The Joint Health and Wellbeing Strategy for the Population of Cheshire East 2014 - 2016

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A Message from Councillor Janet Clowes, Chair of the Health and Wellbeing Board, Dr Paul Bowen, Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group, Dr Andrew Wilson, Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group and Dr Heather Grimbaldeston, Director of Public Health.

This is a refreshed version of the Joint Health and Wellbeing Strategy for Cheshire East. We have reviewed the priorities identified in the first edition, published in March 2013, against the Joint Strategic Needs Assessment and established that fundamentally those priorities remain the same. However we have made a few changes: specifically referencing 'Social Isolation and Loneliness' which we have identified as a significant issue amongst our older population; emphasising the need to focus upon the physical health needs of those with serious mental illness and targeting interventions to reduce childhood obesity.

This document represents a commitment by the NHS and the Local Authority to work in partnership to tackle the complex, difficult and inequitable health and wellbeing issues together.

The Government's Health and Social Care Act (2012) has set out the requirement for the establishment of Health and Wellbeing Boards and Joint Health and Wellbeing Strategies in each local authority area.

The Health and Wellbeing Strategy provides an overarching framework that will influence the commissioning plans of the local NHS, the Council, and other organisations in Cheshire East. It will be a driver for change, focussing upon those key areas that will make a real impact upon improving the health and wellbeing of all our communities.

Our vision is that the

Cheshire East Health & Wellbeing Board will work together to make a positive difference to people's lives through a partnership that understands and responds to the needs of the population now and in the future. The board will do this by:

- ***Engaging effectively with the public.***
- ***Enabling people to be happier, healthier, and independent for longer.***
- ***Supporting people to take personal responsibility and make good lifestyle choices.***
- ***Demonstrating improved outcomes within a broad vision of health and wellbeing.***

A Delivery Plan will be developed to prioritise the actions necessary to make a difference and achieve our outcomes. This will include engagement with a wide range of partners who have expressed support for the Strategy and a commitment to working with the Health and Wellbeing Board.

Councillor Janet Clowes - Chair of the Health and Wellbeing Board
Dr Paul Bowen – Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group
Dr Andrew Wilson – Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group
Dr Heather Grimbaldeston – Director of Public Health

Context

There are two Clinical Commissioning Groups in Cheshire East, the NHS Eastern Cheshire Clinical Commissioning Group and the NHS South Cheshire Clinical Commissioning Group (CCGs). These CCGs took over the control of the local NHS from the Primary Care Trust in April 2013. Representatives from these two organisations, together with Councillors, the Director of Public Health and senior managers from Cheshire East Council and a patient representative (from Healthwatch), form the core membership of the Health and Wellbeing Board. NHS England, commissioners of Primary Care services, are also represented.

In considering the strategic priorities for the area the Board has considered four key documents:

- **'Ambition for All' Cheshire East's Sustainable Community Strategy *2010 - 2025***
  Visit www.cheshireeast.gov.uk and search for 'Sustainable Community Strategy'.

- **'Living Well for Longer' The Annual Report of the Director of Public Health 2012-2013**
  Visit www.cheshireeast.gov.uk and search for Annual Public Health report 2013

- **The NHS Eastern Cheshire Clinical Commissioning Group 2014-2016 Operational Plan**
  Visit www.easterncheshireccg.nhs.uk and search for 'Annual Plan'.

- **The NHS South Cheshire Clinical Commissioning Group Operational Plan 2014-2016**
  Visit www.southcheshireccg.nhs.uk and search for 'Annual Plan'.

These are all informed by and underpinned through the evidence of the **Joint Strategic Needs Assessment** which itself has been refreshed during the course of 2013.

Through the Health and Wellbeing Board, representatives from health, public health, the Council and Local Healthwatch (representing Cheshire East residents), have committed, through this document and future Joint Health and Wellbeing Strategies to work more closely together, with a common focus of ensuring that services are jointly tailored to meet the needs of our residents. Over the last year this work has progressed well with a successful bid (with the Cheshire West and Chester Health and Wellbeing Board) to the Department of Health to become an 'Integrated Care Pioneer', demonstrating their recognition of our effective joint working and the future plans to integrate services. The two CCGS have continued to drive their individual integration programmes with the Council as an active partner in both.

