Central and Eastern Cheshire NHS
Primary Care Trust

Commissioning Strategic Plan 2009 - 2014

Better, Longer Lives

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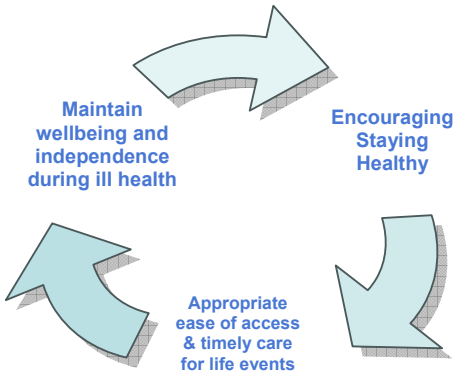
"Work with others to achieve sustainable improvements in health and well-being of the population and to reduce inequalities of health"

The strategic ambition is to be accomplished through the

Lifecycle of care



Strategic Goals

- ***Enable children to reach their full potential by making sure they are healthy***
- ***Ensure older people are supported when needed, so that they can maintain independence for longer and enjoy good health***
- ***Develop High Quality Primary Care Services***
- ***Develop urgent care services, in the right place delivered at the right time***
- ***Improve equity of access to good health services for all our population***
- ***Develop comprehensive (Integrated) care pathways***
- ***Bring care closer to home***
- ***Excellent quality of care is delivered across all our commissioned services***
- ***Optimise resource use and health outcomes by making appropriate use of acute facilities.***

Strategic Direction

17 Change programmes which deliver the strategic goals

Key outcome areas

Each change programme has a number of key outcome areas which show a demonstrable improvement in health outcomes for the population

World Class Commissioning Outcome Areas

10 chosen outcome areas will be used to demonstrate how the change programmes have turned the dial to improve health outcomes for the population, indicating how we are reaching our ambition of sustainable improvements in well-being of the population and reducing health inequalities

Underpinned by Golden Threads which are the basis of our values and principles applied to all our work

Improved health outcomes link directly back up to our strategic ambition

1. Foreword – Chair, Chief Executive & PEC Chair

We are pleased to present this five year Strategic Plan. It focuses on ten outcomes that reflect some of the key health needs in the communities that we serve.

The ten outcomes contribute to the achievement of our established ambition of:

"Work with others to achieve sustainable improvements in health and well-being of the population and to reduce inequalities of health"

To deliver our work as commissioners, we have a set of values that mean we work with stakeholders in an open, honest, ethical and inclusive way. We place a high value on working with others because we know that we cannot effectively deliver this plan on our own.

We believe that our PCT and our partners are well placed to deliver this Strategic Plan; we have a proven track record of improving health and health services.

We hope that this Strategic Plan effectively tells the story of where we are now and where we want to be in the next five years, in particular we believe that by reading this plan you will have a better understanding of the needs of the communities we serve and the opportunities we have to make a real difference to health and well-being.

We look forward to implementing the Strategic Plan and continuing to lead the PCT to develop health and health services through, and with, our partners, including most importantly, the population we serve.

Professor Pauline Ong
Chair

Michael Pyrah
Chief Executive

Dr Bill Forsyth
Medical Director/PEC Chair

2. Vision

2.1. Strategic Ambition

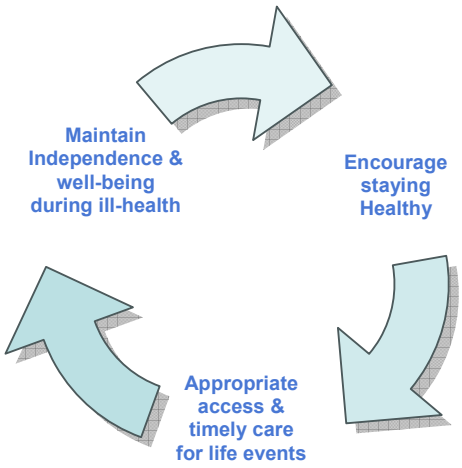
As the local leader of the NHS, Central and Eastern Cheshire PCT (CECPCT) has an ambition to:

> ***"Work with others to achieve sustainable improvements in health and well-being of the population and to reduce inequalities of health"***

Our Strategic Plan, 'Better, Longer Lives', sets out how we will deliver our ambition and overall vision.

2.2. Lifecycle of Care

To encompass all that we do, CECPCT has recognised that the services we commission will be based upon a lifecycle of care:



In order to meet this lifecycle of care we will, for example, **encourage staying healthy** through working with the Local Authority and other local partners to commission services which address the impact of environment, economic, transport and education on health to increase healthy lifestyles. Through this work we aim to raise awareness, in the population, of the early signs of illness and increase the early detection of disease through screening (for example breast screening).

We will commission **appropriate access and timely care for life events;** for example, good accessible primary care services to help people through short-term illness, urgent care services for accidents which occur during life, maternity services and for hospital care, for example cataracts, removal of appendix from which a person will fully recover and carry on their normal life.

We will commission services which **will maintain independence and well-being during ill-health** for example good community services and support for people with long-term conditions such as diabetes and stroke.

2.3. Our Values & Principles – 'Golden Threads'

Delivery of CECPCT's vision is based on a set of values and principles, which we describe as our 'golden threads'. They run through all our work, and particularly underpin our improvement programmes, to ensure a connected way of working. They are essential to delivery of world class services to the people of Central and Eastern Cheshire.

We will :

- Work in **partnership** to be a strong commissioner of **high quality** services (C.A.S.E.).
- **Engage and communicate** with our patients, the public, stakeholders, clinicians and staff to influence decision making.
- Deliver **integrated governance**, which is open and transparent to ensure we are accountable for our actions.
- Strive to be a **learning organisation**, so we can continually improve what we do.
- **Empower** clinicians and other staff to continually improve services and outcomes.
- Make the best use of **knowledge, information and technology** to support our decision making and delivery.
- Take account of **equality and diversity** in all areas of our work.
- **Personalisation** is evident in the services we commission.

We have developed a Quality Framework (C.A.S.E.) as a demonstration to our commitment to continually improving the quality of care, ensuring patients' views are sought, heard and acted upon. C.A.S.E. enables this process and is used as part of the monitoring of clinical quality.

Care – the patient experience must be positive. Patients should be treated as individuals and afforded dignity and respect.

Accessibility – Patients must be able to readily access services. Services must be designed to meet the different needs of communities and individuals to ensure equity of provision.

Safety – it is vital that we protect our patients and staff, and manage all risks effectively.

Effectiveness – it is important that our interventions result in positive outcomes, and that our work is cost-effective. Service must co-ordinate with other health and social care services to ensure patients receive seamless care.

2.4. Our Strategic Goals (for the next 5 years)

We have developed a focused set of strategic goals to deliver our ambition. These have been chosen by using a prioritisation process and developed by reviewing the health needs assessment and national data sets, talking to our partners, stakeholders and the public about outcomes they would want to see improved. We have also considered the National and Regional priorities described in 'High Quality Care for All' and 'Healthier Horizons'. Key questions we asked when considering our strategic goals for the next 5 years were:

- What is the overall performance of CECPCT?
- What factors contribute to health inequalities within Central and Eastern Cheshire?
- What are the issues that the public and patients are telling us about?
- What are the clinicians telling us are the priority areas?
- What's the national, regional and local context we are working within?

	Strategic Goal	**Rationale**
Goal 1	Enable **children** to reach their full potential by making sure they are healthy	Improving the health and well-being of children and young people will have a positive health legacy for those individuals as they grow and will reduce inequalities in health
Goal 2	Ensure **older people** are supported when needed, so that they can maintain independence for longer and enjoy good health into old age	We have the fastest growing **older population** in the North West, which will have significant implications on the type of healthcare provision required. There will need to be an emphasis on healthy aging and self-care to help keep the older population well for as long as possible.
Goal 3	Develop high quality **primary care** services;	**Primary care** should provide high quality personal care and support, treating people when they are sick and also helping them to stay healthy.
Goal 4	Bring **care closer to home**;	We want to develop our community hospitals as a network that provides appropriate services away from secondary care, and **closer to people's homes**
Goal 5	Develop the right **urgent care** services, in the right place at the right time;	We want to commission an **Urgent Care** system built on delivering high quality emergency and urgent care, closer to people's homes, which offers patients greater choice, better information and value from an expanded range of health and social providers.
Goal 6	Improve **equity** of access to good health services for all our population;	Services should meet the needs of every individual in a diverse population; a service which feels personal to each and every individual within a framework of **equity** and good use of public money.
Goal 7	Develop comprehensive and integrated **care pathways**;	Delivering effective and integrated **care pathways** for people affected by poor health and limiting long-term conditions will improve their health outcomes, improve quality and value for money.
Goal 8	**Quality** of care is delivered across all our commissioned services.	Caring about care and putting **quality** at the core of all commissioned services is one of our golden threads. It is also emphasised in Darzi's 'High Quality Health for All', which stated that quality should be the organising principle for health services, and set out proposals for quality accounts to be routinely drafted by all healthcare providers in time.
Goal 9	Optimise resource use and health outcomes by making appropriate use of **acute facilities**	It is our aspiration to provide the right care at the right place at the right time. All services, particularly our **Acute services,** need to be utilised optimally both to provide patients with care in the most appropriate setting, and to make the most efficient use of our resources.

To achieve these goals, we will be focusing our attention and resources over the next 5 years on a range of initiatives - a set of change programmes to deliver, develop and

reshape local services – whilst ensuring value for money and targeting those most in need. These Change Programmes are outlined in Chapter 4; each has a number of key outcome areas to meet which will give tangible indicators to how we are achieving our ambition of sustainable improvements in well-being of the population and reducing health inequalities.

World Class Commissioning Outcome Areas

As part of the World Class Commissioning process 8 outcome areas have been chosen plus 2 national areas to demonstrate how we have turned the dial to improve health in key areas. These areas were selected through a rigorous process which determined which outcomes would show the greatest change; as these are outcome areas for which we are currently struggling to achieve against targets or our performance is lower than expected. The chosen outcomes are:

8 Local Outcomes:

Infants Breastfed – ***"Make Breastfeeding the accepted norm"***
To achieve an increase in breastfeeding initiation rates and make breastfeeding the norm in infant feeding in Central & Eastern Cheshire.

Dignity & Respect for All -***"Caring about care"***
All users of health and social care services to be treated with dignity and respect and that commissioning of services reflect the principles of dignity in care, including robust monitoring systems to ensure dignity and respect underpins all care activity.

Transforming Urgent Care services - ***"Right (urgent care) services, in the right place at the right time"***
To reduce emergency admissions due to ambulatory care conditions, placing the PCT in the top quartile against national performance.

Alcohol Harm Reduction – ***"The population should know what equates to an unhealthy level of drinking"***
To reduce the levels of alcohol health and social care related harm such as hospital admissions and death related to alcohol and achieve systematic screening and assessment of patients who are harmful drinkers and provide targeted pathways of care.

Cancer mortality - *"Treating cancer quickly"*
To increase the proportion of people who are diagnosed at an earlier stage of cancer and treat quickly and effectively to positively influence <75 years cancer mortality rate.

Stroke – ***"Delivery of our stroke care pathway"***
To increase the Percentage of Physiotherapy Assessment within 72 Hours, and to improve services for those who suffer stroke and to intervene early to prevent stroke.

Mental Health – ***"Diagnosed earlier, treated better and independent longer"***
60% of expected dementia sufferers are captured on a practice-based register and they have an active care plan.

CHD - *"We have a systematic approach to diagnosis and treatment."*
We will reduce the **CHD mortality** rate for all ages.

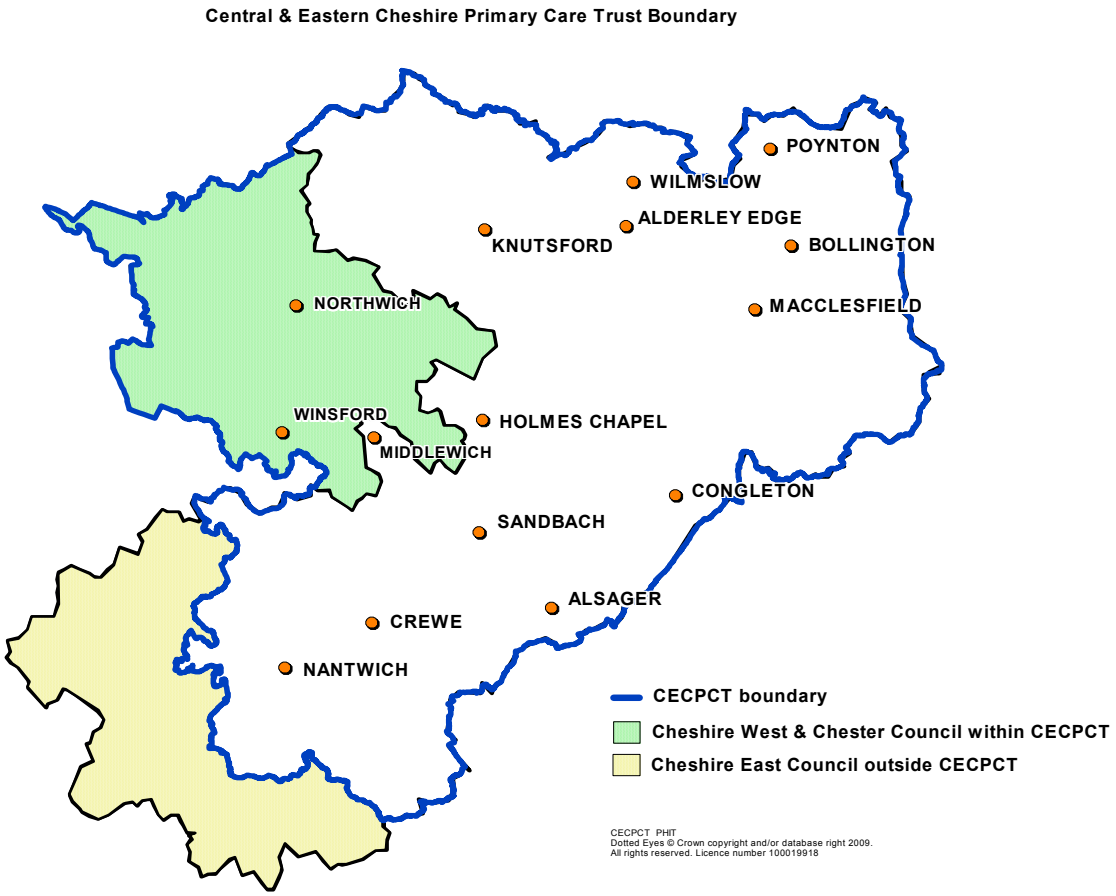
2 National Outcomes:

Reducing Health Inequalities & Improving Life Expectancy - ***"Narrow the gap & move the mean"***
To secure a reduction in health inequalities, improve the health of all but improve the health of the worst off (as defined through life expectancy and poor health) faster.

3. Context - Geographical and Organisational

Central and Eastern Cheshire Primary Care Trust is responsible for organising primary care and community health services for the 453,000 residents across the former boroughs of Crewe and Nantwich, Vale Royal, Macclesfield and Congleton; commissioning other NHS organisations to provide services to our local people; and improving health and reducing health inequalities. From 1st April 2009 the PCT will cover the new Unitary Authority of Cheshire East and the population of Cheshire West and Chester Unitary Authority, mainly located in the former Vale Royal borough area.

Our geography is spread across rural and urban communities, small and larger towns and villages stretching from the southern Pennines in the east across the central Cheshire plain, covering 1547 sq km of Cheshire.



The north east of the district is a commuter belt for Greater Manchester, with the affluent towns of Wilmslow, Alderley Edge and Prestbury. The more rural areas consist of villages still engaged in agriculture, which is mainly traditional dairy and orchard. Post industrial towns such as Macclesfield, Congleton, Northwich, Winsford and Crewe are regenerating with new industries.

The Gender make-up within Central and Eastern Cheshire in 2001 showed 49% of the population were males and 51% were female. This is similar to national average; however there are more females within the older age groups and this is likely to increase.

The 2001 census data which informed the Partnership Disability Equality Scheme across Central and Eastern Cheshire found Disability and Long-term illness within the North West to be 20% of the total population, within Cheshire it is 17.4% of the total population.

Our geographical area has a broad tourist base and includes places of historic interest such as Nantwich. As with other geographically attractive areas there is a significant retired community emerging as Cheshire has a higher than national average population of over 65 year olds. We have the fastest growing elderly population in the North West.

Service Provision
Within our boundaries there are 52 GP practices, 90 pharmacies, 90 dental practices and 59 ophthalmic practices. Cheshire East Community Health (CECH) provides community services across the Central and Eastern Cheshire.

There are two District General hospitals within our area, Mid Cheshire Hospitals Foundation Trust in Crewe and East Cheshire Trust in Macclesfield; three Community Hospitals (Northwich, Knutsford and Macclesfield) and a major Mental Health partner, Cheshire and Wirral Partnership Foundation Trust. We work with a wide range of partners in the community and voluntary sector.

Organisational Changes
There have been a number of complex reorganisations which have impacted on the capacity and capability of the PCT to sustain stability and maintain relationships. The PCT has recently undergone its third reorganisation since 2002:

- In 2002 Central Cheshire PCT was created from two Primary Care Groups (PCGs), part of the South Cheshire Health Authority, and a Community NHS Trust. East Cheshire PCT was created from two PCGs, part of South Cheshire Health Authority, and Community services provided by East Cheshire Hospitals Trust and a Community NHS Trust.
- In 2006 Central and Eastern Cheshire PCTs merged to create the current PCT.
- In April 2008 our provider services, Cheshire East Community Health (CECH) were established as an 'Arms Length Management Organisation'.

A major reorganisation of one of our commissioning partners has had a significant impact on delaying joint commissioning arrangements. Cheshire County Council (along with the 6 local district councils) underwent a major reorganisation in 2009. This created two unitary authorities from the previous two tier system. There is a renewed commitment to partnership working, particularly at a strategic planning level to maximize the opportunities presented by the new 'single-tier' system. As part of the creation of two unitary authorities, the two Cheshire PCTs – ourselves and Western Cheshire PCT will have to reorganise service delivery to reflect the lack of co-terminus approach with the new councils. (See Map on page 9)

3.1. Our Population – Demographics and Health Needs Assessment

This section describes the health of the population in Central & Eastern Cheshire and is based on information derived from health needs assessments from three sources:

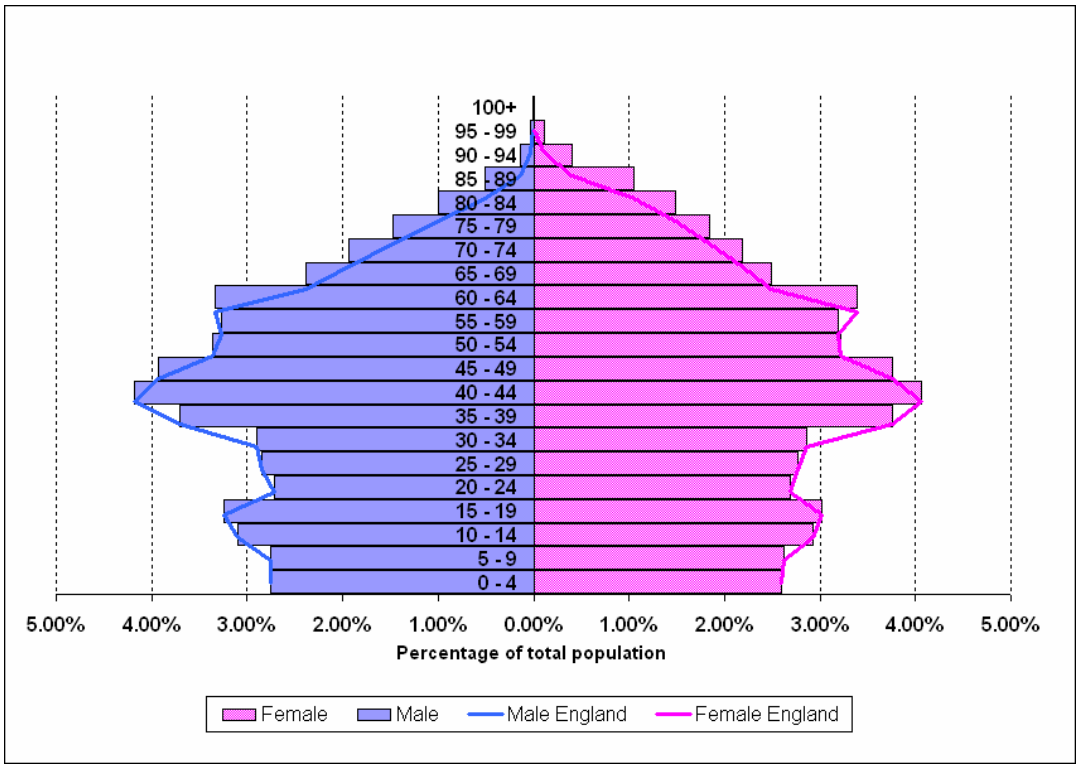
- Local Epidemiological information: CECPCT undertakes an iterative programme of epidemiological comparative and corporate needs assessment.
- Joint Needs Assessment for 2008/09 was undertaken jointly with the County Council and Western Cheshire PCT and was overseen by a steering group comprising of the Director of Public Health, Commissioning, Adult Social Care and Children's Services.
- Director of Public Annual Reports.

These assessments, and the more recent Director of Public Health Annual Report, which focused on our PBC groups and GP practices will continue to influence our commissioning decisions.

