A Transformational Approach to the Integration of Health and Social Care in Central Cheshire 2014-2019

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Document Control

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Change History			
Version	**Date**	**Author/Editor**	**Summary of Change**
1.1	26 Mar 2014	D Eden	Incorporation of feedback comments from Connecting Care Board on duplicated areas and gaps
1.2	9 May 2014	D Eden	Feedback from strategy group, stakeholders and NHSE peer review event and reworking of document

Foreword

To be completed.

- *Seeking a public rep/community leader to write the foreword*
- *To include a description of what integrated care will look like and feel like for a service user or member of the care team e.g. where, by whom, how is it accessed etc.*
- *Include messages from the 'you said, we did' work*

Contents

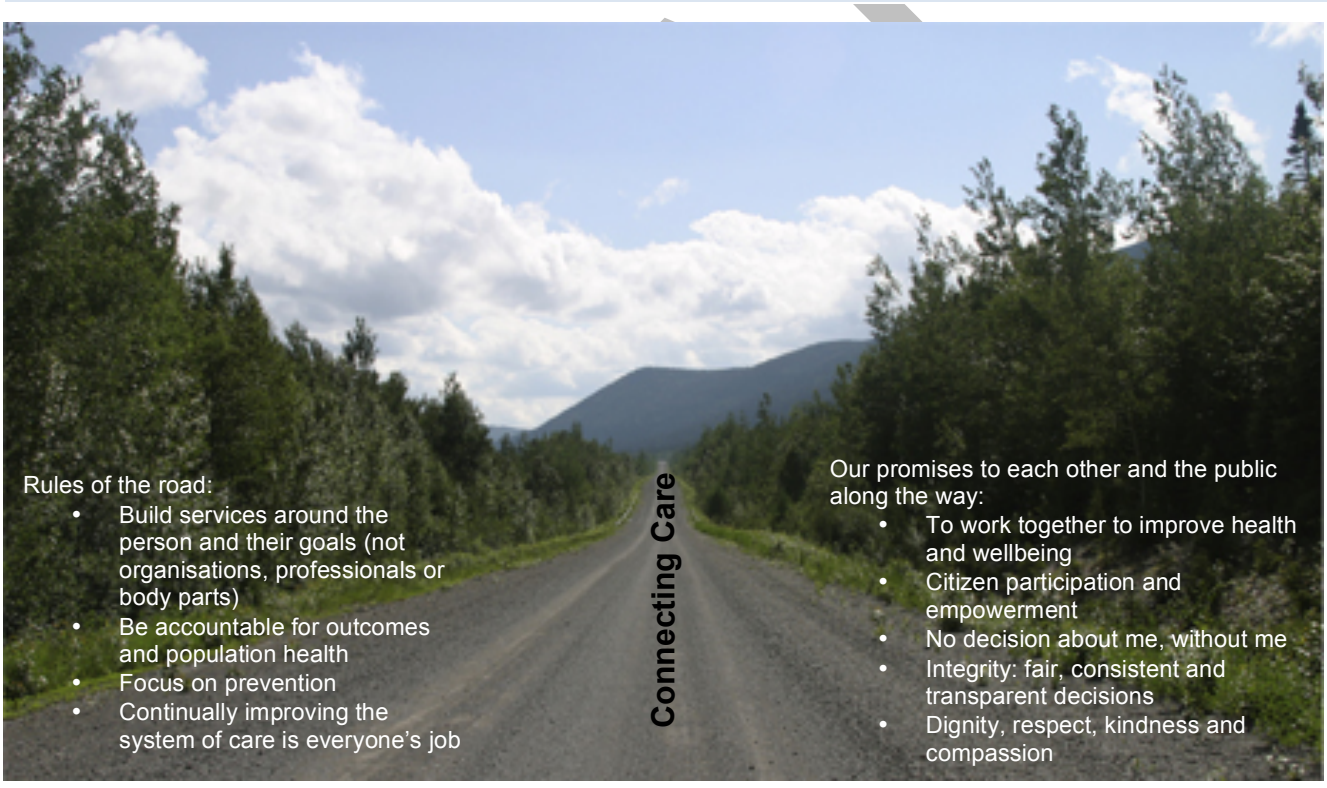
Vision

'Connecting Care in communities to ensure good quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'

Our citizens boast: **'I can plan my care with people who work together to understand me, and my carers, allow me control and bring together services to achieve the outcomes important to me'**

Communities that promote & support healthier living	An empowered and engaged public and workforce leading the way	Personalised care that supports self-care, self-management, independence & enhanced quality of life	People have positive experiences of high quality, safe care, delivered with kindness and compassion	Strengthening our assets – Carers are supported	All the 'care' pounds are spent wisely

OUR DESTINATION



Our Transformational Journey

1. Our vision and ambition

Our 5 year strategic vision is that we will consistently and for all be:

'Connecting Care in communities to ensure good quality, personal, seamless support in a timely, efficient way to improve health and wellbeing'.

In 5 years, the Central Cheshire health and social care system will:

- Centre all care around the individual, their goals, communities and carers
    - Have shared decision-making and supported self-management as integral components to care in all settings
- Focus its attention on prevention, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities and the wider causes of ill-health and need for social care support e.g. poverty, isolation
- Have a strong clinically led primary care and community care infrastructure offering an comprehensive network of extended practice/neighbourhood and integrated care teams delivering modern models of integrated care at scale
- Be delivering fully integrated and co-ordinated care, 7 days a week, close to home for populations of 20-40,000 with a focus on the frail elderly and those with complex care needs
- Provide care that is rated by our citizens as being the best in terms of quality, outcomes and experience.

Supported by:

- Service redesign across the care system – co-produced by our public and our workforce
- Shared information systems across health and social care so that people will only ever have to tell their 'story' once
- New contracting approaches that facilitate costs being moved from the acute sector to the community and that promote collaborations across multiple providers e.g. Alliance contract/Innovation Fund, GP federations
- Joint commissioning utilising the Better Care Fund and other approaches
- A range of new roles to support models of care across traditional providers of care/support in the public, private and voluntary sector e.g. community geriatricians
- Have a robust continuous quality improvement programme in the form of a 'Cheshire Learning and Improvement Academy' (CLIA).

To achieve:

- Accountability for care to the public
- High quality, safe care and a robust system of continuous improvement
- Improved physical/mental health, wellbeing & independence of our citizens, those with chronic disease & those with long term/complex social care needs
- A sustainable and financially stable care system
- Ensure that people receive care in the most appropriate setting with a reported reduction of a fifth in avoidable hospital, care home admissions, delayed transfer of care in 2019 compared to 2014

This will be delivered through a large-scale 5-year transformation programme entitled **Connecting Care,** which is described in outline below and in detail in chapters 5-8**.**

The Connecting Care Programme

The Connecting Care Programme is based on international evidence of integrated care. The Connecting Care Board is leading the programme, with oversight from our two Health and Wellbeing Boards.

We are wholly committed to delivering the National Voices narrative below for all of our citizens requiring care and support:

"I can plan care with people who work together to understand me and my carers, allow me control and bring together services to achieve the outcomes important to me".

National Voices & Making it Real 2013

The Programme comprises the following:

- A 'care system' plan co-produced and delivered by all partner organisations that is focused on prevention, early help and maximising health and wellbeing, informed by local people and delivered in partnership
- Large scale change and systems thinking methodology to drive the transformation programme that will lead to people thinking and behaving differently e.g. NHS Change Model
- Formal programme management infrastructure which is resourced with the money, talent, capability and capacity to deliver at pace and scale
- Working much more closely together and in smarter ways to have in place reliably and without error all the care that will help people and only the care that will help
- Building, strengthening and expanding primary and community based services, support and information around individuals and their needs, their carers and communities
    - Build teams that work to individuals goals but are accountable to populations and accountable for population outcomes (accountable care teams)
- Co-production and transformation of primary care with NHS England
- Developing our workforce, our citizens and our local communities capability and capacity to maximise opportunities for our populations health and wellbeing
    - to identify and deliver new ways of working in a cycle of continuous improvement that is developed in partnership with our staff & public
- Transforming and innovating primary care, urgent care, planned care, specialist care and achieving parity of esteem in mental and physical health care
- An overarching framework of 6 key integration outcomes to which progress will be measured:

The Central Cheshire health and social care integration outcomes framework:

1. Communities that promote and support healthier living
2. An empowered and engaged public and workforce leading the way
3. Personalised care that supports self-care, self-management, independence and enhances quality of life
4. People have positive experiences of high quality, safe services delivered with kindness and compassion
5. Strengthening our assets - Carers are supported
6. Al the 'care' pounds are spent wisely.

These integration outcomes have been created to provide a single framework for integration and transformation, which aligns directly to the existing health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

There are formal programme governance arrangements in place to lead the work and oversee the delivery and progress against these outcomes. Please see **Appendix 1.**

All our future plans, proposed initiatives and redesign work will need to be contribute to delivery of these outcomes if they are to be approved.

The development and execution of this strategy is a work in progress. Some of our objectives and plans require more detailed work and clarification and in breaking new ground we will test out new ways of working and share learning along the way.

Our purpose in publishing this document is to generate debate and elicit feedback in an effort to ensure that our approach is informed by the best ideas available.

2. The national and local context for Connecting Care

The Health and Care system in the UK is recognised internationally as a 'jewel' and as a high performing system particularly in relation to spend per head of population and quality of care. We have a first class primary care service with near universal and fast access to General Practice, a free at the point of access healthcare system and a wide range of care support systems for the most vulnerable in our communities.

We have and continue to make significant advances in the prevention of ill-health, reducing inequalities, ensuring high quality care, shorter waiting times for advice, information, treatment and support, maintaining independent living and increasing life expectancy.

However, worldwide care systems face the twin challenges of rising demand as a consequence of people living longer, increasing number of system interventions and the rising cost of paying for their care. Although, longevity is worthy of celebration, as our population ages, there is a related increase in the number of people living alone, living with multiple health conditions and increasing complexity of care needs.

There is therefore both an increase in need and a change in the nature of need. Our present care systems were originally designed to deal with episodic problems, with the assumption that modern care would solve problems and cure. This remains true for many but there is now increasing need to deal with on-going problems and to help people who need support in addressing personal goals that relate to a mix of social, physical and mental health. We have to learn to better address the need to help when there is no cure and to address all social, physical and psychological needs together. If we do not learn, we will be unable to deliver wellbeing and care costs will increase as people seek further care when their needs are not met.

