Public Document Pack

Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 29th November, 2016**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Declarations of Interest**

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

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

   To approve the minutes of the meeting held on 27 September 2016.

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

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

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

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

5. **Cheshire and Merseyside Sustainability and Transformation Plan** (Pages 9 - 68)

To consider the Cheshire and Merseyside Sustainability and Transformation Plan.

6. **Better Care Fund 2016/17 - Q1 Report** (Pages 69 - 74)

To consider the recommendations in respect of the Better Care Fund 2016/17 Q1 Report.

7. **Children and Young People's Improvement Plan** (Pages 75 - 90)

To receive a report updating the Board on progress against the Children and Young People's Improvement Plan

8. **Promoting Population Influenza Vaccination and Arrangements for Vaccination of Front-line Staff** (Pages 91 - 102)

To consider a report concerning the promoting of population influenza vaccination and arrangements for the vaccination of front-line Council staff.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 27th September, 2016 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members
Dr Andrew Wilson - South Cheshire Clinical Commissioning Group (In the Chair)
Cllr J Clowes – Cheshire East Council
Cllr L Durham – Cheshire East Council
Kath O'Dwyer – Executive Director of People's Services, Cheshire East Council
Mark Palethorpe - Strategic Director of Adult Social Care and Health, Cheshire East Council
Dr P Bowen – Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse – South Cheshire Clinical Commissioning Group
Caroline O'Brien – Healthwatch

Observers
Cllr P Bates – Cheshire East Council
Cllr S Gardiner - Cheshire East Council
Cllr S Corcoran - Cheshire East Council

Cheshire East Officers/others in attendance
Guy Kilminster – Head of Health Improvement, Cheshire East Council
Julie North – Senior Democratic Services Officer, Cheshire East Council
Lucy Heath - Consultant in Public Health, Cheshire East Council
Lauren Conway – Project Manager, Children's Improvement and Development Cheshire East Council
Maureen Hills – Legal Services, Cheshire East Council
Michelle Creed – Associate Director of Quality & Safeguarding, South Cheshire CCG & Vale Royal CCG
Sarah Smith – Corporate Commissioning Manager, Cheshire East Council

Councillors in attendance:
Cllr L Wardlaw - Cheshire East Council
Cllr L Jeuda - Cheshire East Council
Cllr G Baxendale - Cheshire East Council

Apologies

Councillor Rachel Bailey, Jerry Hawker, Tom Knight and Mike Suarez.

29 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a non-pecuniary interest by virtue of his

wife being a GP and a Director of South Cheshire and Vale Royal GP Alliance Ltd.

30 **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes be approved as a correct record.

31 **PUBLIC SPEAKING TIME/OPEN SESSION**

Cllr G Baxendale used public speaking time to address the Board concerning the Cheshire and Wirral Partnership NHS Foundation Trust consultation exercise on the reconfiguration of Adult and Older People's Mental Health Services in Central and Eastern Cheshire. He urged the Board to oppose any proposal to close the Millbrook Unit at Macclesfield Hospital. He stated that if the Millbrook Unit was closed, transport to alternative units would be impossible. He asked to the Board to think carefully of patients and carers when responding to the consultation.

It was noted that the Medical Director would be presenting the proposals to an in public meeting of the NHS Eastern Cheshire governing body and Eastern Cheshire CCG would seek some assurances in respect of this issue.

Cllr L Jeuda used public speaking time to refer to the reorganisation of hospitals in Cheshire and to ask how this would effect the residents of Cheshire East. She asked whether the Health and Wellbeing Board would be given the opportunity to comment if there was to be a reorganisation of hospitals in the Cheshire East area.

Tracy Bullock, Mid Cheshire Hospital Foundation and Independent NHS representative on the Board, responded to say that she was not aware of any firm plans for a reorganisation in the area. Dr Paul Bowen reported that any reorganisation would need to be reported to the Health and Wellbeing Board and the CCG governing body, as the accountable bodies and that assurance would be sought that this would happen.

Simon Whitehouse, South Cheshire CCG, used public speaking time to refer to the successful leg of the Tour of Britain cycle race, which had passed through Cheshire East and considered this to be an important legacy to encourage people to be more active.

32 **THE FUTURE OF COMMUNITY BED-BASED CARE FOR OLDER PEOPLE IN CHESHIRE EAST**

Sarah Smith, Corporate Commissioning Manager, attended the meeting and provided an update report to the Board on action taken to accelerate the alignment of commissioning and operational plans to meet future demand for community bed-based care for older people in Cheshire East.

In September 2015, the Board had received a report on ensuring and improving quality and choice in residential and nursing home provision and had supported the proposal for work to review residential and nursing home provision in Cheshire East.

The report had identified the need for joint action to address the challenge of a forecast growth of 57% in the total number of people living in long term residential and nursing homes in Cheshire East over the next 14 years. It had been agreed that a Task and Finish Group address this systemic challenge and a number of other commissioning and operational challenges amongst which, delays in transfer of care from acute and intermediate care beds, the rising cost of bed-based care and difficulty in finding some services at sustainable cost were the most pressing.

Since September 2015, transformation initiatives, under the Caring Together (East) and Connecting Care (South) programmes, had begun to address the most pressing operational challenges and, in August 2016, the scope had been agreed. Details of the scope, aim and objectives were outlined.

It was agreed that a further update report should be submitted to the next meeting of the Board, in January 2017.

RESOLVED

That the content of the report be noted and the action to deliver a shared vision of the future of bed-based care for older people in Cheshire East and the alignment of individual agency plans be supported.

33 **SOCIAL CARE PRECEPT 16-17 REPORT**

Consideration was given to a report which described the impact of the social care precept, a 2% increase in council tax valued at £3.5M, which was and continued to be invested into adult social care, to benefit service users and those who cared for them. The cost of providing care and support for adults in Cheshire East exceeded this additional funding and had necessitated additional investment of over £21m by Cheshire East Council between April 2015 and April 2017.

It was noted that Council tax was worth approximately £180M in Cheshire East, of which 2%, or £3.4M, was set aside to be invested in adult social care. However, the cost of care was rising, due to the national living wage. In April 2017, Cheshire East Council had implemented an increase in fees to care providers, to ensure the sustainability of the care and support market. Rising demand and complexity for both older people and people with learning disabilities, when coupled with a volatile labour market, meant that adult social care both in Cheshire East and nationally, faced financial challenges. This pressure was exacerbated by both reductions in central funding to the Council and financial deficits for health partners

within the borough. Both Eastern Cheshire Clinical Commissioning Group and South Cheshire Clinical Commissioning Group and also Vale Royal Clinical Commissioning Group had identified reductions in funding for services.

In considering the report, the Board felt that there needed to be more granularity around the finances and the process and it was agreed that this should be discussed at the next informal meeting of the Board, to include the implications of the Sustainability and Transformation Plan (STP), with a view to reporting to a future formal meeting of the Board, as part of the natural budget process.

RESOLVED

That the Board notes that the social care precept is welcomed, but not sufficient to meet the rising complexities and demands of meeting care and support needs in Cheshire East.

34 **JOINT TARGETED AREA INSPECTION ON DOMESTIC ABUSE**

Consideration was given to a report informing the Board of the new Joint Targeted Area Inspection framework for children living with domestic abuse.

The Board had a statutory responsibility to improve the health and wellbeing of the children, young people and their families in Cheshire East and to promote the integration of services. This included services for children and young people living with domestic abuse. Joint Targeted Area Inspections (JTAIs) would assess the effectiveness as a local area in identifying and meeting the needs of children and young people under a specific theme. The theme for the next six months, from the beginning of September 2016 to the end of March 2017, was children living with domestic abuse. It was important that the Health and Wellbeing Board be informed of the new theme for the JTAIs and that it be assured that arrangements were in place to develop services for these children and young people and their families. Clear governance arrangements were in place which would drive, implement and scrutinise developments to these services. An action plan was also in place to ensure preparedness for the inspection.

All JTAIs would review the effectiveness of the “front door” and evaluate the effectiveness of the multi-agency arrangements in the response to all forms of child abuse, neglect and exploitation, at the point of identification and the quality and impact of assessment, planning and decision making in response to notifications and referrals

1. That the contents of the report and the implications of the inspection framework for the Health and Wellbeing Board and it's members be noted.

2. That partner agencies be recommended that activity to support service improvement and inspection preparation be prioritised across the partnership.

3. That an update report be received by the Board in 6 months' time.

35 **ANNUAL REVIEW OF THE HEALTH AND WELLBEING BOARD'S TERMS OF REFERENCE**

The Health and Wellbeing Board's Terms of Reference included the requirement for them to be reviewed on an annual basis. This provided an opportunity to ensure that they remained fit for purpose and were appropriate for the smooth functioning of the Board. The Board was requested to consider the Terms of Reference and whether or not any amendments were required.

In considering the report, the Panel noted that the Terms of Reference did not mention the STP or financial challenges and it was agreed that they should be updated to reflect current demand, resources and the STP.

The Panel also requested that Cheshire East Council review the Local Authority representation, with a view to including one opposition Member.

(The Chairman of the meeting reported that, at the last meeting of the Board, it had been agreed that the draft STP should be submitted to an informal meeting of the Board and then to a formal meeting of the Board for consideration, before submission. It was noted that the timing for the submission and dates of scheduled meetings would not allow for this to happen and it was, therefore, agreed that the draft Plan would be circulated to the Board electronically for comment).

RESOLVED

That a report be submitted to the next meeting of the panel, to include the suggested amendments to the Terms of Reference for consideration.

The meeting commenced at 2.00 pm and concluded at 3.20 pm

Dr A Wilson
Vice-chairman, in the Chair

Cheshire & Merseyside

Sustainability and Transformation Plan

15 Nov 2016 issue version 4.4

2,571,170
people

32%
Live in most deprived areas

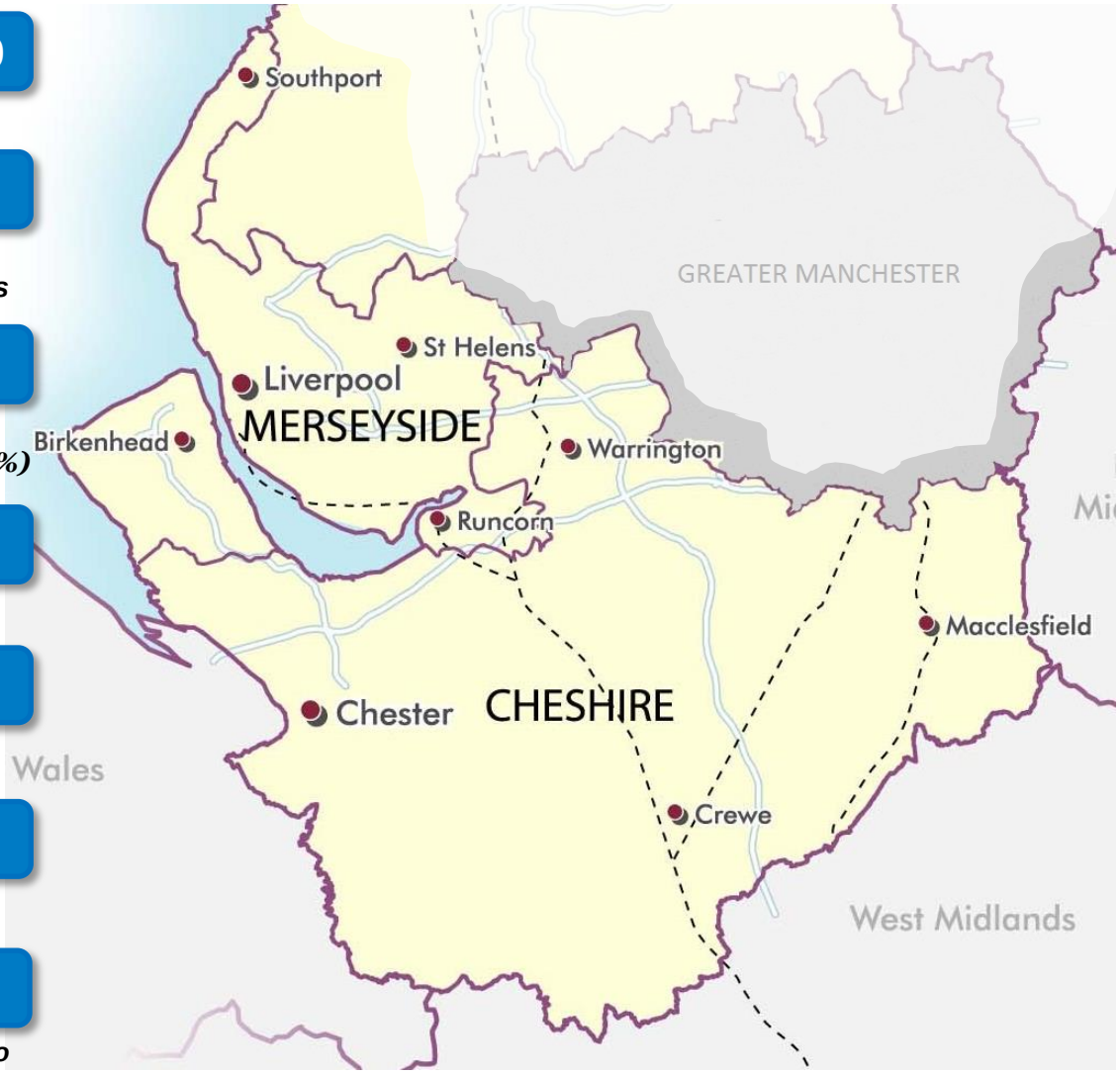
8.3%
Aged 75+ (UK ave. = 7.8%)

12
CCGs

20
Providers

2nd
Largest STP

2
Proposed Devo footprints



Key information
Name of footprint and no: Cheshire & Merseyside; No. 8
Region: North
Nominated lead of the footprint including organisation/function: Louise Shepherd, Chief Executive, Alder Hey NHS FT
Contact details (email and phone): louise.shepherd@alderhey.nhs.uk – 0151 252 5412
Organisations within footprints:
CCGs – Knowsley, South Sefton, Southport and Formby, Eastern Cheshire, Wirral, Liverpool, Halton, St Helens, South Cheshire, Vale Royal, West Cheshire, Warrington
LAs: Knowsley, Sefton, Liverpool, Halton, St Helens, Cheshire East, Cheshire West and Chester, Warrington, Wirral
Providers: Liverpool Heart and Chest Hospital NHS Foundation Trust, Alder Hey Children's NHS Foundation Trust, Royal Liverpool NHS Foundation Trust, Countess of Chester NHS Foundation Trust, St Helens and Knowsley Hospitals Trust, Walton Centre for Neurology and Neurosurgery, Bridgewater Community Healthcare NHS Foundation Trust, Wirral University Teaching Hospital NHS Foundation Trust, Mersey Care NHS Foundation Trust, East Cheshire NHS Trust, Cheshire and Wirral Partnership NHS Foundation Trust, Wirral Community NHS Foundation Trust, Liverpool Women's Hospital NHS Foundation Trust, Warrington and Halton NHS Foundation Trust, 5-Boroughs Partnership NHS Foundation Trust, Mid-Cheshire Hospital NHS Foundation Trust, North West Ambulance Trust, Aintree University Hospitals NHS Foundation Trust, Clatterbridge Cancer Centre NHS Foundation Trust, Southport and Ormskirk Hospitals Trust, Liverpool Community Trust

Contents

Content	Page #
Executive Summary	3
1 - Introduction	4
2 - Our Cheshire & Merseyside strategy	5
3 - Embedding the change locally	27
4 - C&M Financial Gap	50
5 - Delivering the change	52
Appendices	

Foreword

Partners across Cheshire and Merseyside have been working together over the last 4 months to develop further the blueprint we set out in June to accelerate the implementation of the Five Year Forward View (5YFV) for our Communities. We have come together to address head on the challenges we articulated then: that people are living longer, but not always healthier, lives; that care is not always joined up for patients in their local community, especially for the frail elderly and those with complex needs; that there is, as a result, an over-reliance on acute hospital services that often does not provide the best setting for patients; that there is a need to support children, young people and adults more effectively with their mental health challenges. At the same time, there is enormous pressure on health and social care budgets.

We are clear that these issues require us to think much more radically about how best to address the problems we face together, otherwise we will fail to support the needs of our Communities into the future. This document summarises the plans developed to-date to address these challenges across all our different communities in Cheshire and Merseyside and fall into 4 common themes:

- support for people to live better quality lives by actively promoting the things we know have a really positive effect on health and wellbeing;
- working together with partners in local government and the voluntary sector to develop more joined up models of care, outside of traditional acute hospitals, to give people the support they really need in the most appropriate setting;
- designing an acute care system for our communities that meets current modern standards and reduces variation in quality;
- making ourselves more efficient by joining up non front-line functions and using the latest technology to support people in their own homes;

Much of this work is already underway at local level but there is also still much to do. The role of the Sustainability and Transformation Plan (STP) for Cheshire and Merseyside (C&M) is to co-ordinate our efforts, ensuring we promote the best ideas and expertise to provide for the needs of the whole Region in the future.

Executive Summary

Our submission in June identified the key challenges faced by the Cheshire and Merseyside (C&M) STP, including:

- ***high rates of diseases associated with ageing, including dementia and cancers;***
- ***high rates of respiratory disease;***
- ***early years and adult obesity;***
- ***high hospital admissions for alcohol;***
- ***poor mental health and wellbeing; and***
- ***high rates of teenage conceptions.***

Furthermore our analysis confirmed that across the region there are significant service and financial challenges, either at individual organisational level or across whole economies. Health and social care services have grown and developed over time in fragmented, uncoordinated ways that do not meet the changing needs of our Communities. At the same time, there are significant pressures on health and social care budgets. Both these issues mean that we will fail to meet the future needs of our population and provide the standard of care they deserve without a radical change in current delivery. Continuing with current models of care provision will result in a gap in our finances of £908m by 2021 across the Region if we do nothing. This challenge has narrowed from the £999m in our June submission, reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create sustainable, quality services for the population of C&M. This is effectively our ambitious blueprint to accelerate the implementation of the Five Year Forward View (5YFV) across C&M.

Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

We have devised a portfolio of 20 programmes, each with clear objectives, scope and emerging governance structures – some are further ahead than others in developing their detailed plans.

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

Maximising opportunities

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

The key themes we are pursuing

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations.

Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

1 - Our starting point

Our previous submission in June demonstrated a sound understanding of our issues, and a clear strategy for going forward

Our submission in June identified the key challenges faced by the Cheshire and Merseyside STP, including:

- *high rates of diseases associated with ageing, including dementia and cancers;*
- *high rates of respiratory disease;*
- *early years and adult obesity;*
- *high hospital admissions for alcohol;*
- *poor mental health and wellbeing; and*
- *high rates of teenage conceptions.*

Furthermore our analysis confirmed that across the region there are significant financial challenges, either at individual organisational level or across whole economies. *The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be* ***£908m.*** This challenge has narrowed from the £999m in our June submission, to £908m driven by the gap now reflecting the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan, and the remaining gap now reflects the four year period 2017/18 – 2020/21.

Clearly C&M isn't going to sit back and 'do nothing'. In addition to the work already underway within our three Local Delivery Systems (LDS) we identified the strategic STP priorities that would make our health and care system sustainable in the near medium and long term:

1. **Improve the health of the C&M population** (previously referred to as 'Demand Management' and 'Prevention at Scale') by:
   - *Promoting physical and mental well being*
   - *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*
2. **Improve the quality of care in hospital settings** (previously referred to as 'Reducing variation & improving quality in support of hospital reconfiguration') by:
   - *Reducing the variation of care across C&M;*
   - *Delivering the right level of care in the most appropriate setting*
   - *Enhancing delivery of mental health care*
3. **Optimise direct patient care** (previously referred to as Productive back office and clinical support services collaboration) by
   - *Reducing the cost of administration*
   - *Creating more efficient clinical support services*

After the existing LDS plans were modelled we forecast a surplus of £49m by 2021. However, these plans required further analysis and challenge to convert them from sound ideas into robust plans.

Our work since June has been focussed on the development of these 'sound ideas' into 'robust plans'.

We have created a portfolio structure that brings together twenty distinct, but interrelated programmes of work. Each of these programmes has developed clear objectives, is in the process of agreeing its governance model and are developing their plans for delivery. Each is at a different stage of maturity and this STP submission reflects this.

Our strategic STP programmes aim to provide guidance and clear principles about how we will tackle four key issues across the STP footprint:

1. Improving the health of the C&M population
2. Improving the quality of care in hospital settings
3. Optimise direct patient
   a) Reduced administration costs
   b) Effective clinical support services

These programmes are supported by eight clinical programmes looking to improve the way we deliver:

4. Neuroscience;
5. Cardiovascular disease (CVD)
6. Learning disabilities
7. Urgent Care
8. Cancer
9. Mental Health
10. Women's & Children's
11. GPs and primary care

There are five programmes that support and enable the above programmes:

12. Changing how we work together to deliver this transformation.
13. Finance
14. Workforce
15. Estates and facilities
16. Technology, including Digital
17. Communications and Engagement

Delivery of these programmes is at LDS level, each of which has a programme of work delivering improvements locally:

18. North Mersey
19. The Alliance
20. Cheshire and Wirral

The overarching purpose of these programmes is to deliver on our purpose of creating sustainable, quality services for our population.

2 - Our Cheshire & Merseyside strategy

We are clear on the ambition we have for the patients, staff and population of the C&M STP

Our core purpose is to create **sustainable, quality services for the population of C&M**. This is effectively our ambitious blueprint to accelerate the implementation of the 5YFV across C&M.

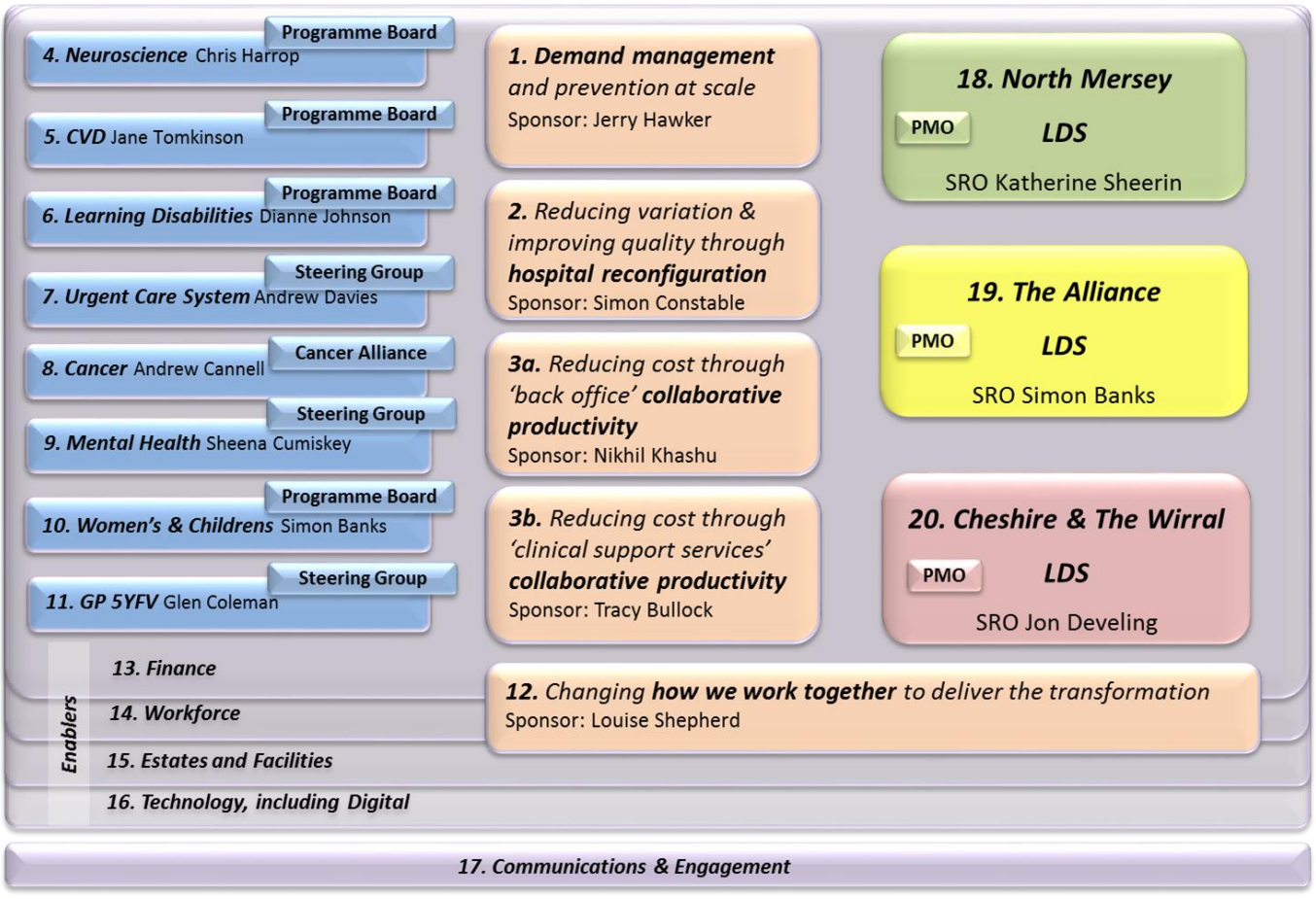
Sustainable means delivering services within the amount of finance made available to C&M for the provision of health and social care.

Quality means services that are safe, and deliver excellent clinical outcomes and patient experience.

Doing the right things

The 20 programmes that form our delivery portfolio have been chosen as a direct consequence of the issues faced by C&M, and with a clear end goal in mind. These were noted in Section 1 and are regularly communicated by way of the graphic below:

Each programme is at a different point of maturity, and this is reflected in the later sections of this plan. As with any portfolio this is not unusual and there is no reason to get them all to the same place. However, there is an overarching process that each programme will go through and that the PMO will use to help assess progress.



2 - Our Cheshire & Merseyside strategy

Clarity on responsibility

The LDS programmes are the delivery vehicles that deliver the principles, guidance and clinical models developed across the other programmes. To effectively deliver the strategy it is important that this is well understood to avoid duplication of effort.

This STP provides a platform for the key themes and direction that we are taking in order to deliver our goals. It draws on much of the work that is already underway across the three LDSs, and aims to deliver additional scale economies, learning and collaboration through the focus on a one C&M approach to those activities where additional scale can bring benefits.

There are no budgets or quality standards held at STP level. Changes will directly impact organisations at level 1, with level 2 LDS plans providing oversight of progress, and, over time, a consolidated view of performance measures.

We have been really clear on the role of people at STP level, ensuring we are not duplicating effort.

Level 1 STP has a focus on:

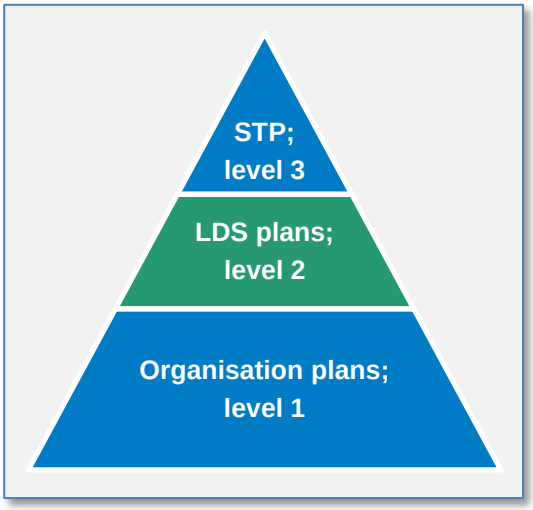
- **Economies of Scale** – what can be done at STP to create additional economies
- **X-LDS learning** – how can each LDS learn from each other
- **National benchmarking** – how is the STP doing compared to national benchmarks
- **STP wide system design** – design once, deliver locally – e.g. ACO/ACS framework
- **Governance** – agreeing and managing an STP wide approach
- **Assurance** – provision of assurance to STP lead, and ultimately NHSE
- **Performance** – responsibility for meeting and reporting against STP wide control totals
- **Communications and engagement** – consistent delivery of overarching key messages

Level 2 LDSs also have a clear role to play:

- **Locality strategy** – how this works in the LDS
- **Detailed delivery plans** - development and delivery of LDS plan
- **Monitor progress** – regular monitoring of plan
- **Reporting to STP** – progress reporting to STP
- **Financial control** – managing impact on finances

across LDS.

At Level 1 the responsibility is well known around meeting financial and quality standards. Currently it is only at Level 1 that a budget can be impacted. Level 1 organisations also have a clear responsibility to manage communications within their organisation and to their Boards/Governors.



Maximising opportunities

Our approach to delivering improvements is that opportunities will be designed and delivered at the highest level of our triangle.

If it can be done at STP level we assume that is where the greatest benefit can be achieved – but we are acutely aware that many initiatives require a more local flavour so they will be designed and delivered locally.

The emergence of an STP plan doesn't reduce the focus on organisational delivery at level 1 or their need for financial balance.

2 - Our Cheshire & Merseyside strategy

All too often really good strategies are developed with clear benefits that aren't ultimately achieved due to poor implementation. The start of successful implementation starts with a clear, detailed plan which is monitored through its various stages.

Managing a portfolio of 20 programmes is a significant undertaking and the dependencies between them need to be effectively managed.

Managing dependencies across the portfolio

With twenty programmes of work there are many interdependencies that need to be carefully managed, such as:

- Effective management of demand on our healthcare system will influence the future configuration of where and how services are delivered;
- Future hospital service configurations will be driven by clear clinical strategies that place patients at the heart of any redesign;
- Very few changes can be made without the implicit inclusion of the Workforce, Estates and IM&T programmes

Section 6 will look in more detail at how the STP will deliver the transformation required.

STP Interventions

This STP does not capture everything that we are doing as a health and care economy. Instead it focuses on the priority areas of focus that we believe will have the greatest impact on health, quality and finance.

