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Health and Wellbeing Board

Agenda

Date:	**Tuesday, 16th June, 2015**
Time:	**2.00 pm**
Venue:	**Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ**

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

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

1. **Apologies for Absence**

2. **Appointment of Chairman**

   To appoint a Chairman for the 2015/16 Municipal Year.

3. **Appointment of Vice-chairman**

   To appoint a Vice-chairman for the 2015/16 Municipal Year.

4. **Declarations of Interest**

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

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

5. **Minutes of Previous meeting** (Pages 1 - 12)

To approve the minutes of the meeting held on 24 March 2015.

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

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

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

7. **Better Care Fund Update (Standing Item)** (Pages 13 - 22)

To note the Better Care Fund Update report.

8. **Quality Premium 2015-16** (Pages 23 - 36)

To consider a report requesting the Board to support and approve the final CCG Quality Premium measures and local priorities for 2015-16.

9. **Future Priorities** (Pages 37 - 40)

To consider and comment upon the proposals for future priorities and to agree a way forward to drive action upon these.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Health and Wellbeing Board**
held on Tuesday, 24th March, 2015 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Councillor J Clowes (Chairman)

Cllr Rachel Bailey, CE Council
Cllr Alift Harewood, CE Council
Mike Suarez, Chief Executive, CE Council
Jerry Hawker, Eastern Cheshire Clinical Commissioning Group
Paul Bowen, Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse, South Cheshire Clinical Commissioning Group
Dr Heather Grimbaldeston, Director of Public Health, CE Council
Tony Crane, Director of Children's Services, CE Council
Brenda Smith, Director of Adult Social Care and Independent Living, CE Council
Kate Sibthorp, Healthwatch
Richard Freeman, NHS England local area team member

Associate Non Voting Members
Lorraine Butcher, Executive Director Strategic Commissioning, CE Council

Officers/others in attendance
Deborah Nicholson, Legal Services, CE Council
Guy Kilminster, Corporate Manager Health Improvement, CE Council
Julie North, Democratic Services, CE Council
Dr Guy Hayhurst, Consultant of Public Health, CE Council
Ann Riley,Corporate Manager,Strategic Commissioning, CE Council
Louisa Ingham, Better Care Fund Finance Lead
Jon Wilkie, Commissioning Manager, CE Council
Karen Burton, Eastern Cheshire CCG
Julia Burgess, South Cheshire CCG
Jacki Wilkes, Eastern Cheshire CCG
Anne Higgins, Head of Transformation Adult Services, CE Council

63. **APOLOGIES FOR ABSENCE**

Apologies for Absence were received from Dr Andrew Wilson, Tina Long (Substitute Richard Freeman) and Anita Bradley (Substitute Deborah Nicholson).

64. **DECLARATIONS OF INTEREST**

There were no declarations of interest.

65. **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes of the meeting held on 27 January 2015 be approved as a correct record.

66. **PUBLIC SPEAKING TIME/OPEN SESSION**

There were no members of the public wishing to use the public speaking facility.

67. **BETTER CARE FUND - SECTION 75 PARTNERSHIP AGREEMENTS**

Consideration was given to a report relating to Better Care Fund (BCF) Section 75 Partnership Agreements.

It was noted that the Board was responsible for the ongoing oversight of the delivery of the Better Care Fund (BCF) plan during 2015/16 and whilst not a signatory of the s75 partnership agreement it would have a role in gaining assurance that partners were collectively working together to deliver the plan.

The BCF was a national pooling of £3.8billion from a variety of existing funding sources within the health and social care system and would be utilised to deliver closer integration across health and social care. The BCF was a pooled budget held between Local Authorities and Clinical Commissioning Groups (CCG's) via a legal section 75 (s75) partnership agreement. The Fund provided a tool to enable local integration programmes. It would be spent on schemes that were integral to improving outcomes for local people. The BCF plans and allocations had been developed on the Cheshire East Health and Wellbeing Board basis and the pooled budget for Cheshire East would be £23.9m and consisted of Local Authority Capital funding of £1.8m, South Cheshire CCG funding of £10.5m and Eastern Cheshire CCG Funding of £11.6m.

On 27th January 2015, the Board had endorsed progressing with two separate s75 pooled budget agreements locally, to support the delivery of the Better Care Fund plan and to be aligned with the respective health integration programmes. The report provided the Board with an update on the implementation and delivery of the Cheshire East Better Care Fund, as approved by NHS England. It requested that the Board support and endorse the scheme specifications included within the s75 partnership agreement and the partnering of the Council and CCGs through two s75 Partnership Agreements from 1st April 2015 until 31st March 2016 and to continue post April 2016, so long as there was a national requirement to operate the Better Care Fund as a s75 pooled budget agreement.

It was reported that new operational guidance in respect of the BCF had been received from NHS England, the Department of Health and DCLG and this would need to be taken into account in the Better Care Section 75

agreement and that the timeframes for presenting a BCF update on performance, as set out at paragraph 4.6 of the report, may need to be revised.

It was reported that the figures in the chart at paragraph 5.1 of the report had been transposed and that the figure for the Eastern Cheshire CCG and CEC pooled budget should be £1,114.000 and the figure for South Cheshire CCG and CEC pooled budget £1,005,000.

RESOLVED

That the Health and Wellbeing Board(HWB):-

i) Supports and endorses that the s75 agreement is consistent with the Better Care Fund plan approved by the HWB on 25th March 2014 and recommends the Council and CCGs enter into two s75 partnership agreements, with Eastern Cheshire Clinical Commissioning Group (for Caring Together Programme) and South Cheshire Clinical Commissioning Group (for Connecting Care Programme) to deliver the Better Care Fund Plan;

ii) Notes the lead commissioning arrangements for delivery of the Cheshire East Better Care Fund;

iii) Agrees that the Cheshire East Joint Commissioning Leadership Team is responsible for reviewing the delivery of the s75 agreement and the Better Care Fund plan (covering commissioning working arrangements and the monitoring arrangements for contract, performance, risk and finance) pending a review of existing governance arrangements and notes the arrangements for reporting progress back to the Health and Wellbeing Board;

iv) Agrees the indicative timeframe for reporting BCF plan updates to HWB as detailed in section 8.6;

v) Accepts that the Joint Commissioning Leadership Team are responsible for reviewing and maintaining the BCF risk register, including agreeing the level of risk and will provide regular updates to the HWB, so that they can gain assurance that risks, level of risk and issues are being managed appropriately;

Recognises the need to undertake further work in respect of the impacts of the non delivery of the pay for performance fund.

vi) Recognises the need to collectively develop data sharing arrangements across organisations which support the delivery of BCF and other wider initiatives;

vii) Accepts that the HWB should be notified of variations to scheme specifications included in the BCF plan, including funding arrangements and fundamental changes to scheme specifications.

