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Cheshire East Health and Wellbeing Board Agenda

Date:	**Tuesday, 26th January, 2016**
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. **Declarations of Interest**

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

3. **Minutes of Previous meeting** (Pages 1 - 10)

   To approve the minutes of the meeting held on 24 November 2016.

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

4. **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.

5. **Appointment of Chairman for the meeting**

To appoint a Chairman for the meeting as neither the Chairman nor Vice-Chairman will be present.

6. **Better Care Fund Draft Plan 2016/17** (Pages 11 - 12)

To receive an update on emerging guidance for the Better Care Fund in 2016/17 and beyond.

7. **NHS Planning Guidance 2016/17 - 2020/21** (Pages 13 - 48)

To consider the most appropriate transformation footprints for the local health system(s).

8. **The Sustainable Community Strategy and the Health and Well Being Board Strategy Refresh** (Pages 49 - 54)

To consider a proposal to merge the Health and Wellbeing Strategy and the Sustainable Community Strategy.

9. **Children and Young People's Improvement Plan Update** (Pages 55 - 70)

10. **Key Worker Accommodaton** (Pages 71 - 76)

To conducting of a survey within the borough, with partner agencies, to gain valuable intelligence into potential key workers affordable housing needs.

11. **Building Community Capacity**

To consider the need to focus upon Building Community capacity as part of the Health and Wellbeing Board's priorities.

12. **Memorandum of Understanding with Scrutiny and Healthwatch** (Pages 77 - 88)

To consider a memorandum of Understanding to support the relationship between the various health and scrutiny bodies.

13. **Ensuring and Improving Quality and Choice in Residential and Nursing Home Provision.** (Pages 89 - 102)

To consider an update on the progress and developments to establish a task and finish group to review current residential and nursing home provision, and to consider what might be required to ensure that it is fit for purpose in the future.

14. **Care Act Update** (Pages 103 - 112)

To note the impacts of the first six months of The Care Act 2014, and the changes implemented by Adult Social Care as a response to the new legislation.

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Agenda Item 3

CHESHIRE EAST COUNCIL

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

PRESENT

Voting Members:
Councillor Janet Clowes – Cheshire East Council
Councillor Rachel Bailey – Cheshire East Council
Dr Andrew Wilson – South Cheshire Clinical Commissioning Group
Simon Whitehouse – Southern Cheshire Clinical Commissioning Group
Jerry Hawker – Eastern Cheshire Clinical Commissioning Group
Tina Long - NHS England
Kath O'Dwyer - Director of Children's Services, Cheshire East Council
Brenda Smith – Director of Adult Social Care and Independent Living, Cheshire East Council
Kate Sibthorp - Healthwatch

Non Voting Members:
Mike Suarez – Chief Executive, CE Council
Heather Grimbaldeston – Cheshire East Council

Observors:
Councillor Stewart Gardiner - Cheshire East Council
Councillor Sam Corcoran – Cheshire East Council

Cheshire East Council officers/others in attendance:

Deborah Nickson– Legal Services, CE Council
Guy Kilminster – Head of Health Improvement, CE Council
Julie North – Senior Democratic Services Officer, CE Council
Gill Betton - Children's Improvement and Development Manager, CE Council
Louisa Ingham – Better Care Fund Finance Manager, CE Council
Lucy Heath – Consultant in Public Health, CE Council
Ali Stathers Tracey - Programme Director, Complex Dependency Programme

Councillor in attendance:
Councillor Jos Saunders

29 **APPOINTMENT OF CHAIRMAN**

Consideration was given to the appointment of a Chairman to the Board.

RESOLVED

That Cllr Michael Jones be appointed as Chairman.

30 **APPOINTMENT OF VICE-CHAIRMAN**

Consideration was given to the appointment of a Vice-chairman to the Board.

RESOLVED

That Dr Andrew Wilson be appointed as Vice-chairman.

(Dr Wilson took the chair).

31 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Cllr Michael Jones, Dr Paul Bowen and Tracy Bullock.

32 **DECLARATIONS OF INTEREST**

Councillor S Corcoran declared a non-pecuniary interest by virtue of his wife being a GP and a Director of South Cheshire GPs Alliance Ltd.

33 **MINUTES OF THE MEETING HELD ON 20 OCTOBER 2015**

RESOLVED

That the minute be approved as a correct record

34 **PUBLIC SPEAKING TIME/OPEN SESSION**

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

35 **COMPLEX DEPENDENCY PROGRAMME**

Ali Stathers Tracey, Programme Director, attended the meeting and gave a presentation in respect of the Complex Dependency Programme.

£5m had been awarded, in December 2014, from the Department of Communities and Local Government (DCLG) for the programme. The vision was to establish a ground-breaking multi-agency approach to tackling issues of complex dependency for children, families and vulnerable adults across Warrington, Cheshire West and Chester, Halton and Cheshire East. The cohort would be drawn from, adults and children involved in crime or anti-social behaviour, children who had problems at school, children who needed help, adults out of work or at risk of financial exclusion, individuals and families affected by domestic violence and abuse, individuals with a range of (non-age related) health problems and young people affected by homelessness/rough sleeping.

