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

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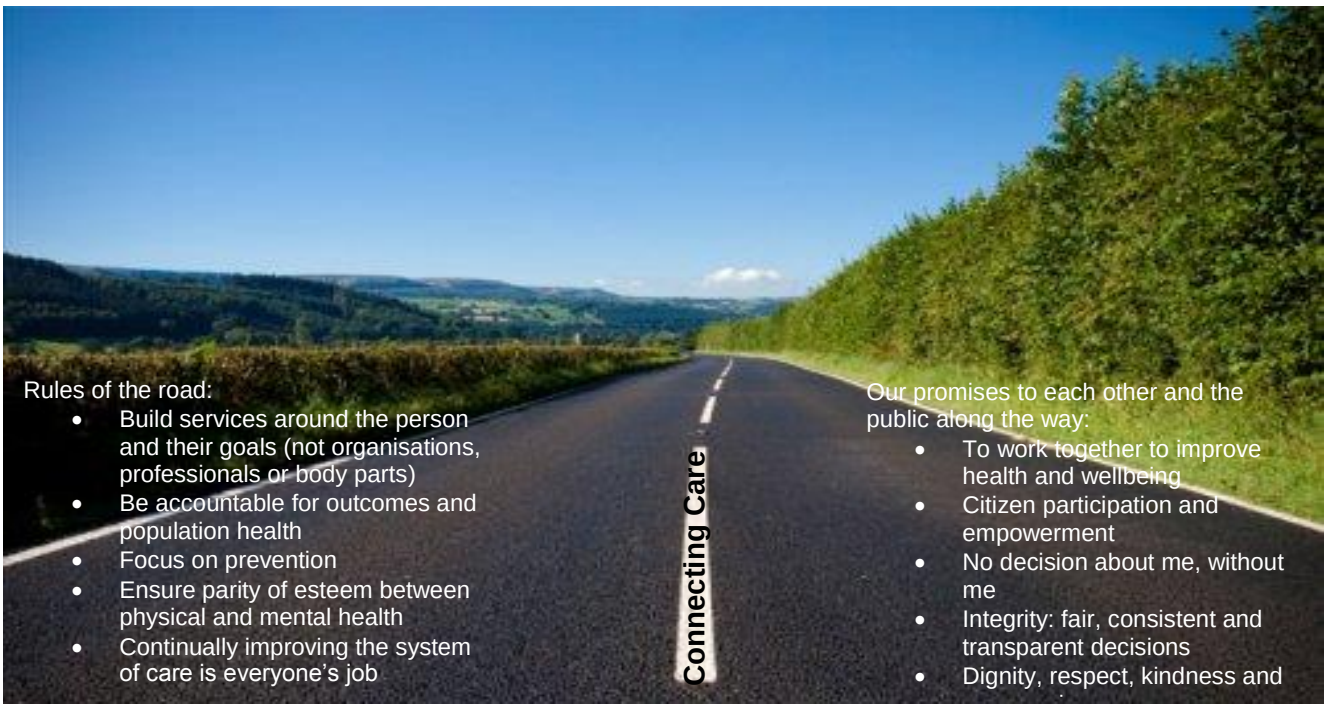
Vision

'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 key assets – Carers are supported	Spending money wisely and where it counts

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-care, family and community care as integral components to all care
    - Teams built around a persons needs and journeys, jointly accountable for outcomes and joint responsibility for continually improving care
- Focus its attention on health promotion, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities, the wider causes of ill-health and need for social care support e.g. poverty, isolation, housing problems and debt
- Have a strong clinically led primary care and community care system offering a comprehensive 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
- Be an integrated 'Accountable Care System'.

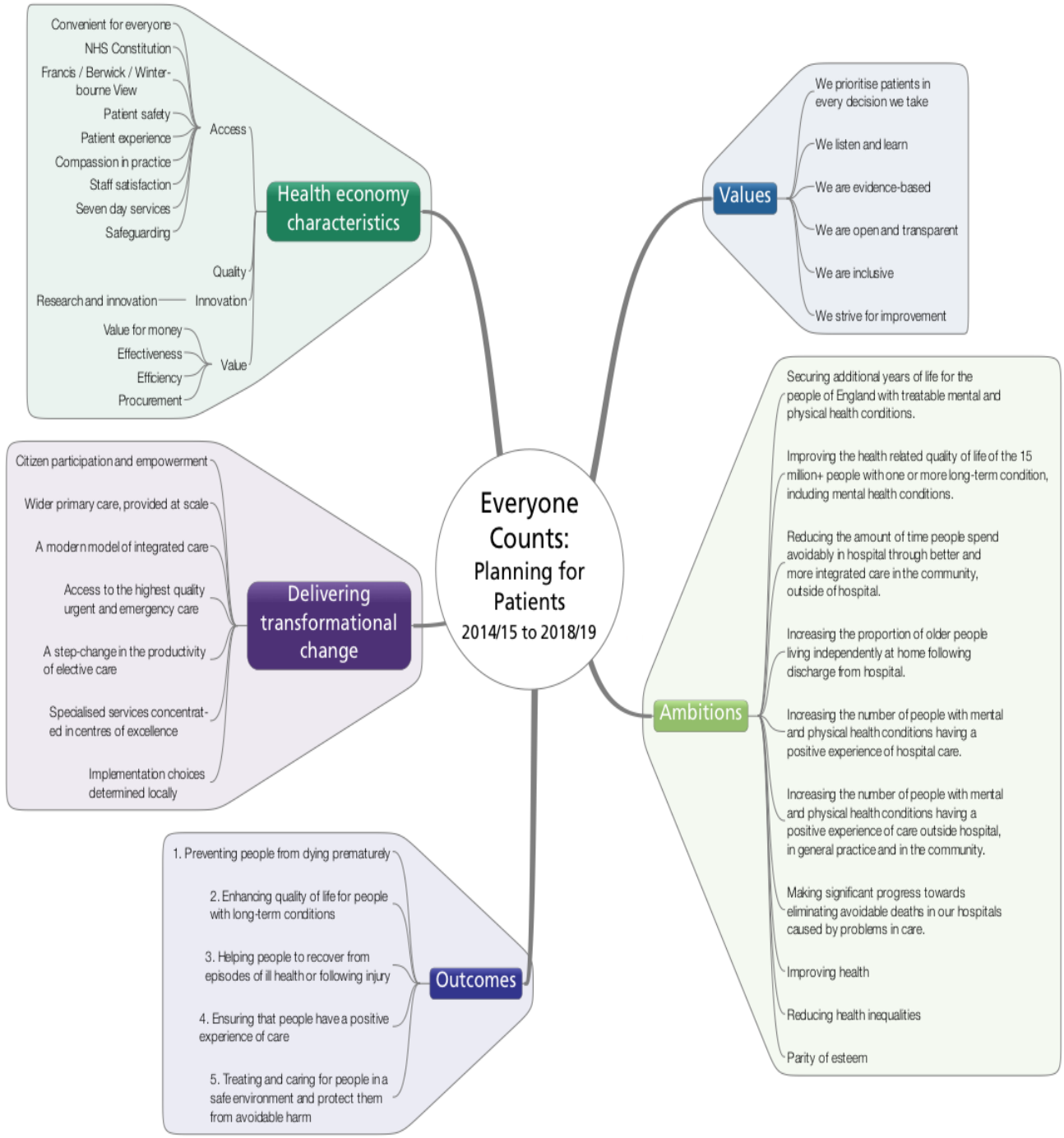
Supported by:

- System re-design of care – co-produced with our public & our workforce
- Strengthened and renewed primary care
- 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 in the public, private and voluntary sector e.g. community geriatrician/general physician, extended roles and wellbeing co-ordinators
- Have a robust continuous quality improvement programme in the form of a 'Cheshire Learning and Improvement Academy' (CLIA).

To achieve:

- Accountability for all health and social treatment and 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
- A transformed and integrated care system that realises continuous positive improvement on the following 'everyone counts' measures and outcomes:



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 subsequent chapters**.**

The Connecting Care Programme

The Connecting Care Programme is based on both UK and international evidence of integrated care demonstrating its benefits e.g. Torbay, Kaiser Permanente and The Veterans Association. 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 'system wide and accessible care 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 as below:

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. Spending money wisely and where it counts.

These integration outcomes have been created by our Central Cheshire Connecting Care Board members to provide a single framework for integration and transformation, which aligns directly to the existing NHS constitution, 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, we are aware that certain groups within our communities continue to fall behind these advances and continue to have large health inequalities e.g. people with mental health conditions.

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, Berwick 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 7 areas for delivering transformational change:

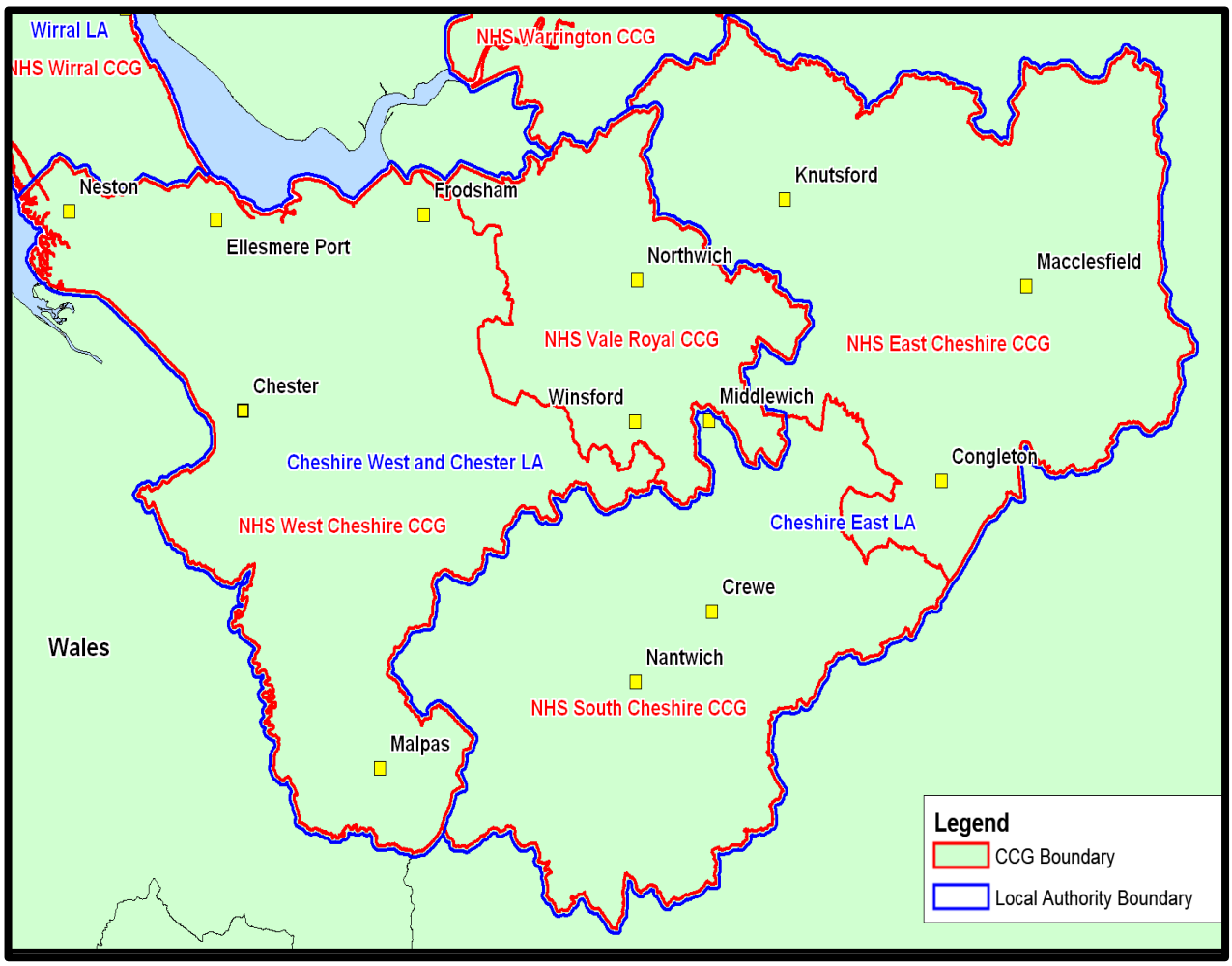
- Citizen participation and empowerment
- Wider primary care provided at scale
- A modern model of integrated care
- Access to the highest quality urgent and emergency care
- A step change in the productivity of elective care
- Specialised services concentrated in centres of excellence
- Local transformational areas.