Our challenges

Demand for health and care services is increasing	**Cheshire and Merseyside face different challenges as a consequence of its geography and demographics. There is therefore unacceptable variation in the quality of care and outcomes across C&M**	**The C&M system is fragmented resulting in duplication and confusion**	**The cost of delivering health and care services is increasing**

Our priorities and areas of focus

Improve the health of the C&M population,		**Improve the quality of care in hospital settings**		**Optimise direct patient care**	
1a. improving the provision of physical and mental care in the community (i.e.outside of hospital) • Agree framework to deliver via ACOs • Managing demand across boundaries • Joint commissioning and delivery models • Community risk stratification • GP Federations, Primary Care at scale	***1b. Promoting physical and mental well being*** • Addressing primary prevention & the wider determinants of health • Pan C&M Alcohol Strategy • Pan C&M High BP Strategy	***2a. Reducing the variation of care across C&M*** • Common standards, policies and guidelines across organisations at C&M level • Standardised care across pathways	***2b. Delivering the right level of care in the most appropriate setting; and enhancing delivery of mental health care*** • Common standards, policies and guidelines across organisations at C&M level • SOPs and high level service blueprints for specialist services	**3a. *Reducing the cost of administration*** • Optimised workforce, reduced agency usage • Consolidated Procurement functions – an integrated Supply Chain Mgmt. function	**3b. *creating more efficient clinical support services*** • Consolidated clinical support services

The impact of our plans

• Reduction in A&E attends and non-elective admissions • Reduced elective referrals • Reduced emergency bed days, and length of stay • Reduced re-admissions • Early identification and intervention • Delivery of care in alternative settings • Increased use of capitation-based and outcomes-based payments	• Improved clinical outcomes and reduction in variation • Improved performance against clinical indicators	• x-organisation productivity and efficiency savings • Reduced duplication • Reduction in temporary staff dependency

Governance and Leadership - Changing how we work together to deliver the transformation

Programme Delivery Structure

Communications and Engagement

Enablers – IM&T; Estates; Workforce

2.1 - Improve the health of the C&M population

Introduction

We previously referred to this programme as 'Demand Management' and 'Prevention at Scale'.

Investment in improving the resilience of services delivered outside of hospital settings (primary care, social care, community care, mental health) is essential for us to transform our system and move towards both lower cost and higher quality care delivery.

By improving the support for self care, better and more proactive care in the community and addressing the wider determinants of health at a CM scale, we can better address peoples need for care and the associated demand on acute services.

What are the objectives

- To maximise the benefits that C&M can gain from the improvement to its population's health.
- To provide the guidance and principles upon which the work around demand management and prevention will be delivered at LDS level.

Why is this programme important?

The current challenges makes integration and consolidation across organisational boundaries a necessity. The NHS five year strategy sets out the ambition for this and local government leaders are keen to take a leading role in the integration agenda. Leading health economies are moving in this direction and they are delivering real reductions in hospital admissions; better population health through prevention; and 10-20% cost savings.

Integrated care is what service users want to have, what providers want to be able to deliver and what commissioners want to pay for. It allows social and health care to work together in a joined up way that improves the outcomes for individuals and the experience for service users and professionals.

Another important feature of the population health PIDs that have been developed is that as well as supporting the development of benefits over the next 5 years directly (from reduced hospital admissions / attendances etc), they will also play a crucial role in supporting the sustainability of the current STP. For example, by not addressing the real behavioural problems that excessive drinking can run the risk of creating future problems and dilute the positive impact that the current set of interventions are expected to have.

What is the scope of the work

Improving the provision of integrated primary and community, health and social care (i.e. Out of Hospital)

1. A substantial range of schemes & interventions which can be broadly categorised as Prevention, CCG Business efficiencies (QIPP) and new Out of Hospital initiatives.
2. Promoting physical and mental well being to reduce the need for people to access care.
3. Developing an STP wide methodology and structure for tackling unwarranted variation in demand for care services and enabling effective delivery of the first two objectives.

What is the structure of the programme?

1. Three STP prevention schemes will be delivered at LDS Level::
   - Alcohol Harm Reduction
   - High Blood Pressure
   - Antimicrobial resistance
2. Three high impact areas help manage demand, delivered at LDS level:
   - Referral management
   - Medicines management
   - CHC
3. Development of integrated primary and community, health and social care
4. Create a framework for the development and implementation for Accountable Care approaches (name of the chosen vehicle may be different but they are nationally known as ACOs)

The first phase of the programme has focussed on helping each LDS develop their plans and to verify the opportunity. This will now be taken forward at LDS level leaving the work at STP to focus on creating a framework to support development of ACOs and supporting the accelerated implementation (delivery) of high impact demand management initiatives (e.g. Right Care).

How will the change be lead?

Sponsor:	Jerry Hawker
Members:	Eileen O'Meara (CHAMPS WG DPH Lead) Alliance – Leigh Thompson/Colin Scales Cheshire & Wirral – Tracy Parker-Priest North Mersey – Tony Woods Local Gov't – TBD Andrew Davies, Urgent Care CCT

2.1 - Improve the health of the C&M population

Current Position

Management of demand

There is a strong symmetry across all three LDS plans and a further opportunity to share best practice and reduce inter-LDS variation. NHS England's referral management audit (template) suggests significant variation across three of the LDSs with respect to implementation of the eight high impact changes.

The high impact change areas being adopted across the LDSs include:

- Medicines management (**£66.6m**)
- Referral management – implementation of eight demand management high impact changes for elective care (**£61.5m**)
- Implementation of Right Care (**£42.5m**)
- Continuing healthcare (**£16m**)

(indicative values)

These are predominantly flagged as business as usual efficiencies within CCG plans.

Prevention

Three population based prevention projects have been developed to support reductions in Alcohol abuse / harm, blood pressure and antimicrobial resistance (AMR).

The first two have identified benefits including reduced hospital admissions & "whole system impact" where appropriate (e.g. prevention of alcohol related violence). AMR will produce more long term impact.

All are key to the longer term sustainability of the STP i.e. doing nothing runs the risk of increasing our challenge post 2021.

The blood pressure team have identified a number of benefit scenarios associated with the level of increases in diagnosis rates. The table below shows the low end estimated net benefits i.e. based on a 5% increase BP diagnosis being achieved – these could be as high as £9.1m if the higher rates are achieved of 15%.

Delivery plans for these projects are noted overleaf

Prevention	Alcohol	Blood Pressure	Total benefit (2021)
Gross benefit	£13.65m	£9.5m	**£23.15m**
STP investment required	£2.45m	£2.5m	**£4.95m**
Net benefit at LDS level • C&W • Alliance • NM	 £4.7m £3m £3.5m	 £2.8m £2m £2.2m	 **£7.5m** **£5m** **£5.7m**
Total STP net benefit (2021)	**£11.2m**	**£7m**	**£18.2m**

2.1 - Improve the health of the C&M population – alcohol prevention and High Blood Pressure Plans

Alcohol Prevention Project	Milestones
STP demand reduction (alcohol) steering group	• Establish a system wide leadership approach through the establishment of a CM cross-sector working group(s), networks and collaborations • Detailed business case worked up • Develop and continue to risk register • Develop and implement a stakeholder engagement and communications • Establish a data/outcomes working group
Enhanced support for high impact drinkers	• Develop multi-agency approaches to support change resistant drinkers' • Ensure the provision of best practice multidisciplinary alcohol care teams in all acute hospitals • Review pathways and commission outreach teams
Large scale delivery of targeted Brief Advice	• Facilitate local agreements with GPs, pharmacy and midwifery to screen patients with staff offering brief advice and referring to local specialist services as required. • Ensure screening and advice for Making Ever Contact Count includes evidence based alcohol IBA, and brief interventions such as high BP, smoking cessation, diet and physical activity.

Effective population level actions	• Ensure all Emergency Departments across Cheshire and Merseyside collect and share enhanced assault data to the optimum standards.
	• Ensure North West Ambulance Services record call outs related to alcohol and share this data with relevant local partners
	• Ensure local partners collaborate to ensure efficient use of data and considerations of improvements, including:
	  • Targeting interventions to prevent violence and reduce alcohol-related harm
	  • Targeting police enforcement in hotspot areas
	  • Use of intelligence in the license review process and targeting alcohol licencing enforcement

High Blood Pressure Project	Milestones
STP demand reduction (BP) steering group	• Detailed business case write up • Risk register write up • Stakeholder engagement and communication plan developed
System Leadership approach	• System leadership approach is ensured in the delivery of the C&M strategy • Systematic triangulation and review of cross-sector patient safety measures is embedded into strategy dashboard
Population approach to prevention	• Develop healthy local policy
BP awareness raising campaigns	• Link with community pharmacies, community partners and voluntary sector partners and inform patients and communities of key messages
Making Every Contact Count at scale	• Roll out MECC across primary and secondary healthcare settings, community pharmacies and with non-clinical community partners
Blood pressure equipment	• Increase availability of BP machines and Ambulatory Blood Pressure Monitoring to meet local need
Primary care education and training programme	• Develop education and training programme that utilises Sector Led Improvement principles
Medicines Optimisation	• Increase uptake of Medicine Use Reviews and New Medicines Services on antihypertensive medicines

2.1 - Improve the health of the C&M population – antimicrobial resistance

Project	Milestones
Ensure every Trust, Community Trust [including non-medical prescribers] and CCG has an AMR action plan	• Obtain assurances that every trust has an AMR action plan • Obtain assurances that every trust has an Antimicrobial Stewardship Committee

Implement back up prescribing for the treatment of upper respiratory tract infections	• Implement Back Up Prescribing via Practitioner-Centred Approach or Patient-Centred Approach
	• Audit post implementation:
	  • Establish whether implementation in Accident and Emergency Departments, Walk-In Centres, Out Of Hours and with Non-Medical Practitioners is required. Consistency can be achieved by harmonising access to GP records.
	  • Prior to implementation, establish whether Healthwatch should be involved.

Engagement	• Pharmacy:
	  • Ensure consistent messages are given by all prescribers and all pharmacists.
	  • Ensure pharmacies support the AMR strategy as appropriate
	• Care Homes:
	  • Establish whether the Care Home Hygiene Award Scheme needs scaling up

Ensure AMR awareness, stewardship and training is delivered to all prescribers, non-medical prescribers and health care workers	• Target all prescribers (medical, non-medical, pharmacists) and consider including AMR in yearly mandatory training • Ensure that training addresses and meets the PHE Antimicrobial prescribing and stewardship competencies
Support public facing media campaigns to aid and inform about Antimicrobial Resistance	• Local authorities and CCGs engage with any national or international AMR campaigns and plan local activities to promote the initiative
Implementation of AMR and Stewardship education at the primary and secondary level	• Utilise the free ‘e-Bug’ resource produced by PHE in all schools to encourage a generational change in the attitude to the use of antibiotics
Identify a dedicated Community Microbiologist function to support AMR Stewardship	• Ensure protected sessions are available and establish whether these can be enhanced to a more proactive and accessible clinical advisor service for GPs and other antibiotic prescribers in the community
Identify an Antimicrobial Stewardship Lead GP	• Establish how this resource can be identified and secured, assuming that the role doesn’t exist already
Ensure that every secondary care trust is implementing PHE Start Smart – Then Focus toolkit	• Obtain assurances that every trust has implemented the tool kit, including a ward-focused antimicrobial team
Ensure that every GP Practice is implementing TARGET (Treat Antibiotics Responsibly, Guidance, Education, Tools) (best practice recommendations)	• Obtain assurances that every GP Practice has implemented the tool kit
Ensure every Trust and CCG has an Antimicrobial Pharmacist and ensure that they are provided with sufficient protected time to fulfil this role	• Obtain assurances that every trust has a dedicated Antimicrobial Pharmacist
Ascertain assurances that community antimicrobial formularies are confluent with secondary care antimicrobial formularies and obtain assurances that community antimicrobial formularies are used by primary care prescribers	• Primary and secondary care formularies should dovetail • Obtain assurances that Community Antimicrobial Formularies exist and include information regarding Antimicrobial Resistance

2.1 - Improve the health of the C&M population

Development of ACOs

ACO's are one option for supporting the development of a standardised care model for non-acute care across the C&M Footprint that includes Primary, Community, Mental Health & Social Care with a view to driving & managing demand and pursuing population health management. We might want to look at this as a way of enhancing care for medically unwell and frail patients in particular, by integrating organisational arrangements, sharing clinical and financial risk across the system

Ambition - There is significant variation in the progress made on developing ACOs across the STP; most are at an elementary stage. St Helens has made the most progress having commissioned advisors to consider the options for an accountable care management system. Further work is required in most localities to fully define the vision and outcomes.

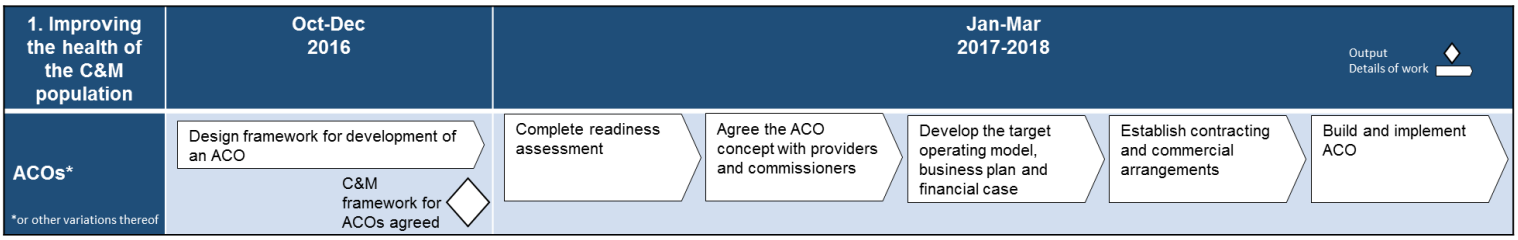
Care Model - Greater focus could be paid on ensuring primary care is at the centre of care models and ACOs are built on GP registered lists. Additionally, processes to engage primary care need to be determined. In parts of the system there is some ambition to build the ACOs around multispecialty community providers. The connection between ACOs and already established/proposed care models in some areas needs to be clearer e.g. the Caring Together programme in Eastern Cheshire.

Delivery Model - There is significant variation in the form of ACOs being proposed and developed across the STP. For instance, in some areas an 'accountable care management system' is being developed whilst in others a 'partnership' is envisioned. In almost all areas there is no defined operating model agreed and no delivery plans in place for implementation.

Capabilities - Learning should be shared as much as possible by those areas who are leading in the development of their ACOs. The process to understand the capabilities required for the successful implementation of an ACO is in place in some areas. Further work is required on the approach to sharing accountability amongst partners include risk and gain sharing.

There needs to be a real focus on the development of an STP wide framework to help design the right ACO model for each locality.

Each locality is at a different state of maturity – the potential plan below is an indicative view of the process and timeline that a more mature locality might aspire to.



Plans

There are a number of next steps to follow on from the work:

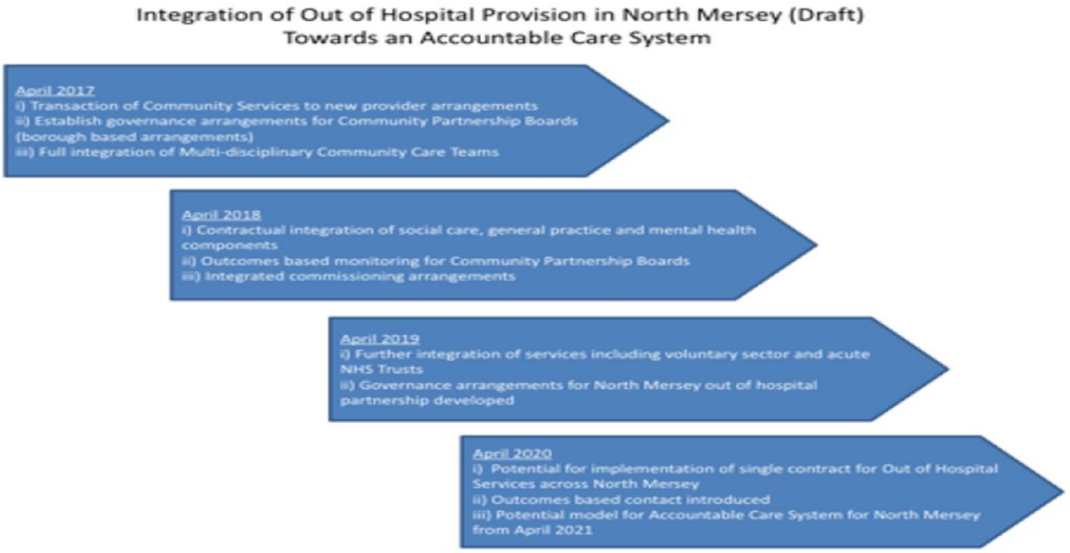
- Need to agree the relevant priorities of the projects and the associated investments.
- There is an immediate need to agree how benchmarking intelligence will be provided and utilised by end November.
- Each LDS should review existing plans against business intelligence to strengthen activity and financial modelling and assure schemes against benchmarked evidence to ensure that plans are targeted appropriately, by end November.
- The STP should identify a way to support each LDSP to stress test its business efficiencies (QIPP) schemes due to the significant financial variation, by end November.
- Develop a framework document to provide structured support to fast track potential exemplar ACOs and provide STP wide guidance and principles.

Much of this is to be delivered as part of the LDS plans, and features in their delivery plans, highlights of which are overleaf.

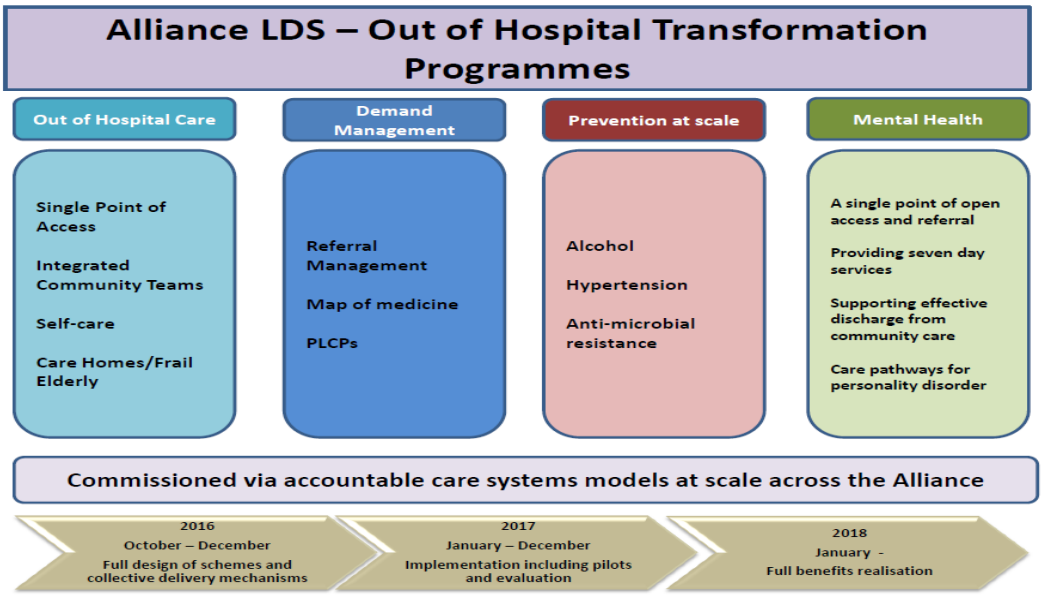
2.1 - Improve the health of the C&M population

Each LDS has plans that will tackle demand, enhance prevention, bring care closer to home and radically improve out of hospital care, the highlights of which are shown below. Full details are in each LDS plan that is within the supporting documents. By providing coordination, guidance, standards and clear principles, LDS's will learn from each other and C&M will achieve greater economies of scale.

North Mersey



The Alliance



Cheshire & Wirral

The core C&W ambitions by 2020/21 are:

- Implement Cheshire and Merseyside Wide Prevention strategies in Hypertension, Alcohol, and AMR.
- Implement Cheshire and Wirral wide prevention strategies for Respiratory conditions and Diabetes.
- Implement Cheshire and Merseyside Wide Neurology, Cancer and Mental Health Programmes.
- Implement a Gain Share agreement with NHSE for specialised commissioning
- Embed integrated community teams by 2017/18 that include General Practice, Social Care and Community Services that will manage demand effectively throughout Cheshire and Wirral.
- Implement high impact demand management initiatives identified by NHSE through our current and ongoing QIPP Programme.
- Implement measures to reduce CHC expenditure by £8m
- Encourage and deliver better management of primary care prescribing (through self-care, over the counter status, repeat prescriptions)
- Continue to implement and optimise the benefit of sharing clinical information through the Cheshire (and Wirral) Care Record.
- Establish an approach to deliver Accountable Care Organisations across Cheshire and Wirral.

2.2 - Improve the quality of care in hospital settings - overview

Introduction

We previously referred to this programme as 'Reducing variation and improving quality to support hospital reconfiguration'.

There remains a need for C&M to undertake an STP wide review of clinical services, to reduce variation and determine future options for hospital configuration. Through taking a pan-C&M approach we can reduce unwarranted variation and improve quality.

A first step will be to identify how acute care is performing under its current configuration. This will enable effective and well informed decisions to be made and will help to identify areas of focus and opportunity. There is a strong need for a service line-by-service line review of the current acute care model, in order to generate the evidence and data required to inform an explicit decision to be taken on the locations of acute provision based through analysis of future patient flows.

What are the objectives

- To maximise the quality of care delivered in hospital settings.
- To provide the guidance and principles upon which work around hospital services will be delivered at LDS level.

Why is this programme important?

There is a wide variation of the quality of care across C&M – this is not acceptable and our population should expect the same quality service and outcomes wherever they live in C&M.
Hospital care is expensive – we should only be treating people in hospital when it is evidenced that their outcomes will be better by treating them there.
Improving care is at the forefront of our STP ambitions, and delivering effective, safe and efficient care in hospital settings is a core principle.

What is the scope of the work

There are two STP Level projects:

1. Technical solutions for the C&M system:
   - Critical decisions developed by specialist and technical expertise which exists already in the clinical networks or Vanguards for new models of care (e.g. Urgent and Emergency Care and Women's and Children's Health)
   - Agree the best clinical models across C&M and their detailed specification, which will include access issues, consideration of co-dependencies and the un-intended consequences. This will be underpinned by the very best evidence base and specialist expertise.
   - Pilot to then be expanded through all the specialities.
2. Reducing variation in outcomes
   - Clinical effectiveness is at the heart of the programme to reduce variation in clinical practice and outcomes across C&M.
   - Existing programmes of work such as Advancing Quality (AQ) and Getting it Right First Time (GIRFT) will be strengthened, standardised and harmonised.
   - Intra-hospital as well as inter-hospital variation will be considered
   - Workforce issues through people as well as processes will be standardised or harmonised at STP level to manage system as well as cultural issues through the assistance of Health Education England, the North West Leadership Academy and the Advancing Quality Alliance (AQuA).
   - An overarching principle will be achieving even modest improvements at scale over the whole C&M and reducing the variation that exists.

How will the change be lead?

Sponsor:	Simon Constable
Members:	Alliance - Ann Marr Cheshire & Wirral - David Allison N Mersey - Steve Warburton/Fiona Lemmens Local Gov't - **TBD** Andrew Davies, Urgent Care CCT Simon Banks, Women & Children's CCT

2.2 - Improve the quality of care in hospital settings – delivery plans

To date, this thinking has largely been driven at the LDS level with little consideration of hospital reconfiguration across the C&M-wide footprint.

However, we believe there is benefit and the financial imperative to undertake this thinking at C&M level to deliver a consistent clinical service across the STP footprint.

We recognise that the current acute configuration within this footprint is unsustainable. This is perhaps most evident in Cheshire. The number of tertiary providers in Merseyside presents an atypical challenge and opportunity as well.

Given the importance and sensitivity of this area, our first task is to instigate a service by service review of the acute care model.

This will be a single programme of work that will run in parallel to the emerging LDS-led reviews and work undertaken by the NW Specialised Commissioning team.

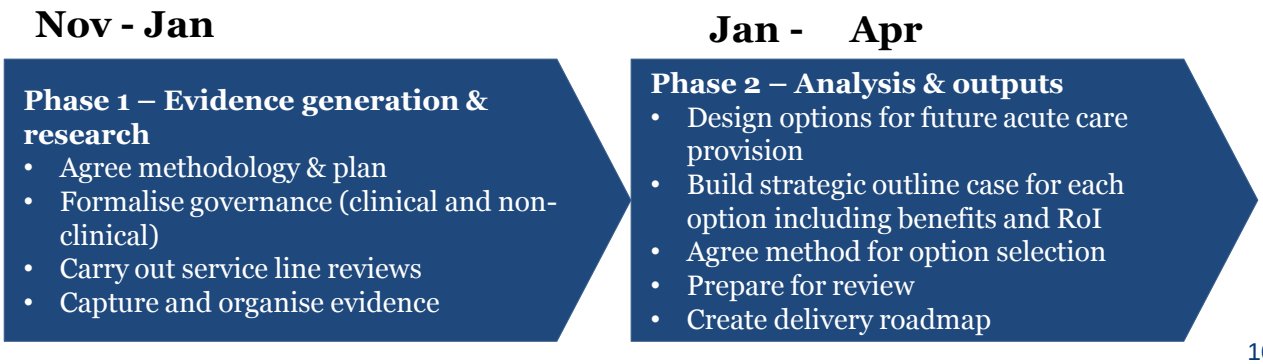
Our view is that the definition and specification of the local District General Hospital will be sustainably supported through a network of specialist provider services, making a virtue of Merseyside's strong cohort of tertiary centres. This big idea is underpinned by health and social care integrated at the core.

The review will be undertaken rapidly with an outcome on the direction of acute provision being available for the next stage of consultation by March 2017 (subject to further discussion and agreement).

Work is underway with AQuA to identify from an international and national evidence base the areas in which reduced variation would give the maximum potential in addressing the quadruple aims of the 5YFV across the whole of C&M. The output of this work is expected in late 2016. In addition one of the early scoping pieces of work across the STP through the local delivery systems is to identify where there are already plans implemented or in train to reduce variation and/or implement hospital reconfiguration, to ensure that outputs and outcomes are known, understood and assessed and adopted at pace and scale utilizing a range of clinical, managerial, patient and other change agents and supporting systems that are already in place.

The engagement strategy for this workstream is critical to its success in delivering against the quadruple aims of the 5YFV. The approach, with the appropriate level of programme management support and resource to oversee the progress of engagement, is to utilize existing networks of clinicians across primary and secondary care, other staff across the health and care system, and patients and carers to create a dialogue in the design of the priority work programmes (utilizing the intelligence identified above as an input) and identify, at a range of levels, change agents who have experience and are motivated to influence at a range of levels. So in addition to the necessary scoping of areas of focus for this workstream both in terms of existing improvement work in the STP area, and national/ international evidence base, we will undertake a piece of scoping around the existing engagement fora in order to enable face to face discussion about areas of focus. We see the STP Clinical Congress as a key engagement mechanism for clinical engagement along with existing networks of clinicians, particularly at and within LDS level. We will also, in conjunction with the STP workstream area around ways of working, explore the possibility of digital collaborative platforms to maximize engagement.

This review will focus on how acute provision will synergistically work within the construct of a demand management system (and potential ACO-driven environment), as well as embracing new technology such as tele-tracking to create individual control centres capable of having visibility across multiple providers who exist in a networked way. The review will consist of 2 phases of work as shown below:



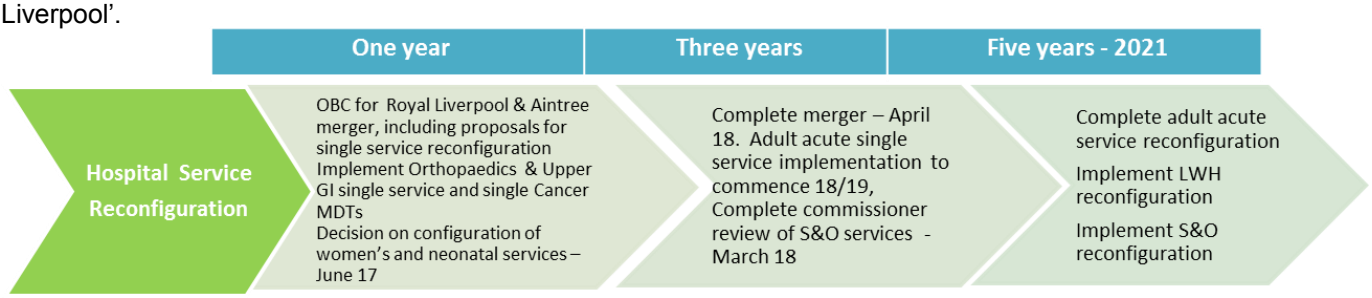
2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

North Mersey

A more granular plan is included in the NM LDS plan. built from well established plans described in 'Healthy Liverpool'.



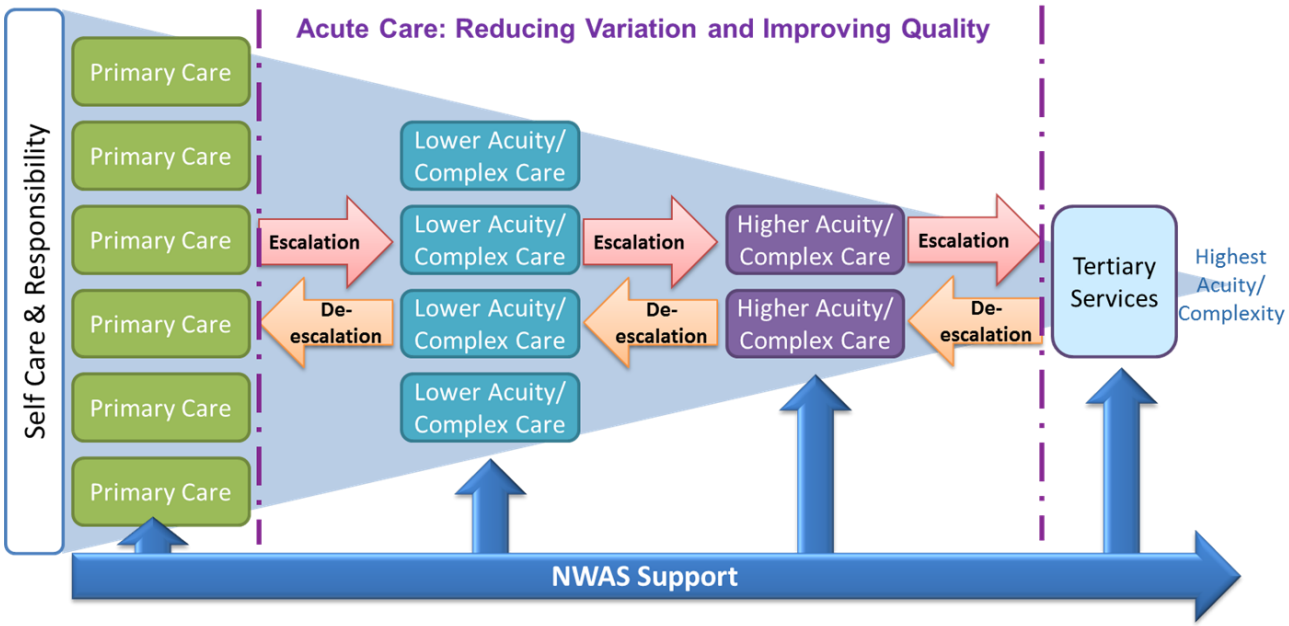
Review of Services at Southport & Ormskirk NHS Trust

NHS Southport & Formby CCG will lead a review of the services provided by Southport and Ormskirk NHS Trust, the outcome of which is to ensure long term clinical and financial sustainability and to meet the particular needs of this population. The review process will be conducted by a multi-stakeholder partnership that will develop a case for change which will inform plans for the future of these services.