3.1.1. Population & Demographics - Key Issues 2008-13

Central and Eastern Cheshire Primary Care Trust (CECPCT) has a population of 453,000 residents spread over rural and urban communities. Table 1 below illustrates that the PCT has fewer young adults and a correspondingly higher proportion of people in all age groups over forty than the national age distribution.

Table 1 - Population Pyramid for Central and Eastern Cheshire Primary Care Trust



Source: Exeter download mid 2008 for CECPCT residents

CECPCT has the fastest growing ageing population in the North West. The overall population is predicted to increase by 16% (70,200 people) by 2031. Over 80% of the overall increase is predicted to occur in those aged 65 and over. Initially the population

aged under 44 is predicted to decline but all age groups will increase over the total time period from 2006 to 2031.

Nationally there has been a rise in fertility in all age groups since 2001. Similar increases have also been taking place in CECPCT where between 2002 and 2006 the number of live births rose from 4,413 to 5,064. CECPCT birth rates vary by age; with the highest rates being seen in women aged 25 to 34.

The proportion of non-white ethnic groups has risen from 1.6% (7700) in 2001 to 2.8% (13,600) in 2005. This population is distributed in the urban centres of Wilmslow, Crewe and Winsford as well as a relatively high percentage (1%) in the rural areas surrounding Crewe, Nantwich and Macclesfield. The highest number of non-white residents are within the Macclesfield area, within 3 wards which includes, Dean Row - 11.59%, Hough - 9.1%, Morley and Styal - 7.1% and Crewe/Nantwich includes two wards St Johns - 8.48% and Minshall - 6.74% Borough's. Some of our towns have experienced recent migration from Eastern European countries; however this is a constantly changing picture as the national and international economic situation shifts.

Further work will be undertaken to identify equality groups within the newly formed local Area Partnership areas and area programme Boroughs and Neighbourhoods. Services planned and delivered within deprived neighborhoods will evidence how they are meeting the needs of the diverse population. By ensuring that all groups are able to access appropriate health care services and appropriate health related information, we can help to reduce health inequalities for all groups

3.1.2. Consequences of Population Ageing - Key Issues 2008-13

The impact of the rapid ageing of our population will have to be considered when planning and prioritising service delivery over the next 5 years. Two issues, falls and long term conditions are considered in detail.

Falls

Falls are common occurrences with increasing age and are strongly associated with chronic/long-term conditions. In the UK falls, are the major cause of disability and the leading cause of mortality due to injury in older people aged over 75 years of age. There are significant costs to individuals, their families and public services due to hospitalisation, social care, repeated falls, loss of independence, impaired mobility and isolation.[1]

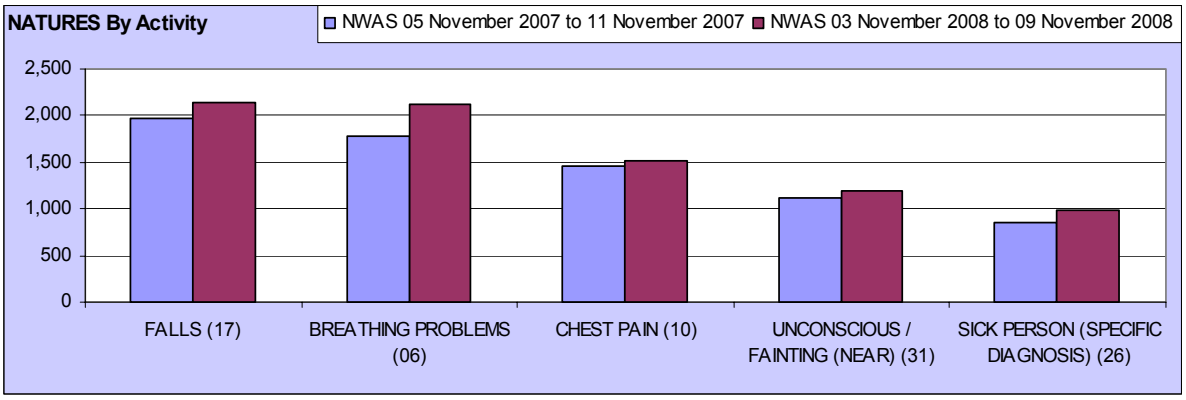
Table 2 on the next page shows the population forecast for people aged 65 and over in CECPCT and the estimated number of fallers. In 2007, it was estimated that there were 23,601 fallers and of these 2360 had an injury and half of these had a fracture.

Table 2 - Forecast of falls for Central and Eastern Cheshire 2007 – 2021

Year	Population Forecast 65+	Estimate of Fallers @30%	Falls with injury @10%	Falls with fracture @5%
2007	78,670	23,601	2,360	1,180
2011	86,800	26,040	2,604	1,302
2016	100,100	30,030	3,003	1,502
2021	109,000	32,700	3,270	1,635

National evidence suggests that approximately 10% of all ambulance call outs are for people aged 65 and over who have fallen, of which approximately 60% are taken to hospital. Table 3 below demonstrates the top five ambulance call outs (taken from a spot week comparator) for the North West for November 2007 and November 2008. Falls is the greatest reason for call outs with 14% in 2008 and 13.8% in 2007.

Table 3 – Top 5 Reasons for an Ambulance Call Out in the North West



Local data suggest that around 3500 to 4000 older people attend A&E each year as a result of a fall. Out of a total of 55,103 people attending A&E at East Cheshire NHS Trust between April 2007 and March 2008, 1484 (2.7%) were fallers over the age of 70 and 51% of these were admitted onto a ward, 22% to fracture clinic, A&E review or GP follow up. 20% had no follow up.

Long-Term Illness Conditions

Table 4 on the next page shows the number of people affected by poor health with limiting long-term illness (LLTI) and Table 5 shows the number of people aged 65 and over 'Not in Good Health' with a LLTI within CECPCT. The numbers will increase roughly in line with the size of the ageing population. Of the total population, over 17% have "limiting long-term illness". There is variation again between the districts both for the total population and for those aged 65 or more. Vale Royal has the estimated highest proportions and Macclesfield the lowest.

Table 4 - Number of People affected by poor health with limiting long term illness

All Age Groups	Total Population in 2005	Not in Good Health and with Limiting Long-term Illness	
		Number	% of Total Population
Vale Royal	124,600	10,100	8.1%
Crewe & Nantwich	113,600	9,000	7.9%
Congleton	91,700	6,400	7.0%
Macclesfield	150,500	10,000	6.6%
4 Districts	**480,500**	**35,500**	**7.4%**

Source: Cheshire Council, Forecast of Health of Older People (2005-2021)

Table 5 - Number of People aged 65 and over affected by poor health with limiting long term illness

Age Group 65 or more	Total Age 65+ in 2005	Not in Good Health and with Limiting Long-term Illness	
		Number	% of Total Age 65+
Vale Royal	20,300	4,600	22.7%
Crewe & Nantwich	19,100	4,300	22.5%
Congleton	15,700	3,200	20.4%
Macclesfield	28,500	5,300	18.6%
4 Districts	**83,600**	**17,400**	**20.8%**

Source: Cheshire Council, Forecast of Health of Older People (2005-2021)

3.1.3. Child and Family Health - Key Issues 2008-13

Childhood Immunisation

Childhood immunisation up-take is generally good. MMR uptake however has remained at or below 88% for the last seven years. This uptake level has been insufficient to prevent sporadic cases or clusters of disease. Approximately 340 more infants need to be immunised each year to achieve the target uptake of 95% that is required to prevent outbreaks of disease. In 2007 there were 16 notifications of measles, 46 of mumps and 8 of rubella in CECPCT. We have recently had a significant outbreak of measles between October 2008 and January 2009 with approximately 146 notifications of measles which required a mass immunisation programme to bring it under control.

Breastfeeding

Breastfeeding rates are lower than the national average and lower than expected when compared with levels achieved by similar PCTs. CECPCT achieved a 59.5% initiation rate in 2007/08, compared to 76.8% achieved by the best performing PCT within the same Office for National Statistics (ONS) grouping 'Prospering Smaller Towns (c)'. Breastfeeding significantly reduces occurrences of certain childhood illnesses such as otitis media (ear infection), gastroenteritis, asthma and reduces the likelihood of obesity later on in life. Breastfeeding also protects mothers from a wide range of illnesses such as breast and ovarian cancers, reduction in type 2 diabetes and an increased likelihood of returning to pre pregnancy weight.

Teenage Pregnancy
The predicted trend in teenage pregnancies means that the 2010 target may not be met. This target is a 50% reduction from the 1998 rate to 20.2/1000 or 179 pregnancies for the PCT. Crewe & Nantwich has the highest rate at 43.9 per 1,000 (or 95 per annum in this borough). Teenage pregnancy shows the traditional links with deprivation, with the deprived wards of Coppenhall, Delamere, Grosvenor, Maw Green and St Barnabas in Crewe all have significantly higher rates of teenage pregnancy. There is a high rate of conceptions leading to abortion (approximately 50%), particularly in Macclesfield and Congleton boroughs.

3.1.4. Lifestyles - Key Issues 2008-13

Many of the major causes of premature death are influenced by individual health behaviours and lifestyle issues. A persons decision or ability to adopt and follow a healthy or unhealthy lifestyle is influenced by a number of factors such as social and environmental influences, family income and size, age, area of residence, access to physical activity opportunities and healthy food options as well as the availability and opportunity of cheap alcohol, tobacco and illicit drugs.

Tobacco
Smoking remains the greatest preventable causes of morbidity and early death. In England it is estimated that 87,000 people per year die due to smoking related illness. Nationally and locally significant progress has been made to decrease the number of smokers. In CECPCT there are estimated to be around 76,800 adult smokers equating to 20.1% of the adult population compared with the national average of smokers 21.0%. Smoking prevalence is highest in urban areas and appears to be linked to high deprivation. West Coppenhall and Grosvenor Middle Super Output Area (MSOA) in Crewe has an estimated smoking prevalence of 36.2%, whereas smoking prevalence in the more affluent Adlington and Prestbury areas are as low as 9.6% (at MSOA level).

Smoking in pregnancy is a particular issue for CECPCT. Our current rate of smoking during pregnancy is 19.6%. National targets for smoking during pregnancy have been set at 15% by 2009/10. CECPCT is carrying out work to address this issue.

Alcohol
The impact of alcohol misuse in CECPCT occurs at all levels of society. It results in increased use of general practice consultations, increased attendance at A&E, ambulance call outs, and out patient and hospital admissions. The chronic effects of alcohol use includes liver cirrhosis, coronary heart disease, cancer and stroke. 5.1% (18,317) of CECPCT adult population are estimated to be harmful drinkers (drinking above “safe limits” – drinking more than 50 units per week for males or than 35 units for females). Reported levels of binge drinking in CECPCT are 21.4%, higher than the national average of 18.0%. As a PCT we have the 7th hazardous drinking in the country and cost of emergency admissions due to alcoholism are increasing by £1 million per annum. The importance of the health system and in particular primary care in assisting people to moderate the excessive but now normalized alcohol intake is understated.

Obesity
In CECPCT children have their height and weight measured in Reception Year (aged 4-5) and Year 6 (aged 10-11). In 2007/08 more than one in five of the children measured in reception year were either overweight or obese (20.4%). In Year 6 children this rate was nearly one in three (29.5%). This is significantly **better** than the national average of overweight and obese children in the same comparative age groups.

Current estimates of the prevalence of obesity amongst our adult population suggest that 89,200 (23.3%) of the adult population of CECPCT are obese, equivalent to the national rate (23.6%). There is significant variation at town level ranging from 28.3% in Winsford to 19.5% in Wilmslow. The benefits of health professionals promoting increased consumption of fruit and vegetables, reduced salt and saturated fat intake is imperative. Almost 70,000 premature deaths could potentially be prevented each year if UK diets matched nutritional guidelines. Encouraging physical activity would also make a significant difference. It not only contributes to well-being, but is also essential for good health. People who are physically active reduce their risk of developing major chronic diseases such as coronary heart disease, stroke and type 2 diabetes by up to 50%, and the risk of premature death by about 20-30%. The estimated direct health care cost of physical inactivity to this PCT is £7.5m per annum.

3.1.5. Main Causes of Early Death Key Issues 2008-13

Nearly 37% of all deaths within CECPCT are a result of cardio vascular disease (CVD) or approximately 1600 deaths from CVD each year.

CVD is the biggest contributor to the life expectancy gaps experienced within all four boroughs in both males and females (range 25.6% - 48.1%). Approximately 26% (1,245) of deaths are premature and could be preventable with lifestyle modification. Almost a third (31%) of these premature deaths would be eliminated if the health experience of the worst MSOA were the same as the very best.

26.4% of deaths are a result of cancer (1160 per annum). Cancer deaths are one of the main causes of death and therefore have a considerable impact on life expectancy. 50% of cancers are preventable with lifestyle modification (smoking, obesity and alcohol), early detection of cancer and improved care.

3.1.6. Life Expectancy – Key Issues 2008-13

CECPCT has a life expectancy that is just better than that of England. The latest data between 2005-07 is indicated in Table 6 below:

Table 6 - Life Expectancy for England, Northwest and CECPCT

	Males	Females
England	77.7 years	81.8 years
North West	76.0 years	80.5 years
Central and Eastern Cheshire PCT	78.1 years	81.8 years

However there are very large differences within CECPCT. The summary on the following page shows the gap in life expectancy calculated at MSOA level for 2005-07.

- **13.5 years in Men**
  Range: 71.6 years East Coppenhall (C&N) to 85.1 years Wilmslow Town West
- **15.5 years in Women**
  Range: 77.9 years Central and Valley (C&N) to 93.5 years Wilmslow Town South East

The largest gap inside a borough is 14 years for women in Macclesfield

When 95% Confidence Intervals are calculated there is still a significant difference in males (7.9 years) and females (9.7 years) between the highest and lowest life expectancy.

To inform priority setting and to identify the geographical areas of concern regarding male and female low life expectancy and the factors that influence it, CECPCT has combined MSOA's into five equal groups based on the overall life expectancy. This approach has:

- created a local CECPCT 'spearhead MSOA group' which identifies those MSOA areas where there is a low life expectancy for either male or females whose poor health experience will be the focus of further attention and;
- enabled CECPCT, and its partners, to look at the various factors that influence life expectancy such as deprivation, poor lifestyles and access to services

Table 7 below identifies the CECPCT 'spearhead MSOA group' with male and female life expectancy.

MSOA Code	MSOA Name	Male Life Expectancy	Female Life Expectancy
E02003813	Middlewich West	78.8	79.8
E02003821	Sandbach South	74.3	80.0
E02003826	East Coppenhall	71.6	78.7
E02003827	West Coppenhall & Grosvenor	73.0	83.0
E02003828	St Barnabas	73.6	78.3
E02003830	Central & Valley	72.2	77.9
E02003832	St Johns	76.6	79.0
E02003833	Wistaston Green	78.1	79.5
E02003834	Alexandra	75.0	81.3
E02003839	West Nantwich	77.9	80.0
E02003868	Macclesfield Town East	75.5	80.9
E02003869	Macclesfield Town Bollinbrook & Ivy	77.4	79.5
E02003873	Macclesfield Town South	73.6	80.2
E02003882	Leftwich, Rudheath & Witton	75.3	80.0
E02003886	East Winsford	73.3	78.8
E02003887	North Winsford	75.6	81.2
E02003888	Winsford Central	73.6	78.5
E02003889	West Winsford	74.8	79.8

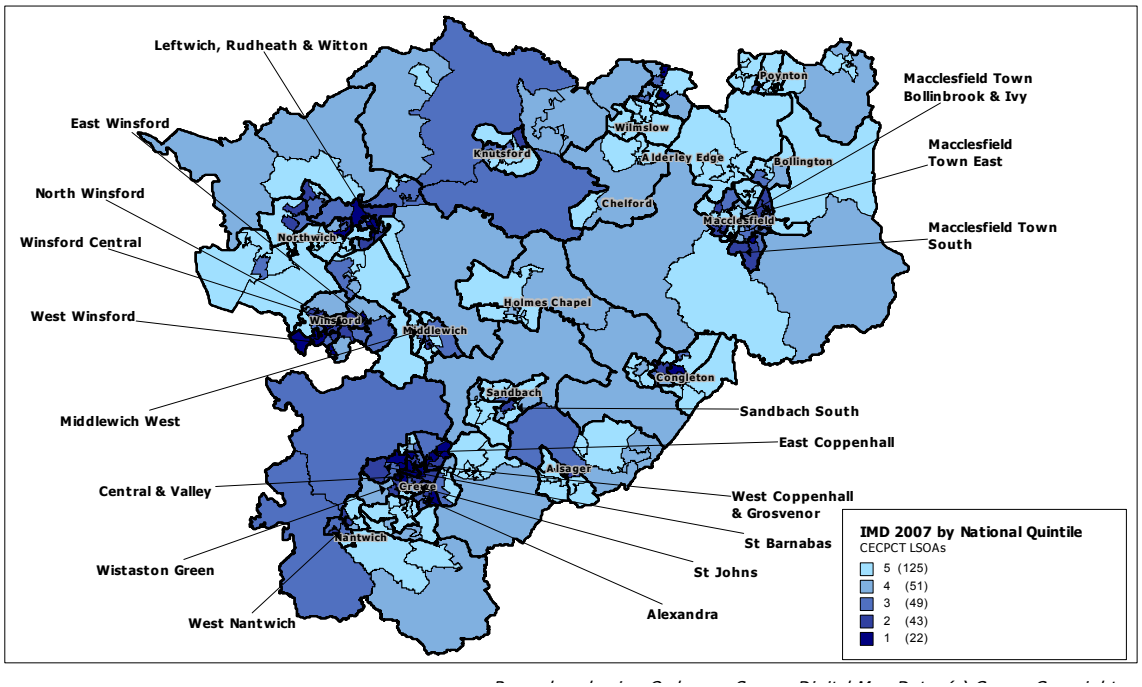
3.1.7. Patterns of Deprivation and Health Inequalities

Across CECPCT most of the local "town" areas have relatively less people affected by income deprivation than the national average, except in Winsford where it affects both children and older people and in Crewe where children are affected. More significantly,

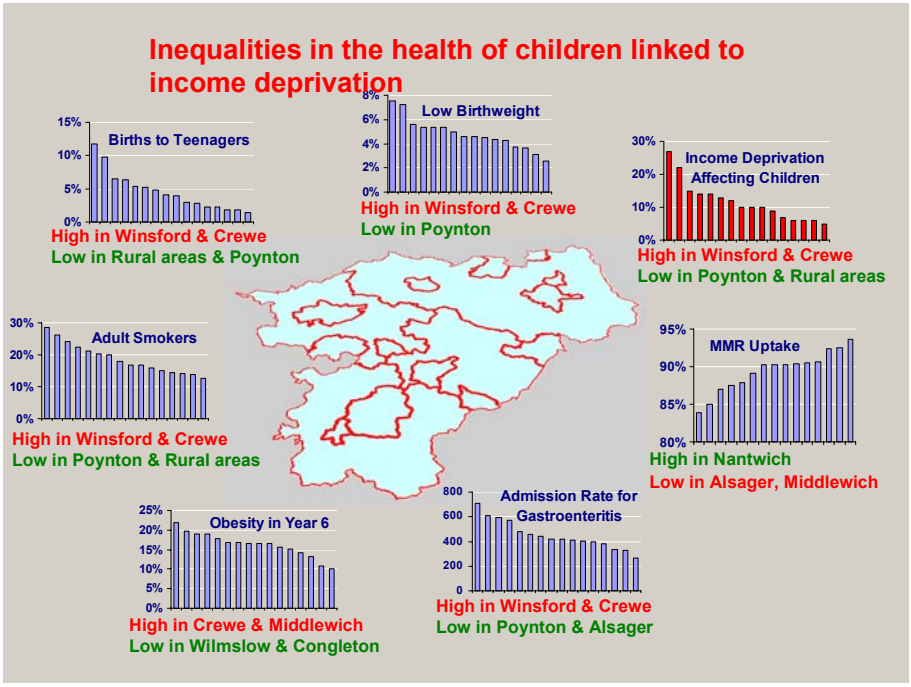
there are three fold percentage differences in income deprivation between our "town" areas. This contributes to poor health and health inequalities which are closely linked to life expectancy.