Our task is to translate the above together with the political philosophy of integrated care into an actionable agenda designed to achieve quantifiable outcomes, and then execute that agenda effectively, measuring progress 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/West Cheshire Way'* 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. However, 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:

- Increasing numbers of older people within our population is 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 is rising e.g. heart disease, respiratory disease, dementia and depression
- 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
- Inequalities in health between those with physical and mental health conditions

- Some of our citizens, both children and adults live in deprived areas and experience poor health, poor educational attainment, deprived income, debt, employment and living environment issues

- 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 and learning disabilities

- 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, taking drugs, a lack of exercise and poor diet

- Our partner organisations are operating in an austere financial climate.

As a result of 'knowing' our population needs through the JSNA, there is a clear focus for our strategy on all of the above areas including prevention and early detection, reducing inequalities, taking local action and continuing to use the outcomes indicators to shape our plans to improve health and wellbeing.

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 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 primary/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 and crisis situations can be avoided.

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 building stronger resilient communities and 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'. We need to utilise the skills of the whole multidisciplinary team to provide the best outcomes for the person and teams who will work together well to achieve this.

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. Roles will need to continue to change across a range of areas if we are to utilize our workforce differently to meet our challenges and to provide continuity of care and more in the community.

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 GPs, 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, voluntary care and primary care teams. The engaged person, third sector support and community assets need to form a core part of the service offer.

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 'carers'. A carer is someone of any age who provides unpaid support to family or friends who could not manage without this help. Caring for someone can be incredibly rewarding, however for many, taking on a caring role can mean facing poverty, isolation, frustration, ill health and depression. Many carers juggle work and caring and others 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, particularly young carers. 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 Act 2014 streamlines the wide range of social care legislation in to a modern framework built around personal wellbeing, emphasising prevention and early support and the person being in control of their care. The Act 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. Future expenditure 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 care system will have to be funded out of existing budgets, although there will be a small annual increase. 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 £30bn 'Nicholson 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. Our level of ambition – what we want to achieve by 2018/19

The Cheshire partners are ambitious in their aspirations for transformation, integration and improving the health and wellbeing of our population. We recognise the opportunities before us and this strategy and our suppporting organisations operational, better care fund and financial plans have at their core initatives with associated ambitious timelines and outcomes in order to achieve this. Central to all our strategic development is the imperative to continuously improve at all levels, continue to provide safe, high quality care and to manage within our resources.

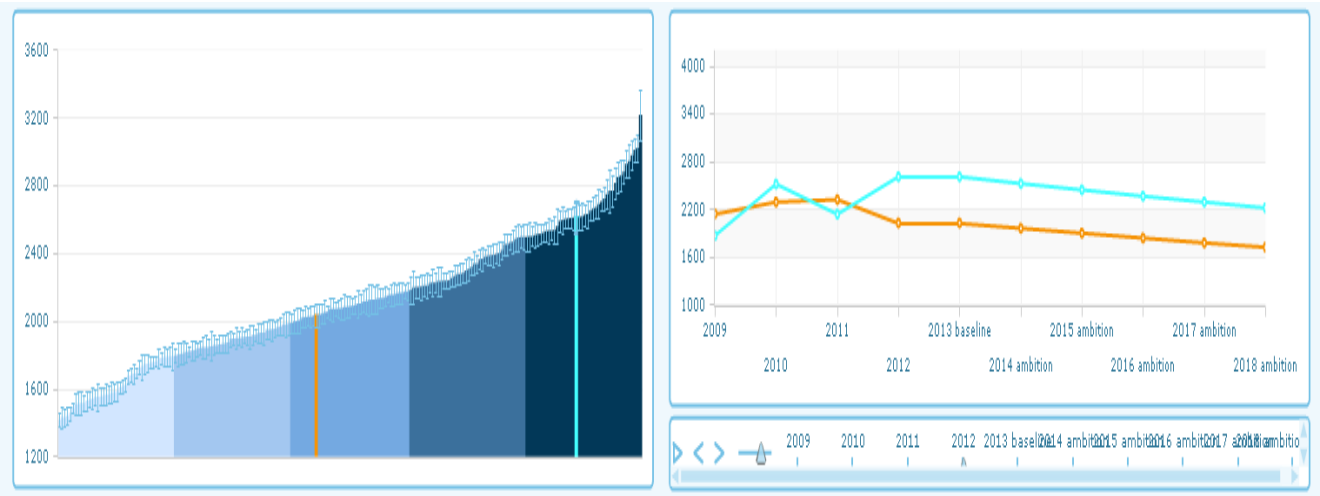
The following sets out our ambitions for both CCGs against 5 key outcomes indicators as illustrated on the NHS England 'Ambition Atlas', Data has been sourced at CCG level and is presented in quintiles and allows for comparisons with CCGs across England.

5.1 Securing additonal years of life for people, particularly those experiencing health inequalities, for conditions whose causes are amendable to healthcare

We hold an overarching ambition to reduce years of life lost for our population and preventing people from dying early from both physical and mental health conditions. This is an ambition which combines all aspects of health and social care commissioning, ill-health prevention, care delivery and citizen participation.

The extract below from the Ambition Atlas sourced from the Health and Social Care Information Centre (HSCIC) compares CCGs in relation to the number of years lost per 100,000 population from amenable causes. The data is directly age standardised to the England population. The tool makes predictions of suggested ambition up to 2018 for the population as a whole, and whilst it examines 2013 baseline data by gender it does not break the ambition data down by gender.

Chart 1: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Currently, Vale Royal CCG is placed in the highest quintile (worse) than most of its comparators and South Cheshire CCG is in the middle quintile.

Generally, CCGs across the country see a gradual improvement year on year and both CCGs share an objective to maintain this downward trend. Our levels of ambition for reducing years of life lost are detailed in the table below:

Table 1:

	Population wide			Males		Female	
CCG	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**	**Levels of ambition by 2018/19 (years of life lost per 100.000 population**	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**	**Years of life lost 2013 (per 100,000 population)**	**Quintile Ranking**
Vale Royal	2610 (95% CI: 2515 – 2608)	Currently in highest fifth of CCGs i.e. highest number of years lost	2219 (15% reduction)	3308 (95% CI: 3157-3464)	Currently in highest fifth of CCGs i.e. highest number of years lost	1909 (95% CI: 1794 – 2030)	Currently in middle fifth i.e. average number of years lost
South Cheshire	2029 (95% CI: 1965-2094)	Currently in middle fifth i.e. average number of years lost	1724 (15% reduction)	2085 (95% CI: 1994 – 2180)	Currently in second lowest fifth i.e. lower than average number of years lost	1975 (95% CI: 1887 – 2066)	Currently in middle fifth i.e. average number of years lost
NHS England	2091	-	-	2267	-	1911	-

Reducing avoidable deaths

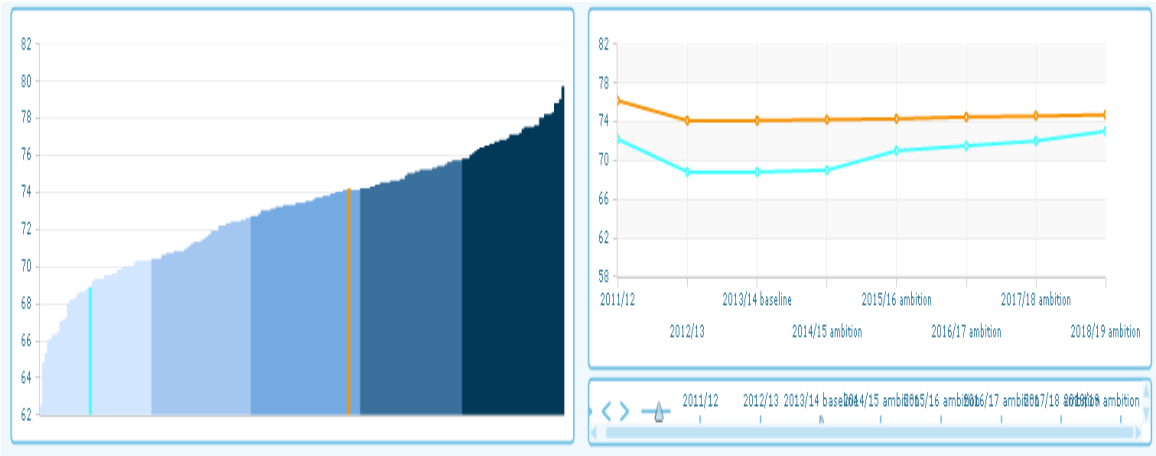
In additiona to reducing years of life lost, Central Cheshire partner organisations strongly support the national objective to eliminate avoidable deaths in hospitals caused by problems in care. Although there is no national indicator for this to date, both CCGs are constantly reviewing local rates in response to our main acute provider having higher than average mortality rates. There is an ongoing external review, triggered via our organisational quality assurance framework, which has produced a number of recommended areas for action and continuous monitoring of progress.

5.2 Improving the quality of life of people with a long term physical and/or mental health condition

Supporting people to lead their own health and wellbeing is a cetral foundation stone within this strategy based on evidence that people should and can be supported to self-care and self-manage their condition and that this will contribute to empowering the person and lead to improved quality of life over time.

This section looks at the 'quality of life' of people with a long term condition and uses data from the GP Patient Survey. The ED-5D is a standardised instrument used to measure quality of life is applicable to a wide range of health conditions and provides a single index value for health status. This tool uses the sum of the ED-5D scores for people with a long term condition, and divides this by the (weighted) count of all responses by people with a long term condition.

Chart 2: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is placed in the lowest quintile (worse) than most of its comparators and South Cheshire CCG is in the upper middle quintile. The trajectories for improvement reflect the different positions of the CCGs.