It was felt that the system, as a whole, was not working and was characterised by multiple assessments, with many key workers and

multiple data systems, fragmented accountability and ownership of the problem, a gap in the space between service users and crisis services, leading to a lack of suitable provision to meet complex needs, with a focus on individuals, without considering their social/family context and a lack of capacity to redesign the system, due to day-to-day pressures.

There had been two sub-regional partnership workshops and a single vision had been agreed, together with governance arrangements, performance outcomes, links between the sub Programme Board, Programme Team and localities, a detailed delivery plan and commissioned programme coordination arrangements with each Local Authority.

The vision was for a better customer experience, with a single point of contact, a single plan, a single lead worker and system, with a more empowering approach that would enable agencies to tackle the root causes involved in complex needs. The Model was for an “Integrated Front Door”, with a defined route into services, with a single point of access and triage. It was proposed to have a dedicated multi-agency team, co-located and coordinated by single line management, with agreed protocols and pathways and links with a wide range of partner agencies. It was proposed to invest in interventions with a proven track record of reducing demand on crisis services and that there be a local directory of services and support that could be accessed by case work staff. Commissioners would co-produce and design new service specifications with health, education and social care providers to align support against the likely demand

Following the presentation, members of the Board raised a number of questions and comments. It was considered that it would be important to be clear on the scope of the programme and who it would support and that it was important that it did not repeat the work undertaken through the Children and Young People and Caring Together and Connecting Care programmes. Further discussions should take place to ensure appropriate alignment and connectivity.

36 **CHILDREN AND YOUNG PEOPLE'S IMPROVEMENT PLAN (TO MEET THE OFSTED RECOMMENDATIONS)**

Consideration was given to a report updating the Board on the proposed action plan to address the recommendations and areas for improvement identified by Ofsted in its inspection report of Children’s Services, published in September 2015.

The Health and Wellbeing Board had a statutory responsibility to improve the health and wellbeing of the children, young people and their families in Cheshire East, reduce health inequalities and promote the integration of services. It was important that the Board was appraised of the strengths and areas for improvement within Children’s Services and was assured that arrangements were in place to develop, implement and scrutinise

plans that met the areas for improvement, as described in the improvement plan, set out at appendix 1 of the report. An action plan was also set out at appendix 2 of the report.

Members of the Board raised a number of comments and questions and it was requested that the Improvement Plan and Improvement Action Plan be linked together, to enable monitoring. It was noted that this would be picked up as part of the governance consideration. It was also felt that there needed to be clarity around the governance arrangements, particularly below the Health and Wellbeing Board, as to accountability and who the various bodies were accountable to. It was noted that there needed to be a development plan for the HWBB, to enable it to take on the new role. The Health and Adult Social Care and Children and Families Overview and Scrutiny Committees would have a joint role in scrutinising the improvement plan and it was suggested that both bodies may wish to come together to do this.

It was agreed that the governance arrangements should be discussed at a future informal meeting of the Board and considered at a future public meeting of the Board.

RESOLVED

1. That the contents of the report, the draft improvement plan at Appendix 1 and the Action Plan at Appendix 2 of the report be noted.

2. That, subject to the above comments, the arrangements for submitting the plan to the Department for Education and Ofsted in December 2015 be endorsed.

37 **CARING TOGETHER/CONNECTING CARE TRANSFORMATION PROGRAMMES PROGRESS UPDATES AND FUTURE TIMELINES**

Consideration was given to two reports providing an update in respect of the Caring Together and Connecting Care Transformation Programmes, including future timelines.

With regard to the Caring Together report, it was reported that Eastern Cheshire was taking a system wide approach to address the challenges of caring for the fastest ageing population in the North West of England, within the available resources. The Caring Together vision of “joining up local care for all our wellbeing” was the first step of bringing together local people and professionals to co-design a new approach to care which had empowering people at its heart. At the centre of the programme was the co-development of eight ambitions, supported by a Caring Together Outcomes Framework, uniquely focussed on a new type of integrated care model. The development of the framework was the first step on the journey towards commissioning for outcomes. Core to the Caring Together

Programme was the introduction of an integrated care system, which was depicted in Diagram 1 of the Caring Together report.

The report provided an update on recent progress within the programme, focussing specifically on two workstreams: Community Based Co-ordinated Care and Primary Care. It also provided an update on the recent changes to the governance structure for the programme.