With such changing need, the definition of health has been challenged (Huber et al 2011) and new definitions have been suggested. New definitions describe health in terms of the ability to cope with social, physical and psychological challenge and the ability to adapt and to self-manage. These definitions are more dynamic in nature and may have more meaning and usefulness for those with increasing frailty or living with disability.

Changing need, together with the current financial challenge and significant failures within the care system, has and continues to force a fundamental rethink of how health and social care should be organised in future. The Francis and Winterbourne reports, amongst others have exposed significant variances in quality within our current system and provide a steer to us on how we need to change our existing system.

There are long-standing fault lines in the current provision of care that result from historic divisions between budgets, between the major groups of healthcare providers and between health and local authority funders of care. Care is often fragmented and poor co-ordination can be a recurrent problem, resulting in frustration for the individual receiving care but also in delays, duplication, higher costs, waste, sub-optimal care and avoidable ill health.

Many people accessing care feel that they must 'slot into a number of services' rather than the service being tailored to their own needs and situation. Current policy to address this is to provide 'integrated care' in a 'personalised' way, wrapping care around those who need it, provided by teams who work effectively together to improve outcomes.

The premise of personalised, integrated care is that it will not only help to improve the co-ordination of care for a person and therefore prevent avoidable ill health, but also that it will result in greater value for money. The current climate embodies a strong commitment from all our partners across health, social care and the voluntary sector to radically reshaping how we care for our citizens.

In reality, our care systems have seen little fundamental change of organisation and delivery since their inception decades ago. The existing system, in the main, is designed to respond reactively to urgent care need and ill health but we need a system with pro-active approaches to support our aspirations for wellbeing and sustainability.

The focus of recent years has been on moving care closer to people's own homes, making care more personalised and supporting people to live independently for longer. However, it is now apparent that the scale of achievement has fallen short of the ambition and we can no longer afford the current rising demand for care.

By integrating care across health and social care, we aim to improve the physical and mental health and wellbeing of people living in our communities, to prevent ill health wherever possible, to continually drive up standards of care and to improve the care experience. By working together across disciplines, teams, care settings and organisations, we believe that we can drive out current inefficiencies across our fragmented systems and achieve our aims within our existing resources.

A National Integration Pioneer site

In the UK, the need to encourage integrated care is central to current government policy and system reform. As a result, a shared cross government commitment – the National Collaborative for Integrated Care and Support, was created in May 2013 with the aim of generating a new culture of co-operation and co-ordination between care sectors.

In early 2013, partners in 'care' across Central Cheshire united behind a common purpose of transforming and integrating services to improve the health and wellbeing for local people during a period of austerity. This resulted in the creation and initiation of the 'Connecting Care' Programme. In parallel to this, Cheshire was successfully selected as a national pioneer site for integration in December 2013.

The contents of the Pioneer plan '**Connecting Care Across Cheshire 2013'** provides a summary of our joint and ambitious 'Pioneer-wide' plans to deliver better care outcomes through integration which focus on the following 4 key areas: ***integrated communities, integrated case management, integrated commissioning and integrated enablers*** - ***Please see Appendix 2.***

The Connecting Care Board is leading integration locally within Central Cheshire, with local partners across the Cheshire wide Pioneer footprint and nationally as a Pioneer site.

Key national documents outlining the drive for integrated care are highlighted below:

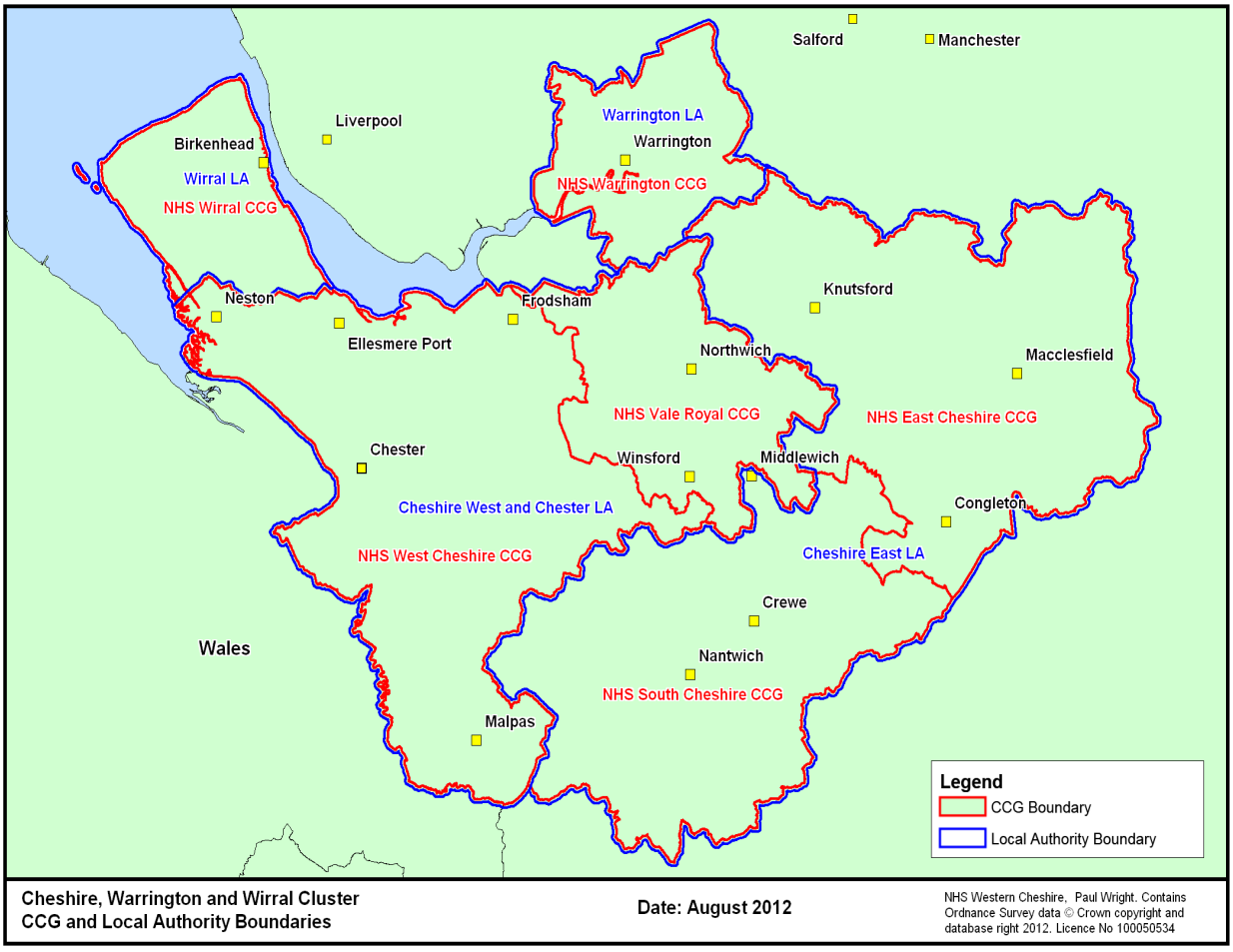
- The NHS belongs to the people: A call to Action - July2013
- Everyone Counts: Planning for patients – December 2013
- Closing the Gap: Priorities for essential change in Mental Health – Feb 2014
- The Better Care Fund 2014
- The Care Bill 2014.

'Every One Counts: Planning for Patients' places a focus on delivering transformational change. Our task is to translate the political philosophy of integrated care into an actionable agenda designed to achieve quantifiable outcomes, and then execute that agenda effectively, measuring progress towards them as we go.

3. An overview of Central Cheshire

Cheshire represents a large geographical county covering a population of over a million residents. Cheshire has a rich diversity of urban centres, market towns and rural communities, Cheshire is an area of outstanding beauty with its idyllic scenery and parkland but it also has urban towns with a comprehensive range of shops, businesses, local amenities high performing schools and can boast its low crime rates, great commuter links, rolling plains and stunning parkland. The population comprises of both affluent areas and deprived areas.

The map below shows in outline the county of Cheshire and the composite Clinical Commissioning Groups, Local Authorities and their boundaries.



The National Integration Pioneer Site footprint encompasses the Central Cheshire *Connecting Care* programme together with our partner health and social care organisations in western and eastern Cheshire and their respective programmes of integration: '*Altogether Better'* and '*Caring Together'* respectively. The population covered is more than 700,000.

The 'Connecting Care' programme is the local approach covering the Central Cheshire area.

The Central Cheshire area

Central Cheshire is a descriptive term used to describe the 'central belt' of Cheshire that includes the 2 local populations of NHS Vale Royal Clinical Commissioning Group (CCG) and NHS South Cheshire CCG. The Vale Royal CCG falls completely within the boundary of Cheshire West and Chester Council and the South Cheshire CCG within the boundary of Cheshire East Council.

NHS Vale Royal CCG has a total registered population of 102,000 and South Cheshire CCG has 173,000. The population has a higher than national average of older people. In terms of ethnicity, the population is predominantly white British.

The 2 CCGs and the 2 local authorities have responsibility for commissioning local health and social care services to meet the needs of local citizens, a total central Cheshire population of 275,000.

NHS England commission primary care services from the 30 GP practices within Central Cheshire. Community services are provided by East Cheshire NHS Trust and Cheshire & Wirral NHS Partnership Foundation Trust (CWP). CWP also provide mental health services. Mid Cheshire NHS Hospital Foundation Trust provides urgent, emergency and elective care. Specialist services are provided across the region, commissioned by NHS England.

What we know about health & social care need in our local area

A significant proportion of our population enjoys good health and seldom needs to seek care services or support. Our 2 local authority Joint Strategic Needs Assessments steer our strategy and inform us of where to focus our attention in order to improve the health and wellbeing of our population.