68. **NHS SOCIAL CARE ALLOCATION 2014/15**

The NHS Social Care Allocation to Cheshire East Council for 2014/15 was an amount of funding, determined by the DH, that was to be transferred from the NHS (NHS England) to Councils (Gateway Reference 01597). The funds were to be used to "support adult social care services….. that also had a health benefit". The way the funds were spent has to be agreed with local health partners. The formal agreement was between NHS England and Cheshire East Council via a s.256 agreement. However the NHS England Cheshire, Warrington and Wirral Local Area Team were seeking support from the Clinical Commissioning Groups, Eastern Cheshire CCG and South Cheshire CCG, to the proposals for spending. Consideration was given to a report outlining the proposed spend areas that had been agreed locally. It also included the proposed governance arrangements. The overall areas of spending had been identified and were detailed in a table within the report, including continuations of existing spending, agreed in-year new spend and proposed carry forward of all underspends to 15/16 and onwards under BCF plans.

The total allocation from NHS England to CEC for 2014/15 was £6.649m. Locally there were unspent allocations from 2013/14 which had been carried forward and ring-fenced for agreed spending in 2014/15, or for future BCF plans. This had produced a total available budget for 2014/15 agreement of £8.42m.

In considering the report the Board considered that it was necessary to understand the reason for the underspend and felt that, in order to demonstrate best value, it would be useful to have a detailed breakdown of the figures. It was noted that this information was already available and was reported to the JCLT on a monthly basis and it was agreed that the information should be passed onto the Board in order to provide reassurance.

The Board was requested to endorse the proposed spending of the allocation of social care funding and to regularly scrutinise performance against the agreed outcomes to ensure these contributed to the Health and Wellbeing Strategy outcomes.

RESOLVED

1.That the proposals for the spending areas and the governance arrangements be endorsed.

2.That it be noted that a review had taken place between CEC and the two CCGs of both current and future spend areas to ensure these proposals were agreed as the best ways of using this allocation for social care.

3.That the Board receive performance reports on this funding twice per annum at half-year and year-end.

4.That NHS England be recommended to release the funding allocation to CEC, based on the summary paragraph 1.2 of the report with any underspends ring -fenced for future years of BCF plans, as agreed.

69. **PHARMACEUTICAL NEEDS ASSESSMENT**

Consideration was given to a report relating to the final version of the Pharmaceutical Needs Assessment (PNA). The draft PNA had been consulted upon for 60 days between 19th November 2014 and 19th January 2015, with those specified in the Regulations. A total of 8 completed responses had been received and these comments had been incorporated where appropriate into the final version. No major changes to the PNA or to the Six Statements had been needed as a consequence of the consultation.

A new subsection 21.2 had been added to the PNA. It described the main new housing developments in Cheshire East, which should help to guide assessment of any new pharmaceutical provision. Three tables were included, covering dwellings currently under construction, those where development was likely to start or be completed within the next 3 to 5 years and also the main Strategic Sites which were identified within the Local Plan Strategy. The Board was requested to approve the PNA for publication.

RESOLVED

That the PNA be approved for publication.

70. **JOINT HEALTH AND SOCIAL CARE LEARNING DISABILITY SELF ASSESSMENT 2014 AND ACTION PLAN 2015/16**

Consideration was given to a report relating to the Joint Health and Social Care Learning Disability Self Assessment 2014 and Action Plan 2015/16.

The Learning Disability Health Self-Assessment Framework (LDSAF) had been an annual process since being used in England in 2007/8. 2013 had seen the introduction of a revised Joint Health and Social Care Self-Assessment Framework to emphasise the need for a joint commissioning approach between health and social care. As part of this process all Local Authority areas had again been asked to complete the self-assessment in 2014, working with their local health partners and learning disability partnership boards. The aim of the self assessment was to provide a framework for a comprehensive local stock- take exercise.

The self assessment for 2014 required each area to assess themselves against 26 measures using a RAG (Red Amber Green) ‘Traffic Light’ system. These measures were divided into three broad areas in the self

assessment, which were Staying Healthy, Being Safe and Living Well. Learning Disability Partnership Boards had been asked to rate provision in their area against this set of 26 measures. In Cheshire East, this had been undertaken by NHS and Local Authority colleagues, in collaboration with local care providers, self-advocates and family carers, through the Learning Disability Partnership Board.

An Action Plan had been devised with the Learning Disability Partnership Board to drive improvement in the areas where the rating was amber or red and to ensure that services continue to improve where they have been rated green. The full Action Plan was provided at appendix I of the report, with a summary of the actions to be taken included on the final 2 pages of the Plan.

With reference to Appendix 1 of the report – Actions Linked to SAF Section and 2014 Rating, it was noted that Action A2 had been recorded as been rated red and it should have been listed as amber.

The Board was requested to consider and endorse the Joint Health and Social Care Learning Disability Self Assessment Action Plan.

RESOLVED

That the Joint Health and Social Care Learning Disability Self Assessment Action Plan be endorsed.

71. **CONTINUOUS IMPROVEMENT IN COMMISSIONING FOR BETTER OUTCOMES**

Consideration was given to a report relating to Continuous improvement in commissioning for better outcomes.

It was reported that a single common commissioning model for all partners pan-Cheshire would support continuous improvement in commissioning for better outcomes. There were several commissioning models currently being used. Informed by learning from the Cabinet Office Commissioning Academy, the Commissioning Academy Cohort had offered to develop a single commissioning model for adoption across all partners.

The Commissioning Academy was a development programme for senior leaders from all parts of the public sector. It was designed to equip a cadre of professionals to deal with the challenges facing public services, to take up new opportunities and commission the right outcomes for their communities. The academy was supported by the Local Government Association, the Department for Communities and Local Government, the Ministry of Justice and the National Offender Management Service, the Department for Education, the Department of Health, the Department for Work and Pensions and the Home Office. Two cohorts from Cheshire East had been participating in the Cabinet Office Commissioning Academy. The first cohort included representatives from Cheshire East Council, Eastern

Cheshire CCG, South Cheshire CCG and the Office for the Police and Crime Commissioner. The cohort from Cheshire East was unique in terms of the partners represented, as all other area cohorts attended from a single organisation. This provided a unique opportunity to use the learning as a partnership.

RESOLVED

1.That Cheshire East Health and Wellbeing Board approach Cheshire West and Chester Health and Wellbeing Board to adopt the twelve standards described in 'Commissioning for Better Outcomes'

2.That the two Health and Wellbeing Boards adopt continuous improvement in commissioning for better outcomes as a joint project.

3.That the two Health and Wellbeing Boards (together or separately)complete the self assessment tool and establish a baseline of the quality of commissioning for better outcomes pan-Cheshire.

4.That the two Health and Wellbeing Boards establish a working group with appropriate representation to:-

- Review the available commissioning models and propose a single common commissioning model for pan-Cheshire.
- Review governance arrangements for commissioning decisions and propose a governance model to compliment the adopted commissioning model
- Develop a communications strategy to embed the commissioning model and governance arrangements in all partner agencies across Cheshire.

5.As the Pioneer Project already works across Cheshire East and Cheshire West and Chester, the Health and Wellbeing Boards delegate oversight of the work group to the Pioneer Project steering group.