Meaningful engagement with our communities, patients and carers will inform all that we do and we will commission to improve health and health/social care for our local populations and to lead the integration agenda around the needs of individuals.

Our Population and Place

In general, all partners recognise that the health and wellbeing of the residents of Cheshire East is good. However there are still very significant challenges that need to be addressed.

Amongst these are:

- Reducing the number of people leading unhealthy lifestyles;
- preparing for an increasingly ageing population (by 2029 the numbers of people aged 65 or over will increase by more than 50% to 108,000 and those aged 85 or over will more than double to 20,000);

- Improving the mental health and emotional wellbeing of residents;

- Addressing some stark differences across Cheshire East (for example a difference in life expectancy which at its worst sees a gap of 8 years for men and 9 years for women depending on which area you live in Cheshire East).

There is good practice to build upon to tackle these challenges with high quality general practice, effective NHS / local authority joint working and innovative Council led projects already in place. But we recognise that more needs to be done and the Board, through the Strategy will drive improvement in health and wellbeing.

The Joint Health and Wellbeing Strategy is an evolving document, responding to the changes that occur through these new ways of working and to new challenges that we may face in the future, the priorities will modify over time. This refreshed version follows a review of the priorities within the 2013 - 2014 Strategy against the Joint Strategic Needs Assessment and the Annual Report of the Director of Public Health 2012 – 2013.

Every community in Cheshire East is different and local solutions will reflect local challenges. But our action will be united around the four shared commitments from our **Pioneer vision**:

Integrated communities: Individuals will be enabled to live healthier and happier lives in their communities with minimal support. This will result from a mindset that focuses on people's capabilities rather than deficits; a joint approach to community capacity building that tackles social isolation; the extension of personalisation and assistive technology; and a public health approach that addresses the root causes of disadvantage.

Integrated case management: individuals with complex needs – including older people with longer term conditions, complex families and those with mental illness will access services through a single point and benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

Integrated commissioning: People with complex needs will have access to services that have a proven track record of reducing the need for longer term care. This will be enabled by investing as a partnership at real scale in interventions such as intermediate care, reablement, mental health services, drug and alcohol support and housing with support options.

Integrated enablers: We will ensure that our plans are enabled by a joint approach to information sharing, a new funding and contracting model that shifts resources from acute and residential care to community based support, a joint performance framework and a joint approach to workforce development.

We recognise that the current position of rising demand and reducing resources make the status quo untenable. Integration is at the heart of our response to ensure people and communities have access to the care and support they need. Prevention to support people from needing health or care interventions will be a priority as will addressing the wider determinants of health that are significant contributors to ill health.

Our Principles

Equality and fairness – Provision of services meet need, reduce health outcome variations, and are targeted to areas which need them the most. **Proportionate universalism** will be a key tenet – the idea that health inequalities can be reduced across a community through universal action, but with a scale and intensity that is proportionate to the level of disadvantage.

Accessibility – services are accessible to all, with factors including geography, opening hours and access for disabled people and other vulnerable groups considered.

Integration – To jointly commission services that fit around the needs of residents and patients, encouraging providers to collaborate to create integrated services where appropriate. This will maximise the benefits of delivery through the Health and Wellbeing Board.

Quality – The strategy is based on sound evidence and reasoning, and focuses on quality, within our resources

Sustainability – Services are developed and delivered considering environmental sustainability and financial viability.

Safeguarding – services and staff prioritise keeping vulnerable people of all ages safe. There will be proactive and effective relationships with the Safeguarding Children and Adults Boards.