There are a range of different groups within our population that require episodic, intermittent or continuous care and support. These groups and the challenges they present to the capability and capacity of the existing care system are outlined in brief below:

- The population is predominantly older than the national average creating a continuing and spiraling higher level of need for care
- Due to the higher numbers of older people, the number of people with long term health conditions e.g. heart disease, respiratory disease, Dementia is rising
- There are wide variations in life expectancy among our population groups, with some being well below the national average
- There is a higher than national average number of people who live alone and increasing the incidence of social isolation and loneliness

- Inequalities in health persist creating gaps in access to care, life chances and wellbeing
- A proportion of our citizens, both children and adults live in the most deprived areas in England and experience poor health, poor educational attainment, deprived income, employment and living environment
- Certain localities have a high incidence and high mortality rate for a range of diseases e.g. lung cancer and stroke rates in Crewe town
- There are high numbers of excess deaths of adults with serious mental illness
- High levels of fuel poverty and winter deaths
- We have higher utilisation rates for a range of conditions, above the national average e.g. alcohol related emergency admissions
- Increasing levels of obesity in all age groups
- Some of the biggest health and wellbeing problems are avoidable but are being caused by peoples lifestyle choices including smoking, drinking alcohol, a lack of exercise and poor diet
- Our partner organisations are operating in an austere financial climate.

In Central Cheshire, there is a long history of successful partnerships and collaborative ventures across our partners' organisations.

4. Our challenges and our opportunities

We have undoubtedly made major progress in tackling the principle causes of premature death, successful secondary prevention and addressing risk factors such as smoking over the past decade. However, in many key areas such as health outcomes, potential years of life lost, life expectancy and deaths amenable to health care intervention, there is still further room for improvement to be among the 'best in the world'.

New challenges have emerged that pose a threat to population health and wellbeing in the future, for example demographic changes and increasing levels of obesity and we need to exploit every opportunity to address these, building on our existing strengths and developing new models of care.

Can our current care system address these challenges?

We have an outdated system

The current delivery models in all providers, hospitals, primary care and across community services, social care and mental health, are based in the main on outdated ways of working that result in poor value for money and a lack of user responsiveness.

The health and social care systems are largely concerned with the treatment of ill health and complex/critical social care need rather than on the promotion of health and wellbeing. It gives too little priority to preventing illness and actively supporting people to live independently and healthy lives. We need to flip this to a strong focus on pro-active and preventative approaches.

The focus of care commissioning is often on the hospital. Hospitals are open all day every day and until we can provide robust care services with similar coverage, they will continue to be the default setting for any lack of alternative options of support. We need to rapidly develop robust alternatives to hospital care. Currently, our pathways are set up to deal with single illnesses and need to be adapted to deal more effectively and efficiently with people experiencing multiple conditions and ongoing chronic illnesses.

One of our key strengths is our primary care system. However, it also brings with it some challenges as our current general practice infrastructure is akin to a cottage industry. GPs are independent contractors running their own small businesses, which can be isolated from each other and they are constrained in the range of services they are able to provide. Working much more closely together would enhance both their capability and capacity.

Nationally, mental health services have been radically transformed over past decades and have seen the adoption of a dramatically different approach to historical care, with a range of community care services, assertive outreach, early intervention and crisis resolution services. Although there is still more to do, these are successes that we can learn from and develop further.

Presently, our guidance and our measurements are formulated around single disease models. Guidance needs to be more flexible and informative to support shared decision making and to offer guidance when care becomes more complex.

At present there are significant health inequalities for those with mental health conditions compared with physical health conditions and we need to develop a care model that embeds parity of esteem for both mental and physical health to improve care outcomes.

Can we meet our productivity and efficiency challenge?

In terms of measuring how our current care system operates, we tend to measure episodic snapshots of activity, process, interventions and outcomes. There is very limited measurement of impact across longitudinal pathways, across organisational boundaries and incorporating impact of care on quality of life. Developing person level pathway and/or end-to-end measures will facilitate the identification of areas for improvement and increased efficiency e.g. E W Deming/Toyota approaches. We need to develop measures that measure improvement and care experience and embed them within our everyday care delivery and evaluation.

We have implemented changes and improvements by means of short-term fixes to parts of our system, which has been in part a response to our short term planning cycle and short term funding mechanisms. We need to move to longer term planning timelines.

We now know that small-scale change approaches will not assist us in meeting the current productivity and efficiency challenges. Radical system change is now required.

Moving care 'closer to home' – in spirit and in geography

Medical advances and advances in treatments have enabled care to be delivered in different ways or in different settings. They have revolutionized treatment, leading to a major shift away from in-patient to outpatient and day-case treatments and from hospital care to community care. This has led to a reduction in the number of beds in our hospitals and more care services being delivered in the community.

However too much care is still provided in hospitals and care homes and treatment services continue to receive higher priority than prevention and community care services. Specialist treatment services have been funded in preference to generalist services. We are currently planning to build our community services capacity but to do this we have a key challenge of how to release resource currently spent in hospitals and move that spend to the community.

To date, changes to how General Practice and community services are organised and delivered have only been small scale and at the margins and we know that we need to undertake change on a larger scale and at greater pace.

Technology

Current models of care are outmoded particularly with respect to use of technology. In our wider society, technologies are evolving rapidly and are changing the way in which we interact with each other. Our care systems have and continue to be very slow in utilising technology to improve care and transform how it is delivered.

Locally there is some testing of telehealth and telecare models but there is significant untapped potential here for delivering care more effectively. Technology should enable greater shared decision-making and a move of focus of control towards individuals.

Fragmented and reactive care

The case for integration has been argued for decades now, yet our services remain fragmented and fail to act together, other than at the margins. This is in part due to the fragmentation between organisations, between physical health and mental health, between primary care and hospitals, but also due to professional group boundaries and specialisms creating false silos of care. These separations are 'hard-wired' into service provision, payments, professional training and each organization in the main continues to work on separate strategies, initiatives and outcomes.

The separation between general practitioners and hospital based specialists and between health and social care inhibits the provision of timely and high quality integrated care to people who need to access a range of services.

Services have not kept pace with changing demands. We know that if we spend more time involving the individual in their care planning in a proactive way that the need for interventions reduces.

There is poor recognition of the importance of investing in public health, which is often influenced by long lead times for impact on outcomes. We currently spend over 95% of our resource on reactive care and only 5% on public health preventative initiatives and interventions. Increasingly, pressures on social care budgets are making it more difficult to act early with relatively simple and inexpensive interventions that help people in their own homes.

It seems that we are always responding reactively to pressures in the system rather than pro-actively managing them and there is little concerted effort to tackle the wider determinants of health.

Quality

There are wide variations in access to services, the quality of both health and social care provision and clinical outcomes across all care settings. Recent national publicity over the serious failings at Mid Staffordshire NHS Foundation Trust and Winterbourne View, underline the need for change in all parts of the system. We currently work on a number of targeted areas to improve quality yet they tend to focus only on individual parts of the system and individual organisations.

We need to consider quality from an individual's perspective, across pathways and the system of care.

Much of our care system operates on a 5-day 9am to 5pm working week with reduced support over the weekend yet we know that this does not meet the needs of our population. Concerns have also been raised over the quality of these reduced services and the impact that this has on outcomes e.g. increased weekend mortality rates in hospitals. Locally we know that our mortality rates are higher than the national average and we need to continue to work hard to reduce these with our partners.

Another particular area of concern is patient and service user experience of health and social care. International comparisons show that we are not doing as well as many other countries (Davis et al 2010 & Cornwell et al 2012). We will need to develop a robust approach to citizen partnership to gain insights into experiences of care and co-produce actions to address poor experiences of care.

Staff/workforce capacity and capability

We know that the people working in our care system are strongly motivated to providing the best possible care to service users but are often frustrated in their ability to do so.

Constant re-structuring of the health and social care system has focused on organisational changes which has diverted staff attention from the real key area of focus, which is continuous quality improvement in care services.

A major challenge for us today and for the future is to align the skills of the workforce with the needs of our service users. There is a growing awareness that the current workforce is not well matched to patient needs. We need to ensure that more senior skilled staff are supporting those who are acutely ill and who have complex health and social care needs rather than those who are junior or in training. Training schemes have been designed from a professional standpoint, not an individual's and this leads to gaps in skills, knowledge, ability from the individuals perspective. If a professional is unable to meet an individuals need, then the question should be asked 'do I need to learn to do that' rather than 'who can I pass this onto'.

Our current system is built on specialisms and sub-specialism but the growing burden of disease demands a growth in generalist skills across all care settings. There are particular gaps, where our general workforce, lack key skills to meet future models of care. These need to be incorporated into core training programmes across a range of staff groups e.g. dementia care, caring for those with complex physical and mental health needs and providing health promotion and prevention advice e.g. Every Contact Counts.

The workforce has been changing slowly over recent years with new roles emerging and new ways of working involving delegating roles from one professional group to another e.g. medical to nursing. This needs to happen across a range of areas if we are to utilize our workforce differently to meet our challenges.

If the inappropriate use of hospital care is to be reduced and care closer to home is to be enhanced, then much more attention needs to be given to the work of nurses, allied health professionals, mental health and social care workers. Their separate systems of work need to move to an integrated care model across community services, social care and primary care teams.

Historically professional training models have reflected a paternalistic approach to care and although significant progress is being made, our citizens tell us that they are not as involved as they would like in decisions about their care.

Our plans are to move to increasing community capacity yet workforce intelligence predicts that soon we will have an oversupply of hospital doctors and a shortfall in a wide range of community health, social care and supporting roles. There is also a significant cohort of the workforce with extensive knowledge, skills and experience that will retire in the next decade leaving a large deficit in our care system. It is clear that we need to use our workforce differently and we need to plan to address discrepancies in future supply or manage over-supply of key staff groups.

A large part of care is delivered informally from a group we call 'carers'. A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. Taking on a caring role can mean facing a poverty, isolation, frustration, ill health and depression. Many carers juggle work and caring or they can often give up an income, future employment prospects and pension rights to become a carer. At present, the number of carers accessing support is in the minority. We need to strengthen our carer assets to enable them to feel supported in their caring role, to maintain their own health and that of the person they are caring for.

Third sector and community organisations locally also provide significant additional capacity but their work if often poorly resourced and small scale. Public funding of third sector organisations needs to be increased to support their work on a larger scale and a substantial basis but at present their funding is being reduced.

Public expectations

Patient and public expectations are changing with people expecting improvements in how and where care is delivered, how it is organized and how they can be supported to manage their own health. Our public has an expectation that care services will be similar to services in other service industries such as leisure and retail. In many instances there is a significant gap in the expectation and the reality.