6.That the Health and Wellbeing Boards re-assess quality of commissioning for better outcomes in January 2016.

7.That an update report be submitted to the June meeting of the Board.

72. **CARING FOR CARERS: A JOINT STRATEGY FOR CARERS OF ALL AGED IN CHESHIRE EAST 2015 - 2018**

Consideration was given to a report relating to Caring for Carers: A Joint Strategy for Carers of all aged in Cheshire East 2015 – 2018.

Eastern Cheshire Clinical Commissioning Group had worked in partnership with carers, South Cheshire Clinical Commissioning Group

and Cheshire East Council to develop a new three year strategy for carers. An evaluation of the previous strategy (2011-2015) showed that some progress has been made to improve the health and well-being of carers in Cheshire East. A number of engagement events had been held over a 12 month period to understand the stated needs of carers and review opportunities to meet those needs.

The publication of the 2014 Care Act outlined specific changes to the offer of support for carers and the impact of these changes had been assessed and included in the strategy. There were five priority areas outlined in the new strategy and an implementation plan would be developed for each area with a detailed set of actions to be undertaken in year one.

The implementation of the plan would be monitored by a Carers Reference group, which would look to develop a 'hub and spoke' approach to engagement, accessing existing carer groups within third sector organisations. An outcomes framework, with measures of success would be developed alongside the implementation plan and used to monitor progress. This would report to the Health and Wellbeing Board via the Joint Commissioning Leadership Team. It was reported that delivery of the strategy would require additional resources from across the three commissioning organisations and agreement was sought in principle for shared appointment of a project coordinator and associated costs.

The Strategy had been amended to include the development of a carer co-production charter and the detailed implementation plan would look at empowering carers.

RESOLVED

1.That the strategy for 2015-18 be agreed as a direction of travel in that it aligns to the Caring Together and Connecting Care vision and transformation agenda and as such is a key priority for Cheshire East Council, South Cheshire and Eastern Cheshire Clinical Commissioning Groups.

2.That the proposal to consider the implementation action plan and resource requirements via the partnership Executive Teams be approved.

3.That the proposal to monitor progress of delivering this strategy via the Joint Commissioning Leadership Team and report as required to the Health and Well Being Board be endorsed.

73. **NHS SOUTH CHESHIRE CCG DRAFT OPERATIONAL PLAN 2015-16**

The refreshed NHS South Cheshire CCG Draft Operational Plan 2015-16 was intended to inform local people, partners and staff about the healthcare services that would be commissioned during 2015-16 on behalf

of the population covered by NHS South Cheshire Clinical Commissioning Group (CCG).

In the previous year the CCG had developed a 2 Year Operational Plan 2014-16. The CCG was now in the process of reviewing and refreshing the Operational Plan. *Forward View into Action: Planning for 2015-16* built on the direction of travel that all CCGs would have been following over the past year. Therefore, the refreshed Plan would not only reflect the progress that had been made against the stated plans and priorities from Year 1, but also realigned the narrative and focus in line with the *Five Year Forward View*.

Importantly the refreshed plan would reflect more fully on the Connecting Care Strategy and ensure that the programmes of work better reflected the CCGs clinical strategy, with greater focus on delivering the Priority Projects, whilst also remaining focused on the operational assurance of the NHS Constitution rand the NHS Mandate requirements.

As part of the NHS South Cheshire CCG Refresh Operational Plan the CCG had incorporated the work that had been undertaken as part of their Connecting care Strategy, to bring all local providers together to improve the health and wellbeing of the local population. The Strategy was underpinned by 6 key integration outcomes/foundation stones created by the Connecting Care Board to provide a single framework for integration and transformation, which aligned directly to the exiting NHS Constitution, health, public health, social care and 'Everyone Counts' outcomes frameworks and measures.

Each stone identified the specific area of the Connecting Care programme plan and the relative plans, aspirations and measures of success that related directly to the 6 health and social care integration outcomes. The CCG had adopted the foundation stones from the Connecting Care Strategy, along with reviewing the top health inequalities for its locality. From this work the CCG had adopted Strategic Priorities and local ambitions that would support the delivery of the Connecting Care Strategy, details of which were set out in the report.

The NHS South Cheshire CCG Operational Plan Refresh 2015-16 had reflected what the CCG had achieved during 2014-15 to enable them to look at their commissioning intentions that needed to be delivered starting in 2015-16. The achievements had been categorised again the NHS Outcomes Framework Domains. A list identifying some of the key areas of the CCGG's achievements was included in the report and further detail was contained within the plan, which was appended to the report.

It was noted that the full narrative detail of the CCGs refreshed Operational Plan would be made available locally, to be shared with partners and stakeholders, including NHS England following the final sign off form the Governing Body and NHS England, on 10th April 2015. The

CCG had prepared a programme for sharing the Plan with stakeholders and members of the public.

Members of the Board were requested to submit any comments in respect of the Plan by the end of the current week.

RESOLVED

1. That the draft Operational Plan 2015-16 be noted.

2. That it be noted that the final version would be published on the CCG website, following approval by NHS England in April 2015.

74. **CARE ACT UPDATE**

The Board received a short presentation providing an update in respect of the Care act 2014, which was the biggest change in Adult Social Care legislation for 60 years and included reforms in the the law and funding regime relating to care and support for adults and carers. The new legal framework brought legislation together into one modern law and encompassed the whole population, not just those with eligible social care needs.

The key features of phase one were a duty to promote people's wellbeing and to prevent need for care and support; a duty to provide an information and advice service about care and support; a requirement to carry out an assessment of both individuals and carers wherever they had needs, including people who would be ‘self-funders’; a duty to facilitate a vibrant, diverse and sustainable market of care and support provision and to meet people's needs if a provider of care failed; a national minimum eligibility threshold for support, a minimum level of need which would always be met in every Council area; a requirement to offer a universal deferred payment scheme, where people could defer the costs of care and support set against the value of a home they owned; a duty in some cases to arrange independent advocacy to facilitate the involvement of an adult or carer in assessing needs and planning for care; a duty to provide social care support to people in prisons and bail hostels; a duty to strengthen Safeguarding Adults Boards and to make safeguarding ‘personal’; embedding the right to choice through care plans and personal budgets.

The key features of phase two were the introduction of a revised upper and lower capital limits; a £72,000 cap for meeting eligible needs, care accounts; support after reaching the cap; free care for life (zero cap) for those born with an eligible need or who developed one in early life and an appeals process.

Everyone with eligible needs would be able to progress towards the cap, which would be set at £72,000. The rate at which they progressed would be based on what the cost was, or in the case of self-funders would be, to the local authority. This cost would be set out in a personal budget or an

independent personal budget. Progress towards the cap would be recorded in a care account. The local authority would maintain the care account and provide people with annual statements so they were informed of their progress. There would be a different approach for adults of working age.