Our Priorities

What we want to achieve for 2014-2015	What we need to focus on
Outcome one - Starting and developing well… *Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.*	Children and young people feel and are kept safe Children and young people experience good emotional and mental health and wellbeing - Reduce the levels of alcohol use / misuse by Children and Young People - Reduce the numbers of children and young people self harming. Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met Targeted prevention interventions to reduce children and young people's obesity[1]
Outcome two - Working and living well… *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.*	Reducing the incidence of alcohol related harm. Reducing the incidence of cancer. Reducing the incidence of cardiovascular disease. Ensuring the health and wellbeing of carers to enable them to carry out their caring role Better meeting the needs of those with mental health issues, in particular to focus upon

[1] Following a review of obesity levels in children and young people during 2013, it has been identified that although Cheshire East overall is below the national average, there are some parts of the Borough where rates are significantly higher than that average. This is where activity will be targeted.

	improving the physical health of people with serious mental illness[2]. Seven day care services provision
Outcome three - Ageing well… *Enabling older people to live healthier and more active lives for longer:*	Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).[3] Providing high quality palliative care service Supporting older people, their families and carers, to prepare for the rest of their lives.

It should be noted that some of the areas of focus will apply across more than one priority outcome, for example reducing social isolation and loneliness may be as applicable to some children and young people and as to older people. The Board will ensure that where this is the case appropriate actions will be put in place.

It must be emphasised that the constituent organisations of the Health and Wellbeing board will also be working themselves on other areas that they have identified as key to supporting improvements in health / health and social care.

Conclusion

The Health and Wellbeing Board is committed to ensuring that the NHS and Cheshire East Council (including Public Health) work together on areas of shared need, as expressed through this Health and Wellbeing Strategy.

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

[3] The Board has recognised the impact upon health and wellbeing of loneliness and social isolation (Holt-Lunstad et al, 2010 Social Relationships and Mortality Risk: A Meta-analytic Review) and with the growing older population of the area identified this as a new priority.

Annex One
Partner Priorities

Partner organisation	What we will do
CEC Adult Social Services	1. To have available information, advice and signposting to enable people to access information about staying well (prevention) and where to get the right help if they need it (early intervention). 2. To develop community services across all sectors to ensure care can be provided at home wherever possible (reduce admission to residential care and avoidable visits to A&E and hospital) 3. To reduce social isolation and loneliness and ensure support is available to promote social inclusion 4. To ensure that all services and organisations in Cheshire both universal and targeted understand their obligation to ensure their services safeguard those adults who may be more vulnerable 5. To ensure that people with dementia are supported to live safely in the community 6. To ensure a range of accessible community activities are available for people to stay fit and health both physically and mentally 7. To ensure a range of accessible services and support for people who take on a caring role to maintain their health and well being 8. To ensure our services are developed to provide joined up care from health and social care services 9. To ensure that people feel safe in their communities to allow them to fully access all the community has to offer 10. To ensure that people in rural communities can access the same types of support , services and activities as those in more urban areas 11. To ensure that support is available to help people gain and maintain stable employment 12. To ensure that support is available to help people secure and maintain stable accommodation
CEC Children's Services	1. Helping families earlier when problems arise 2. Improved identification of children at risk of sexual exploitation 3. Increasing the awareness amongst professionals and the public of the identification of child sexual exploitation. 4. Improving assessment of risk to children and young people including family history, especially in families where there is a history of alcohol misuse. 5. Reducing the risk in key areas such as children living in homes where domestic abuse is present. 6. Improving access to timely support for families with mental health issues. 7. Improved resilience of young people with a range of problem solving skills 8. Improving understanding of self-harming behaviour in children and young people and support services to develop skills and approaches 9. Improving access to a range of evidence based psychological