- Process, Governance and Stakeholder Mapping (Jan-March 2017)
- Case for Change (April-June 2017)
- Pre-consultation engagement (July-September 2017)

The Alliance

The Alliance has developed a vision for hospital reconfiguration, and started to develop a range of options. A plan for the assessment and design of these services will be completed by December.



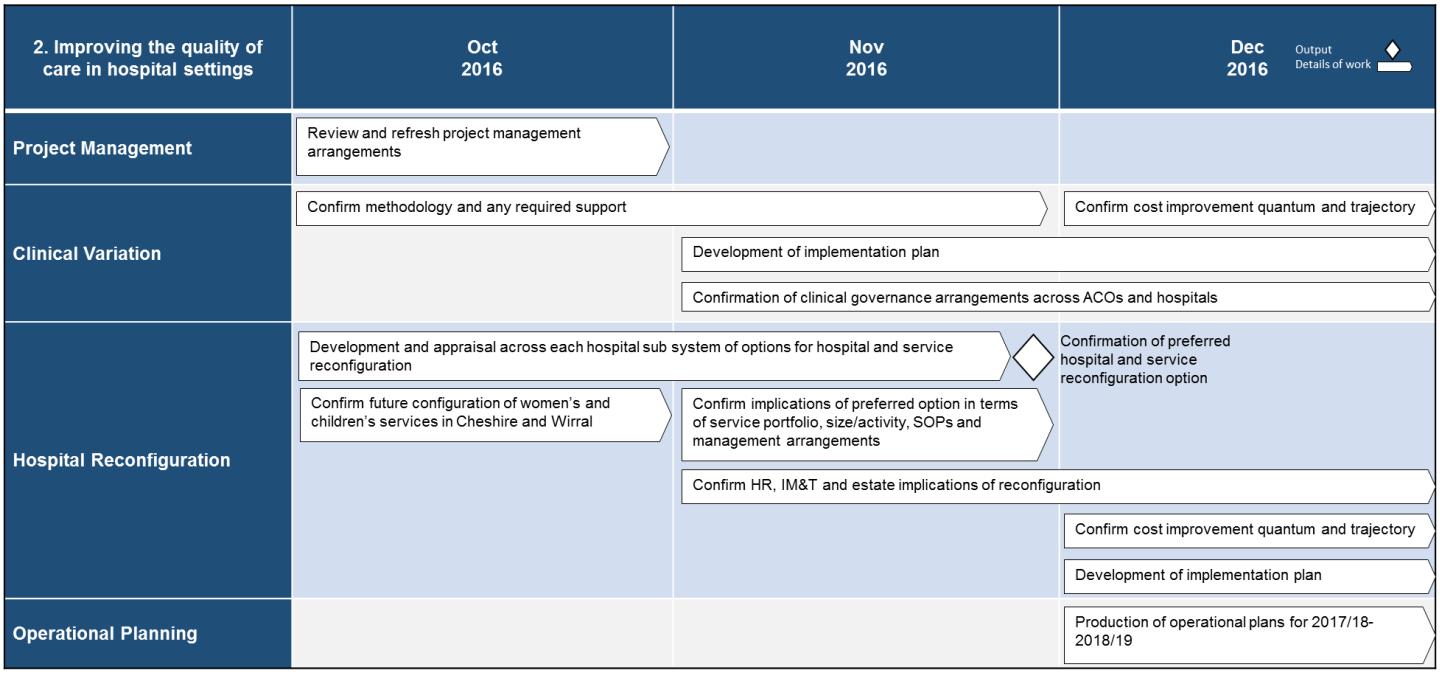
2.2 - Improve the quality of care in hospital settings – LDS plans

Whilst there is clear benefit in developing this thinking at STP level there remains a great deal of similar work across the three LDSs, supported by work in the cross cutting clinical programmes that will also inform potential solutions.

The highlights from the LDS plans shown below are designed to drive out variation, improve standardised levels of care and configure hospital services in a way that best provides efficient quality care.

Cheshire and Wirral

C&W have a short term plan to rapidly address variation and reconfigure hospital services across Cheshire and Wirral



Hospital Services in Eastern Cheshire

The Caring Together programme is a well-established transformation programme within Eastern Cheshire. The programme aims to improve the health and wellbeing of the local people by implementing enhanced integrated community care supported by clinically and financially sustainable hospital services.

Extensive modelling work has been completed and indicates that transforming just one segment or service of the local health and social care economy will not be sufficient to address the challenges the economy is now facing. Instead a system-wide solution is needed. The Caring Together Programme Board met with system regulators (NHS England and NHS Improvement) on 17 October 2016 and agreed to complete financial modelling on two care model options.

The two options are based on clinical and financial sustainability of hospital services at East Cheshire Trust, taking into account clinical dependencies and the impact these options have on the development of enhanced proactive community care for the local population.

Options for the future of high risk general surgery are currently under review and The CCG is working with East Cheshire Trust to assess compliance of the *Healthier Together* standards from April 2017.

The modelling of Options 1 and 2 including capital requirements and potential impacts of tariff plus payments/MFF will be completed by the end of 2016 with the findings being presented to the Caring Together Programme Board and NHSI/NHSE for a final decision in early 2017.

2.3a - Optimise direct patient care – reduce the cost of administration

Introduction

We previously referred to this programme as 'Back Office'.

While performance improvements within organisations remain important, we are making a move to longer term transformation and strategic planning across the health and care economy.

Our vision for collaborative productivity is to deliver cost effective, efficient and commercially sustainable Back Office operations. The ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.

What are the objectives

- Reduced spend in the Back Office will enable additional spend and effort to be directed towards front line services.
- Cost reduction in Back Office is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services.
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system.
- Improve links and engagement with stakeholders to ensure that reconfigured services meet both corporate and clinical need.
- Identify the required changes to ways of working and to organisational culture to enable delivery of collaboration.
- Create an engaging and rewarding place to work, operating flexibly across structures and ensuring staff are able to build a broad framework of skills and experience
- Ensure that Back Office operations are sufficiently flexible to meet changing needs of the organisations in the footprint

Why is this programme important?

The Carter Review made clear that we can no longer rely on traditional efficiencies and cost improvement programmes within single organisations.

Instead, we are working more collaboratively to realise the productivity and service improvement opportunities which lie beyond organisational boundaries. This is how real efficiencies are identified and how greater economies of scale can be delivered.

Values - Where appropriate, Back Office services will be maintained within the NHS to provide wider economic benefit to communities in Cheshire & Merseyside region.

What is the scope of the work

For all Back Office services, the ambition is to collaborate at STP level, but to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint.
The projects that will delivered are to be prioritised on the basis of deliverability, scale of benefit and time to transform.

Projects can be described in two ways:

- Transactional savings leveraging economies of scale and best in class approaches and models across the patch
- Procurement at category level, then built up to a cluster approach at LDS and then STP level

How will the change be lead?

Sponsor:	Nikhil Khashu
Members:	Alliance – Andrea Chadwick, WHH Cheshire & Wirral – Tony Chambers North Mersey – Aidan Kehoe Local Gov't - **TBD**

2.3a - Optimise direct patient care – reduce the cost of administration

Delivery

The 'Plan on a Page below is a summary of the more detailed plans that are included in the Appendices.

There is a clear opportunity to create some early wins in this programme, though there are risks and challenges - he key challenge being the capability and capacity to deliver within the timescales.

The main enablers for the Back Office programme will be:

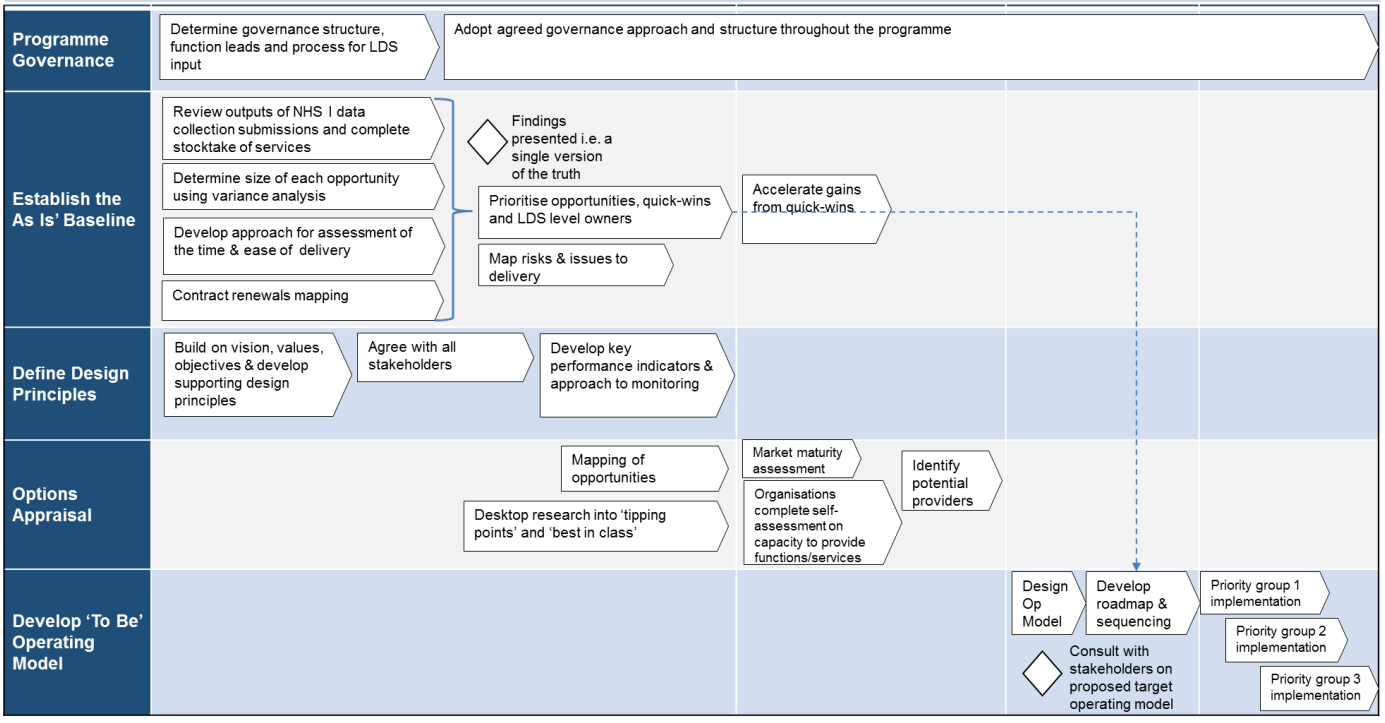
- Breaking down department or Trust silos and ensure open communication and sharing of data.
- Sharing lessons learnt and good practice swiftly and openly
- Investment in required technology and systems.
- Balanced focus across business as usual and future state development – being future focussed according to the needs of our stakeholders.

Proposed Governance Arrangements

- The existing Back Office Steering Group is to become the Back Office Programme Board
- Back Office SRO is a member of the Steering Group representing the 3 LDSs, with a remit to challenge, drive and support the LDSs in the delivery of the programme and where appropriate, escalate issues or opportunities to STP Membership Group for consideration
- LDS Back Office leads / SROs will be part of the Programme Board
- Governance at the level of the LDS leads for the functional areas will be determined as part of the next phase of work.

Immediate next steps

- Determine governance for the Back Office programme considering the structure, leads for identified function areas and process for LDS input
- Collate and analyse the organisation submissions for the NHS Improvement corporate and administrative data collection exercise
- Complete stocktake of services delivered at an organisational level
- Present findings from both of the above and gain agreement from all stakeholders on the current 'as-is' state



2.3b - Optimise direct patient care – efficient clinical support services

Introduction

We previously referred to this programme as 'Middle Office, or Clinical Support Services'.

The vision is to deliver cost effective, efficient and commercially sustainable Clinical Support Services which can be transformed to deliver improved services to front line services across the STP footprint.

What are the objectives

- Reducing variations in practice / services across the STP footprint area and develop a set of standards which every service can comply with irrespective of *how* they are delivered (e.g. either via a "network" arrangement or a single managed service).
- Reduced spend by delivering increased efficiencies generated by Clinical Support Services operating differently across the C&M footprint, enabling additional spend and effort to be directed towards front line services.
- Cost reduction in Clinical Support Service areas is a key driver of change, but the programme must also deliver increased customer services and better user experience, reducing the time and effort clinical staff spend interacting with non-patient-facing services
- Existing good practice in the STP will be shared and form the minimum benchmark for improvement, and national examples of best practice should form the basis of the approach to collaboration where appropriate to the local system
- Reduction of on call rotas through better / increased use of digital enablers

Why is this programme important?

The Carter Review, and indeed Lord Carter's review of pathology services some 15 years ago, demonstrated that there is still a significant potential saving if these services are consolidated on a regional basis.

Therefore, there are a range of future collaborative models which we are considering across the different support services in C&M, ranging from, for instance, setting up a single wholly owned subsidiary organisation for manufacturing and dispensing medicines, to outsourcing dialysis services to a satellite dialysis provider.

What is the scope of the work

- Radiology
- Pharmacy
- Pathology

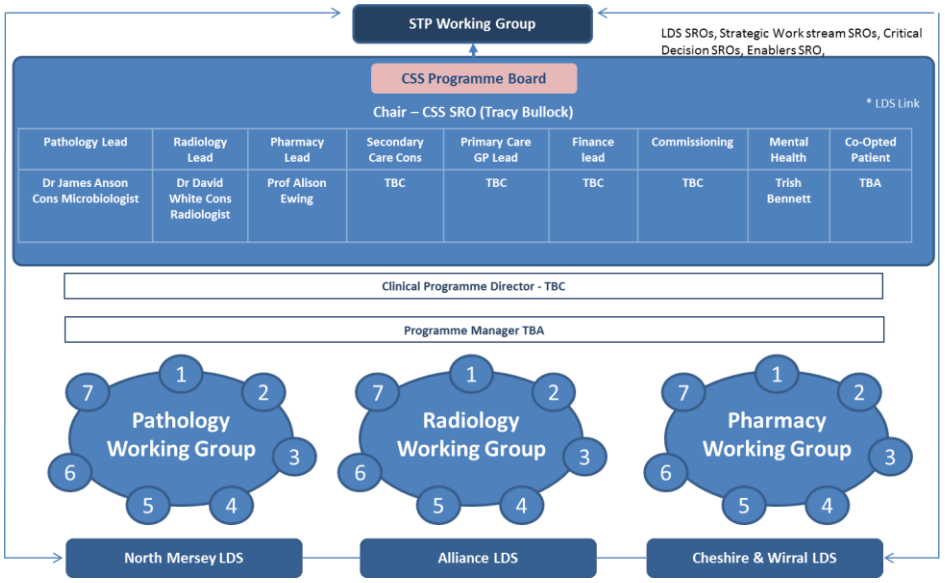
The ambition is to collaborate at STP level wherever possible and to build to this capability in phases, recognising the organisational and operational challenges of working together at scale and across a complex footprint

How will the change be lead?

Sponsor:	Tracey Bullock	
Members:	Pharmacy:	Karen Thomas, Prof. Alison Ewing
	Pathology:	Dr James Anson
	Radiology:	Dr Dave White

2.3b Optimise direct patient care – efficient clinical support services

Proposed Governance Arrangements



Delivery

The principle is collaboration across the entire STP but recognising that this will be a journey starting with programme based collaboration at STP level in the first 18 months of the programme, building to full STP collaboration where appropriate between 18 and 36 months or even longer in some cases.

The 'Plans on a Page, below and overleaf, are summaries of the more detailed plans that are included in the Appendices.

3b. Optimise direct patient care: Clinical support services- Radiology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019
Collaborative reporting arrangements	Develop project scope and review 'as is' model Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify and evaluate options for future delivery arrangements Develop new operating model and a business case Determine investment costs required to ensure IT systems are compliant across the footprint	Consult on the proposed business case proposal Examine governance and HR requirements to support proposed new model of care
Flexible reporting arrangements – home reporting	Identify how working practices might need to be changed to promote a change in reporting arrangements Agree new design principles Identify the options for future delivery arrangements Identify any infrastructure/IT costs to support/facilitate home care reporting arrangements Carry out gap analysis of how future reporting arrangements compare to current and identify potential investment costs	Increased use of honorary contracts Examine governance and HR/legal issues in support of changing practices Introduce trials of home reporting arrangements and carry out evaluation of results Expansion of home reporting across the C&M footprint
Flexible reporting arrangements- establishing 'hub and spoke' units	Consideration and development of new operating model including establishment of a central management team charged with managing requests for work/balancing demand with capacity in system Explore flexibility/use of honorary contracts to support flexible working arrangement across Trusts	Examine implications of introducing honorary contracts to allow flexible working arrangement across Trusts Establish central reporting hubs to allow group involvement in speciality reporting Consolidation and expansion of radiographer role extension
Greater collaboration around procurement	Carry out audit of equipment which is regularly purchased by type, manufacturer and value Identify when larger items are due for replacement and synchronise purchasing schedule Standardise range of equipment lines Establish a single managed service via a lead Trust/supplies team to lead the negotiations with potential suppliers about the range of items required and agree potential discounts	Commence the procurement of standard range of interventional radiology equipment Central procurement of contrast media Central procurement of imaging technology

Output Details of work

2.3b Optimise direct patient care – efficient clinical support services

Delivery, cont.

3b. Optimise direct patient care: Clinical support services- Pathology	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output Details of work
LDS consolidation and partial centralisation (phase 1)	Alliance merger consolidate further with Warrington North Mersey LDS to complete consolidation by merger of Regional Genetic Service into LCL and examine the potential merger/centralisation of Alder Hey pathology service into LCL Cheshire and Wirral- to review collaborative models feasible between the current collaboration and CoCH & Wirral. Identify options for further consolidation/centralisation of services Identify current unsustainable services and opportunities across C&W/C&M for short term sustainability Identify IT and support system investments required vs financial/sustainability benefits Develop business cases	Develop Project Implementation Boards to implement agreed business cases
STP wide/C&M single managed service	Commence scoping of potential future strategic direction of services including development of baseline position (costs, staffing, service and performance issues) Look at demand and capacity and site options to accommodate any further centralisation options Undertake workshops and engagement sessions with key stakeholders to define a well understood and agreed set of design principles that could govern future change with specific focus on the use of increased collaborative working arrangements. Define which processes are suitable for delivery through a more consolidated function versus those that should be retained within local hospitals / LDS level	Review potential governance models that could best support an STP single managed service Review governance arrangements that could support the operation of the above solution and clarify performance of services required Review and discuss potential vision and models with stakeholders to seek buy-in and support Consider how this supports the acute service reconfiguration model which evolves from the STP work Undertake an options appraisal of the best solution and identify the relevant costs and benefits associated with this for the C&M footprint area Examine the potential for novation of contracts over time

3b. Optimise direct patient care: Clinical support services- Pharmacy	Phase 1 Oct-Mar 2016-2018	Phase 2 Apr-Sep 2018-2019 Output Details of work
Medicines information	Develop project scope Identify and evaluate options CEO/STP sign off	Implement new operating model and establish and transfer services
Aseptic service	Develop project scope and clarify investment/support costs Establish 'as is' position- audit what is currently provided at each site and identify those areas that could be centralised and what would need to remain under local direction Agree vision ('to be' operating model) and establish design principles	Establish a communication plan Evaluate estate's capacity/capability to meet potential transfer of services Develop business case to support service proposal Develop stakeholder engagement plan and engage key stakeholders Finalise options Develop implementation plan Commence roll out of proposed service moves
Clinical Pharmacy Templates	Develop project scope and clarify investment/support costs Establish 'as is' position- Assess what is currently done and how pharmacists/technicians currently spend their time delivering these functions Identify what a good pharmacy service looks like Establish patient:pharmacist contact criteria eg when a patient would see a pharmacist, how long consultation should take (average) Establish criteria which would support a medicines review for a technician	Design templates for pharmacists and technicians and agree new standards of working Undertake a gap analysis- compare proposed solution with the 'as is' situation and develop a case for change Develop a shared medicines management training programme via e-learning package Staff side engagement and consultation Establish potential opportunity for improvement across the STP footprint from moving to the new operating model Set KPIs to inform performance management and to adhere to standards
Forging links with the community Pharmacy	Develop project scope and clarify investment/support costs Establish vision of the proposed future state Undertake assessment of current pharmacy dispensing arrangements across every Trust in the C&M footprint and how they are funded Explore legal implications of the proposed operating model Evaluate potential options/commercial vehicles to support the proposed venture/operating model	Develop service specification and obtain professional advice Develop tender arrangements to secure preferred partner Develop appropriate legal documentation to support the proposed commercial partnership arrangement Determine new governance arrangements Set up new commercial vehicle(s) with proposed community pharmacy partner
Formulary management and application	Review current plans/proposals being developed in C&W in short term for proposals to cover the five existing Trusts in the area Undertake assessment of staffing costs Agree, if applicable, a wider vision and target operating model prior to regional centres being established Consider proposed governance arrangements to support proposed model	Consult with stakeholders on proposed single sit solution and how this will work Implement single formulary arrangement with the advent of the Regional Medicine Optimisation Committee coming on line for the North West area

2.4 - Mental Health

Introduction

Mental disorder is responsible for the largest proportion of the disease burden in the UK (22.8%), which is larger than cardiovascular disease (16.2%) or cancer (15.9%). One in four adults experience at least one diagnosable mental health problem in any given year. *Mental health problems represent the largest single cost of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.* In England, if you have a serious mental illness, you are twice as likely to die before the age of 75 years. On average, you will die 15-20 years earlier than other people.

People with long term illnesses suffer more complications when they also develop mental health problems, increasing the cost of care by an average of 45%. For example, £1.8billion additional costs in diabetes care are attributed to poor mental health.

Two thirds of people with mental health needs are seen in primary care. Local GP registers indicate that 9 out of the 12 CCGs in Cheshire and Merseyside have a higher number of adults with depression than the England average. The number of people on Cheshire and Merseyside GP registers with severe mental illness is also higher than the England average and over 50% of Cheshire and Merseyside CCGs have been flagged for having a high prevalence rate of dementia.

Additional funding to support the transformation of mental health services will include centrally-held transformation funding and allocations via CCGs. It is assumed that an appropriate share of national monies will be made available and that this investment will rise to at least £57.9m in Cheshire and Merseyside by 2020/21. Evidence provided within the Centre for Mental Health Economic Report indicates that significant savings across the health and care system will outweigh the investment needed to deliver services.

What are the objectives

- Additional psychological therapies so that at least 19% of people with anxiety and depression access treatment, with the majority of the increase from the baseline of 15% to be integrated with primary care;
- More high-quality mental health services for children and young people, so that at least 32% of children with a diagnosable condition are able to access evidence-based services by April 2019, including all areas being part of CYP IAPT by 2018;
- Expand capacity so that more than 53% of people experiencing a first episode of psychosis begin treatment with a NICE-recommended package of care within two weeks of referral.
- Increase access to individual placement support for people with severe mental illness in secondary care services by 25% by April 2019 against 2017/18 baseline;
- Commission community eating disorder teams so that 95% of children and young people receive treatment within four weeks of referral for routine case; and one week for urgent cases;
- Reduce suicide rates by 10% against the 2016/17 baseline.
- Ensure delivery of the mental health access and quality standards including 24/7 access to community crisis resolution teams and home treatment teams and mental health liaison services in acute hospitals.
- Increase baseline spend on mental health to deliver the Mental Health Investment Standard.
- Maintain a dementia diagnosis rate of at least two thirds of estimated local prevalence, and have due regard to the forthcoming NHS implementation guidance on dementia focusing on post-diagnostic care and support.
- Eliminate out of area placements for non-specialist acute care by 2020/21.

A C&M Mental Health Programme Board will be established to oversee nine workstreams to facilitate delivery of these key objectives. The Board will identify workstream owners and confirm timescales for delivery of all workstreams.

How will the change be lead

Sponsor:	Sheena Cumiskey
Members:	Alliance – Simon Barber C&W – Sheena Cumiskey North Mersey – Neil Smith / Joe Rafferty

2.4 - Mental Health

Delivery

Three priorities have been identified for early implementation:

- Eliminate out-of area-placements
- Develop integrated clinical pathways for those with a personality disorder
- Enhance Psychiatric Liaison provision across the footprint and establish Medically Unexplained Symptoms (MUS) service

The nine projects below have been developed to deliver the objectives. Detailed plans for each workstream are currently being prepared.

A Mental Health plan on a page is included overleaf to provide the headline phases of work.

Project	Impact	'Workstream'
Children & Young People's (CYP) MH	Increased number of CYP receiving community treatment; reduced use of inpatient beds; improved outcomes for children with conduct disorder leading to savings in the public sector, mainly the NHS, education & criminal justice	• Community access • 24/7 crisis & liaison • School age screening & education
Perinatal MH (PMH)	Improved identification of perinatal depression & anxiety; improved health outcomes; reduction in adverse impact on the child (which account for >70% of total long-term costs to society);	• Build PMH capacity & capability • Improve screening programmes & access to psychological therapy
Adult MH: Common MH Problems	Relieve pressure on General Practice , reduce A&E attends & short stay admissions. Target most costly 5% of patients with medically unexplained symptoms (MUS)	• Increase access to psychological therapies • Develop Medically Unexplained Symptoms Service
Adult MH: Community, Acute & Crisis Care	Reduced bed days, lower rates of relapse, reduced admissions and lengths of stay Reduced use of MH services and improved outcomes	• Early Intervention in Psychosis • 24/7 Crisis Resolution & HTT • All-age MH Liaison in acute • Increase GP screening & access • Scale up IPS employment services • Improve psychological therapies
Secure Care Pathway	Prevent avoidable admissions & support 'step-down' and ongoing recovery	• Improve pathways in & out of secure care
Health & Justice	Fewer GP consultations, hospital admissions & inpatient MH treatment	• Expand access to liaison & diversion services
Suicide Prevention	Main benefits relate to non-public sector costs relating to the individual and the family	• Suicide Prevention
Sustaining Transformation	Prevent avoidable admissions, reduce length of stay, improve community access and eliminate out-of-area placements	• Care pathways • Workforce MH
Dementia Care	Increase dementia diagnosis rates & create dementia-friendly health & care settings	• Implement commitments from PM's Challenge on Dementia 2020

2.4 - Mental Health – plan on a page

9. Mental Health		2016-2017	2017-2018	2018-2019	2019-2020	2020-2021
Enablers	Output / Details of work	Establish Transformation Board; Identify BI capacity & capability to complete baseline assessments & provide ongoing support / delivery of schemes; Confirmation of funding as per 5 YFV for MH				
Children & Young People's (CYP) Mental Health	Community access	Design	Implementation	Post-implementation phase. PDSA		
	24/7 crisis & liaison	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Screening of school children & provision of parenting programmes	TBC				
	Develop school based mental health curriculum (social & emotional learning)	TBC				
Perinatal Mental Health	Build PMH capacity & capability and improve screening programmes & access to psychological therapy	Recruitment	Full implementation	Post-implementation phase. PDSA		
Adult Mental Health: Common MH problems	Increase access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Develop a specialist Medically Unexplained Symptoms (MUS) service	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Provide collaborative care for long-term conditions & co-morbid MH		Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Early Intervention in Psychosis	Implementation	Post-implementation phase. PDSA			
	24/7 Crisis Resolution & HTT	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Deliver all-age mental health liaison teams in acute hospitals	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Armed forces community MH		Baseline assessment, design & implementation	Post-implementation phase. PDSA		
	Increase GP screening & access		TBC			
	Scale up IPS employment services		TBC			
	Improve access to psychological therapies	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
	Supported housing step-down facility		TBC			
	Improve pathways in & out of secure care		TBC			
	Expand access to liaison and diversion services		TBC			
	Suicide Prevention	Design	Implementation	Post-implementation phase. PDSA		
	Care pathways (multi-phased)	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		
			Baseline assessment & design	Implementation	Post-implementation phase. PDSA	
	Workforce MH		TBC			
	Implement the 18 commitments outlined in the Prime Ministers Challenge on Dementia 2020	Baseline assessment & design	Implementation	Post-implementation phase. PDSA		

3 - Embedding the change locally

Please see separately attached LDS plans in full

LDS Plans

The previous section has described the programmes of work at the STP level, together with the LDS's contribution to them. Delivery happens at LDS level, and in the organisations that make up the LDS so it is important that the LDS's have a clear set of plans to effect implementation of the STP programmes, as well as delivering on their own portfolio of change and transformation.

The strategic programmes that will drive transformation across C&M are not new or particular to C&M. They are issues that health economies have tackled over many years but so often failed to deliver on.

However, there is now an compelling need to deliver on these ideas that have been developing. This is reflected in the plans of the three LDSs. All three have already put in place programmes to help improve out of hospital care, to reduce the demand on our acute hospitals and to persuade people that they need to take responsibility for their own health.

Acute hospitals in each LDS have started work on aligning and sharing services, including clinical service lines, and in North Mersey, merger discussions are at an advanced stage. There is also a, mixed, history of back office collaboration and working together on city and county wide issues.

Over the following pages we have summarised the key programmes being developed in each LDS, together with their delivery plans.