Our level of ambition for improving quality of life for those with long term conditions is set out in the table below:

Table 2:

CCG	Total EQ-5D score (per 100 people with a long term condition)	Ranking	Levels of ambition by 2018/19
Vale Royal	68.8	Currently in lowest quintile i.e. lower quality of life score	73.0 (6% improvement)
South Cheshire	74.1	Currently in middle quintile ie average quality of life score	74.7 (1% improvement)
NHS England	73.1	-	-

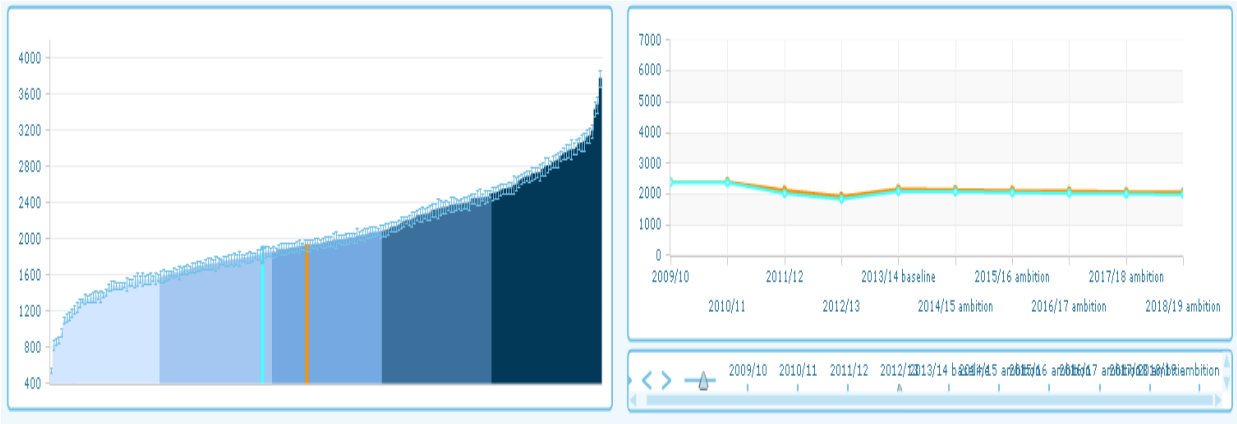
5.3 Reducing the amount of time people spend unnecessarily in hospital through better and more integrated care, more care outside hospital and to increase the people living independently at home following discharge

Our ambition is to significantly reduce emergency admissions for conditions considered avoidable by 15% by 2018/19. The measure by which we will assess our progress is a composit measure comprising the following 4 areas:

- Unplanned hospitalisation for chronic ambulatory care sensitive conditions
- Unplanned hospitalisation for asthma, diabetes and epilepsy (under 19s)
- Emergency admissions for acute conditions that should not usually require hospital admission
- Emergency admissions for children with lower respiratory tract infections.

The chart below measures the total emergency admissions for conditions considered avoidable compared to the total number of patients registered in the geographical area. Data is from hospital episode statistics and has been indirectly age and sex standardised to England rates.

Chart 3: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is placed in the second lowest quintile (better) than many of its comparators and South Cheshire CCG is in the lower middle quintile.

We believe that our plans to expand primary and community care and improve the range of services and support will have a significant impact on our ability to care for people in their own homes and communities.

Our level of ambition for reducing avoidable stays in hospital is set out in the table below:

Table 3:

CCG	Admissions per 100,000 population – baseline 2013/14	Ranking	Levels of ambition by 2018/19
Vale Royal	2085.5	Currently in second lowest quintile of CCGs i.e. low number of avoidable emergency admissions	1772.5 (15% reduction)
South Cheshire	2159.2	Currently in middle fifth ie average number of avoidable emergency admissions	1735.2 (15% reduction)
NHS England	2096.9	-	-

In addition to the above we have established plans and impact trajectories for delivery of our Better Care Fund integration programme, which augment the acheivement of the above.

Cheshire East Better Care Fund ambitions:

Metrics		Baseline*	Performance underpinning April 2015 payment	Performance underpinning October 2015 payment
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	561.6	N/A	679.0
	Numerator	423		543
	Denominator	75325		79974
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	79.30	N/A	84.10
	Numerator	260		276
	Denominator	328		328
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	301.0	296.0	295.0
	Numerator	900	891	891
	Denominator	299123	300675	302449
		Apr 2013 to Nov 2013	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	633.0	618.0	622.0
	Numerator	7597	3705	3730
	Denominator	374183	376071	376071
		Oct 2012 to Sep 2013	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience *For local measure, please list actual measure to be used. This does not need to be completed if the national metric (under development) is to be used*		67.3	N/A	73.5
		Jul 2011 to Mar 2012		*(State time period and select no. of months)*
Local measure *Injuries due to falls (65+)*	*Metric Value*	1783.1		1747.5
	Numerator	1343		1398
	Denominator	75325		79974
		2011/12	*(State time period and select no. of months)*	*(State time period and select no. of months)*

Cheshire West Better Care Fund ambitions:

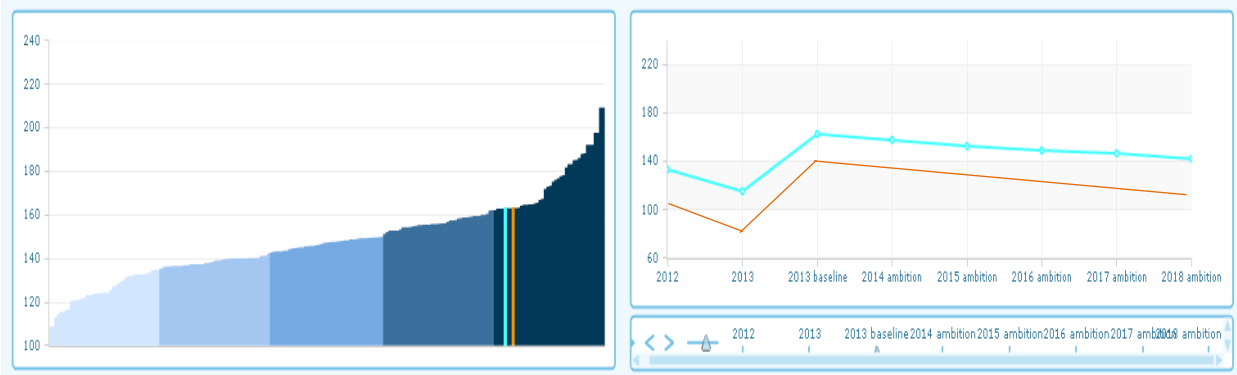
Metrics		Baseline*	Performance underpinning April	Performance underpinning
Permanent admissions of older people (aged 65 and over) to residential and nursing care homes, per 100,000 population	*Metric Value*	914.9	N/A	812.0
	Numerator	585		550
	Denominator	63946		67749
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services *NB. This should correspond to the published figures which are based on a 3 month period i.e. they should not be converted to average annual figures. The metric can be entered either as a % or as a figure e.g. 75% (0.75) or 75.0*	*Metric Value*	0.82	N/A	0.72
	Numerator	190		180
	Denominator	230		250
		(Apr 2012 - Mar 2013)		(Apr 2014 - Mar 2015)
Delayed transfers of care (delayed days) from hospital per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	564.0	630.0	600.0
	Numerator	6750	3780	3600
	Denominator	264100	266090	266902
		(State time period and select no. of months) 12	Apr - Dec 2014 (9 months)	Jan - Jun 2015 (6 months)
Avoidable emergency admissions per 100,000 population (average per month) *NB. The numerator should either be the average monthly count or the appropriate total count for the time period*	*Metric Value*	559.0	561.0	566.0
	Numerator	6706	3366	3396
	Denominator	330200	332617	333558
		(State time period and select no. of months) 12	Apr - Sep 2014 (6 months)	Oct 2014 - Mar 2015 (6 months)
Patient / service user experience: Proportion of people who feel supported to manage their long-term-condition		West CCG: 73.5% and Vale Royal CCG 68.8%	N/A	Still to be fully developed following weighting of figures and GP breakdown
		April 2012 - March 2013		*(State time period and*
Local measure: Injuries due to falls in people aged 65 and over (per 100,000 of population).	*Metric Value*	2136.0 1		2007.0 1
	Numerator	1366	N/A	1360
	Denominator	63946		67749
		April 2012 - March 2013	*(State time period and*	*April 2014 - March 2015*

5.4 Improving a persons care experience both inside and outside hospital to be among the best in the country

Care in hospital

This tool looks at peoples experience of hospital care by reporting the average number of negative ("poor") responses per 100 patients. The data has been collected from an acute hospital inpatient survey.

Chart 4: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Both Vale Royal and South Cheshire CCGs are in the highest quintile (worse) and we recognise that there is significant room for improvement here. Our ambitious targets is for a 15% reduction in patient reported 'poor' responses per 100 patients by 2018/19.

Table 4:

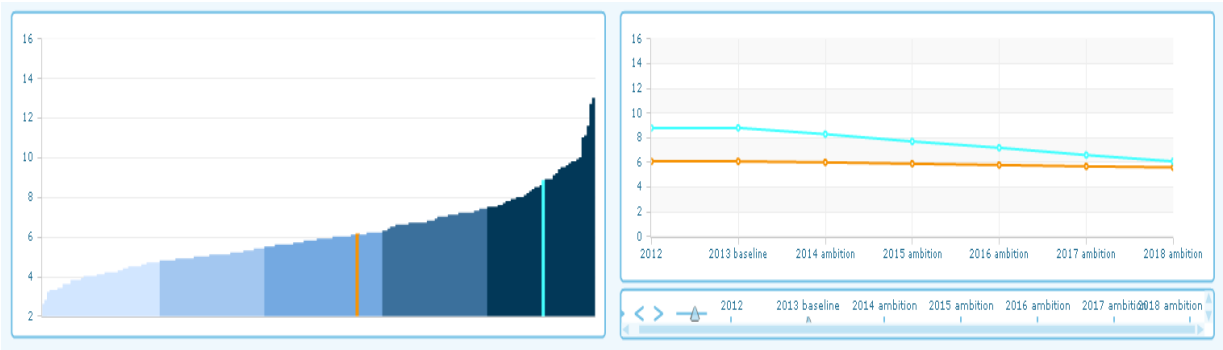
CCG	Number of poor responses – 2013 baseline data per 100	Ranking	Levels of ambition by 2018/19
Vale Royal	162.0	Currently in highest quintile of CCGs i.e. high number of poor responses	138 (15% reduction)
South Cheshire	162.7	Currently in highest quintile of CCGs i.e. high number of poor responses	138 (15% reduction)
NHS England	148.4	-	-

In addition to this, we will continue to roll-out Compassion in Practice (6Cs).

Care outside hospital – GP, out of hours and dentistry

This tool looks at peoples experience of primary care by reporting the average number of negative ("poor") responses per 100 patients. The data has been collected from the GP patient survey.

Chart 5: Graph to show position in national ranking and trend for Vale Royal CCG (turquoise) and South Cheshire CCG (orange)



Vale Royal CCG is ranked in the highest quintile (worse) and South Cheshire CCG is in the middle quintile.

