated falls referral email address to accept falls referrals from other professionals falls@peaksplains.org

5.10 The Falls Advisor's visit, provides falls prevention advice and signposting, a falls prevention booklet, undertake a falls risk assessment and make appropriate referrals. They have forged links with Community rehab and have a rapid referral route to Physio and Occupational Therapy home visits within 72 hours. The opportunity is taken to use this intervention to undertake a holistic approach referring to a range of services including Red Cross, Eye Society, Opticians, DIB, Care and repair, Money Advice, Social Service and Gp's. There is also a referral route to Community Outreach pharmacy for medication reviews

5.11 Many of the Partner organisations have now built winter preparation into their all year round activities advocating that work to prevent winter deaths and excessive admissions takes place throughout the year, well before it gets cold. Much of this is aimed at tackling fuel poverty and ensuring that suitable befriending schemes are in place.

5.12 Although the Winter Wellbeing partnership has improved the co-ordination of efforts to support vulnerable people and protect them from the impacts of cold weather there is still more to do.

- The November 2015 data needs to be more fully reviewed and analysed to try to better understand the reasons for the reversal in the improving trend and identify potential interventions to try to shift the position to a downward trend again. Although the ineffectiveness of the flu vaccine may be a significant factor other issues may apply, for example in relation to those with dementia, and this needs considering.

- Further work is required to identify vulnerable people and improve our data sharing between organisations, including overcoming data protection issues relating to sharing data about individuals if that data sharing is in their best interest;

- We need to further develop the research in relation to admissions and vulnerability;

- We need to be better able to act quickly when a vulnerable person is identified at a time of crisis;

- Continue to improve joint communications and engagement to ensure key messages are co-ordinated;

5.13 Next steps will be a review of the 2015 – 2016 Winter responses in relation to the NICE guidance recommendations and initiating a planning process to ensure that for 2016 – 2017 we can demonstrate that we have in place the majority of the recommendations of the NICE Guidance.

6.0 Access to Information

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

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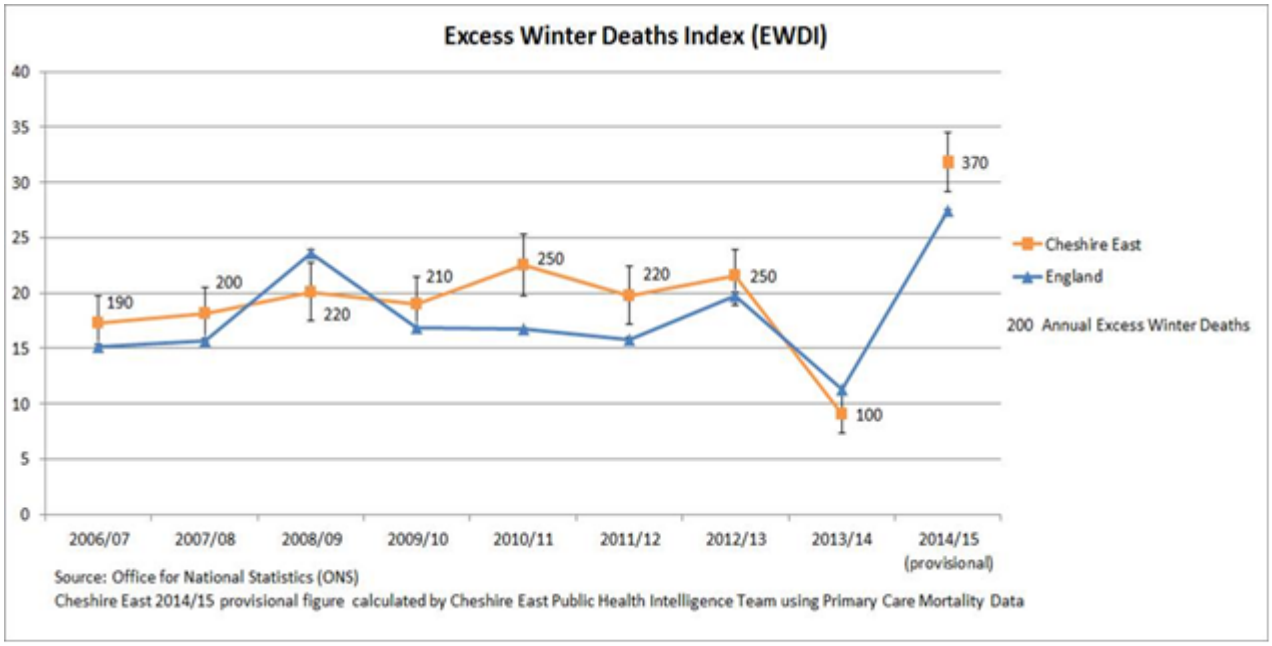
Appendix One



Appendix Two
The Winter Wellbeing partners
CEC Services
Health Improvement Team
Benefits
Partnerships & Communities
Highways
Care & Repair Team
Emergency Planning Team
Flood Risk Team
Business Intelligence
Public Health
Safeguarding Team (children's)
Communications

Commissioning
Libraries
Housing
Adults Social Care & Independent Living
Trading Standards
Environmental Services
Community Safety Team

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

CHESHIRE EAST COUNCIL

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

Date of Meeting: Thursday 14th January 2016
Report of: Eastern Cheshire System Resilience Group
Subject/Title: Managing winter pressures
Portfolio Holder: Janet Clowes

1.0 Report Summary

1.1 Significant pressures across health and social care are expected during the winter months and there are concerns that a number of agreed key sustainability measures are not progressing at sufficient pace, including intermediate care beds procurement and rapid response services.

This is a collective risk that needs to be owned and addressed at executive level across health and social care.

Eastern Cheshire System Resilience Group (SRG), which is a collaborative group of health, social care and voluntary sector representatives, has developed a four point priority plan for winter.

The plan aims to deliver:

- A phased reduction in the number of delayed transfers of care (DTOC) to 2.5% of total bed stock by June 2016
- 20% reduction against projections in admission to hospital for groups of people including those with COPD and frailty by end March 2016
- 50% increase in discharges of people before 1pm and 80% of weekday discharges at the weekend

2.0 Recommendation

2.1 The Cheshire East Health and Adult Social Care Overview and Scrutiny Committee is asked to note the approach to managing winter pressures across health and social care.

3.0 Reasons for Recommendation

3.1 The four point plan aims to ensure patients who need it can access the urgent care system in a timely way.

3.2 The focus of the plan is to ensure people move safely through the health and social care system and receive the right care in the right place.

3.3 A significant proportion of demand for urgent care is from people with complex needs and therefore it is imperative that health and social care continue to plan and deliver services in partnership.

4.0 Wards Affected

4.1 All within Eastern Cheshire.

5.0 Background

5.1 This report is intended to provide the Cheshire East Health and Well Being Overview and Scrutiny Committee with an understanding of the work currently being undertaken by the Eastern Cheshire System Resilience Group, and the arrangements in place to support management of people's safe and effective care over the winter period.

5.2 Senior system leaders (Chief Executives) have been asked to establish an executive forum and commit their organisation to key actions for system management, escalation and governance.

5.3 Significant winter pressures across health and social care are expected during the winter months and there are concerns that a number of agreed key sustainability measures including intermediate care beds procurement and rapid response services, are not progressing at sufficient pace. This is a collective risk that needs to be owned and addressed at executive level.

5.4 To mitigate this risk, the Eastern Cheshire System Resilience Group (SRG), which is a collaborative group of health, social care and voluntary sector representatives, has developed a four point priority plan (see table one below) which focuses on clinical support in primary care, rapid access to health and social care 7 days per week, proactive management of frailty and partnership working with the care home sector.

5.5 The four point plan is based on learning from a number of recent clinical audits, internal and external reviews of processes and performance and if implemented will support delivering the following system benefits and release much needed capacity:

- A phased reduction in the number of delayed transfers of care (DTOC) to 2.5% of total bed stock by June 2016
- 20% reduction against projections in admission to hospital for groups of people including those with COPD and frailty by end March 2016
- 50% increase in discharges of people before 1pm and 80% of weekday discharges achieved over the weekend

5.6 The plan is included below however it is important to note that this is a live plan which is progressed and updated weekly by a senior group of health and social care representatives.

System Resilience Executive Forum - Four Point Plan and Update

Change/ Priority Area	Actions	Time scales	Project lead	Update
Respiratory – predict and reduce unnecessary admissions for COPD **SRO - Jacki Wilkes**	**Build capacity in primary care** – identify investment required to pump prime practices to case find patients at risk of COPD admission (e.g. frequent attenders and people with complex needs) over winter	**End Dec**	**Karen Burton** **And GP Practice Lead**	• 21 of 22 Practices signed up to proactive management programme for COPD • Practices to start identifying patients • Pump priming investment confirmed to recruit people onto winter proactive management programme • Text technology to be tested in one practice/Peer Group • Targets agreed with each Practice
	Standardise approach – send new Clinical protocol for respiratory management to every Care Home follow up with a telephone call to discuss/ensure understanding	**End Dec**	**Karen Burton**	• New Protocol written and issued to all Practices • New Protocol issued to all Care Homes
	Promote self-management – issue rescue packs to COPD patients identified at risk by Practices and follow up with regular telephone calls to check understanding and use (inform Breatheasy group of approach over winter to promote/cascade message)	**End Dec**	**Identified Practice Lead**	• Agree targets with each practice relating to rescue packs, contacts and saved admissions, reduced LOS
	Support to assess – increase medical capacity in Acute Visiting Service to see and assess patients at risk of admission in their own home	**Dec 22**	**Jacki Wilkes / Kath Senior**	• Funding available but unable to secure additional capacity
Frailty – manage people with increasing frailty to prevent unnecessary admissions and delays in hospital **SRO – Steve Redfern / Ann Riley**	**Build capacity in Frailty team** – (Primary Care, A&E and AVS) determine investment required for additional capacity to extend hours, capacity and skill mix of new Frailty team over winter Proactively case manage people with frailty. Communicate with Practices about what the Frailty team is and how they refer/ask for advice. Promote Integrated	**Dec 8** **End Dec**	**Karen Burton** **Debbie Burgess**	• Health element for the Trust to cover currently able to provide via bank staff. Agency cap issue escalated to the LAT awaiting response on any flexibility allowed • Mental health capacity will be via the intermediate care team CPN • Update on integrated working arrangements between AVS and Frailty Team needed • OT starts on 3/1/16 between 8.30 - 4.30 • physio starts 11/1/15 between