Increasingly our citizens expect more involvement in decisions about their care, their level of choice and that care will be local, accessible, personalised and provided in modern buildings. At the moment, access, choice, public engagement and involvement are variable across organisations. Participation needs to increase to a level never seen before.

Finance

We face an unprecedented period of financial constraint as a consequence of the banking crisis in 2008 and its impact on the economy and its impact on public finances. The effects have been felt strongly by local authorities, with the NHS having had a degree of protection. This constraint will continue for the foreseeable future.

The funding for health and social care is allocated using different formulae, with services being delivered in the health sector free at the point of demand whilst services remain means tested within the social care environment. This is a significant difference, which causes pressures across the system. Nationally, spending constraints on social care have led to local authorities to tighten eligibility criteria. This has resulted in resources being increasingly focused on people whose needs are substantial/critical/those with the lowest means and is associated with an increase in the level of unmet need. As a result, the care offer to those deemed eligible has and continues to be reviewed and refined.

In the short term, additional funds are being transferred through the NHS to local authorities to help tackle the shortfall with greater efficiencies achieved through integrated commissioning across health and social care. We will need to maximise the opportunities that the Better Care Fund offers. However, it is unlikely that this will be sufficient to cover the financial challenges within our local authorities. In addition to this the new Social Care Bill will increase the number of people who will be eligible for social care support from April 2014.

In Central Cheshire there is a combined budget of Health and Social Care expenditure relating to 2014/15 of c£420m for the Connecting Care Area. This represents the expenditure on health, strategic commissioning in Cheshire West and Chester and adult social care and independent living in Eastern Cheshire Council. Expenditure in future years will be limited by the available resources of the commissioning organisations.

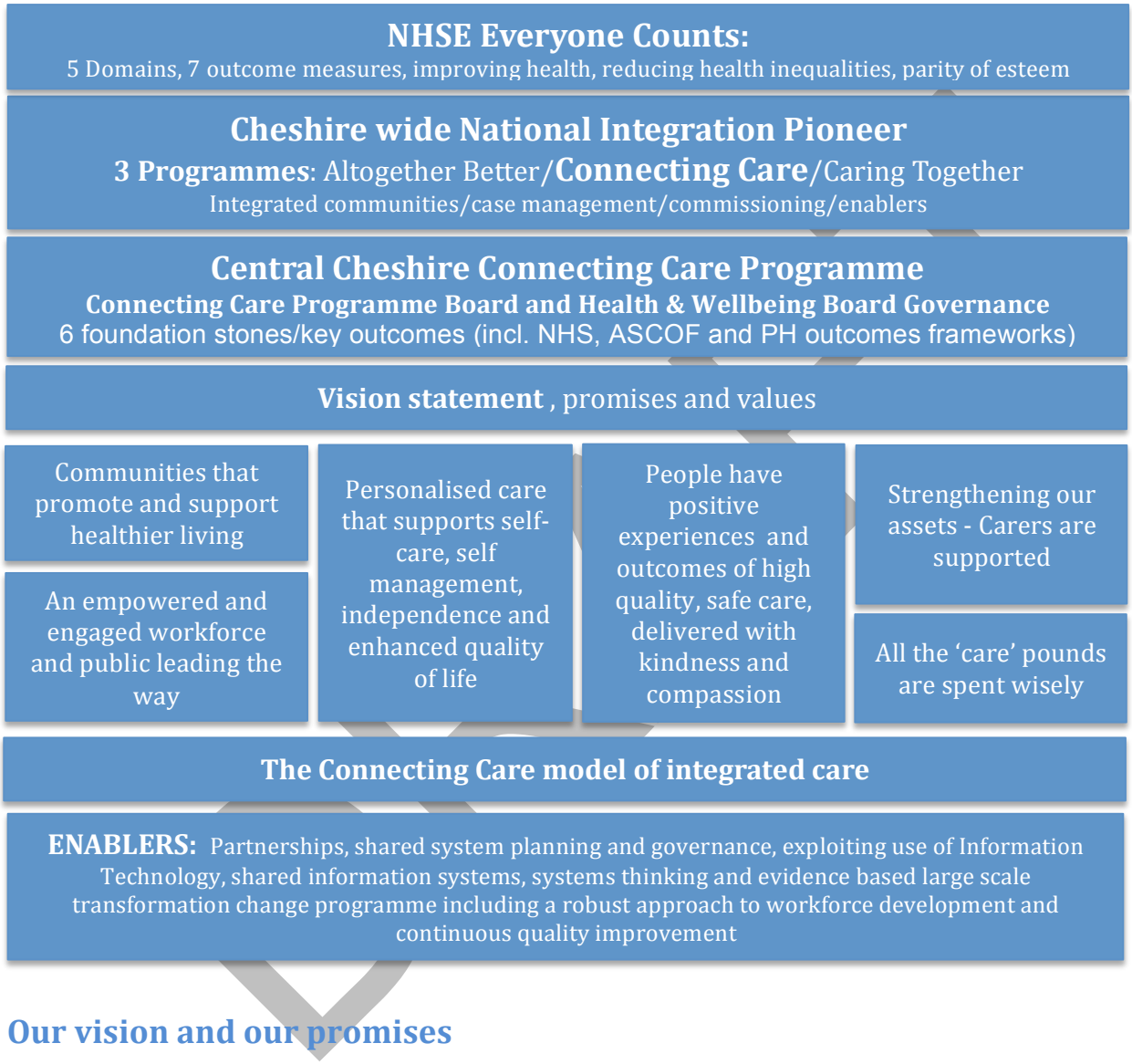
At present across the Central Cheshire local health and social care system, there is an existing financial gap of c£20m and an increasing financial gap across the commissioning and provider landscape, which is predicted to rise to a shortfall of c£59m by 2019. Individual organisations may see larger financial challenges but the figure above relates to the Central Cheshire element of contract activity or relative population. Continuing on this trajectory is not an option and we need to implement radical transformation in order to maintain a sustainable care system.

Public spending constraints mean that any improvements to our system and care will have to be funded out of existing budgets although there will be a small annual increase. However, within the health sector, it is envisaged that the Quality, Innovation, Prevention and Productivity initiatives, which are included in this plan, will deliver the required proportion of the £30m Nicolson Challenge over the next 5 years. Remaining financially viable across the health and social care system is one of our most significant challenges ahead.

5. Transforming, integrating and connecting care

This chapter will outline the overall connecting care programme and go on to describe our model of integrated care that will facilitate the planned transformation.

The following diagram illustrates how all the differening elements of the Connecting Care Programme come together.



Our vision and our promises

In order to '***Connect Care in communities to ensure quality, personal, seamless support in a timely, efficient way to improve health and wellbeing***' we make the following promises to each other and the public along the journey:

- To work together to improve the health and wellbeing of our citizens
- Citizen participation and empowerment
- No decision about me, without me
- Integrity, fair, consistent and transparent decisions
- Dignity, respect, kindness and compassion.

What is 'integrated' or 'connected' care?

There is no one definition of integrated care. It can be defined as an approach that seeks to improve the quality of care for service users and carers by ensuring that services are well co-ordinated around their needs regardless of professional, team, service or organisational boundaries. The citizen's perspective is the organising principle of care delivery.

The definition of integrated care selected for use in the Connecting Care Programme is one produced by the public during the recent National Voices and Making it Real national public consultation exercise:

'I can plan my care with people who work together to understand me, and my carers, allow me control and bring together services to achieve the outcomes important to me'

The Connecting Care integrated care model –in 2019

The diagram below illustrates the model of integrated care that the Connecting Care programme is aiming to delvelop and implement over the next five years.

Core aspects of the Connecting Care integrated care model include:

- The person is at the centre of all care – 'no decision about me, without me' with all care services and resources wrapped around them for when they are in need
- People will get the right care, at the right time, by the right person, in the right place and only the care that they need
- More care will be organised and delivered outside of traditional hospital settings, in local communities with closer collaboration across teams
- People will use services differently with more provided in primary care/community and less in the hospital:
    - with integrated extended GP practice/neighbourhood teams and integrated community services delivering integrated care and support 'closer to home' incorporating physical & mental health, social care & the voluntary sector
    - Traditional 5 day per week community services will be extended to offer support, when needed 7 days a week
    - with a smaller, more flexible community facing hospital delivering planned, emergency and specialist care and
    - regional specialist hospitals continuing to deliver supra specialist and specialist care, some of which will be in the community setting
- Asking people what they want - Personalised care planning with embedded shared decision making and the individual's identified goals driving care
- Supporting people, their families/carers to take responsibility for their own wellbeing and make choices about their care based on their personal goals
    - Supported self care and self management through targeted programmes and 'making every contact count' approaches
- Much more cross organisational planning, commissioning and provision of care, that reduces duplication and achieves the best use of resources
    - A focus on prevention, and early detection and interventions/support through risk stratification, care co-ordination &proactive case management
- Be accountable to our citizens for outcomes and population health
- Focus on the multiple determinants of both physical and mental ill-health and creating innovative solutions across partners
- Supporting 'enablers' of integration
    - Workforce – development of CLIA – 'Cheshire Learning & Improvement Academy' to support cultural change, workforce education and development, leadership capacity and capability within individuals and teams across the lifespan of the programme to support the new model of care and developing new roles e.g. interface geriatrician, generic care roles
    - Information Technology – Creating shared information systems and exploiting the use of technology to support care
    - Public and workforce Engagement, Communications and Participation using range of techniques/approaches e.g. campaign methodology.

Impact of the Connecting Care integrated care model

The model will shift focus from episodic and reactive care to longitudinal, long term, chronic care and from a paternalistic to a person centred model. This new integrated care model aims to deliver services in a way that puts the citizen at the centre, giving them more control. This means that instead of citizens trying to navigate their way around the multitude of services that currently exist, we are redesigning services to fit around their needs. We want to avoid any duplication of care, prevent people having to tell their story multiple times and to minimise waste across care settings.

Key to the new model is the formation of Integrated Extended Practice and Neighbourhood Teams. The core component of the approach is scaling up access to generalist services and scaling down unnecessary access to more specialist services. These are multi-disciplinary teams comprising GPs, geriatricians, nurses, palliative care, allied health professionals across physical and mental health disciplines, social workers and social care support workers and voluntary sector support workers, working together in a specific geographical area. The population covered by each team is planned for between 20-50,000. Services will be planned on the basis of each defined population and timely response is a key factor. Populations will be risk stratified and by aligning health, social care and voluntary sector teams and resources, we will be better able to work together around our population's needs, share information and combine experience to provide a positive experience of care for our citizens and shape continuous improvement.