The respective ambitions of each CCG are in the table below:

CCG	Number of poor responses – 2013 baseline data	Ranking	Levels of ambition by 2018/19
Vale Royal	8.8	Currently in highest fifth of CCGs i.e. high number of patients reporting poor care	6.1 (30% reduction)
South Cheshire	6.1	Currently in middle fifth ie average number of people reporting poor care	5.6 (8% reduction)
NHS England	6.1	-	-

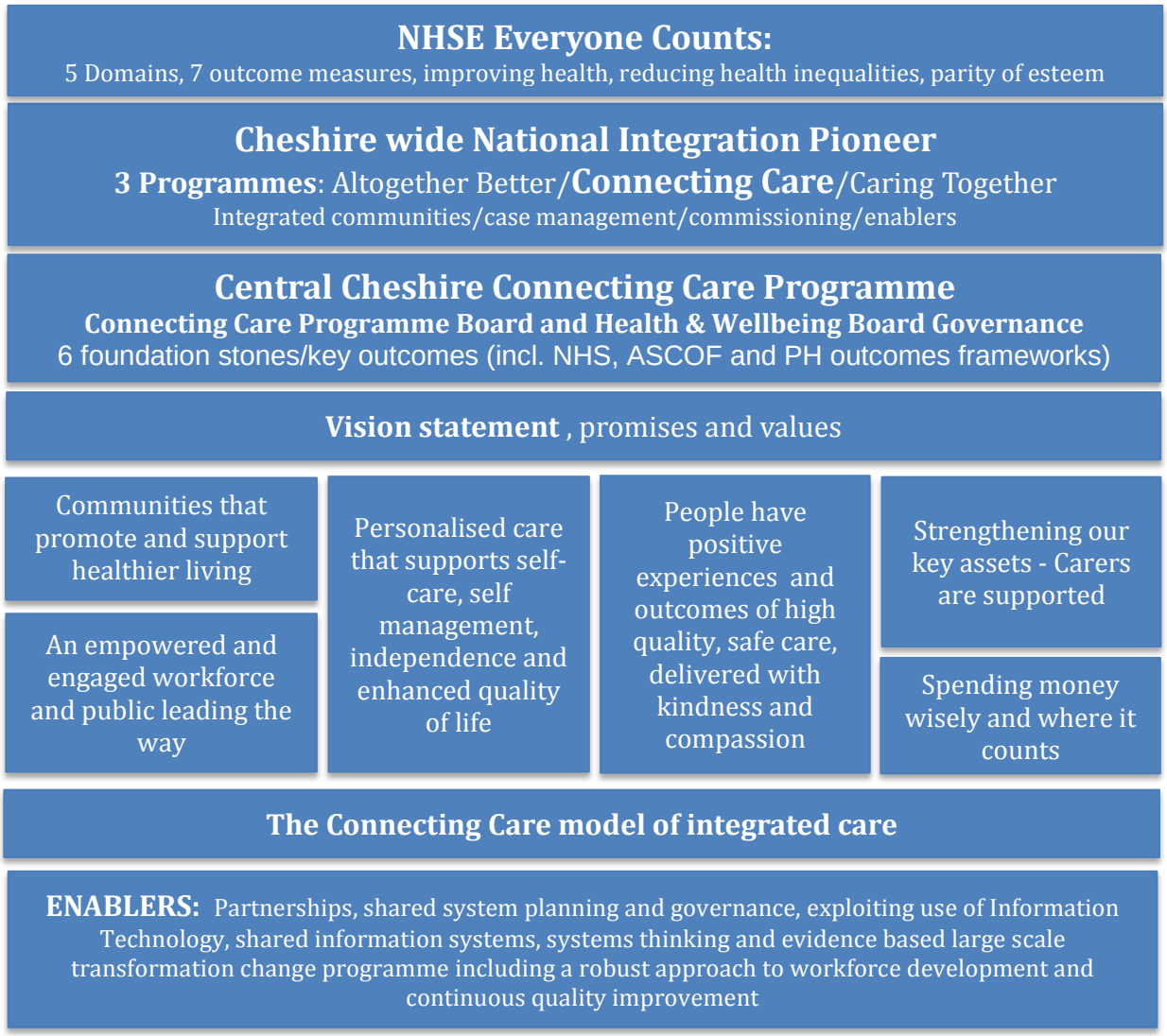
Our ambition for all other NHS, Public Health, Adult Social Care and NHS Constitutional measures can be viewed wihtin our finance, activity and operational plans that support this strategy.

The following chapters outline how the above ambitions will be realised through tranformational change initiatives over the lifespand of this strategy.

6. 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?

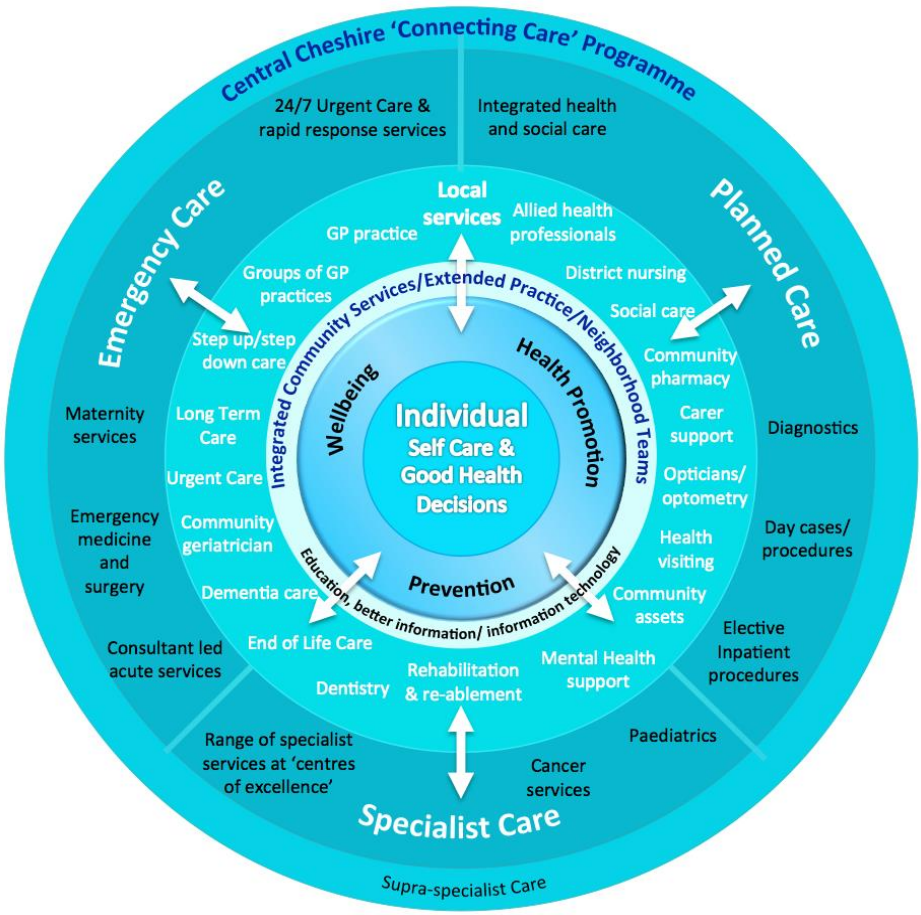
There is no single definition of integrated care. It can be defined as an approach that seeks to improve the quality of care for service users and carers by ensuring that services are well co-ordinated around their needs regardless of professional, team, service or organisational boundaries. The citizen's 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 heatlh and social care model –in 2019

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



A modern model of integrated care – 'Connecting Care' key components:

- 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, quality, safe care delivered in new ways that support empowerment and shared decision making and people will receive only the care that they need
- Integrated care teams will provide physical, mental, psychological, emotional and social care to their communities and will focus on supporting people to remain in their own homes/out of hospital or institutional care wherever possible
- More care will be organised and delivered outside of traditional hospital settings, in local communities with closer collaboration across teams, 7 days a week
- 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
    - Building of community assets and resilience
    - Targeting care where it delivers the greatest benefits, thus avoiding the need for rescue or repair care because prevention or good long-term care is lacking
- Be accountable to our citizens for outcomes and population health through the establishment over time of accountable care teams, which will have the following characteristics:

  2014/15
    - Multi-organisational teams with a responsibility to a population and working to shared objectives and outcomes for that population

- Meaningful measurement related to patient defined purpose (objectives and outcomes) that is freely available to all team members & used frequently.
- The use of quality improvement and systems approaches to improvement to continually improve the care delivered.

2015/16

- The development of 'care panels' at locality level (town based) with membership from:
    - Patients
    - Patients representatives
    - Local political leadership
    - Commissioners
    - Health & social care staff

➢ Focus on the multiple determinants of physical and mental ill-health and creating innovative solutions across partners

- Supporting 'enablers' of integrationWorkforce – 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, roles that can assess both mental and physical health needs
- 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.

Citizen participation and Empowerment

Over the next 5 years we will make a significant step change in our engagement activity so that individuals, families, carers and communities feel supported and empowered to achieve more control over their health and to work in partnership with care professionals to improve health and wellbeing. We will achieve this through creation of a culture of partnership and knowledge sharing, effective partnerships, clear and ongoing communication and engagement and utilisation of a full range of digital support/media.

Increasing the capacity and capability of primary/community care

The development of the neighbourhood and expended practice teams will bring additional capacity within primary and community care which will broaden their ability to respond to the health and social care needs of our population. Our integrated care model incorporates expansion of primary care teams across the entire patch covering a population of over 200,00 and includes a full range of disciplines, functions and roles to support primary care. The planned investment in primary/community care is in excess of £3m for 2014-2016. Resources have been made available within our financial plan to support the £5 per head investment.

Both CCGs have also expressed their interest to NHS England in relation to exploring the opportunity of co-commissioning primary care.

Access to the highest quality urgent and emergency care: 'The Urgent Care Project'

All partners are working collaboratively to transform urgent and emergency care services, so that people have easy access to a consistently high quality service, seven days a week, which is part of the wider model of integrated health and social care and an integral part of a sustainable care system.

The new approach will see the introduction of a 'health-point', utilising an approach similar to NHS 111 to identify when additional effective support and health advice in an alternative setting is better for a person rather than waiting in an Emergency Department. We believe that, by providing this additional support, by 2015 the number of patients with a long term condition who say, when asked, that they feel better supported to effectively self-manage their conditions will increase by 6.2% from our current baseline.

Patients requiring further clinical assessment will be transferred to a 'care-hub' where by 2015 97% of patients will be seen by a member of the multi-disciplinary team dependent upon their symptoms within 4 hours. Where patients require an admission to hospital we want them to experience shorter hospital stays. Patients will be discharged to the comfort of their own home for mobility and activity assessment, rather than being kept in hospital to be assessed. Our ambition is that, these changes will by 2015 reduce the number of delayed transfer of care including those attributeable to social care by 4% from our baseline.

If patients require additional support on discharge, a member of the multi-disciplinary team will liaise with the Integrated Care Teams to ensure services are provided enabling the patient to live independently at home more easily.

All the above changes will reduce spend in the acute sector and this will be re-invested into the expansion of primary/community services. It is anticipated that these changes will reduce acute activity related to emergency admission by 3% in 2014-15 and by 15% by 2019. Our Connecting Care Board has developed an innovative solution to enable this to be delivered. The board has established a 'Provider Board' which brings together multiple acute, mental health, community and primary care providers. An 'Innovation Fund' of £3.2m has been created from a range of sources e.g. tariff deflator, multi-partner contributions and this has created the resource to contract for outcomes via an 'Alliance contract' to achieve our ambitions for the care system inclusive of the shift of activity and resources from the acute to the community setting. As patients move out at scale and the providers can realise a reduction in costs e.g. close wards, there is an iterative cycle created to continually shift monies and invest where needed to support community care.