	working between the AVS and the Frailty team			8.30 - 4.30 • Second physio will be covering OT and Physio at the weekend • After 5pm the Integrated Discharge Team will cover ED and undertake basic assessments with access to equipment to support discharge. • Locum social workers have been identified and telephone interviews will take place on 3/1/16 • Capacity for community reviews will be provided from specialist nurses and nurse bank
	Increase capacity of wraparound care : model requirements and secure rapid access domiciliary care reablement and psychiatric liaison/mental health	**End Dec**	**Pete Gosling/ Ann Riley** **Gill Sydney**	• External procurement for long term rapid access Dom Care in place by mid Jan. Block contract approach - confirm additional capacity this will provide? • Changes to workforce to support short term dual role: rapid reablement / Dom care now available • Commenced monitoring of availability of care packages
	Commission additional bed placements agree criteria/need to inform model (e.g. support to assess) consider alternative providers (housing association) continue to work with private sector to build capacity invest in health and social care community teams and third sector to provide intensive support at home	**End Jan**	**Jacki Wilkes** **Kim Cundiff** **Neil Evans / Ann Riley**	• 16 of the 30 intermediate care/ assess beds secured • Utilise shortfall to fund other community support services e.g. intermediate care at home, additional primary care • NE has met with Peaks and Plains to explore options for additional capacity in supported accommodation. Possibility of short term 'assisted living' facility for people waiting for respite at home. • Cheshire East support requested - Ann Riley to speak to Sarah Smith regarding arrangements required for the assisted living capacity
Reduce delays in patient journeys by increasing 7 day working **SRO - Steve Redfern**	**Deliver the time to go home initiative** to increase discharge at the weekend by at least 20% and 50% more discharges before 1pm	**End Jan**	**Steve Redfern**	Update needed KS to determine the measures of success for this initiative
	Invest in Pharmacy to increase and extend capacity over 7 days to complete TTOs within 2 hours following decision to	**Dec 21**	**Kashif Haque**	Update needed

	discharge (Cross reference Care Homes)			
	Increase access to equipment Establish process improvements to expedite access to equipment	**End Dec**	**Debbie Burgess / Jo Allcock**	Update needed
	Transport - commission additional assistive transport to expedite discharge	**End Dec**	**Karen Burton**	Funding identified to support additional capacity. Trust to use local trusted taxi service
	Discharge led protocols in place for all patients	**End Dec**	**Steve Redfern / Kath Senior**	• Discharge- led Protocol in place for all patients • Update on progress needed • Spot audit planned for January?
Targeted support for Care Homes to reduce unnecessary admissions **SRO – Julia Curtis**	**Implement new respiratory protocols**	**End Dec**	**Karen Burton**	• Written and shared.
	Implement new respiratory protocols	**End Jan**	**Julia Curtis**	• Follow-up needed to ensure protocol understood and being followed • Review call data to residential care home from NWAS to identify residential homes for targeted support
	Implement new respiratory protocols	**18 Jan**	**Julia Curtis**	• Share protocols with residential homes and offer targeted support • Review call data to residential care home from NWAS to identify residential homes for targeted support
	Employ additional nursing and GP staff in targeted care homes to improve care and pull patients back from hospital following admission (cross reference 7 day working)	**End Jan**	**Julia Curtis**	• Offer to care homes with adequate staffing models and no quality/safeguarding issues to fund additional nursing time on weekends/bank holidays. The condition is that they receive new/existing patients OOH and undertake assessment on the day of request. Julia to work with Kate at CEC to identify homes • New respiratory protocols shared with care homes and to be overseen by care home GP • Limited response from care homes regarding additional support. Re issue invite in the new year
	Increase primary care medical services in care homes over winter. Target homes with high admission rates. Consider via AVS/	**Jan 15**	**Jacki Wilkes**	• Only One practice offered to open on weekend/bank holidays • ECCCG has identified funding for additional capacity in OOH

	increased visits OOHs		**Steve Redfern/ Kath Senior**	over the holiday period • ECT to advise on approach to increasing capacity in OOH • GP OOH approached to provide additional primary care during these days only but issues with rates of pay • ECT to determine the way forward • Unable to recruit additional capacity before New Year. Explore again in January

11.0 Access to Information

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

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Report

Agenda No.:

Report To:	**Cheshire East Overview and Scrutiny Committee**
Report Title:	**SRG non-recurrent funding Impact Assessment**
Meeting Date:	**14th January 2016**

Report Author(s)		**Governing Body Lead**	
Name	Sue Milne	**Name**	Tracy Parker-Priest
Title	Service Delivery Manager System Resilience	**Title**	Director Operations and Systems Management

CCG Strategic Priorities (5+1) supported by this paper	
Transforming Primary Care	✓
Transforming Mental Health	
Transforming Urgent Care	✓
Integration	✓
Person Centred Care	✓
NHS Constitution Targets	✓

Outcome Required	**Approval**		**Assurance**		**Discussion**		**Information**	✓

Recommendations:

The Overview and Scrutiny Committee are asked to:

1. Note the content of the paper.

Executive Summary (key points, purpose, outcomes)

Through the delegated authority of the Central Cheshire Strategic System Resilience Group (SRG) the Central Cheshire Operational System Resilience Group (ORG) produced and implemented the SRG plans to support system resilience in 2014/2015 and 2015/2016.

This report highlights the impact of the 2014/15 initiatives and the process for the implementation of the 2015/16 plans

Reviewed by (e.g. committee/team/director)	
Name (Individual or Group)	**Date**

Have the following areas been considered whilst producing this report?	Yes	N/A
Other resource implications		✓
Equality Impact Assessment (EIA)		✓
Health Inequalities (JSNA, ISNA)		✓
Risks relating to the paper		✓
Quality & Safeguarding (6 C's +1, CASE)		✓
Stakeholder engagement/involvement (member practices/GP Federations, patients & public, providers, LAs etc.)	✓	
Regulatory, legal, governance & assurance implications	✓	
Procurement processes	✓	

Glossary/Acronyms	
BRC	British Red Cross
CCG	Clinical Commissioning Group
CEC	Cheshire East Council Local Authority
CEO	Chief Executive Officer
CFO	Chief Finance Officer
CWAC	Cheshire West and Chester Local Authority
ECT	East Cheshire Hospitals NHS Trust
KPI	Key Performance Indicator
MCHFT	Mid Cheshire Hospitals NHS Foundation Trust
NHS	National Health Service
NHSE	NHS England
NWAS	North West Ambulance Service
PES	Paramedic Emergency Services
PTS	Patient Transport Services
REACT	Rapid Emergency Assessment and Community Therapies Team
SCCCG	NHS South Cheshire Clinical Commissioning Group
VRCCG	NHS Vale Royal Clinical Commissioning Group

1. Introduction

1.1. In 2014/2015 the System Resilience Group (SRG) for Central Cheshire, which covers the geographic area of NHS South Cheshire CCG (SCCCG) and NHS Vale Royal CCG (VRCCG), was allocated £3M in SRG Non-recurrent funding to support winter pressures.

1.2. In 2015/2016 the SRG was allocated £1.7M, of which NHS England mandated that funding should be used in April 2015 to support pressures over Easter. The funding remaining to develop plans for winter 2015/2016 was £1.4M.

1.3. This paper outlines the SRG's approach to reviewing the outcomes and impact of the 2014/2015 initiatives and how this supported the development of robust plans for 2015/2016.

2. Review of 2014/2015 SRG Initiatives

2.1. 33 initiatives were implemented by the Central Cheshire SRG in 2014/2015 (see appendix 1) from two NHSE funding announcements. Phase one was announced in July 2014, with Central Cheshire being awarded £1.7M, allowing time to plan and implement initiatives in advance of winter. Unprecedented demand and failure of the A&E 4 Hour Target across England and the UK led to a further allocation to SRGs in December 2014. For Central Cheshire SRG, this equated to £1.3M. Processes and governance developed for phase one were also used in deciding priorities for the phase two funding.

2.2. The initiatives put in place in 2014/2015 were given four areas to measure their success against, these were agreed by the ORG group as follows:

1. Recognised Impact on system
2. Cost for Impact
3. KPIs and outcomes
4. Avoided activity and costs

2.2.1. Recognised Impact on system

As a group, the ORG assessed each initiative against six key areas of impact, with a score of 1 (one) for each area, the six areas were:

- Delivers care closer to home
- Supports integrated working
- Improves patient experience
- Protects core hospital services
- Improves patient flow
- Supports 18 weeks elective activity

The maximum scored by any of the initiatives was 5 out of the 6, the only initiatives achieving this were the British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team and the YMCA Homeless support with Liaison Mental Health. Those scoring 4 were; Urgent Care Centre (UCC) weekend opening, additional Out Of Hours (OOH) Service capacity and Acute Visiting scheme, additional ambulance transport and the Rapid Care Service and additional social workers provided by the Local Authorities.

2.2.2. Cost for Impact

In 2014/15, the average investment per patient seen by an SRG initiative was £120. It is difficult to compare the costs per patient across different services and sectors of care, as a bed based service will cost fundamentally more than support delivered in a patient's own home by third sector partners with volunteers.

To allow comparisons on a more "like for like" basis, 3 graphs were used to group similar areas of service delivery to compare the cost per patient to the impact achieved (see 2.1.1).

The key used is as follows:

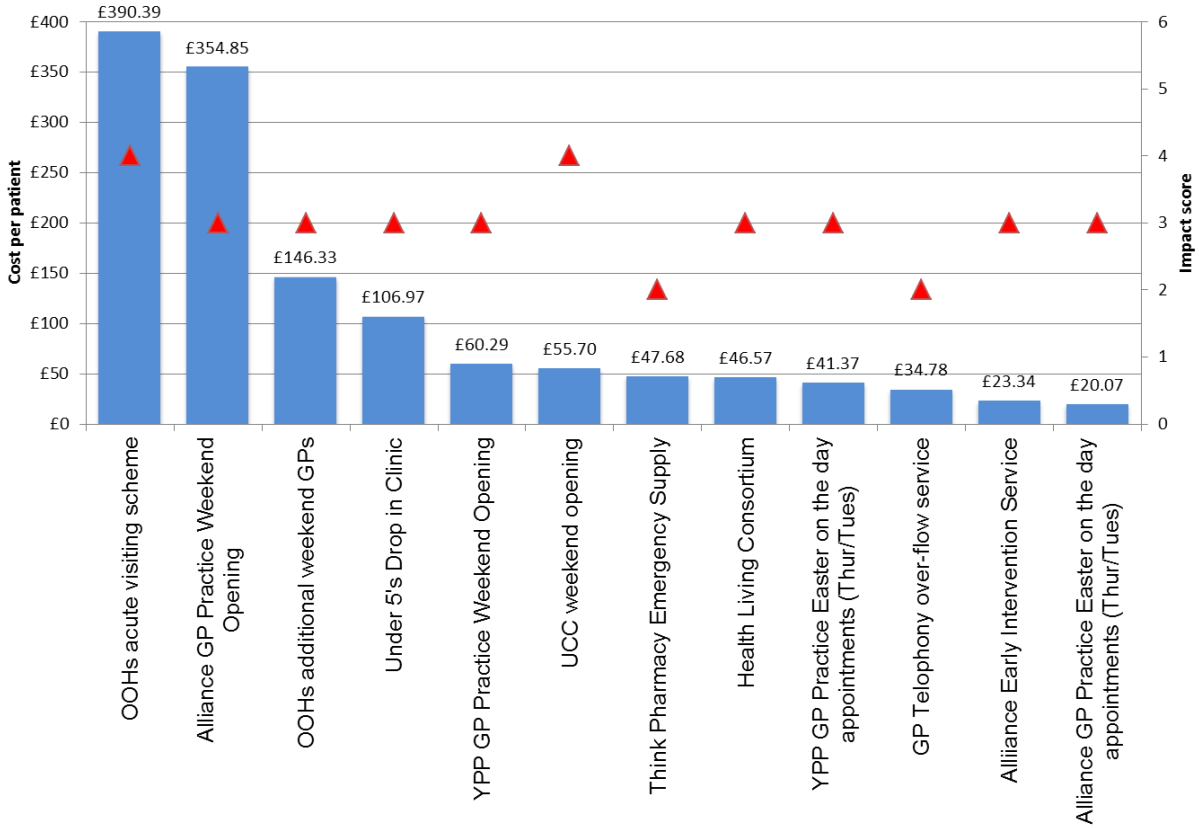
Cost per patient Impact

Admission avoidance/Emergency Department (ED) deflection

The 12 SRG initiatives reviewed for this area of the system have been included in Graph 1 (see below) were based either in the community, in primary care or on the front door of the ED at MCHFT.