Central and Eastern Cheshire PCT LSOAs by IMD 2007 Quintile with Spearhead MSOAs labelled

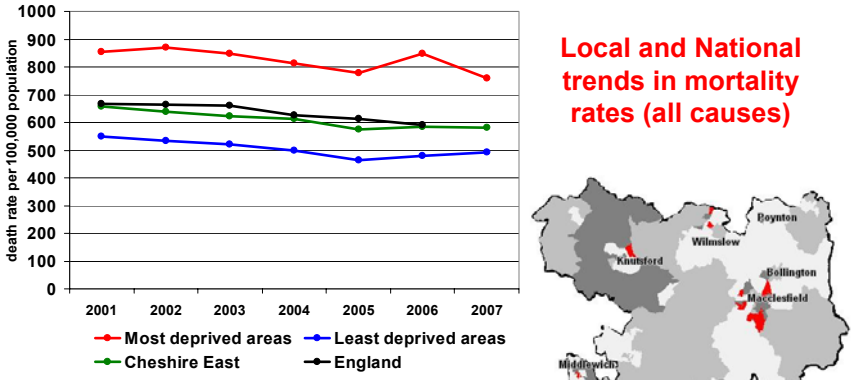
CENTRAL AND EASTERN CHESHIRE PCT LSOAS BY IMD 2007 QUINTILE, WITH SPEARHEAD MSOAS LABELLED



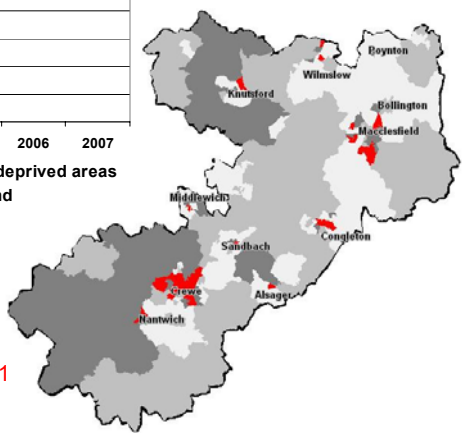
The link to variation in health (or factors that directly affect the health) of children is shown on the next page:



Whilst higher levels of deprivation are generally associated with a lower life expectancy and hence larger 'gap', MSOAs with low LE do have populations consisting of the most affluent. A review of mortality trends by deprivation quintile (undertaken for the new Local Authority area of East Cheshire) shows that whilst death rates are reducing in our most deprived 40% those in the least deprived 20% appear to be levelling off and may now be starting to rise. See illustrate below:



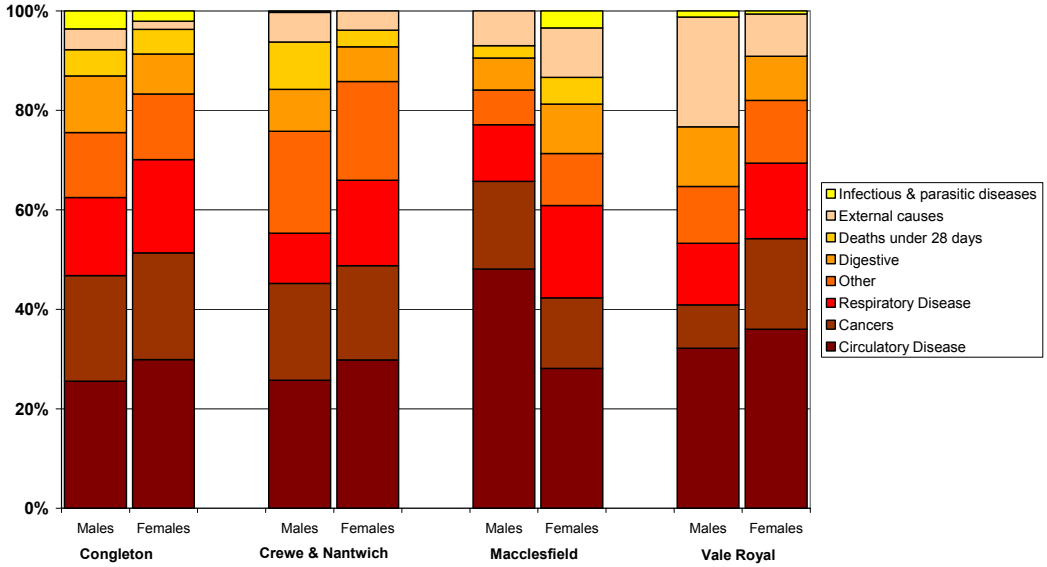
Local and National trends in mortality rates (all causes)



Most deprived = areas in the bottom 40% nationally = 701 (20%) of 3,591 deaths in East Cheshire in 2007

Least deprived = areas in the top 20% nationally = 1,329 (37%) of 3591 deaths in East Cheshire in 2007

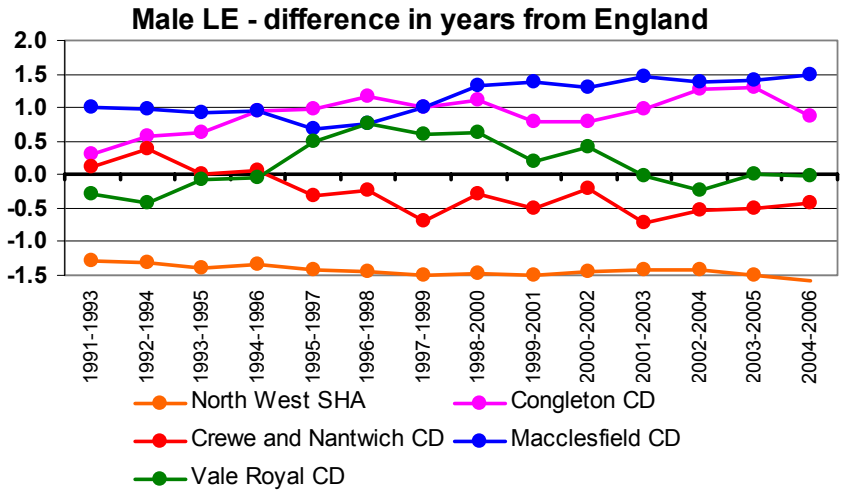
Life Expectancy gap between most deprived and least deprived quintile



As illustrated earlier Circulatory diseases (including coronary heart disease and stroke) and cancers account for around 37% and 26% of deaths respectively in Central and Eastern Cheshire PCT and are a major contributor to our gaps in life expectancy. If we are to reduce variations in life expectancy; the PCT and its general practices need to highlight and prioritise actions on the causes of ill health in the different towns and the various lifestyle risk factors that influence the occurrence of disease.

Reducing health inequalities for all groups is a priority for Central and Eastern Cheshire PCT (CECPCT). We intend to secure a sustained reduction in health inequalities, improve the health of all but improve the health of the worst off (as defined through life expectancy and poor health experience) faster.

The PCTs aim is 'to improve health to become comparable with the best in England and minimize the internal gaps in our health experience'. CECPCT has a higher life expectancy (LE) than England and the North West, although there are important differences between local authority areas. Two areas have a life expectancy for both males and females that is worse than that for England (Crewe and Nantwich and Vale Royal). Crewe and Nantwich have a relatively declining rate in men compared to nationally over a long period of time and a particular worsening in females over the last three to four years.

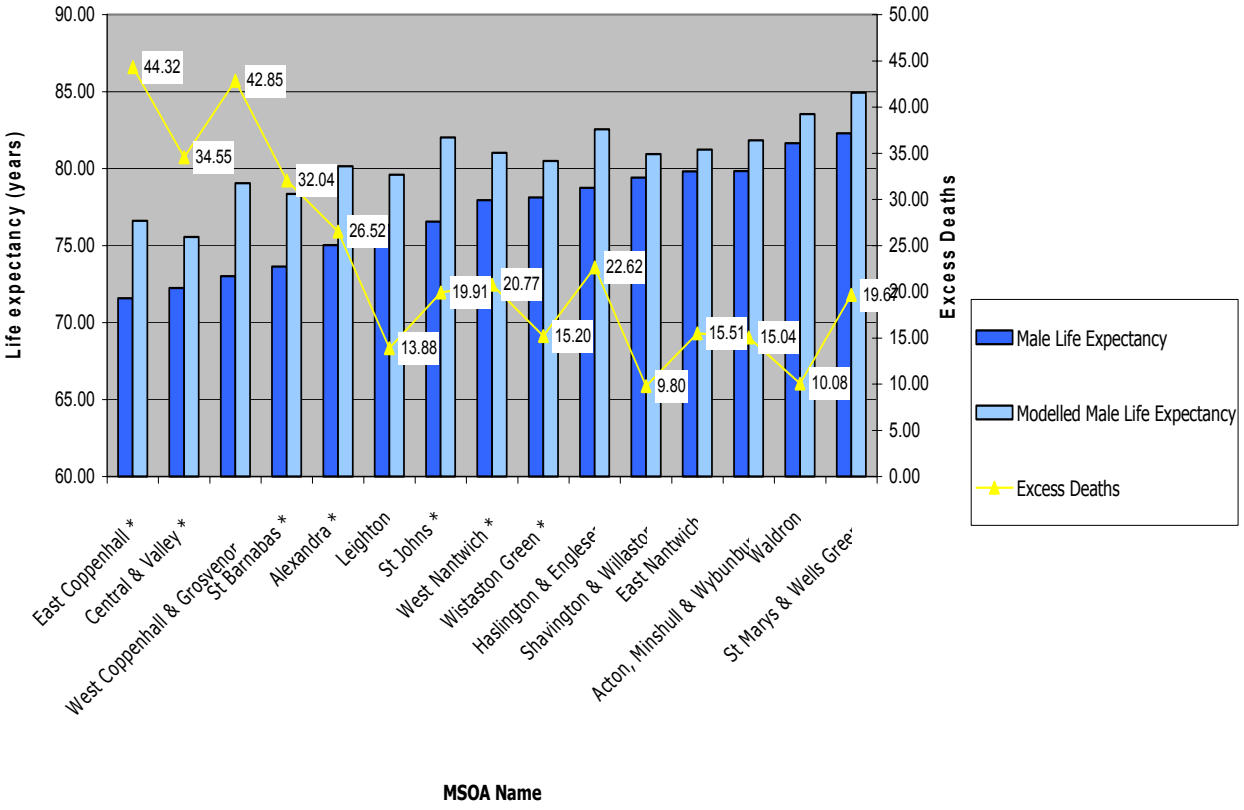


To improve life expectancy for men and women overall (from all groups – including black minority ethnic, gay, lesbian, bisexual, transgender, disabled, religious background and age) and to narrow the gap in life expectancy *targeted action* is needed *across the whole PCT*. Whilst the challenge to improve is most noticeable in the more deprived areas even the more affluent areas have substantial gaps in life expectancy and the most affluent have a static as opposed to reducing mortality rates.

The Graph overleaf is an example of the work being undertaken looking at improvements in life expectancy and avoidable deaths. If we improved the mortality experience of the bottom 4 life expectancy quintiles to that of the best we could improve the chance of 343 males over 3 years or 114 males per annum not dying prematurely across Crewe and Nantwich Borough.

'Avoidable deaths' have been defined by combining the number of 'excess deaths' from Circulatory disease all ages, 'excess deaths' from external causes all ages and 'excess premature deaths' from healthcare amenable cancers. The male picture reinforces the importance of focusing on the spearhead areas where the majority of lives can be 'saved' (e.g. 44 over 3 years in East Coppenhall).

Crewe and Nantwich MSOAs – Difference between male life expectancy 2005-07 and modelled male life expectancy to reflect prevention of avoidable deaths (*= local spearhead area)



3.1.8. Population Health and Drivers for Change

The following is a headline summary of health in the PCT area:

- Central and Eastern Cheshire Primary Care Trust (CECPCT) has the fastest growing ageing population in the North West.
- CECPCT has one of the highest life expectancy in the North West and a slightly higher life expectancy than the England average however this masks the gaps in life expectancy in individual towns.
- Linked to life expectancy and health inequalities Cardio Vascular Disease (CVD) and Cancer are the greatest cause of early death.
- Smoking is one of the highest contributors to morbidity and early death. CECPCT smoking rates are similar to the England average however rates are significantly higher in Crewe, Winsford and Northwich.
- Reported levels of binge drinking in CECPCT is higher than the national average, with levels reported as 23% higher in Crewe & Nantwich Borough. Hazardous drinking is significantly worse than England and the North West and averages 7th highest in the country. The cost of emergency admissions for alcohol are growing by over £1m per year.
- Current estimates of the prevalence of obesity suggest that 23.3% of the adult population of CECPCT are obese which is equivalent to the England average, with significant variation from town to town.
- In the CECPCT area more than one in five 4-5 year olds are overweight or obese and more than one in three 10-11 year olds are overweight or obese. This is significantly better than the national average.
- Breast feeding rates are lower than the national average and are much lower than those Primary Care Trust's (PCTs) with similar populations (60% v 77%).
- Uptake of vaccination in CECPCT is generally good however Measles, Mumps and Rubella (MMR) vaccination has been historically low over the past 10 years and has lead to sporadic outbreaks of disease, with a recent significant outbreak of measles.
- There is a high rate of teenage conception with approximately 50% leading to abortions. Crewe & Nantwich has the highest rate of teenage pregnancy at 43.9 per 1000.
- The increase in the number of older people and those with health conditions that reduce independence will result in a proportionate increase in the number of fallers (26,040 by 2011) and associated fractures (1,302 by 2011) in those aged 65 and over.
- The numbers of emergency ambulance call outs due to a fall are significant (6332 in 2007). The cost to the PCT for ambulance call related to falls is approximately £2 million - £315 per fall.

- Within CECPCT 17% of the population have a limiting long-term illness which will increase roughly in line with the size of the ageing population

This section on population health has painted a picture of the make up and health of our population. The local health needs assessment have identified the following 3 key issues:

1. Rapidly ageing population

The size of the population with a limiting long-term illness (long term condition) will increase in line with the size of the ageing population

⇩

This means:
Higher CVD rates with stroke as a particular issue
Higher rates of dementia
High rates of falls
Higher rates of cancer

⇩

Higher requirement for intermediate care services
Increasing reliance on Primary Care and community services
Need for improved care pathways

⇩

In order to reduce long term illness towards middle and older age emphasis needs to be placed on keeping the population healthy and improving lifestyles particularly around action to reduce levels of obesity, reduce tobacco harm and reduce alcohol harm and increase physical activity and healthy eating habits.

2. Wide gaps in Life Expectancy between town areas

CVD and Cancer are the greatest cause of early death

⇩

This means:
Significantly worse hazardous drinking rates than the national average
High rates of smoking in some town areas

⇩

High impact urgent care services

⇩

Reduce the gaps further emphasis on working with partners on improving lifestyles and improving primary prevention in primary care practices.

3. Health Inequalities are having a significant impact on Health

Lower than expected rates of breastfeeding
Lower uptake of Measles, Mumps and Rubella Vaccination
High teenage conceptions

⇩

This leads to a need to: Improved maternity and children's services to increase health outcomes
Develop primary care services

These Key issues together with views from patients, public, staff and assessment of key areas of service development are the drives for change in terms of influencing the strategic direction of the PCT and its prioritized work programmes.

The following diagram shows the link between key health needs and strategic goals:

KEY ISSUE	STRATEGIC GOAL	CHANGE PROGRAMME
Ageing Population ⇩ Increase in long term condition ⇩ Higher CVD Rates with stroke particular issue Higher rates of dementia Higher rates of falls Higher rates of cancer	Develop High Quality Primary Care services Bring Care Closer to Home Develop the right urgent care services in the right place at the right time Improve Equality of access to good health services for all our population Develop comprehensive Care Pathways Quality of care is delivered across all our commissioned services	CP1 Lifestyle CP2 Urgent Care Modernisation CP3 Intermediate Services CP4 Deliver Comprehensive care pathways for Long Term Conditions CP6 Improving Dementia Care CP7 Redesign of Stroke Services CP8 Developing Community hospital project CP9 Improve Cancer Outcomes CP10End of Life Care CP11 Primary Care Development CP14 Reduce CVD & Improve Cardiac Services CP15 Transforming Community services CP17 Dignity & Respect

KEY ISSUE	STRATEGIC GOAL	CHANGE PROGRAMME
Wide gaps in Life Expecta between town areas ⇩ Significantly worse hazardous drinking rates Higher rates of smoking in some town areas	Develop High Quality Primary Care services Develop the right urgent care services in the right place at the right time Improve Equality of access to good health services for all our population Develop comprehensive Care Pathways Quality of care is delivered across all our commissioned services	CP1 Lifestyle CP2 Urgent Care Modernisation CP9 Improve Cancer Outcomes CP11 Primary Care Development CP14 Reduce CVD & Improve Cardiac Services

KEY ISSUE	STRATEGIC GOAL	CHANGE PROGRAMME
Health Inequalities are hav a significant impact on Health Lower than expected rates of breastfeeding Lower uptake of Measles, Mumps and Rubella High teenage conceptions	Develop High Quality Primary Care services Bring Care Closer to Home Develop the right urgent care services in the right place at the right time Improve Equality of access to good health services for all our population Develop comprehensive Care Pathways Quality of care is delivered across all our commissioned services	CP1 Lifestyle CP2 Urgent Care Modernisation CP5 Deliver Improved outcomes for maternity & children's services CP8 Developing Community hospital project CP11 Primary Care Development CP12 Modernising Healthcare at Styal Prison CP13 Implementation of Sexual Health Strategy CP14 Reduce CVD & Improve Cardiac Services CP15 Transforming Community services CP17 Dignity & Respect

3.2. Capturing Insights of Patients, Public and Staff

Engaging with patients and the public is one of the PCT's 'Golden Threads'. The PCT believes that the experience of patients and the views of the community we serve are an essential component of commissioning high quality care.

The PCT has a good track record of community and patient engagement and will seek to build on this to improve what we do. Examples of work we have done to capture the insights of patients and users include:

- Discussion with group of community representatives on determining the strategic priorities of the PCT. This was supplemented with a stakeholder bulletin survey seeking views on what the priorities should be. This process identified the following as areas as priorities:

    - Respect and dignity
    - Cancer Treatment
    - Physiotherapy Assessment following a Stroke
    - Waiting Time at A&E
    - MMR Immunisation
    - Mental Health—Dementia
    - Breastfeeding
    - Coronary Heart Disease - Controlled Blood Pressure

- Community Panels set up for each of our primary care developments. Membership for the panels is drawn from patient representatives at the GP practices covered by the developments. The Panels provide reference groups for the PCT to test proposals and developments with prior to formal consultation;

- The PCT has patient representatives on standing groups of the PCT, for example Dignity and Respect, Healthcare Governance and risk and groups looking at specific service developments such as the urgent care centres and community hospitals.

- There has also been engagement with the public, staff and community groups on the race, gender, disability schemes and most recently on the Single Equality Scheme. People from local black and minority ethnic groups, gay and lesbian groups and migrant worker groups were all involved in the consultation process. This engagement has continued and has recently involved Bangladeshi women, deafness support and the disability information bureau in Macclesfield. Comments received have been developed into action plans to develop and improve services to meet the individual needs of patients

The PCT acknowledges that it can strengthen its approach to community and patient engagement. The following are the key areas to be addressed to improve our community and patient engagement:

- Build - up a Community Reference Group – a cross section of the local population to act as a sounding board for the PCT and provide input on the development of strategic priorities for example.;

- Establish a cycle of involvement linked to the business cycle of the PCT;

- Increase the ways in which the community can interact with the PCT – for example, through the website and the introduction of a stakeholder bulletin;

- A more systematic approach to patient experience: link activity with priorities and ensure we can demonstrate that we make use of the feedback we receive and demonstrate the influence this has on the commissioning of services;

- For each of our change programmes identified there will be a communications and engagement plan to ensure these are embedded in our priority areas and reflect their status as 'Golden Threads';

- Ensure we use the feedback from the national patient surveys – GP, 18 weeks and acute etc. to identify areas for improvement; and\

- Ensure our approach to engagement is inclusive and we reach all sections of the community including seldom heard groups such as young people and black and minority ethnic groups.

The PCT will enhance the opportunities for patients and public to be involved with the PCT and will seek at all times to be innovative and adopt good practice. We will support people to be involved in the PCT by having a transparent policy on involving patients. This will cover expenses and provision of training.

A system – wide approach to engagement will be developed by working with partners including providers, LiNKs, the new Cheshire East and Cheshire West Council, voluntary/third sector and other public sector partners. This will ensure we avoid consultation overlap and duplication as well as using the expertise of others to build capacity and capability in the PCT.

The PCT will ensure providers are routinely taking account of patient experience and that this is reported to us through contract monitoring. Providers will be asked to demonstrate how they use feedback from patients to improve the quality of care.

A Patient Experience Group will be established to act as a focal point for overseeing all patient experience activity, developing our approach to seeking patient views and for monitoring how effectively we are using the feedback we receive. The Group will also develop the expertise in tools and techniques to ensure the PCT adopts good practice in seeking patient engagement.

The PCT's integrated Communications and Engagement Plan describes in details the actions we will to take to improve and enhance how we deliver these functions and how they support the delivery of the PCT's priorities.

3.3. Our Current Performance and Quality

How we manage the delivery of our objectives:
We have developed three systems to support organisational effectiveness and manage performance monitoring:

- **A management plan**
  ('How to Guide') has been developed for each area of our 54 roles and functions. These plans detail the way each role and function is delivered and set out the action to be taken to develop competence. The plans support the WCC commissioning competencies and will build into the annual organisational development plan.

- **Project plans**
  As part of the management planning process we have identified a number of key 'Change Programmes' (initiatives) which are crucial to achieve our overall vision and goals. Each key 'Change Programme' has an agreed project plan. Within the project plan the action plans are monitored on a monthly basis by our Leadership Team.

- **Knowledge and Performance Management**
  During 2009/10 we will be establishing a Directorate of Knowledge and Performance Management. This will enable us to concentrate on the development of our business intelligence and to reinforce our delivery management structures to ensure that our strategic objectives are achieved. This will fit neatly into our existing governance and reporting structures.

Performance, Outcomes and Activity

- **Performance against local and national targets (including Standards for Better Health)**

We are committed to regularly reviewing our performance against all national and local targets, vital signs, quality and outcome measures. We recognise that there over 350 indicators which we need to manage.

All local and national targets (vital signs) are within the Operational Plan 2009 -10 [insert link to revised Operational Plan] to ensure that monitoring is captured and tracked regularly. The governance of performance monitoring is through the Leadership Team (executive and senior managers which meets every two weeks) and Performance Committee (sub committee of Board with Executive and Non Executive Directors representation which meets on a monthly basis) using information from the performance management system and detailed analysis of risk areas.

Performance data is also used to inform and manage the contract monitoring monthly processes for activity, quality and finances for the two major acute service providers (MCHFT, ECT), the Partnership Trust (CWPFT) and the PCT Community Services (CECH).