The graphics below illustrate the overall alignment of LDS plans with the STP's strategic programmes:

1. Demand Management,
2. Variation and Hospital Reconfiguration,
3. a) Back Office, b) Clinical Support Services, and
4. Mental Health

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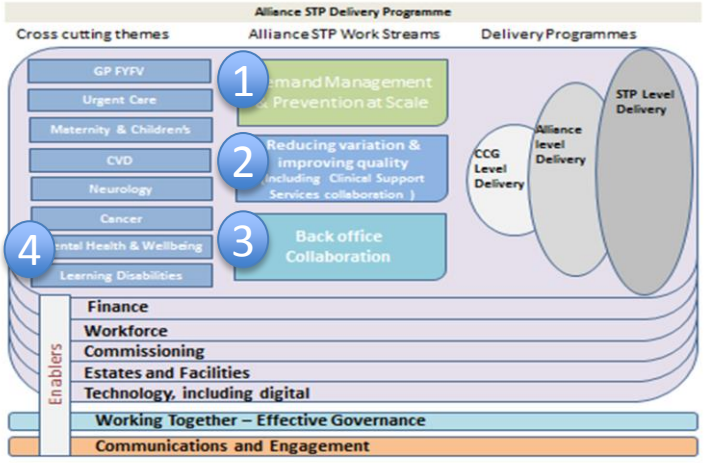
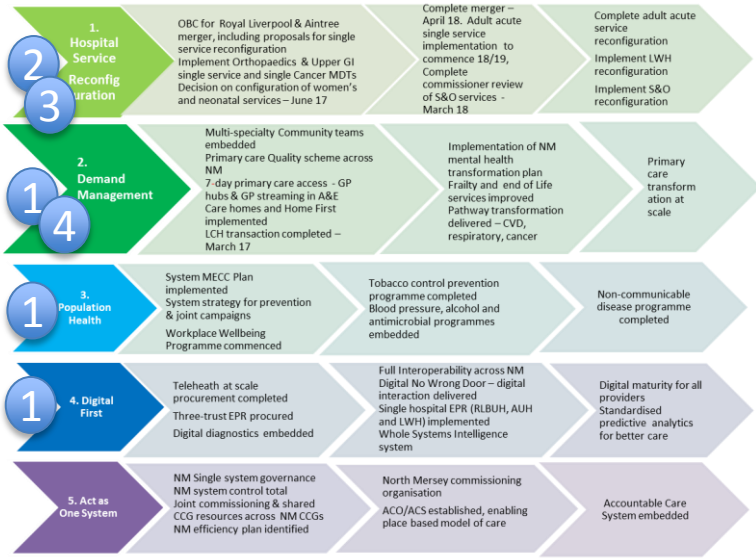
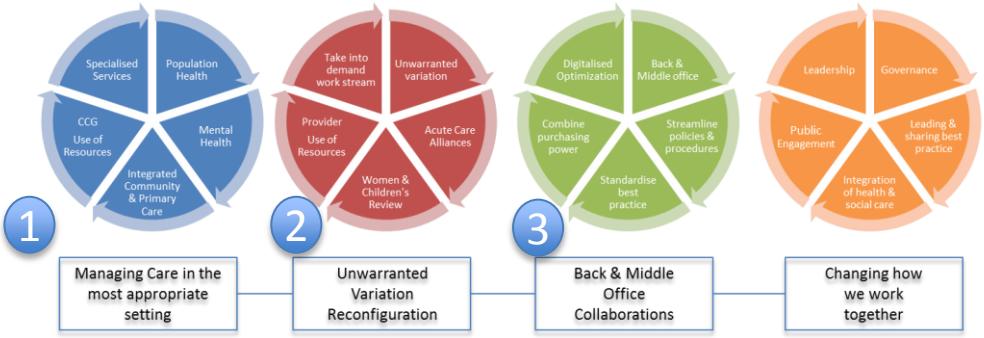






3.1 - Alliance approach and plans

The Alliance LDS has aligned its transformational work streams and delivery structure to mirror that of the C&M STP to ensure that delivery will be at the most appropriate level – organisational, LDS level or STP footprint.

Since the June submission the Alliance has gained a greater understanding of the potential service models that will transform services and achieve long term financial sustainability.

This plan represents options and models of transformation for the local health system that have been developed by the member organisations and are still subject to wider engagement and where necessary formal consultation with stakeholders.

Alliance LDS – Transformation Plan on a page

Transformation Programmes	Schemes (subject to consultation)	Benefits	Net Saving	Year (full benefits delivered)
Prevention at Scale	Alcohol Blood Pressure AMR	Improved population health Less MRSA	£3.5m	2019/20
Out of Hospital Care /Demand Management (Inc. Mental Health)	• Referral Management • Single Point of Access • Integrated Community Teams (Virtual Ward, Intermediate Care, Discharge to Assess, Rapid Assessment) • Self-care – Tele-health, Telemedicine, Meds Management • Care Homes/Frail Elderly • Mental Health	Contain predicted growth in; • A&E Attendances • NEL Admissions • OP Appointments • Elective & Day case procedures	£52.5m	2018/19
Acute Care - Reducing Variation and Improving Quality (Inc. Clinical Support Services & Estates)	Single Acute Service Models • Urgent Care • Elective Care • Maternity and Children's Clinical Support Service Collaboration • Pathology • Radiology • Pharmacy Estates	• Improved outcomes • Reduced LoS • Reduced premium/agency costs • Improved efficiency (Carter metrics) • Achieve access targets	£30.1m	2020/21
Back office Collaboration	Payroll Transactional HR Procurement Financial services	• Reduce overhead costs • Reduce variation and duplication	£15.5m	2020/21

The Alliance is still developing its programme of work and the detailed plans that explain how delivery will be effected.

In addition to the core programmes shown above the Alliance is working closely with the Clinical programmes and have clear objectives with regard Urgent Care, Women's and Children's, Elective Care and Clinical Support Services

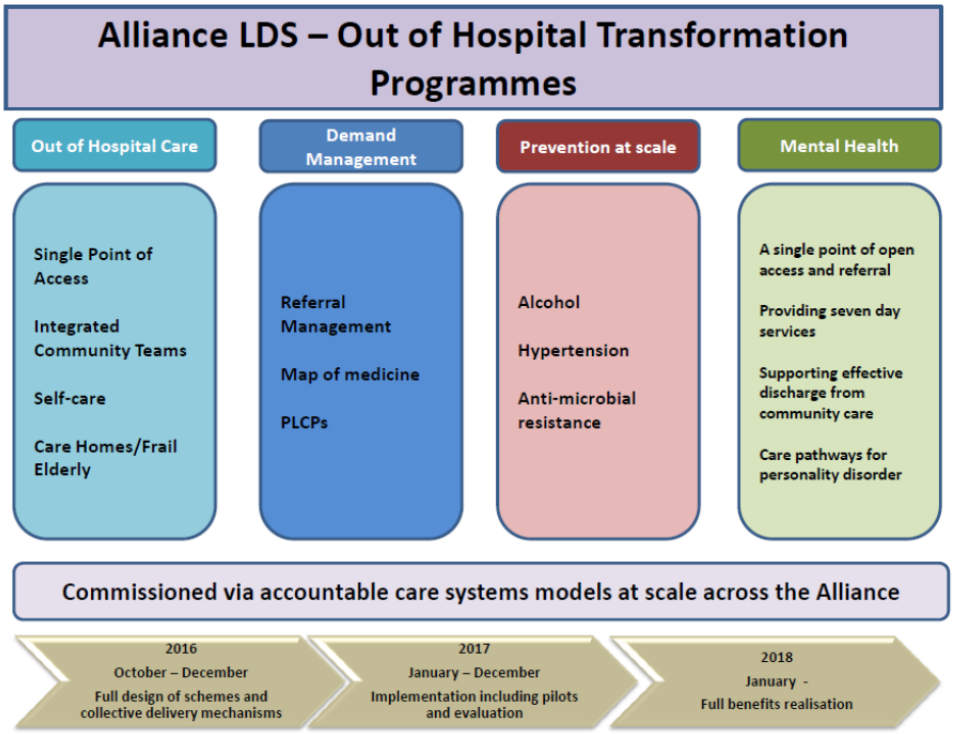
Over the page are the models and frameworks they have developed for developing improved out of hospital care and also improving the quality of acute care.

3.1 - Alliance approach and plans

Improve the health of the C&M population by:

- *Promoting physical and mental well being*
- *Improving the provision of physical and mental care in the community (i.e.outside of hospital)*

Out of hospital care is a key component of the future vision for services across the Alliance. The individual CCGs have already started to develop plans and the challenge now is for the commissioners to come together and work collaboratively to scale up the ambition and impact of these plans to impact on the overall sustainability of the LDS. This is a complex programme of work that has 4 core elements as shown below:

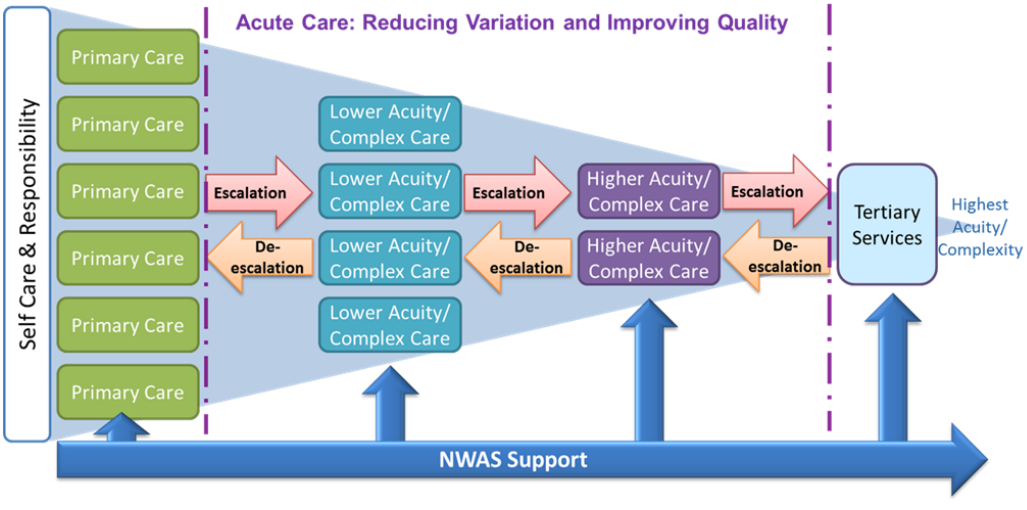


Improve the quality of care in hospital settings by:

- *Reducing the variation of care across C&M;*
- *Delivering the right level of care in the most appropriate setting*
- *Enhancing delivery of mental health care*

The Acute Providers will work together to develop a new model of working, including:

- More streaming of patients depending on their acuity and complexity
- The highest acuity care can be delivered on fewer sites with the appropriate facilities
- Site specialisation to suit that patient cohort with the appropriate resources and facilities
- NWAS streaming patients to the site/service appropriate to their need



3.1 - The Alliance plans - Demand management

Projects	Change Delivered	Outcomes
Quality Referral Management	Single quality referral management system across the Alliance LDS managing demand using Map of Medicine and generic pathways agreed between the acute hospital sites. Utilisation of Map of Medicine and greater scrutiny of PLCP.	Impacts Acute Outpatient Activity and Acute Elective and Day Cases Activity For Acute Outpatient: 20% activity reduction (equiv. 150,000), and £22.5m gross saving in FY202/21 For Acute Elective and Day cases: 4% activity reduction (equiv. 7,000) and £7m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Single point of access	Single clinical governance regime and infrastructure which enables access to the appropriate level of support in a variety of settings for patients and professionals in instances of unscheduled care	Impacts Acute Elective and Day Cases Activity and Acute Non Elective Activity For Acute Elective and Day Cases: 5% activity reduction (equiv. 5,000), and £5m gross saving in FY202/21 For Non Elective: 6% activity reduction (equiv. 5,000) and £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Integrated community management teams (virtual ward)	Integrated services involving social care which not only involves the work of professional teams but also integrated information systems and the sharing of patient and client information; this also supports discharge by linking into SPA - including domiciliary care and care homes.	Impacts Acute A&E Activity and Acute Non Elective Activity For Acute A&E: 4% activity reduction (equiv. 15,000), £1.8m gross saving in FY2020/21 For Acute Non Elective: 5% activity reduction (equiv. 5,000), £7.5m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Medicines Management Optimisation	Reduction in primary care medicines management spend	£4m gross saving in FY2020/21 0-1 year timeframe for benefits delivery
Telehealth and telecare	Identifying individuals to support better self care to provide them with IT equipment in their own home to monitor their conditions to reduce emergency admissions	For Acute A&E: 4% activity reduction (equiv. 15,000) and £1.8m gross saving in FY2020/21 2-3 year timeframe for benefits delivery
Rapid response/ rapid assessment	Rapid response and assessment team respond quickly to urgent requests at home, with one of the boroughs employing a community geriatrician	Acute A&E Activity: 3% activity reduction (equiv. 10,000) with £1.2m gross saving in FY2020/21 1-2 year timeframe for benefits delivery
Prevention	STP-wide strategy to reduce the prevalence of alcohol-related conditions or episodes and impact on primary and acute	

3.1 - The Alliance plans - Variation and hospital reconfiguration (1/3)

Projects	Change Delivered	Outcomes
Urgent Care System **Model of Care 1**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 3 Trusts will have a Type I - 24hr A&E, but through shared rotas and federation of staff premium payments would be reduced. Modelling of staffing rotas and new working patterns/processes will improve productivity	Reductions in the consultant on call cover and presence Reduction in the use of locums /agency. Productivity improved through the use of best practice Alignment with commissioner interventions
Urgent Care System **Model of Care 2**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 3 Trusts will have a 24hr A&E High acuity patients will be transferred to the Emergency centre (for example: stroke, heart attack, compound fracture, burns, emergency dialysis, some trauma, GI Bleeds) By federating staff and remodelling of staffing rotas and new working patterns/ processes will improve productivity and reduce premium payments Alignment with commissioner demand management interventions	Accelerated flow through departments to achieve more optimal performance Reduction in the use of staff premium payments. Consultant presence and cover will reduce on call payment Activity transfer of patient numbers per year (one site) More effective use of bed capacity Redistribution of elective activity to other centres (To Be Determined)
Urgent Care System **Model of Care 3**	S&O will consider the potential options for new models of A&E delivery – subject to further engagement 1 Trust will have a Type I - 24hr A&E, 2 trusts will re-profile opening hours with activity flowing to other 24/7 centres Alignment with commissioner demand management interventions	Reductions in the consultant cover from 3 to 2 on call covering 3 sites. Reduction in the use of locums /agency staff. Activity transfer of 8,700-20,000 patients per year (one site) Increase in bed capacity of 80-150 beds required/freed up. Redistribution of elective activity to other centres To Be Determined
Stroke Services	The Acute vision is for Whiston to be the Hyper Acute provider for the LDS support by a 1 in 8 rota. Single point of contact and standardise referral process All ESD teams to have equal access to discharge plans for proactive discharge planning Single CCG lead for ESD and Community for cross organisational services Development of Unified ESD and Community teams.	Single provider for Hyper Acute, networked support across acute units and community teams Consistent approach across the Alliance Patients repatriated to local centre A reduction in premium payments

3.1 - The Alliance plans - Variation and hospital reconfiguration (2/3)

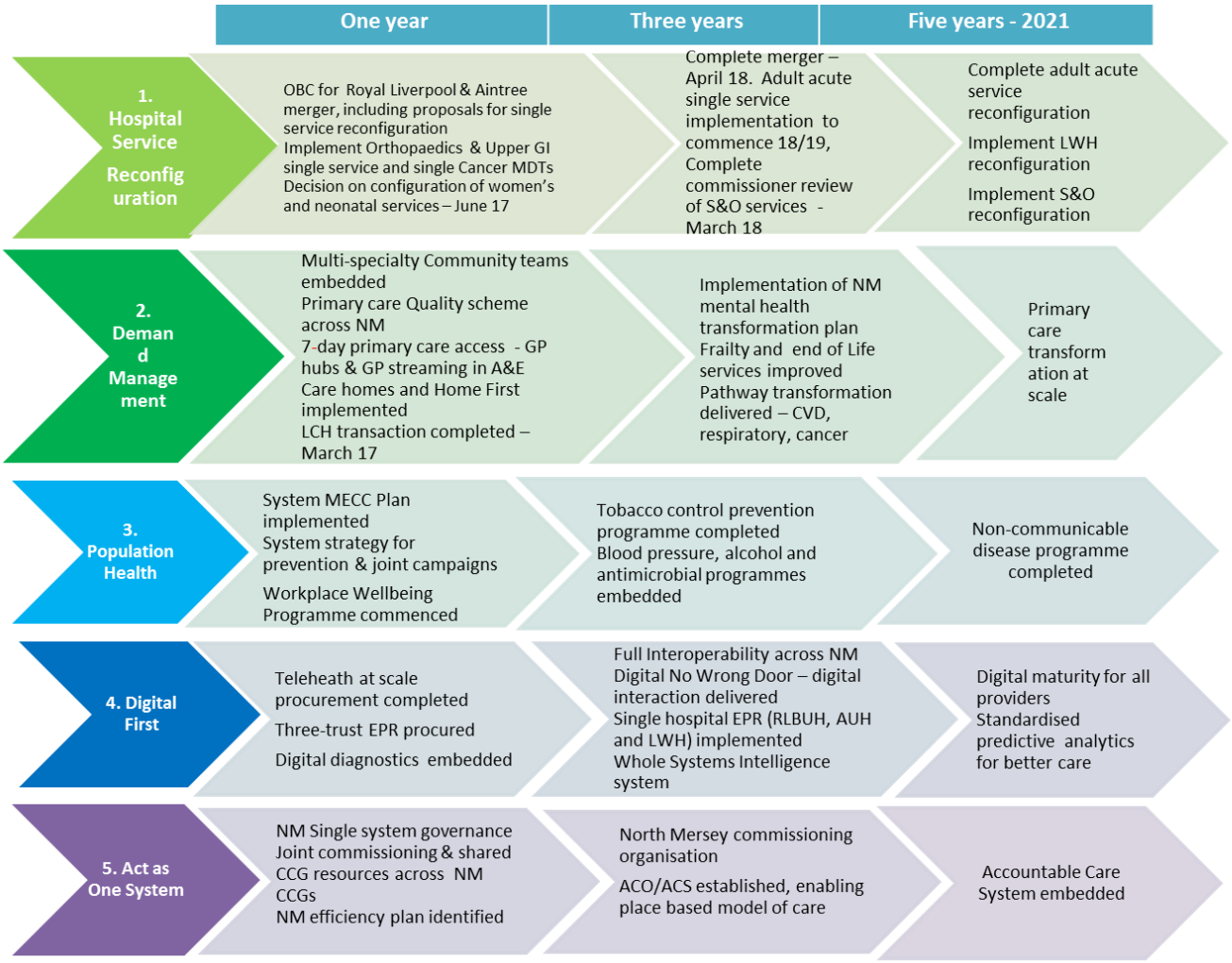
Projects	Change Delivered	Outcomes
Paediatric Services Review	Alignment with Vanguard Proposals for a 'Single Service' Move from 3x level 2 units to: 2x high acuity units & 1 lower acuity unit or 1x high acuity units & 2 lower acuity unit or Higher and Lower levels of Acuity **Acute Inpatient Unit – 24hrs** Paediatric A&E 24hrs GP hotline Outpatients Rapid access clinics HDU Inpatient unit Neonates: Level 1/2 Community home nursing sup. Day case surgeries Anaesthetic cover **Short Stay Unit – 12hrs** Paediatric A&E GP hotline Outpatients Rapid access clinics Neonates : level 1/2 Community home nursing sup. Day case surgeries APNPs Safe transfer to AIU	**High Quality** Resources, facilities and the care delivered in each site is tailored to the patient cohort treated ALL hospitals will be required to attain Quality and Safety standards. **Safe** Specialist consultant resources will be concentrated on the highest acuity patients Evidence shows that the more times a surgeon performs a procedure, the better the outcome. Focusing the delivery of highly specialist care in fewer locations means that our professionals will gain the volume and breadth of experience to deliver excellent quality care **Accessible** Better access to Primary care will alleviate pressure on services. Streaming the highest acuity cases to a Red Hospital means a Green hospital can deal efficiently with lower acuity demand Staffing levels will be standardised and ALL hospitals will be required to attain standards. This means quality care will be delivered in ALL our hospitals **Sustainable** This model proposed is a more effective use of existing resources
Maternity Services Review	Alignment with Vanguard Proposals for a single service	
Elective Services Review & Productivity Review	Improvement in Length of stay benchmarked against Better Care Better Value Ward reductions / closures based on reductions in Delayed Transfer of Care Premium pay reductions resulting from the application of standardised care pathways Benchmark against upper quartile and within the Alliance to move to the most productive amongst peers and best in class Exploration of a Factory Model for simple high volume procedures such as: • Orthopaedics • Ophthalmology • Plastics These could be scheduled for day case and short stay <72hrs procedures at Treatment Centres Alignment with commissioner demand management interventions	Better Care Better Value Reduction in Delayed Transfers Of Care Reductions in Premium Payments Reduction in bed days Reduced number of delayed transfers of care Reduction in costs Alignment with commissioner demand management interventions Reduction in variation of care and outcome Higher productivity levels Improved utilisation of theatres Lower length of stay

3.1 - The Alliance plans - Variation and hospital reconfiguration (3/3)

Projects	Change Delivered	Outcomes
Sub-scale Services Review	Federate services to make them more clinically sustainable and reduce the premium payments , see above Urology; Dermatology, Rheumatology; Diabetology, Orthodontics; Respiratory Medicine; Acute Medicine, Geriatric Medicine	Clinically Sustainable Services Reduction in on-call rotas Reduction in premium payments amounts to around £4.7m Alignment with commissioner demand management interventions
Pathology	Moving from a Bi-partite arrangement between STHK and S&O to a tri-partite arrangement to include WHH	Lower unit costs Reduced investment required Increased productivity Consolidation of staffing levels 4% reduction in costs year on year
Pharmacy	Opportunity to outsource/ create a JV for outpatient dispensary Alignment with STP Review, sub regional solution likely	VAT advantages 4% reduction in costs year on year
Radiology	Alignment with STP Review, sub regional solution likely	4% reduction in costs year on year

3.2 - North Mersey approach and plans

The North Mersey plan builds upon and joins-up established transformation programmes; including *Shaping Sefton* and *Healthy Liverpool,* which was established in 2013 in response to the city's Mayoral Health Commission. The commission's ten recommendations recognised that such was the extent of poor health outcomes, and the relentless pressures on resources, that only a whole-system approach to the transformation of health and care would succeed. The commission's insight and mandate to the local NHS and partners to deliver change has given the North Mersey delivery system a three year head start in identifying and now delivering the whole system transformation plans that are set out in the Cheshire and Merseyside STP. It is represented by this 'Plan on a Page':



Each of the programmes above has a delivery plan that clearly lays out the projects that are being mobilised, the expected outputs and outcomes and forecast benefits.

Overleaf are North Mersey's plans for each of these programmes

3.2 - North Mersey plans for hospital reconfiguration

Programmes	Projects	Outputs	Start Date	End date
Single service system-wide delivery for adult acute services **Plan** SOC completed OBC commenced Project plan in development	Reconfiguration of 35 adult acute services across RLBUH, AUH and LHCH, to establish single service, system-wide services. Detailed service reconfiguration plan to be set out in an Outline Business Case, currently in development	• Single service pathways across all adult acute services • Single clinical workforce for adult acute services across 3 trusts • Site rationalisation across 4 to 5 hospital sites in the city	April 2016	March 2021
Merger of the Royal Liverpool, Aintree and Liverpool Women's Hospitals **Plan** As above	Establish a single organisation from 3 NM trusts - RLUH, AUH and LWH Milestones: • Strategic Options Case – approved by boards, June 16 • Outline Business Case – to be completed June 2017 • Joint HLP and trust PMO to be established, Nov 16 Full Business Case and approval by regulators and mobilisation for a new trust by 1st April 2018	• Single trust to deliver the majority of adult acute service sin the city from April 2018	April 2016	March 2018
Reconfiguration of women's and neonatal services **Plan** Project plan completed and delivery on track (see below)	Women's and Neonatal Review. The objective is to achieve clinical and financial sustainability through a reconfiguration of the services provided by Liverpool Women's FT NHS Trust. Milestones: •Pre-consultation engagement – completed Aug 16 •PCBC – Oct 16 – completed •Assurance process – Sept – Nov 16 • Public consultation Jan17 •Decision May/June17	• Reconfiguration of services which address the clinical and financial challenges of delivering these services, as set out in the Review Case for Change • Improved access to essential co-dependent acute services, for example blood transfusion services, associated surgical expertise, diagnostics , interventional radiology etc • Increased scope for involvement in and patient benefits from research and innovation • Reduced transfers of care • Protecting the future delivery of specialist services within the city	Jan 2016	Decision: May 17
Neuro Network Vanguard **Plan** Programme plan	The programme objective is for a clinically and cost effective comprehensive whole system neuroscience service. People with neuro or spinal problems will receive the appropriate clinically effective care to assured standards, wherever they live, via local access points, and have an efficient and person centred experience.	• Integrated, high quality neuro, rehabilitation and pain pathways across Cheshire & Merseyside, delivered via a hub and spoke model of care • More care delivered in community settings	2016/17	2020/21
Southport & Ormskirk NHS Trust **Review of Services**	The objective is to achieve clinical and financial sustainability facilitated by a review of the services provided by Southport and Ormskirk NHS Trust. Milestones: Establish formal commissioner led major service review in a multi-stakeholder partnership. • Process, Governance and Stakeholder Mapping (Jan-March 2017) • Case for Change (April-June 2017) • Pre-consultation engagement (July-September 2017) Further milestones will follow in accordance with NHSE published "Planning, assuring and delivering service change for patients"	• Expansion of current integrated care organisation strategy. Emphasis on partnership, standardised pathways and self care in the community and primary care setting. • Reconfiguration of services which address the clinical and financial challenges, as determined by the Reviews "Case for Change" • Implementation of specialist commissioned strategy for the North West Regional Spinal Injuries Centre	January 2017	July 2018

3.2 - North Mersey plans for demand management – community 1/2

Programmes	Projects	Outputs	Start Date	End date
Integrated Multi-disciplinary Community Teams	Delivering proactive care through multidisciplinary teams operating on neighbourhood footprints of 30-50k. MDT to include general practice, community nursing, mental health, social care and a range of relevant care professionals relevant to an individuals' care.	• Reconfigured integrated multi-disciplinary teams operating on smaller neighbourhood units of 30-50k • Shared records platform • Single multi-agency assessment process (GATE Framework) • Single point of access	2015	March 2018
Primary Care Transformation	Transformation of primary care aligned to the GP Forward View and forming an essential component of the Community Model of Care Consideration of the Liverpool GP Specification across NM	• Increased integration of services across primary care • Improved workforce capacity and skill mix • Improved optimization of prescribing solutions • Standardised approach across the NM footprint	June 2016	March 2019
Primary Care Demand Management in Acute	1. Addressing activity at the front door of NM AEDs through the provision of GP streaming 2. Developing capacity and utilization of primary care through the creation of primary care hubs in the community for routine and urgent care 7 days a week	• Increased capacity to provide same day access to routine and urgent primary care 7 days per week • Urgent delivered closer to home • Increased integration of the urgent care system	Jun 2016	TBC
Effective Discharge Plan Borough specific plans in operation.	Implementation of whole system approach to support effective discharge for patients into community/home care. Focus on discharge to assess to deliver required assessments and reablement services in the patient's home (or community facility).	• Agreed pathways across whole system for discharge to home/community • Consistent protocols across the NM system • Clear system of escalation • Increase in levels of domiciliary care provision • Integration of health and social care resources • Single assessment process	Oct 2016	Mar 18
Organisational Transition **Decision October 2016 (New provider in place by April 2017)**	Transition of community services to new provider arrangements, delivering a new specification aligned to the NM community model.	• Enabler to embed the new model of care for out of hospital services • Financial sustainability	Jan 2015	Apr 17
Mental Health Plan Implement pan NM approach to Mental Health. Plan to be developed.	North Mersey Mental Health Health Transformation Board has been established. • Agreement of approach to implement new model for mental health care including: • Integration with physical health services • Implementation of new national standards/requirements Merseycare delivery of 5 year financial plan	• Integration of mental health into community model of care • Financial efficiencies	July 2016	Mar 2021
Enhanced Care Home Model **Plan** Elements in operation within South Sefton. Implementation within Liverpool from November 16.	Delivering proactive care through multi-disciplinary teams to provide regular MDT reviews in older peoples care homes. Introduction of telehealth with 24/7 access to a clinical telehealth hub	**Outputs** • Introduction of telehealth into care homes • Increase in the uptake of telehealth and telecare • MDT approach introduced • Increase in the numbers of people with a Comprehensive Geriatric Assessment	Nov 2016	Mar 2018

3.2 - North Mersey plans for demand management – community 2/2

Programmes	Projects	Outputs	Start Date	End date
Cardiology **Plan** North Mersey delivery plans in place and on-track	Whole system approach to delivering a single service delivery for cardiology services aimed at improving value from cardiology spend and improving outcomes. Six workstream areas: • Chest Pain • Cardiac Rehab • Breathlessness • Heart Rhythm • Healthy Imaging • Prevention	• Reduction in Consultant to Consultant referrals • Reduction in Outpatient appointments • Reduction in duplicate diagnostics • Reduction in inter-hospital transfers • Strengthening business continuity to support 7 day working	Oct 2015	Mar 2018
Respiratory **Plan** Plan in place but to be reviewed in line with wider North Mersey delivery arrangements	Development of a new model of integrated respiratory care with city wide delivery	• Single service pathways across all adult respiratory services. • Single clinical workforce for all adult respiratory services across the City	Jan 2016	Mar 2018
Children	Redesign of children's service infrastructure across multiple partners and sectors with a focus on integrated, community based services; primary care / general practice, community services, social care, CAMHS, education and voluntary sector. At the core is a proactive approach to health, wellbeing and care delivery, focused on children and families, utilising the Levels of Need and the Early Help tools. Prime focus on prevention and early identification of need via universal services.	• There is a clear set of objectives for this programme and a clinical blueprint is being developed to underpin the integration of teams & services.	Oct 2016	TBC
Telehealth and Assistive Technologies **Plan** Delivery plan to be reviewed in line with revised North Mersey delivery arrangements. Currently in procurement to deliver scale requirements.	• Significant scale up of the telehealth programme across North Mersey • Telehealth procurement route and specification complete; new contract enabling scale up to be implemented in December 2016 to March 2017. • Clinical technology hub embedded in community service, with amended specification.	• Full telehealth monitoring for patients with COPD, Diabetes or Heart Failure with a risk of admission above 25% and also pass the clinical suitability gateway. • Provision of 'light touch' and self care telehealth systems and apps for patients below 25% risk and for a wider range of diseases. • North Mersey wide clinical engagement and referral routes established to take advantage of economy of scale.	Apr 2016	Mar 2019