7 day working - 10 Clinical standards

National evidence and campaigns links poor patient outcomes, including a higher risk of death for patients admitted to hospital at weekends to a lack of a seven-day service.

Our transformational agenda aims to make better use of expensive diagnostic equipment and improve clinical outcomes by providing a more patient focused service, available seven days of the week. We want people to be actively involved in making choices about their health care seven days a week and see this being achieved by giving people timely access to services, results and reports so that treatment can be start as early as possible from a convenient location close to their home.

This will be achieved by adopting the 10 clinical standards recommended by Sir Bruce Keogh in the NHS Services, Seven Days publication and by partnership working to embed these standards across each organisation.

A step change in the productivity of elective care

There is a current challenge in terms of our current growth in elective activity and all partners are working collaboratively to understand the demand, the activity and agree how and where capacity should be sourced in the most efficient way possible. We are developing plans to reduce the current 8-13% annual growth down to an average annual growth of 3%.

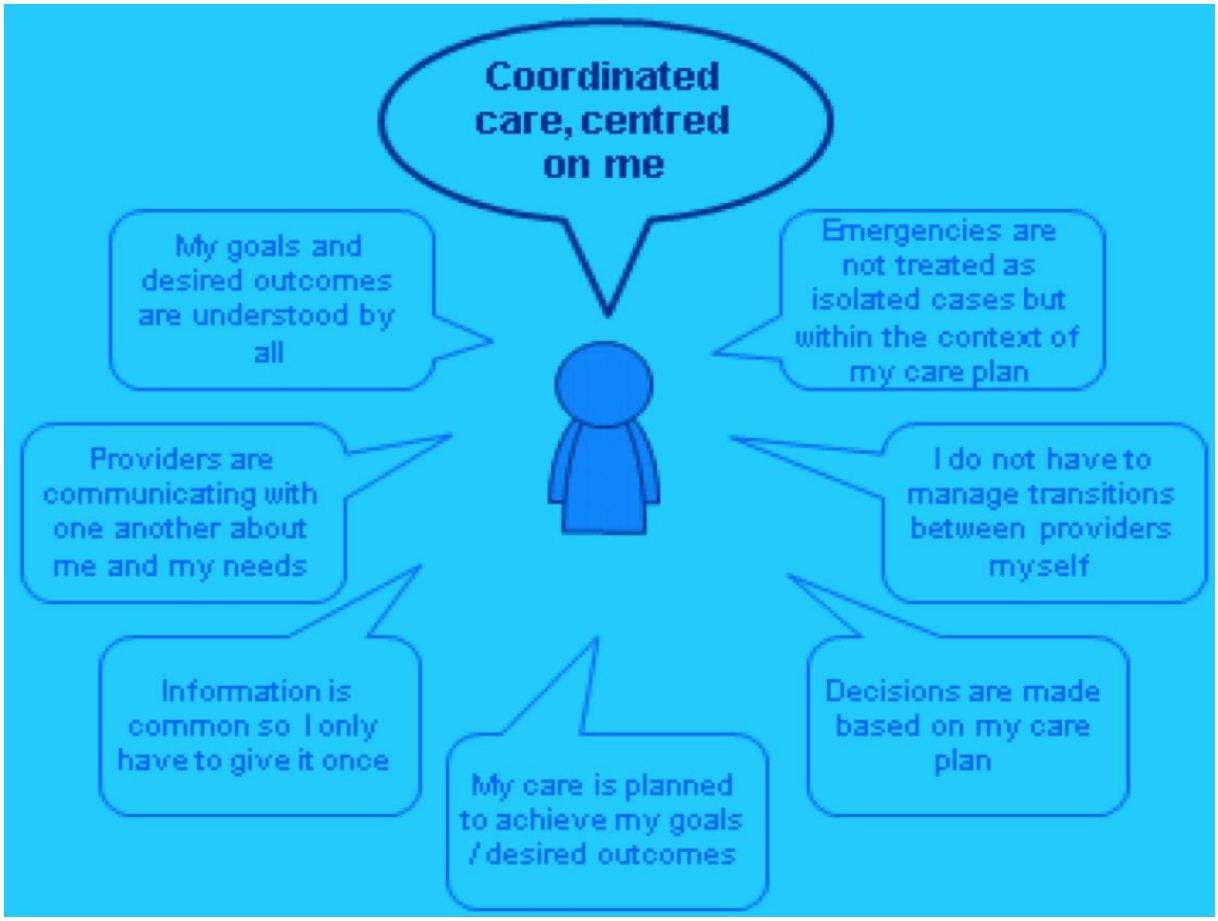
High quality elective care will be provided by centres undertaking sufficient volumes to maintain expertise, using modern equipment and evidence-based techniques. Our elective care services will continue to be concentrated within a small number of providers and we are committed to driving up productivity in line with international benchmarks, treating more patients at a lower cost.

Our drive to reduce referrals and follow up attendances will continue, developing shared care pathways, fuller work-ups/optimization of patients in primary care and avoiding unnecessary visits to hospitals. Efficiencies gained in reducing out-patients will be redirected to increase productivity in elective care.

Specialised services concentrated in centres of excellence

There is recognition of the transformation agenda at specialised services level, outlined in the Specialised Services Strategy, to ensure that people requiring specialised services receive the best quality clinical care and outcomes. We are committed to working with our partners, clinical networks e.g. Cancer, Vascular, Major Trauma and specialist commissioners to understand the impact of national standards and the national strategy for specialised services. We will work collaboratively to align these with the local system development. We are committed to securing services in line with national footprints, specifications and guidance and will work hard to reduce avoidable referrals and activity at specialised services e.g. Neurology.

Impact of the Connecting Care integrated care model



The model will shift focus from episodic and reactive care to longitudinal, continuous, 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 reduce 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 GP will be the accountable professional, supported by the wider teams with the aim of supporting the individual to maintain/improve their health and wellbeing. 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. Effective co-ordination of the multi-disciplinary team surround the person/patient and their authority to access efficiently broader health and social care substantially improves pro-activity of care, consistency and access. The population covered by each team is planned for between 15-50,000. Services will be planned on the basis of each defined population and timely response is a key factor.

Populations will be risk stratified using formal and informal methods 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 person centred primary care e.g. The B Starfield principles – first contact care, comprehensive care, person-focused care over time and care-co-ordination. Incrementally the teams will be expanded to cover all needs of their relevant populations and teams will focus support on the individuals own goals. There will be embedded systems of quality improvement within the teams.

These integrated extended practice/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 care co-ordinator/key worker and they will know how and where to access information, care and support when it is needed. There will be improved access to information and support in all care/support settings to improve health and wellbeing. The aim is to help people with their individual need before it becomes a problem and to support learning, to share skills and knowledge and promote self-care.

The current cycle of reactive interventions and subsequent hospital admissions will be broken, through the above model, which incorporates an integrated urgent care/rapid response service, spanning primary, community and secondary care. This will reduce hospital attendances and admissions. Our local district hospital will shrink over the next 5 years and will begin to utilise their buildings and staff in different ways to support more community based care. They will become community-facing organisations taking direct referrals from the extended practice/neighbourhood teams, supporting those with complex needs until they can be returned into their community. In 5 years time, there will be significantly less of our population attending or staying in hospital as is today. We plan to close one or two wards at our local hospital in the next 12 months as a result of this integration model, increased community support and shifting care provision into the community.

People will only be admitted to hospital for emergency care or when it is absolutely necessary and where it would not be possible or safe to provide that care in the community setting. Both the hospital and community will begin to offer a wider range of services on 7 days of the week.

When a hospital admission is necessary, the stay will be much shorter. Community in-reach and hospital team outreach will support the individual to return to their own home/community.

The lines between primary and secondary care will become blurred with specialists working in the community e.g. community geriatrician, dementia, mental health specialists and GPs/ generalists and community teams working in an in-reach way with secondary care teams and all working collaboratively as part of an 'accountable care team'. It will be a truly integrated care system for those with physical, mental, psychological and emotional needs.

The new care system will require closer, smarter, working, between organisations and the development of new relationships between care professionals and between care professionals and those people 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 and can deliver the new ways of working. Teams will be formulated differently, based on a persons needs and their journey rather than on buildings and organisations. The Cheshire Learning and Improvement Academy will support this transition through learning and development e.g. leadership skills, quality improvement approaches, clinical skill, working effectively to achieve citizen participation.

Specialised services will be accessed at centres of excellence and local pathways will develop in line with these changes.

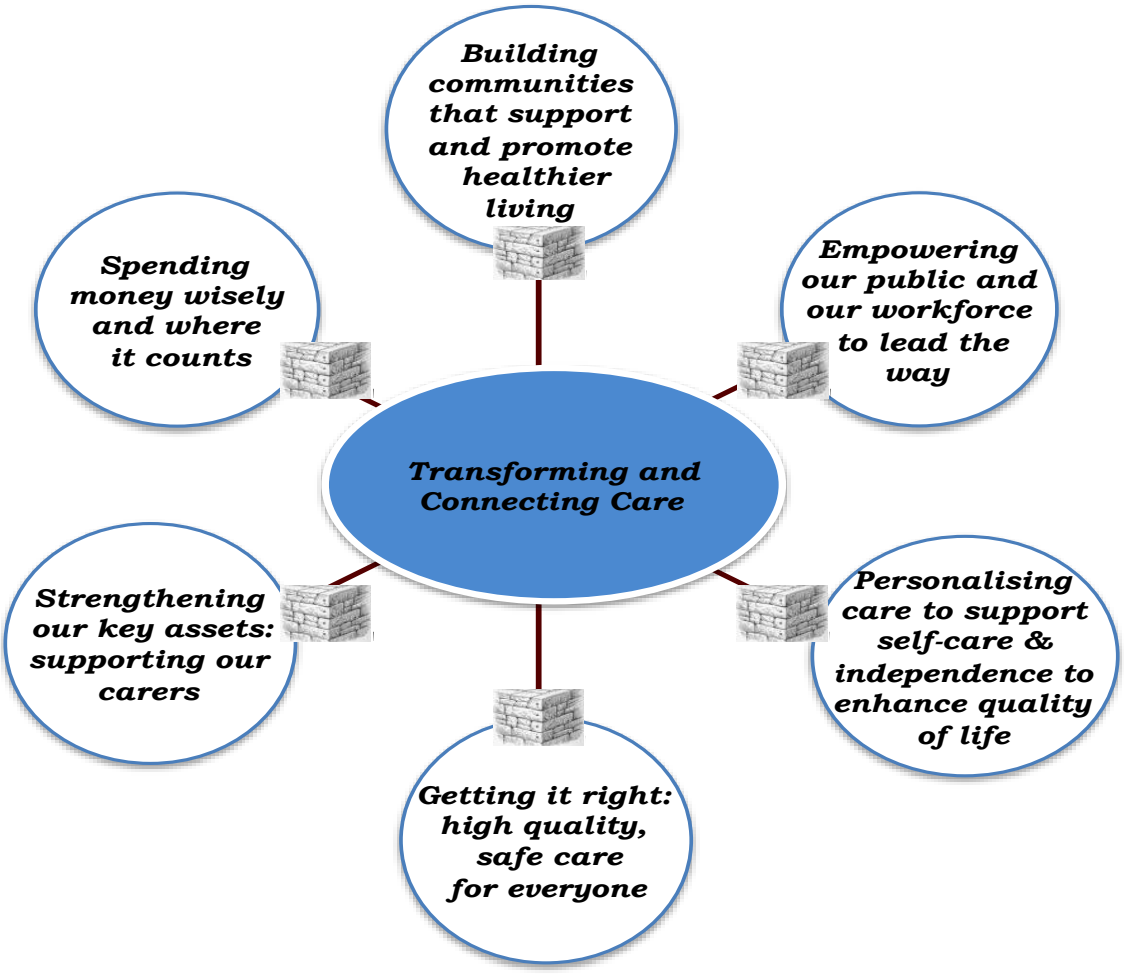
The model will use the defined outcomes, metrics and quality evidence to support ongoing development, shared learning and evaluation of impact at key stages over the lifespan of the programme. Learning will no doubt lead to recommended changes. Connecting Care is part of an international study to evaluate integration models which will report findings in 2017.