In 2007/8 we achieved all our major targets. However, there are some targets which we have continued to struggle to achieve (or our performance is below our expected level). These challenging performance targets have been reflected in our World Class Commissioning outcome areas for next 5 years. They include mental health services for dementia patients, cancer mortality, breastfeeding initiation rates, alcohol, CHD mortality, treatment of stroke patients and urgent care.

We have also challenged ourselves as part of the delivery of our strategy to improve dignity and respect. This has become one of our strategic goals as well as being a priority outcome.

The Assurance for the Board of the quality of compliance is monitored through the Governance and Audit Committee. The annual declaration of compliance across all standards is discussed at informal Board meeting (seminar) before the formal agreement of the full Board. We are separating compliance for our own directly provided services (CECH) and the Commissioning functions. This is to support CECH to become a self-managing arm's length unit in line with Transforming Community Services

2008/09 Acute Activity Performance against Plan

A number of Acute Providers have shown increased activity against plan. The contract with Mid Cheshire Hospitals Foundation Trust overspent for 2008/09. It accounted for the largest single over-performance, although other Trusts also over-performed.

MCHFT over-performed significantly in non elective work. The MCHFT and the PCT continue to work together to understand the issues being encountered within Emergency Care with a full review in 2009/10 of the services offered and the methods of coding and counting being used by the Trust

In general the PCT is seeing elective activity increasing due to increased GP referrals, the increase in activity to meet the 18 week referral to treat pathway and the introduction of new services such as ophthalmology services for patients with Age Related Macular Degeneration.

Quality of Service – Performance

All main provider contracts have significant quality schedules within them for 2009/10 covering dignity challenge, essence of care, patient experience, infection rates, clinical audit, patient safety, risk, complaints, as well as clinical outcomes, mortality rates, re-admission rates etc. We have also included quality themes for each monthly contract monitoring meeting (with clinicians present) e.g. Maternity services, Smoking Cessation, Orthopaedic services etc. These elements of the quality contracts are supported through a Clinical Quality Team that 'shadows' each provider to build a detailed knowledge base of all elements of quality. A quality summary report is provided each month to challenge the provider Trusts. In future quality monitoring will follow our CASE approach to quality monitoring:

C are - the patient experience must be positive. Patients should be treated as individuals and afforded dignity and respect

A ccessibility - Patients must be able to readily access services. Services must be designed to meet the different needs of communities and individuals

S afety - it is vital that we protect our patients and staff, and manage all risks effectively,

E ffectiveness - it is important that our interventions result in positive outcomes, and that our work is cost-effective. Services must co-ordinate with other health and social care services to ensure patients receive seamless care

MCHFT was a pilot for the Advancing Quality Project, which is an initiative by NHS North West, in conjunction with Premier Health in the USA, to look at the clinical quality of services being provided in our hospitals. Mid Cheshire Hospital Foundation Trust has been collecting data since April while East Cheshire NHS Trust is in the 2nd wave and is now starting data collection.

There are 4 topics covered by the project, Heart Attacks, Hip & Knee Replacement, Heart Failure and Community Acquired Pneumonia. Information being collected has been chosen by clinicians on the basis that it will accurately reflect the true quality of care being provided. This will also include diversity information.

We are actively involved in the project and will be monitoring its implementation and using the results as part of the commissioning process to ensure that both hospitals are providing the best possible care to the residents of Central & Eastern Cheshire.

Risk Management

Risks are identified by all members of staff, patients or public and are reported on a bi-monthly basis to the Healthcare Governance and Risk Committee. The key strategic risks to the organisation are identified by senior managers and directors which, along with operational risks, formulate the basis of the risk register and are on the Assurance Framework via Performance Accelerator. A control mechanism is identified and the PCT Board seeks assurance that the control works. The Keele modified Australian/New Zealand risk methodology is used for risks looking at the "likelihood" of the risk occurring and the "consequence" should it happen, resulting in a score to prioritise extreme, high and moderate risks.

Risks are mapped utilising the Assurance Framework, in compliance with national guidance. Directors and Senior Managers identify/demonstrate on the Assurance Framework that controls are in place and assurance that the controls are effective. The Assurance Framework is reviewed by the Leadership Team and the Governance and Audit Committee, which reports directly to the Board. The High Level risks are reported to the Board on a quarterly basis.

Current Organisational Challenges

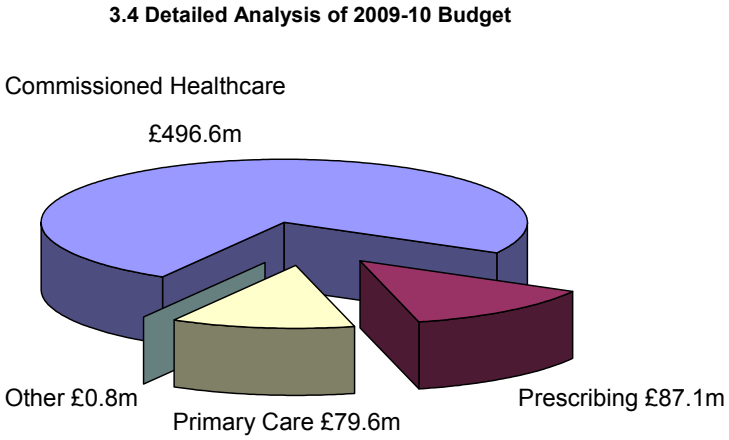
The Panel assessment in November 2008, with regard to the WCC competencies and the on-going review of organisational effectiveness have highlighted a number of key areas which will be addressed in a review our management structure and operational arrangements, these areas are:

- Board Development – the need to utilise the newly procured WCC Board Development programme to meet the needs arising from the WCC assessment.
- Communications and engagement – the implementation of our newly agreed Communication and Engagement Plan.
- The production of intelligence to support effective management. We recognise the need to fully integrate local initiatives with the Contracting Information Support Services (CISSU) and the proposed North West Intelligence consortium.
- The development of a local Health Economist function to ensure we are able to better match investment to outcomes.
- The development of effective joint management and commissioning arrangements with our new unitary Local Authority.
- The development of a more focussed approach to 'delivery' ensuring that proposed changes happen and are sustained.
- The implementation of Transforming Community Services
- The ongoing development of the 3 PBC clusters and the way in which the PCT adapts and utilises capacity to be out ward facing

The PCT intends to move all 5 level 1 WCC competencies to at least a level 2 and ensure all level 2's are maintained and improved.

3.4. Expenditure on Commissioned Activity

The majority of expenditure (and associated activity) is within primary and secondary care as shown below:



3.5. Provider Landscape

The health system in Central and Eastern Cheshire is complex, primarily because many of the Towns that make up the area do not have any affinity with any single major City conurbations. This pattern is reflected in the specialist and tertiary service configuration with our population accessing services in Manchester, Liverpool and Stoke-on-Trent.

This situation is further complicated as we border two other NHS SHA regions (East Midlands and West Midlands). We therefore have complex Clinical networks. Our two local NHS trusts do not have natural partnerships, but have established collaborations in some areas e.g. Diabetes and Pathology. We have traditionally been part of the Cheshire and Mersey grouping of PCTs, however, much more of our work relates to Greater Manchester. It is important to recognise that we do not (on the whole) share the same health needs or social characteristics as the rest of the North West (as identified in 'Healthier Horizons' for the North West 2008).

Provider Trusts (Acute Care)

The majority of acute Healthcare is provided by two Acute trusts – Mid Cheshire Hospitals Foundation Trust (MCHFT) and East Cheshire Hospitals Trust (EHCT).

MCHFT is a Foundation Trust which aims to grow its share of the acute services market. Whilst ECHT is a small District General Hospital based Trust, seeking to be a Foundation Trust

Both Trusts face similar challenges which affect the health economy:

- The effect of greater 'specialisation' for example the impact of the implementation of the Cancer Improving Outcome Guidance (IOGs).

- The impact of the proposed significant changes as a result our key strategic 'Change Programmes'. Both Trusts are likely to be seeking to be the provider of both urgent care and intermediate care services; however both 'Change Programmes' are subject to procurement processes.
- The impact of the development of Payment by Results (PbR) and our initiative to improve the commissioning of Non-PbR services. Over 25% of the Trusts' income is outside PbR. We are committed to improve its commissioning arrangements for these services.
- The future management arrangements of our provider services.
- The impact of Practice Based Commissioning (PBC).

Some specific challenges for MCHFT include:

- The systems inability to effectively forecast activity – currently 08/09 activity is significantly over plan.
- The impact of the potential re-provision of the Victoria Infirmary Northwich (Strategic Goal 4 – Care Closer to Home).
- The future organisational arrangements for East Cheshire Hospital Trust.
- The need for the Trust to continue to develop effective clinical networks including the full roll out of the Map of Medicine software to support the use of agreed care pathways in Primary Care.

Some specific challenges for ECHT include:

- The impact of the potential re-provision of the Knutsford Hospital and the Congleton War Memorial Hospital.
- The future management arrangements of our provider services – ECHT in particular are keen to explore the potential for vertical integration.
- The implications of the Trusts FT bid failing. We are currently exploring the strategic implications for ECHT with the SHA.
- The need for the Trust to continue to develop effective clinical networks.

Provider Trusts (Mental Health)
Cheshire and Wirral Partnership foundation Trust (CWPFT) is a successful Mental Health Trust being one of the first in the country to achieve FT status. The key challenges for the Trust and therefore the health economy are:

- The need to demonstrate equity of provision across the population served (as part of our strategic ambitions).
- The impact of PBC.
- The implications of not having PBR for Mental Heath Services.
- The impact of the Local Government Review Changes particularly if the two new LA's take different approaches to the commissioning of Mental Health and Learning Disability services.
- Limited choice for patients (only provider of Secondary Care in the area).

PCT Provider services
We commission services from our 'Provider Arm' to provide a wide range of community based healthcare services in various settings such as GP surgeries,

health centres, clinics and patients' homes. Circa 1800 people are employed in the Provider 'Arm', with more than 1600 providing community-based healthcare, involving a broad range of nursing, medical and therapy services.

In line with the DoH Operating Framework for 2007, our Provider Services was set up as an arms length managed organisation (ALMO) from 1st April 2007. On 1st April 2008 the Provider entered a 12 month 'autonomous period of operation' becoming 'Cheshire East Community Health' (CECH) with a Shadow Board and agreed plans to develop separate governance arrangements. During this ALMO period, the CECH Shadow Board is strengthening its organisational arrangements in readiness for separation whilst assessing the viability of various organisational models for the future provision of community health services.

The PCT has begun the changes required under 'Transforming Community Services' (TCS), which is central to delivering the vision for Primary and Community Care set out in the NHS Next Stage Review.

The TCS Programme will see CECH (our main provider of community services) move its relationship with the PCT to a purely contractual one. TCS will require providers to consider what type(s) of organisations would best meet the future needs of patients and local communities, and how change can be managed to support the transformation of services to patients.

Three key elements feature in the TCS programme of change:

- The development of a Quality Framework for community services, giving a high priority to enabling the transformation of clinical practice by disseminating best practice and investing in developing clinical and leadership skills;

- Transform the commissioning of community services through World Class Commissioning and provide commissioners with the tools they need to drive service improvement i.e. a new standard contract, guidance on costing and pricing, information and metrics; and

- The need to ensure that the organisations providing the community services are fit for purpose. Organisations are needed which enable and empower front line staff to innovate and free up their time to care for patients.

The following table highlights the proportion of income received by our four main providers compared to the total contracted income:

	CECPCT Contract Income('000)	Total Contract Income ('000)	Proportion %
CECH	45,162	45,162	100
ECT	72,175	84,437	85
MCHST	110,361	117,202	94
CWPFT	31,694	98,491	32

Independent Contractors

General Practices - We are served by 52 GP practices. We have only one single handed practice. We have the lowest number of over 65 year old GPs still practising. However our practices do face some common challenges:

- The potential impact of changes to the Minimum Practice Income Guarantee (MPIG).
- The effect of the PCTs Urgent Care Modernisation Change Programme (CP2).
- The development of Practice Based Commissioning (PBC).
- The demoralisation of the workforce.
- The increase in the drive towards specialisation.

Pharmacies – We are served by 90 Pharmacies in the PCT area and all have an NHS contract.
The key challenges for our pharmacy contractors are as follows:

- Our desire to ensure a common range of services across the PCT area (including the roll-out of a comprehensive Minor ailments scheme).
- The impact of the pharmacy White Paper.
- The impact on community pharmacy of the development on the new Medical centres in, Knutsford, Congleton, Northwich, and Middlewich.

Optometry providers – We are served by a total of 64 independent Optometry Contractors.
Key challenges are as follows:

- The continued development of the Diabetic retinopathy screening programme.
- The impact of the new General Ophthalmic Services (GOS) contracts
- The implementation of practice premise inspections on a 3 year rolling programme

General Dental Practitioners - We are served by 90 dental practices; across these practices there is a variety of NHS dental contracts.
Key challenges are as follows:

- Uncertainty regarding the continuation for restricted Personal Dental Service Agreements e.g. those contractors who only see children and have a three year agreement which is due to end in March 2009.

- Practice premises that could be deemed unfit for purpose e.g. fail to meet the Disability Discrimination Act (DDA) standards or decontamination requirements.
- Loss of 'Goodwill' from the sale of their practices, should the commissioners consider it inappropriate to continue with an NHS contract at that particular practice.

Local Authority (LA) - Local Government in Cheshire has been the subject of a Local Government review and reorganisation. The new Local Authority – Cheshire East Council was established on 1st April 2009. We are working with the LA to agree the establishment of a Joint Commissioning unit. We will also be working with the new LA to determine the arrangements for integrated provision and public health and wellbeing delivery. The known key challenges for the new LA are as follows:

- Financial position.
- The impact on planning and delivery of the new LA.
- The continued difficulty in recruitment for LA provider and commissioned services (see below).

Local Area Agreements (LAA)

The PCT is also a partner in the Local Area Agreement. Following individual discussions with partners through the Cheshire Partnerships Framework and GONW it was agreed that a "severable" transitional LAA, to include disaggregated targets where appropriate, for East and West Cheshire for at least 2008/9 would be agreed that would also set a longer-term direction of travel for 2009-11 for the new unitaries and their partners. This required an important balance to be struck between planning for a longer-term horizon whilst ensuring the two new local authorities and their partners are not hidebound by inappropriate targets set by their predecessors.

Key local target areas for health:

People killed or seriously injured in road traffic accidents (DfT DSO)
Obesity in primary school age children in Year 6 (DCSF DSO)
Achieving independence for older people through rehabilitation/intermediate care (DH DSO)
Healthy life expectancy (at 65)
Under 18 conception rate
Substance misuse by young people
All-age all cause mortality rate
Mortality rate from all circulatory diseases at ages under 75 (DH DSO)
Stopping smoking

Independent Sector (IS) providers - We have contracts for service provision with a number of Independent sector providers. The key challenges for our Independent Sector (IS) providers are:

- The impact of the extension of Patient choice – patient feedback on IS services continues to be very positive.
- The development of local care pathways and the full implementation of 'Map of Medicine'.

- The impact on the traditional private sector of reduced waiting times.

Other key Providers including third sector provision - We have a range of contracts with Nursing homes, and other providers for community services, the key issues for these providers are as follows:

- The impact of recruitment difficulties (one existing community care provider is recruiting from Eastern Europe only).
- The impact of our strategy to develop commissioning from third sector organisations.
- The impact of Local authority (and potentially PCT) boundary changes.

3.6. Financial Position

- **2006/07 Financial Year**

We were formed as a PCT on 1 October 2006 from the merger of two predecessor organisations (i.e. Central Cheshire Primary Care Trust c. £325m and the Eastern Cheshire Primary Care Trust c. £250m).

For the financial year 2006/07, covering the whole twelve month period from 1 April 2006 to 31 March 2007, as a new PCT we reported a small surplus of £630,000 on a turnover of £575m or 0.1%. However, this small surplus was only generated following delivery of an ambitious in year Recovery Programme of c. £10m which was devised, and implemented, post formal establishment.

In addition to being financially challenged in our first year, it also was clear that the two predecessor PCTs were funded at different levels to target level, as calculated by the Department of Health.

	Distance from Target [Using 2007/08 Allocation]	
Central Cheshire PCT	- £10m	- 3.0%
Eastern Cheshire PCT	+ £17m	+ 7.3%
"New" Central & Eastern Cheshire PCT	+ £7m	+ 1.2%

- **2007/08 Financial Year**

For the financial year 2007/08, covering the twelve month period from 1 April 2007 to 31 March 2008, we reported a surplus of £1,007,000 on a turnover of £582m, meaning the surplus equated to approximately 0.2% of turnover. This reported surplus being in line with the figure previously agreed with the Strategic Heath Authority.

Unlike many PCTs, we were not in a position to lodge any surplus monies with the SHA over and above this declared balance.

- **2008/09 Financial Year**

For the financial year 2008/09 the PCT is reporting a small surplus of £1,007,000 (i.e. similar to surplus for 2007/08). However, not included within this position are a number of disputed invoices with East Cheshire totalling £1.7m. The reported surplus equates to 0.2% of turnover (£620m).

- **PCT baseline funding, target funding and distance from target**

The Department of Health allocates monies to PCTs based on a funding formula.

As can be seen from the table on the previous page, for 207/08, the PCT received circa £7m more than its fairshare (i.e. over target).

However, during 2008/09, the impact of the new Allocations Formula became clear.

As can be seen from the table below, the impact of the new formula was to reduce the PCT's "over target" income, from £7m in 2007/08 to £3.7m in 2009/10.

However, similarly, to previous years, the PCT has continued to receive the lowest rate per head when using crude population, in the North West (i.e. £1427 per head compared to a regional average of £1675).

REVISED NATIONAL FORMULA FIGURES

REVISED NATIONAL FORMULA FIGURES 2009/10 AND 2010/11

ALLOCATIONS :-		**2009/10**	**2010/11**
Recurrent Baseline allocation (£000's)		645,100	679,543
National Target Spend (£000's)		641,337	677,116
Distance from Target(DFT) :-	Over target (£000's)	3,763	2,427
	Over target %	0.6%	0.4%
POPULATIONS :-			
CECPCT Crude Population		452,016	454,786
CECPCT Weighted Population		417,366	421,278
Allocation per Head (£'s):-	CECPCT Crude	1,427	1,494
	SHA Average Crude	1,675	1,758
	Highest Crude- Liverpool PCT	2,031	2,137
	Lowest Crude - CECPCT	1,427	1,494
	CECPCT Weighted	1,545	1,613
	SHA Average Weighted	1,522	1,597

As can be seen, using crude population rather than weighted, if the PCT was funded on par with Liverpool, which has virtually identical numbers of persons, we would receive an additional £273m annually. The funding difference is designed to target the relative needs of the local population but they do lead to a number of local challenges, especially where all PCTs are required to provide

universal NHS Services (NICE guidance etc) and are subject to national tariffs and programmes (i.e. PbR, QOF and A4C).

- **The impact of funding to General Practice level**

In order to stimulate Practice-based Commissioning (PBC), during 2008/9 we have endeavoured to use the allocation tool provided, which is different to the PCT funding formula, in order to allocate monies directly to Practices.

Using the 2008/09 Recurrent Allocation (c. £602m), and our published Budget Book, it has been possible to allocate approximately 50% of expenditure directly to Practices (i.e. Payment by Results activity and Prescribing). However, it should be noted that Non Payment by Results activity, Specialist Activity, Learning Disabilities and a number of other areas, remain apportioned (c. £300m). Therefore, whilst initial results would indicate variations in the region of only +/- 10% for individual Practices, these disparities become greater when reported at a Cluster level, as outlined above:

Actual Allocation v Capitation Allocation	
	Variation £m
Macclesfield Cluster	+ 3.5
South Cheshire Cluster	+ 3.5
Vale Royal Cluster	- 7.0

What is effectively demonstrated, is that the Macclesfield and South Clusters still spend in excess of its fair share allocation, (although this is potentially under-estimated in the table above due to the level of apportionments), and that further work is required, both internally and externally with Providers, in order to refine this level of analysis.

Local Government Reorganisation

Cheshire East Council became effective on 1 April 2009. It took over responsibility for all local government services from the former boroughs of Crewe & Nantwich, Congleton and Macclesfield, and half of Cheshire County Council.

Cheshire East has a population of 358,800. The age structure of Cheshire East is slightly older than that of England & Wales and 17% of the population are under 14; 18% are aged 65 or more and the number of people aged 85+ is expected to double between 2006 and 2026.

The financial scenario for local government is challenging and this is likely to be the position for Cheshire East. Elected Members and officers are working together to develop the financial scenario for the new authority and to build service structures which can be afforded within available resources.

The final budget and council tax levels were set at the full Council meeting in February 2009.

Despite the intention to continue joint planning and commissioning, during 2008/09, work has been difficult to plan 'long-term' due to uncertainty and lack of identified officers able to commit resources until appointments were made. The position continues to improve and the PCT will be maximising the opportunity of working with both Cheshire East and Cheshire West and Chester City Council Local Authorities in the near future.

3.7. National and Regional Drivers for Change

3.7.1. National Priorities

In developing our Strategy we have reviewed the priorities identified within the Darzi report *'High Quality Care for All'* and the NHS Northwest response to this report *'Healthier Horizons'*.

A focus of the Darzi report was about improving the quality of services and making sure people have greater influence and control over their health and healthcare. Specifically:

- Creating an NHS that helps people stay healthy through comprehensive wellbeing and prevention services, better partnership arrangements, CVD screening, workplace schemes and family support.
- Creating a more responsive NHS through extended GP choice, everyone with a long-term condition having a personalised care plan and guaranteed access to clinically cost effective drugs.