Initially, the newly established primary care/community teams will focus their attention on those aged over 60, the frail elderly and those with the most complex health and social care needs. Primary and community care will be expanded and strengthened and will work with new models of care e.g. Starfield principles. Incrementally the teams will be expanded to cover all needs of their relevant populations and teams will focus support on the individuals own goals with the lead professional e.g. GP being in an accountable role for their care. There will be embedded systems of quality improvement within the teams.

These integrated extended practice and neighbourhood teams will pro-actively manage their population groups, offering higher levels of support than is possible at present, innovating support, care pathways and processes that will maximise care provision in the home or community, providing self-care support and education, manage down the existing growth in avoidable hospital and care home admissions, implement admission avoidance plans and incrementally increase the numbers of people being supported to live independently in their community. People will have their own key worker and they will know how and where to access information, care and support when it is needed.

Building services around individuals means that their needs come before those of organizational priorities, professional groups or the conventions of payment mechanisms. It requires closer, smarter working between organisations and the development of new relationships between care professionals and between care professionals and those using services. It means strengthening community and generalist based services and developing the workforce to ensure they have the right balance of skills and knowledge.

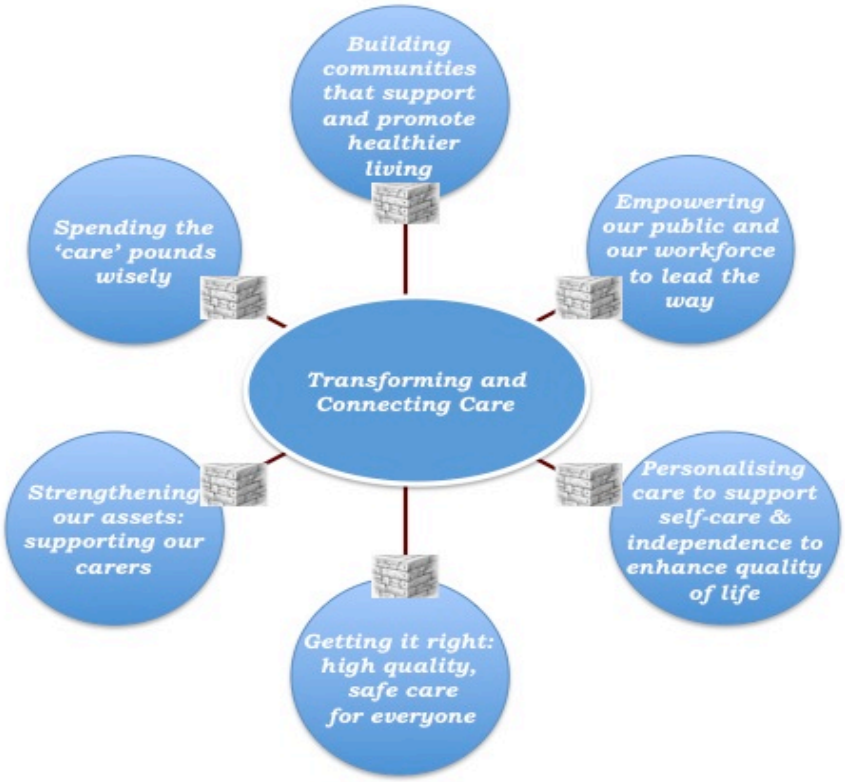
The model will use the defined outcomes, metrics and quality evidence to support ongoing development, shared learning and evaluation of impact at key stages over the lifespan of the programme. Learning will no doubt lead to recommended changes.

The above model will be implemented through a framework of 6 key outcomes or foundation stones and these are described below.

6. Laying the six foundation stones for success

The followign chapter describes the 6 key foundation stones for success that comprise our strategy. Each stone identifies the specific area of the Connecting Care Programme Plan and the relative plans, aspirations and measures of success that relate directly to the 6 health and social care integration outcomes outlined in chapter 1.

These 6 foundation stones will form the key building blocks of our transformed health and social care system and will build capacity and capability across the care system and move us incrementally towards our goals.



6.1 Building communities that promote & support healthier living

Our strategic objective

Our citizens will be enabled, motivated and supported to look after and improve their health and wellbeing to live healthier and happier lives in their communities.

Our plans

To create a culture and mindset that focuses on people's capabilities rather than deficits and the collective assets of the communities in which they reside. We will develop and implement an integrated approach to community capacity building across all partner organisations, that supports independent living at all levels, tackles social isolation, increases personalisation and maximises the use of assistive technology.

Our plans will be built around a public health approach that addresses the root cause of disadvantage.

Plans and initiatives:

- Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term acute and specialist services
- A new third sector strategy jointly agreed across partner agencies, setting out an investment plan for voluntary and community sector support
- Implementing a joint information and advice strategy to help individuals make informed choices about their care
- Roll-out of personal health and social care budgets to enhance local choice, independence and local microenterprises
- Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation
- Integrated support for carers across health and social care
- A suite of interventions that tackle the causes of unhealthy lifestyles
- Rolling out time-banks to attract volunteers and mutual support networks
- The Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models
- Implementation of integrated extended practice/neighbourhood teams
- Extend existing models of and implement new approaches to increase levels of self care and supported self management
- Investment in time banking models to foster community delivery and create a closer link between residents and their neighbourhoods
- Extension of schemes such as Street Safe and Nominated Neighbourhoods that promote social inclusion, supporting older people to feel safe within their communities.
- Deliver Falls Awareness training to all frontline staff through online learning
- Develop and implement a new approach to Community Transport Grants that support local transport initiatives
- Extension of telecare and telehealth to support residents to be safely supported to live independently in their own homes for longer.

Our aspirations and measures of success

- Increasing percentage of adult social care users who have as much social contract as measured in the Public Health outcomes framework
- Increasing numbers of people and carers accessing personal budgets

- Increasing numbers of people utilising assistive technologies, telehealth and telecare support that supports healthier living
- Decreasing percentage of people experiencing poverty of all types (fuel, economic etc.) adult social care users who have as much social contract as measured in the Public Health outcomes framework
- Increasing health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks.

6.2 Empowering our public and our workforce to lead the way

Our strategic objective

People who work in health and social care across all sectors are positive about their role, are supported to improve the care and support they provide and are empowered at a local level to lead change and develop new ways of working.

Our citizens are fully engaged in the shaping the development and re-design of health and care services and supported to make positive choices about their own health and wellbeing.

Our plans

It is essential in any service design and service delivery that the people who will use the service and those that deliver the service are recognised as key stakeholders at every stage of the process. From design to implementation and from evaluation to improvement, our commitment is that we will proactively involve and engage the public, those who use our services and also those who care for them and our wide groups of staff.

Our challenge is to ensure that our communication, involvement and engagement is honest, meaningful and effective. We are further challenged by the sheer scale of the numbers of people involved and want to avoid a system of involvement and engagement that becomes tokenistic. We recognise that the people using our services and the staff within them are experts in their own right and clearly have intimate knowledge and views of the world from their own perspective. Our challenge is to ensure that we seek as many expert opinions as possible to ensure we have a balanced and representative view. It is acknowledged that the meaningful involvement and engagement of all key stakeholders takes skill, planning, time and effort. In a climate of time pressures and deadlines this is often an area of compromise. It is our clear intention that this will not be the case within the Connecting Care Programme. We need to recognise that communication and engagement are not the same things and that we cannot reassure ourselves that because we have told people what is happening that we have engaged them.

We will therefore:

- Utilise a joint Communication and Engagement group representing the partner organisations to establish explicit principles regarding our approach to communication and engagement with all stakeholders
- Establish a joint Communication and Engagement Strategy which all partner organisation will sign up to which will govern all activity whether routine business or planned service design
- Ensure that all existing patient/user/carer groups are identified and linked into Connecting Care with effective two-way communication systems and opportunities for direct involvement
- Identify gaps where specific groups are not represented and establish mechanisms to ensure their voices are heard and their involvement is active
- Develop varied systems of engagement with the workforce to facilitate effective two way communication and allow staff to contribute, influence, design and be creative in their individual services and across the whole system of care
- Develop a culture where staff can feel confident in sharing their views and suggestions with an understanding they will be heard and listened to
- Establish mechanisms to have regular evaluation points to include all key stakeholders in our service design, service delivery and service improvement
- Ensure that any service design group has representation from the public and workforce groups and that representation is meaningful and effective
- Ensure that services establish service monitoring and evaluation forums with public and workforce representation to ensure on-going engagement with key stakeholders to ensure their contribution and influence is present in measuring the effectiveness and quality of services and taking an active role in determining continuous service improvements
- Develop a system of regular communication to key stakeholders with the opportunity for feedback and ensure that all means of communication are utilised including social media
- Utilise local Health Watch teams together with wider third sector partners through a newly established Cheshire wide communications and engagement network
- Deliver training programmes for our workforce to ensure that they understand and effectively apply the principles of effective communication and engagement with customers on an individual, service and whole system level
- Utilise the broad range of information already being collected from people and staff and ensure these are constantly referenced and utilised to inform service design and service improvement

Our aspirations and measures of success

- Utilisation of the National Outcomes Frameworks for NHS, Public Health and Adult Social Care
- Evidence of co production with public and staff in the whole system design
- Feedback and evaluation from public and staff of how engaged and involved they have been in the design of the whole system
- Review of consultation feedback using both qualitative and quantative measures
- Evidence of 'You said' 'We Did' communications with public and staff
- Evidence of promotional materials for involvement and engagement opportunities and evidence of take up.
- Use of Think Local Act Personal Markers for Change (ASC measures)
- Evidence of CC Communication and Engagement Strategy
- Evidence of delivery and application of staff training in involvement and engagement skills
- Evidence of staff and public involvement/membership of key design, development and service evaluation groups.

6.3 Personalising care to support self-care, self-management, independence and enhanced quality of life

Our strategic objective

The programme aims to increase the opportunities and scope for an individual to self-care/self-manage and to live as independently as possible within our communities and to make self-care integral to the maintenance of health and wellbeing for people with long-term physical and mental health conditions.

Our plans

Personalised, high quality care will be planned and delivered through a process of discussion of an individuals specific needs and shared decision making between the individual receiving the care, the professional and the carer/family.