Together all the elements described above will develop into a locality 'accountable care team'. They together take responsibility for the outcomes for their population, frequently come together to examine quality, delivery of outcomes, patient journeys and experience. This quality improvement work will be supported by the 'Cheshire Leadership and Improvement Academy, that will be formed to lead continuous quality improvement in the area.

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

7. Laying the six foundation stones for success

The following 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.

Work will be undertaken to establish baselines across all the key measures of success and the composite metrics for each foundation stone. These will be translated into a 'dashboard' for monthly review by the Connecting Care Board.

A high level summary outline of the planned interventions planned to deliver the vision is provided in Appendix 3.

7.1  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 key measure of success

Locally designed questions asked via the local authority quarterly citizens panel survey.

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, including employers, that promotes healthier living, 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:

- New approaches and scaling up of existing self-care support and education programmes
- 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 and the supporting information to help individuals make informed choices about their care
- Jointly commission prevention services across all partner organisations to effectively align prevention and treatment services in order to improve health
- 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 ill-health, links with unhealthy lifestyles, housing, debt or increasing levels of stress including the public, employers and voluntary agencies
- 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, Anti-bullying programmes 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 metrics to measures our progress

- Increasing numbers of people and carers accessing personal budgets that empowers them to take responsibility for improving their own outcomes
- 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 improvements in health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks
    - PHOF 1.18 Measure of social isolation – percentage of adult social care users that have as much social contact as they would like
    - PHOF 1.19 Older people's perception of community
    - PHOF 1.17 Fuel Poverty - percentage of households that experience fuel poverty
    - PHOF 0.1i Healthy life expectancy at birth for both males and females
    - PHOF 4.03 Mortality rate from causes considered preventable

- ASCOF - 1c People receiving self directed support - what percentage of people using community services receive self directed support e.g. personal budgets
- PHOF 2.12 Excess weight in adults
- PHOF 2.13 Percentage of physically active adults
- PHOF 2.14 Smoking prevalence
- PHOF 2.18 Alcohol related admissions.

7.2 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 of all ages, in schools, in the workplace, as members of communities 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 key measures of success

Increasing levels of communications and engagement 'listening events', increasing evidence of public co-production using 'Think Local, Act Personal (TLAP) – Markers for Change' and improvements in feedback via staff surveys.

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
- Commission a range of person empowerment and self-management courses e.g. expert patient, diabetes
- 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
- Establish the Cheshire Learning and Improvement Academy to support workforce development inclusive of citizen participation.

Our aspirations and metrics to measures our progress

- Evidence of co-production on care system redesign with the public utilising the local authority 'TLAP' markers of change
- Evidence of co-production with staff in the whole system design
- 100% citizen participation on all change projects by March 2015
- 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/quantative measures
- Evidence of CCG 'You said' 'We Did' communications with public and staff
- Evidence of promotional materials for involvement and engagement opportunities and evidence of take up
- Evidence of Connecting Care 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
- Achievement of 'Dementia Friendly' communities.

7.3 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 key measure of success

The percentage of people on the GP survey who 'feel supported to manage their long term condition' will increase year on year.

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 individuals/patients monitor their symptoms and know when to take appropriate action and in managing the social, psychological, emotional and physical impacts of their conditions
- Motivating individuals using targeted approaches and structured support e.g. health coaches, expert patient programme or befriending services

- Helping people to monitor symptoms and know when to take appropriate action e.g. Minor ailments schemes, telehealth
- 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, our primary care strategy, with support wrapped around the individual at 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 of a range of long term conditions
- Proactively maximise all care 'contacts' to promote healthy lifestyles and wellbeing
- Working together across partners to tackle the wider determinants of ill-health and social care need
- Create and support an environment for proactive personalised care, self-care/self management and shared decision-making are a reality across our system
- Development of the Cheshire Learning and Improvement Academy to provide a vehicle for learning and improvement over the lifetime of the Connecting Care Programme.

Our aspirations and metrics to measures our progress

- The percentage of people who 'feel supported to manage their long term condition' will increase year on year e.g. via GP survey
- Increasing numbers will access self-care/self management information, advice and support and/or attend disease specific education models
- A ten-fold increase in the numbers of people being supported through telecare/telehealth
- 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 emergency department attendances and admissions

- Increasing improvements in health and wellbeing metrics as measured in the NHS, Public Health and Adult Social Care Outcomes Frameworks
    - PHOF 0.1i Healthy life expectancy at birth for both males and females
    - PHOF 4.03 Mortality rate from causes considered preventable with annual decline in avoidable deaths
    - ASCOF - 1c People receiving self directed support - what percentage of people using community services receive self directed support e.g. personal budgets
    - PHOF 2.12 Excess weight in adults
    - PHOF 2.13 Percentage of physically active adults
    - PHOF 2.14 Smoking prevalence
    - Decrease premature mortality from Cancer, Respiratory Disease, Mental Health related conditions, Heart Disease and Gastro-intestinal conditions
    - Improve quality of life for people with Learning Disabilities
    - Earlier diagnosis rates for Dementia
    - Meeting the health needs of the Armed Forces through implementation of the single management model and plans, increasing identification in primary care and offering veterans priority services
    - Increasing numbers of people with life limiting conditions e.g. dementia or other long-term conditions who express their care requirements via advance statements or preferred priorities for care

7.4 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 key measures of success

The NHS 'Friends and Family Test, the 'NHS/Mental Health Safety Thermometer', together with the local authority annual survey.

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 including the development of new roles and new additional capacity to deliver new models of care
- Development and implementation of our primary care strategy
- Implementation, awareness and continuous training on protection and safeguarding
- Parity of esteem of physical, emotional and mental health across health and social care
- Ensure 'care' is defined by its ability to meet the needs of the individuals rather than being defined by its organisation and service
- Implementation of the 6 C's framework
- Robustly evaluate the 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
- Implementation of CQUiNs and Quality Premium.

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, with parity of esteem of physical and mental health
- 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
- Eliminate avoidable deaths in our hospitals caused by problems in healthcare.

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 metrics to measures our progress

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 in 2015/16
- **Achievement of the 7-day service, 10 clinical standards** by 2016/17
- **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.

7.5 Strengthening our key assets – supporting our carers

Our strategic objective

Carers 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 key measure of success

Locally devised questions via the bi-annual Carers Survey and an increase in the number of carers of all ages receiving assessments and support.

Our plans

There is no single definition of a 'carer'. In general, when a health or social services member is planning what services to provide for a person in need e.g. a disabled person, they need to 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.

Carers experiencing inequalities in health and social care and our carers have told us that having access to a short break, respite services or employment opportunities can make a significant difference to their ability to cope with and maintain their caring role. Our work will focus on a community based assets approach and building of social capital.

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
- 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
- Enable Carers to feel empowered through positive engagements and interactions with service providers and professionals, having positive experience of services
- 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
- Enable and support Carers of all ages to feel safeguarded from abuse within their caring role, family and local communities
- 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 metrics to measures our progress

- 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 Public 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.

7.6 Spending money wisely and where it counts

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 key measure of success

All partner meet their statutory and regulatory requirements and achieve the outcomes identified within the 6 foundation stones initiatives.

Our plans

We will spend wisely, on the right things that meet our population's needs and that will have the highest impact and ensuring best value for money.

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:

- Commission, target and deliver care in line with JSNA identified priority areas, with a focus on prevention and self-care
- Increase investment in evidence based prevention, self-care approaches and high impact interventions e.g. early diagnosis of Dementia, mental health, rapid response, carer support, medications to reduce high blood pressure and high cholesterol
- Targeting care at the most appropriate level including those most in need through risk stratification and those for who preventative and pro-active approaches can have the most impact e.g. upstream approaches
- Increased levels of joint working, joint commissioning, planning and integration

- Work towards the establishment of a population wide, citizen led and governed 'Accountable Care System' working to shared objectives and outcomes for that population
- Collaborative working by providers of care and support across all care settings and in participation with our citizens
- Collective approaches to care, redesign to increase efficiency and productivity within both existing and new services/care approaches whilst still maintaining a focus on quality
- Transforming community and primary care services and maximise the capability & capacity of our workforce via development and support
- 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
- Implementation of the 'commissioning for prevention' 5-step framework and priority areas within 'commissioning for value' packs
- Test out new contracting approaches – Provider Board/Alliance contract/Innovation Fund – working differently and closing wards to re-invest in community services – £3.2m
- Increasingly using Information Technology to support care processes and systems and linking data across organisations e.g. digital front door for people with long term conditions and a single shared integrated care record
- Sustainability plans – QIPP, CIPs, bridging the financial gap
- Alignment of resources to priorities to deliver on agreed objectives and outcomes identified in all 6 foundation stones.

Our aspirations and metrics to measures our progress

- Achieve Better Care Fund metrics
- Achieve health, public health and social care system wide outcome measures/quality benchmarks/markers and constitutional targets
- All partner organisations meet their statutory and regulatory requirements
- Development of a transformational model for moving from existing system to future model through robust financial, activity and impact modeling
- Integrated neighbourhood/extended practice teams – all metrics
- 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.

8. 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 Connecting Care Board is dedicated to achieving the above transformation and existing and new resources have be aligned/redesigned to facilitate this. A dedicated Programme Director for Connection Care was appointed jointly across the 7 partner organisations in October 2013 and is leading the programme development, implementation and evaluation on behalf of and in partnership with the members of the Connecting Care Board. Programme governance is detailed in Appendix 1.

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 utilisation 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 and our citizens take-up initiation of changes in line with the Connecting Care change direction. We will continue to celebrate these changes but the work during this phase will move more towards coordination and supporting staff and citizen 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.