The cap only included the cost of care to meet a person's eligible needs. Where a person was in a care home the local authority would deduct £230 per week for daily living costs to work out how much counted towards the cap. The rate included would be based on what the cost was, or in the case of self-funders would be to the local authority. This would not affect how much the provider received. Other costs which would not count included Top-up fees, NHS-funded care and only costs from April 2016 onwards would count.

Details of Cheshire East's approach to the act were reported. A new customer journey through adult social care was being designed and would be the foundation of all other developments. A new ICT system to support assessment and care management has been procured. The Care Act Project Board had overseen the implementation of the Care Act and task and finish groups, drawn from adult social care and corporate colleagues, had developed the detail of the changes. Public consultation on policy changes regarding fees had taken place and a detailed communications plan had been put in place.

RESOLVED

That the update be noted.

The meeting commenced at 2.00 pm and concluded at 4.25 pm

Councillor J Clowes (Chairman)

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CHESHIRE EAST COUNCIL

REPORT TO: Health and Wellbeing Board

Date of Meeting:	16th June 2015
Report of:	Lorraine Butcher – Executive Director of Strategic Commissioning
Title:	Better Care Fund – Update Paper
Portfolio Holder:	Councillor Janet Clowes – Health and Social Care

1.0 Purpose of Report

1.1 Cheshire East Health and Wellbeing Board (HwB) is responsible for the ongoing oversight of the delivery of the Better Care Fund (BCF) plan during 2015/16 and whilst not a signatory of the s75 partnership agreement it will have a role in gaining assurance that partners are collectively working together to deliver the plan.

1.2 An updated position on the Cheshire East Better Care Fund plan was presented to the Health and Wellbeing Board (HwB) on 28th April 2015. The HwB agreed the revised timescale for signing of the s75 agreements and acknowledged the risks associated with the delay. Partners agreed to support work to ensure the s75 agreements were signed off in line with the new timeframes. Given the timeframe for reporting to NHS England was not in line with the next meeting of the HWB (29th May v 16th June respectively), it was agreed to delegate responsibility for sign-off of the NHS England return to the Chair of the HWB for this to be done electronically.

1.3 South Cheshire CCG and Eastern Cheshire CCG have both signed their s75 agreements as of 29th May 2015 and these were executed by Cheshire East Council's Legal Services department on 1st June 2015.

1.4 The required report for NHS England was submitted on 27th May 2015 following sign-off from the Chair of the HWB. This report was focussed on allocations, budgets and national conditions rather than the high level budgets which future returns are expected to focus upon. A copy of this return can be seen in Appendix 1.

1.5 This report provides the HwB with an update on the progression of the Better Care Fund s75 agreement.

2.0 Recommendation

2.1 Members of the Health and Wellbeing Board are asked to note the content of this report.

3.0 Outstanding Actions

3.1 Next steps include:

- Formally pooling budgets
- Implementing a robust programme management and reporting framework regarding individual schemes and high level metrics
- Ensuring BCF scheme leads are working across departmental and organisational boundaries to maximise benefit to the public and avoid gaps/duplication

4.0 Implementing the Better Care Fund Plan

4.1 The Cheshire East Better Care Fund plan became operational on the 1st April 2015, with an ambition to improve the co-ordination and delivery of health and social care services across the Cheshire East area. The BCF plan is aligned with the local health and social care transformation programmes, Caring Together (Eastern Cheshire geography) and Connecting Care (South Geography).

4.2 The implementation of the BCF schemes is on target, including the dementia re-ablement service that became operational from 1st May 2015. It is anticipated that the Universal Outreach service will go live during 2015, subject to the tender evaluation process. These new services are focused on early intervention and prevention and aim to provide support and advice to Cheshire East residents so that they have the confidence and information to manage their situation before it escalates to a crisis.

4.3 As part of the transformation programmes and the BCF plan, partners are working collaboratively to review existing services including integrated care assessment and the support services delivered in the community with a particular focus on Short Term Assessment Rehabilitation and Recovery Services (STAIRRS).

4.4 The BCF plan includes ambitious performance monitoring targets, including a 3.5% reduction in non elective admissions (hospital admissions) during 2015/16 and this equates to a collective reduction of 1,422 non elective admissions across Cheshire East.

5.0 Performance Monitoring and Reporting

5.1 Further work is required by the BCF Commissioning Manager and the BCF Finance Lead to consolidate and co-ordinate performance monitoring and reporting, including delivery, performance and financial. It is acknowledged that there are a number of existing reporting mechanism in operation across organisations and where possible existing reporting mechanisms will be adopted.

5.2 The NHS England Operationalisation guidance outlines a minimum quarterly reporting process that must signed off by the HwB. The deadlines for the returns are outlined below:

HwB Board Date	To NHS England	Period Covering
25th August 2015	28th August 2015	April to June 2015
24th November 2015	27th November 2015	July to September 2015
26th January 2016	26th February 2016	October – December 2015

5.3 The next Health and Wellbeing Board is scheduled for 25th August 2015 at which the NSH England return due 28th August 2015 will be formally presented for sign-off

Report prepared by:

Caroline Baines (Strategic Commissioning Manager)

Louisa Ingham (Senior Accountant)

Appendix 1: BCF Quarterly Reporting Template for NHS England (Submitted 27th May 2015)

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Quarterly Reporting Template - Guidance

Notes for Completion

The data collection template requires the Health & Wellbeing Board to track through the high level metrics from the Health &

The completed return will require sign off by the Health & Wellbeing Board.

A completed return must be submitted to the Better Care Support Team inbox (england.bettercaresupport@nhs.net) by

This initial Q4 Excel data collection template focuses on the allocation, budget arrangments and national conditions. Details on future data collection requirements and mechanisms (including possible use of Unify 2) will be announced ahead of the Q1

To accompany the quarterly data collection we will require the Health & Wellbeing Board to submit a written narrative that contains any additional information you feel is appropriate including explanation of any material variances against the plan and

Content

The data collection template consists of 4 sheets:

1) Cover Sheet - this includes basic details and question completion
2) A&B - this tracks through the funding and spend for the Health & Wellbeing Board and the expected level of benefits
3) National Conditions - checklist against the national conditions as set out in the Spending Review.
4) Narrative - please provide a written narrative
To note - Yellow cells require input, blue cells do not.

1) Cover Sheet

On the cover sheet please enter the following information:
The Health and Well Being Board
Who has completed the report, email and contact number in case any queries arise
Please detail who has signed off the report on behalf of the Health and Well Being Board.

template have been completed the cell will turn green. Only when all 4 cells are green should the template be sent to england.bettercaresupport@nhs.net

2) A&B

This requires 4 questions to be answered. Please answer as at the time of completion.
Has the Local Authority recived their share of the Disabled Facilites Grant (DFG)?
If the answer to the above is 'No' please indicate when this will happen.
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?
If the answer to the above is 'No' please indicate when this will happen

3) National Conditions

Fund Planning Guidance are still on track for delivery (http://www.england.nhs.uk/ourwork/part-rel/transformation-fund/bcf-plan/). Please answer as at the time of completion.

are on track. If 'No' or 'No - In Progress' is selected please detail in the comments box what the issues are and the actions that are being taken to meet the condition.
'No - In Progress' should be used when a condition has not been fully met but work is underway to achieve it by 31 March 2016.
Full details of the conditions are detailed at the bottom of the page.