	therapies across the pathway of provision, and children and young people known to be at risk are identified and supported early 10 Improving the percentages of young people aged over 16 in drug treatment services who receive a treatment outcome profile (TOPS) assessment 11. Supporting young people to develop a range of problem solving skills and techniques 12. Supporting young people to make positive choices in respect of risk taking behaviour through awareness, information and access to services 13. Introducing a more streamlined integrated assessment process across education, health and care for children and young people with special educational needs/disabilities. 14. Introducing the new 0-25 Education, Health and Care Plan. 15. Publishing a clear and transparent local offer of services for children with disabilities. 16. Introducing personal budgets. 17. Better preparing children with disabilities for adulthood. 18. Tackling inequalities in low birth weight in order improve health outcomes in childhood and adulthood 19. Targeting approaches to young people who are or are at greater risk of not engaging in education, employment or training (NEET) 20. Continue to target the Family Nurse Partnership programme to support the most vulnerable new parents. 21. Increase the uptake of free early education for two year olds in deprived areas. 22. Narrowing the gap in educational attainment between children and young people from different socio economic backgrounds
Eastern CCG Starting & Developing Well	• Improving transition from children's to adult services – initially focussing on CAMHS 16-19 service • Empowered Children, Empowered Parents – looking into resources that encourage self-management • Monitor the progress of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) pilot • Continuing to develop the Joint Early Years and Early Help Commissioning Strategies with Public Health, NHS England, South Cheshire CCG and East Cheshire Council • Implement redesigned neuro-developmental pathways • Developing CCG capability to meet statutory responsibilities for children with Special Educational Needs
Working and living well	• Development of services to deliver "24-7" access to care • Implementation of proactive systems to identify and recall patients with serious mental illness or learning disabilities for health checks • Improved access to primary mental health services, including IAPT (Improving Access to Psychological Therapies) • Improving a range of clinical pathways and services through application of best practice evidence. This includes application of NICE guidance and working with the Academic Health Science Network

	• Redesign of ENT, Upper GI, Urology, Gynaecology and Hepatobiliary pathways
Ageing well	• Developing the Caring Together Model with "early implementation schemes" developed around wider Primary Care Services. This includes stratifying high risk patients, proactive multidisciplinary case management, sharing of relevant information through patient passports and shared records • Development of a quality framework for care homes. Expansion of the care home doctors service and development of multidisciplinary support. • A range of quality improvement projects including reducing the prevalence healthcare acquired infection of falls, pressure sores and medication errors • Developing ambulatory care services and urgent response services in order to support caring for patients closer to home rather than in a hospital setting. This includes ambulance pathfinder, urgent primary care access and • Development of dementia services and promotion of dementia friendly communities • Further development of end of life care services • Enhancement of the range of support and services available for Carers in our community • Continued development of stroke care. The CCG is engaged in the expansion of the Greater Manchester Acute Stroke Model, development of community rehabilitation and early supported discharge from hospital
NHS South Cheshire CCG	1. To introduce Extended Practice Teams in order to improve care for adults with one or more long-term conditions/ complex needs by treating efficiently within community setting in order to reduce fragmentation, duplication and communications between healthcare services. 2. To reduce the overall number of avoidable Paediatric 'short stay' admissions and develop alternative pathway to hospital admission when appropriate. 3. To reduce the proportion of cancers that are diagnosed following an emergency presentation by 3% over three years. 4. To improve mortality rates for those with learning disabilities. 5. To ensure the configuration and capacity of memory services is sustainable in the context of the rise in numbers with the condition. 6. To detect and diagnose dementia earlier and ensure appropriate support services are available. 7. To ensure there is sufficient and appropriate bed capacity for intermediate and transitional care services. 8. To develop and implement an integrated urgent care system across health and social care that is both responsive to patient need and delivers quality care in the most suitable setting. 9. To commission a specialist community based stroke and rehabilitation services in order to improve outcomes for stroke survivors and their families. 10. Supported self-management of people with long term conditions including shared risk profiling for early detection. 11. To support the reduction in the number of direct admissions to long-term care from acute care from baseline by 2% by 2015

	12. Increase in the proportion of older people (65 yrs. and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services from baseline by 6% by 2015 13. Reduction in delayed transfer of care including those attributable to social care from baseline by 4% by 2015 14. Reduction in emergency admissions from baseline by 3% by 2015 15. To increase in the proportion of people who feel supported to manage their long-term conditions(s) from baseline by 6.2% by 2015 16. Reduction in the number of injuries due to falls from baseline by 2% by 2015