3.2 - North Mersey plans for demand management – population health

Initiatives	Projects	Benefits	Start Date	End Date
Non-communicable disease prevention strategy for North Mersey	health policy initiatives that make the healthy option the default social option.	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Jan 2017	March 2021
Making Every Contact Count (MECC)	NM MECC Plan to be developed – Dec 16 Phased implementation plan across all providers	Outcomes • Improved health outcomes • Reduced emergency admissions • Improved quality of life • Reduced years of life lost	Sept 16	March 17
Tobacco control	Prevention programmes for young people Smokefree areas Reduce outlets selling tobacco and licencing Implementing PH guidance 48 on Smoking: acute, maternity and mental health services	Outputs • Stop smoking pathway adopted across all disciplines, which includes electronic referral to the stop smoking services • Number of staff trained • 100% of patients with recorded smoking status & given brief advice • 50% of smokers electronically referred to community stop smoking service & 50% achieve a 4-week quit Outcomes • % reduction in smoking-related hospital admissions • Improved health outcomes • Reduction in smoking prevalence	Apr 17 Apr 17 Oct 17	Ongoing Mar 18 Sept 18
Workplace Wellbeing Programme	Develop programme, charter and accreditation framework Roll out across NHS and care system first Extend to NM workplaces	Outputs Numbers of accreditations and reaccreditations achieved Evidence within 6 months of accreditation through audit of hospitals as health promoting environments e.g. • Increase in physical activity programmes at work • Increase in vending machines using healthy foods and drinks • Longer term measures - 6 months/1 year • Reduction from an agreed baseline - sickness absence, staff turnover Outcomes • Improved health outcomes • Reduced hospital admissions	Dec 16	March 18

3.2 - North Mersey plans – digital roadmap

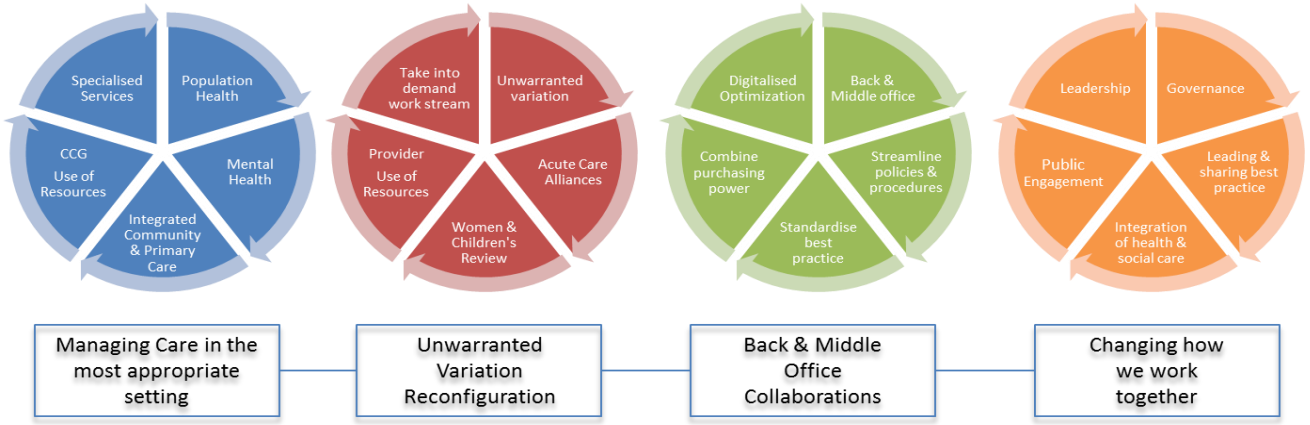
Programmes	Projects	Benefits	Start Date	End Date
Digitally Empowered People **Digital No Wrong Door & Assistive Technology** **Plan** Digital no Wrong Door plan in development Telehealth scale up in procurement phase	**Digital No Wrong Door** • Digital No Wrong Door; enabling people to interact digitally and online with the health and care system, as well as supporting population health Programmes	**Digital No Wrong Door** Outputs • A single source and platform to access information, advice and services • Online consultations with care providers and online appointments. • Use their choice of device and app to manage their care • Patients to be enabled to use assistive technology to manage their care and interact with professionals, and to access information about their own health and conditions to support them to self care. • Establish a workforce that is digitally skilled with the appropriate technology and culture to enable effective working through technology.	16/17	18/19
	Assistive Technology • Establish a range of assistive technologies that can be deployed across North Mersey in primary care, community and acute settings. This work supplements the demand management plans for deployment at scale. • Support integration and interoperability with clinical systems for improved intelligence, referral mechanisms (to increase scale and sustainability) and clinical decision making.	**Assistive Technology** Outputs • Increase in available technology • Wider range of conditions supported by assistive tech • Interoperability with clinical systems Outcomes • Further reduced emergency admissions • Improved patient experience • Improved health outcomes • Improved access to digital services	16/17	18/19
Connected Health and Social Care Economy **Plan** Plans fro all lines developed sharing agreements in place EPR procurement for 3 trusts in progress	To ensure that information is available to the right people, in the right place, at the right time Delivery of Information Sharing Framework • Digital maturity transformation of all H&S Care providers • Interoperability Programme –joining up key systems to deliver information sharing framework • Single Adult Acute Hospital EPR (3 trusts) • Maximisation of technology in Community Care Teams • Consolidated Infrastructure; enabling work across sites and better patient access **Delivered through implementation of the Merseyside Digital Roadmap**	Outputs • Every health and social care practitioner will directly access the information they need, in near real time, wherever it is held, digitally on a 24x7 basis. • Consolidated and rationalised Electronic Patient Record systems moving to a common system for out of hospital care and a common system in our hospitals with interoperability between the two. • Duplication and paper processes will be removed. • Standardised, structured, digital clinical records across all providers in the pathways of care. • No patient will need to 'repeat' their story. • All health and social care professionals record clinical information in a consistent way, digitally, at the point of care, by 2018/19. • All clinical correspondence between professionals caring for patients is sent digitally and integrated into core clinical systems by 2017/18. • Community care teams can integrate for person-centred care with technology that "just works", by 2017/18. • Individuals interact with their care services digitally should they choose to by 2018/19. • All clinicians can order diagnostic tests electronically and view share diagnostics results around a patient by 2016/17. • Single Service Teams have a single EPR to operate as a team by 2018/19.	15/16	18/19

3.2 - North Mersey plans – act as one

Programmes	Projects	Outputs	Start Date	End Date
Single-System Governance	Establish North Mersey system governance for strategic oversight, delivery of the LDS Plan and input into STP delivery. Healthy Liverpool Leadership Group to extend to NM. Financial Governance; establish governance framework for single-system accountability for managing financial risks and benefits, to achieve NM control totals and financial balance by 2021.	• Robust, embedded governance model to enable whole-system accountability and decision-making • Financial risk sharing to achieve system control total	July 16	Oct16
Commissioning Arrangements	Objective: to establish the optimum commissioning arrangements to deliver NM LDS Plan: • Establish joint commissioning programmes, with clear lead roles and resourcing across NM CCGs, Local Authorities and NHS England • New organisational arrangements for NM commissioning; reflecting Devolution and ACS plans.	• Integrated commissioning model across health and social care for North Mersey system • Single commissioner in organisational form • Place-based strategic commissioning plan for North Mersey to enable transformation	July 16	March 18
BAU Efficiency Programme - Organisational	Develop a detailed NM plan for Level 1 BAU efficiencies for: • Royal Liverpool • Aintree • Liverpool Women's • Alder Hey • Walton Centre • Liverpool Heart & Chest • Clatterbridge Cancer Centre • Merseycare • Liverpool Community Health • Liverpool CCG • South Sefton CCG • Southport & Formby CCG	• Organisational BAU efficiency plans for every NM provider • Merger of three adult acute trusts with associated efficiencies	July 16	March 2021
Collaborative Efficiency Programme – North Mersey	• Develop North Mersey plan for back office, clinical support and non-viable services • Implementation of plan – prioritised & phased	• North Mersey plan aligned for collaborative efficiencies, aligned and part of wider C&M STP plan	July 16	18/19
Accountable Care System	Explore options for the development of an Accountable Care System to support the radical step change required to manage demand and improve health outcomes. <u>North Mersey System Control Total</u> The North Mersey Leadership Group has agreed to explore the submission of an expression of interest for a North Mersey system control total, which would be submitted to NHSE by 31.10.2016 in line with the opportunity set out in the NHS Planning Guidance.	• Establish an accountable care system/organisation with the right geography and scope, providing optimal model for improved outcomes and sustainability. • Whole pathways of care managed across provider and commissioner boundaries • Establish a sustainable financial model for shared benefit and risk	Oct 16	Marc19

3.3 - Cheshire and Wirral approach

We have identified four priorities to make our health and care system sustainable in the near, medium and long-term. To transform our services, we need to reduce demand, reduce unwarranted variation and reduce cost. To comprehensibly address these we must priorities the areas that we will have the greatest impact to our system. Based on our knowledge of our local challenges, and as a result of engagement across the system, we have identified the following four priorities:



Demand Management

1. Prevention £14m
2. Integrated Out of Hospital £37.9m
3. QIPP/BAU £26m
4. Accountable Care £3m
5. Specialised Services £30m

Total £110.9m

Variation / Reconfiguration

1. Unwarranted Variation and Standardisation £24m
2. NHS Provider Collaboration £8m
3. Women & Children's £2m
4. Accountable Care £3m
5. Model Hospital/BAU £107

Total £144m

Back & Middle Office

1. Back & Middle Office £3.75m
2. Streamlining £1.4m
3. Best Practice £1.2m
4. Combined P`Power £22.5m
5. Digitalisation £1 m

Total £28.8m

Ways of Working

1. Outcomes Commissioning £1m
2. Patient based need £1m
3. Systems Leadership £1m
4. Collaborative working £2m
5. Learning partnership £1m

Total £6m

The following pages provide further detail of the projects and outputs these programmes will drive. We still have a lot to do in respect of determining:

1. Capability & capacity at STP and Local Delivery System level (LDSP)
2. Full development of schemes and business cases including quality and impact assessments.
3. True impact of each of the programmes on each other. (Critical interdependencies /impact and activity assumptions – STP and LDSP).
4. Robust governance driven bottom up that Governing Bodies and respective Boards and Local Authorities recognise and be part of (including local leadership groups)
5. Capital requirements need to be refined and better linked to benefits realisation.
6. Subject to the outcome of stages 1-5 above any material service changes would follow an appropriate consultation processes.

3.3 - Cheshire & Wirral plans for demand management 1/3

Projects	Change Delivered	Outcomes/Benefits
Alcohol Strategy (NHS, Local Authorities. Police, Community and Voluntary sector)	System wide interventions to reduce alcohol related harm: • Social Marketing Campaigns. • Schemes to restrict high strength alcohol sale. • Cumulative impact policies (reduced opening hours) • Children and Young persons interventions to reduce alcohol use. • GP Screening and life course setting approach. • 7 day alcohol care team within acute hospitals. • Alcohol assertive outreach teams.	• Per 100 alcohol dependent people on treatment planned reduction of 18 AE visits, 22 hospital admissions saving approximately £60k. • Cost benefit ratio £1-£200 per £1 spent • Assertive outreach services expected to return £1.86 per £1 invested. • Net benefit by 2021 estimated at £4.76m. • A reduction in adverse child events.
Hypertension (High Blood Pressure)	Implementation of the Pan Cheshire Hypertension Strategy: • A model of care that focuses on empowering patients and communities, enhancing the role of community pharmacies in detecting and managing high BP, and high quality BP management in primary care. (including reducing variation in care)	• For Cheshire and Wirral up to 300 heart attacks and strokes could be prevented per year through optimising blood pressure treatment alone. • If all GP practices performed as well as the 75th best percentile for managing known BP patients, over 5 years could prevent 183 strokes, 118 heart attacks, 256 cases of heart failure, 96 deaths. • It is estimated that a 15% increase in the adults on treatment controlling BP to <140/90 could save £120m of related health and social care costs nationally over 10 years. • Net benefit by 2021 estimated at £2.8-£3.3m.
Accountable Care introduced across CW plus introduction of strategic commissioner.	Building on the 4 existing Transformational Programmes, Discussions are underway to support the introduction of: • Accountable Care established in the four areas across Cheshire and Wirral. For example in Central Cheshire the development of "Primary Care Home "can be developed as a model for Accountable Care. • Budget Alignment on population outcomes • Risk Sharing Arrangements across commissioning and delivery of services as per Accountable Care. • Delivery of new contract mechanism. • Clear operating model. • New population health management systems. It is recognised that to support Primary and Community Care, resources are required to deliver these changes.	• Improved population health management. • Care will be managed in a more appropriate setting . • Better Patient and Client Experience.
Referral Management	Implementation of referral management schemes across Cheshire and Wirral.	• Reduction in elective and non-elective referrals.
Primary Care Prescribing	Encourage and deliver better management of primary care prescribing. (through self-care, over the counter medicines and waste associated with repeat prescriptions)	• Reduction in prescribing expenditure.
Respiratory Strategy	Exploring best practice and options for a single approach across Cheshire and Wirral to integrate Respiratory Services; • Building on the Healthy Wirral respiratory model of care (clinical registries)we will seek to develop a collaborative approach to respiratory services across Cheshire and Wirral.	Fewer hospital visits, fewer unplanned primary care visits (>1000 Emergency Admissions Avoided) • Easier and earlier access to care and support. • Earlier, evidence-based treatment e.g. pulmonary rehab. • Improved data sharing across Wirral health care economy. • Improved diagnosis and case finding (undiagnosed population < England Avg 2.91% (<7,800)) • Consistent approach to care. • Better case management . • Improved targeting of services to meet population need. • Earlier identification of people with certain respiratory conditions. • Improved knowledge and awareness of population. • Improvement of lifestyle factors e.g. reduced smoking/higher quit rates. (<18 per 100,000) • It is anticipated that if a satisfactory option can be developed that a transformational approach to respiratory care could deliver a system saving £2m by 2021.
Diabetes Programme	Implement at scale a national evidence-based diabetes prevention programme capable of reducing not only the incidence of Type 2 diabetes but also the incidence of complications associated with Type 2 diabetes; heart, stroke, kidney, eye and foot problems. Deliver services which identify people with non-diabetic hyperglycaemia who are at high risk of developing Type 2 diabetes and offer them a behavioural intervention that is designed to lower their risk of onset of Type 2 diabetes.	• It is forecast that over 56,000 Cheshire and Wirral residents suffer from Diabetes Mellitus and a further 99,000 residents suffering from non-diabetic hyperglycaemia. • Assuming programme growth to 5000 patients, Cheshire and Wirral LDP anticipate an annual saving of over £500k per annum by 2021 with significant additional wider-systems savings resulting from a reduced incidence of diabetes.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes/Benefits
Mental Health **Delivery of the priorities set out in the 5Year Forward View for mental health and the Prime Ministers challenge on dementia (2020) Including :** • **Prevention and Early Detection** • **Better Mental Health Care for people with Physical conditions.** • **Improved services for people with severe Mental Health Conditions**	Reducing variations in clinical practice – through the development of consistent care pathways, developing standard approaches to key processes such as assessment, access, discharge and caseload review. Improving patient safety – including a commitment to 'zero suicide.' Improving effectiveness – through a focus on care pathways with clear outcomes and evidence-based practice. In year 1, a priority will be the establishment of fully functioning mental health liaison services across Cheshire and Merseyside. Cost of investment expected to be funded from central allocations as per planning guidance.	• Better health and care outcomes for Patients and their families. • Improved opportunities for community based social prescribing and enhanced employment opportunities. • Reducing pressures on acute services within Hospital, Primary Care and Community setting. • Enhanced primary care support for mild to moderate mental health need.
Specialised Commissioning • **A collaborative approach that will seek to address the current inequality in access for Cheshire and Wirral residents.**	The early interventional programme identified above will ensure that patients are seen and treated earlier so reducing the need for consultant to consultant referrals. In partnership with NHS England, Cheshire and Wirral will adopt an approach to reducing the £30m overspend in specialised commissioning.	• Referral pathway improvement to ensure services are patient centred and outcome based. • Improve productivity and value of these services.
High Impact Community Based Integrated Care Schemes:	As detailed in the four Transformation Programmes (Healthy Wirral, West Cheshire Way, Connecting Care, Caring Together) we will strengthen and expand primary and community care services. • Integrated Community Teams • New Models of Primary Care • Long Term Conditions Management • Intermediate Care • Care Homes Support • Intermediate Care Development • Integrated Discharge Processes • Community Services MCP This will be done with reference to the Five Year Forward View for General Practice and the development of integrated health and social care. It is recognised that to support Primary and Community Care, resources are required to deliver these changes.	• Improved Patient Experience. • Reduction in non elective admissions. • Reduction in Length of Stay. • Reduction in Delayed Transfers of Care. • Shift in activity and associated resources from acute to community sector.
Neurology (Cheshire and Merseyside) ***This supports the work that has been lead across Cheshire and Merseyside as a cross cutting theme.*** **The Neuro Network neurology model aims to achieve a clinically and financially sustainable integrated neurology service by enhancing the community support, clinical pathways and advice and support for primary and secondary care.** **The spinal model is to implement a whole system spinal services network, integrating the two key components of the national Spinal Transformation Project.**	Explore best practice and the options around 7 day acute inpatients, specialist diagnostics, subspecialty/MDT clinics, access to neurosurgery, specialised pain and rehabilitation. DGH satellite services from visiting neurologists plus support: outpatient clinics, weekday ward consultation service, supported from the centre by: • Acute referral pathways • 7 day advice line • Telemedicine • Second opinion/specialist neuroradiology reporting via PACS • Community nurse clinics, nurse specialist support, homecare drugs, home telemetry • GP referral pathways • Ready communication between community and specialist neurology services for advice and practical help • Standards and clinical governance: common standards across network delivered services, with a single clinical governance structure, developing and using clinical outcomes as available. A network for the provision of spinal surgical procedures, managed from the centre with partner services in secondary care, working to common standards, and outcome measures, with MDT discussion of complex cases and all specialised surgery undertaken in a centre fully compliant with national specialised serviced standards. Implementation of a single whole system patient pathway through a network of all providers of spinal services, with common and audited service standards and outcome measures.	• It is projected to save up to £3.2m a year recurrently by 2020-21 compared with the do nothing scenario. • Hospital services reconfiguration: with its single service system wide delivery, providing a specialist centre well placed for future consolidation, and networks of specialised providers and hub and spoke models to improve collaboration across tertiary and secondary care.

3.3 - Cheshire & Wirral plans for demand management

Projects	Change Delivered	Outcomes
Thresholds and Procedures of Limited Value	Following NICE guidance maximise the outcome of clinical procedures optimising the effective use of resources.	• Improved utilisation of available capacity. • Increased awareness of self-care. • Resources will be targeted to deliver effective interventions.
Cheshire and Wirral Cancer Strategy	Targeted interventions to address areas of low screening uptake. Focus on improving the key worker arrangements for cancer patients and roll out the Recovery Package. Diagnose or exclude cancer within 28 days by creating multi-disciplinary diagnostic centres and new pathways for patients with vague cancer symptoms. Address together our capacity, workforce and organisational bottlenecks, which are preventing delivery of the 62 day cancer standards.	• Seeking to improve early stage cancer detection rates, associated with better survival and lower cost impact. • To limit emergency presentation rates during treatment and the follow-up costs of delivering cancer care respectively.
Operational Control Centre For Risk Stratified Population	Use technology enabled shared patient care records to identify and better coordinate care for the top 5-10% highest users of healthcare services, this will be achieved by using a centralised control facility to signpost and direct appropriate care services to those managing their conditions more effectively in the community and reducing inappropriate hospital admissions.	• Effective and personal communication with a vulnerable cohort of patients across Cheshire and Wirral in a coordinated manner. • Improved navigation of Vulnerable Patients through Health and Social Care systems. • Improved clinical outcomes for Patients. • Reduction in variation and ability to control demand.
Cheshire & Wirral Shared Care Records	Further development of Cheshire and Wirral shared care records.	• Improved patient experience by only having to tell their story once. • Less time wasted by staff tracking down important clinical records. • Reduction in repeat diagnostics and avoidable errors. • Use of near real-time data. • Enabler for key measures in all workstreams.
Implementation of Continuing Healthcare Collaborative Commissioning	Improved joint working with local authorities and across CCGs. Improved team metrics (reducing sickness and turnover rates).	• Planned reduction in outstanding reviews, improved experience for patients, family and carers. • Delivery of assessment targets. (i.e. 28 days) • Reducing the number of dispute cases.
New Models of Primary and Community Care	Delivery of a range of physical and mental health initiatives designed to deliver care closer to home and reduce demand on acute services. Introduction of new models of primary care and community care. Explore the resource requirements that would be associated with this.	• Reductions in non-elective admissions. • Reductions in Length of Stay. • Reduction in Delayed Transfers of Care. • Shift in activity from acute to community sector.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
Organisational structures and system architecture	We are planning: • An integrated Cheshire & Wirral strategic commissioner. • Accountable Care established in the 4 respective geographies that will determine the shape and form of health and social care delivery across Cheshire and Wirral. • A provider collaborative, the shape and size to be determined.	A change in the Commissioning and Provider landscape that will support : • Better patient experience • Care closer to home • Health and Social care integration • Better use of resources • Strengthen local clinical commissioning
Enhanced technology supporting care through the development of strategic alliances and relationships with subject matter experts	Technology that support s and enables the delivery of integrated health and social care services: • Single IT/ informatics platform to support management of variation • Examples such as clinical registries, patient and asset tracking, operational control centre Access to global thought leadership/ expertise in management of variation.	Effective IT and information flows across all sectors supporting the management of variation/optimum approach to management of variation.
Development of a common approach to the delivery of clinical support service	A common approach to: • Medicines Management • Infection Prevention Control • Pharmacy • Radiology • Pathology	Optimised clinical support services to ensure clinical, operational and financial sustainability.
Development of model care pathways	Development of care pathways (across primary, secondary and social care) for high cost/ high volume diagnoses.	Optimum management of high cost/ high volume diagnoses including: • Pneumonia/ upper respiratory tract infection • Cardiac disease • Acute abdomen • Alcohol • Ophthalmology • Orthopaedics • Dermatology Standardised care pathways. Reduced length of stay.
Improved system performance to match best decile NHS England performance	Benchmark ourselves against national metrics to match or better NHS England best decile for: • Admissions • Overnight stays • Average Length of Stay • A&E attendances • Outpatient referrals and follow ups Participate in the NHS Right Care programme. Model impact to understand extent of overlap with other work streams.	• Management of demand in appropriate setting will produce a range of between £30-£60m.. • Appropriate use of secondary care services.

3.3 - Cheshire & Wirral plans - variation and hospital reconfiguration

Projects	Change Delivered	Outcomes
In-line with existing transformation work streams, (Caring Together) a remapping of elective and emergency care models in Eastern Cheshire	Agreed long term models for elective and emergency care in Eastern Cheshire are being developed based on strategic hospital partnerships, building on existing relationships, including those with hospitals in Greater Manchester. A number of emerging clinical models are being developed and will form the basis of an option appraisal. Clinical modelling covers emergency care (including options to retain the A&E department or the development of an urgent care centre) and elective care. The frailty pathways being developed will be explored to share best practice with other parts of Cheshire and Wirral.	Clinically , operationally and financially sustainable services .
In-line with existing transformation work streams, (Connecting Care) a remapping of elective and emergency care models in Central Cheshire	Agree long term models for elective and emergency care in Central Cheshire based on strategic relationship both within Cheshire and Wirral and surrounding localities so as to reflect patient flows.	Clinically , operationally and financially sustainable services .
Explore an option to consolidate elective care between the Countess of Chester Hospital NHS Foundation Trust and Wirral Teaching Hospital NHS Foundation Trust on the Clatterbridge Hospital site	Develop an options appraisal in relation to the future delivery of elective care in order to support : • Consolidation of elective care • 7 day working • Improved referral to treatment waits • Centre of excellence in recruitment and retention with potential to reduce reliance on specialised service activity flows if appropriate.	Clinically , operationally and financially sustainable services . .
Explore the consolidation of Acute Care Alliance between Countess of Chester Hospital NHS Foundation Trust and Wirral University Teaching Hospital NHS Foundation Trust – creation of integrated low and high dependency units for women's and children's services	Creation of a clinically integrated service between providers with the consolidation of high and low dependency care as appropriate. (Women and Childrens)	Clinically , operationally and financially sustainable services .
Explore the development of Cheshire and Wirral wide clinical services at scale .	Building from the review of clinical services undertaken by the Trust Medical Directors, we will benchmark all specialities against clinical effectiveness and outcome indicators so that we can deliver improvements to clinical care .(Advancing Quality, NHS Right Care) The emerging clinical models will also be developed in conjunction with Primary Care.	Clinically , operationally and financially sustainable services .
Specialised / 3° services	Explore the options for provision of Maxillo facial services Oesophago-gastric services, plastic surgery to 3° providers in Manchester, Wirral, Chester, Liverpool, North Midlands and North Wales. Where existing arrangements are in place that optimise clinical and financial sustainability then they would remain in place.	Clinically , operationally and financially sustainable services .

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Cheshire and Wirral Local Delivery System recognises that the projects outlined below focus on a Cheshire and Wirral approach to collaborative productivity This is to optimise the speed of delivering those benefits. A Cheshire and Merseyside solution will also be considered and implemented where appropriate for back office and clinical support functions.		
Payroll Workforce, Process & Product	Across Wirral & Cheshire – • Standardise services • Streamline services • Explore the integration and centralisation of teams	A single centralised payroll will reduce duplication, improve efficiency and responsiveness, improve access for staff, reduce queries, and reduce software licensing costs.
Model Hospital & Delivery of Business As Usual Efficiencies	Model Hospital (LOS) Model Hospital (Theatre Utilisation) Model Hospital (New Opat Models) Model Hospital (Other efficiency gains)	Delivery of Provider Business As Usual efficiencies. Delivery of higher quality service for patients.
Procurement Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced cost of overheads and duplication, Improved efficiency and responsiveness, and standardised processes. Economies of scale.
Procurement Purchasing Power	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Procurement cost savings at scale. Greater purchasing power, standardisation and consistency. Compliance with Carter recommendations.
Library Service	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	More efficient service Cheshire and Wirral focus
Occupational Health	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Clinical Sustainability
Occupational Health Streamlining of Process	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication of localised management.
Recruitment Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Comms and Engagement	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Litigation service	Explore the development of an in-house legal service across Cheshire & Wirral	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Finance Processes Transactional Services	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Pathology	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Automated processes scaled up to provide a service that is more cost effective and efficient and responsive so as to speed up diagnostic support.

3.3 - Cheshire & Wirral plans - collaborative productivity

Projects	Change Delivered	Outcomes
Capital Estates Planning and Hard Facilities Management	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Regional Estates Team Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Workforce	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Cheshire and Wirral Informatics Processing and Coding	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Utilities management approach across Cheshire and Wirral	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced overall cost of utilities. Single supplier for all organisations. Economies of scale and consistency. Intelligent energy procurement.
Teletracking	Introduce new technologies in order to undertake the tracking of Assets in support of patient care. The use of real time data will also enable the management of patient care in the most appropriate setting. This technology will be used across all 4 Hospital sites, 2 community trusts and mental health providers.	Better matching of resources and capacity to demand, reduce duplication, improve efficiency and responsiveness.
Pharmacy	Explore the integration of services across Cheshire & Wirral, with exact form and localities to be determined.	Reduced duplication, improved efficiency and responsiveness, and standardised processes. Economies of scale.
Agency Cost Reduction	Reduction in Agency Staff use by investment in substantive roles where required and using a joint strategy as 1 organisation approach	Substantive recruitment of staff in order to reduce overall agency costs by £2m, by 2021.
Clinical Commissioning Group (CCG) Business As Usual Quality Innovation Productivity & Prevention (QIPP) and Cost Improvement Programme (CIP)	Single approach to QIPP with best practice and learning being adopted across Cheshire & Wirral	Economy of scale, rapid acceleration and adoption – contribute toward year on year savings.
CCG Business as Usual QIPP Continuing Healthcare (CHC) and Funded Nursing Care (FNC)	Cost reduction from Cheshire and Wirral approach	Harnessing collaboration to reduce cost of Continuing Health Care and Funded Nursing Care Packages.

3.3 - Cheshire & Wirral plans - ways of working

Projects	Change Delivered	Outcomes
Shared Care Records	All our providers will have the ability to access shared care records in a local setting and face to face with the patient in real time. Avoiding Duplication	Improved and consistent patient care across the system Reduces cost due to patients not being lost in system.
Real time data	A single digitalised platform that we will facilitate a population health management approach. When integrated with respective risk stratification tools and the shared care records this will manage the rising risk of future patients	A preventative approach that will identify patients at risk and enable supportive intervention before the patient's needs become urgent.
Outcome based commissioning	Outcomes-based commissioning seeks to solve the issue of how financial flows and the commissioning process can best support quality and efficiency improves across the health care system.	Clear outcomes associated with all service areas, which will increase the clarity and therefore quality of provision.
Meeting patients' needs	Costs can be reduced significantly if patients are at the heart of decision making and that clinical decision making is based on outcomes with incentives aligned to doing less rather than more work.	Patients will be engaged at all levels, from shaping NHS plans to the development of services around patient need, and in decisions about their own individual care.
Clinical and Systems leadership	A new and heightened role for clinical networks, clinical leadership and multi-disciplinary working. A single Cheshire and Wirral approach to Organisational Development and cultural change with the public sector and NHS Leadership Academy and Health Education England.	Improved communication and information sharing across the system. System leaders and staff who fully support and are engaged with system leadership. Connect into the systems leadership work from Planning guidance
Collaborative working	Driving out costs where there is a benefit of procurement at scale. We will examine opportunities for integration both vertically within local systems and horizontally across providers	A system that works effectively and efficiently, driving out duplicated processes and costs.
Accountable care.	Commitment to providing accountable care, on a population health management approach in all 4 geographies within Cheshire and Wirral.	Care Systems that will focus on system benefit and change rather than organisational benefit.
CW Health & Social Care Teaching & Learning Partnership	support the creation of a sustainable local supply and the ongoing development of existing staff	workforce development to underpin national and local priorities – e.g. reception and clerical staff training and support leaders to develop system wide transformation skills

4 - Closing the Cheshire & Merseyside financial gap

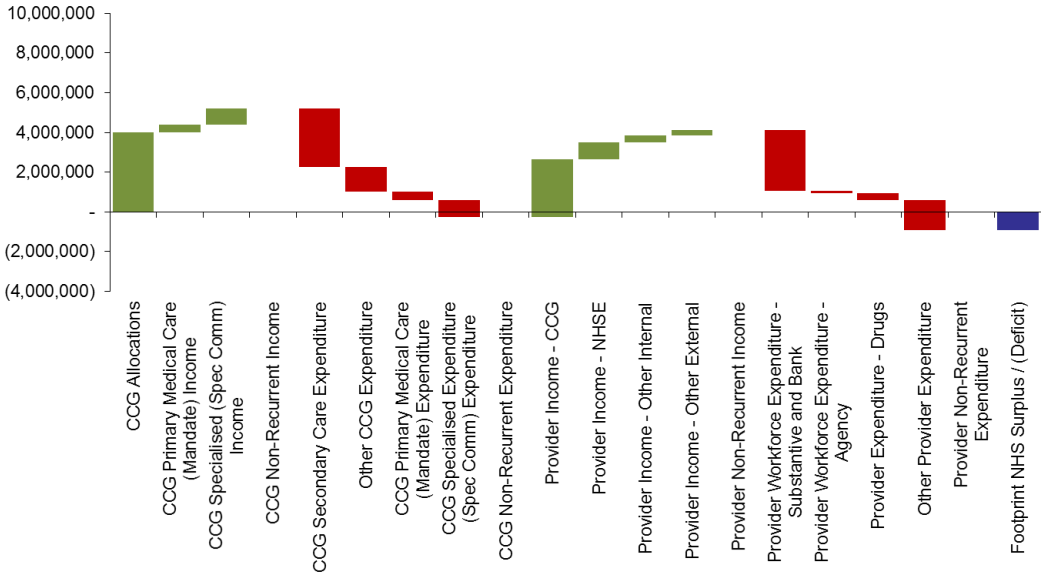
Financial Gap – current position

The 'do nothing' affordability challenge faced by the Cheshire & Merseyside health economy is forecast to be **£908m**, as illustrated below. The drivers of the affordability gap is a growing population that accesses health care more often, and are – positively – living longer but often with one or more long term conditions.