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/Neighbourhood 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						
Establish the Cheshire Learning and Improvement Academy (CLIA) - to build capacity and capability of the workforce & support delivery of a large scale transformational change						
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 = Milestone achieved

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

The challenge and complexity of delivering this programme can not 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 this strategy and detailed within our financial and operational plans will have in terms of narrowing it is yet to be defined with clarity. This will be established as part of our planned modelling work, which is currently 'paused' due to national Information Governance issues. Current month 1 financial positions for both CCGs are provided below:

South Cheshire CCG:

Summary Position	Recurrent	Non Recurrent	Total
	£000	£000	£000
Total Planned Resource	202,565	1,942	204,507
Total Planned Expenditure	(202,565)	(922)	(203,487)
Planned Surplus	**-**	**1,020**	**1,020**
Forecast Surplus	-	1,020	1,020
% of resource (plan)	**-**	**0.5%**	**0.5%**

Vale Royal CCG:

Summary Position	Recurrent	Non Recurrent	Total
	£000	£000	£000
Total Planned Resource	119,535	3,200	122,735
Total Planned Expenditure	(119,535)	(1,000)	(120,535)
Planned Surplus (Control total)	-	2,200	2,200
% of resource(plan)	**-**	**1.8%**	**1.8%**

South Cheshire CCG:

Summary of Planned Expenditure	Total Budget £000	Year to Date Budget £000	Year to Date Expenditure £000	Year to Date Variance £000	Year Forecast Outturn £000	Year variance £000
Total NHS Provider	145,380	12,133	11,963	170	145,380	-
Total Non NHS Contracts	2,897	240	225	15	2,897	-
Other Contracts	7,241	611	617	(6)	7,241	-
Continuing Care Services	11,377	948	731	217	11,377	-
Prescribing	29,130	2,427	2,246	181	29,130	-
Other Programme	3,937	329	164	165	3,937	-
Running Costs	4,238	353	289	64	4,238	-
Earmarked & General Reserves	(714)	(84)	-	(84)	(714)	-
Total Forecast Expenditure	**203,486**	**16,957**	**16,235**	**722**	**203,486**	-
Surplus budget	1,020	85	-	85	1,020	-
Total	**204,506**	**17,042**	**16,235**	**807**	**204,506**	-

Vale Royal CCG:

Summary of Planned Expenditure	Total Budget £000	Year to Date £000	Year to Date Expenditure £000	Year to Date £000	Year Forecast Outturn £000	Year Forecast variance £000
Total NHS Provider Contracts		6,762	6,697	65	81,029	-
Total Non NHS	2,203	183	161	22	2,203	-
Other Contracts	6,212	524	524	-	6,212	-
Continuing Care Services	8,151	679	521	158	8,151	-
Prescribing	17,562	1,463	1,381	82	17,562	-
Other programme	3,090	257	182	75	3,090	
Running Costs	2,403	200	113	87	2,403	-
Risk reserve & general reserve	(115)	(25)	-	(25)	(115)	-
Total Forecast Expenditure	**120,535**	**10,043**	**9,579**	**464**	**120,535**	-
Surplus Budget	2,200	183	-	183	2,200	-
Total	**122,735**	**10,226**	**9,579**	**647**	**122,735**	-

The interventions within our strategy are being resources from within existing baselines, through efficiencies and increased productivity across the care system and from new models of contracting including the Better Care Fund and the Alliance Contract.

The Better Care Fund plans include joint investment levels of £47m across both Central Cheshire.

The key risks for delivery are summarised below and will need to be monitored closely:

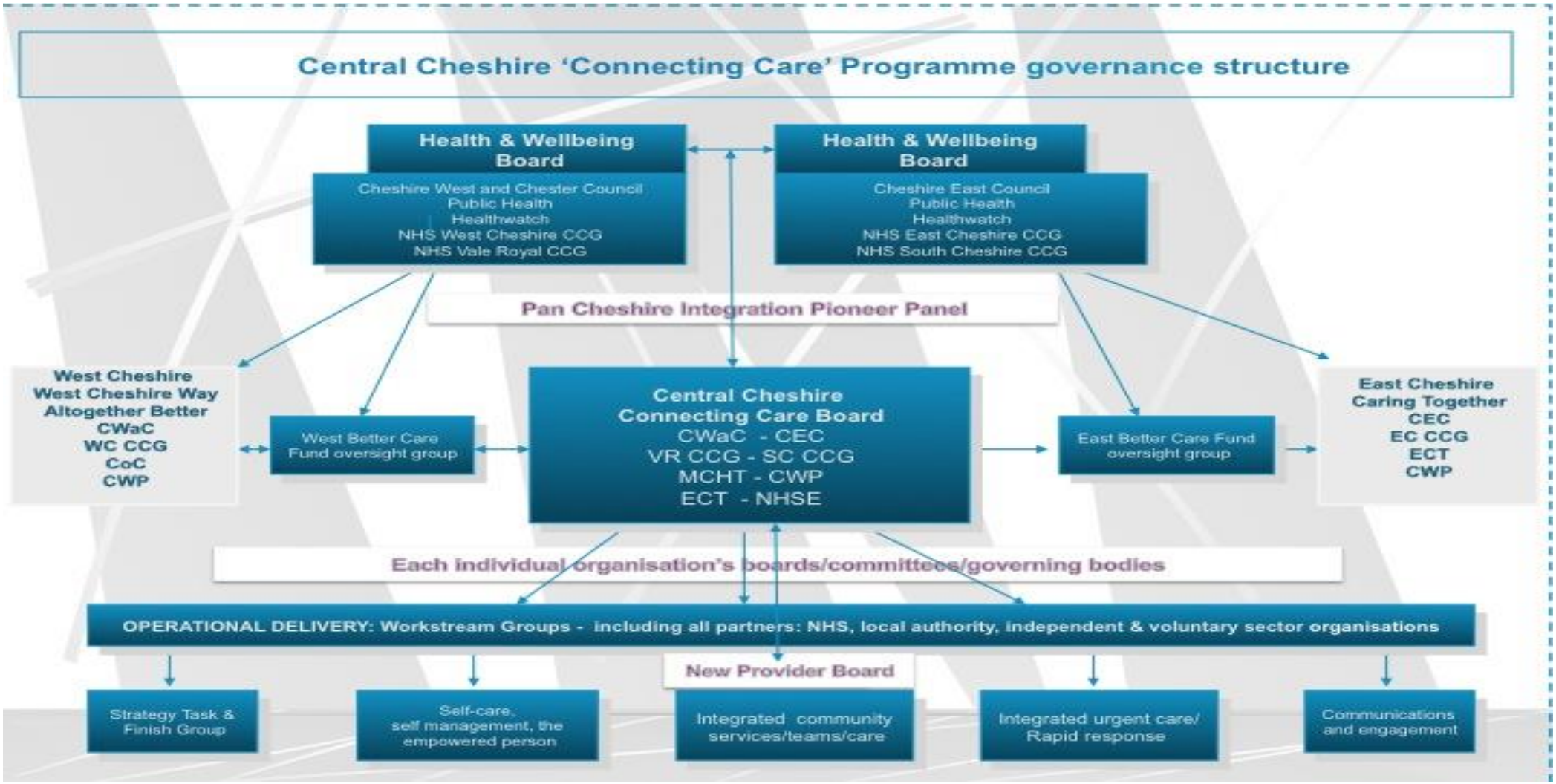
- Delivering the integration agenda within existing resources
- Over performance of activity within secondary care
- Continuing healthcare assessments and complex claims relating to Learning Disabilities
- Impact of NHS England adjustments including primary care information technology, the national shortfall relating to NHS Property services and the national risk pool for CHC legacy claims
- Increasing demand due to demographic changes.

Our strategy is based on the above assumptions and that our plans will narrow the financial gap and ensure viability and sustainability of the care system.

Delivering financial stability and sustainability will be a significant challenge yet with a system wide approach and partnership working as outlined in this strategy, our aim is to achieve transformation that will shift resources across the care system, at scale without the need for significant pump prime funding.

2014/15 is a critical year for our health and social care economy and it is essential that our interventions outlined in this document deliver on their intended outcomes.

Appendix 1: Connecting Care Programme Governance



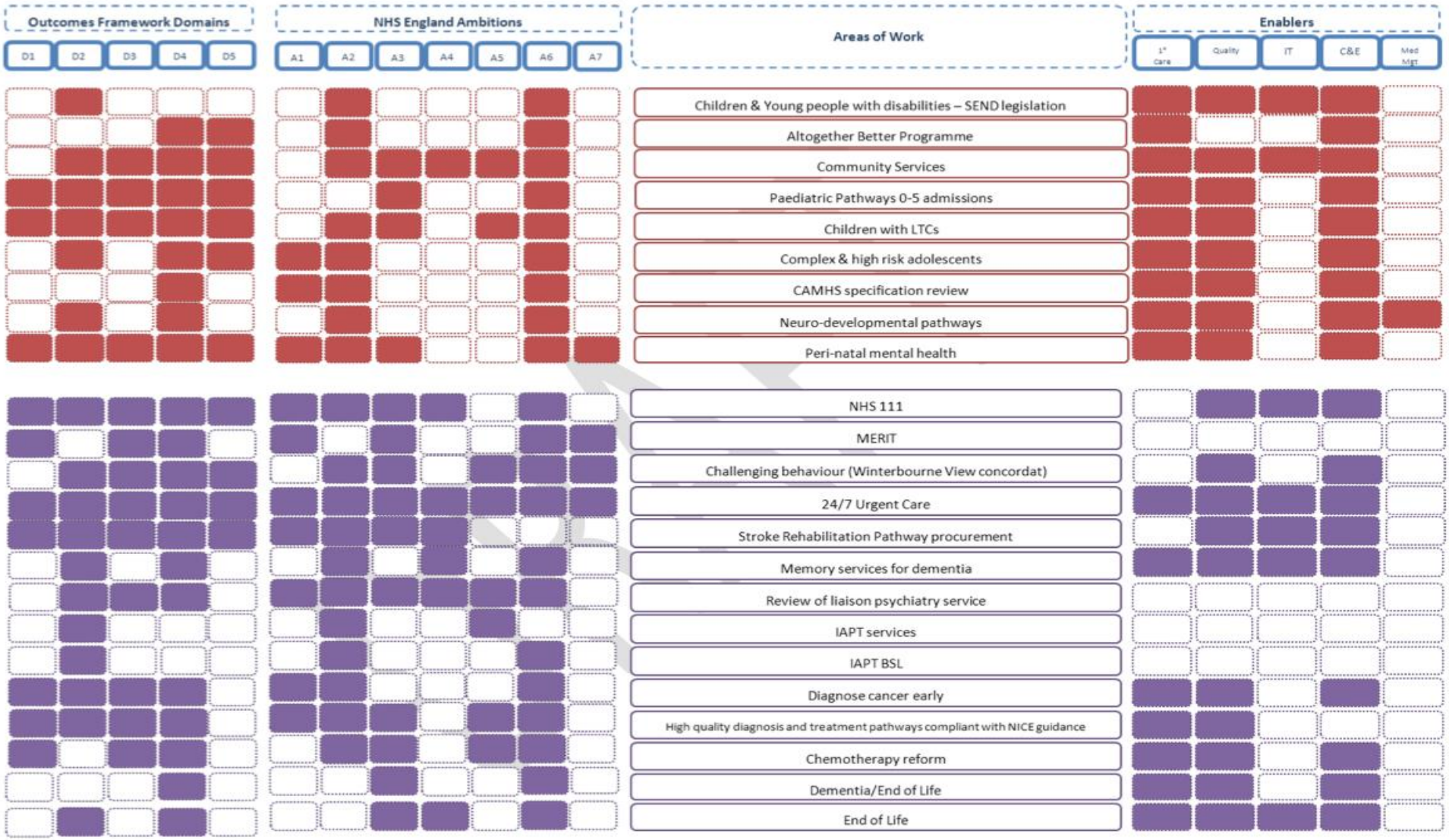
Appendix 2: The Cheshire wide 'Pioneer' Plan