Cover and Basic Details

Q4 2014/15

Health and Well Being Board	Cheshire East

completed by:	Louisa Ingham / Caroline Baines
e-mail:	louisa.ingham@cheshireeast.gov.uk /
contact number:	01270 686223 / 01270 686248
Who has signed off the report on behalf of the Health and Well Being Board:	Janet Clowes (Chair, Cheshire East Health & Wellbeing Board)

Question Completion - when all questions have been answered and the validation boxes below have turned green you should send the template to england.bettercaresupport@nhs.net saving the file as 'Name HWB.xls' for example 'County Durham HWB.xls'

	No. of questions answered
1. Cover	5
2. A&B	4
3. National Conditions	16
4. Narrative	1

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q4 2014/15

Allocation and budget arrangements

Has the housing authority received its DFG allocation?	Yes
If the answer to the above is 'No' please indicate when this will happen	dd/mm/yy
Have the funds been pooled via a s.75 pooled budget arrangement in line with the agreed plan?	No
If the answer to the above is 'No' please indicate when this will happen	29/05/15

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q4 2014/15

National Conditions

The Spending Round established six national conditions for access to the Fund.
Please confirm by selecting 'Yes', 'No' or 'No - In Progress' against the relevant condition as to whether these are on track as per your final BCF plan.
Further details on the conditions are specified below.
If 'No' or 'No - In Progress' is selected for any of the conditions please include a comment in the box to the right

Condition	Please Select (Yes, No or No - In Progress)	Comment
1) Are the plans still jointly agreed?	Yes	
2) Are Social Care Services (not spending) being protected?	Yes	A pro active approach to investing in preventative services, including dementia re-ablement and universal outreach services.
3) Are the 7 day services to support patients being discharged and prevent unnecessary admission at weekends in place and delivering?	No - In Progress	A review of existing services is currently underway to support the delivery of seven day services and the Social Care Act. The reconfiguration of service delivery needs to be handled in a sensitive manner to support the workforce, internally and externally through this change. In South Cheshire the GP's have committed to an additional 2,000, 7 day appointments in
4) In respect of data sharing - confirm that:		
i) Is the NHS Number being used as the primary identifier for health and care services?	No - In Progress	Whilst there is a strong existing dataset where the NHS number is recorded within social care records, we are experiencing some difficulties with accessing relevant information to keep this data in sync. We are trying to identify a solution to this but as yet this has not been resolved. Any assistance would be gratefully received. Clarity nationally surrounding
ii) Are you pursuing open APIs (i.e. systems that speak to each other)?	Yes	
iii) Are the appropriate Information Governance controls in place for information sharing in line with Caldicott 2?	No - In Progress	Ongoing through the Cheshire Care Record work. This is expected to go live towards the end of 2015.
5) Is a joint approach to assessments and care planning taking place and where funding is being used for integrated packages of care, is there an accountable professional?	No - In Progress	A review is underway of existing services including the assessment process and work is underway to design integrated care teams and this would incorporate a joint approach to assessment and care planning.
6) Is an agreement on the consequential impact of changes in the acute sector in place?	No - In Progress	Logic modelling sessions planned for June and discussions at transformatino boards will look at the expected impact more closely.

National conditions - Guidance

The Spending Round established six national conditions for access to the Fund:

1) Plans to be jointly agreed

The Better Care Fund Plan, covering a minimum of the pooled fund specified in the Spending Round, and potentially extending to the totality of the health and care spend in the Health and Wellbeing Board area, should be signed off by the Health and Wellbeing Board itself, and by the constituent Councils and Clinical Commissioning Groups. In agreeing the plan, CCGs and councils should engage with all providers likely to be affected by the use of the fund in order to achieve the best outcomes for local people. They should develop a shared view of the future shape of services. This should include an assessment of future capacity and workforce requirements across the system. The implications for local providers should be set out clearly for Health and Wellbeing Boards so that their agreement for the deployment of the fund includes recognition of the service change consequences.

2) Protection for social care services (not spending)
Local areas must include an explanation of how local adult social care services will be protected within their plans. The definition of protecting services is to be agreed locally. It should be consistent with 2012 Department of Health guidance to NHS England on the funding transfer from the NHS to social care in 2013/14: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213223/Funding-transfer-from-the-NHS-to-social-care-in-2013-14.pdf

3) As part of agreed local plans, 7-day services in health and social care to support patients being discharged and prevent unnecessary admissions at weekends
Local areas are asked to confirm how their plans will provide 7-day services to support patients being discharged and prevent unnecessary admissions at weekends. If they are not able to provide such plans, they must explain why. There will not be a nationally defined level of 7-day services to be provided. This will be for local determination and agreement. There is clear evidence that many patients are not discharged from hospital at weekends when they are clinically fit to be discharged because the supporting services are not available to facilitate it. The recent national review of urgent and emergency care sponsored by Sir Bruce Keogh for NHS England provided guidance on establishing effective 7-day services within existing resources.

4) Better data sharing between health and social care, based on the NHS number
The safe, secure sharing of data in the best interests of people who use care and support is essential to the provision of safe, seamless care. The use of the NHS number as a primary identifier is an important element of this, as is progress towards systems and processes that allow the safe and timely sharing of information. It is also vital that the right cultures, behaviours and leadership are demonstrated locally, fostering a culture of secure, lawful and appropriate sharing of data to support better care.
Local areas should:
• confirm that they are using the NHS Number as the primary identifier for health and care services, and if they are not, when they plan to;
• confirm that they are pursuing open APIs (i.e. systems that speak to each other); and
• ensure they have the appropriate Information Governance controls in place for information sharing in line with Caldicott 2, and if not, when they plan for it to be in place.
NHS England has already produced guidance that relates to both of these areas. (It is recognised that progress on this issue will require the resolution of some Information Governance issues by DH).

5) Ensure a joint approach to assessments and care planning and ensure that, where funding is used for integrated packages of care, there will be an accountable professional

Local areas should identify which proportion of their population will be receiving case management and a lead accountable professional, and which proportions will be receiving self-management help - following the principles of person-centred care planning. Dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals. The Government has set out an ambition in the Mandate that GPs should be accountable for co-ordinating patient-centred care for older people and those with complex needs.

6) Agreement on the consequential impact of changes in the acute sector
Local areas should identify, provider-by-provider, what the impact will be in their local area, including if the impact goes beyond the acute sector. Assurance will also be sought on public and patient and service user engagement in this planning, as well as plans for political buy-in. Ministers have indicated that, in line with the Mandate requirements on achieving parity of esteem for mental health, plans must not have a negative impact on the level and quality of mental health services.