This challenge has narrowed from the £999m in our June submission, to £908m driven by the following:

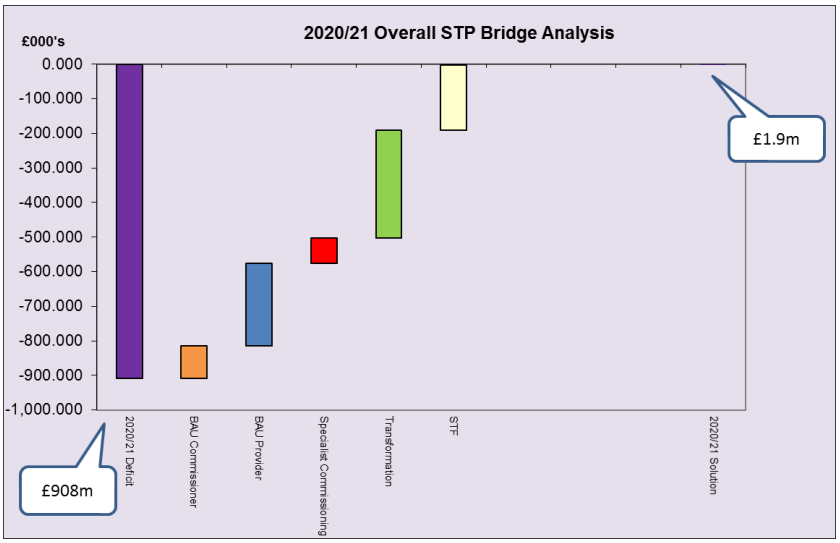
- The gap now reflects the fact that some cost reduction plans are already being delivered in 2016/17, which is year 1 of the 5 year plan
- The remaining gap now reflects the four year period 2017/18 – 2020/21

However, there is still risk associated with the delivery of organisation's 2016/17 financial plans, which at this stage may not fully reflected within the forecast gap.



The 'Do Something' position

After the impact of our transformation solutions, our business as usual and specialist commissioning efficiencies, and the expected STF funding the 'do something' gap is £1.9m, as illustrated below:



Risks to delivery

- Whilst the plans at this stage show a balanced position there is still a significant amount of further planning required on many of the solutions before we could present them as robust and with confidence of delivery
- We will continue to pursue further solutions in order to provide a contingency for when the current plans do not deliver the levels of savings currently forecast in the plan. In particular the focus will be on extending the opportunities in the strategic programmes at STP level.

4 - Closing the Cheshire & Merseyside financial gap

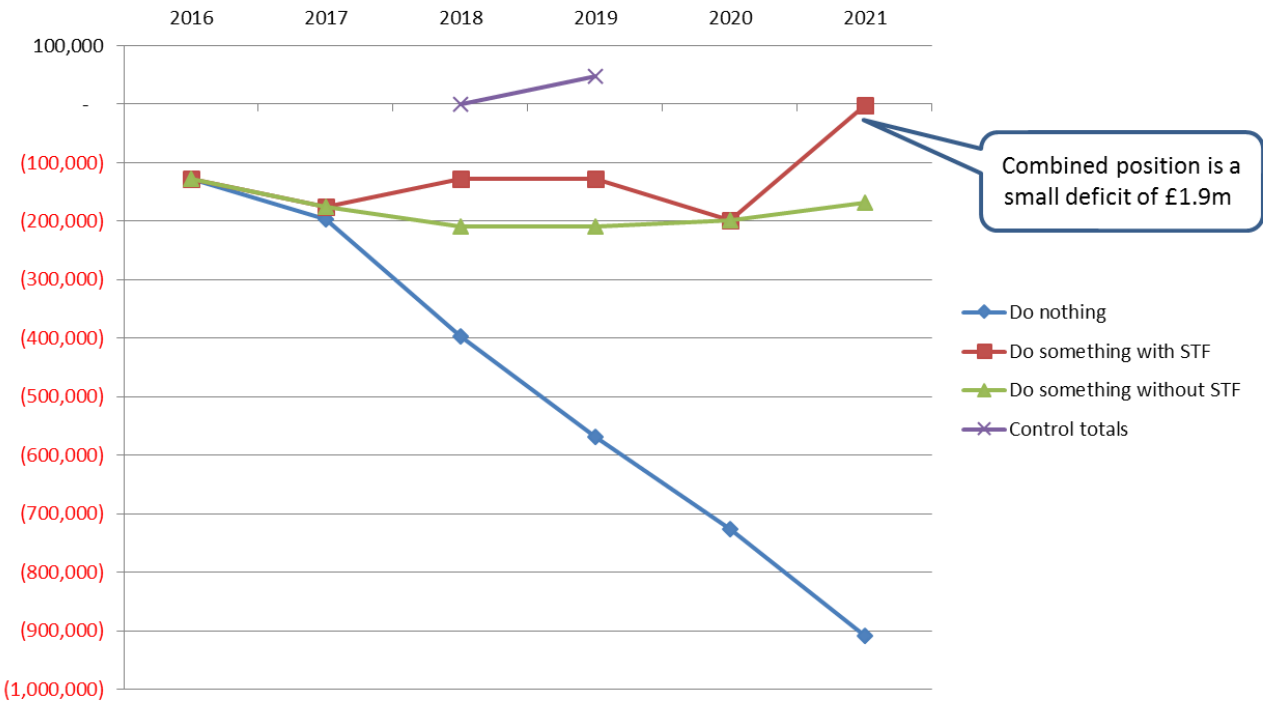
Capital

- We recognise that these plans are heavily dependent upon capital – up to £755m additional funding requirement in current plans as shown below. However we recognise there is still significant work to do before these high level requirements are turned into robust business case ready solutions. In particular to fully articulate the cost/benefits associated with the proposed investment.
- We also understand that Capital funding is extremely limited and that we will need to focus investment in those schemes that provide the most beneficial impact on our STP plans. In doing so we recognise that there may be schemes that do not get approved and the STP will therefore the benefits will also need to be reassessed.

Capital	£000s
Do Nothing	
Locally funded	726,150
Business case funding approved	150,785
Other funding source	47,634
Funding identified/approved	**924,569**
Funding not yet approved/identified	
Do Nothing	387,012
Do Something	368,232
Total funding not yet identified/approved	**755,244**
Grand Total	**1,679,813**

Pace of Change

Whilst we are forecasting balance in 2021, the profile of our solutions reflect that many of the benefits are forecast to be achieved in the latter half of the plan. Therefore the current financial plan does not demonstrate delivery of the aggregate Control Total across Providers and Commissioners for both 2017/18 and 2018/19. We will need to do further work to identify where pace can be increased, and to ensure that we are capturing all the quick wins that might be available.



Next Steps

In addition to addressing the issues noted above our focus now will be on strengthening the financial modelling through development of a demand and capacity model at STP level. This will enable us to more accurately and quickly reflect the impact of our solutions through a more thorough understanding of the drivers of costs across the system.

5 - Delivering the change

Successful delivery of transformation this size requires:

- *Governance enabling decision making*
- *Strong leadership*
- *Robust programme management*

Governance

A successful governance structure will enable leaders to govern with confidence, making timely decisions using high quality management information

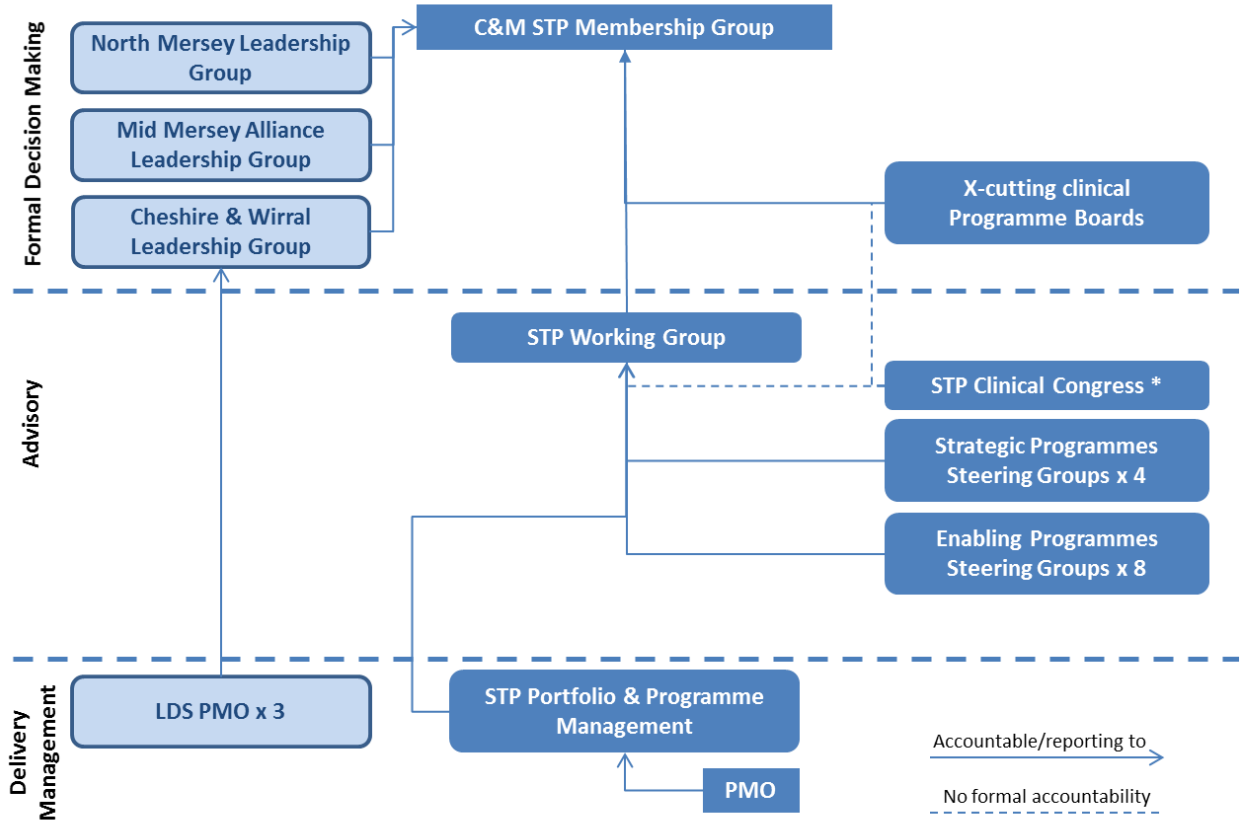
Effective governance of a programme is fundamental to successfully delivery and alignment with the STP strategy and direction, and are built on some key principles:

Each LDS already has its own Governance arrangements that will underpin the STP, and be responsible for the delivery of local programmes of work.

We will look to define governance arrangements early and comprehensively as this will create clear roles and responsibilities at all levels and allow for effective and timely decision making throughout the transformation plan.

We have drafted a Memorandum of Understanding and shared this with the STP Working Group. Once approved this will provide a sound footing to move forward from.

The current governance structure is shown below. This will be developed by the Membership Group in the short term so that Terms of Reference and membership details are agreed across C&M quickly.



** The Clinical Congress constitutes the clinical leadership of the member organisations (medical and nursing directors) and will be led by the STP Clinical Advisory Group which is the clinical advisory group to the STP Working Group. All of the three local delivery systems, four strategic workstreams and eight cross cutting themes will have a nominated senior Clinical Lead/Sponsor who will represent their workstream, their organisation, their sector, and their local delivery system and will also be expected to take a 'holistic' clinical view across the whole STP. The STP Clinical Advisory Group will be chaired by Dr Kieran Murphy, NHSE Medical Director (C&M).*

5 - Delivering the change

The ambitions within the STP will only be delivered under strong leadership

A programme of this size and complexity will need strong leaders with sufficient knowledge, experience and skill to operate at C&M level, while having a national network.

These leaders should also be freed up from their day job in order to provide the necessary system leadership to deliver at pace.

Leadership and Organisational Development

The aim of this section is to set out the forms of leadership and leadership development required to implement, sustainably realise and maximise the impact and benefits of the Cheshire and Merseyside Sustainability and Transformation Plan for the citizens of the region. In particular, to realise the benefits of inclusive, integrated service design, delivery and on-going development, that has the potential to significantly contribute towards improved population health and the reduction of health inequalities. STPs are more than just plans. They represent a different way of working, with partnership behaviours becoming the new norm. What makes most sense for patients, communities and the taxpayer should always take priority over the narrower interests of individual organisations.

Context and Drivers

The context and drivers for change and new forms of leadership and leadership development within the region are both complex and diverse including factors, such as, both the national agenda, as expressed in the 'Five Year Forward View' and the region's, political, economic, social, demographic, legislative, technological, geographical, physical, industrial, agricultural, commercial, educational and service sector history and current architecture, infrastructure and landscape.

The opportunities and challenges within the region's, sub-region's, cities, sub-cities, rural and urban environments are incredibly diverse and distinctive. However, all share the vision of a healthier population for all. A vision within which: -

- the assets and talents of local communities and populations are rigorously harnessed
- health inequalities are proactively addressed
- the promotion of health and well-being is the primary focus
- health and well-being services are integrated, resilient, culturally appropriate and sustainable

Regional Leaders

This vision requires regional leaders able to act, engage, learn, influence, challenge, develop, initiate and sustain change within differing volatile, uncertain, complex, ambiguous and diverse environments (VUCAD). We need to identify, develop, support and future proof inclusive, culturally competent leaders to become more impactful 'place' based, collaborative system leaders, implementing and continually developing fully integrated health and well-being strategies and services. This strategy to then support leaders to articulate and 'live' the ambitious Cheshire and Merseyside vision, and gain 'buy in' towards/for it from a range of stakeholders.

Conclusion

Twenty-first century leaders are expected to be VUCAD leaders; Cheshire and Merseyside leaders are no different. They are expected to respond to these environments by providing vision, understanding, clarity, and adaptability, to possess a VUCA approach, to fully immerse themselves in place, to work in place with individuals, groups and communities with an asset based approach, harnessing the talents of all diverse stakeholders, listening to and learning from differing perspectives, responding with agility and humility, whilst remaining personally resilient. Acting at all times as Inclusive Leaders, Cheshire and Merseyside leaders do and will work with others to ensure the successful achievement of the Cheshire and Merseyside STP, promoting innovation, creativity, entrepreneurism and inclusive, sustainable growth.

A Cheshire and Merseyside leader is and will be fulfilling an exciting, demanding, innovative and often challenging role and will need differing levels, forms and opportunities for development. This STP will work with the NHS North West Leadership Academy (NHS NWLA), and other agencies, to support the development of leaders and the region's leadership community, spanning Cheshire and Merseyside leaders within, across and beyond organisations, systems, and place. It is recognised that the NHS NWLA's experience developing, supporting, stretching, growing and caring for a diverse and inclusive leadership community can support the Cheshire and Merseyside leadership community in the vital role of supporting new and existing leaders to excel in role, to excel in new 'bigger' roles, to excel in identifying new talent and in making the region's health and well-being services world leading.

5 - Delivering the change

Robust Programme Management

The Cheshire & Merseyside STP comprises a significant number of programmes. Programmes are about managing change, with a strategic vision and a route map of how to get there; they are able to deal with uncertainty about achieving the desired outcomes. A programme approach should be flexible and capable of accommodating changing circumstances, such as opportunities or risks materialising. It co-ordinates delivery of the range of work – including projects – needed to achieve outcomes, and benefits, throughout the life of the programme.

A programme comprises a number of projects. A project has definite start and finish dates, a clearly defined output, a well-defined developmental pathway, and a defined set of financial and other resources allocated to it; benefits are achieved after the project has finished, and the project plans should include activities to date, and both measure and assess the benefits achieved by the project.

For a portfolio of this size and complexity, the illustrative model below tells us that successful delivery is wholly dependent upon having the right set of capabilities in place. Any significant weaknesses in the capability generated to deliver projects, at any level of the programme, are likely to impact negatively upon delivery.

The aim is to ensure that the right people are in a team and a clear and transparent project resourcing process is in place; this will mean that ways of working are understood.

Project Management

All members of the project teams must be committed to the vision and plan; moreover, impacted stakeholders should be willing to put in the additional effort required to deliver the programme. The use of milestone trackers, with enough detail to monitor on a weekly basis, and that are understood and agreed by the project lead and team, is critical.

Accountability

There must be clear accountability for project delivery of benefits (including savings) and the consequences of non-delivery understood. The work-stream lead is accountable for project delivery as delegated to them by the Executive Sponsor for each project.

Document Sharing

An intranet knowledge base should be established for the projects that comprise the programme. The use of the programme 'SharePoint' facility is an efficient and effective medium for joint viewing arrangements for documents, specifically workbooks, as well as maintaining good configuration (version) control.

The project teams will be responsible for ensuring that the latest version of the project documentation is always available on the SharePoint site. The access to the workbooks in terms of editing rights will be restricted to the Programme Assurance Framework, work stream and project team members.

Training & Development

The Programme Assurance Framework will promote exemplars of best practice project documentation. All staff completing these documents should be trained (by means of on-the-job training) during the development phase of that project.

Progress Meetings

Each project team will be expected to meet with the Programme Assurance Framework on a monthly basis. The objective of the meeting will be to gather evidence to ensure that the assurance update to the programme dashboard is based on documented evidence and is factually correct.

The conduct of the meeting will be based on a comprehensive review of the project documents as the evidence base. The progress meeting will also be an opportunity for the project to raise any issues for which the assistance of the Assurance Framework/Steering Group may be required to address to 'unblock' the route ahead.

The Programme Assurance Framework will ensure that there is a sufficiently formal process in place to ensure that any assurance reports are produced for governance meetings. This will support the embedding of an appropriate accountability framework and the provision of escalation reports, by exception, to the sub-committees; this latter process will form part of the role of the Programme Assurance Framework.

Programme Dashboard

The Programme Dashboard is intended to enable the governance bodies a more qualitative view of the development and implementation of projects. It will provide cues to focus executives on the strategic issues that require a degree of anticipation, like communications with stakeholders, or problems that need unblocking, for example questions relating to financial investment. The Programme Dashboard will also assist with the monitoring of milestones, KPIs, financial status and risks. Specifically, the dashboard reporting allows executive sponsors to review all of their projects easily, at a glance. Furthermore, it will include a responsibility matrix – given the complexity of the programme - identifying the key staff needed to deliver the project and identifies the dedicated resource required.

5 - Proposed resources required

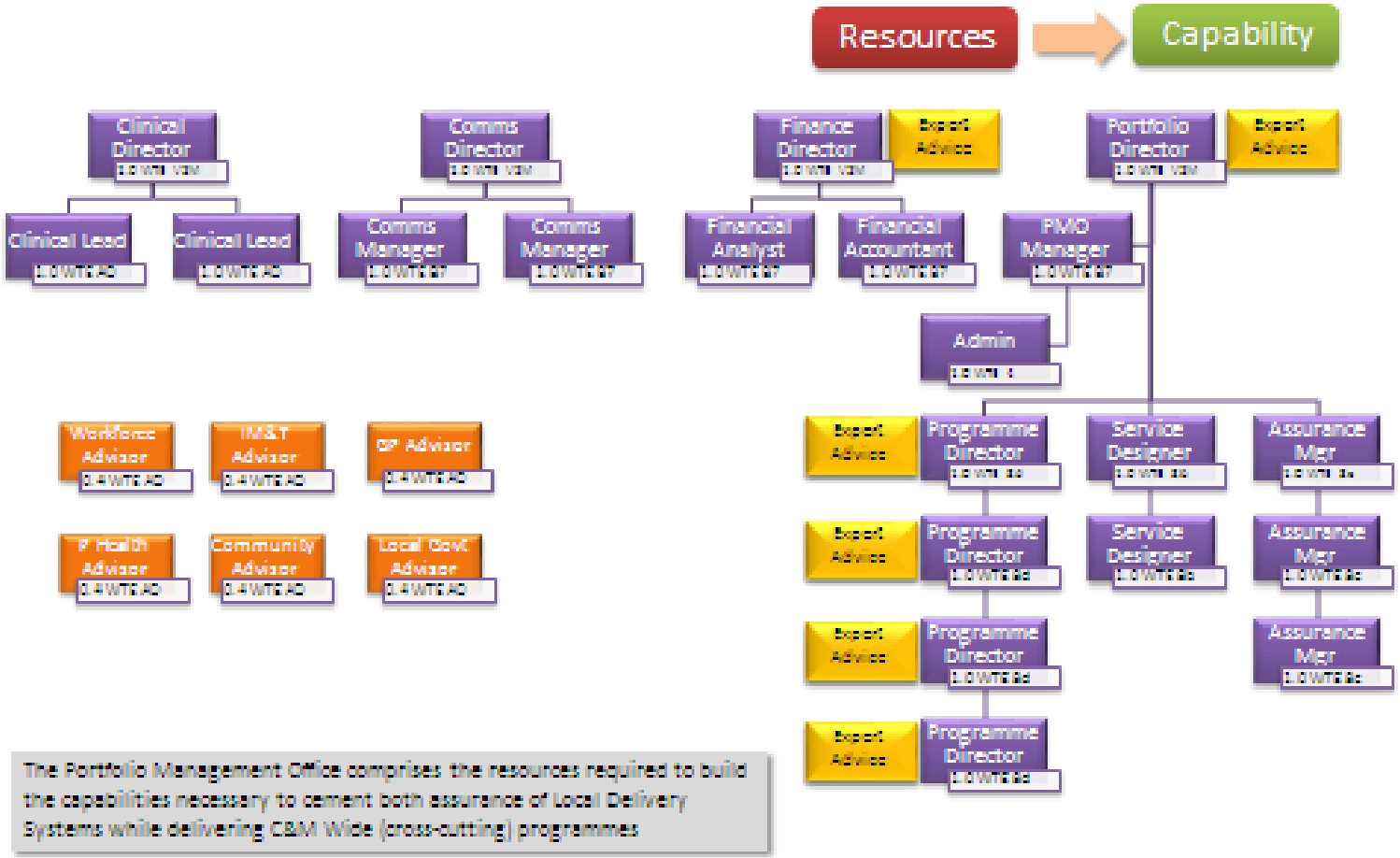
The current proposals before the Cheshire & Merseyside STP Working Group are shown below. The resource and skill mix may come from a number of sources and the capability sets will need to change as programmes mature through the gated phases.

The Portfolio management Office will reside at the centre of the STP, as the engine room, meeting the demands and requests of external stakeholders while directing and assuring the programmes (as appropriate and cognisant of local governance arrangements) that fall within the agreed scope of the STP.

Similar structures will need to be agreed and mobilised, where they do not already exist, for the work of the Local Delivery Systems and each of the programmes within the Portfolio.

Delivering the change

Portfolio Management Office



The Portfolio Management Office comprises the resources required to build the capabilities necessary to cement both assurance of Local Delivery Systems while delivering C&M Wide (cross-cutting) programmes

5 - Proposed communications and engagement plan - subject to further work and detailed discussion, including with individual governing bodies

Introduction

Our communications & engagement strategy sets out the approach to communicating the STP across Cheshire & Merseyside and engaging in an open & honest manner, with patients, public, staff and stakeholders. Stakeholders are recognised in terms of their level of interest and influence, and the corresponding level of engagement and communication is applied to enable each audience to have the opportunity to comment on proposed changes to health service provision.

This STP is a 'live' document that is subject to regular revision throughout the programme, and recognises and documents the work that has already taken place and is still ongoing at a local level. Much engagement work has already taken place to support area transformation plans such as 'Healthy Wirral', 'Healthy Liverpool' and 'Connecting Care' and this work is currently in the process of being scoped and logged.

The plan has been developed in collaboration with the Communication & Engagement Leads for each of the three 'Local Delivery Systems', providing a joined up, partnership approach across the region, and utilising all available channels to reach stakeholders.

What stage are we at now?

The Cheshire and Merseyside Sustainability Programme (STP) is still at a developmental stage. We are in the design phase of a programme that will help to create healthier NHS services across Cheshire and Merseyside for future generations.

We know that these changes can't happen overnight and that they shouldn't. Some NHS care models haven't changed much in over fifty years and it is unrealistic to expect them all to be suitable for a growing, aging, online population with changing expectations and needs.

This is why we are taking time to create an STP that is worthy of consideration by the public, patients, clinicians and the wider health economy and why the STP itself is still expected to go through a number of changes and adaptations – beginning with a phase of review and revision after the 21st October.

An initial period of pre-engagement will follow this date - setting the scene, considering and communicating available options and making sure that we are having the right conversations with the right people. The conversations that we have started about this process are extremely valuable and we will continue to engage with all of our stakeholders.

Engagement & Communications Objectives

The communications and engagement strategy has a number of over-arching aims. It is based on the three LDS areas being the "engine room" for developing and implementing any plans for transforming services. At a Cheshire and Merseyside level a joint Communications and Engagement Steering Group will be established to oversee the following:

- Establish standards for communication and engagement with members of the public, NHS staff and other stakeholders, taking into account the needs of any groups of people with protected characteristics, so that local people have the opportunity to contribute to discussions about NHS services. These standards will build on existing good practice and draw on expertise from partner organisations
- Where there is a need to formally consult with the public, staff and stakeholders on options for making major changes to services, ensure that standards of best practice are adhered to. Provide peer support, advice and guidance to support this and if necessary seek external expertise
- Build on existing good practice in order to transform how the NHS engages with members of the public, staff and stakeholders for the future.

Our Local Delivery Systems

A joint calendar will be created for the three LDS areas, identifying key milestones, which will be dependent on the priorities for each area. Communications and engagement activity will be planned to support these milestones. Where appropriate this activity will take place across LDS areas.

A senior communications and engagement lead has been identified for each LDS. Each lead will be responsible for overseeing the co-ordination of activity in their LDS area, providing strategic advice and guidance to their LDS chair and delivery board and will be a member of the Cheshire and Merseyside wide communications and engagement steering group.

STP Key Messages

- All health and social organisations across Cheshire and Merseyside are committed to delivering sustainable services that deliver the best care for local people
- We need to think differently about how we deliver services to meet the changing needs of our population
- We know we need to use our limited resources wisely, to meet the demands on the system and stay within our allocated budgets. By working together we can plan our services to deliver the maximum benefit for patients

5 - Strategic Risks

Financial Sustainability challenge. Since the June 2016 submission of the Cheshire & Merseyside STP, we have taken the opportunity to commence some initial steps to create a common standard of assurance across the footprint. What we have since received in the STP Working Group is a set of high level assurance assessments, both documented and verbally, which demonstrates that our current plans are extremely unlikely to close this gap.

The size of the current gap is an estimate and more work to agree the future assurance framework is yet to be completed. However, two dimensions can be described in that: firstly, the current level of planning has no level of contingency (indicatively 25-50%) that would normally be associated with programmes of this size and complexity ; secondly, the robustness of the 'plans' and associated risks regarding measurability, capability and deliverability all serve to make us discount the current value of the whole by a figure of 30% equating to some £300m.

Decision-making. As we stated in our June submission, while there is an emerging clarity about what needs to be done to deliver system-wide change, the challenge of delivering the decisions to effect this should not be underestimated. The strategic aim of the STP to deliver a work stream entitled 'How We work together to Make it Happen' is progressing but now needs to accelerate to agree the draft Memorandum of Understanding that has been circulated, define the governance bodies going forward (evolving the current Membership Group, Executive Group and Working Group) and cement the growing relationship with local Authorities. In due course, t is likely that a number of the decisions required may face public resistance and political challenges. We therefore need to have mature and well oiled governance mechanisms to receive and involve the concerns of our staff and our communities with their representatives.

Internal capacity. The issue of the capacity and capability needed to generate and coordinate detailed design and the delivery of the STP has still to be resolved. Attempting to deliver a change programme of this scale without freeing up key members of staff from other duties, or without bringing in additional resource, is destined to fail. The lack of transformation capacity and expertise released from within the system will result in momentum being lost. We are at a watershed moment and the Membership Group has recently agreed to consider all requests for capacity and skills in the light of insufficient progress being made to exploit the goodwill and discretionary efforts of all those contributing to this plan to date.

Appendices

Content	Page #
A1: Enablers	
Technology	
Estates	
Workforce	
A2: Financial model highlights	
A3: Communications and Engagement Plan	
A3: Cross cutting Clinical Programme PIDs	

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Cheshire East Council

Health & Wellbeing Board

Date of Meeting: **29th November 2016**

Report of: **Mark Palethorpe (Director of Adult Social Care)**

Subject/Title: **Better Care Fund 2016/17 – Q1 report**

Portfolio Holder: **Cllr Janet Clowes (Adults and Integration)**
Cllr Paul Bates (Communities and Health)

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1 Introduction

1.1 On 2nd September 2016, Cheshire East submitted the 2016/17 quarter 1 BCF return. The complete submission is attached to this paper. This return was signed-off by Cllr Rachel Bailey as Chair of the Health & Wellbeing Board.