3.7.2. Regional Priorities

The NHS North West's response to the Darzi review identified the need to address inequalities in life expectancy driven by unhealthy lifestyles. A number of priorities within the North West are relevant to Central and Eastern Cheshire:

Staying healthy:
(Linked to all 9 Goals. Linked to Change Programmes – 1, 8, 9, 11and 14)
Address CVD mortality and screening, implement the North West Cancer Plan, reduce the impact of alcohol, deliver social marketing solutions and continue to address tobacco control.

Children:
(Linked to all Goal 1 - Children. Linked to Change Programmes – 1, 5, 11 and 15)
Tackle impact of inequalities on children and strengthen focus on children and young people through commissioning.

Urgent Care:
(Linked to all Goal 5 – Urgent Care. Linked to Change Programmes – 2, 3, 8 and 11)
Develop streamlined and integrated services across pathways and develop intermediate care models.

Planned Care:
(Linked to all Goal 9 – Elective Care. Linked to Change Programmes – 16)
Ensure a range of good quality providers is available to all, increase personalised care, implement evidence-based clinical pathways and improve accessibility.

Long-Term Conditions:
(Linked to all Goal 2 – Older People. Linked to Change Programmes – 4, ,7 ,8, 11 and 17)
Put patients in charge of their care and improving coordination of care, improve pathways to take account of co-morbidities and use care plans to reflect this.

Mental Health:
(Linked to all Goals 4,5,6 and 7. Linked to Change Programmes – 1 and 6
Recognise mental health and prevention, including among young people.

End of Life:
(Linked to all Goal 2 – Older People. Linked to Change Programmes – 10 and 17)
Ensure integrated commissioning arrangements are in place, improve the standard and consistency of care to support patient's and carers needs.

3.8. Equality and Diversity

We recognise that some people do not get an equal chance in life and that this can affect their health. Our foremost aim is to promote equality and diversity to help to close the gap in health inequalities. We also know that people do not fit into neat categories. Indeed some people present with multiple characteristics. In recognition of this we have developed a holistic view of equality and human rights in the form of the Single Equality Scheme. The scheme is a demonstration of our compliance with equality legislation and continuing commitment to equality for all groups in our population, to ensure services are suitable and of a high standard for everyone.

Our Single Equality Scheme sets out the vision for Equality and Diversity within Central and Eastern Cheshire PCT. As a result of the Scheme, Equality and Diversity is be embedded in the culture of the PCT to ensure that while it strives to achieve universal health for all and serves all its users, social cohesion, stability and economic prosperity will remain important goals and where possible will be advanced to improve the social and economic wellbeing of the communities the PCT serves.

As an employer and commissioner of health care services, we recognise the diversity of people and communities in and around Central and Eastern Cheshire and we are committed to:

- Making continuous progress in establishing equality for all.
- Tackling areas of potential discrimination and social exclusion, so that the way we commission and deliver our health care services, employment arrangements and staff opportunities are fair and appropriate.

- Making sure all levels of our workforce reflect the communities we serve. All job applicants and employees receive fair treatment and our recruitment process is easy for our local population to access.

- Making sure our information and services are accessible to diverse groups.

- Involving staff, local communities and partners to assist us to develop and apply our equality goals.

- Auditing our services and maintaining effective monitoring arrangements to identify areas for improvement.

As a PCT we can begin to improve peoples health by making sure that our populations can access information to help make the best health choices for themselves, and access health services without undue delay that are responsive and sensitive to their individual needs

We have an Equality Monitoring Group (chaired by a non-executive director) reporting to the Performance Committee and Board on progress made against Equality and Diversity, and the Single Equality Scheme Action Plan. Our main acute provider contracts are required to report monthly on equality and diversity (schedule 5).

The organization aims to ensure that the impact of functions and policies does not discriminate against race, disability, gender, sexual orientation; religion/belief and age. Therefore Equality Impact Assessments (EIA) are undertaken on all policies and public documents by way of limiting the health inequalities that exists between people from different ethnic backgrounds.

We have undertaken an Equality Impact Assessment the Strategic Plan, 'Better, Longer Lives', and identified the following:

- Health inequalities data should be analysed to inform the Change Programmes
- The need for consultation and engagement with key minority groups
- Equality to be clearly outlined in service specifications and contract clauses
- Performance management systems should review equality outcomes

Equality Impact Assessments will also be undertaken on all Change Programmes.

4. Strategy

4.1. Strategic Development Process

The process of developing our Strategic Plan has been rigorous. It has involved patients, the public, partners, stakeholders, clinicians and staff. The Plan has been shaped by key issues that are underpinned by a range of national and more local information sources ('Next Stage Review', 'Healthier Horizons'), the Joint Strategic Health Needs Assessment and engagement with the public and our partners. Ultimately the PCT Board have steered the Strategic Plan.

The process began with the development of a local and then joint health needs assessment that identified our key health needs. The outcome of this work was shared amongst our partners, stakeholders and the public.

4.2. Desired Outcomes

CECPCT has identified specific outcomes measures which link our strategic goals, focus our actions and monitor our long term success.

The PCT Board and Professional Executive Committee (PEC) reviewed and selected the final WCC outcomes that would be the best measures to track delivery of our strategic goals. The following table presents the selection with supporting rationale:

STRATEGIC GOAL	WCC OUTCOME MEASURE	RATIONALE FOR OUTCOME CHOSEN
Strategic Goal 1: Enable **children** to reach their full potential by making sure they are healthy.	We will increase **breastfeeding** initiation rates and 6-8 week maintenance and make breastfeeding the norm in infant feeding in Central and Eastern Cheshire.	• Health legacy for both mother and baby. • Reduction of health inequalities. • PCT currently not meeting national target.
Strategic Goal 2: Ensure **older people** are supported when needed, so that they can maintain independence for longer and enjoy good health into old age;	We will transform the quality of **dementia care** by ensuring 60% of expected dementia sufferers are captured on a practice based register, with an active care plan.	• Fastest growing elderly population in Northwest – 2.5% increase every 5 years. • Higher than average requirement for dementia care • Evidence that the PCT are not finding and effectively managing all people with dementia • PEC and PBC priority area.
Strategic Goal 3: Develop high quality **primary care** services;	We will reduce the **CHD mortality** rate for all ages from 83.94 per 100,000 (2007) to 56.50 per 100,000 by 2013. We will reduce the <75 **cancer mortality** rate from 112.55 per 100,000 (2007) to 81.07 per 100,000 by 2013.	• CVD is largest cause of death and premature mortality across Central & Eastern Cheshire • Cancer is a key health issue and significant cause of death across Central & Eastern Cheshire.
Strategic Goal 4: Bring **care closer to home**;	We will reduce the <75 **cancer mortality** rate from 112.55 per 100,000 (2007) to 81.07 per 100,000 by 2013.	• Improving cancer mortality will improve life expectancy and reduce the inequalities gap.

Strategic Goal 5: Develop the right **urgent care** services, in the right place at the right time;	We will reduce the rate of **alcohol** -related hospital admissions by 4,000 over 5 years. We will transform **Urgent Care** services and reduce emergency admissions due to ambulatory care conditions.	• Identified as a PEC priority • North West worst position on ill-health from alcohol and CECPCT is poorly performing. (7th worst for hazardous drinking nationally)
Strategic Goal 6: Improve **equity** of access to good health services for all our population	We will reduce the **CHD mortality** rate for all ages from 83.94 per 100,000 (2007) to 56.50 per 100,000 by 2013.	• Major health issue for our population • Identified as a PEC priority • Links to LAA
Strategic Goal 7: Deliver comprehensive and integrated **care pathways**;	We will increase the percentage of **stroke** admissions given a physiotherapy assessment within 72 hours.	• Major health issue for our population • Identified as a PEC priority • Highlighted by patients and the public as a key area of concern • LAA target
Strategic Goal 8: **Quality** of care is delivered across all our commissioned services	We will improve patient and user reported measure of **respect and dignity** by ensuring all providers are in the top 20% when benchmarked against similar organisations.	• Underpinning value of the PCT • Board and PEC priority. • Key concern for patients and the public
Strategic Goal 9: Optimise resource use and health outcomes by making appropriate use of **acute facilities**	We will transform **Urgent Care** services and reduce emergency admissions due to ambulatory care conditions	• Desire to transform and improve urgent care and ensure the provision of urgent care is accessible, safe and effective. • Identified as a PEC priority
	We will improve **Life Expectancy** for men and women overall and to narrow the gap by *targeted action* across *the whole PCT*.	• Mandatory • Priority area for PCT • Significant internal variations in LE and measures of health & illness.
	We intend to secure a sustained reduction in **Health Inequalities**, improve the health of all but improve the health of the worst off faster.	• Mandatory • Priority area for PCT • Significant internal variations in LE and measures of health & illness.

Attachment 1 provides an overview of each of our WCC outcomes measures, the baselines, trajectories and benchmarks for each.

4.3. Change Programmes (Initiatives)

Our initiatives are the specific programmes of work that we will carry out to help us achieve our strategic goals. Within each initiative there are several components, or project therefore we refer to the initiatives as 'Change Programmes' (CP). In many cases these Change Programmes already form part of the work of the PCT. However, in light of World Class Commissioning we have taken the opportunity to review each programme to ensure it will contribute to our strategic goals. All Change Programmes are supported by a project plan. The table below shows how each Change Programme links back to our strategic goals:

	Strategic Goals								
Change Programme	**SG 1: Children**	**SG 2: Older People**	**SG 3: Primary Care**	**SG 4: Care Closer to Home**	**SG 5: Urgent Care**	**SG 6: Equity**	**SG 7: Care Pathways**	**SG 8: Quality**	**SG 9: Acute Facilities**
CP1 – Health4Life (Lifestyle) Programme	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP2 – Urgent Care Modernisation	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP3 – Intermediate Services		✓	✓	✓	✓	✓	✓	✓	✓
CP4 – Developing Comprehensive (Integrated) Care Pathways for LTC		✓			✓		✓	✓	✓
CP5 – Deliver improved Maternity and Children's Services	✓		✓	✓		✓		✓	✓
CP6 – Improving Dementia Care		✓	✓	✓		✓	✓	✓	✓
CP7 – Redesign of Stroke Services		✓	✓	✓	✓	✓	✓	✓	✓
CP8 – Developing Community Hospitals Project	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP9 – Improve Cancer Outcomes	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP10 – End of Life Care	✓	✓	✓	✓	✓	✓	✓	✓	
CP11 – Primary Care Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP12 – Modernising Healthcare at Styal Prison			✓			✓	✓	✓	
CP13 – Implementation of Sexual Health Strategy	✓		✓	✓	✓	✓			
CP14 – Reduce CVD and improve cardiac services		✓	✓	✓	✓	✓	✓	✓	✓
CP15 – Transforming Community Services	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP16 – Development of Orthopaedic Care Pathways		✓	✓	✓	✓	✓	✓	✓	✓
CP17 – Dignity & Respect	✓	✓	✓	✓	✓	✓	✓	✓	✓

4.4. Prioritisation Process

The Change Programmes (CP) have been identified by considering our local population need, areas of poor performance and consideration of national guidance. The PCT has a priority setting framework that has assisted in prioritising the Change Programmes in order to deliver our strategic goals. We have assessed relevant information from national and local datasets, and compared these with the perspectives of key stakeholders, including patients and the public. The priority setting framework is based upon the following principles, while also being firmly focused on 'caring about care':

We will give priority in our choices to:

- National targets and local targets that are based upon local identified needs and demographics.
- Equity based on assessed need, which at times may result in differential distribution of resources.
- Health outcomes: we will prioritise needs for which effective interventions exist, and that offer the greatest benefit for our population. We will use validated clinical and economic measures (e.g. Health Technology Assessments and National Institution for Clinical Excellence evidence) alongside patient-related outcome measures.
- Cost effectiveness: choosing those interventions that have a robust evidence base for the return on investment.

In pursuing these priorities we will be cognisant of:

- Disinvestment: we will continually review the services we commission in order to improve efficiency (within our overall plan) so that resources can be re-invested more appropriately
- Innovation: we will encourage innovations that can provide evidence of improved outcomes, that have assessed risks and demonstrate an understanding of how new ways of working affect other current services or interventions within the NHS and beyond.
- Quality: we will commission services that deliver outcomes that are meaningful to patients and carers, and that demonstrate their commitment to dignity and respect.
- Resources: we will remain within our resource limits, and this may mean that not all services that are clinically effective and cost effective can be commissioned.

We have also used multi-criteria analysis technique – a scoring system aimed to assess priorities against an agreed set of criteria. The benefit criteria used were themed against the following headings:

- Impact Assessment (40 points)
- Financial (20 points)
- Engagement (30 points)
- National Requirements (10 points)
- Addressing Unmet Identified Need (20 points)
- Only treatment or Alternative (10 points)
- Achievability (10 points)

4.5. Overall Impact of Change Programmes on Outcomes

By reviewing the impact of each Change Programme against each outcome we will deliver:

- An additional 241 infants breastfed per year
- 60% of expected dementia sufferers captured on practice based registers
- Reduce deaths from CHD by 282 per year
- 138 fewer death <75 per year from cancer
- 4,000 fewer alcohol related admission over 5 years
- Fewer deaths within 30 days of an emergency admission to hospital with a stroke.
- CECPCT will move to the top quartile for reported patient experience
- 1,300 fewer (emergency) ambulatory care conditions

Such changes will increase life expectancy to 79.8 years (male) and 83.3 years (female) by saving 419 deaths per year by 2013. This will also reduce the gap in life expectancy between the lowest quintile.

Each Change Programme was also assessed against their level of impact on the outcomes and given a Low, Medium or High rating. The table below gives a summary of this assessment:

	CHANGE PROGRAMMES (INITIATIVES) - IMPACT ON OUTCOME MEASURES (H= High, M=Medium, L=Low)										
Change Programmes (Initiatives)	**Impact over 5 Years**	**Breast feeding**	**Dementia**	**CHD Mortality**	**Cancer Mortality**	**Stroke**	**Dignity & Respect**	**Alcohol**	**Urgent Care**	**Life Expectancy**	**Health Inequalities**
CP1 – Health4Life (Lifestyle) Programme	• Increase positive lifestyle choices e.g. 241 more infants breastfed p.a. • 4,000 fewer alcohol related admissions • Increase in early detection of cancer	H	H	H	H	H	M	H	H	H	H
CP2 – Urgent Care Modernisation	• Reduction in emergency bed days (10-20% reduction in av. LOS) • 6,500 fewer A&E attendances • Reduced emergency admission due to Ambulatory Care Sensitive conditions from 14.48/1000 population to below 11.50/1000	L	M	H	M	H	M	H	H	H	H
CP3 – Intermediate Services	• Improved health and well-being due to appropriate care and support in most appropriate environment – supporting independence • Improved quality of life by maximising rehabilitation and re-ablement • Increased control and choice by enabling service users involvement in care planning	L	M	L	L	H	H	L	H	M	H
CP4 – Developing Comprehensive (Integrated) Care Pathways for LTC	• New model of health and social care in place • Reduced inappropriate admissions	L	H	H	H	H	H	H	H	H	H
CP5 – Deliver improved Maternity and Children's Services	• Performance dashboards in place across services • 'Baby Friendly Initiative' (BFI) achieved in both local providers • Enhanced community support for pregnant women and breastfeeding mums	H	L	M	M	L	H	M	H	H	H
CP6 – Improving Dementia Care	• All staff trained within 1° and 2° care setting • Improved early diagnosis of dementia – tools and training in place • 3,860 people with dementia will be captured on a dementia register	L	H	M	L	M	H	H	H	L	H
CP7 – Redesign of Stroke Services	• All patients admitted with a stroke will have a physiotherapy assessment within 72 hours • All patients will suspected stroke will be assessed within 1 hour of contact with NHS services.	M	L	M	L	H	H	L	H	H	H
CP8 – Developing Community Hospitals Project	• Existing services operating from new purpose built facilities • Improved access to diagnosis to support the 18 week pathway • Reduced average length of stay for people aged 65+	L	H	M	M	H	H	L	H	H	H
CP9 – Improve Cancer Outcomes	• Improved life expectancy for CECPCT residents • Reduced lifestyle related illness • Earlier detection & treated more quickly	H	L	L	H	L	H	H	M	H	H
CP10 – End of Life Care	• More people support to die in their preferred place. • Bereavement and psychological support more widely available	L	H	H	H	M	H	M	M	L	H

	CHANGE PROGRAMMES (INITIATIVES) - IMPACT ON OUTCOME MEASURES (H= High, M=Medium, L=Low)										
Change Programmes (Initiatives)	**Impact over 5 Years**	**Breast feeding**	**Dementia**	**CHD Mortality**	**Cancer Mortality**	**Stroke**	**Dignity & Respect**	**Alcohol**	**Urgent Care**	**Life Expectancy**	**Health Inequalities**
CP11 – Primary Care Development	• Relocate a further 14 practices into new multi-use centres • Continue to improve GP access • Introduce more outcome initiatives to build on the LeQOF 'Excellence in Primary Care' – stretch targets	H	H	H	H	H	M	M	M	H	H
CP12 – Modernising Healthcare at Styal Prison	• Improved access to services • Reduced inequalities • Improved quality of services	L	L	M	M	L	M	H	L	M	H
CP13 – Implementation of Sexual Health Strategy	• Improved care pathways • Timely and easy access to psychosexual and sexual dysfunction therapies • Reduced unintended pregnancy rates	M	L	L	M	L	L	M	M	M	H
CP14 – Reduce CVD and improve cardiac services	• Improved detection of people with CHD & CVD • Improved speed to and quality of treatment offered • More comprehensive care for people with CHD & CVD	L	L	H	M	H	H	M	H	H	H
CP15 – Transforming Community Services (TCS)	• Delivery of the Commissioning Strategy for TCS • Market analysis and understanding • Met 5 key gateways	H	H	M	L	H	H	L	H	H	H
CP16 – Development of Orthopaedic Care Pathways	• Increased patient choice • Increased orthopaedic capacity • Reduced waiting times	L	L	L	L	L	M	L	H	M	M
CP17 – Dignity & Respect (D&R)	• PCT in upper quartile of all PCTs against patient experience in relation to D&R • All major contracts have D&R embedded within them	L	H	M	M	M	H	L	M	M	M

4.6. Specific Change Programmes (Initiatives) and Impact

CP1 – Health4Life (Lifestyle) Programme
The aim is to increase the uptake and maintenance of healthy lifestyle choices by Central and Eastern Cheshire Population. It will:

- Reduce the levels of Health and Social Care use caused by specific risky behaviours e.g. Alcohol, smoking, unhealthy weight, unsafe sex
- Increase positive lifestyle choices e.g. Breastfeeding, Physical Activity, Healthy Eating, Cancer awareness
- Increase knowledge and awareness about lifestyle choices and risks
- Increase early detection i.e. cancer
- Reduce prevalence of lifestyle related ill-health and disease.

The steps in programme development are: assessment of need, mapping of current initiatives and services, Identifying gaps and potential cost savings, reviewing, redesigning and developing services, using social marketing deliver targeted interventions. Lifestyle risk by practice and PBC cluster has already been assessed and presented to GPs and PBC groups.

This programme contributes to all of the prioritised outcomes. This programme will lead to more activity within services that support good health such as leisure facilities and those that offer support and advice (e.g. stop smoking clinics). The programme will reduce the need for treatment services.

CP2 – Urgent Care Modernisation
This Change Programme aims to inform the effective commissioning of an Urgent Care System.

Within 5 years Central and Eastern Cheshire PCT will commission an Urgent Care system built on delivering high quality emergency and urgent care, closer to people's homes, which offers patients greater choice, better information and value from an expanded range of health and social providers.

The Main Objective of the Change Programme is to achieve:
a reduction in the rate of Emergency Admissions due to Ambulatory Conditions from 14.48 /1000 population (above national average) to below 11.50 / 1000 population placing the PCT in the top quartile against national performance.

This will deliver the following outcomes:

- 6500 fewer A&E Attendances
- Over 100,000 patients will receive an initial assessment within 30 minutes of arrival at an Urgent or Emergency Care Centre. Benchmarked against current activity level
- Over 1000 patients per year will access a new integrated respiratory service benchmarked against current activity level
- 500 patients who fall, will be managed at home rather than conveyed to hospital
- Approximately 1300 fewer emergency admissions due to Ambulatory Conditions

The PCT will invest over £3.5 Million in developing services to support its strategy for Urgent & Emergency Care. Over £125 million /year is currently invested in Urgent Care by the PCT through its baseline.

However, investments will be complemented by decommissioning of existing acute services with an aim that the total financial impact will be cost neutral. There will be movement of resource between providers to allow the PCT to deliver the proposed outcomes.

Stakeholder events were held last year to inform the development of the urgent care centres. Further patient and staff involvement will be organised in the pathway work and implementation by means of focus groups and questionnaires. Patient representatives are members of the Urgent Care Network that will be over seeing this programme.

CP3 – Intermediate Services
This Change Programme aims to Commission care closer to home to meet the needs of the population in 5 years time using a range of intermediate services that focus on prompt time-limited interventions to support older people in their own homes or in community beds to avoid unnecessary hospital admissions or support early discharge from hospital. .

We will commission:
- Intermediate services hubs alongside each urgent care centre and hospital
- Intermediate bed based services in each key town – see Community IBBS by Borough and Type
- Intermediate home based services

This Programme is a key project within the Urgent Care Plan 2007 – 2011 and forms part of the Healthcare Services in a Community Setting programme. Its outcomes are critical to the delivery of our reductions in Emergency Bed Days.