Selected Health and Well Being Board:

Cheshire East

Data Submission Period:

Q4 2014/15

Narrative	remaining characters	31,333

Please provide any additional information you feel is appropriate to support the return including explanation of any material variances against the plan and associated performance trajectory that was approved by NHS England.
The Cheshire East BCF plan was approved in January 2015 and partners have been working collaboratively to develop a s75 partnership agreement. The BCF plan was ambitious aligning the BCF with local health and social care transformation programmes (Connecting Care in the South Cheshire Geography and Caring Together in the Eastern Cheshire Geography). This has involved working across organisational boundaries to design co-ordinated services for the residents of Cheshire East. We have recently received the 2014/15 performance indicators and these will then be reviewed against the BCF plan. The implementation of seven day services across Cheshire East is subject to a review, redesign and reconfiguration of existing resources and it is anticipated that phased changes will be introduced during 2015/16, with integrated care teams being implemented during the later part of 2015/16. South Cheshire CCG has also secured Prime Minister's Challenge Funding and are currently working with GP's to extend 7 day services across the South Cheshire area. Cheshire East has also been successful with a central government funding bid for technical fund 2 funding to develop and implement an Integrated Digital Care Record. A number of new initiatives are being launched during the first quarter of 2015/16, including Dementia Re-ablement and an Universal Outreach Service, the impact of each of these schemes is to be externally evaluated.

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REPORT TO: Health and Wellbeing Board

Date of Meeting:
Report of: Simon Whitehouse, Chief Executive NHS South Cheshire CCG
Subject/Title: Quality Premium 2015-16

1 Report Summary

1.1 This paper provides the Health and Wellbeing Board with an overview of the Quality Premium 2015/16 national measures.

1.2 This paper provides a summary of the national guidance for the Quality Premium 2015/16 (published 27th April 2015).

1.3 This paper seeks final support of the national measures and the two local priorities that NHS South Cheshire CCG has selected for 2015-16.

2 Recommendations

2.1 The Health and Wellbeing Board are asked to support and approve the final CCG Quality Premium measures and local priorities for 2015-16.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board are asked to support and approve the proposed Quality Premium 201/16 national measures and two local priorities as recommended by the Governing Body of NHS South Cheshire CCG.

3.2 CCG rationale and recommendations for support and approval are illustrated in appendix one.

4.0 Background and Options

4.1 Composition of Quality Premium 2015/16 National Measures and Local Priorities - The national guidance for the Quality Premium 2015/16 was published on 27th April 2015.

4.2 The quality premium paid to CCGs in 2016/17 – to reflect the quality of the health services commissioned by them in 2015/16 – will be based on the following measures that cover a combination of national and local priorities. These are:

National Quality Premium Measure 2015/16		**Value**
Reducing potential years of life lost		10%
Urgent and emergency care menu		30%
Mental Health menu		30%
Improving antibiotic prescribing		10%
Local Quality Premium Measure		
Local QP 1	To be approved by Governing Body and Health and Wellbeing Boards	10%
Local QP 2	To be approved by Governing Body and Health and Wellbeing Boards	10%

- **Reducing potential years of lives lost through causes considered amenable to healthcare** (10 per cent of quality premium);

- **Urgent and emergency care** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

- **Mental health** - a menu of measures for CCGs to choose from locally in conjunction with their relevant Health and Wellbeing Board(s) and local NHS England team. The menu is overall worth 30 per cent of the quality premium. CCGs, with the above partners, can decide whether to select one, several, or all measures from the menu and also what proportions of the 30 per cent are attributed to each measure.

- **Improving antibiotic prescribing in primary and secondary care** (10 per cent of quality premium);

- **Two local measures** which should be based on local priorities such as

those identified in joint health and wellbeing strategies (20 per cent of quality premium-10 per cent for each measure).

a. Penalties **-** A CCG will have its quality premium reduced if the providers from whom it commissions services do not meet the NHS Constitution requirements for the following patient rights or pledges:

NHS Constitution requirement	**Reduction to Quality Premium**
Maximum 18 weeks from referral to treatment, comprising: • 90% Completed Admitted standard; • 95% Completed Non-admitted standard; • 92% Incomplete standard	30% total, (comprising 10% for each standard, separately assessed)
Maximum four hour waits in A&E departments-95% standard	30%
Maximum 14 day wait from an urgent GP referral for suspected cancer-93% standard	20%
Maximum 8 minutes responses for Category A (Red 1) ambulance calls-75% standard	20%

b. **Local Measures** - As per the national guidance the local priorities will reflect the local health and wellbeing strategies (and the JSNA) and will be based on indicators from the CCG Outcomes Indicator Set (unless the CCG and the relevant Health and Wellbeing Board and local NHS England team mutually agree that no indicators on this list are appropriate for measuring improvement in the identified local priorities).

c. The levels of improvement needed to trigger the reward will be agreed between the CCG, the Health and Wellbeing Board and the local NHS England team.

d. The local measures will not duplicate the national measures, including individual components of composite national measures, nor will they duplicate the NHS Constitution measures. They will reflect services that the CCGs are responsible for commissioning, or are commissioning jointly with other organisations. They may include aggregate or composite indicators.

5 Access to Information

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

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Appendix One - Quality Premium 2015/16 - NHS South Cheshire CCG

CCGs are required to include their choice of urgent and emergency care indicators (plus targets), choice of mental health indicators and target for reducing potential years of lives lost through causes considered amenable to healthcare.

Reducing Potential years of lives lost through causes considered amendable to healthcare

Level of Ambition	Rationale
Percentage Reduction of 1.2% NB Percentage reduction should be no less than 1.2% (Nationally set)	Male life expectancy in the South Cheshire CCG area has increased by almost two years since 2007 (and has overtaken England). However, life expectancy for women in the South Cheshire CCG area has only increased by half a year over the same period of time. Differences in male life expectancy have been reducing over the last four years but differences in female life expectancy have been growing wider. The widening in female life expectancy is entirely due to high death rates among women in the Crewe LAP, where life expectancy is significantly lower than the national average and also has not made any improvements for several years. Female life expectancy in the Congleton and Wilmslow LAPs is higher than in Crewe, but these areas have also not improved over time. There have been gains in female life expectancy in all the other LAP areas.Male life expectancy has been increasing in all the LAP areas except Wilmslow. Women in the Crewe LAP have 53% higher mortality from “all other causes”, 31% higher circulatory mortality and 20% higher cancer mortality than the Cheshire East average. Men in the Macclesfield LAP have 23% higher cancer mortality than the Cheshire East average. Men in the Crewe LAP have 28% higher mortality from “all other causes” and 24% higher circulatory mortality than the Cheshire East average