The initiatives that stood out as being the most cost effective, delivering the greatest impact on reducing, or better management of ED attendances were:
the GP Alliance Early Intervention scheme (weekdays), the Healthy Living Consortium Home Support for at risk groups and the UCC weekend opening.

Graph 1: Admission avoidance/ED deflection



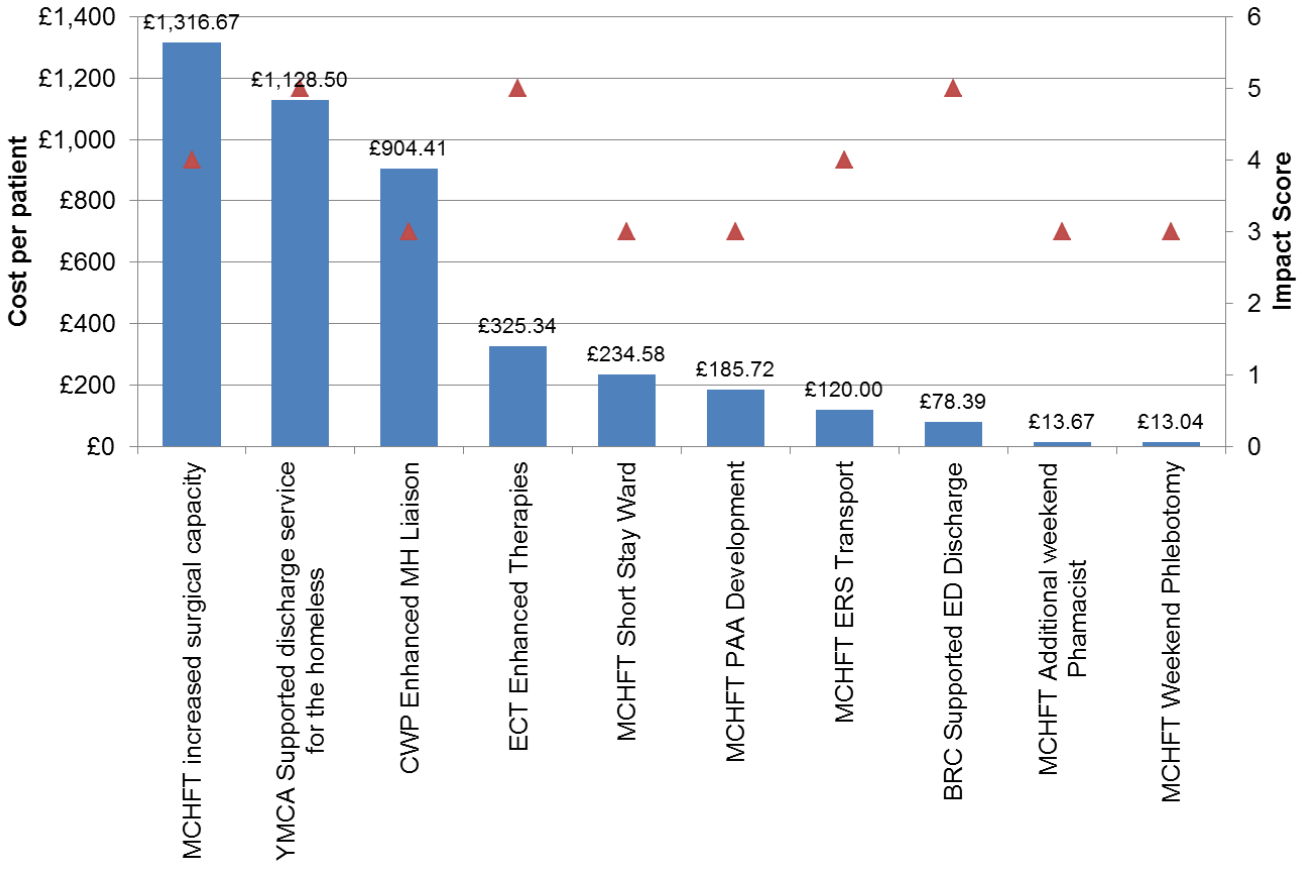
Hospital Patient Flow

The 10 SRG initiatives reviewed for this area of the system have been included in Graph 2 (see below) based on initiatives delivered within the ED and through the patient episode at the Trust.

The initiatives that stood out as being most cost effective and delivering the greatest impact on improving patient flow were: the YMCA Homeless support with Liaison MH, Rapid Emergency Assessment and Community Therapies (REACT) Team, the Short Stay Ward and Primary Assessment Area at MCHFT, British Red Cross Supported Discharge.

The additional pharmacists and phlebotomy, that both had a positive impact, have since been mainstreamed by MCHFT

Graph 2: Hospital Patient Flow

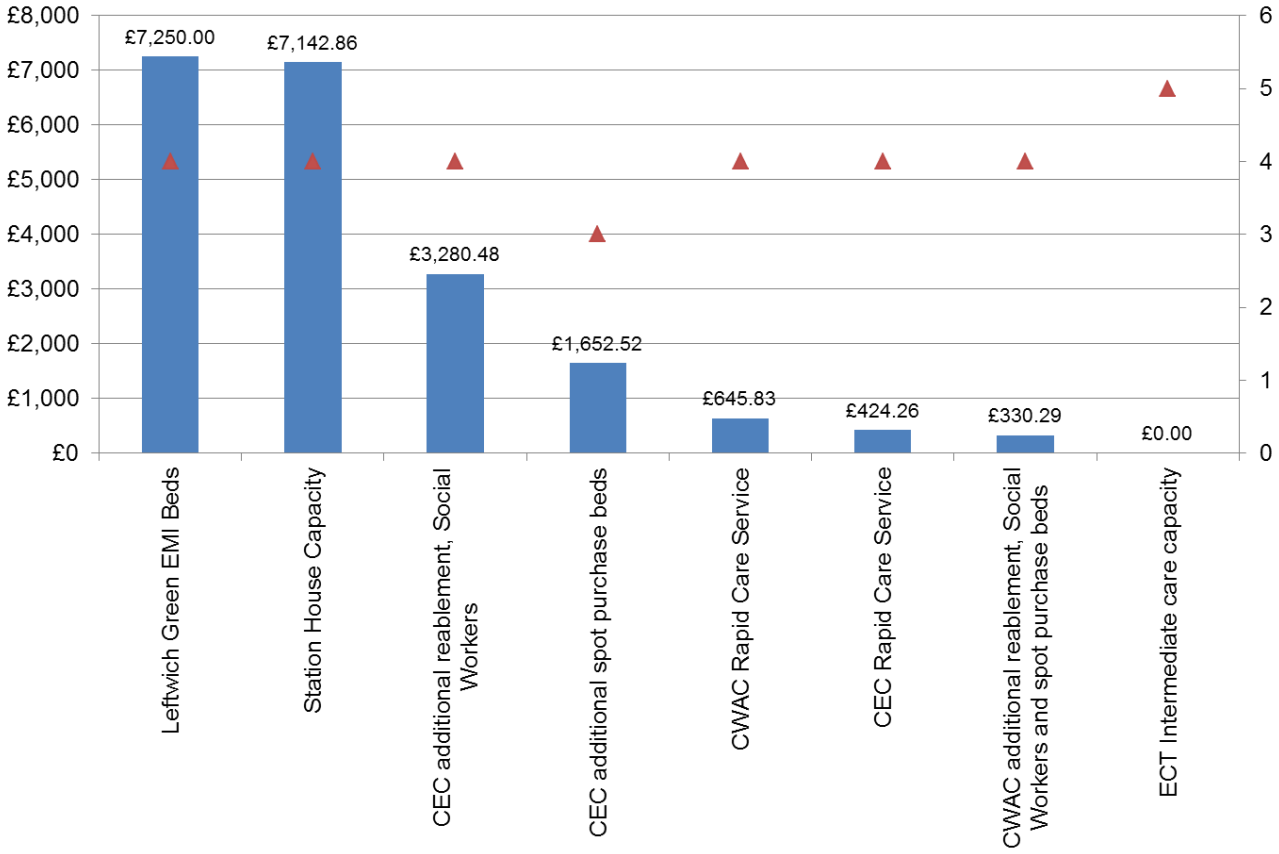


Discharge and Community Care

The 8 SRG initiatives reviewed for this area of the system have been included in Graph 3 (see below) and cover initiatives that delivered care within the community - the majority of which are bed based, or support patients at home who wouldn't otherwise have been able to be discharged home.

The initiatives that stood out as being the most cost effective and delivering the greatest impact on providing bed based care outside the Trust were:
the additional social workers, reablement beds and the Rapid Care Service provided by the Local Authorities. The Intermediate Care beds did not open in 2014/15.

Graph 3: Discharge and Community Beds



2.2.3. KPIs and Outcomes

Data was collated monthly from all providers to allow the ORG to measure:
where patients were seen by each of the initiatives
where they would have been referred to if the initiative had not been in place.

Across the 33 initiatives the following outcomes were achieved for our residents:

25,000 – People received additional care & support
4000 – People stayed at home or treated locally
1000 – People were supported home from the ED
3500 – People went home earlier

The initiatives that achieved the best outcomes for our patients were judged to be those that supported 500 people or more to either remain in their usual place of residence, or that helped then get home from hospital more quickly.

The initiatives showing the highest impact in these areas were:
The British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team, additional OOHs capacity, the GP Early Visiting scheme, additional social workers in the ED and Discharge team, additional pharmacist capacity, Short Stay Ward and PAA at MCHFT.

2.2.4. Avoided activity and costs

Costs avoided for each area were apportioned after some debate, but as all providers were reporting against the same criteria, if was felt the following criteria would ensure a fair review when comparing avoided costs across services and providers - the agreed costs can be seen in table one below:

Table 1: Agreed avoided costs by type

1	ED attendance avoided – minors	£57
2	ED attendance avoided – majors (of which 30% would be admitted)	£130
3	Admissions avoided (= av. 3 bed days)	£1500
4	Reduced LoS (= av. 3 excess bed days)	£900
5	Day of discharge – home support (= av. 1 excess bed day)	£300
6	Day of discharge – expedited prescribing (= av. 0.5 days)	£150

Based on the measures agreed above, it is estimated that 4155 Bed days were saved (over 20 a day) across all the initiatives and total avoided costs were estimated as c£5.5M against an investment by the SRG of £2.7M

The initiatives that achieved the highest level of avoided costs and reduced length of stay in the hospital, were judged to be those that supported 100 or more early discharges or avoided admissions from the Trust, the initiatives showing the highest impact in these areas were:
the British Red Cross supported discharge, the Rapid Emergency Assessment and Community Therapies (REACT) Team, the additional pharmacist in the Trust, OOHs Acute Visiting Scheme and the Rapid Care Service provided by the Local Authorities. The Short Stay Ward and PAA at MCHFT also had a positive impact

It was also agreed that the British Red Cross Supported Discharge initiative reduced a number of readmissions, many of the patients were referred into the Charity's Support At Home service who would not have previously been able to access it.