The planning to support this change programme has looked at what level of health and social care services will be required, for the population of central and eastern Cheshire, if we continue to provide care in the same way as we do today for the growing numbers of older people. Using 2007 as the baseline this has shown that by 2016 we would have/require:

414 additional hospital admissions each year
11 additional acute hospital beds each year
74 admissions to care homes each year
123 additional people living in care homes each year

The planning also shows that if the type of services and the way we provide them were changed through the use of intermediate services we would have/require:

255 additional hospital admissions each year, which is 159 less
5 additional acute hospital beds each year, which is 6 less
30 admissions to care homes each year, which is 44 less
41 additional people living in care homes each year, which is 82 less

Bed Requirements across Central and Eastern Cheshire by 2012

Bed Type	Beds in 2008	Northwich	Winsford	Macc-lesfield	Knutsford	Congleton	Crewe	Total Beds (2012)
Intermediate Services		18	30	36	26	30	22	**162**
Specialist Rehab.		8		8		8	8	**32**
General Palliative Care		6		6		6	8	**26**
Total Intermediate Services	**115**	**32**	**30**	**50**	**26**	**44**	**38**	**220**

The current intermediate care services have a joint health and social care budget of £6,415,000 in 2007/08.

This is a whole system plan so the involvement of stakeholders is critical to its success. The Cheshire Intermediate Work stream involved all health and social care organisations and consulted with the public and third sector organisations. Whole system events and specific events for key players, e.g. primary care, are planned for key stages in the commissioning.

Table 3 below identifies the outcomes using the Cheshire "Every Older Adult Matters" Framework.

The outcomes of this programme can be defined as:

- Reductions in the forecast hospital admissions
- Reductions in the forecast admissions to ling term care
- Reductions in delayed discharges

Outcome	Intermediate services will:
Improved health and wellbeing	• Provide appropriate care and support in an environment that is most conducive to promoting independence, health and well-being; • Rapid response elements of services will optimise recovery; • Prevent admission to hospital where appropriate and therefore minimise risk of increased dependency or hospital acquired infections.
Improved quality of life	• Provide care at home or as close to home as is possible to enhance quality of life; • Will maximise rehabilitation and reablement with a view to maximising independence and therefore quality of life.
Making a positive contribution	• Prevent premature admission to long term care enabling opportunities for greater local engagement; • Maintain independence and home based support.

Outcome	Intermediate services will:
Increased choice and control	• Enable service user involvement in care planning and the setting of personal outcomes; • Facilitate links to mainstream community services and third sector organisations.
Freedom from discrimination	• Ensure equity of access and clear assessment and eligibility criteria; • Ensure access on the base of need not age or condition.
Economic wellbeing	• Enable smooth transition through reablement to optimise levels of independence and therefore a persons potential to make an economic contribution to their local community.
Maintaining personal dignity and respect	• Improve people's experience of hospital care; • Provide more care at home where an individual has greater control and confidence to work with service providers.

CP4 – Developing Comprehensive (integrated) Care Pathways for LTC
This Change Programme aims within 3 years to ensure that all patients with a Long Term Condition receive personalized care, providing the most intensive care, in the least intensive setting.

The main objectives are:

- All patients with a LTC will have a personalised care plan, putting the person with the LTC and/or their carers in charge.
- All care plans with individuals will be supported by multi-disciplinary teams focused around PBC/practice clusters.
- District Nursing services are recommissioned to take a leading role in the treatment and management of house bound patients with LTC
- Programmes promoting knowledge of prevention will be widely implemented increasing individual independence.
- New Integrated Respiratory Services and Neurological Nurse specialists will be commissioned to provide specialist care in the community.

This Change Programme will deliver the following outcomes:

- A new model of health and social care will have been introduced with services commissioned to meet the 3 levels of need described with the LTC strategy.
- There will be a significant reduction in patients inappropriately admitted with a LTC (see ACS condition outcome).

The PCT will meet the objectives of this change programme through the redesign and recommissioning of existing services and by stimulating the market.

Stakeholder events were held during 2007-08 to inform the development of the Long Term Conditions Strategy, which is instrumental in delivering the programme. Further patient

and staff involvement will be involved in the pathway work by means of focus groups and questionnaires to gather views.

Patient and staff focus groups and questionnaires will seek the views of patients on proposed implementation plans, ensuring views are taking into account.

This programme requires commitment across the whole health economy and particularly the development of health and social care partnerships.

CP5 – Deliver Improved Maternity and Children's Services

Maternity Services

The aim is to ensure maternity services are delivered to high standard and are compliant with *'Maternity Matters'* and the national *'Standards for Maternity Care'. A* locally agreed set of standards for maternity & obstetric services within the acute trusts will be agreed. Access to maternity care will be improved, antenatal care developed. Women will be offered a choice of place of birth. Place of postnatal care will be reviewed. All women will have access to support from a known and trusted midwife. Maternity Services Liaison Committees in both Central and Eastern Cheshire are involved. There are interdependencies in relation to the configuration Health Visiting services, which will be taken into account within the 'Transforming Community Service's' Change Programme.

Children's Community Nursing

Children's & Women's Community Nursing Services aim to improve the health outcomes of children, young people and women through prevention, early intervention and ongoing management.

The objectives are to review the outcomes, structures and resources for children, young people and women's community nursing services. Work is being undertaken to establish the desired outcomes, proposed interventions, resources required, implications of a change in delivery and establish monitoring systems. The process should lead to a prioritizing of activity based upon need and what makes a difference. Meetings with stakeholders have already been undertaken and a small working group has been established.

Paediatrics

Paediatric services development aims to improve the health outcomes and management of sick children and young people. The objective is to establish a locally agreed set of standards for all elements of paediatric care within the acute trusts and relay these in a performance dashboard. A piece of work is underway between joint commissioning and public health to understand patient flows across primary care, community and the acute trusts.

Across all three services of this Change Programme outcome measures will be integrated and described within the performance dashboards and will cover areas such as staffing, activity, clinical indicators and environment.

CP6 – Improving Dementia Care

The aim is to raise awareness of the public and professionals to dementia combating stigma, ensure people are diagnosed as early as possible and raise the quality of care for people with dementia.

The main objectives of the Programme are:

- Training to be rolled out to all staff working within health settings
- People with dementia to be diagnosed earlier in their condition to allow them to be more involved in decisions and to facilitate better planning of their care.
- Support and advice to be given to carers particularly with regard to end of life care.
- High quality care and support in hospital

This Change Programme will deliver the following outcomes:

In five years time it is envisaged that 60% of the total expected numbers of people with dementia will be captured on a dementia register with an active care plan.

Baseline	37% of expected prevalence 2008	2200
Year 1	42% of expected prevalence 2009	2590
Year 2	47% of expected prevalence 2010	2942
Year 3	52% of expected prevalence 2011	3345
Year 4	60% of expected prevalence 2012	3860

Based on expected prevalence the 2012 figure is over 75% of the baseline figure, due to the expected prevalence increasing over these years.

CP7 – Redesign of Stroke Services
The main aim is to improve services for those who suffer stroke and to intervene early to prevent Stroke. There are approximately 700 new strokes per year in CECPCT. In addition there are 150 TIAs admitted to hospital but the total number of people having TIAs is much greater and could be double or triple this number.

A fully comprehensive service for people with stroke and TIA will reduce future mortality and morbidity. Prompt interventions will speed recovery and reduce the burden of disease.

The main objectives are:

- to map current service delivery across the whole health economy in order to identify gaps and develop an action plan to ensure the delivery of services across the whole pathway complies with the 20 Quality Markers identified in the National stroke strategy.

- To ensure at least 90% of patients who have a stroke are firstly admitted to a dedicated stroke unit and subsequently receive physiotherapy assessment within 72 hours. Although, the main outcome is about physiotherapy assessment, the PCT will ensure all other therapy assessments are carried out in the first few days

- Develop an overall PCT stroke action plan, following two recent stakeholder events (2008) to ensure all people who have had a stroke follow timely, rapid and clinically appropriate pathways.

- The PCT has already asked the providers to transfer appropriate patients to rehabilitation within 19 days, if clinically appropriate. This work began in April 2009 and is linked to the PCTs rehabilitation plan.

This will deliver the following outcomes:

- Sept. 2009 - 90% all patients suspected of having a stroke will be assessed within 1 hour of contact with the NHS in a hospital setting.

- 2009-2010 - 90% and
- 2010-2011 - 95% and
- 2011-2012 - 100% of patients admitted with stroke will have Physiotherapy assessment within 72 hours

CP8 – Developing Community Hospitals Project
This Change Programme aims to develop our community hospitals as a network that provides appropriate services away from secondary care, and therefore closer to people's homes

The main objectives are:
- Use healthcare resources (money, staff, buildings) more effectively and draw in additional resources, if possible, to improve patient services and reduce inequity of service provision.
- Improve the quality of facilities available locally to meet identified patient need.
- Develop a greater range of local services that staff can influence and take a pride in delivering to patients.
- Develop a joint plan for identified communities of need, that describes the vision of healthcare services locally, bringing a range of service providers together to better meet patient needs.

The key principles for these developments include:
- The development of modern primary care and community hospital facilities in Knutsford, Congleton and Northwich;
- The delivery of "Care Closer to Home" through the provision of flexible, integrated clinical services across the main towns of Central and Eastern Cheshire
- Increased access to a range of intermediate tier services, both in patients' own homes and in purpose-built community bed facilities.
- Expanded community teams to support people with long term conditions in their homes and avoid unnecessary admission to hospital.
- Increased access to diagnostic and outpatient facilities in the community. Community-based mental health teams to support service users in their homes. This will deliver the following outcomes

  This Programme will deliver the following outcomes:
- Existing services operating from new purpose-built facilities.
- New services bringing together clinical teams across primary, community and secondary care, with shorter care pathways and local access wherever possible.
- Improved access to diagnostics to support delivery of 18-week pathway.
- Reduced acute hospital admissions in people aged over 65 years (against trajectory).
- Reduced average lengths of stay in people aged over 65 years.
- Reduced admissions to long term care.
- Reduced outpatient attendances
- Reduced A&E attendances
- Improved recruitment and retention of staff
- Local ownership of new multi-purpose facilities encouraging access to services by young people and supporting healthy lifestyle choices.

Stakeholders have been engaged from the "ideas" stage, to the development of plans and the appointment of developers and preferred providers. The Acute and Community Trusts and Social Services representatives, have been members of the Healthcare in a

Community Setting Strategy Group and have participated in the "Task and Finish" group that determined the community bed model. A multi-agency group across Cheshire developed the model and activity planning, involving patients and third sector groups. Large public meetings have been held in Knutsford, Northwich, and more recently in Congleton to engage the wider public at an early stage. This approach to engaging the public has been commended by the Overview and Scrutiny Committee. Full formal public consultation will be required for the health centre schemes in due course.

CP9 – Improve Cancer Outcomes
This Change Programme aims to:

- Increase by 20% the proportion of people who are diagnosed at an earlier stage of cancer.
- Offer rapid and effective treatment for cancer following diagnosis.
- Reduce <75yrs deaths from cancer per year by 2014 by 18 per 100,000 of our population.

The main outcomes of the Change Programme are to:

- Reduce the premature cancer mortality by 24% (137 deaths per year) within the areas of low life expectancy. Tackling these health inequalities would result in an increase of almost 9 months in male life expectancy to 78.8 years and an increase of almost 11 months in females to 82.7 years

- Reduce proportion of women never screened for cervical cancer from 5.4% to 3% (current range 3.4%-7.0% at town level). We will reverse decline in cervical screening coverage, and increase to 85% (82.3% in 2007/08, 78.6% nationally)

- Reduce proportion of women never screened for breast cancer from 8.4% to 4% (current range 5.4%-11.2% at town level). We will Increase breast screening coverage to 87% (83.1% in 2007/08, 76.7% nationally)

- Increase bowel screening coverage to 66% (62% in 2008, 57% in C&M)

- Use informed choice in PSA testing to reduce number of tests undertaken

- Ensure waiting times from screening to first appointment (assessment) meet and exceed current standards of 90% within 3 weeks for breast screening and 90% within 8 weeks for cervical screening.

- Reduce smoking prevalence - this links directly to the Health4 Life Change Programme.

- Reduce prevalence of obesity, specifically in women (as breast cancer determinant) - this links directly to the Health4 Life Change Programme

On average around 2,140 local people develop cancer each year before the age of 75 and 578 people die early from this disease. By 2013, we expect an additional 84 premature deaths will occur, due to the aging population.

	Actual (DSR per 100,000)	**VBS03 plan** (DSR per 100,000)	**WCC stretched plan** (DSR per 100,000)
2007	112.55 (597 deaths)		
2008			106.56
2009		101.23	100.89
2010		99.06	95.52
2011		96.93	90.43
2012		*91.53*	85.62
2013		*87.53*	81.07

CP10 – End of Life Care
This Change Programme aims to commission an integrated whole system approach to end of life care, that will ensure a personalized approach, support choice and facilitate easy access to services for patients and their families.

It also aims to fully implement the key recommendations within the National End of Life Strategy and Healthier Horizons for the North West.

The main objectives of the Change Programme are to:
- Ensure that 10% less people die in hospital by 2012, and a greater portion of people die in their preferred place of care.
- Work with the Nationally recognized Marie Curie Choice Toolkit to review unmet need, local demographics and forecasts.
- Increase the use of all End of Life Care Tools through all care settings for patients at End of Life regardless of diagnosis.
- Extend the use of the Gold Standard Framework in Primary Care for ALL End of Life patients.
- Ensure comprehensive education and training availability for professionals working with patients at End of Life.
- Raise the profile of death and dying in a positive manner within the local population, particularly working closely with local schools.
- Review rapid discharge pathways for people choosing to die at home or in a setting outside of hospital.

This will deliver the following outcomes:

- More people will die in their preferred place of care and have had a positive experience of their last days of life.
- Hospital death rates will be reduced
- Use of the End of Life Care tools will be increased
- Rapid discharge pathways will be in place and working
- Marie Curie toolkit in use and demonstrating effective use of resources, facilitating patient choice and demonstrating value for money by less urgent care episodes and less unnecessary hospital admissions.

The impact of the Change Programme on activity levels:
- 10% less people will die in Hospital by 2012

- Increased people will die in their preferred place of care.
- Community Care activity will rise.
- End of Life Care Tools – full uptake through all care settings
- Urgent Care – support to prevent unnecessary hospital admissions

CP11 – Primary Care Development
This Change Programme will support the modernization of primary care services, specifically with regard to GP practices in Central and Eastern Cheshire PCT

Services will be commissioned from GP practices which support the patients of our PCT to maximize health and wellbeing, consequently sustaining improvement in health outcomes and reduction in health inequalities, ultimately to enable the population to have a choice of at least 2 high quality GP practices, with the aspiration that patients in Central and Eastern Cheshire PCT will have access to the best primary care service in England

The main objectives of the Change Programme are to achieve:

- consistently high quality primary care across the PCT's population as defined by the PCT's CASE approach to quality. The intention is to improve health and reduce health inequalities using a sound knowledge of health care needs and a robust evidence base

- high quality primary care services close to patient homes and to commission appropriate health care services by actively involving community and patients views.

The updated balanced scorecard will set out the key outcomes for this Change Programme

This Change Programme should reduce secondary care activity over time e.g. inappropriate A&E attendances, inappropriate referrals to hospital and in time should reduce costs associated with non electives especially A&E attendances, and elective activity.

CP12 – Modernising Healthcare at Styal Prison
This Change Programme aims to:
- improve the standard of services and health outcomes;
- deliver the Styal health development plan; and
- streamline the contracting and accountabilities, having appointed one provider organisation for the delivery of primary and community healthcare services in Styal Prison.

The main objectives of the Change Programme are:
- to deliver a range and quality of services equivalent to that offered to people outside of Prison and to work toward 'mainstreaming' prison health at every opportunity;
- to ensure that integrated services are provided;
- to ensure that services are accessible and responsive;
- to ensure that prison health services are needs evidence based and clinically effective;
- to ensure resources are used effectively;

- to secure a pace of change that will avoid destabilisation of the wider prison regime and allow developments to be thoroughly established and evaluated;
- to recognise both the Prison Service and NHS agendas and to achieve a balance between security requirements and health provision.

This will deliver the following outcomes:

- Improved access
- Reduced inequalities
- Developed capacity to meet need
- Better value for money
- Improved quality
- Improved integration with mainstream services

Within this Change Programme, stakeholder involvement has been evident, working in partnership with the Prison Governor and Cheshire Community Voice (a voluntary organisation) throughout the tender process. Some of the women at Styal have also been involved in the tender process, as part of focus groups and participating in the bidder day. Prisoner involvement in service design and delivery was a key feature of the service being tendered for.

CP13 – Implementation of Sexual Health Strategy
This Change Programme aims to enable people to access a full range of high quality, integrated, person-centred and culturally sensitive sexual health services, to reduce both the number of sexually transmitted diseases and teenage conceptions.

The Main Objective of the Change Programme is to achieve:
- Establish high quality community based integrated sexual health care (with sufficient capacity) that promotes equity and has a single point of access for service users.
- Modernise services provision by developing clear service user care pathways, ensuring greater choice, enhanced efficiency and equity in care. This will include developing capacity and expertise in general practice and primary care settings.
- To provide timely and easy access to psychosexual and sexual dysfunction therapies, and to provide prompt and easy access to a high quality sexual assault referral centre (SARC).
- To develop and implement an education and sexual health promotion framework which conforms to equality and diversity requirements, and that prevents unintended pregnancy and sexual infections (including HIV).
- To increase active user participation and involvement in the planning, organisation and evaluation of services
- To reduce unintended pregnancy rates by linking to the Cheshire Teenage Pregnancy Strategy, to ensure sexual health services are accessible to young people and national standards are met.

The outcomes for this Change Programme are currently being developed.

CP14 – Reduce CVD & Improve Cardiac Services
This Change Programme aims, over the next five years, to reduce CVD Mortality through its prevention, management, reduce the incidence of Stroke and Cardiac Events and improve access to essential Cardiac services.

Tackling vascular disease will be key to achieving the national 2010 health inequalities target relating to life expectancy.

The directly standardised mortality rate for Cornoary Heart Disease (CHD) was 83.94 per 100,000 (683 deaths) in 2005-07. We will reduce this rate by 282 deaths per year. This will result in a directly standardised rate of 56.50 per 100,000 by 2013.

This reduction in CHD deaths will reduce the directly standardised rate for Circulatory Disease from 199.96 per 100,000 in 2005-07 to 158.11 per 100,000 in 2013. This is a reduction of 21%.

The main objective(s) of the Change Programme are to:

- Improve detection of people with CHD and CVD
- Improve speed and maximise quality of treatment offered
- Ensure comprehensive care for people suffering from CHD and CVD.

This will deliver the following outcomes:

- Reduction in the number of Stroke, Emergency AAA's and Heart Attacks.
- Increase the number of risk assessments performed.
- Increase the number of patients identified on the hypertension registers in General practice.
- Increase the number of patients prescribed anti-Hypertensive drugs.
- Increase the number of patients called for annual review.
- Increase in the number of patients setting a quit day.
- Reduction in Heart Failure Readmissions
- Reduction in subsequent Cardiac events following improved access to Cardiac Rehabilitation.
- Achievement of the Advancing Quality targets
- Increase in patients receiving Revascularisation
- Increase in the number of Pacemaker inserted locally
- Reduction in out-patient follow ups
- Improve Thrombolysis access times
- Increase the number of patients receiving Primary Angioplasty.

CP15 – Transforming Community Services (TCS)
This Change Programme aims to deliver on the Transactional and Transformational agenda of Transforming Community Services (TCS)

The TCS program is central to delivering the vision for Primary and Community Care set out in the NHS Next Stage Review.

Three key elements feature in the TCS program of change:

- The development of a Quality Framework for community services (due June 2009), giving a high priority to enabling the transformation of clinical practice skills;

- Transform the commissioning of community services through World Class Commissioning and provide commissioners with the tools they need i.e. a new standard contract, guidance on costing and pricing, information and metrics; and

- The need to ensure that the organisations providing the community services are fit for purpose. Organisations are needed which enable and empower front line staff to innovate and free up their time to care for patients.

The main objectives of the Change Programme are:

- Meet the 5 key gateways:
  - Separation
  - Strategy and Commissioning
  - Service Viability and Productivity assessment
  - Infrastructure Strategy
  - Organisational option
- Develop a 5 year commissioning strategy - focused around the 7 key pathways
  - High quality care for children and families
  - High quality care in services for long term conditions
  - High quality care in acute services closer to home
  - High quality care in services for rehabilitation and long term neurological conditions
  - High quality in end of life care
  - Promoting health and well being and reducing inequalities
  - High quality care in Mental Health (North West only)
- Development of procurement plan
- Development of market analysis
- Development of contestability plan
- Review the options for the most appropriate organisational forms that best suit local need and circumstances.

This will deliver the following outcomes:

- Delivery of the commissioning strategy.
- Clear market analysis undertaken and thus clear understanding of gaps/arrears/risks to deliver.
- Meeting the 5 key gateways and proposing the type of organisation for community services.

The TCS programme of work is in accordance with the National drivers for the modernisation of community providers. Consideration will be afforded to the other national initiatives which include:
Healthier horizons North West (2009)
End of life strategy (2008)
World Class Commissioning
Healthier Lives Brighter Futures (2009)
(This is not an exhaustive list)

TCS is a national programme and has to be delivered - to ensure this the 5 year commissioning strategy will be developed.

Stakeholder involvement has been key at the very start of this Programme. A launch event, took place on 13th March 2009. Linked with this all the key pathways leads and overall TCS lead will demonstrate public involvement.

CP16 – Development of Orthopaedic Care Pathways

Demand for acute Orthopaedics is forecasted to continue to grow during 2009/2010, creating concerns over the level of available capacity and ensure compliance against 18 week performance. Analysis of population trends suggests that referrals will continue to increase.