Annex Two
Key Performance Indicators

What we want to achieve…	What we need to focus on	Proposed KPIs (NB where bold text the Performance Team proposes these as the selected indicators)
Outcome one - Starting and developing well…	Children and young people feel and are kept safe	The % of cases taking 45 days or less from the start of the combined assessment Percentage of children and young people participating in their child protection plan % of children and young people who self report that they feel safe The number of children in households with reported repeat incidence of domestic abuse Number of children killed or seriously injured in road traffic accidents
	Children and young people experience good emotional and mental health and wellbeing	Number of children and young people accessing tier 2 CAMHS Number of children and young people accessing tier 3 CAMHS
	- Reduce the levels of alcohol use / misuse by Children and Young People	Number of hospital admissions for alcohol misuse for under 18s
	- Reduce the numbers of children and young people self harming.	Number of A&E attendances age 0-19 with deliberate self harm diagnosis or complaint (confirm with Guy Hayhurst)
	Children and young people who	The % of children and young people

	are disabled or who have identified special education needs have their aspirations and hopes met	with a statement achieving 5 A*-Cs (including English and Maths) Number of young people accessing personal budgets (from Sept 2014) Number of learners with learning difficulties and/or disabilities (LLDD) in employment, education and training (EET)
	Targeted prevention interventions to reduce children and young people's obesity	Excess weight in 4-5 year olds Excess weight in 10-11 year olds
		% of pupils achieving a good level of development across the Early Years Foundation Stage Profile % of good and outstanding early years settings Achievement gap at KS4 between the lowest 20% and the rest Number of multi-agency early help assessments/CAFs per 10,000 population
Outcome two - Working and living well…	Reducing the incidence of alcohol related harm.	
	Reducing the incidence of cancer.	
	Reducing the incidence of cardiovascular disease.	
	Ensuring the health and wellbeing of carers to enable them to carry out their caring role	• **ASCOF 1D: Carer-reported quality of life** (score out of 12) – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • **ASCOF 3B: Overall satisfaction of carers with social services** – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • ASCOF 3C: Proportion of carers

		who report that they have been included or consulted in discussion about the person they care for services – *N.B. This is from a biennial survey; the next survey results will be available in14/15.* • ASCOF 3D (Disaggregation): Proportion of people who use services and carers who find it easy to find information about services – *N.B. This is from a biennial survey; the next survey results will be available in14/15* • **Carers receiving needs assessment or review and a specific carer's service, or advice and information** • Number of carers receiving a carers specific service (per 10,000 population) • **Number of completed Carers Assessments** • Percentage of carers declining an assessment
	Better meeting the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness	• ASCOF 1F: Proportion of adults in contact with secondary mental health services in paid employment – *N.B. Official outturn not known until after year end* • ASCOF 1H: Proportion of adults in contact with secondary mental health services living independently, with or without support - *N.B. Official outturn not known until after year end* • **Number of Mental Health service users receiving self-directed support as a proportion of Mental Health service users who would benefit from self-directed support** – *N.B. This would be a disaggregation of an existing measure. This disaggregation is not currently routinely produced but data is available*
	Seven day care services provision	
Outcome three -	Improving the co-ordination of	• ASCOF 1A (Disaggregation):

Ageing well…	care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).	Social care-related quality of life (score out of 24) – *N.B. This is taken from an annual survey.* • **ASCOF 1I (Disaggregation): Proportion of people who use services and their carers, who reported that they had as much social contact as they would like**. *N.B. This is a new measure from 13/14. This is taken from an annual survey.* • **ASCOF 2A: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** • ASCOF 3A (Disaggregation): Overall satisfaction of people who use services with their care and support – *N.B. This is taken from an annual survey.*
	Providing high quality palliative care service	
	Supporting older people, their families and carers, to prepare for the rest of their lives.	