The first care is self-care with individuals owning their care. We will support and strengthen this as a right and responsibility.

There is good evidence to suggest that better understanding of a long-term condition can improve people's understanding of their symptoms, prevent disease escalations and complications arising and enhance long-term health and wellbeing. The role of the care professional is to support people by promoting self confidence and self care, help them feel more in control of their lives, support problem solving, and to direct people towards the type of support and information they need. This means listening to their goals and having a more outcome focused approach to planning and reviewing their care plan.

Our plans to support people to be as independent as possible and to self care are:

- Developing a robust self-management strategy which will promote, encourage and support self-care and independence
- Providing advice, information and educational support to the individual to facilitate self-care e.g. test results, pro-active approaches to prevent crises
- Commission self-management education programmes and utilise new models of support
- Helping patients monitor their symptoms and know when to take appropriate action and in managing the social, emotional and physical impacts of their conditions
- Motivating individuals using targeted approaches and structured support e.g. health coaches or befriending services
- Helping patients to monitor symptoms and know when to take appropriate action e.g. Minor ailments schemes
- Shared decision making: Involving the person in all care decision-making at every level
- Developing holistic, whole person 'personalised' care plans as a partnership between the individual and the person providing support and or care
- Individual will tell their own story, set their own care agenda, goals and actions and will lead problem solving discussions supported by their identified key workers/case manager/co-ordinator
- Setting goals with the individual, development of action/care plans with pro-active follow up on achievements
- Implementing new modern models of care, with support wrapped around the individual at practice, neighbourhood or locality level via integrated community teams using care co-ordination and case management approaches
- Utilise technology and telehealth/telecare to support self-care and self management
- Proactively maximise all care 'contacts' to promote healthy lifestyles
- Working together across partners to tackle the wider determinants of ill-health and social care need
- Support and develop our care workforce and the public to ensure that the belief in and environment for proactive personalised care, self-care/self management and shared decision-making are a reality across our system.

Our aspirations and measures of success

- The percentage of people on the GP survey of 'those who feel supported to manage their long term condition' will increase year on year
- Increasing numbers will access self-care/self management information, advice and support and/or attend disease specific education models
- Citizens will feel more involved and in control of their care
- People with Long Term physical and mental health conditions will report higher satisfaction and quality of life
- There will be an increase in the amount of care delivered locally or in the home and an associated reduction in utilization of GP consultations, emergency department attendances and admissions.

6.4 Getting it right – people have positive experiences of high quality, safe care, delivered with kindness and compassion

Our strategic objective

Our citizens will have positive experiences of health, social care and support services to maintain and improve their health and wellbeing, will feel safe, will have their dignity and human rights respected and will be safeguarded from harm.

Our plans

For our citizens accessing care, the programme will:

- Deliver person centred care without service gaps, so users will experience a single service of continuous care with no joins visible to the service user or their family/carer when crossing service or organisational boundaries
- Deliver more care and support in a local setting wherever it is safe and appropriate to do so
- Ensure 'care' is defined by its ability to meet the needs of the individuals rather than being defined by its organisation and service
- Robustly evaluate the 3 key programme workstreams
- Measure care experience by asking those who receive the care, support and information, with the aim of demonstrating a high proportion of service users are experiencing a good standard of care.
- Build incrementally engagement with service users, their carers and families, as well as wider public representatives, so they are able to actively support and influence the design of the programme

- Act swiftly and professionally in pro-actively seeking information on, dealing with and resolving any quality and safety issues within established governance frameworks
- Only approve service developments where service users, carers and citizen participation is evidenced.

It is our vision that the Connecting Care Programme will begin to address the seven improving outcome ambitions identified in the publication '***Everyone counts: planning for patients':***

- Securing additional years of life for in your local population with treatable conditions
- Improving the health related quality of life of people with one or more long term conditions
- Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- Increasing the proportion of older people living independently at home following discharge from hospital
- Increasing the number of people having a positive experience of hospital care
- Increasing the number of people having a positive experience of care outside of the hospital, in general practice and in the community
- Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

It is fundamental that all partners Operational Plans are consistent with the Connecting Care Programme and can deliver the intended outcomes in line with our populations needs., at the required pace and to the identified sequence of priorities.

Please see ***Appendix 2*** for an illustrated table of the current shared vision, actions and collaborative working between partner organisations across health and social care which will facilitate consistency in approach for delivering quality and which builds upon the findings of the local Joint Strategic Needs Assessments.

Our aspirations and measures of success

The Connecting Care Programme will use a number of different outcome measures, which will be triangulated against each other, to evaluate and therefore determine the success of both the individual components and the overall programme. This will involve:

- **Reporting performance against the national outcome frameworks**: NHS, Public Health and Social Care as a measure of our success, which can then be compared with other care economies and national standards. We will aim for continuous improvement towards the best

- **Achievement of the 'Better Care Fund'** outcome measures
- **Programme evaluation via triangulating national and local data**:. Analysis of primary care, hospital care, public health and social care activity, financial and service user experience data
- **Feedback from service users**, their families and the public: via engagement events, focus groups and citizen participation approaches.

6.5 Strengthening our assets – supporting our carers

Our strategic objective

People who provide unpaid care for others are supported, are consulted in decisions about the person they care for, they are able to maintain their own health and wellbeing and achieve quality of life.

Our plans

There is no single definition of a 'carer'. The law makes reference to carers in many contexts. In general, when a social services department is deciding what services to provide for a disabled person, it should consider the views of significant people in that person's life. This will include people who provide some form of care for that person (usually family members or friends or neighbours), be that physical care or emotional support, advice or advocacy support etc. In this guide a carer is a person who provides care to another person and is not paid for providing that care (nor is she or he providing the care as a volunteer placed into the caring role by a voluntary organisation).

Some commentators have used the term 'informal carer' to distinguish actual carers from paid care workers who are often wrongly described as carers. Many carers actively dislike the term, seeing nothing informal about caring for substantial amounts of time. (Luke Clements- Carers and their Rights 2011)

We are all aware of the significant health and social care inequalities faced by Carers. Having access to a short break, respite services or employment opportunities can make a significant difference to an individuals' ability to cope and maintain their caring role.

Our vision is to 'Enable Carers to experience and have a life outside of caring' and our commitment is to:

- Enable Carers to be respected as Equal Care Partners who are treated with Dignity and Respect
- Enable and support Carers of all ages to feel safeguarded from abuse within their caring role, family and local communities

- Enable Carers to feel empowered through positive engagements and interactions with service providers and professionals, having positive experience of services
- Enabling Carers to live full and meaningful lives in their own right
- Enable Carers to feel supported by offering them a range of support and practical help
- Identify "hidden" carers and supporting them to access services and information appropriate to their needs
- Enable Carers to access Information and Advice – including practical and emotional support in a timely way to support them in their caring role
- Enable Carers to access services and support through their GP and practice staff which supports their health and wellbeing
- Support Carers to access training and learning which helps to maintain or access employment opportunities
- Consider how we will support on-going involvement by people who are in caring roles where respite is required to support that engagement.

Our aspirations and measures of success

- Improved numbers of adult, parent carers and young carers identified in caring roles on GP registers
- Decreasing percentage of adult carers feeling loneliness and isolation as measured in the Pubilc Health Outcomes Framework
- Increasing percentage of adult social care users who have as much social contract as measured in the Public Health outcomes framework
- An increase in the number of carers receiving an assessment
- To provide Carers with the opportunity to take part in an activity or interest of their choice, with or without the cared for person, that improves the carers health and emotional and physical wellbeing
- Increasing numbers of carers receiving respite support
- To increase knowledge, skills and awareness of GPs and other primary care services to identify and support Carers
- Raised awareness of safeguarding issues and management among carers and the workforce
- Measureable improvements in health and well-being of carers including safeguarding events
- Carers feedback indicates positive experience of services
- Aligned commissioning processes and effective use of health, social care and community resources
- Development of Personal Budgets for carers

- Carers are supported and protected from financial hardship
- Carers access training and learning which helps to maintain or access employment opportunities
- Carers access information and advice – including practical and emotional support
- "Hidden" carers access services and information appropriate to their needs.

6.6 Spending the 'care pounds' wisely

Our strategic objective

The most effective use is made of resources across health and social care to create a robust and sustainable system, involving partnership working, joint commissioning, sharing of information, new contracting and funding approaches, exploiting new technologies and avoiding waste and unnecessary duplication.

Our plans

Over the next 5 years, the level of resources available to be invested by our partner organisations to improve the care of our citizens is constrained and may in some areas be reduced. It is therefore essential that we maximize the use of all the resources within the care system and also to minimize duplication and waste at every opportunity.

In developing an integrated approach to the care provided, we will ensure that citizens receive the right care, in the right place and at the right time. To support this, all our staff, regardless of organization will be empowered to act as advocates for this and reduce duplication and ineffective treatment/care.

Initiatives and plans:

- Increased levels of joint working, joint commissioning and planning
- Collaborative working by providers of care and support across all care settings
- Innovate with new collaborative provider models to support integrated care
- Implementation of our Better Care Fund plans and integrated initiatives to support care provision in the most appropriate setting
- Test out new contracting approaches
- Maximise the capability & capacity of our workforce via development and support
- Increasingly using Information Technology to support care processes and systems

- Sustainability plans – QIPP, CIPs, bridging the financial gap
- Working towards the establishment of a population wide, citizen led and governed 'Accountable Care System'.

Our aspirations and measures of success

- Achieve Better Care Fund metrics
- Achieve health, public health and social care system wide outcome measures/quality benchmarks/markers
- All partner organisations meet their statutory and regulatory requirements.

7. The Connecting Care Transformational Roadmap

How are we and how will we Transform Care

We recognize that this level of transformational change is significant and complex. It will require strong leadership, dedicated people, financial resource, collaborative working, and high-energy commitment from a high volume of people and tenacity to the cause. Realising our new ways of working is not about creating new structures or teams but it's about what we all believe and how we behave.