Both local Trusts have failed to achieve the 18 week target for orthopaedics during 2008/09, even though they both met the overall 18 week target. The Health Economy invests over £18 million / annum in the provision of Orthopaedic services.

The aim is to develop a robust approach to commissioning of Elective Orthopaedic services, that stimulates market competition, leads to improved patient access, choice and quality of care.

The main objectives of this Change Programme are:

- to ensure that Orthopaedic capacity is matched to future demand,
- to ensure providers are compliant with the 18 week access targets
- to commission services which maximizes patient choice, ensuring value for money.

The PCT's current annual expenditure across all orthopaedic services is £18 million, which also includes a number of IS contracts.

Improved outcomes include:
1. Increased patient choice.
2. Increased orthopaedic capacity across the health economy.
3. Reduction in waiting times for orthopaedic procedures, leading to
4. Improved performance against the 18 week targets for orthopaedics.

CP17 – Dignity and Respect
This Change Programme aims to demonstrate, in five years time, a level of patient experience in relation to dignity and respect that is in the upper quartile of all PCTs.

The main objectives of the Change Programme is to:

- build on existing targets in relation to dignity and respect and agree further targets with providers on an annual basis;
- identify priority areas/services based on health needs assessment, results of local audits/surveys and national studies;
- identify core standards based on evidence from national guidance and directives and local/national best practice;
- devise a commissioning framework around dignity and respect that includes KPIs relevant to different population groups;
- agree targets and ways of monitoring and evaluating dignity and respect with local providers including through contract monitoring;
- identify measurable patient-centred outcomes;
- develop a plan to ensure dignity and respect remains high on everyone's agenda;
- link with SHA/Universities re-commissioning/provision of professional training to ensure dignity and respect are a core element in the curriculae;
- identify dignity champions' focus groups for each of the priority areas/services.
- evaluate project at the end of each year and make any necessary amendments to project plan.

- final evaluation at end of year to a) demonstrate robust commissioning process in place in relation to dignity and respect; b) demonstrate year on year improvement in patients' experiences against an agreed baseline in year 1; c) outline core standards that apply to all groups and specific standards that apply to individual services and sectors; d) robust monitoring and evaluative process that demonstrates year on year improvement

This will deliver the following outcomes:

- In five years time the PCT will be able to demonstrate improvements for patient experience in relation to dignity and respect that is in the upper quartile of all PCTs.

- By the end of year one all major contracts will have standards and targets in place with year on year increases in the number of provider service contracts involved so that by year 5 every contract will have dignity and respect embedded within.

In order to ensure the programme is developed a Steering Group involving key individuals with appropriate skills and perspectives (e.g. Local Dignity Champions) will be established at an early stage. They will agree the Project Plan, including timescales for completion, project outcomes and will meet on a monthly basis to guide and steer the project. There will be some Investment required to support patient and public feedback processes.

It is not anticipated this initiative will have a direct impact on activity since it is focussed on improving quality and patient experience rather than efficiency of services.

Stakeholder involvement in developing and implementing this Change Programme is vital. There will be patient and public involvement through detailed surveys, audits, focus groups and analysis of complaints etc. Key stakeholders will be represented on the Steering Group including Dignity Champions, Lay Representatives, Key Commissioning Managers and Staff representatives. Awareness-raising sessions with key stakeholder groups will also be undertaken. There will also be involvement of stakeholders in an annual evaluation process.

The main risks to the Change Programme are that Providers may not be able to deliver year on year improvements in dignity and respect in care within resources; there is a lack of consensus amongst stakeholders regarding a) appropriate indicators b) target levels required: a lack of stakeholder time to fully contribute to initiative.

4.7. Investments

As can be seen from the table below, the PCT is not planning to invest significant amounts of new money but rather to focus on using the existing expenditure in a more targeted fashion. The following table shows the new investments in two programmes with the remainder of funding being drawn from existing sources.

Change Programme	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000	Total £'000
CP1 – Lifestyle Programme	100	0	0	0	100
CP2 – Urgent Care Modernisation	1180	1180	0	0	2360
Total	**1280**	**1180**	**0**	**0**	**2460**

The following Table represents an overview of how each of the 9 Strategic Goals link to the 10 WCC outcomes and the 17 Change Programmes.

VISION	Encourage staying Healthy		Appropriate access & timely care for life events			Maintain Independence & well-being during ill-health			
GOALS	Enable **children** to reach their full potential by making sure they are healthy	Ensure **older people** are supported when needed	Develop high quality **primary care** services	Improve **Equity** of access to good health services	Develop the right **urgent care** services, in the right place at the right time	Optimise resource use and health outcomes by making appropriate use of **acute facilities**	Bring **care closer to home**	Develop Comprehensive (Integrated) **Care Pathways**	**Quality** of care is delivered across all our commissioned services
WCC OUTCOME MEASURES	**Breast feeding** - Increase initiation rates and 6-8 week maintenance	**Dementia -** 60% of expected sufferers captured on practice register	**CHD mortality –** Reduce CHD mortality for all ages		**Urgent Care -** Reduce emergency admissions due to ambulatory care conditions	**Alcohol –** Reduce the rate of alcohol related hospital admissions		**Stroke –** Increase % of stroke admissions given a physio assessment **Cancer Mortality –** Reduce <75 cancer mortality	**Dignity & Respect –** All providers in top 20% against all National Patient Survey indicators
	Deliver sustained reduction in **Health Inequalities**, improve the health of all but improve the health of the worst off faster								
	Improve **Life Expectancy** for men and women overall and to narrow the gap by targeted action across the whole PCT								
CHANGE PROGRAMMES **(linked to Strategic Goals)**									
CP1 – Health4Life (Lifestyle) Programme	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP2 – Urgent Care Modernisation	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP3 – Intermediate Services		✓	✓	✓	✓	✓	✓	✓	✓
CP4 – Deliver comprehensive and integrated care pathways for Long Term Conditions (LTC)		✓	✓	✓	✓	✓	✓	✓	✓
CP5 – Deliver improved outcomes for maternity and children's services	✓		✓	✓		✓	✓		✓
CP6 – Improving Dementia Care		✓	✓	✓		✓	✓	✓	✓
CP7 – Redesign of Stroke Services		✓	✓	✓	✓	✓	✓	✓	✓
CP8 – Developing Community Hospitals Project	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP9 – Improve Cancer Outcomes	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP10 – End of Life Care	✓	✓	✓	✓	✓		✓	✓	✓
CP11 – Primary Care Development	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP12 - Modernising Healthcare at Styal Prison	✓		✓	✓				✓	✓
CP13 – Implementation of Sexual Health Strategy	✓		✓	✓	✓	✓	✓		✓
CP14 - Reduce CVD & improve cardiac services		✓	✓	✓	✓	✓	✓	✓	✓
CP15 – Transforming Community Services	✓	✓	✓	✓	✓	✓	✓	✓	✓
CP16 – Development of Orthopaedic Care Pathways		✓	✓	✓	✓	✓	✓	✓	✓
CP 17 – Dignity & Respect	✓	✓	✓	✓	✓	✓	✓	✓	✓

5. Scenario Planning – Adapting For The Future

We have considered various scenarios that MAY affect the delivery of our Strategic Plan in an ever changing environment, and tested out the robustness, resilience and recoverability of the plan under different scenarios.

The Health Needs Assessment section (Section 5, on pages 17-32) sets out the current assessed needs of our population. Whilst this assessment takes account of forecast changes in need and demand (e.g. through changing demographics) it is vital that our Strategic Plan is also able to adapt to other changes which may impact on both supply and demand.

In determining our Strategic Plan (and in particular our specific outcome plans) we have undertaken a detailed PESTEL analysis looking at possible impacts in:

Political

Economic

Social

Technological

Environmental

Legal

Terms

Each of our project plans (for both the World Class Commissioning outcomes and the key PCT 'Change Prgrammes') have been subject to a PESTEL analysis. However we recognise that this analysis will inevitably reflect the current 'known impacts' and that we must engage in more 'blue sky' analysis in order to make sure our strategic plan is able to adapt to significant external factors in the medium and long term.

We have therefore used the North West SHA Scenario Planning work to engage Clinicians and Managers in discussions about the future and in supporting the PESTEL analysis. This work has led us to identify the following factors which we have included into our strategic plan for the next 5 year timeframe:

1) **The impact of the increased use of technology**. In particular we believe that the development of WEB 2.0 will have a huge impact on the way services are delivered and how we interact with our patients and, most importantly, patients and public interact with each other on health and healthcare issues. We have been an early adopter (in conjunction with our two main provider Trusts) of the Patient Opinion web-site. We now recognise that we must better understand the potential impact of WEB 2.0 as the 'my space' generation grows older and the whole of society recognises the Web as an interactive tool.

2) **The development of the NHS constitution**. In particular we believe that the society will move from perceiving that the NHS is free at the point of delivery to recognising that it is paid for by the population through taxation. Over time this may lead to users thinking both as patients, but also as citizens i.e. developing a better understanding of the difficult balance between individual and population needs. There may be a growing awareness of shared responsibility for the cost-effective use of limited resources and a move towards the 'fully engaged scenario' (Wanless 2002). We have identified two immediate challenges:

I. We need to define the responsibilities of our providers to deliver high quality services; and define the responsibilities of the users of the services to use them appropriately.
II. The need to assess the impact of these changes on equity and reducing inequalities. Will we continue to be able to justify different services for different communities? What will be the effect of any change in co-funding rules for more affluent populations?

3) **The impact of National Global Economics.** We have experienced significant migration into Crewe and this has had unpredictable affect on services, for example the migrant community are used to a service that is delivered from a secondary care base resulting in low use of primary care services. The level of migration now appears to be falling as some individuals and families are returning to their homelands.

   As a result of changing economic circumstances in Britain and across the globe, we need to work with partners to model future migration patterns as these are not as yet fully factored into our demographic projections. We are working with partners to understand these trends, and in particular we will commission research to look at the effect of greater job mobility on health in our more affluent communities. In addition to studying this we must also factor into our plans the general effect of the financial position on our communities (One of our largest employers 'Bentley Motors' have recently – 05/09/08 -announced the introduction of a 3 day week).

4) **The development of new health technologies**. In particular we need to understand the impact over the next 5 years on the development of Gene Therapy, robotics, minimally invasive surgery, enhanced monitoring (telemedicine), ref. Sc2, Sept 2008.

5) **The implications of different approaches to commissioning**. We need to better project the impact on activity and care pathways of our improved approach to commissioning. In particular we need to model the likely impact of the 'Advancing quality' initiative as it is rolled out across the Northwest.

6) **The implications of an increase use of the Private sector and in 'private sector' behaviours.** The increase in Private sector provision as an NHS partner has been factored into our Strategic Plan; however we need to do further work to understand the implications of the policy and behaviours on traditional Health Service providers. In particular we need to recognise that our GP practices feel 'threatened' by some recent developments and therefore their traditional position in the NHS family may change. We also need to understand how NHS Foundation Trusts will develop as they focus on their future business viability as well as on Healthcare provision. We are keen to work with partners across the North West to develop new approaches to promote the social responsibilities of NHS organisations recognising that the State and the Private sectors can only function effectively with a strong and innovative social sector.

7) **The impact of developing Healthcare systems worldwide.** We will ensure that we keep abreast of healthcare system development across the world. All health systems are looking for answers to the problems caused by rising demand and rising costs – we need to ensure that we learn from good practice and innovation elsewhere as we have done with the 'Advancing Quality' initiative.

6. Delivery - Implementing Our Strategic Plan

6.1. Organisational Development to Support Delivery

We recognise the importance of developing an organisation that can function effectively. To this end our Organisational Development Plan is designed to ensure that we will focus equally on:

- **planning** – what we intend to do and why
- **competencies** – our ability to deliver
- **performance** – what we actually deliver, and
- **culture** - how we do things

In doing this we deliver the business and create an environment and relationships that make people want to work for us and with us. We regard ourselves as a **commissioning organisation** in which everyone has a contribution to make directly or indirectly.

We recognise from the WCC panel report and our own reflections, that we need to concentrate our efforts and build on our developments so far to become “world class”. The WCC assurance process has given us an external view of our current abilities and highlighted areas for further development. This balanced with our internal and stakeholders’ perceptions is a powerful insight.

We will actively respond to the challenges in the next 12 months in order to be able to demonstrate at the next panel visit in 2010 that we have made significant progress on the development continuum and we will address the **non green areas** within the governance elements.

We recognise that our staff are highly committed and go the ‘extra mile’. This is also true of clinicians and local people who get involved with the work of the PCT. We place a high value on this and know that we could not be effective without it.

Organisational Development for the commissioning part of the organisation is significantly different from that envisaged at the end of 2006. The WCC competencies have refocused the way the PCT needs to work and how it develops and deploys the capability and capacity it has in order to deliver the business of commissioning. In this context we have looked at a number of areas to determine what we need to do to increase our ability to deliver the Strategic Plan.

Examples of these are:

- The development work undertaken by the Board, PEC, Leadership Team and Directorates since the beginning of the PCT, using external OD consultants and internal resources. This along with, for example, staff surveys and HR data, has been used to inform our organisational needs for culture, people, processes, systems and structure. This has been valuable as the building blocks for this process.

- The views of staff as part of our commitment to staff influence.

- The Board self certification

- Competency sessions undertaken both with staff, Executive and Non Executive Directors.

- The report from the WCC panel has provided us with an external and different view of our current abilities and highlighted areas for further development, in particular the 5 competencies that were scored at level 1 by the panel. This, along with stakeholder feedback and our own further reflections has provided a further and powerful insight.

The Organisational Development Plan identifies clear action that needs to be taken (most already underway) to ensure we are able to deliver this Strategic Plan, the action is focused on the following areas:

Structure

Outcome: To have in place a structure that is aligned to the delivery of the aspirations of WCC and achievement of the separation of the provider unit.

The structure is underpinned by a culture which promotes a 'flat' way of working with 'freedom to act' balanced with accountability.

Actions for Structure:

- The PCT Board will undergo a development process in line with the emerging national programme – this will also consider how the organisation is structured including committees of the Board to ensure effective delivery.
- The Directors will continue with the review of the management structure, taking into account the World Class Commissioning Competencies, Local Government Review, provider separation and PBC for the best use of our capability and capacity. This will build on the review of Directors portfolios in early 2009. The current portfolio of Directors has been revised to reflect WCC competencies including Partnership work**,** Performance Management, Finance and Public Health. The skill shortage of health economist will be addressed in 2009 as capacity becomes available. The Directors have already begun to recruit to key roles based on weaknesses identified in the SWOT analysis done in 2008.
- Staff who are going to work fully with CECH transferred from April 2009 and others who will continue to work across the two will have SLA's
- For PBC, a workshop was held in December 2008 as the start of a process to identify what was required in terms of resources to support the development of the 3 PBC clusters. An action plan is being implemented to take forward the recommendations from the workshop to refocus commissioning to become PBC facing
- Put into place programme/project and matrix working arrangements - an internal development process has been devised to support staff to understand what matrix working means and how it can add value to achieving projects.
- Build into performance management reporting – not just to report on what but also to include reference to how, e.g. did we set up a cross functional team as part of the initial project management plan for commissioning xyz?

Systems

Outcome: To have in place robust systems that enable the organisation to make decisions, plan, execute and manage at world class level.

We are and will further develop the Management systems in place to support the delivery of this operational plan

Actions for Systems:

- Take forward the recommendations from the external review of Communications and Engagement
- Take forward the recommendations of the internal review of our performance management system and information to manage - this emerged as a key issue in an externally facilitated development process for the Leadership team. We will also be increasing our capacity in the area of performance monitoring and management to reflect the needs of the organisation's responsibilities.

Staff

Outcome: To ensure we are best placed to recruit, develop and retain staff to deliver the Strategic Plan

Actions for Staff:

- We will review the current recruitment and selection process across the PCT and assess the process fit into the competency toolkit according to level and occupation. The development of a proactive PCT wide Recruitment and Retention Strategy will provide managers with a clear guideline to attract and retain high quality talent against external competitors within current financial constraints. Further work is ongoing on competencies where we will review all post profiles under the Key Skills framework linking into the World Class Commissioning Competencies.
- Effective succession planning will ensure that we have a pool of internal talent that can be deployed to meet our future business needs. Use of the NHS North West Academy toolkit is being considered and we will be actively encouraging the usage of the SHA mentoring Scheme for our employees.
- We will develop an action plan linked to the Talent Management strategy by exploring the best fit tools to provide clear criteria of how to identify and develop our future leaders.
- We will optimize employee engagement and address key areas such as retention, wellbeing and recognition by building on existing staff communication tools such as the recently established staff forum for commissioning staff, to enable us to measure employee engagement and identify key drivers and execute action plans to address those areas requiring close attention. The 2008 Staff Survey results are currently being analysed and have been broken down into a provider / commissioning split allowing for greater analysis of the results. An Action Plan is being developed to ensure continued progress.
- We will develop a formal staff engagement strategy to address frequency of communications and feedback, staff involvement and improve our utilisation of staff survey data providing feedback for a two way engagement process, incorporating key employment issues raised via communication forums and staff surveys into working objectives at organisation, divisional and individual levels.
- We will continue to monitor contract and procurement processes to ensure the inclusion of workforce criteria from our providers.

Skills

Outcome: To have a workforce that collectively has a comprehensive breadth and depth of skills across the WCC competencies

Actions for Skills:

- We will review options for programmes to support the development of clinical leadership
- We will look to the NHS NW Leadership Academy programmes to support the development of existing and aspiring leaders in the organisation
- We will explore the possibility of using a team learning needs assessment tool linked into the WCC competencies and if this is not suitable, develop an internal assessment model.
- We will develop our managers' and leaders' coaching skills so that staff development forms an integral part of their managerial style
- We will develop a programme of learning events to increase skills to support WCC competencies. In particular we will focus on:
  - Health needs assessment
  - Understanding PBC
  - Procurement
  - Market development and management
  - Contract negotiation and management
  - Project management
  - Political awareness
  - Financial management
  - Change management
  - Communicating and engaging with stakeholders

The design of these will be short sessions using key internal experts where appropriate

- Look to developing key competencies for all job roles taking into account KSF outlines
- Develop a strategy to assist Bands 1- 4 to utilise current learning opportunities in particular NVQs
- Produce and implement a Skills For Life strategy so that English and Maths assessment is embedded at recruitment

Governance to Oversee Organisational Development (OD):

Governance arrangements for OD were established early in the life of the PCT. This continues to be through the Directors and the Governance & Audit Committee (a sub committee of the Board). The lead is the Associate Director for Organisational Development and the Director for Governance and Strategy is the accountable Executive.

6.2. Resourcing our Strategic Plan

The financial template starts with the actual position for 2007/08, as per our published audited accounts, and covers the next 5 year period (i.e. from the current year 2008/09 through to 2012/13). The template is underpinned by a number of assumptions, most notably on income, expenditure and activity changes. Where guidance has been provided, by either the Strategic Health Authority or the North West Specialist Commissioning Team, these assumptions have been reflected in their entirety within the plan.

In addition, the PCT Board had already adopted a 3 year Financial Plan (covering the period 2008/09, 2009/10 and 2010/11) during the last financial year. Accordingly, where possible, this new 5 year strategy is simply predicated on this earlier model.

Finally, the impact of the recently announced transfer of Learning Disability, Social Care funding to Councils has not been reflected within this plan.

Delivering a surplus
We have always aspired to balance its income and expenditure, seeing a large surplus as a significant failing as a large deficit.

Accordingly, in previous years, the surplus has ranged from £286,000 in 2005/06 on a turnover of £506m, to £1,007,000 in 2008/09 on a turnover of £620m.

Therefore, within the plan, and in line with the Strategic Health Authority guidance, it is envisaged that an annual surplus of £1,007,000 is achieved in each successive financial year, on a turnover ranging from £621m in 2008/09, to £747m in 2012/13, although this requires significant Cost Improvement and Demand Management Savings to be delivered.

Financial Context
Whilst the PCT are really pleased with the progress recently made to improve the health of the people of Central & Eastern Cheshire, together with improvements to the healthcare systems, there are some significant financial challenges that we face for the coming financial year.

This is because we have significantly over performed during the current year (2008/09) on both the levels of acute hospital activity purchased (circa £12m), and also on the amount of NHS Continuing Care provided (circa £5m).

However, during 2008/09 we have been able to deliver a number of one off, non recurrent, savings through either the sale (re-use) of assets or by delaying planned expenditure.

This level of over performance is anticipated to continue with little, or no, room left for any further non recurrent savings. Therefore, 2009/10 will be challenging. In addition, the emerging public sector funding position is unlikely to resolve these pressures.

What is therefore required is not another “quick fix”, but a sustained focus upon our finances, with all staff, and contractors, questioning every pound we spend, or commit to spend.

Financial Recovery
With regard to the “Unidentified Demand Management Savings” for 2009/10 work remains ongoing within the PCT focusing on Recovery, to both target the additional £13,120k savings required, and also to effectively manage the Cost Improvement Programs (£5,309k) and the High Risk Demand Management Savings (£8,000k).