In addition, the Ambulance Trust Pathways initiative, which was not funded by SRG monies, was also seen as a success. Although the SRG chose not to continue the Acute Visiting Scheme with recurrent funding, it was agreed that GP practices and OOHs would continue to take calls from the ambulance crews to maintain "See and Treat" and the subsequent reduction in conveyancing of patients to the ED with a Primary Care need.

2.2.5. Summary by Impact

The following table (table two) indicates the initiatives with a recognised impact across the 4 areas as identified above:

Table 2: Initiatives and impact

Initiative	Recognised Impact on system	Cost for Impact	KPIs and outcomes	Avoided activity & costs	Comment
British Red Cross supported discharge	✓(5)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Rapid Emergency Assessment and Community Therapies (REACT) Team	✓(5)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Rapid Care Service provided by the Local Authorities.	✓(4)	✓	✓	✓	Achieved an impact in all four areas. The ORG believe this should be mainstreamed
Additional OOHs capacity and Acute visiting scheme	✓(4)	✓ if no AVS	✓	✓	Additional OOHs GP cost effective in own right and repeated in 15/16, but without the Acute Visiting Scheme (AVS). ORG added the AVS role to the GP early intervention scheme for 15/16.
GP early visiting scheme	✓ if inc. AVS	✓	✓	✓ if inc. AVS	
Trust Short Stay Ward		✓	✓	✓	Setting up and mainstreaming of the “fit to sit” ambulatory care area replaced this initiative in 2015/2016
Trust PAA		✓	✓	✓	GPs speak to the acute physician first. Trust mainstreamed in 15/16 with additional 1 WTE physician
Trust additional pharmacists		✓	✓	✓	Implemented recurrently by MCHFT
YMCA Homeless support with Liaison MH	✓(5)	✓			Achieved an impact in two areas as a niche service, should be repeated in 15/16, but ORG believe this should not be mainstreamed
UCC weekend opening.	✓	✓			Achieved an impact within the ED, should be repeated in 15/16, but ORG believe this should not be mainstreamed
Additional in hours ambulances	✓				
Trust extended Phlebotomy hours		✓			Implemented recurrently by MCHFT
Healthy Living Consortium home support		✓			Although cost per patient is low the service does not give the impact that BRC service is able to, the ORG believe this should not be mainstreamed

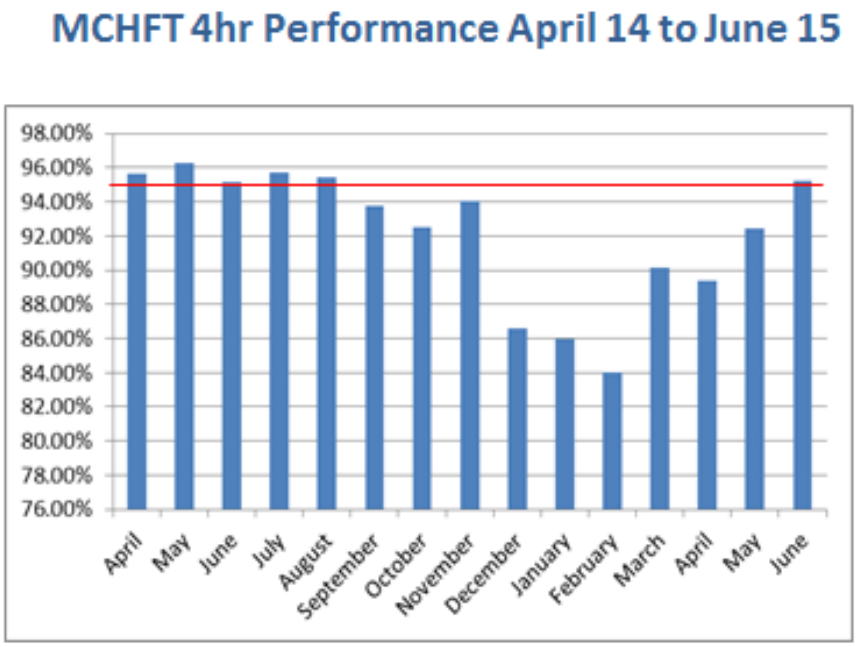
3. Review of 2014/2015 Performance

3.1. A&E performance

3.1.1. The A&E 4 hour target is the measure that is used by NHSE to benchmark the performance of individual SRG areas.

3.1.2. Performance in A&E across the UK in 2014/15 failed, across England A and E performance was 93%, for MCHFT, their performance was 92.26%. Attendances were up by 9% on 2009/10. However analysis of attendances shows that 50% of attendances in the UK either, had no treatment, or only required guidance and advice. Graph 4, below, indicates MCHFT performance by month between 1st April 2014 and 30th June 2015

Graph 4



3.2. Ambulance performance

3.2.1. Ambulance Trust performance is measured at a regional level, for North West Ambulance Service (NWAS), this covers a population of 7 million and 33 CCGs. NWAS failed the 8 minute performance target for both “Red 1” (where the call is immediately classed as a Red) and “Red 2” (where the call is classed as Red during the call) at regional level, Significantly, there is no statistical difference in patient outcomes between the attendance of an ambulance within 8 minutes and attendance in 19 minutes. Locally, NWAS attendance was achieved within an average of 8 minutes and 43 seconds.

3.2.2. SRG continue to work with NWAS to mainstream the referral of patients with a primary care need to the most appropriate service and also to develop further areas of support to help improve performance in Cheshire.

3.3. Winter deaths 2014/15

3.3.1. Excess Winter Deaths (EWD) is a marker of outcomes for patients over winter. The number of daily deaths in 2014/15 was above the five-year average throughout most of

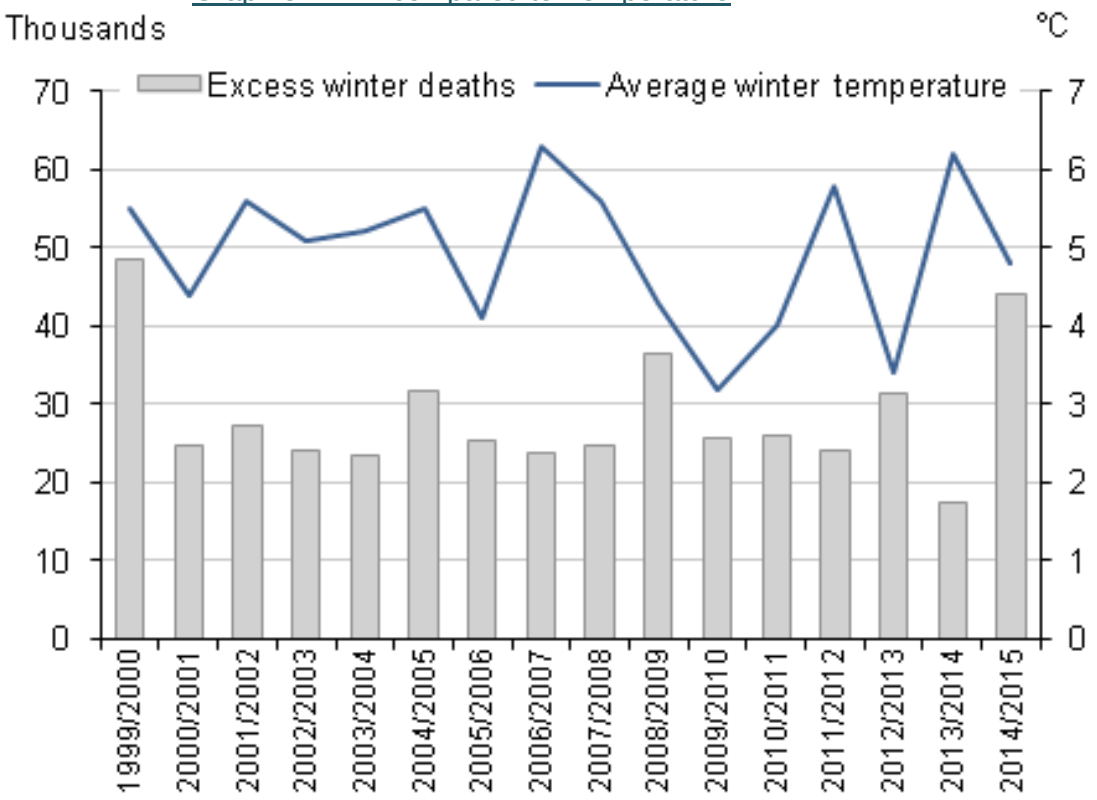
the year (on 304 out of 365 days). During the winter period, there were only 2 days where the number of daily deaths was below the five-year average.

3.3.2. In early December, the number of daily deaths began to climb noticeably higher than the five-year average. The number of daily deaths peaked on 1st January 2015, and remained about 30% above average until 10th January, and around 10% above average until early March.

3.3.3. Winter deaths in Cheshire East are 26% higher among people over the age of 85, compared to 17.2% for those aged 65 - 84 and 9.8% for those aged under 65. The equivalent figures for England are 24.4% for people over the age of 85, 15.1% for those aged 65 - 84, and 7.1% for under 65's.

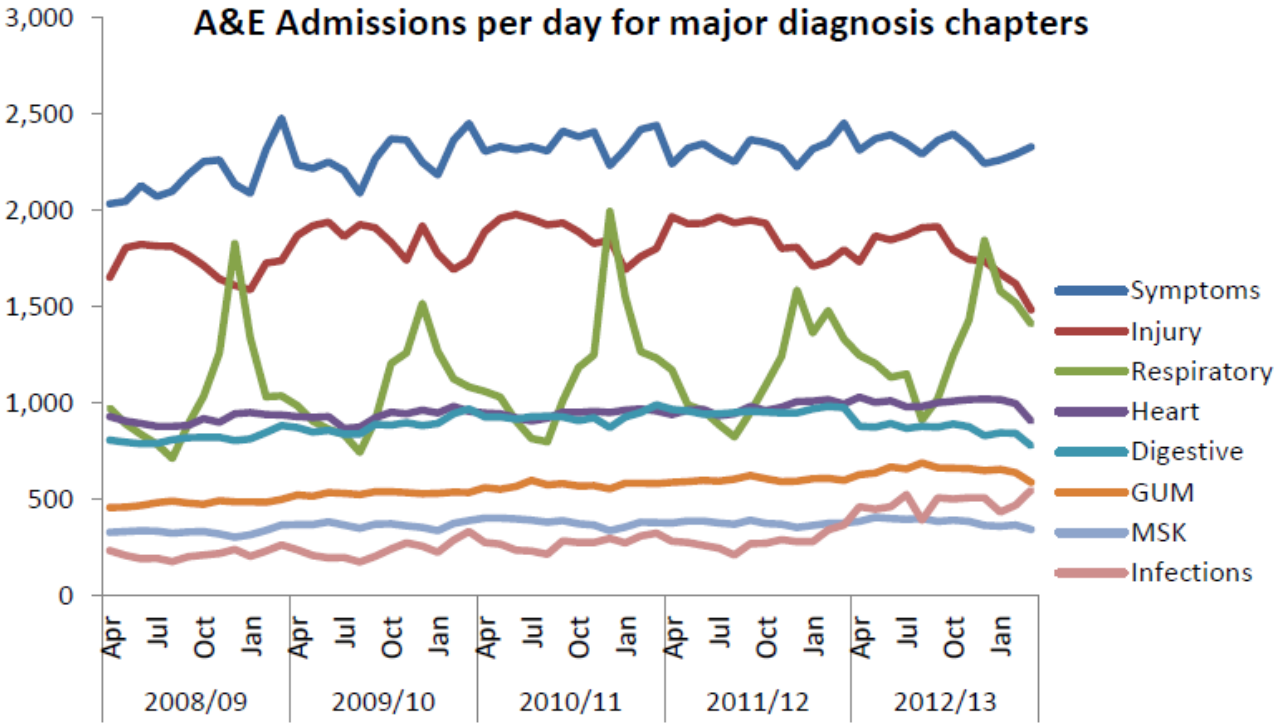
3.3.4. Although it is often thought the main cause of excess winter deaths is climate temperature, it is not the only factor affecting levels of mortality. Though climate temperature clearly is a factor, the link between average winter temperature and EWDs is very unclear in some years. For example, winter 2009/10 was exceptionally cold, but excess winter mortality (EWM) was similar to years with mild winters. In contrast, the higher number of EWDs in 2012/13 was likely to be due to cold weather, but it was the unusual pattern of a sustained cold from mid-January until early April, rather than just a cold January period, that influenced mortality. Graph 5 below compares temperature and EWDs.