1.2 The purpose of this paper is to provide Health & Wellbeing Board with a summary of the key points arising from the return, and to recommend next steps to improve performance within the Cheshire East health and social care system.

1.3 The paper will look at the following in turn:

- National conditions
- Income and expenditure
- Metrics
- Additional measures
- Next steps

2 Recommendations

2.1 The following recommendations are made:

2.1.1 HWB is asked to note the contents of the quarter BCF report

2.1.2 HWB is asked to note the areas of improvement

2.1.3 HWB is asked to note the areas where performance has not improved and commitment from all partners to collectively address this in the coming months.

2.1.4 HWB is asked to support the recommended next steps to improve performance where needed.

2.1.5 HWB is asked to support the two-year planning of the BCF for Cheshire east for 2017-19.

3 National Conditions

3.1 At the end of quarter 1 2016/17, the following national conditions were fully met in Cheshire East:

- Jointly agreed plans signed off by the HWB
- Social care spend being protected
- Agreement for the delivery of 7-day services across health and social care to prevent unnecessary admissions and delayed transfers of care
- Pursuing open APIs (systems that talk to each other)
- Appropriate information governance controls in place for information sharing in line with Caldicott2
- Ensuring people have clarity about how data about them is used, who may have access and how they can exercise their legal rights
- Agreement on the consequential impact of changes in the acute sector are in place.
- Agreement to invest in NHS commissioned out of hospital services, which may include a wider ange of services including social care
- Agreement on a local target for delayed transfers of care and a joint local action plan

3.2 The following national conditions, whilst not fully met, are progressing well:

- Support services are available seven days a week in hospital, primary, community and mental health settings to ensure that the next steps in the ptioent's care pathway can be taken, as determined by the daily consultant-led review
- NHS number being used as the consistent identifier for health and care services
- Joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, there is an accountable professional

4 Income and Expenditure

4.1 The total BCF budget in 2016/17 is £25.51 million.

4.2 The overall income in quarter 1 was £7.6million, £1.2 million higher than expected. The reason for the variation was the that whole Disabled Facilities Frant was received by the council in quarter 1, rather than on a quarterly basis as expected.

4.3 Overall expenditure in quarter was £6.44million, slightly higher than the £6.38 million planned. The variation is less than 1% and therefore not classed as material.

5 Metrics

5.1 Non-Elective Admissions: Both CCG areas have seen quarter on quarter rises in non-electives from 2015/16 to 2016/17 (i.e. deteriorating performance). This trend has also been seen at a national level.

5.2 Delayed Transfers of Care: Both CCG areas have seen quarter on quarter rises in DToC from 2015/16 to 2016/17 (i.e. deteriorating performance). It is possible that this increase is, in part, due to improvements in data reporting validity. Both CCG areas have daily reported DTOC profiles which are monitored and remedial actiion is taken to address issues that arise on a daily basis. Further work is ongoing across health and social care to further reduce these trends. This trend has also been seen at a national level.

5.3 Injuries Due to Falls in People Aged 65+: Both CCGs have seen quarter on quarter rises in falls from 15/16 to 16/17 (i.e. deteriorating performance).

5.4 People who Feel Supported to Manage Long-Term Conditions: Both CCG areas have experienced year on year increases in this metric (i.e. improvements in performance).

5.5 Admissions to Residential Care: The latest 12-month rolling figures up to and including Q1 show a decrease of 3.1% (502 people). A lot of work has been done to reduce the historical recording issue that meant permanent admissions were sometimes recorded as "respite", and whilst this has led to a higher admissions figure than planned, we are confident that this more accurately reflects the position.

5.6 Reablement: As June data was still being gathered at the time of reporting, the March - May period was used to provide a valid picture of current performance. For this period, 80.2% of people were still at home after 91days, which is behind the target of 88.4% and lower than the 15/16 year end figure of 84.1%.

6 Additional Measures

6.1 Use of NHS Number as Primary Identifier Across Care Settings: NHS number is used as the consistent identifier on relevant correspondence in all settings excluding social care, but this is increasing and will be complete within 2016/17. Staff in all settings can retrieve relevant information about a service user's care from their local system using the NHS number.

6.2 Digital Sharing of Relevant Service-User Information: Data is currently shared between all settings excluding specialised palliative and community services. Plans are in place and work is underway to ensure this is in place across all settings by the end of March 2017.

6.3 Personal Health Budgets (PHBs): Across Cheshire East there were 44 PHBs in place by the end of quarter 1, with 28 of these in Eastern Cheshire.

7 Next Steps

7.1 Whilst good progress has been made in meeting national conditions, the significant challenges faced by the health and social care system is evidenced in some of the performance metrics.

7.2 The BCF Governance Group intends to undertake the following action to mitigate against these challenges, and HWB are asked to approve and support this.

7.3 Undertake an in-depth analysis of all BCF-funded schemes with a focus on costs and benefits. This will take place in monthly meetings from October to February inclusive culminating in an extended seassion in early February where all partners will agree the work areas to be jointly funded in 2017/18 and 2018/19. It is proposed that membership of the Evaluation Group consists of wider partners than the Governance Group by including the VCFS sector, public health, and the Pioneer / Sustainability and Transformation Plan.

8 BCF 2017/19

8.1 On 22nd September, NHS England and NHS Improvement published the NHS Operational and Contracting Planning guidance document *"Delivering the Forward View: NHS Operational Planning Guidance"*.

8.2 The guidance provides local NHS organisations with an update on the national priorities for 2017/18 and 2018/19, as well as updating on longer term financial challenges for local systems.

8.3 The Better Care Fund is referenced in paragraph 69, and states:

"CCGs and Upper Tier Councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) from 2017/18 via the Health and Wellbeing Board. The plan should build on the 2016/17 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care. Further guidance on the BCF will be provided later in the autumn."

8.4 For the first time, the guidance covers two financial years, to provide greater stability and support transformation, and has been released three months earlier than normal to enable earlier agreement locally. Colleagues in DH and DCLG are currently developing the Better Care Fund policy framework which will also cover 2017/18 and 2018/19 and the Better Care Support Team (BCST) will be developing the Better Care Planning Guidance in parallel.

8.5 Current expectations are that this guidance will be published on 11th November 2016, with the first submission due before the end of December 2016.

9 Summary

9.1 Good progress is being made across the system to fully meet the national conditions.

9.2 Performance metrics are variable, with some positives such as people feeling supported to manage their long-term conditions. Other areas are proving to be more challenging, such as non-electives and DToCs. However, this is not unique to Cheshire East as recently published BCF national data shows deteriorating NELs and DTOCs at a national level. Health and social care colleagues are working hard together to address these challenges.

9.3 BCF will continue for at least two more years in Cheshire East, with a 2-year planning cycle for 2017-2019 commencing in November 2016.

9.4 The HWB is asked to support the recommendations in Section 2.

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

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 29th November 2016
Report of: Kath O'Dwyer, Director of People's Services and Deputy Chief Executive
Subject/Title: Children and Young People's Improvement Plan Update

1 Report Summary

1.1. This report updates the Health and Wellbeing Board on the progress against the Children and Young People's Improvement Plan.

2 Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a) Note the progress achieved against the Improvement Plan, as set out at Appendix 1 and 2, respectively; and
b) Note that the new Improvement Plan for 2017 will be presented to the Health and Wellbeing Board for endorsement in January 2017.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board is the accountable body for the Improvement Plan and has a responsibility to ensure that sufficient progress is being made to address the 25 recommendations for improvement identified by Ofsted in its 2015 inspection report of Children's Services.

4 Background and Options

4.1 The Improvement Action Plan was endorsed by the Health and Wellbeing Board in November 2015 and subsequently approved by the Department for Education (DfE). The Health and Wellbeing Board has subsequently received a number of updates around progress against the plan. Appendix 1 provides an annual review of progress since the inspection in July 2015. This review will inform the development of the new Improvement Plan for 2017. Appendix 2 sets out progress against the key quantitative measures to assess impact of the plan.

4.2 Progress against the plan is set out under the four key objectives below:

- Embedding listening to and acting on the voice of children and young people throughout services
- Ensuring frontline practice is consistently good, effective and outcome focused

- Improving senior management oversight of the impact of services on children and young people
- Ensuring the partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East

4.3 In summary, significant activity has taken place since the inspection, and a number of recommendations have now been fully met. The remaining recommendations concern the key cornerstones of practice and providing a consistently good quality of practice, which will require a longer timeframe to achieve the shift in culture and practice to ensure services reach the 'good' level achieved by the Adoption Service. A number of expressions of interest have been submitted to the DfE's Innovation Fund to implement a new model of practice across the service. This will be the focus of the Improvement Plan for 2017, which will be presented to the Health and Wellbeing Board in January 2017.

5 Access to Information

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

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Cheshire East
Children and Young People's
Improvement Plan
to meet the Ofsted Recommendations

Creating a great place to be young

Progress Report July 2016

Improvement Progress Report July 2016

Overview of this Report:

This report reviews our progress to date against the recommendations from the Ofsted inspection; we are now one year on from the inspection period. This report evaluates where our key areas are for further development in order to inform the new improvement plan for November 2016-17.

Overview of the Quality of Services:

Children are safe in Cheshire East, and there is good quality practice taking place with families. Audits show that thresholds are being applied appropriately at ChECS (97%), and social workers are effectively identifying and challenging safeguarding concerns (95%), and taking the right action at the right time to protect children (94%). Action by social workers and other professionals is resulting in improved outcomes for our children and young people in the vast majority of cases (86%).

Children are being seen regularly (89%), and their views and wishes are reflected in assessments and plans (80%). The number of children being taken into care has increased, with the number of children on section 20 decreasing, this is now down to 14% in June 2016 from 18% in April 2016, which is further evidence that the protection system is operating effectively.

Overall, the majority of our social work practice requires improvement (66%) with some good practice (22%). We have high aspirations for our children and young people, and we continue to relentlessly drive improvements and scrutinise practice to continually learn, reflect and develop our services further.

There is evidence of much higher proportions of good practice when considering specific elements of work, for example the majority of child protection plans in the last audit were judged to be of good quality (64%) and 46% of plans for cared for children were judged as good quality.

In terms of overall judgements, the quality of casework has remained at roughly the same level over the last 12 months. Requires improvement is a broad category in terms of the quality of work it covers, so it will take time before we see a significant shift in terms of the quality of work. This broad category is screening significant improvements that have been achieved; new processes within teams have been introduced this year, and arrangements for driving progress and monitoring and tracking outcomes for children and young people are now much tighter than they were during and prior to the inspection.

Significant Improvements Achieved:

- Action by social workers and other professionals is resulting in **improved outcomes for our children and young people in the vast majority of cases** (86%).
- **Children are being seen regularly** (89%), and their **views and wishes are reflected** in assessments and plans (80%).
- There is **good quality work at the front door.** ChECS show a clear trajectory of progress, and around 50% of work within ChECS is good or outstanding. Thresholds are being applied consistently (97%), there is clear management oversight (100%) and decisions are informed by information from partners (80%) and family history (100%).
- **More assessments are good quality** (37% combined assessments, 40% assessments for cared for children).
- The **majority of child protection plans are good quality** (64%), and **more plans are good quality for cared for children** (46%).
- The **quality of PEPs has significantly improved** in terms of the standard of PEP completion, and improvement in the quality of targets set by the school (90%).
- **Managers are scrutinising work** and that there is evidence to support this in their authorisation of plans (88%) and direction upon the allocation of work (98%). The quality of management decision making in the Permanence and ThroughCare Team has significantly improved from a low of 45% in Q2 to 80% in Q4.
- **Step up is appropriate**
- The **timeliness of requests from children's social care for initial health assessments has significantly improved**, from 4% within timescale in Q1 to 88% in June 2016, resulting in improvements in the timeliness of completion of the assessments, from a low of 12% in Q4 to 57% in June 2016.
- **Later in life letters are now being produced to a good standard** and processes are in place to quality assure these and support consistency.
- This year we have **nearly doubled the number of privately fostered children** and young people we are aware of in Cheshire East due to awareness raising activity.
- **We have significantly strengthened monitoring arrangements within children's social care,** including but not limited to the Safeguarding Performance Challenge Sessions and scrutiny of children and young people subject to a CP plan for more than 12 months, introducing the permanence case tracking meeting, and the tracker for care leavers in unsuitable accommodation.
- **Key strategic posts within Children and Families have been filled** and are driving improvements to and join up between services, and effective scrutiny, monitoring and challenge.
- **Recruitment and retention** continues to be a challenge to our services, but we have a robust recruitment and retention strategy in place and this is attracting the right people to work in Cheshire East.
- **Cheshire East's LSCB has achieved an Investing in Children Membership Award** this year for listening and engaging with children and young people. Two of our other services also hold this award – the Safeguarding Children in Educational

Settings (SCiES) Team, and the Missing from Home and Care or at Risk of Child Sexual Exploitation Service.

Ofsted recommendations that we can demonstrate we have fully met:

We can demonstrate that we have made fully met the following recommendations:

- ***11. Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays.***
- ***17. Ensure later-in-life letters provide details of all known information, are written in plain English, and are accessible to children so that they understand their stories.***
- ***13. Ensure audit arrangements have a sharper focus on looked after children.***
- ***14. Ensure that comprehensive and clear data and performance information are provided to managers and strategic leaders to enable them to better understand, oversee and scrutinise performance. This includes ensuring the accuracy of the information provided through the electronic recording system so that managers have effective oversight of frontline practice.***
- ***16. Strengthen commissioning arrangements to ensure that services meet the needs of families and children in need of help and protection and children looked after by:***
    - ***Reviewing the use of foyer accommodation for 16-17 year olds***
    - ***Ensuring that rigorous risk assessments are undertaken before the placement of young people in foyer or hostel accommodation, and review the practice of using this provision***
    - ***care leavers who are homeless***
    - ***private fostering and connected persons' arrangements to ensure that these arrangements are suitable and comply with regulations***
    - ***Ensuring sufficient health provision for older looked after children and care leavers***
    - ***Increasing the capacity of advocacy services to support children and young people identified as in need.***
- ***151: Complete work to develop the LSCB performance management framework so that service effectiveness can be evaluated rigorously across all agencies***
- ***152a: Provide regular scrutiny of services for looked after children.***
- ***154. Develop links with the Local Family Justice Board so that CESCB can monitor how well the needs of children in public and private law proceedings are met.***
- ***156: Improve the influence of CESCB in the work of the Health and Wellbeing Board to ensure that safeguarding is embedded within its priorities.***
- ***158: Implement a protocol that outlines when the National Panel should be notified about SCRs and incidents in order to strengthen scrutiny of decision-making.***

These will now be monitored through existing business as usual processes, subject to agreement from the Health and Wellbeing Board, and will no longer be monitored

through the Improvement Plan for 2016-17. A self-evaluation against all the Ofsted recommendations will be undertaken in July 2017.

Ofsted recommendations we will monitor for sustained impact:

For a number of recommendations, activity has been undertaken which has resulted in improved performance. As we cannot yet be assured that impact is sustained, performance will remain monitored over the next six months for the following recommendations:

- ***15. Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice.***
- ***1. Strengthen senior managers' oversight and monitoring of:***
  - ***complex cases where there are historic drift and delay in taking decisive action***
- ***12. Improve the timeliness of initial health assessments so that children who become looked after have their own health needs assessed within the expected timescales.***
- ***155: Review the arrangements for monitoring the quality of private fostering work.***

Activity to meet these recommendations will not be included within the Improvement Plan for 2016-17, as performance indicates the action already undertaken is resulting in the improvements needed. Performance in these areas will be continued to be monitored as part of the new plan and action will be taken if performance and impact is not sustained.

The next phase in our continual development:

Some of the recommendations are regarding the core elements of practice. As discussed earlier, requires improvement is a broad category, in order to achieve good services we need a whole service culture change to one that puts children and young people first. This is more difficult to achieve than the compliance we achieved in our first phase of improvement. Based on inspections in other authorities, it is estimated that improvement from requires improvement to good takes about three years to achieve.

As we move into the next phase of our service development, we will be moving away from the recommendations prescribed by Ofsted to focus on the areas that we know are our key areas for improvement. All the Ofsted recommendations which are outstanding will remain referenced to our key areas, but we feel it is important to be driving and shaping developments to our own narrative, and focusing this around our mission to put children and young people first in our services. A self-evaluation against the recommendations will be completed at the end of next year (July 2017) to ensure our progress against these is evaluated and documented.
This year we will be implementing a new delivery model for children's social care to change the culture of our work to one that puts children and young people first.

Implementing strength-based delivery models has been shown to be effective in other local authorities in achieving culture change, improving outcomes for children and young people, reducing the number of children brought into care, and reducing demand to higher level services. We are confident that will provide the step and culture change we need to achieve consistently good quality services.

We are also implementing a targeted approach to improvement across the partnership to develop a shared culture and ambition for children and young people in Cheshire East, and improve the quality, consistency and ownership of partnership work. This approach will focus on key practice areas each month under a shared quarterly theme, and will act as a campaign for change within agencies to raise awareness of good practice and expectations, and provide professionals with the mandate and support to challenge instances of poor practice.

Areas for Improvement for 2016-17:

We need to ensure our services put children and young people first, and understand their daily lived experience**.** We need to work inclusively with our families - being clear about what impact situations are having on children and young people, what intervention will entail, and what we want to achieve together with them to improve outcomes for our children and young people.

We want to ensure that all our children and young people achieve good outcomes, and that families can sustain these outcomes once services are no longer involved. Supporting families to take responsibility, support each other through wider family networks, and develop the skills to solve their own problems and keep their children safe will be a key element of the new delivery model.

Our key areas for development are given overleaf along with the links to the Ofsted recommendations.

Area	Link to Recommendation
Quality of management oversight, support and challenge: o Putting children and young people first - leading good practice and challenging delays o Recording management directions and rationale for decisions o Good quality supervision which evaluates CPD and links to PDPs	***3. Ensure that supervision is reflective, challenging and consistently focuses on continual professional development.*** ***6. Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded.***
Quality of social work practice: o Putting children and young people first – demonstrating an understanding of their lived experience o Focused and purposeful work, and SMART plans	***6. Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded.*** ***7. Strengthen frontline practice to ensure***

○ Analysis of the salient issues and recording rationale for decisions ○ Plans have clear contingencies ○ Linking direct work to the plan ○ Using history to inform decisions and assessments ○ Updating assessments in response to new information, e.g. return home interviews ○ Professional curiosity and continual questioning ○ High ambition for children and young people ○ Concise recording ○ Timeliness of private fostering and connected persons arrangements	***effective action is taken to support children at risk of child sexual exploitation and those who go missing.*** ***8. Ensure assessments for children in need of help and protection and children looked after are timely, consistently consider the full range of children's needs, contain thorough analysis and are routinely updated to reflect changes in circumstances.*** ***9. Ensure that plans to help children in need of help and protection, looked after children, and care leavers, are specific, clear, outcome-focused and include timescales and contingencies so that families and professionals understand what needs to happen to improve circumstances for children. This includes improving the clarity of letters before proceedings so that the expectations of parents are clear.***
Involving families: ○ Hearing the voice of children and young people ○ Involving families in creating the plan and identifying strengths ○ Demonstrating the views of children and young people, parents and carers on the salient issues ○ Clear communication on why we are involved and what needs to change ○ Timely information sharing ○ Working with the whole family and wider network ○ Plans are clearly evaluated ○ We are creative in our approach to support families ○ We seek feedback from and listen to families on what our areas for improvement are and take action ○ Use of family group conferencing	***16. Strengthen commissioning arrangements to ensure that services meet the needs of families and children in need of help and protection and children looked after by:*** • ***Improving the use of family group conferences so that all possible options for children are consistently explored***
Quality of oversight, support and challenge from IROs: ○ Putting children and young people first - leading good practice and challenging delays ○ Evaluating the impact of Practice Alerts ○	***2. Ensure the challenge provided by child protection chairs and independent reviewing officers (IRO) addresses drift and improves planning for children***
Involving key professionals: ○ In strategy discussions	***5. Ensure that strategy meetings and decisions are informed by relevant***

○ In communication – including GPs ○ In multi-agency meetings ○ In evaluating plans ○ Improving the join up with adult services ○ Addressing gaps between services	***partner agencies.***
Using the right tools: ○ Graded care profile ○ CSE screening tool ○ Toxic Trio Assessment tool	***153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.***
Good early help ○ Families receive a service when they need it ○ CAFs are good quality ○ We have a good early help offer which meets the needs of our families	***4. Ensure that where children do not meet the threshold for social work intervention their circumstances are considered promptly and they receive appropriate and timely early help.***
Sustainable outcomes and robust step down	***10. Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded.***
Joint Strategy for Female Genital Mutilation	***157: Develop and implement a coordinated strategy in relation to female genital mutilation so that the impact of multi-agency work within Cheshire East can be evaluated and understood.***
Strengthen work to tackle Neglect ○ Use of the graded care profile ○ Evaluation of the neglect strategy	***153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.***

Partnership Improvement:

Improvements to partnership working will be owned and driven by the LSCB. The LSCB has agreed four key priorities for 2016-18:

1. **Implementation of the neglect strategy**
2. **Improving the effectiveness of Child Protection Conferences**
3. **Improving the Board's role and traction in relation to early help**
4. **Delivery and scrutiny of the children and young people's improvement plan.**

The partnership improvement and development plan will sit within the LSCB Business Plan, and progress will be driven and scrutinised by the LSCB. Areas that will be led by the LSCB are included overleaf.

Area	Link to Recommendation
Quality of partnership practice: o Putting children and young people first – demonstrating an understanding of their lived experience o Focused and purposeful work, and SMART plans o Analysis of the salient issues and recording rationale for decisions o Plans have clear contingencies o Linking direct work to the plan o Using history to inform decisions and assessments o Updating assessments in response to new information, e.g. return home interviews o Professional curiosity and continual questioning o High ambition for children and young people	***9. Ensure that plans to help children in need of help and protection, looked after children, and care leavers, are specific, clear, outcome-focused and include timescales and contingencies so that families and professionals understand what needs to happen to improve circumstances for children. This includes improving the clarity of letters before proceedings so that the expectations of parents are clear.***
Involving families: o Hearing the voice of children and young people o Involving families in creating the plan and identifying strengths o Demonstrating the views of children and young people, parents and carers on the salient issues o Clear communication on why we are involved and what needs to change o Timely information sharing o Working with the whole family and wider network o Plans are clearly evaluated o We are creative in our approach to support families o We seek feedback from and listen to families on what our areas for improvement are and take action	
Involving key professionals: o In strategy discussions o In communication – including GPs o In multi-agency meetings o In evaluating plans o Improving the join up with adult services o Addressing gaps between services	***5. Ensure that strategy meetings and decisions are informed by relevant partner agencies.***
Using the right tools: o Graded care profile o CSE screening tool o Toxic Trio Assessment tool	***153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.***

Good early help o Families receive a service when they need it o CAFs are good quality o We have a good early help offer which meets the needs of our families	***4. Ensure that where children do not meet the threshold for social work intervention their circumstances are considered promptly and they receive appropriate and timely early help.***
Sustainable outcomes and robust step down	***10. Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded.***
Joint Strategy for Female Genital Mutilation	***157: Develop and implement a coordinated strategy in relation to female genital mutilation so that the impact of multi-agency work within Cheshire East can be evaluated and understood.***
Strengthen work to tackle Neglect o Use of the graded care profile o Evaluation of the neglect strategy	***153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.***
Application of thresholds	***152b: Monitor and review the application by partner agencies of the threshold framework and take appropriate action where necessary***

Next Steps:

Engagement with staff and partners, and other key stakeholders, will take place in Autumn to inform the development of the new plan for 2016-17. This plan will be informed by feedback from children, young people and parents/ carers – the key areas they want to see improve and how they want us to support them.

Quarterly Improvement Performance Scorecard - June 2016

No	Rec	Rec Summary	Measure	Thresholds RI	Thresholds Good	Thresholds Outs.	Q1 15/16	Q2 15/16	Q3 15/16	Q4 15/16	Q1 16/17	Comment/Additional Information
Listening to and acting on the voice of children and young people												
1	15	Learning from complaints	Percentage of complaints resolved at stage 1	75-84	85-93	95-100	80%	94%	100%	80%	100%	Of the 25 new complaints received in Q1: 13 have been responded to and closed at Stage 1; 8 are ongoing or outstanding; 1 is suspended; and 3 have expressed dissatisfaction with the Stage 1 response and further work including meetings is underway to try and resolve at Stage 1. No complaints have been escalated to Stage 2 as yet.
Frontline practice is consistently good, effective and outcome focused												
2	2	CP Chairs and IROs address drift and improve planning	Number of Practice Alerts made				58	60	28	23	51	The number of Practice Alerts has increased. The Practice Alert Process has been revised to increase consistency in raising alerts, so it expected that the number of alerts focused on these priorities will increase in the next quarter.
3			Percentage of Practice Alerts resolved at formal stage 1 or before	75-80	81-85	86-90	100%	100%	100%	100%	100%	All were resolved without needing further escalation which is very positive and shows professionals are responding to practice alerts.
4			Percentage of Child Protection Review Conferences held within timescale	85-89	90-94	95-100	82%	92%	98%	100%	99%	The improvement on the performance in this area has been maintained for 2 quarters and is ahead of stat neighbour and national average. This is reflective of improved practice around timely notification and arrangement of review conferences. It is important to note that there were always be the occassional unforseen circumstance that will prevent performance being 100% continually.
5			Percentage of Child Protection Plans open for more than 15 months	16-20	10-15	Below 10	11%	6%	6%	6%	7%	All CP plans over 12 months are scutinised closely by Safeguarding and frontline teams to ensure plans are appropriate and achieving aims in a timely fashion. This equates to 19 children and young people.
6			Percentage of children and young people's views that are heard at Child Protection Conferences	70-80	81-90	91-100	87%	94%	95%	90%	88%	This measure is giving an inaccurate figure due to coding in the case management system. This is now being addressed so we should see a subsequent increase in performance. Current service information suggests performance is close to 100%. This measure reflects all children over the age of 4 where their views have been articulated via a range of participation methods at both initial and review conferences.
7	4	Timely Early Help	Percentage of decisions made within 1 working day	70-80	81-90	91-100					71%	The standard for decisions in relation to Early Help cases is within 3 working days. For this quarter 84% of cases had a decision and were passed on to services within that timeframe.
8	7	Strengthen frontline practice for CSE and MFH	Percentage of cases where return interviews have been completed following missing from home or care (Individuals)	65-75	76-80	81-90		71%	69%	71%	65%	45 return interviews were not fully completed in Q1. Some parents refuse return home interviews as they are voluntary - this accounted for 52% of those not completed, and is usually due to the incident being the first time the young person has been missing, or due to a one off incident, or as a result of mis-communication on curfews, under which circumstances parents feel an interview is not necessary. 18% were due to young people declining the service. Other circumstances where interviews were not conducted include instances when the young person was not availble for the interview due to going missing on another occassion, and instances where workers were still trying to visit the child at the point of data collection. Where a Cared for Child declines the service the social worker would address the missing incident in their visits and complete a RHI form but this would not captured in this figure. Cheshire East are still receiving a high number of notifications being reported into the service with an increase this quarter of 16%. It currently takes 3 days on average to see a child/ young person, and complete a return interview which is consistent with the last quarter. The demographics of the young people going missing are the same as those in the last quarter with children averaging around 15 years old.
9	8	Quality of assessments	Percentage of children and young people seen within 10 days of the combined assessment start date	75-84	85-94	95-100	29%	54%	59%	65%	62%	Whilst an improved picture audit suggests that the figure for this is higher and work is ongoing to ensure the true picture can be readily extracted and reported
10	9	Quality of plans	Percentage of children and young people subject to a child protection plan for a second or subsequent time (cumulative)	15-20	10-14	5-9	23%	21%	21%	19%	23%	Whilst this is showing a continued upward trend our most recent comparison data in the NW (from Q3) indicated that the majority of authorities were reporting rates higher than the national average for 14-15, with %'s ranging from 5.9% to 30.3%. Repeat plans for Q1 represent a small number of families with multiple siblings.
11	10	Appropriate step down or closure	Percentage of repeat referrals (cumulative over a 12 Month Period)	25-30	20-24	Below 20	25%	22%	22%	22%	25%	Whilst there is a small increase in the number of re-referrals the rate of re-referral remains fairly constant. This continues to illustrate the need to develop better early help for complex families and to support agencies in continuing their lead role with the family. An audit was completed on all children subject to a repeat plan and the common reasons for this were identified and have been fed back to the service to improve practice.
12	12	Timeliness Initial Health Assessments	Percentage of initial health assessments requested within 48 hours of coming into care	70-80	81-90	91-100	16%	4%	4%	20%	69%	During the first quarter of 2016-2017 there were 57 children who entered the care system, 55 of which required IHA Part A completing within 48 hours of entering care. The number of IHA Part A being completed within timescale has increased each month from 42% in April 2016 to 88% by the end of June 16 with a total of 69% for Quarter 1. This is due to a review and change in process to enable operational efficiency
13			Percentage of initial health assessments completed by paediatricians within 20 days	70-80	81-90	91-100	41%	32%	29%	12%	36%	50 children in Q1 required an IHA completing within 20 working days. Seven did not require completion due to one transferring from another local authority with a completed IHA and six returned home within 20 days of entering care. The number of IHA completed within timescale has increased each month from 24% in April 2016 to 57% in June 2016, with a total of 36% for Quarter 1 2016-2017.
Senior management oversight of the impact of services on children and young people												
14	1	Senior managers' oversight of connected persons	Percentage of Reg 24 assessments presented to the fostering panel in statutory timescales	80-89	90-94	95-100	NA	100%	66%	100%	67%	3 Reg 24 Assessments were approved by the Fostering Panel in the last 3 months. Extension requested on 1 assessment due to checks not being returned within timescales.
15	1/155	Senior managers' oversight of private fostering	Percentage of Private Fostering cases visited in timescales	80-89	90-94	95-100	100%	67%	83%	93%	96%	7 young people received statutory vists within the quarter, 21 statutory visits completed, 1 visit went outside of timescales due to a failed visit.
16			Percentage of Private Fostering cases that are reviewed by the ADM within 45 working days of notification	80-89	90-94	95-100	0%	0%	0%	0%	0%	4 cases were due for sign off by ADM this quarter but none were within timescales. Further training on Private Fostering has been offered to teams
17	1	Senior managers' oversight of YP in unsuitable accomodation	Number of care leavers recorded as homeless						3	9	0	We currently have no care leavers recorded as homeless
18	16	Strengthen commissioning arrangements	Number of children and young people using advocacy				41	39	46	71	283	87 in April, 95 in May, and 101 in June. The numbers have risen due to the automatic referral by CP Chairs for Child Protection Advocacy
19			Number of children and young people using advocacy that are at risk of CSE				0	1	1	3	8	All children subject to CSE CP plans are referred for advocacy - many attend the meetings theselves and do not want an advocate. In the last quarter 2 young people have used the advocacy service.
20			Number of children who agreed to access advocacy services who did not receive the service prior to the first Child Protection review.				0	3	1	0	2	2 siblings due to not being able to make contact before conference so the advocate attended conference and made contact with family for their next review.