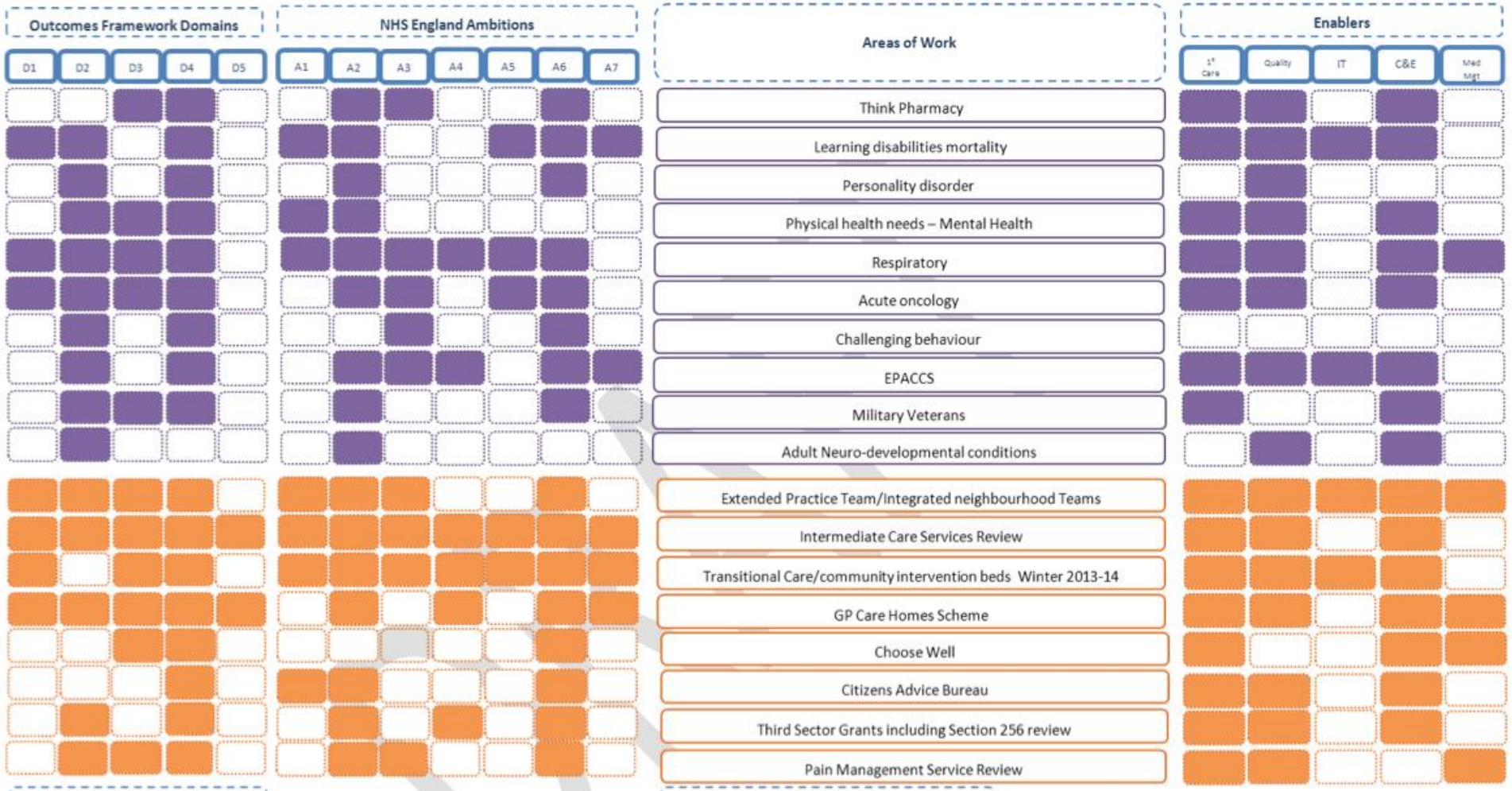
The following section outlines further detail on the key changes that will be made as a pioneer site both across Cheshire and for each of our three localities:

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: Improvement interventions summary and impact ambition – for South Cheshire CCG

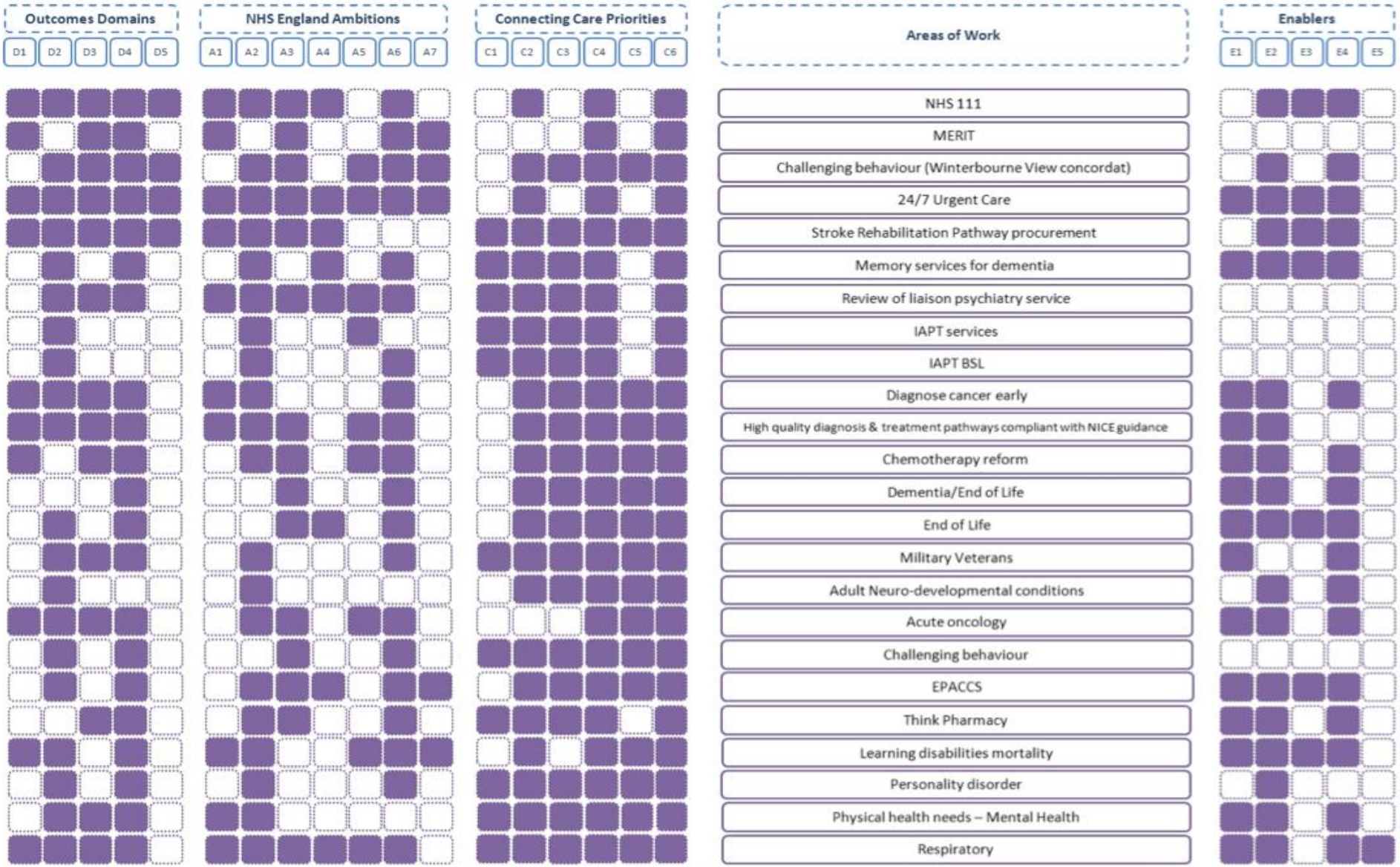


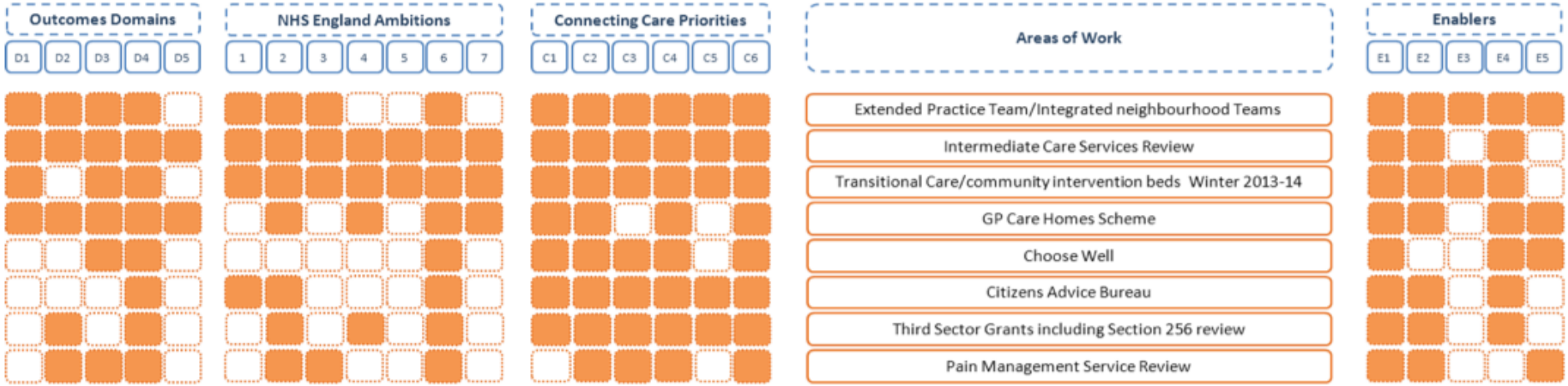


Outcomes Framework Domains	
D1	Prevent people from dying prematurely
D2	People with long term conditions have the best possible quality of life
D3	Patients are able to recover quickly and successfully from episodes of ill health & injury
D4	Patients have a positive experience of care
D5	Patients in our care are kept safe and protected from all avoidable harm

NHS England Ambitions	
A1	Securing additional years of life for people with treatable mental and physical health conditions
A2	Improving the health related quality of life for people with long term conditions, including mental health conditions
A3	Reducing the amount of time people spend avoidably in hospital through better, more integrated care in the community
A4	Increasing the proportion of older people living independently at home following discharge from hospital
A5	Increasing the number if people having a positive experience of hospital care
A6	Increasing the number of people with mental & physical health conditions having a positive experience of care outside hospital, in general practice & in the community
A7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Appendix 3: Improvement interventions summary and impact ambition – for Vale Royal CCG





Outcomes Framework Domains

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D5	Patients in our care are kept safe and protected from all avoidable harm

Enablers

E1	Primary Care
E2	Quality
E3	Information Technology
E4	Communications and Engagement
E5	Medicines Management

NHS England Ambitions

A1	Securing additional years of life for people with treatable mental and physical health conditions
A2	Improving the health related quality of life for people with long term conditions, including mental health conditions
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A7	Making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care

Connecting Care Priorities

C1	Communities that promote and support healthier living
C2	An empowered and engaged workforce and public
C3	Personalised care that supports self-management and independence and enhances quality of life
C4	Individuals will have positive experiences and outcomes of safe services
C5	Carers are supported
C6	Effective resource use