Graph 5: EWD compared to Temperature



3.3.5. The risk of EWD is 55.9% higher locally for people who have respiratory disease and 22.3% higher for cardiovascular disease. As can be seen from the chart below, respiratory admissions peaks noticeably in winter.

Graph 6:NHS England data to 2012/13



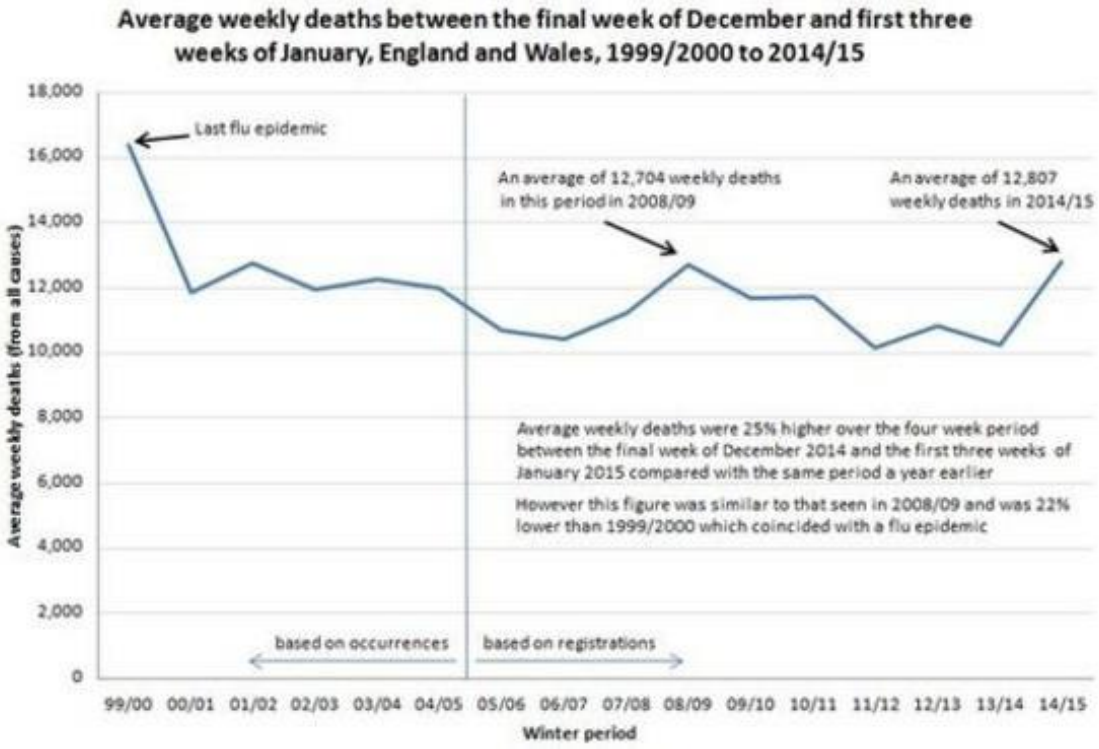
3.3.6. Admissions and deaths from respiratory disease peak when the UK has increased Influenza rates. Influenza infection is associated with potentially life threatening complications, such as bacterial pneumonia. The elderly, and those with underlying health conditions, are particularly at risk of developing complications (Public Health England, 2014b), which can result in hospitalisation and death (Public Health England, 2014c).

3.3.7. Respiratory disease is known to be one of the main causes of excess winter deaths (EWDs); for example in 2014/15, respiratory disease was listed the underlying cause of death for 36% of all excess winter deaths, with the majority of these deaths occurring in the 75+ age group. Pneumonia was the underlying cause in 19% of all excess winter deaths in 2014/15.

3.3.8. The predominant influenza virus in winter 2014/15 was influenza A(H3N2). This strain of flu had a particularly noticeable effect on the elderly, resulting in numerous care homes outbreaks and far higher levels of excess mortality than the last notable H3N2 season of 2008/09 (Public Health England, 2015). By comparison, in the previous winter of 2013/14 the predominant influenza virus was influenza A(H1N1), which was particularly virulent in younger people (Public Health England, 2014).

3.3.9. High levels of influenza occurred in 1999/2000 and were associated with a high level of mortality. In 2014/15 influenza-like illness rates rose above the epidemic threshold in week 50 and remained above or at that threshold until week 14 (Public Health England, 2015).

Graph 7: NHS England data to 2014/15



3.3.10. In conclusion, EWD were higher than average in 2014/2015; however they were in line with levels expected when there are high Influenza rates.

4. Post winter planning

4.1. The ORG have put in place an action plan to address areas of pressure in services that occur throughout the year, these areas of work support the ongoing delivery of the 8 high impact areas identified by NHS England, ADASS (Association of Directors of Adult Social Care), Monitor and the Trust Development Authority, the recommendations from the Tripartite visit to MCHFT in 2015 and other areas of best practice identified both regionally and nationally.

4.2. MCHFT have implemented initiatives that will support them in planning for these surges in demand, this included enhancing A&E, Short Stay and PAA protocols and processes and also the following actions have been implemented:

4.2.1. Senior decision making: additional consultants in A&E (5.0 whole time equivalent (wte) to 8.5wte) moving to 14 wte in future. This now provides A&E consultant cover 8.00am to 10.00pm every day. In addition, there are now 5.00 wte acute physicians who are able to provide cover over the same period 7 days a week.

4.2.2. Clinical support: the workforce review also increased nurse staffing on all medical wards and increased the number of nurse practitioners enabling cover in A&E to be extended to midnight every night , soon to be extended again to 2.00am every night.

4.2.3. New “Fit to Sit” Primary Ambulatory Care unit: opened on 1st October with 16 “beds”, to be extended in Jan by a further 16 beds. This is used for patients for up to 72 hrs with rapid discharge. This has a double impact : ensuring fast turnaround i.e. waiting for assessments after admission, all in one location within the hospital. It also minimises medical outliers e.g. in December 2015, week 2 - 1 medical outlier, this time last year circa 30. Impact is that zero length of Stay (LOS) has increased and current conversion rate in A&E is very high (40%) but A&E 4 hr standard is delivered.

4.2.4. Review of all long waiters: Clinical Peer review of all over 28 day stays. Formal review of all “over 14 day” LOS patients.

4.2.5. Admission avoidance: due to having additional acute physicians, no patient can be admitted to the Primary Ambulatory Unit (PAU) by a GP, unless the GP speaks to the acute physician first; this saves at least 3 admissions per day. This is the portal for all GP referrals

4.3. Availability of beds and care packages in the community to support discharges has also been a main area of issue throughout the year. Delayed Transfers of Care (DToCs) are currently running at 8% for the year against a national target of 2.5%. The level of delayed transfers of care indicates the performance of the health and social care discharge functions and community bed capacity.

4.3.1. Timely discharge of patients, particularly those over 75 is important for their outcomes. About 75% of patients who are ≥ 75 and functionally independent at admission are not functionally independent when they are discharged. Acute hospital care should last only long enough to allow patients to become medically fit for discharge. The outcome of hospitalisation is poorer with increasing age, although physiologic age is a more important predictor of outcome than is chronologic age. Outcomes are better for patients hospitalised because of elective procedures (eg, joint replacement) than for those hospitalised due to an emergency admission.

4.3.2. NHS England have provided the SRGs in Cheshire and Mersey with standardized score cards that compare Local Authority averages, As can be seen from the charts below the proportion of spend on residential and nursing care in Cheshire East (Chart 1) is lower than average, and the level of DToCs higher than average, while in Cheshire West and Chester (Chart 2) the opposite is evident, with a higher proportional spend and a lower level of DToCs.