The Groundwork

Over the past year, partners across Central Cheshire have been preparing the landscape for change, building expectations, relationships and trust to create the culture for collaboration and integration. To date we have successfully undertaken the following 'groundwork' across our partners;

- Definition of our collective common cause in overcoming fragmentation between services and developing more integrated models of care better suited to meet the needs of our population and achieve value for money
- Definition of our shared vision and narrative to explain what we mean by Connecting Care and why integrated care matters
- Established shared leadership and governance arrangements to support whole-system working and delivery of our integration outcomes
- Baseline mapping of all integrated work in progress or planned
- Create 'learning space' or 'headroom' for leaders to come together and collectively explore new ways of working and models of care and contracting and the potential roles and impact on all partners
- Agreeing services and user groups where the potential benefits from integrated can have the most impact
- Agreement that change needs to be at scale and pace to ensure a sustainable local care economy.

The following are areas in which work is already progressing or is being planned:

In progress

- Building integrated care from the bottom up as well as top down through the implementation of a single point of access and integrated multi-disciplinary community teams that wrap around the service user and provide whole person care
- Increasing pooled resources to reduce duplication and maximize the available resources through joint commissioning and the Better Care Fund

- Testing of new innovative collaborative contracting approaches including a new 'innovation fund', a collaborative provider contract and an outcomes based contracting model
- Exploration of ways to support and empower more users to take more control of their own health and wellbeing
- Exploration of ways to increase the sharing of information about service users with the support of appropriate information governance
- Bringing challenge to all plans and proposed initiatives in respect of 'do they offer parity of esteem across physical and mental health'
- Reviews of existing services and key work areas in readiness for redesign and transformation in line with the Connecting Care Programme, e.g. Emergency Care, Intermediate Care, Mental Health, Specialist Commissioning and Community Services.
- Build a robust case for change from a detailed analysis of service utilsation and cost across health and social care in order to define our system 'roadmap' to move all partners from the 'here and now' to the 'future system'

In the planning stage

- Build capacity & capability of the workforce to lead improvements, challenge existing practice and systems and to implement and evaluate change
- Utilize the workforce effectively and be open to innovations in skill-mix, staff substitution, new roles, hybrid roles, 7-day working and roles that span organisational boundaries
- Put 'Listening into Action' – to re-engage our workforce to drive and own the changes needed as part of an ethos of continuous improvement
- Create a 'learning network' and 'the Cheshire Learning and Improvement Academy' (CLIA) to support cultural and behavioural changes required to deliver new models of care
- Set specific objectives and measure and evaluate progress towards them.

How will be get to our 2019 vision of 'Connecting Care'?

We appreciate that in seeking to achieve significant rather than 'marginal' change, we must align the way we work with training, contracting approaches, incentives, and key programmes of work.

We envisage our approach to have a number of phases:

- Initial '**direction setting'** during which all our partner organisation leaders will lead within and across their organisations in building a collective understanding with pace for the direction in which we wish our changes to take us. We will aim to communicate our vision, direction and to spread energy throughout the programme, empowering our service users and our staff to look for improvements projects that align with the direction.

- The second, '**power-up'** phase will start not long after the 'direction setting' phase has started, during which critical transformational programmes of work will be initiated by leaders in our partner organisations. Our aim during this phase will be to start to make to necessary changes, to show all how, and how quickly, changes can be done. The focus here will be on both making required changes and involving key well-networked staff in making these changes, so they can see what is required. This phase therefore will include an important communications element to evidence leaders involvement in making changes happen, and modeling the approaches through which we wish this delivered. We will need to get staff together, show them the approaches we wish to use to secure changes, and recognise them where they have done this. We expect an inter-organisational Connecting Care Awards event to be part of this phase, for example
- Our third '**viral-change'** phase will see the number of change projects and programmes accelerated as partner organisation staff take-up initiation of changes in line with the Connecting Care change direction. We will continue to celebrate staff changes but the work during this phase will move more towards coordination and supporting staff initiated changes, ensuring this is done in an aligned way.

During each of these phases, communications and the narrative of what is being done will need increasing refinement. The 'story' of Connecting Care will thus be evolved through the three phases, endeavoring to guide and set the direction for each phase.

The key initial projects for Phase two delivery are those we have identified as being most critical to delivering benefits for all service users of partner organisations' services, and where those organisations will see most initial benefit. The Connecting Care Board have identified these within 3 dedicated key workstreams of the proramme with support from our identified enablers:

- Self-care and self management
- Integrated community services/teams/care
- Integrated urgent care/rapid response

These changes are seen as delivering real benefits and as 'totemic' in communicating our seriousness about securing transformational change.

The matrix below presents an overview of the phases, necessary actions in each, and the changing narrative for them:

Phase	Objective	Deliverables	Narrative
1 – direction setting	• Set-out key characteristics of the journey 'destination' • Explain 'how' we should work to get there • Leaders lead by example; initiate a key project • Ensure delivery 'architecture' is agreed and in place	• Single story used by all leaders to explain our enterprise • Agree a 'Code of Practice' describing model behaviours • Initial projects set-up and delivered • Programme metrics and dashboard agreed to record deliverables progress, communications awareness and behavioural approaches used	A common destination for all with clear benefits and initial priorities Reinforce messages via in-house comms, Connecting Care branding, a 'visual' destination & direction Set-up Connecting Care website and ensure it is a live source of info with Dashboards published
2 – power-up	• Deliver initial programmes of change • Ensure visibility of leaders in delivering this change	• Single assessment • Integrated Extended Practice and Neighbourhood teams • Enhanced care • Sense of pace in programme overall • Rolling our support for staff to get on & recognise where this has been done (shared training, Connecting Care Awards, etc)	'we're all doing it; how will you help' message
3 – viral-change	• Ensuring continued change is aligned and coordinated, and far more extensive & comprehensive	• Joint training • Joint Connecting Care awards • Published Dashbaord	

Connecting Care key milestones

The table below presents a summary of the key milestones planned for the programme:

	Connecting Care Key Milestone Plan for 2014/19					
	2014	2015	2016	2017	2018	2019
Agree shared vision, narrative and strategic approach						
Robust baseline position, activity, financial and impact modelling						
Programmed areas defined, resourced and plans in place for implementation						
New contracting approach agreed: Provider Board and Alliance contract in place						
Develop a robust communication, engagement and citizen participation approach						
Extended Practice Teams established across communities						
Maximise opportunities of Better Care Fund						
New models of care researched, tested, refined and evaluated						
Dashboard metrics agreed, introduced and monitored to inform direction and pace						
Exploit IT capability and functionality to support new models of care						
Cheshire Learning and Improvement Academy (CLIA) - to build capacity and capability of the workforce and support the delivery of a large scale transformational change programme e.g. through systems thinking methodologies						
Information sharing across health and social care						
Teams are seeing impact in terms of improved care quality, experience of care, reducing escalations of need, reduced avoidable admissions						

Box = Delivered milestone

8. 'Building the best' – a sustainable care system for our communities

This chapter is under construction and will be further informed by discussions at the strategy group and by outputs from the Case for Change activity, financial and impact modeling work

The challenge and complexity of delivering this programme can't be underestimated. We know that this strategy will be outdated almost as soon as it is written but it is our first step on a pathway of complex and chaotic change. The Connecting Care Programme is a key driver for delivering a sustainable care economy over the next five years.

At present across the Central Cheshire local health and social care system, there is an existing financial gap of c£20m and an increasing financial gap, which will need to be addressed over the next five years.

Although our modelling work is in its early stages at present, the current financial challenge across Central Cheshire is predicted to increase to be a gap across the commissioning and provider landscape of c£59m by 2019 if we 'do nothing different'.

This gap and the impact that the initiatives within our plans will have to narrow it is yet to be defined. This will be established as part of our modelling work. Our strategic plan is based on the above assumptions that our plans will narrow that financial gap.

Format 1 for consideration:

Our approach to system sustainability is summarised below in terms of 4 key areas:

Improving productivity within existing services

- Citizen and workforce communication, engagement and participation
- A prevention focused care system
- Improving unplanned care services and outcomes
- Productive elective care

Outcome: set out what we will achieve by 2019 (against the everyone counts 7 ambitions or the 6 foundation stones?)

Delivering the care in the most appropriate place

- Supporting self-care and self-management approaches
- Transforming community and primary care services
- Knowing your population and targeting care to meet their needs
- Targeting care at the most in need through risk stratication and preventative and pro-active approaches
- Hgh impact interventions e.g. Dementia, mental health, rapid response, carer support

Outcome:

Developing new ways of delivering care

- Ask the person what they want – real person centred care
- Integration of services across health and social care
- Utilisation of the Better Care Fund and achievement of the metrics
- Care co-ordination and case management
- Integrated extended practice/neighbourhood teams

Outcome:

Allocating spend more rationally

- Adhering to our Everyone Counts planning guidance as described in detail in the 2 year operational plans and trajectories
- Keeping within regulatory frameworks e. g. Monitor guidance
- Delivery of QIPP targets
- Joint commissioning approaches using Better Care Fund and other mechanisms
- New contracting and funding mechanisms e.g. Alliance contract and Innovation Fund which allows pump priming of community resources and when activity in the actute sector reduces, allows cost to be taken our and re-invested in community services expansion in an iterative and cyclical way.

Outcome:

We will reduce the gap year on year by:……..