Urgent and Emergency Care

Indicator	Proportion	Level of	Rationale

	of 30%	ambition	
Avoidable emergency admissions Composite measure of: a) unplanned hospitalisation for chronic ambulatory care sensitive conditions (all ages); b) unplanned hospitalisation for asthma, diabetes and epilepsy in children; c) emergency admissions for acute conditions that should not usually require hospital admission (all ages); d) emergency admissions for children with lower respiratory tract infection.	15%	Zero per cent change in emergency admissions for these conditions for our CCG population over the 4 yrs. - 2012/13 to 2015/16	We have chosen to focus on this measure as it remains high on the agenda of our Health and Wellbeing Board strategic plans. It aligns to our CCG strategic objectives to transform our urgent care system and will support our local ambitions to reduce hospital admissions. We have a number of commissioning intentions that contribute to this measure during the year. The measure supports JSNA findings as summarised below: Crewe has high rates of adult smoking and more pregnant women smoke at the time of delivery than the England average. Children in Crewe have higher rates of respiratory admissions and asthma than elsewhere in South Cheshire. We have acted quickly to look into the reasons why children are being admitted to hospital, and are working closely with the specialist children's service at Mid Cheshire Hospitals Trust to develop alternatives to hospital admission and improve primary care clinical pathways for children with chronic respiratory disease and develop community-based alternatives in the early stages of the clinical pathway. Smokers with asthma have poorer control of their condition with a higher frequency of asthma attacks than non-smokers. Locally, emergency admissions to hospital for asthma seem to reflect this. We have significantly worse emergency admission rates (per 100 patients on the asthma register) compared to the England average (2.5% vs

			1.8%). Compared to its peers within the ONS Cluster of Prospering Smaller Towns, NHS South Cheshire CCG has the worst rates of emergency admission for asthma (55th out of 55).
Increase in the number of patients admitted for non-elective reasons, who are discharged at weekends or bank holidays.	15%	Zero % change in 2015-16	We have chosen to focus on this measure as it aligns to programmes of work regarding integrated working with social care and the development of 7 day services. This also aligns with HWWB strategy and will capture planned commissioning activity relating to intermediate care and transitional care. This measure also supports JSNA findings.

Mental Health

Indicator	Proportion	Level of ambition	Rationale

	of 30%		
Reduction in the number of patients attending an A&E department for a mental health-related needs who wait more than four hours to be treated and discharged, or admitted, together with a defined improvement in the coding of patients attending A&E.	10%	Patients with a primary diagnosis of mental health-related needs or poisoning that spend more than 4 hours in A&E is no greater than the average for all patients	This supports our parity of esteem agenda for mental health, and supports our intentions to ensure the same quality markers and targets for waits are equal to that for physical illness. There is work underway this year within primary care mental health services to seek to support people within the community requiring A&E services. We are seeking to improve the clinical coding in A&E regarding mental health presentations which we hope will improve the quality of care for these patients, allowing analysis of right place right time and the development of our liaison services.
Reduction in the number of people with severe mental illness who are currently smokers	20%	2% reduction from baseline April 14/15 Baseline = the number of practice based registered smokers and who also are registered as having a severe mental health illness.	We would like to focus the Quality Premium on this measure as our JSNA findings highlight health inequalities for this population. If we can improve our health education messages to this hard to engage group they will reap great rewards in terms of both length of life for people with severe mental illness and the quality of life.

Improved antibiotic prescribing in primary and secondary care

Indicator	Level of ambition (Targets are set by NHS England)	Rationale (Targets are set by NHS England)
Reduction in the number of antibiotic prescribed in primary care	Reduction in the number of antibiotics prescribed in primary care by 1% (or	The target is to reduce from 1.242 to 1.239 items per STAR PU

	greater) from each CCG's 2013/14 value.	
Reduction in the proportion of broad spectrum antibiotics prescribed in primary care	Number of co-amoxiclav, cephalosporins and quinolones as a percentage of the total number of selected antibiotics prescribed in primary care to be reduced by 10% from each CCG's 2013/14 value, or to be below the 2013/14 median proportion for English CCGs (11.3%), whichever represents the smallest reduction for the CCG in question	The target is to reduce from 13.1 to 12.1%
Secondary care providers validating their total antibiotic prescription data	MCHFT to complete the validation audit (request this via the Quality Schedule to the contract)	PHE Audit tool provided to Acute Trusts

Local Measures – NHS South Cheshire CCG

QP No	Name of QP	Rationale

C1.19	**Lung Cancer – record stage at diagnosis** **Target:** NB: We will assess this indicator in the context of stage of lung cancer at diagnosis and route of presentation to lung cancer diagnosis The data source is the Somerset cancer system. Baseline data Proportion of patients that received best supportive care Palliative care) for lung cancer: 2013 - 33% 2014 - 29% Proportion of patients	This has been selected as a local priority measure by NHS South Cheshire CCG Clinical Commissioning Executive and approved by the Governing Body (4th June). **The measure and its subsequent work seek to improve the known health inequalities as highlighted within the East Cheshire Joint Strategic Needs Assessment (JSNA):** Around 28% of deaths in Cheshire East are due to cancer, making it the most common cause of death. The three most commonly occurring cancers among men in Cheshire East in 2009 were prostate (292), large bowel (151) and lung (140). Among women, the top three cancers were breast (323), large bowel (116) and lung (106). The main killers were lung cancer, upper gastrointestinal cancer (oesophagus, stomach and pancreas), colorectal cancer and haematological cancers (leukaemia, lymphoma). The JSNA recommends the following actions to reduce this health inequality: • Diagnose more cancers early by raising public awareness and encouraging participation in cancer screening programmes • Minimise delay in investigation and referral for specialist assessment • Accurate staging of disease so that treatment is appropriate to the spread of disease • Use of effective new treatments approved by the National Institute for Health and Clinical Excellence (NICE) • Multidisciplinary teams (MDTs) improve delivery of care for patients **This measure and its subsequent work seek to contribute to the Cheshire East Health and Wellbeing Strategy (2014-16).** *'Outcome two - Working and living well…* *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.'* *'Reducing the incidence of cancer'.*

	that received effective treatment for lung cancer: 2013 - 67% 2014 - 71% Target for the proportion of patients that will receive effective treatment in 2015 - 73%	**This measure and its subsequent work contributes to CCG Strategic and Operational priorities for 2015/16:** This Local Quality Premium measure supports a number of CCG and wider health and care strategies. Along with its strategic objectives NHS South Cheshire CCG have identified six local ambitions. These have been identified through key health inequalities. In South Cheshire we aim to focus our commissioning activities to address the following with regard to lung cancer. As part of our CCG priorities to reduce the premature mortality of our local population we are reviewing our cancer pathways. This will include ensuring the highest quality of care that meets the NICE Improving Outcome Guidance and national performance standards. This review will include moving care closer to home. As part of Mid Cheshire Hospitals Foundation Trust and University Hospitals of North Midlands 'Stronger Together' Programme there is commissioner commitment to review all cancer pathways that currently do not flow to the University Hospitals of North Midlands. This will be led by the specialised commissioning unit and follow a commissioning led process being patient centred, clinically led and outcome focused considering also capable provider and competition rules. The CCG will continue to review the of the whole lung cancer pathway with a focus on survivorship. This will align cancer care reviews, after treatment summaries and holistic needs assessment with a focus on self are/self-management. The CCG will continue to review cancer waiting times and performance against the NICE Improving Outcomes guidance. This measure supports CCG operational objectives and we anticipate it to have an impact on diagnosing lung cancer earlier, so that the number of lung cancers diagnosed as an emergency presentation reduces