Chart 1: Cheshire East Council

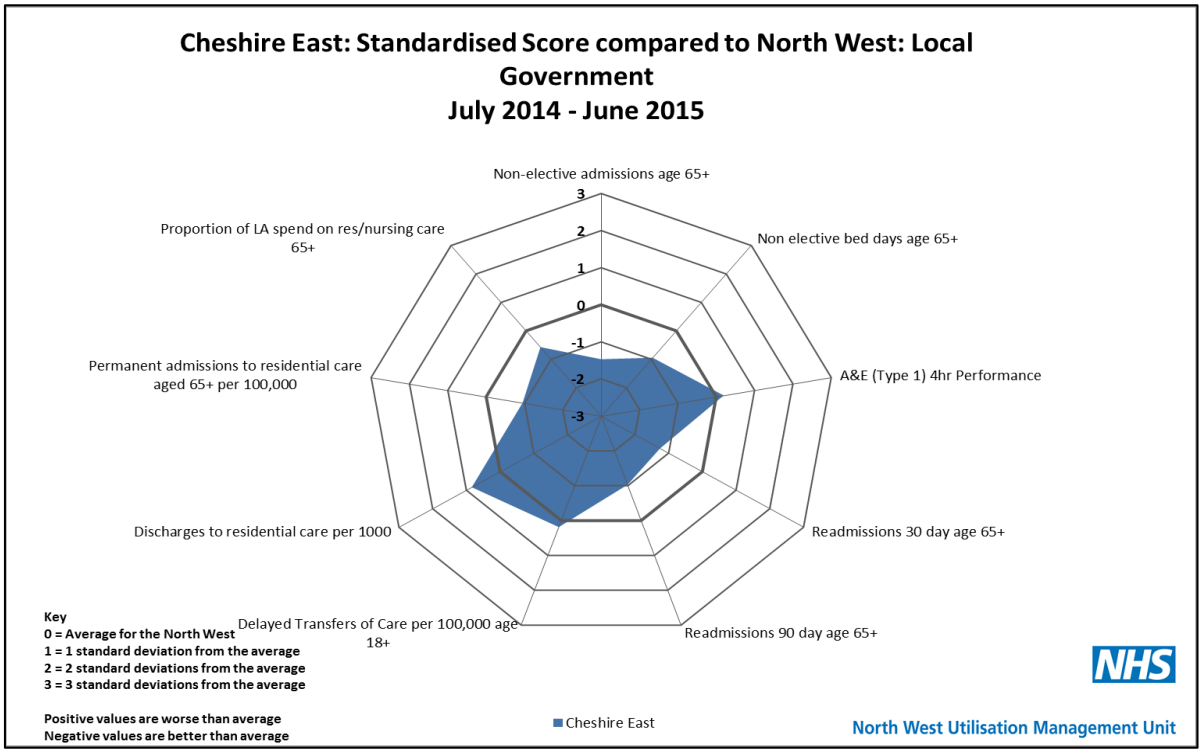
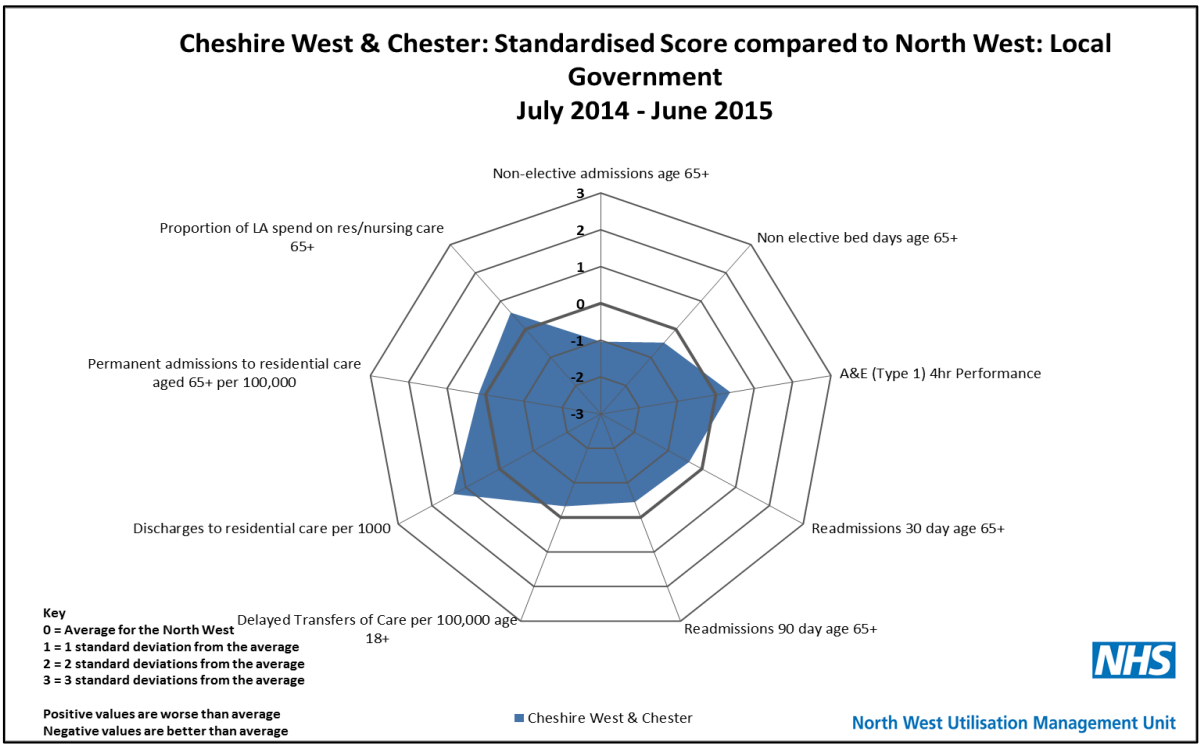


Chart 2: Cheshire West and Chester Council



5. Approach to SRG Planning 2015/2016

5.1. The SRG was allocated £1.7m by NHSE for 2016/2015.

5.2. However, due to the pressures that continued within the system during Quarter 1 2015/16, NHSE mandated that the SRGs should fund the successful 14/15 winter initiatives to the end of April 2015. This requirement took £287k of funds from the SRG budget for winter 15/16, (see breakdown below):

Table 3: Mandated investment April 2015/2016

Organisation	Initiatives	£
MCHFT	Additional ED Staffing	£38.3K
MCHFT	16 beds - ward 12	£71.5K
MCHFT	PAA overnight & weekends	£61.1K
MCHFT	ST3 Discharge Dr at weekends	£4.0K
MCHFT	SAU	£26.9K
MCHFT	Pharmacy TTOs	£0.5K
MCHFT	Reduced Medicine capacity	£4.8K
MCHFT	UCC	£2.4K
ECT	GP OOHs additional weekends	£16.5K
ECT	Enhanced Therapies	£43.2K
ECT	Station House IC staffing	£14.1K
CEC	Social Worker	£2.0K

CWAC	Social workers	£2.0K
TOTAL		**£287.3K**

5.3. To mitigate against the shortfall of funding in 15/16, the ORG developed an approach to developing plans in 2015/2016 - three task and finish groups were established to work jointly on three specific work streams.

- Avoidance of attendances and admissions to hospital
- Improved flow within the acute trust
- Integrated supported discharge and community care

Each group was allocated £400k and a lead from the providers was identified for each group, stakeholders from all SRG partner organisations were members of each group.

5.4. Each group was asked to address:

- The key areas of development discussed for each work stream at the June ORG (based on the performance of the previous winter initiatives)
- The areas of work identified for their group within the eight high impact areas as highlighted by NHSE
- The areas of work identified for their group from the report produced by Ian Sturgess for UHNM (University Hospital of North Midlands).
- Identify initiatives and solutions that could be delivered at no cost
- Not to include any bed based services. An additional SRG Task and Finish group had already been established earlier in the year to review community bed provision and develop proposals for the local health and social care economy

5.5. All local organisations were involved in the decisions for which initiatives would be implemented in 2015/2016 and developed balanced proposals that were ratified by the SRG.

5.6. Table four below shows the initiatives agreed for 2015/2016:

Table 4: 2015/2016 Initiatives

	Organisation	Initiatives	£
Group 1 Attendance and Admission Avoidance	GP Alliance	Rapid response from Primary care	£330k
	OOHs	OOHs enhanced capacity	£60k
	NWAS	NWAS Pathfinder/direct conveyancing	£0
	CCG	Implementation of MIG for EPACCS/EOL	£25k
	BRC	Patient Transport to support Primary Care	£25k
Group 2 Hospital Patient Flow	MCHFT	ED additional Staffing	£195k
	ECT & MCHFT	Enhanced therapy provision (REACT)	£214k
	MCHFT	UCC Weekend and evening opening	£78k
	MCHFT	Additional weekend medical cover	£27k
	CEC	Acute Social Workers	£66k
	CWaC	Acute Social Workers	£44k
	CCG	Community Bed Bureau	£50k

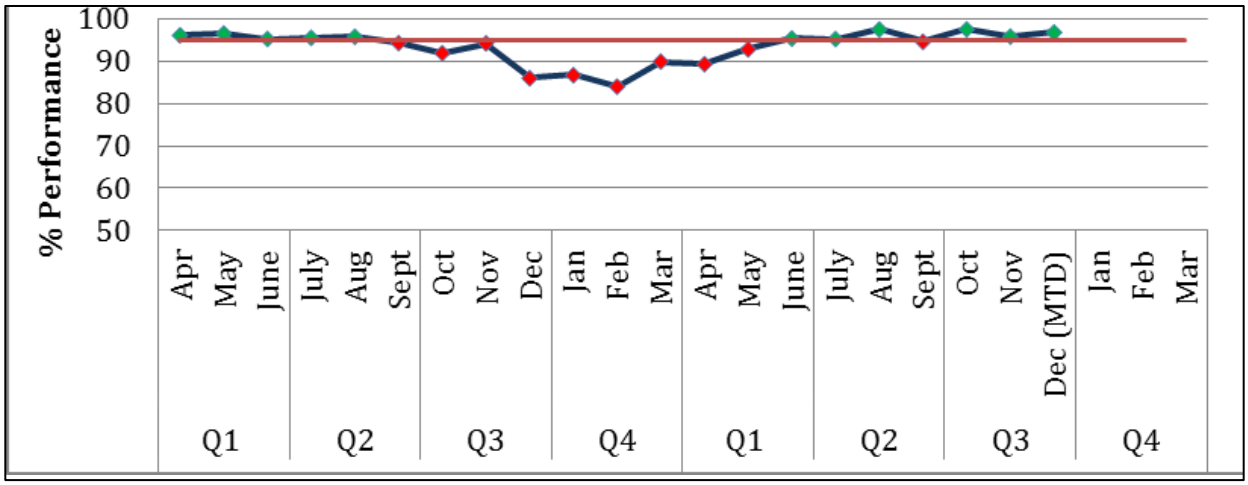
Group 3 Supported Discharge and Community Care	BRC	Enhanced discharge from wards and ED	£130k
	BRC	Enhanced home support	£35k
	ECT & MCHFT	Enhanced therapy provision	£45k
	CEC	Rapid Care Service	£162k
	CWaC	Rapid Care Service	£108k
TOTAL			**£1595K**

6. Current performance

6.1. MCHFT met the four hour access standard in 6 of the last 9 month and all three months in Quarter 3 (Q3) with December reporting 96.3%, November 95.72% and October 97.41% giving a Q3 position of 96.4%. The trust are currently the highest performing acute trust in Cheshire and Mersey.

6.2. Overall performance year to date currently stands at 94.89%, narrowly missing the target due to poor performance in April and May 2015 and a dip, marginally under at 94.6%, in September.

Graph 8: MCHFT 4hr performance as at 8th Dec 2015



6.3. It is felt that the SRG initiatives put in place during October and November have gone some way to achieve the improved performance; however the additional beds and the fit to sit area implemented by MCHFT, which are not funded by the SRG, have also ensured that the target is met by increasing bed capacity at the trust.

6.4. Additional community capacity was not implemented through SRG funding. An SRG Task and Finish Group have looked at community capacity and opportunities for increasing bed numbers in the community to reduce the number of DToCs, which will be key to freeing up beds within the trust and the achievement of the p4hr target in Quarter 4 (Q4) 2015/2016.

7. Summary

7.1. The processes undertaken in developing plans for both non-recurrent SRG funding in 2015/2016 and in year development work are seen as being innovative by NHS England. NHSE are

following the work of our SRG closely and have shared some of the initiatives and work undertaken as best practice across the North West.

7.2. Functionally this has been achieved by the setting up groups at two levels; the Strategic SRG, meets monthly and is attended at Chief Executive and Executive Director level and the Operational SRG which is attended at Director and Senior Manager level meets two weeks after allow rapid escalation or delegation of issues between the two groups, in summary:

- The Strategic SRG provides a clear direction of travel and fully supports and engages with any issues that are escalated by the Operational SRG.