21			Average time young people wait to be matched with an independent visitor				5-6 months	4-7 months	3 months	2 months	2- 3 months	We have had 4 matches this quarter. An IV stocktake has been carried out this quarter and the report and analysis will be provided to CLT.
The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.												
22	153	Impact of the neglect strategy	Percentage of children and young people on child protection plans due to neglect	2% reduction	5% reduction	10% reduction	56%	48%	47%	44%	47%	Slightly higher than last quarter but still comparable with Stat Neighbours
23			Percentage of plans for neglect which have had a previous plan for neglect	20% - 16%	15%-10%	Below 10%	11%	16%	13%	17%	12%	As at 31/3/2016 there were 35 individuals on a plan for neglect that had been subject to a plan previously. Of these 15 has been subject to a previous plan for neglect.

Annual Improvement Performance Scorecard - March 2016

No	Rec	Rec Summary	Measure	What it Shows	Thresholds			Annual Figure 2015-2016	Additional Information
					Requires Improvement	Good	Outstanding		
Listening to and acting on the voice of children and young people									
1	15	Learning from complaints	Number of compliments received to Children's Social Care	The number of compliments should increase as we improve services	High is good			61	The number of compliments received this year has exceeded last year's figure of 42.
2			Number of complaints around particular themes.	The number of complaints on specific themes should reduce as these themes are addressed.				99	The number of complaints received last year in 2014-15 was 98, therefore the amount of complaints has stayed more or less the same.
Frontline practice is consistently good, effective and outcome focused									
3	2	CP Chairs and IROs address drift and improve planning	Number of good Practice Alerts made	Good Practice Alerts show that there is good practice and this is being recognised by IROs.				195	More good practice alerts have been made than those that challenge bad practice (157) which is positive, and shows that there is evidence of good practice and that this is being recognised.
4	3	Supervision is reflective, challenging and focused on CPD	Percentage of PDPs in place (ensuring gaps in practice identified through supervision are addressed)	All staff in post over 6 months should have a personal development plan (PDP) in place.	70-79	80-89	90-100	69%	This is in line with the wider Council's performance which overall has 71% of plans in place. However, this does also include a large proportion of new starters, who would not have a PDP until they had completed their 6 month probation period, so performance on this measure is higher than this figure suggests. We will be working to increase our performance in this area and a workshop will be given to social work staff and managers at the Practice and Performance workshops in September on PDPs to improve engagement with process and the quality and continued use and evaluation of development plans.
5	7	Strengthen frontline practice for CSE and MFH	Percentage of Social Workers who have been trained in using the CSE tools for assessment and intervention	The amount of Social Workers who have had the training to support them to work effectively with children and young people at risk of child sexual exploitation.					The core training offer for social workers has been launched in March 2016, which includes CSE training. The takeup of this offer will be closely monitored and evaluated over the next 6 months, and reporting will be available against this measure. Sessions on CSE have been provided to social work staff through the Practice and Peformance workshops in December 2015. CSE training is also available through e-learning. Members of the CSE/ MFH team also sit in the social work teams once a month to promote informal support.
6			Percentage of children and young people reporting that they feel safer at the end of the intervention for CSE	Children and young people feel safer as a result of the work that was completed to address the CSE risks	70-79	80-89	90-100	100%	This quarter saw an increase in work related to teenage boys aged between 13 and 16. Prior to this quarter it was largely girls being worked with in this age bracket. The girls coming to the attention of the service have been largely very young or in the 17-18 year old bracket with a smaller percentage being in the 13-16 age range. The service has further strengthened partnerships with other agencies and service in this quarter which has had an impact on the offer of support available to professionals working with these vulnerable young people and more seamless safeguarding.
7	8	Quality of assessments	Percentage of assessments completed within 15 days **Threshold only up to 50% as any higher would not be considered outstanding*	The amount of assessments completed within the target of 15 days to drive improvement to timeliness for assessments.	20-24	25-29	30-50*	28%	This measure is used to drive progress and ensure there is not unnecessary delay for children and young people. Performance on this measure is good, but we know form audit that the quality of assessments still require improvement overall.
8			Percentage of assessments completed within 35 days	The amount of assessments that are completed in line with Cheshire East's practice guidance.	65-70	71-75	76-100	78%	This shows that assessments are being completed in a more timely fashion and that the majority of children and young people don't experience delays, however we know that the quality of assessments are not at the level we want them to be.
9	11	Implementation of delegated authority	Percentage of Foster Carers that are clear on what decisions are delegated to them (Foster carer annual survey)	Foster carers are clear on the decisions they can make so this does not cause delays for children and young people	70-79	80-89	90-100	98%	In the last Foster Carers' Survey in June 2016, 98% (53) were aware of delegated authority. 82% (37) felt they were supported to make reasonable and appropriate decisions using delegated authority.
Senior management oversight of the impact of services on children and young people									
10	1/155	Strengthen senior managers' oversight of private fostering	Number of open Private Fostering cases	Private Fostering is identified				14	The Annual Figure last year 2014 - 2015 was 6, this year we have nearly doubled this figure with eleven new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases.
11	1	Strengthen senior managers' oversight of YP in unsuitable accomodation	Percentage of care leavers in homeless accommodation that have an appropriate risk assessment which references the risk presented by older residents	Risk assessments are being completed which consider the risks from other residents in order to protect young people	80-89	90-94	95-100		A newly revised risk assessment tool is being implemented from April 2016, as this has just been implemented reporting is not yet available for this measure. The new risk assessment tool has been sent out to every Personal Advisor and Social Worker working with these young people, and we are in the progress of re-assessing them using this new tool. Outcomes for all of these young people are being monitored by the Service Manager.
12	16	Strengthen commissioning arrangements	Number of young people placed in foyer accommodation	Young people in foyer accommodation are identified and monitored				11	We know how many young people are placed at Foyer accomodation. As of the first week of April this was 11, 5 of which are care leavers. Those that are care leavers have personal advisors who are risk assessing their placements using the new risk assessment tool. This risk assessment tool is also being rolled out to other parts of the service to ensure consistency of risk assessments for all young people placed in Foyer accomodation. A tracker reviews all young people placed at the Foyer on a monthly basis.
13			Percentage of children and young people that were pleased with the advocacy or independent visiting service they received	Children and young people felt that the service met their needs and their views were represented	75-79	80-89	90-100	94%	We carried out 39 Outcome wheels with children and young people and under Having my Say there was an increase in score in 37 of them. We also carried out a National Service User satisfaction survey in December, we had 30 returns 21 were very happy and 9 were happy. We are looking at doing this every quarter rather than twice a year and splitting it into Issue based Advocacy, CP Advocacy and Independent Visitor to give more accurate results
The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.									
14			Number of FGM cases identified in any age group that are recorded on the FGM enhanced dataset	Evidence that healthcare professionals are identifying and recording FGM				3	

15		FGM Strategy	Number of FGM cases identified in young people undr 18 reported to Cheshire Police via 101	Professionals are reporting FGM in accordance with the Serious Criome Act (2015)		0	
16			Number of Police investigations following reported cases of FGM	Female Genital Mutilation is responded to and investigated		0	
17	158	National Panel is notified about SCRs	Number of cases referred to Ofsted	Cases are referred to Ofsted		2	Two cases were notified by CSC in 2015-16.
18			Number of cases referred for consideration for a case review	Cases are considered for case reviews		3	3 referrals were received but not met the criteria for a SCR. 2 multi-agency reviews were held and 1 single agency review. 1 True for Us exercise was carried out.
19			Number of single agency case reviews held	Number of cases meeting this level of review		1	1 case (SAR001) was reviewed this year on a single agency basis.
20			Number of reflective reviews held	Number of cases meeting this level of review		3	3 reflective reviews have been held and lessons learnt have been disseminated through LSCB communications and the Sfaeguarding Children Operational Group (SCOG)
21			Number of serious case reviews held	Number of cases meeting this level of review		0	There have been no serious case reviews held as no cases this year met the criteria.
22			Number of 'True for Us' reviews held	Number of opportunities for learning we have used to develop services in Cheshire East		1	City and Hackney true for us exercise completed and reviewed for learning
23			Number of cases referred to the National Panel	Compliance with the protocol and that cases are referred to the National Panel		1	1 case which did not meet the criteria for SCR was notified to the NPE for verification by LSCB Chair.

Cheshire East Council

Health and Wellbeing Board

Date of Meeting: 29th November 2016

Report of: Lucia Scally – Senior Manager Public Health

Subject/Title: 1. Promoting population influenza (flu) vaccination
2. Arrangements for vaccination of front-line Council staff

Portfolio Holder: Cllr Paul Bates - Communities and Health

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1. Report Summary

1.1. This report provides a summary of the Councils work to raise awareness of the Department of Health (DOH), Public Health England (PHE) and NHS England (NHSE) winter Flu Vaccination Programme 2016/17.

1.2. This work fits with the Councils Corporate Plan 2016 - 2020:

Health – Safeguarding the vulnerable and providing appropriate care that helps people live well and for longer.

1.3. The eligible vulnerable groups for this programme are identified in section 4.2 of this report and some of the local initiatives to raise awareness of this national programme across the life course are set out in Appendix 1.

1.4. The report also describes how the flu vaccine is being offered to front-line staff in 2016/17, and suggests a review of this and the wider promotional work to inform next years approach.

2. Recommendation

2.1. To acknowledge the Directorates work and that of the Health and Safety Team.

2.2. All staff who work in children's and adult's services should be encouraged and empowered to endorse and promote flu vaccination.

2.3. To advise of any further areas of awareness raising that are required.

2.4. To support a review of learning from this years work to develop proposals for the 2017/18 Flu Vaccination Programme and Council vaccination scheme for reporting to Peoples DMT.

3. Other Options Considered

3.1. No alternative considerations are identified, as this is a national programme and is of importance to the local Health and Care economy (ensuing that the vaccination programme is accessed by vulnerable groups would minimise the risk of health complications which may lead to additional health or care interventions being required).

4. Reasons for Recommendation

4.1. In 2015/16, over 93,000 residents of Cheshire East received their annual free flu vaccination, with more than 1,000 jabs being given every day. Most flu vaccines are given between late September and early November to provide people with protection in case the flu season arrives early in December.

4.2. In 2016/17, the following individuals are advised to have flu vaccination:

- All children aged two to seven on 31 August 2016 (This includes all children of appropriate age in school years 1, 2, and 3, even if their age falls outside the birth cohorts specified. This also includes all children in the relevant age cohort irrespective of whether they attend school).
- Those aged six months to under 65 years in clinical risk groups
- Pregnant women
- Those aged 65 years and over
- Those in long-stay residential care homes
- Carers
- Frontline health and social care workers should be provided flu vaccination by their employer. This includes general practice staff.

4.3. Most flu vaccinations are delivered by the NHS in general practices, community pharmacies and other settings. Although vaccine uptake in Cheshire East among people aged 65 and over was 76.0% last year (5% higher than England), fewer than half of pregnant women and young children were vaccinated. (See Appendix 3)

4.4. Pregnant women have a seven times higher risk of dying from flu than non-pregnant women. This is why all pregnant women should be offered the flu vaccination including those who become pregnant during the flu season. Flu is the most frequent single cause of death in pregnancy.

4.5. A recent Joint Strategic Needs Assessment has identified the following priorities for enhancing public protection through vaccination:

- Maintain the high levels of annual flu jabs in people aged 65 and over
- Increase uptake among those who are at-risk from pre-existing health problems - their uptake in Cheshire East was only 50.8% last year
- Particular initiatives are needed in the town of Crewe to increase flu vaccination uptake among pregnant women and pre-school children
- Increase flu vaccination uptake among people who are very old, particularly those who are aged 85 and over

- Increase uptake in people with dementia, Alzheimer's disease, or with respiratory disease

4.6. The Council's main role is to oversee the influenza vaccination programme and ensure that the NHS has robust arrangements to vaccinate the target groups. Some flu vaccines are given in schools and fall under the jurisdiction of local government even though the NHS is responsible for their provision.

4.7. The role of the Council also includes the promotion of flu vaccination, supporting national campaigns designed to encourage all those eligible to be vaccinated. Staff, particularly those working in adults and children's services, should endorse and promote flu vaccination among their service users.

4.8. Together with partners in the NHS, the Council also helps to address health inequalities by promoting vaccination in hard-to-reach groups, and works with schools and communities to improve awareness about the importance of vaccination.

4.9. The Department of Health, Public Health England and NHS England have produced information leaflets and other materials for the 2016/17 campaign, including posters for GP surgeries and community pharmacies.

4.10. Locally we have sent out these promotional materials as outlined in Appendix 2.

4.11. Front line social care workers have a duty of care to protect vulnerable service users from infection. The Health flu vaccination programme helps to prevent transmission of influenza in this group of staff.

4.12. The Corporate Health and Safety Team have purchased 300 Flu Vaccination vouchers from Boots chemist for Council employees who work with vulnerable clients. The identified key managers have received a briefing about how this process will be administered by the Health and Safety Team. The availability of these vouchers has also been promoted through Team Voice. Guidance on how to access the flu vaccination independently with approximate attributable costs has also been included. These can be accessed from local pharmacies, and some GP Practices.

4.13. Although the flu voucher scheme is convenient to administer, managers may find it time-consuming to track which staff have used their vouchers, and it is difficult to measure the overall vaccine uptake. When staff uptake was last measured in 2013/14, it was only 14.5% among eligible employees. We will undertake a review of this years scheme, and explore other options for the delivery of the staff vaccination programme in 2017/18 for consideration.

5 Background/Chronology

5.1 We have noted that there is no national information for Care settings for vulnerable adults. Locally we have developed this information, and sourced referenced consent advice for such care settings. This information is set out in

Appendix 1, and will be circulated electronically to settings through Commissioners within the Peoples Directorate and CCGs.

5.2 We propose to undertake a review of the work undertaken to promote the Flu Vaccination programme this year. This will inform the approach for 2017/18 to both promotion and the voucher delivery scheme for council staff that support vulnerable people.

6 Wards Affected and Local Ward Members

6.1 All Wards.

7 Implications of Recommendation

7.1 Policy Implications

7.1.1 There are no policy implications.

7.2 Legal Implications

7.2.1 The main legal implication is that of seeking vunerable adults consent to receive the vacination, or where an individual lacks capacity that a best interest assessment and decision is taken in relation to receiving the vaccination. The guidance included in the leaflet for care settings has been sourced from the Medical Defence Union website who have provided advice for GP practices: https://www.themdu.com/guidance-and-advice/latest-updates-and-advice/flu-vaccinations---assessing-capacity-to-consent .

7.3 Financial Implications

7.3.1 NHS England have made available a funding stream that local authorities can apply to, to support the promotion of the vaccination programme locally. We have submitted an application for a total of **£1725**: £1100 for 200,000 information cards, £300 for postage (81 pharmacies), and £325 for leaflet design for care homes.

If we are successful all of the above costs will be covered by this NHS England funding. Should we need to, we will cover these costs within the ring fenced Public Health Grant for 2016/17.

7.4 Equality Implications

7.4.1 An equality impact assessment has not been completed, as we are following the national programme and promoting its availablity to the identified vulnerable groups.

7.5 Rural Community Implications

7.5.1 The geography of Cheshire East poses no specific challenge in relation to accessing this vaccination programme, as local GP practices and local pharmacies are delivering the programme.

7.6 Human Resources Implications

7.6.1 The promotion of this vaccination programme is being led by Public Health and therefore there are no wider work implications for colleagues

within the Council. The Councils Health and Safety Team are administering the employee voucher scheme, there will be work implications here for managers of staff who work with vulnerable clients.

7.6.2 The benefit of promoting the availability of the scheme for the wider Health and Social Care system is that service sustainability during the flu season would positively benefit from vunerable individuals taking up the vaccination programme.

7.7 Public Health Implications

7.7.1 Individuals aged six months to under 65 years in clinical risk groups, pregnant women and those aged 65 years and over are all at particular risk of becoming very unwell from flu and flu-related illness. They are then at a higher risk than the general population of having a flu-related death. Influenza is the main contributor to excess winter deaths in Cheshire East.

7.7.2 The Excess Winter Deaths JSNA can be downloaded from:

http://www.cheshireeast.gov.uk/social_care_and_health/jsna/jsna.aspx

7.8 Implications for Children and Young People

7.8.1 Children are the main transmitters of the flu virus in the general population. Vaccinating children every year means that they are protected and there will also be reduced transmission across all age groups, lessening levels of flu overall and reducing the burden of flu for the whole population.

8 Risk Management

8.1 The risks of flu are covered in sections 7.7 and 7.8. The conseqences of significant levels of influenza within the borough would realise increasing demand on Health & Social Care system at a critical period (winter months). Therefore this flu vaccination promotional work is important to mitigate this risk.

9 Access to Information/Bibliography

9.1 **https://www.gov.uk/government/publications/flu-vaccination-who-should-have-it-this-winter-and-why**

9.2 **https://www.gov.uk/government/publications/flu-leaflet-for-people-with-learning-disability**

10 Contact Information

Contact details for this report are as follows

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Appendix 1
Seasonal Flu vaccine promotion

Age group	Information distributed	Vaccine provided by
2, 3 and 4 year olds	15 posters and 150 leaflets sent for use in Children's Centres and Family Centres. Information also to be added to relevant stops of the "Parenting Journey" and on their Facebook page	GP surgeries
2, 3 and 4 year olds	Electronic versions to be distributed to contracted nurseries and childcare providers. Includes Foster Carers	
2, 3 and 4 year olds	20 posters for display in libraries. 250 leaflets for use in Crewe at Baby Bounce/ Rhyme time/ Story time sessions which reach over 100 parents/ pre-school children. Some libraries also have electronic display screens - information sent as PowerPoint for use. Also 15 posters for display in Leisure Centres	
Years 1, 2 and 3	Information and consent forms via schools to parents. Information also included in Schools Bulletin	School health service
At risk under 65's	200,000 small cards ordered to be added to prescription bags in pharmacies during November. Will need distributing late October. Information for residential & nursing care or other shared living settings for vulnerable people on vaccination. With guidance on ascertaining consent.	GP surgeries
Over 65's	200 leaflets provided for use via Reablement - Shared Lives service. Information for residential & nursing care or other shared living settings for vulnerable people on vaccination. With guidance on ascertaining consent.	
Others	Articles to be included in Team Voice.	Provides guidance on accessing Councils Voucher Scheme for employees working directly with vulnerable people. As well as guidance for those who would wish to purchase the vaccinations direct.

Note: Communications team are also involved in Winter Wellbeing promotion and will develop press releases alongside the national publicity

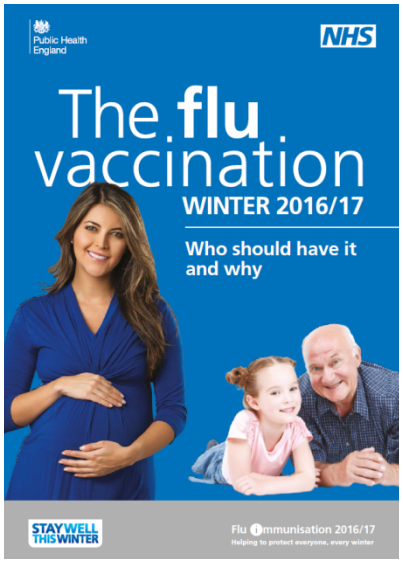
Appendix 2 Flu vaccination in Care Homes

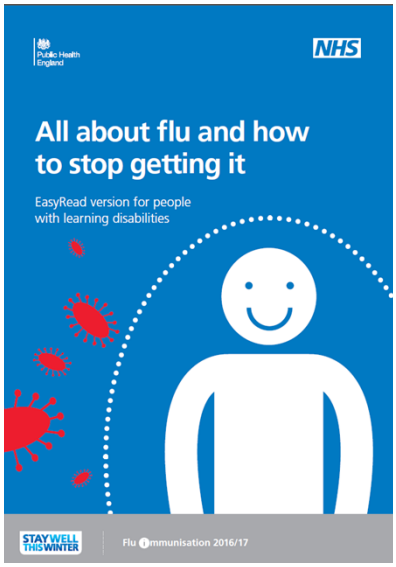
With the flu season upon us, we've been looking at ways of promoting access to the vaccine across various groups within Cheshire East. Residents in both nursing and residential homes are eligible for a free vaccine.

Flu immunisation is one of the most effective interventions to reduce harm from flu for individuals and pressures on health and social care services during the winter. It is important to increase flu vaccine uptake in clinical risk groups because of increased risk of death and serious illness if people in these groups catch flu. During 2014/15 it was found that 80% more people died with dementia or Alzheimers in the winter than the summer months. By preventing flu infection through vaccination, secondary bacterial infections such as pneumonia are prevented. This reduces the need for antibiotics and helps prevent antibiotic resistance.

If arrangements are not already in place, homes should make contact with their GP surgeries to discuss how vaccination can be provided for their residents. The link below is for the main information leaflet (pictured) that provides information about the illness and who should be vaccinated.

https://www.gov.uk/government/publications/flu-vaccination-who-should-have-it-this-winter-and-why





An "easy read" version is also available which can be used for adults with learning disability.

https://www.gov.uk/government/publications/flu-leaflet-for-people-with-learning-disability

Staff

Vaccination of health and social care workers not only protects them but it also reduces the risk of spreading flu to their patients, service users, colleagues and

family members. The vaccine is not available on the NHS, but is an Occupation Health responsibility of the employer.

Local pharmacies may be willing to either offer the vaccine to care staff at the pharmacy, or possibly even come to the home to provide the vaccine to staff, once an agreement has been reached regarding cost between the employer and the pharmacy.

Flu vouchers are also widely available widely and can be purchased on-line a minimum order size usually applies. Two examples are:

https://www.fluvouchers.co.uk/

http://www.boots.com/en/Boots-for-business/Corporate-flu-scheme/

Vaccination and capacity (Medial Defence Union)

It is important that consent is obtained prior to vaccination. Some information has been provided by the Medical Defence Union regarding capacity, assessment and best interest decisions all of which must be documented in the residents notes.

Key points

- Consent to vaccination required from patients with capacity
- Act in best interests of patients lacking capacity
- Nursing home patients need special consideration, especially if their capacity fluctuates
- Document in the notes decisions regarding patients without capacity
- Guidance on delegation, patient specific direction and patient group direction.

The Mental Capacity Act 2005 makes clear that all patients should be deemed to have capacity to consent to medical treatment such as vaccination, unless there is evidence to suggest that capacity is limited in some way.

It's important to ensure patients who have capacity have consented to vaccination, or to act in the best interests of those without capacity.

Capacity is time and decision-specific. A decision cannot therefore be based solely on the doctor's prior knowledge of the patient, or on an assumption of capacity based on age, appearance, medical conditions or behaviour.

Assessing capacity

A patient may need to be assisted to reach a decision, and every effort should be made to support an individual to make a decision, if they are able. If capacity fluctuates, for example if a patient has an inter-current infection, then a decision should be postponed to see if capacity is regained when the patient recovers.

When assessing capacity, it needs to be decided, on the balance of probabilities if the patient is able to:

- understand relevant information about the decision
- retain that information long enough to make the decision required
- use or weigh up (evaluate) that information
- communicate their decision.

If a patient is unable to do any one of these things, then they are deemed not to have capacity.

Best interests

If a patient lacks capacity, it will be necessary to make a decision about vaccination in their best interests. The assessment and the reasons on which the decision was reached should be clearly documented in the patient's records.

Even if the patient has been deemed to lack capacity, they should be encouraged to be involved in the process as far as possible. A decision on best interests should include determining what is in the patient's actual interests at the present time, taking into account any wishes they may have expressed. This is likely to involve a discussion with those close to and caring for the patient, and should include anyone appointed as a Lasting Power of Attorney (LPA), if practical. If a carer, relative or LPA feels that it may not be in the patient's best interest to be vaccinated, then it will be necessary to meet and discuss matters to try and reach a resolution.

If vaccination is felt to be in the patient's best interests, but the patient resists it, then it may be necessary to restrain the patient. The Mental Capacity Act makes clear that restraint must only be used to prevent harm to the patient. Health professionals have a common law right to use restraint to prevent harm to others. You must be able to justify that restraint is necessary, and the restraint must be proportionate and the minimum amount necessary to achieve the vaccination.

Advance planning

In a nursing or residential home, there may be a number of patients who will lack capacity and each needs to be considered individually. Doctors who are responsible for delivering healthcare in nursing homes, or to patients who may have restricted capacity, may wish to ensure the nursing home management team is given enough time before a vaccination clinic so that relatives are informed if appropriate and any concerns or issues can be discussed and documented.

Delegating

In the event that a doctor is delegating the task of vaccination to a practice nurse or another colleague, the GMC guidance on delegation applies (Good medical practice (2013), paragraph 45). When delegating care, doctors must be satisfied that the person providing care has the appropriate qualifications, skills and experience to provide safe care for the patient.

Delegation includes the assessment of capacity and the individual doctor who is delegating the task retains overall responsibility for the care and treatment of the patient.

Patient group directions

The prescription for a flu vaccine can be issued either by a patient specific direction (PSD) or a patient group direction (PGD).

A PGD is a legal framework which allows licensed medicines to be supplied or administered by a named, authorised and qualified health professional to a group of patients who fit the criteria defined in the PGD. It also acts as a protocol for the administration of the medicine or vaccine. The person administering a vaccination or any medication under a PGD will be responsible for selecting appropriate patients and for obtaining each patient's consent or, in the case of patients who lack capacity, assessing and acting in their best interests.

Non-NHS staff, for example nurses employed in a private nursing home, cannot administer vaccines authorised by a PGD. They would need a PSD for each patient. This is a written or electronic instruction from a GP or independent nurse prescriber to supply and/or administer medicine directly to a named patient or several named patients. The prescriber is responsible for assessing the patient(s).

Articles on Mental Capacity Act & Vaccination

Griffith, R. (2009) The Mental Capacity Act 2005 in practice: influenza immunisation. Nurse Prescribing 7(2) pg.78-81.

Griffith, R. (2009) The Mental Capacity Act 2005 in practice: best interests. Nurse Prescribing 7(4) pg. 172-175

Appendix 3

The tables below illustrate flu vaccination uptake by GP clusters across Cheshire East. Vaccine uptake is higher than the England average and has been over 75% for those aged 65 and over for many years.

	65y and over			6m-64y at risk			Pregnant women		
	Number of 65y+	Number vaccinated	% uptake	Number 6m-64y	Number vaccinated	% uptake	Number pregnant women	Number vaccinated	% uptake
Nantwich and Rural	7654	5554	72.6%	3649	1812	49.7%	331	161	48.6%
Crewe town	13944	10564	75.8%	10427	4963	47.6%	1027	438	42.6%
SMASH	14357	10740	74.8%	7799	3985	51.1%	621	318	51.2%
South Cheshire CCG total	**35955**	**26858**	**74.7%**	**21875**	**10760**	**49.2%**	**1979**	**917**	**46.3%**
Congleton & Holmes Chapel	10560	8085	76.6%	4701	2534	53.9%	406	205	50.5%
Macclesfield	12176	9543	78.4%	6878	3719	54.1%	806	432	53.6%
Bollington, Poynton and Disley	8578	6508	75.9%	3388	1717	50.7%	295	154	52.2%
Chelford/AEdge/Wilm/Handforth	9918	7618	76.8%	4502	2252	50.0%	454	236	52.0%
Knutsford	5468	4166	76.2%	2405	1221	50.8%	219	114	52.1%
Eastern Cheshire CCG total	**46700**	**35920**	**76.9%**	**21874**	**11443**	**52.3%**	**2180**	**1141**	**52.3%**
Cheshire East total	**82655**	**62778**	**76.0%**	**43749**	**22203**	**50.8%**	**4159**	**2058**	**49.5%**
England	9921156	7040630	71.0%	6787958	3063355	45.1%	719142	303928	42.3%

For children aged 2, 3 and 4 years most practice clusters in Eastern Cheshire CCG are achieving higher uptake than the Cheshire East average. Overall Cheshire East achieves 10% to 12% higher uptake than England as a whole, although there are very wide variations in different areas of the borough.

	2 year olds			3 year olds			4 year olds		
	Number aged 2y	Number vaccinated	% uptake	Number aged 3y	Number vaccinated	% uptake	Number aged 4y	Number vaccinated	% uptake
Nantwich and Rural	290	127	43.8%	327	166	50.8%	336	126	37.5%
Crewe town	1004	341	34.0%	1111	448	40.3%	1095	312	28.5%
SMASH	581	260	44.8%	684	312	45.6%	691	262	37.9%
South Cheshire CCG total	**1875**	**728**	**38.8%**	**2122**	**926**	**43.6%**	**2122**	**700**	**33.0%**
Congleton & Holmes Chapel	422	270	64.0%	457	279	61.1%	480	266	55.4%
Macclesfield	666	356	53.5%	745	354	47.5%	675	328	48.6%
Bollington, Poynton and Disley	283	166	58.7%	314	183	58.3%	347	173	49.9%
Chelford/AEdge/Wilm/Handforth	549	273	49.7%	506	263	52.0%	555	197	35.5%
Knutsford	301	150	49.8%	245	143	58.4%	293	149	50.9%
Eastern Cheshire CCG total	**2221**	**1215**	**54.7%**	**2267**	**1222**	**53.9%**	**2350**	**1113**	**47.4%**
Cheshire East total	**4096**	**1943**	**47.4%**	**4389**	**2148**	**48.9%**	**4472**	**1813**	**40.5%**
England total	689648	244142	35.4%	708012	266807	37.7%	710306	213478	30.1%

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