In addition, there is a degree of clarification required, and ongoing work, with regard to the PCT’s two main Contracts, namely Mid Cheshire Hospitals Foundation Trust and East Cheshire Trust, which may ameliorate the headline recovery required. The PCT is currently using the following **five point plan** to aid the focus of attention, namely:

- establishing a Task Group focusing on Demand Management issues (including analysis of activity and coding trends);

- producing a comprehensive list of areas which are discretionary, in order that expenditure can be reviewed against the PCT’s Priority Setting Framework (before

June 2009). (NB. These areas may have a significant impact on existing service delivery);

- analysing where the PCT's expenditure is greater than expected compared to either Budget, Allocation or expected (using benchmarking data). This to include core and recent developments and to include options for addressing any imbalance;

- an extensive Communications Strategy both internally and externally, to ensure the financial situation is thoroughly understood;

- a robust management of the Recovery Planning process, possibly including the short term appointment of a Recovery Director, should this be required

The PCT investment plan

Secondary & Tertiary Care (i.e. Payment by Results) – links to Goal 9
The largest investment in financial terms is the additional monies being invested into secondary care (i.e. hospital) services, equating to an additional £12m in 2009/10 (pre recovery).

The main components of this increase (in 2009/10) being an assumed 2.2% inflationary uplift, plus the impact of the migration to Healthcare Resource Group 4.0.

Specialist Commissioning – links to Goal 9
In terms of percentage increases in expenditure, the Specialist Services receive the largest uplift totalling circa 10%, for 2009/10 and 2010/11. This investment being a reflection of both the growth in treatment able to be provided (i.e. earlier intervention) and also a remedy of historic under investment, principally due to geography (i.e. local services).

Urgent Care Centres – links to Goal 5
As part of our strategy to tackle urgent and unplanned care, both capital and revenue investments (circa £1m 2009/10 and £1m 2010/11) are being targeted to tackle this particular issue.

Whilst a small reduction in hospital activity is envisaged, the major driver remains the focus on improving both quality and access.

Primary Care Premises Developments – links to Goal 3
The only major change to our previously adopted 3 year Financial Plan is the movement from 2009/10 and 2010/11 to 2011/12 and 2012/13 of a number of Primary Care developments (i.e. to "push out").

This is, in part, due to a reflection on current progress and a realistic rebasing of when these new premises are likely to actually open (circa £1m and £1.5m).

New Services – Improving Access to Psychological Therapies – links to Goal 2
Following a successful bid to the Department of Health, it is envisaged that the PCT will receive, and invest, a total of £1.5m per annum between 2009/10 and 2011/12.

However, there is currently a degree of uncertainty surrounding the 2012/13 financial year (i.e. "pick up") as to whether this scheme will be continued to be centrally supported.

Continuing Care – links to Goal 2
An additional £1m per annum, over and above inflation, has been factored into the Financial Plan to meet the assessed needs of our more dependent population. For 2008/09 this expenditure totals circa £15m, and this investment reflects a significant increase.

WCC Outcomes
The investments required to achieve our WCC outcomes have been factored into our 5 year financial plans. A proportion of this investment will be shown separately in the Financial Plan. However some of the resources will be included under more generic headings (e.g. secondary care activity, or Primary Care developments).

Underlying Assumptions And Risk
PCT Allocation Uplift (Income)

	Financial Year			
	2009/10	2010/11	2011/12	2012/13
PCT Uplift	5.5%	5.5%	4.0%	4.0%

As previously noted, these percentage uplifts have been received from the Strategic Health Authority and are considered to be prudent, although should the economic climate result in lower growth it is anticipated that pay awards and inflation will also be reduced correspondingly.

We remain optimistic that the imminent revision to the current PCT "needs based" funding formula may lead to increases in excess of this amount.

Inflationary Uplifts (Expenditure)

		Financial Year		
Inflation:	2009/10	2010/11	2011/12	2012/13
GP Contract	1.7%	2.8%	1.0%	1.0%
Dental Contract	1.7%	2.8%	1.0%	1.0%
PbR	2.2%	2.8%	1.0%	1.0%
Non PbR Tariff	2.2%	2.8%	1.0%	1.0%
Prescribing	8.0%	8.0%	8.0%	8.0%

These percentage uplifts have been received from the Strategic Health Authority and are considered to be robust, although similarly to the allocations, should the economic climate result in lower growth it is anticipated that inflation will also be reduced correspondingly.

However, these uplifts are after an assumed 3% annual cost improvement programme across the board on all expenditure headings (i.e. PbR Tariff pressures are acknowledged to be 5.2%, but we will only fund 2.2% with a further 3.0% assumed to be found internally by Providers from efficiency savings).

This assumption of 3% year-on-year savings look increasingly "harsh", especially in the later years of 2011/12 and 2012/13 when inflationary pressures are estimated to be circa 4%, yet only 1% will be actually funded (i.e. 3% to be found internally).

In addition, given the recent rises in inflation, these assumptions may need to be revisited which, without increases in the PCT uplift, would result in pressures within the Plan.

Activity Growth
Within the secondary care activity, a significant amount of modelling work has been undertaken, led by the Cheshire & Merseyside Contract & Information Shared Services Unit (CISSU).

This modelling work has focussed on individual hospital activity at a healthcare related group (HRG) level starting with 2003/04 and running through to 2007/08.

This activity has been then used as a basis on which to estimate future growth, and also applied to the non PbR activity.

Accordingly, it has been assessed, as a prudent estimate, to use a 2% year-on-year growth in activity for both 2009/10 and 2010/11, when using previous trends. However, it is considered that these increases will plateau in 2011/12 and 2012/13 with a reduced increase of only 1% for these two years respectively.

Further work is now being undertaken to examine the actual impact of our demographics (i.e. reduced children and increased elderly) but modelling this through the actual PbR costing system.

6.3. Governance and Performance Management of the Strategic Plan

We will ensure that strategic objectives are achieved and targets delivered through our existing robust performance management systems.

The current infrastructure and reporting arrangement for governance will support the governance of the implementation of our strategic plan.

The Strategy has been developed into detailed project plans. The detailed project plans will be monitored by the Performance Committee (on behalf of the Board) and the Leadership Team (executive and senior managers), to give full assurance to the Board that strategic objectives will be achieved.

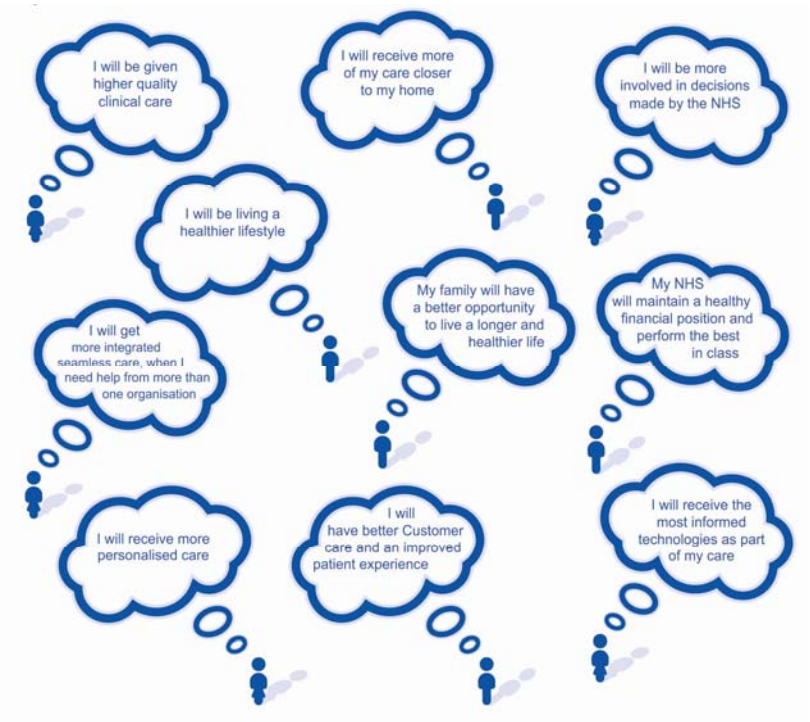
The Governance and Audit Committee will, as part of their reviews of services, incorporate the governance arrangements for each project into their annual timetable.

This approach ensures both governance and performance are monitored by both executive and non-executive directors in detail, outside of a formal Board meeting. The detailed monitoring will give the Board full assurance that implementation of the Strategy is taking place or that risks are being mitigated.

The monthly formal Board meetings will receive and consider reports setting out the progress made in delivering the plan, these reports will focus on the achievement of the agreed outcomes and impact of the strategic plan on the health of the communities we serve and the health services we commission.

6.4. Delivering Our Strategic Plan to Drive ‘Healthier Horizons’

‘Healthier Horizons’ is the North West strategy for transforming health and healthcare, the strategy sets out 10 “Touchstones” through which individuals will be able to ‘judge’ improvements in health and healthcare, see below.



Our Strategic Plan has been designed to deliver these 'touchstones' and thereby contribute to the overall transformation across the North West. Each of the Touchstone tests will be adopted by us as an integral part of our Strategic Plan success criteria.

7. Declaration of Board Approval

Central and Eastern Cheshire PCT's Trust Board have been fully involved and engaged throughout the development of the Strategic Plan. The Board has regularly reviewed the progress of the plan and spent focussed and dedicated time on it's development. We have also revisited Central and Eastern Cheshire PCT s vision, goals and outcomes, set out our commissioning intentions and agreed a five year financial plan.

The Board therefore fully endorses and accepts its responsibility to ensure that the improvements in health outcomes it describes are delivered. It will do this by identifying and mitigating the risks, overseeing a system of effective governance and developing a world class performance and learning culture within the organisation to benefit the people of Central and Eastern Cheshire.

Attachment 1 – WCC Outcome Measures

<table>
<tr><td colspan="4">We will increase breastfeeding initiation rates and make breastfeeding the norm in infant feeding in Central and Eastern Cheshire.</td></tr>
<tr><td>Outcome Measures</td><td>Baseline</td><td>Trajectory</td><td>Benchmark</td></tr>
<tr><td>An additional 106 initiations year on year for MCHFT, 79 year on year for ECT and 26 year on year for our other providers.</td><td>
<table>
<tr><th></th><th>PCT</th><th>ECT</th><th>MCHT</th></tr>
<tr><td>2007/08 Annual</td><td>61%</td><td>67%</td><td>54%</td></tr>
<tr><td>2008/09 Q1</td><td>65%</td><td>71%</td><td>59%</td></tr>
<tr><td>Q2</td><td>63%</td><td>65%</td><td>59%</td></tr>
<tr><td>Q3</td><td>64.6%</td><td>67.9%</td><td>60.3%</td></tr>
<tr><td>Q4</td><td>66.2%</td><td>73.7%</td><td>59.5%</td></tr>
<tr><td>2008/09 Annual</td><td>64.7%</td><td>69.7%</td><td>59.2%</td></tr>
</table>
</td><td>MCHFT have been successful in gaining DH Inequalities funding for 09/10 – 2011/12 (3 years) to achieve Baby Friendly status. An increase has therefore been set of 3% per year.

ECT has not received additional funding and therefore the national target of 2% has been set.

Other Providers – A small number of mothers receive maternity services from providers, other than MCHFT and ECT. An increase of 2% per year at these providers will give a year end initiation rate for the PCT of 77%

This gives a PCT increase of 13% over the 5 year project.</td><td>The highest rate within the CECPCT's ONS group - prosperous small towns (c) - is currently at 79%.</td></tr>
<tr><td colspan="4">We will transform the quality of dementia care.</td></tr>
<tr><td>Outcome Measures</td><td>Baseline</td><td>Trajectory</td><td>Benchmark</td></tr>
<tr><td>By 2014 60% of expected dementia sufferers will be captured on a practice based register, with an active care plan.</td><td>Currently we have 2,200 people registered with our practices. It is expected that there are in the region of 3,900 people undiagnosed. This is 37% of the expected number registered with a GP practice.</td><td><u>End of year 1: Increase of people on dementia registers by 5%</u>
Clear plan, based on local population and services of how to redesign, recommission and invest in memory services in order to provide world class commissioning memory services and dementia registers.
<u>End of year 2: Increase in dementia registers by a further 5%</u>
Working with MH trust to incorporate new pathways, and develop the planning done in year one. Looking at redesigning and or recommissioning current services
<u>End of year 3: Increase in dementia registers by a further 10%</u></td><td>CECPCT is the only PCT that has chosen Dementia as one of its WCC objectives. However it is possible to benchmark against other PCT areas.

The average % for those people diagnosed with</td></tr>
</table>

<table>
<tr><td></td><td></td><td>Look at further investment to enhance and develop further memory services
<u>End of year 4: Increase in dementia registers by a further 10%</u>
Implementation and contract monitoring</td><td>dementia and on a register against the expected prevalence is 35%. CECPCT is slightly above that at 37%.

Looking beyond the Northwest Dartford will be used as a benchmark as they have 52% people diagnosed with dementia and on a register.</td></tr>
<tr><td colspan="4">We will reduce the CHD mortality rate for all ages.</td></tr>
<tr><td>Outcome Measures</td><td>Baseline</td><td>Trajectory</td><td>Benchmark</td></tr>
<tr><td>We will achieve equity by reducing the CHD mortality rate. This will increase male and female life expectancy.</td><td>Within Central and Eastern Cheshire around 37% of deaths are specifically related to CHD.

Current 2007 directly standardized death rate for CHD person all ages is 83.94 per 100,000 (683 deaths)

CECPCT currently ranked 56th out of 152 PCTs (1 being the lowest rate nationally).</td><td>
<table>
<tr><th>Year</th><th>CHD Rate/100,000</th><th>WCC stretched pan rate <75 years/100,000</th></tr>
<tr><td>2002</td><td>122.28</td><td></td></tr>
<tr><td>2003</td><td>110.81</td><td></td></tr>
<tr><td>2004</td><td>109.92</td><td></td></tr>
<tr><td>2005</td><td>104.56</td><td></td></tr>
<tr><td>2006</td><td>95.72</td><td></td></tr>
<tr><td>2007</td><td>83.94</td><td></td></tr>
<tr><td>2008</td><td></td><td>78.58</td></tr>
<tr><td>2009</td><td></td><td>73.56</td></tr>
<tr><td>2010</td><td></td><td>68.86</td></tr>
<tr><td>2011</td><td></td><td>64.46</td></tr>
<tr><td>2012</td><td></td><td>60.35</td></tr>
<tr><td>2013</td><td></td><td>56.50</td></tr>
</table>
</td><td>Compare ourselves with European rates, local Cardiac Network PCT rates, like PCT's and national rates</td></tr>
</table>

<table>
<tr><td colspan="4">We will reduce the <75 cancer mortality rate.</td></tr>
<tr><td>Outcome Measures</td><td>Baseline</td><td>Trajectory (incl. baseline)</td><td>Benchmark</td></tr>
<tr><td>To increase by 20% the proportion of people who are diagnosed at an earlier stage of cancer. This will positively influence CECPCT <75 years cancer mortality rate.</td><td>Current 2007 directly standardised death rate for cancer in persons aged under 75 is 112.55 per 100,000 (597 deaths).

CECPCT currently ranked 65th out of 152 PCTs nationally (1 being the lowest rate).</td><td>
<table>
<tr><th>Year</th><th>Cancer mortality rate <75 yrs /100,000</th><th>VBS03 plan rate <75 yrs /100,000</th><th>WCC stretched plan rate <75 yrs /100,000</th></tr>
<tr><td>2002</td><td>119.47</td><td></td><td></td></tr>
<tr><td>2003</td><td>109.78</td><td></td><td></td></tr>
<tr><td>2004</td><td>112.11</td><td></td><td></td></tr>
<tr><td>2005</td><td>113.75</td><td></td><td></td></tr>
<tr><td>2006</td><td>106.2</td><td></td><td></td></tr>
<tr><td>2007
2008
2009
2010
2011
2012
2013</td><td>112.55</td><td>

101.23
99.06
96.93
91.53
87.53</td><td>112.55
106.56
100.89
95.52
90.43
85.62
81.07</td></tr>
</table>
</td><td>Vital signs metrics indicate delivery against most new and existing targets over the next 5 years

Cancer Intelligence system (cancer registry)

Registrars office death data

Cheshire & Merseyside Cancer Network Cancer Screening Group</td></tr>
<tr><td colspan="4">We will increase the percentage of stroke admissions given a physiotherapy assessment within 72 hours.</td></tr>
<tr><td>Outcome Measures</td><td>Baseline</td><td>Trajectory</td><td>Benchmark</td></tr>
<tr><td>April 2009 - all implementation plans for stroke approved by the Boards.
Patient Surveys
Achievement of targets</td><td>Taken from 2007 Sentinel audit: East Cheshire Trust - 59% compliance with target. Mid Cheshire Hospitals Foundation Trust - 98% compliance to target. More accurate data shows 80% compliance. Both hospitals achieve this on the stroke units only and figures taken in first quarter of 2008/09</td><td>Physiotherapy assessment within 72 hours for all patients suspected of having a stroke
• September 2009 - 90% all patients suspected of having a stroke will be assessed within 1 hour of contact with the NHS in a hospital setting.
• September 2009-2010 - 90% of patients admitted with Stroke will have physiotherapy assessment within 72 hours
• September 2010-2011 - 95% % of patients admitted</td><td>Compare ourselves with European rates, local Stoke Network PCT rates, like PCT's and national rates.

National Sentinel</td></tr>
</table>

	show only 25% compliance in both hospitals when all stroke admissions are taken into account. Some of the issues may be due to current data collection problems at the hospitals.	with Stroke will have physiotherapy assessment within 72 hours • September 2011-2012- 100% of patients admitted with stroke will have Physiotherapy assessment within 72 hours	Audit for Stroke (2008)
We will improve patient and user reported measure of **respect and dignity** in their treatment. All providers will be within the top 20% of benchmarked against similar organizations in relation to all indicators in the National Patient Survey.			
Outcome Measures	**Baseline**	**Trajectory**	**Benchmark**
By 2014 all Providers' performance, including Independent Contractors, will be within the top 20% benchmarked against similar organisations in relation to all indicators in the National Patient Survey.	2007/2008 National Patient Survey results for CECPCT, MCHfT, ECT, CWPfT. (NB. No current benchmarking data available for PCT Community Services, however, a National Patient Survey is planned for 2009/10.)	End of year 1: All major provider's performance, including independent contractors, will be within the top 80% benchmarked against similar organizations in relation to all relevant* indicators in the National Patient Survey. (I.e. Providers' scores will not feature in the lowest 20% for any of the indicators.) End of year 2: All providers' performance, including independent contractors, will be within the top 65% benchmarked against similar organizations in relation to all relevant indicators in the National Patient Survey. End of year 3: All providers' performance, including independent contractors, will be within the top 50% benchmarked against similar organizations in relation to all relevant indicators in the National Patient Survey. End of year 4: All providers' performance, including independent contractors, will be within the top 35% benchmarked against similar organizations in relation to all relevant indicators in the National Patient Survey. *Relevant indicators are those questions that relate directly to services that are directly within the power of the organization to influence. These will be agreed with Providers.	The National Patient Survey Programme, co-ordinated by the Healthcare Commission, gathers feedback from patients on different aspects of their experience of care they have recently received, across a variety of services/settings*, with a particular focus on dignity and respect. *Services/settings covered include: Inpatients, Outpatients, Emergency care, Maternity care, Mental health services, Primary care services and Ambulance services.

We will reduce the rate of **alcohol**-related hospital admissions by 4,000 over 5 years.

Outcome Measures	Baseline	Trajectory	Benchmark
Achievement of 1% reduction target described above Increase in the number of hazardous/harmful drinkers being given brief interventions to reduce their drinking Improve access for people with alcohol related problems to appropriate services	In 2006/07 the rate of hospital admissions for alcohol related harm in the PCT area was 1604.87 per 100,000. In 2007/08 this rate increased to 1820.01 per 100,000.	1% reduction in percentage changes year on year from baseline (2006/07)	Compare ourselves regionally and nationally using Local Alcohol Profiles and data from the National Drug Treatment Monitoring System.

Year	Trajectory rate/100,000	Target of +1% decrease per year Rate/100,000	Admissions to prevent
2008/09	2063.82	2009.55	244
2009/10	2340.3	2218.46	548
2010/11	2653.81	2426.92	1021
2011/12	3009.33	2630.69	1704
2012/2013	3412.47	2825.26	2643
2013/2014	3869.61	3005.97	3887

We will transform **Urgent Care** services

Outcome Measures	Baseline	Trajectory	Benchmark
A reduction in the rate of Emergency Admissions due to Ambulatory Conditions from 14.48 /1000 population (above national average) to below 11.50 / 1000 population placing the PCT in the top quartile against national performance.	14.48 ACS admissions / 1000 population.		NHS Comparators data repository. Benchmark information from the GP Out of Hours national benchmark. Focus groups

Year	Trajectory rate/1000 population	Approx Admissions to prevent
2008/09	14.48	0
2009/10	13.80	200
2010/11	13.00	400
2011/12	12.20	400
2012/13	11.40	300

Health Inequalities			
Outcome Measures	**Baseline**	**Trajectory**	**Benchmark**
Reduce premature mortality from conditions amenable to prevention or treatment – 'preventable deaths'.	Reduce premature cancer mortality by 24% (137 deaths per year) within the areas of low life expectancy. Reduce premature CHD mortality by 38% (282 deaths per year) within the areas of low life expectancy.	An increase of almost 9 months in male life expectancy to 78.8 years and an increase of almost 11 months in female life expectancy to 82.7 years. An increase of over 14 months in male life expectancy to 79.3 years and an increase of over 11 months in female life expectancy to 82.7 years.	
Life Expectancy			
Outcome Measures	**Baseline**	**Trajectory**	**Benchmark**
Increase life expectancy in the 18 spearhead MSOA areas, which have the lowest life expectancy.	2005-07 the Life Expectancy in the lowest life expectancy quintile was 76.2 years for males and 79.8 years for females.	An increase in life expectancy in this quintile to 79.5 years for males and 84.5 years for females, equivalent to life expectancy in the highest life expectancy quintile.	