- The Operational SRG has a hands-on approach to developing plans and addressing issues that can be quickly escalated to the Strategic group, which provides access to senior support to enable implement and

7.3. Overall the Central Cheshire SRG is recognised by NHS England as a high performing SRG that proactively and successfully manages the challenges and surges in demand through effective partnership working - partner organisations should acknowledge and recognise the contribution that their representative members have made to achieving this recognition.

8. Appendices

APPENDIX 1: 2014/15 Initiative Summary

Bid No	Initiative	Actual cost of initiative £	Total No Patients supported	Actual Cost per patient	Avoided cost (see full performance reports for detail)	Diff between actual cost and avoided costs
001	Health Living Consortium	£60,540	1300	£46.57	£111,608	-£51,068
004	BRC Supported Discharge	£68,903	879	£78.39	£380,950	-£312,047
005	CEC Rapid Care Service	£28,850	68	£424.26	£71,400	-£42,550
019	OOHs Acute Visiting Scheme	£144,835	371	£390.39	£977,250	-£832,415
020	Additional OOHs weekend cover	£59,997	410	£146.33	£108,507	-£48,510
025	ECT Enhanced Therapies	£203,987	627	£325.34	£745,041	-£541,054
036	MCHFT Weekend Phlebotomy	£3,600	276	£13.04	Difficult to Quantify	N/A
037	MCHFT Enhanced ED Staffing	£20,700	?	?	Difficult to Quantify	N/A
038	MCHFT Short Stay Ward	£194,000	827	£234.58	£193,900	£100
039	MCHFT PAA Development (16 beds)	£463,000	2493	£185.72	£1,062,500	-£599,500
040a	MCHFT ST3 at Weekends	£0	0	£0.00		N/A
040b	MCHFT Additional weekend Pharmacist	£9,200	673	£13.67	£235,550	-£226,350
041	MCHFT increased surgical capacity	£158,000	120	£1,316.67	£0	£158,000
042	UCC weekend opening	£31,636	568	£55.70	£47,895	-£16,259
044	Think Pharmacy Emergency Supply	£3,528	74	£47.68	£2,590	£938
049	Leftwich Green EMI Beds	£116,000	16	£7,250.00	£166,400	-£50,400
051	CWAC Rapid Care Service	£62,000	96	£645.83	£101,500	-£39,500
100	CWAC additional reablement, Social Workers and spot purchase beds	£196,192	594	£330.29	£259,750	-£63,558
101	CEC additional reablement, Social Workers	£68,890	21	£3,280.48	£22,050	£46,840
102	CEC additional spot purchase beds	£38,008	23	£1,652.52	£33,600	£4,408
200	Under 5's Drop in Clinic	£29,630	277	£106.97	£83,649	-£54,019
201	Alliance Early Intervention Service	£330,400	14157	£23.34	£439,738	-£109,338
205	GP Telephony over-flow service	£3,617	104	£34.78	Not reported	N/A
301	NWAS Green Care	£45,474	??	??	Not reported	N/A
400	CWP Enhanced MH Liaison	£123,000	136	£904.41	£87,380	£35,620
401	YMCA Supported discharge service for the homeless	£9,028	8	£1,128.50	£19,472	-£10,444
501	Proactive Comms Newspapers/radio	£6,851	??	??	Difficult to Quantify	??

502	Station House Capacity	£50,000	7	£7,142.86	£7,350	£42,650
505	MCHFT ERS Transport	£3,600	30	£120.00	£10,500	-£6,900
999a	Alliance GP Practice Easter Weekend Opening	£35,840	101	£354.85	£6,060	£29,780
999b	Alliance GP Practice Easter on the day appointments (Thur/Tues)	£22,400	1116	£20.07	£270,327	-£247,927
999c	YPP GP Practice Easter Opening	£4,160	69	£60.29	£4,140	£20
999d	YPP GP Practice Easter on the day appointments (Thur/Tues)	£9,680	234	£41.37	£54,952	-£45,272

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Mid Cheshire Hospitals NHS
NHS Foundation Trust

Report

Agenda No.:

Report To:	Health and Adult Social Care Overview and Scrutiny Committee
Report Title:	Hyperacute Stroke Pathway for South Cheshire and Vale Royal Patients
Meeting Date:	14 January 2016

Report Author(s)	
Name	Tony Mayer
Title	Divisional General Manager, Mid Cheshire Hospitals NHS Foundation Trust

Glossary/Acronyms	
CCE	Clinical Commissioning Executive
CCG	Clinical Commissioning Group
MCHFT	Mid Cheshire Hospitals NHS Foundation Trust
UHNM	University Hospital of North Midlands
COCH	Countess of Chester NHS Foundation Trust
FAST	Face, Arms, Speech, Time
NWAS	North West Ambulance Service
NICE	National Institute of Clinical Excellence
TIA	Transient Ischaemic Attack

Outcome Required	**Approval**	✓	**Assurance**		**Discussion**		**Information**	✓

Recommendations:

The Health and Adult Social Care Overview and Scrutiny Committee are asked to:

- Note the report following the service review and approve progression with the proposed option described in the report. The recommended option being that MCHFT and UHNM combine the stroke services within a collaborative model of care, with patients retaining primary support and diagnosis at MCHFT after which, where appropriate, 24-72 hours of intensive stroke support will be provided at UHNM with repatriation back to MCHFT when the patient is sufficiently recovered.

- Support the continuation of this work until its conclusion. MCHFT and UHNM will develop a proposal for the new service provision in January 2016, with a planned implementation of the service by 1 April 2016. This will include a full financial impact and a clear communication plan that can be used to inform local clinicians and the public of the changes.

Executive Summary (Key points, purpose, outcomes)

The current arrangements at MCHFT for Hyperacute Stroke patients is unsustainable due to revised clinical standards and an inability to recruit to a sufficient number of senior clinical posts.

In order to address the current issues, service design options have been discussed extensively between provider organisations, the two relevant CCGs and the Stroke Regional Network over the past 12 months.

A number of options have been reviewed and discounted during these discussions with a final proposal agreed by the Joint CCG Clinical Commissioning Executive group on the 10 December 2015.

The proposal is for a collaborative working arrangement between UHNM and MCHFT that provides 7 day consultant cover for newly diagnosed strokes, whilst retaining the benefit of local access to clinical interventions where time to treatment is an important factor in patient outcomes.

The new arrangement will mean that patients who would previously have been an inpatient at Leighton hospital for the full duration of their stay will now spend the first 24-48 hours of their stay at UHNM.

Overview Summary of Stroke Clinical Standards

Stroke is the fourth single largest cause of death in the United Kingdom and second in the world. By the age of 75, 1 in 5 women and 1 in 6 men will have a stroke. 1 in 8 strokes are fatal within the first 30 days and 1 in 4 strokes are fatal within a year (Stroke Association, 2015).

There is a growing evidence base to demonstrate that the outcomes for stroke patients improve if the first 72 hours of care (known as hyperacute care) are delivered according to stroke clinical standards set out in:

- Stroke Strategy (2007)
- NICE Stroke Quality Standards (2010)
- NICE guideline 68 – Diagnosis and initial management of acute stroke and transient ischaemic attack (TIA)
- NICE Technical Appraisal No 264 - Alteplase for the treatment of acute ischaemic stroke
- Royal College of Physicians (RCP) National Clinical Guideline for Stroke (2012)

The clinical standards set out in each of these documents are consistent for care of patients with stroke for the first 72 hours and are as follows:

- People seen by ambulance staff outside hospital, who have sudden onset of neurological symptoms who screen positive using a validated tool* and who have a possible diagnosis of stroke, are transferred to a specialist stroke unit within 1 hour.

  *FAST – face-arm-speech-test or ROSIER – an assessment used in the emergency room to recognise stroke.

- Patients with acute stroke receive brain imaging within1 hour of arrival at the hospital if they meet any of the indications for immediate imaging.

- Patients with suspected stroke are admitted directly to a specialist stroke unit and assessed for thrombolysis, receiving it if clinically indicated.

- The recommended drug for treating acute ischaemic stroke (stroke caused by a blood clot rather than bleeding into the brain) in adults is Alteplase (a drug that dissolves blood clots). In adults, if treatment is started as early as possible, within 4.5 hours of onset of stroke symptoms, it has been reported that for every 1,000 patients treated with thrombolysis within three hours, about 100 more will be alive and live independently than 1,000 patients not treated with thrombolysis (Stroke Association 2015).

- Patients with stroke are assessed and managed by stroke nursing staff and at least one member of the Specialist Rehabilitation Team within 24 hours of admission to hospital and a ward round undertaken by a Stroke Consultant 7 days per week.

Current Service Provision at MCHFT

All patients with suspected stroke are admitted through the A&E department. If arriving by ambulance there will usually be a 'standby' notification. Once A&E is aware of the stroke arrival the stroke specialist nurse is notified. A ROSIER score is completed by the A&E team and if patients are suitable, rapid assessment is undertaken for delivery of thrombolysis. This is usually delivered in the A&E department before movement to the acute stroke unit.

Patients who are not suitable for thrombolysis are preferentially admitted directly to the acute stroke unit or the acute medical assessment unit.

The Thrombolysis Service is available Monday-Friday, 9am – 9pm. Patients arriving out-of-hours who are suitable for thrombolysis will be discussed with the Stroke Team at Royal Stoke University Hospital and appropriate transfer will be arranged.

Once on the stroke ward patients are admitted to the Acute Stroke Bay and commence 72 hours of physiological monitoring. Swallowing assessments are performed by nursing staff on the wards who have been trained to perform this. Once stable patients are moved to the rehabilitation section of the unit, to continue their care.

There is a consultant ward round 5 days a week in the acute stroke unit. There are twice consultant ward rounds a week for the patients in the rehabilitation ward.

Rehabilitation needs are provided on the combined unit and as of December 2014 a stroke Early Supported Discharge team has been in place to provide continued rehab in a community setting.

External Review of Current Service at MCHFT

Dr Deborah Lowe (Clinical Lead for Regional Stroke Network) provided the following assessment of the service currently provided at MCHFT:

Dr Salehin and his colleague work extremely hard to sustain a hyperacute stroke service at the Trust. It is clear however with the developments in hyperacute care over the last 2 years that the service falls short in some areas, mostly due to manpower issues in terms of Consultant support to provide the service. Of concern is the possibility that Royal Stoke University Hospital will no longer be able to support the out of hour's telephone advice unless the two Consultants at Leighton are able to input into the rota. This would mean that all patients out of hours would need to be directly transferred to Royal Stoke University Hospital for their acute stroke care.

The potential models that would address the current issues rely on partnership arrangement with neighboring trusts and could be:

i. All hyperacute stroke care is delivered at Leighton. In hours the thrombolysis rota is supported by the two stroke physicians. Out of hours and at weekend the rota is supported by the resident A&E Senior medical staff (consultant or middle-grade) at Leighton with telephone advice from the regional thrombolysis consultant on call (1:14). The Leighton consultants don't currently input into this rota as they are required to participate in the 1:12 General Medical on call rota.

ii. All thrombolysis / hyperacute care delivered at Royal Stoke University Hospital with repatriation after hyperacute care complete.