Format 2 for consideration:

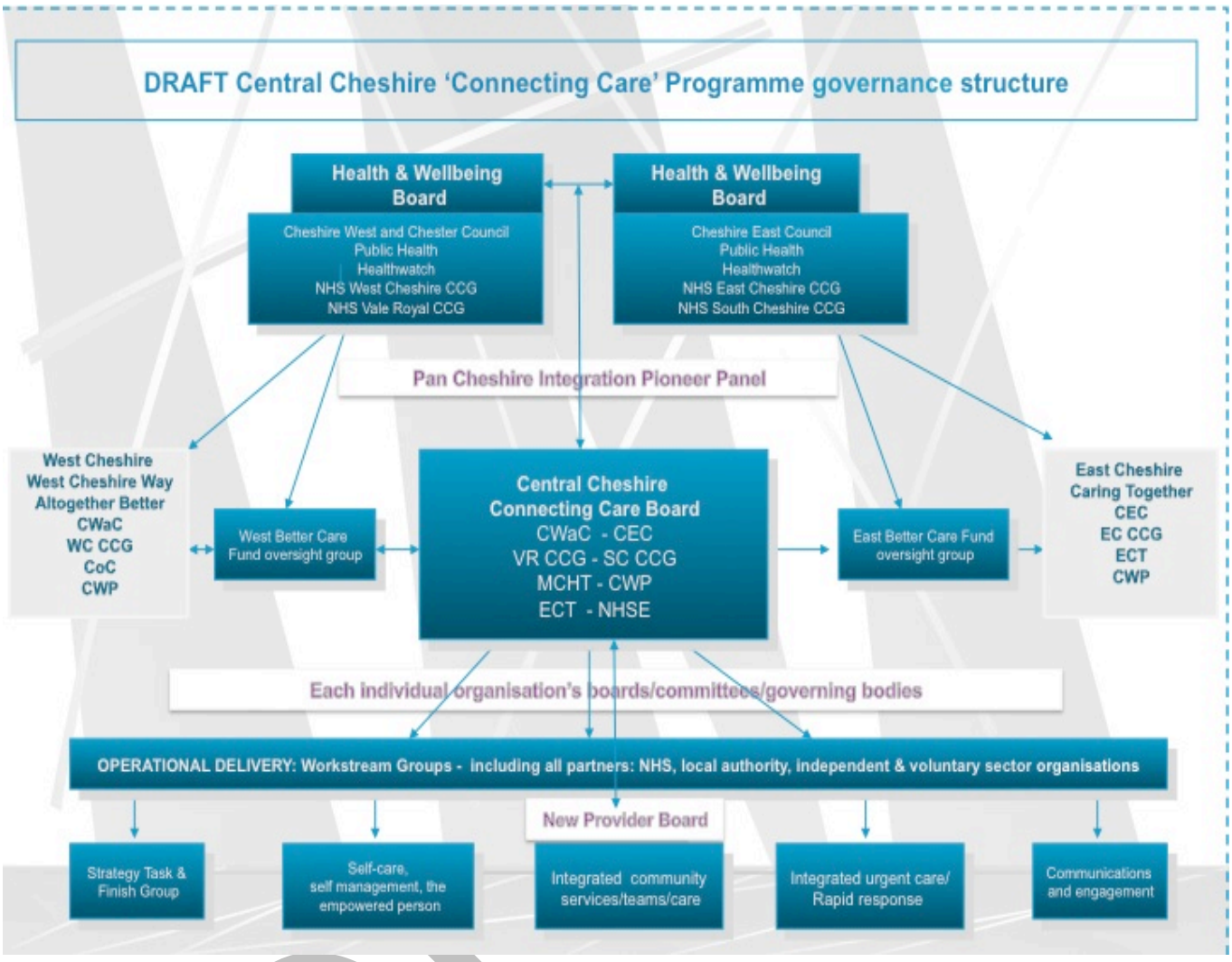
Bulleted list of key improvement interventions and intended impact e.g.:

- Development of a transformational model for moving from existing system to future model through robust financial, activity and impact modeling (Case for Change work)
- Integrated neighbourhood/extended practice teams – all metrics
- Alliance contract/Innovation Fund – working differently and closing wards to re-invest in community services – £3.2m
- Internal organisational CIPs/savings – NHS 4%
- Reduce variances in referral rates
- Redesign of urgent care/rapid response
- Agree shared risk contract – Non-PbR for Non-elective work at MCHT
- 3-5% reduction in avoidable hospital and care home admissions annually

Format 3 for consideration:

Key Outcomes	Improvement interventions	Baseline	Impact
Foundation stone 1			
Foundation stone 1			

Appendix 1: Connecting Care Programme Governance



Appendix 2: The Cheshire wide 'Pioneer' Plan

The following section outlines further detail on the key changes that will be made as a pioneer site both across Cheshire and for each of our three localities:

Pan-Cheshire

Our Commitment	What does this mean?	Key Stakeholders
Integrated communities	• Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term demand on acute and specialist services; • Implementing a joint information and advice strategy to help individuals make informed choices about their care • Rollout of personal health and social care budgets to enhance local choice, independence and local microenterprises; • Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation; • Integrated support for carers across health and social care. • A suite of interventions that tackle the causes of unhealthy lifestyles • Rolling out timebanks to attract volunteers and mutual support networks • Rolling out the Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models	• All residents across Cheshire • The voluntary and community sector • Public Health • All health and social care services • Wider health and social care providers • North West Ambulance Service
Integrated case management	• A single point of access into services in each area. • A risk stratification tool to identify target populations requiring joined-up support • Real and virtual case management teams each working with patient populations of between 30,000 and 50,000. • A common assessment tool to support the sharing of information across professionals with joint information systems to support collaboration. • Care coordinators and lead professionals who will hold the case, step up and step down the appropriate interventions and help the individual and family navigate the system. • Develop a Multi-Agency Safeguarding Hub covering both Adults and Children's that will enable strategic safeguarding leads to work closer together	• Complex families (as per locally defined troubled families cohort) • Individuals with mental health issues • Older adults with long terms conditions • All health and social care services • Vulnerable Children and Adults • Ambulance service
Integrated commissioning	• A redesigned model of bed-based and community-based intermediate care to enable demand for long term care to be better managed. • A full package of interventions which support older adults to live in their own home including assistive technology, admission avoidance/hospital discharge schemes and reablement. • Scaled-up plans for Supported Housing to maximise independence within an additional supported environment. • Evidence-based interventions to support families requiring additional support including triple P and Family Nurse Partnership. • A jointly commissioned community equipment service • A jointly commissioned offer for children in care • A jointly commissioned offer for children with disabilities • Jointly commissioned drug and alcohol services across health and social boundaries. • Move towards a coalition approach to co-ordinated care. • An Integrated Wellness Service that addresses the root causes of poor health outcomes alongside other partners outside of Health and Social Care.	• Clinical Commissioning Groups and Local Authority Commissioners • Transitional care providers • Strategic Housing and Planning • Emergency Services
Integrated enablers	• A joint approach to information sharing • Development of a single case management ICT system • A new funding contracting model to ensure that incentives are in place to shift activity from acute provision to community based care (likely to include capitation or cap and collar supported by new contracting models such as prime provider models, joint ventures or accountable care organisations)	• All health and social care services • Acute Foundation Trusts • Community Health Providers • Monitor • Information Commissioner

Appendix 3: Everyone Counts shared vision, initiatives and outcomes

	Priority Area	Key aims	How the health economy plans to improve these?	Level of improvement expected 2014-2019 These metrics need review to check they represent the care system
1.	**Securing additional years of life for in your local population with treatable conditions**	• Reducing premature mortality from all major causes of death • Reducing premature deaths for severe mental illness • Reducing deaths in babies and young children • Reducing deaths in people with a learning disability	1. **Diagnose cancer early** – through GP and nurse education, use of campaigns to increase awareness of signs and symptoms and through age extensions to cancer screening programmes 2. **To improve the mortality rates of those with learning disabilities –** through promotion of screening and improve health outcomes from Health Checks, introduction of a health inequalities framework and undertaking of a cross organisational audit of deaths in people with learning disabilities	• Decrease premature mortality from cancer in the under 75s to • 110/100,000 in 2 years in South Cheshire • 140/100,000 in 2 years in Vale Royal • Cancer screening uptake to be in top 20% in England • Diagnose at an earlier stage (20% improvement) • Decrease number of avoidable deaths in people with a learning disability • Improve the quality of life in people with a learning disability
2.	**Improving the health related quality of life of people with 1 or more long term conditions**	For people with long term conditions • Ensuring people feel supported to manage their condition • Improve functional ability • Reduce time spent in hospital • Enhance quality of life for carers, people with learning disabilities, mental illness and people with dementia	Generic plans to: Reduce number of admissions to hospital, number of readmissions and number of admissions to long term care Increase the number of people who have a positive experience of care, die in their preferred place of care and who feel able to manage their own conditions There are individual proposals and plans for addressing this by clinical specialty e.g. respiratory, pain management services etc.	• Achievement of all Better Care Fund metrics: • Increasing numbers of people feel supported to manage their condition as per GP survey • High quality patient experience measures • 20% reduction in delayed discharges each year • 2% reduction in injuries due to falls annually
3.	**Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital**			
4.	**Increasing the proportion of older people living independently at home following discharge from hospital**	• Focuses on helping people to recover from episodes of ill health • Improving outcomes from planned treatments • Improving recovery from injuries and trauma, from stroke, fragility fractures and mental illness, • Helping older people to recover their independence after illness or injury	• Keeping people out of hospital when appropriate • E.g. developing an integrated urgent care system to manage patients through ambulatory services and therefore decrease number of unplanned admissions • Effective interfaces between primary, secondary and community care • High quality, efficient care for people in hospital e.g. ensuring clinical pathways are compliant with NICE guidelines • Co-ordinated care and support following discharge e.g. Transitional care intervention beds to provide additional step up/down capacity	• Reduction in non elective admission –of min 3% per year from April 2014 • Reduction in A&E attendances - 7% from April 2015 • 90% patient discharged home from the transitional care beds. Length of stay not to exceed 21 days • 11% reduction in permanent admissions to care/nursing homes by 2016 • increasing proportion of older people still at home 91 days after discharge from hospital • 6% increase in re-ablement effectiveness

5.	**Increasing the number of people having a positive experience of hospital care**	Improving patients experiences of outpatients, A&E, maternity services Improving hospital's responsiveness to personal needs Improving experience of health care for children and young people, people with a mental illness or with a learning disability and people at the end of their lives Improving patient's experiences of integrated care	Working with the Citizens Advice Bureau to help people access support to address underlying issues affecting health Working to enable cancer care to be delivered more locally Pilot for a specialised dementia 'End of Life' team providing training to staff, working with the clinical team to manage complex cases and working to promote best practice Improving the end of life care programmes Review of CAMHS services and services for complex and high risk adolescents	Length of stay and cancer related admissions to decrease 70% of people, and their families for patients being treated for dementia EOL report a positive experience 10% increase in dementia patients at EOL care being treated in their preferred place of residence 84% achieving their preferred place of death by Dec 2015 15% reducing in A&E attendances by people in their last year of life
6.	**Increasing the number of people having a positive experience of care outside of the hospital, in general practice and in the community**			
7.	**Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care**	To reduce the incidence of avoidable harm and to care for people in a safe environment	This will be addressed through: Work of the Quality and Performance Committee Development of the all partner Quality Dashboard Through Quality Review meetings discuss how performance relates to quality and patient safety Safeguarding Review meetings	Annual decline in avoidable deaths until zero is achieved.

Bibliography/references

To be completed……