		from 21% to 16% by March 2016.
C2.13	**Estimated diagnosis rates of dementia** **Target:** Our target for 2015-16 is 66.7%. The proposed numerator for this is: 1499 The proposed denominator for this is: 2247	This has been selected as a local priority measure by NHS South Cheshire CCG Clinical Commissioning Executive and approved by the Governing Body (4th June). **The measure and its subsequent work seek to improve the known health inequalities as highlighted within the East Cheshire Joint Strategic Needs Assessment (JSNA):** There are estimated to be 4,500 people living with Dementia in east Cheshire over the age of 65. •65% are likely to be women •One in five people over 80 has a form of Dementia. One in 20 people over 65 has a form of Dementia] •There are currently 820,000 people in the UK with Dementia and this costs the UK economy £23 billion a year. •The total number of people with Dementia in the UK is forecast to increase to 940,110 by 2021 and 1,735,087 by 2051, an increase of 38% over the next 15 years and 154% over the next 45 years. Analysis of data indicates that the CCG's actual dementia diagnosis rate is 61.2% and your estimated prevalence for people with dementia is 2263. This identifies an estimated gap of 878 people who may benefit from access to support by way of a dementia diagnosis, and a gap of 124 to achieve the national ambition. The All-Party parliamentary Group on Dementia recommends utilising existing opportunities for identification of people with dementia. It recommends that primary care workers and other health and social care professionals in contact with people with an established risk of dementia, should routinely ask

		questions to identify symptoms of dementia. Many people with dementia have complex needs. These will include a combination of mental, physical and social needs. A recent research study identified that only 5% of patients with dementia have dementia with no other Comorbidities. Cardiovascular conditions and depression are key comorbidities. At the later stages, people can have high levels of dependency and morbidity. (ISNA Dementia Summary 2012). Most people with dementia are over the age of 65 and are also more at risk of discrimination and infringements of their human rights because they may not have the capacity to challenge abuses or to report what has occurred. **This measure and its subsequent work seek to contribute to the Cheshire East Health and Wellbeing Strategy (2014-16).** *'Outcome three - Ageing well…* *Enabling older people to live healthier and more active lives for longer'.* *'Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness)'.* **This measure and its subsequent work contributes to CCG Strategic and Operational priorities for 2015/16:** NHS South CCG has been working with their GP practices to improve rates of diagnosis and ensure that people living with dementia can access the support they need. Throughout 2015/16, practices will be supported to achieve and maintain a high level of diagnosis. Memory Services with Dementia: The CCG have introduced a shared care arrangement for primary and secondary care, to ensure that patients living with dementia and their carers\families are well supported.

		Dementia Services for people at End of Life: The CCG have piloted a dementia end of life service to enhance the quality of experiences from patients, carers and family members Within the Better Care fund plans have been agreed between NHS South Cheshire CCG and Cheshire East Council and adopted by the Health and Well Being Board. The overarching local pioneer programme Connecting Care will provide a structure for the development of these plans. Plans include dementia reablement within integrated community services. Primary care mental health teams: The aim of this project is to develop a new primary care mental health team which will have a focus on improved dementia care and mental health liaison in the community. The aim of an integrated team would be to provide high quality care that result in improved health and wellbeing and a better experience for adults with complex care needs. This will be achieved by joining up mental health and physical health services to focus on individuals in their own homes and community, and reduce the need for emergency care during 2015/16. The team will provide the additional skills and knowledge necessary to manage patients living with dementia, and patients who have a mental health condition as well as a physical health problem. It is envisaged that the team will work closely with GP practices and link with the developing integrated neighbourhood team model.

REPORT TO: Health and Wellbeing Board

Date of Meeting:
Report of: Dr Heather Grimbaldeston, Director of Public health
Subject/Title: The Health and Wellbeing Board – Future Priorities

1 Report Summary

1.1 The report highlights progress made by the Board over the last two years and proposed areas of focus the future.

2 Recommendations

2.1 That the Board considers and comments upon the proposals for future priorities and agrees a way forward to drive action upon these.

3 Reasons for Recommendations

3.1 To improve the health and wellbeing outcomes for the people of Cheshire East and ensure the Health and Wellbeing Board delivers the statutory functions required of it by the Health and Social Care Act 2012.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The work of the Board is central to ensuring that the Health and Wellbeing Strategy is drafted agreed and delivered and that its priorities are at the heart of the commissioning intentions of the Local Authority, the Clinical Commissioning Groups and where appropriate other commissioners.

5 Successes to date

5.1 The Health and Wellbeing Board has received external endorsement in relation to a number of areas of activity[1]. These included:

- The political commitment, vision and ownership of health improvement, clearly articulated by the Leader of the Council;
- Good health outcomes for the majority of the population;

[1] Local Government Association Peer Challenge 18-21 November 2014

- A scale of ambition that is supported by a culture of innovation for example the Cheshire Integrated Health and Care Pioneer programme;
- Good senior partner relationships;
- A high level of focus on children's health and wellbeing within the Joint Strategic Needs Assessment and the Children's Improvement Plan and Public Health Annual Report;
- Good models of provider engagement in parts of the health and care system;
- The Joint Strategic Needs assessment being valued as a comprehensive compendium of intelligence across the system.

6 Future priorities

6.1 A facilitated workshop was held earlier in 2015 which most Board members as well as the Chair and Deputy Chair of Scrutiny were able to attend and some areas for future focus were considered:

- The Health and Wellbeing Strategy should be reviewed to ensure the identified priorities remain current (based upon the existing JSNA);
- Identify a small number of priorities that the board itself will focus it`s time and attention on and that require collective leadership;
- A shared narrative should be developed that can be easily understood by partners and the wider community to explain how the Health and Wellbeing Board is going to make a difference;
- Quickly undertake a review of existing Programme Boards and partnership structures, to ensure they are fit for purpose, and to empower them to deliver on a mutually agreed set of outcomes;
- Identify new joint commissioning and financial accounting procedures to improve clarity of partner activities both singly and collectively to ensure open and transparent working that better enables both scrutiny bodies and the Public to hold the Partners of the HWBB to account.
- Hold partners to account for delivery on different elements of the HWB Strategy and develop a small set of metrics or key indicators to enable the Board to do this effectively;
- Consider investing in a joint Organisational Development programme to facilitate large scale change (note this is being considered through the pioneer Programme);
- Develop a more robust work-plan , investing time in agenda planning and agreeing how items appear on the agenda and consider how to best support the Board in it`s future role;

- Create space and opportunities for meaningful discussion and debate, making greater use of informal meetings. Alongside this agree a public engagement and communication strategy beyond holding meetings in public;
- There should be consideration as to how best to engage with the public and Stakeholders to contribute to the identification of priorities.

6.2 The Board is asked to consider these future priorities and confirm, add to or amend to allow for the formulation of a revised future work-plan.

7 Access to Information

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

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