The main issues that need addressing from an SCN prospective following the Gap Analysis for the initial Stroke Summit in July 2014 and subsequent follow up Gap analysis in January 2015 are:

- Plans for hyperacute services to be delivered at Leighton 24/7 are not sustainable when compared to other services both regionally and nationally
- There are only two stroke consultants (one consultant for 30% of the year when leave taken into account) to cover 28 bedded combined stroke unit, a 32 bedded elderly care ward and a 24 bedded general rehabilitation ward. A third consultant (Dr Garcia-Alen), share beds in stroke rehabilitation unit and elderly care ward but not in general rehabilitation ward
- There is no provision currently for 7 day ward round of the acute stroke unit
- Consultants are currently unable to commit to supporting the regional thrombolysis rota as they already do a 1:12 general medical on call rota and an additional morning weekend rota which means there are two consultants available. There is also a large bed base to cover
- There is no provision for a weekend TIA service in this model however the hospital is currently managing this in collaboration with UHNM.

Service Re-design Proposal

In December 2014 a Stroke Pathway Group was formed to review the options for delivering a sustainable and effective Hyper cute and acute stroke service for patients within South Cheshire and Vale Royal. A number of options were reviewed by the group leading to the approval of a final proposal at the SC and VR Clinical commissioning executive group on 10th December 2015.

Service Considerations

The proposal was made with consideration to:

- Transport links between Crewe to COCH & Crewe to UHNM
- Data analysed to ascertain true numbers of patients presenting with stroke mimic symptoms
- Availability of thrombectomy service within UHNM & COCH
- Impact on NWAS repatriating stroke mimic patients
- Impact of NWAS vehicle being out of area and then unable to return
- Transfer time in cases where patient needs thrombolysis
- Current NWAS arrangements whereby patients are already taken to the nearest hospital from the incident
- "Stronger Together" working relationship between MCHFT and UHNM.

Revised Pathway Proposal

- FAST positive patients in the locality attend MCHFT.
- Patients are assessed and diagnosed at MCHFT with under the clinical management of a Stroke Consultant at UHNM.
- Thrombolysis administered at MCHFT when appropriate
- All patients (where appropriate) with a stroke diagnosis then transferred to UHNM.
- Non Stroke patients remain at MCHFT
- Stroke patients repatriated to MCHFT following hyperacute phase

Benefits of Proposed New Pathway

- All patients will have access to a 7-day dedicated stroke service
- Reduced stroke onset to needle time
- Stroke mimics would remain at MCHFT
- Definitive pathway for patients, clinicians and NWAS 24/7
- In line with "Stronger together" partnership agreement with UHNM
- 24/7 access to full tertiary additional services including Thrombectomy at UHNM without the need for second transfer
- Better working relationships with one external team
- Reduced ambulance transfers
- Development of MCHFT staff delivering assessment and thrombolysis
- Reduced complexity of single partner arrangements

Conclusion

The Stroke working group comprising of representatives from UHNM, MCHFT, CoCH, NWAS and the 2 CCGs believe that the amended pathway is an improvement on previous proposals and improves patient care and outcomes not just for stroke patients but for those patients who are initially seen to be a potential stroke and subsequently diagnosed with a different condition.

Next Steps

Following approval to proceed with the revised option, the stroke working group will continue with the ongoing work to review the clinical pathway, the staffing arrangements and the financial implications of the new pathway. Discussions have been had with UHNM to confirm that they have the ability to deliver the service and the appropriate infrastructure to accommodate the additional inpatient demand. Key work streams have been developed to address the following required action points

- Stroke pathway for MCHFT / UHNM to be modified to reflect new ways of working
- Analysis of current staffing establishment for ward 6 at MCHFT
- Identification of nurse availability to provide 24 hour cover to ED for patients FAST +ve
- Training analysis for medical & nursing staff
- Promotion of new ways of working, communication to staff
- Evaluate impact on NWAS
- Bed management model ensuring protection of repatriation availability
- Engagement of bed management team to ensure timely transfers & repatriation
  Infection control engagement inter-hospital transfer protocols

The group will need to develop robust documentation to support the new pathway and aim to have this in place and the service established by the **1st April 2016**.

Recommendations:

The Health and Adult Social Care Overview and Scrutiny Committee are asked to:

- Note the report following the service review and approve progression with the proposed option described in the report. The recommended option being that MCHFT and UHNM combine the stroke services within a collaborative model of care, with patients retaining primary support and diagnosis at MCHFT.

- Support the continuation of this work until its conclusion. MCHFT and UHNM will develop a proposal for the new service provision in January 2016, with a planned implementation of the service by 1 April 2016. This will include a full financial impact and a clear communication plan that can be used to inform local clinicians and the public of the changes

Agenda Item 9

CHESHIRE EAST COUNCIL

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

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Date of Meeting: 14 January 2015
Report of: Democratic Services
Subject/Title: Work Programme update

1.0 Report Summary

1.1 To review items in the 2014/15 Work Programme, to consider the efficacy of existing items listed in the schedule attached, together with any other items suggested by Committee Members.

2.0 Recommendations

2.1 That the work programme be reviewed and updated following actions from the meeting and other amendments.

3.0 Reasons for Recommendations

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

4.0 Wards Affected

4.1 All

5.0 Local Ward Members

5.1 Not applicable.

6.0 Background and Options

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

6.2 Following this meeting the document will be updated so that all the appropriate targets will be included within the schedule.

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

- Does the issue fall within a corporate priority

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

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

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

7.0 ***Access to Information***

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

Name: James Morley
Designation: Scrutiny Officer
Tel No: 01270 686468
Email: james.morley@cheshireeast.gov.uk

Essential items

Item	Description/purpose of report/comments	Lead Officer/ organisation	Suggested by	Current position	Key Dates/ Deadlines
Implementation of the Care Act 2014	Committee offered the opportunity to take part in co-design of new service and delivery models for care	Brenda Smith Sarah Smith	Brenda Smith	Committee accepted invitation to take part. Work to be scoped	TBA
Adult Social Care Provider Fees	Committee offered the opportunity to take part in the review of delivery models for domiciliary and residential care in future	Brenda Smith Dominic Oakeshott	Brenda Smith	Committee accepted invitation to take part. Item deferred by Cabinet until Feb	TBA once Cabinet decision is made
Public Health Funding	To receive a briefing on the future of funding for Public Health and consider the potential impact on services and health outcomes	Heather Grimbaldeston	Heather Grimbaldeston	Committee agreed to receive report	TBA
Ambulance Services	Committee wishes to hold a workshop with NWAS and partners to consider improving ambulance services in CE	NWAS CCGs	Committee	Stakeholders contacted regarding involvement	Provisional 19 February meeting In Crewe
Access to GPs and GP Services	To consider the level of access and range of services provided by GPs across the Borough with a view to promoting greater access and reducing health inequalities- also to include pharmacies, recruitment of GPs and nurse specialists.	GPs/NHS England CCGs Healthwatch	Chairman	Healthwatch CE is currently conducting a piece of research into GP access. This will inform the Cttee's direction	On hold 20 January 2016 Healthwatch CE is holding a event to publish its Report
Pharmacies	Potentially to be considered alongside GP Access	HG, CCGs, NHSE	Committee		On hold
East Cheshire NHS	To examine the CQC's report and	East Cheshire	Scrutiny Officer	Provider and	Provisional 11

Trust CQC Report	reasons for rating of "requires improvement" with the Trust and to hear what action has been taken	NHS Trust		commissioners contacted regarding meeting	March 2016 meeting In Macclesfield
Developing the Roles of Social and Private Landlords in Health and Wellbeing	To facilitate a discussion with partners about developing the role of social and private landlords in improving/maintain health and wellbeing and reducing health inequalities. Workshop was held on 8 Jan 2015. Summary report was written and sent to attendees. Possible follow up workshop involving more private landlords	Council CCGs RSLs James Morley/	Committee	Consideration has been given to the role of the committee in relation to housing at Corporate Scrutiny. Potential future work involving JRA and CommunitiesCttees	TBA
Maternity Services at local hospital trusts – Kirkup Report	Following the Kirkup Report into incidents in maternity services in Morecambe all trusts were recommended to review their maternity services and committee is recommended to discuss with local trusts	East Cheshire Trust and MCHFT	Heather Grimbaldeston	Providers to be contacted regarding initial briefing at an informal meeting	4 February 2016
Director of Public Health Annual Report 2013 and 2014 review	To look at whether the recommendations of the DoPH in previous reports have been implemented and improvements made	All Cheshire East commissioner and providers	Chairman	Committee to approve date of meeting and contact stakeholders	Possible March 2016

Monitoring Items

Item	Description/purpose of report/comments	Lead Officer/ organisation/	Suggested by	Current position	Key Dates/ Deadlines

Joint Strategy for Carers	Presentation of the draft Joint Carers Strategy 2016-2018 and the planned 3 year action plan to support carers in Cheshire East. Response to the Task Group that reported to Cabinet in Feb15.	Rob Walker CEC Jacki Wilkes Eastern Cheshire CCG	Committee	Strategy and response to Carers Task Group Report requested.	14 January 2016 6 Jan agenda
Winter Wellbeing	To consider plans for dealing with winter pressures and activity with community and voluntary sector	Guy Kilminster CEC & CCGs	Heather Grimbaldeston	Confirmed with officers	14 January 2016 6 Jan agenda
Future of Carer Respite	Further to the Call In Meeting – to review the progress of the decision to secure alternative carer respite support via a formal tender process, initially in November 2015, and subsequent at periodic intervals to review the effectiveness of this decision specifically on the quality and number of beds available, starting 6 months after the introduction of the new arrangements.	Brenda Smith	Committee	Report updating the committee on the current position regarding the implementation of the Cabinet decision was received in Nov 2015. First report on performance to be received at April 2016 meeting	April 2016
Health and Wellbeing Board (HWB)	Consider report and action plan developed following a peer review of the HWB in November 2014	HWB Guy Kilminster	Committee	Delay due to current changes in HWB ToRs	On hold
Better Care Fund	To monitor the achievement of health and social care integration and improved health outcomes through BCF schemes	Lou Ingham/ Caroline Barnes HWB	Committee	Committee received a briefing at Nov15 meeting. Continue to monitor at HWB	Ongoing
Assistive Technology	Task Group reported to Cabinet in March 2015. HWB considered in Sept 2015. Committee requested a response to the recommendations aimed at	Jon Wilkie	Health and Adults PDG	Response to the report required at future meeting.	3 March 2016 Meeting

	developing the use of AT in Health and Care Services and to maintain people's independent living				
Adult Social Care Local Safeguarding Board	The Committee wishes to receive a presentation from the Board at an informal meeting as part of it's scrutiny role to monitor the adult safeguarding	Katie Jones	Committee	Committee have agreed to consider at an informal meeting	4 February 2016

Possible Future/ desirable items

- Screening – Cancer and other health screening – informal meeting
- Annual Report on Residential Care Commissioning – info to be emailed rather than cttee meeting
- Future of Care4CE
- Public Health Service
- Healthwatch (Lynn Glendenning)
- Devolution – possible briefing on activity in Greater Manc
- Mental Health – NHS England reviewing plans (Nov 15)

Dates of Future Committee Meetings
14 January 2016, 3 March 2016

Dates of Future Informal Meetings
4 February 2016, 7 April

Dates of Future Cabinet Meetings
12 January 2016, 9 February, 8 March, 12 April, 10 May

Dates of Future Health and Wellbeing Board Meetings
26 January 2016, 15 March