With regard to the Connecting Care report, it was reported that the Connecting Care Programme existed to realise a different future for public and staff delivering health and social care. That future was one in which people were supported to maintain and improve their health and well being and one where services were integrated and seamlessly designed around people. The Connecting Care Board (CCB) had responsibility for the Connecting Care Strategy and it was the responsibility of the Senior Responsible Officer (SRO) group to implement this and report progress to the CCB. This report served to update on progress since March 2015 and focused on six main developments: Connecting care 'reason for being', Transformation delivery, Connecting Care programme workstreams, Connecting Care configuration and other update issues.

RESOLVED

That an update report be submitted to a future meeting of the Board, when the Implementation Plan was available and that consideration be given to which plans needed to be revisited at a future informal meeting of the Board.

38 **JOINT STRATEGIC NEEDS ASSESSMENT POLICIES**

Consideration was given to a report, requesting the Board sign off the Joint Strategic Needs Assessment (JSNA) Policies. It was reported that the JSNA informed the identification of Health and Wellbeing Strategy priorities. The proposed approach for creating and updating the JSNA would support the development of associated plans and their monitoring and evaluation.

At the Health and Wellbeing Board meeting on 28th April 2015, it had been agreed that, as part of the JSNA presentation, three JSNA policies would be brought back to the Board. The Board was now asked to endorse testing the implementation of these policies, namely :-

- JSNA work programme development
- JSNA content production -partnership working and community involvement
- JSNA governance

RESOLVED

That the testing of the above policies be endorsed.

39 **HEALTH AND WELLBEING STRATEGY UPDATE**

Dr Andrew Wilson provided an update in respect of the Health and Wellbeing Strategy. The Health and Wellbeing Strategy Steering Group had been asked to refresh the current Strategy, which would come to an end in March 2016.

The Steering Group had discussed the geographical footprint that the Strategy should cover and whilst it was clear that this was a strategy for the Health and Wellbeing Board footprint, the group had asked whether this would always be the case, in a changing world. There were considered to be two major areas which needed to be addressed: what was the health and wellbeing need for the system in terms of resilience and flexibility and, taking a place based approach, what could not be done and where more needed to be done, in terms of need. The group had set 10-15 key indicators and the agenda had been driven by the strategy.

The next meeting of the Steering Group was due to take place on 10 December and it was proposed to consider what the public, staff and leaders considered needed to be in the strategy. It had not been felt necessary to speak to the staff and public again, but to collate the information that had already been taken.

There was to be a separate workstream for the leadership consultation and the evidence of need in this area and it was agreed that that this issue should be included on the agenda for a future informal meeting of the Board. It was also suggested that consideration be given as to whether the horizon scanning work should be done at the next informal meeting.

Following the update, members of the Board raised a number of questions and commented that, as the strategy was updated, the work done on the Peer Review and workshop needed to be borne in mind and that 10-15 key indicators seemed rather a lot and that 2-4 might be more appropriate.

RESOLVED

That the update be noted.

40 **JOINT COMMISSIONING LEADERSHIP TEAM REVIEW**

Consideration was given to a report concerning the recommendations from the Joint Commissioning Leadership Team (JCLT), which had been formally created in April 2013, with a shared purpose of collaboratively commissioning and reviewing services across Cheshire East.

A number of drivers had led to the need to review the form and function of JCLT, both as a joint commissioning group and in relation to overseeing

the progress of the Better Care Fund (BCF). . The review had involved a series of small groups or individual conversations with strategic partners, to gather the views and experiences and, most importantly, to identify what collective commissioners believed needed to be in place to support integrated service delivery and commissioning for the future.

The review work had commenced in July and concluded in mid August. The report had been shared with the JCLT / BCF group, at its September 2015 meeting and this has informed the final report of the group to the Health and Wellbeing Board. There had been a number of key areas of agreement and one lack of agreement had been identified with regard to the challenge around the geography and what footprint should be operated to. It had been agreed that a number of recommendations should be made to the Board. Details of these are set out below:-

i) Acknowledge the findings of the review as highlighted above.
ii) Advise on the future expectations of JCLT.
iii) In the interim, consider delegating authority for developing joint commissioning governance to key members of HWB (namely CCG Chief Executives, Directors of Adults' and Children's Social Services and the Director of Public Health).
iv) Approve BCF governance being withdrawn from JCLT and managed via a discrete sub-group comprising finance and commissioning leads from the CCGs and CEC. This group will provide assurance and monitoring prior to formal reports going to HWB for approval. Reports to JCLT will be by exception.
v) Approve the draft Terms of Reference for both JCLT and BCF Governance Group (see Appendices 1 and 2 respectively).

In considering the recommendations, the Board agreed that it would be better to withdraw the BCF governance from the JCLT. However, it was not felt that the Terms of Reference should be approved at this stage and that work should continue under the existing arrangements and that the Terms of Reference be considered at a future meeting, early in the new year, if required. It would be necessary to discuss the governance arrangements, including collaborative governance and to consider at what point there needed to be a report back to Cabinet.

It was suggested that it may be appropriate to look at geographical/footprint issues in the commissioning approach and to link this to the horizon scanning work, in order to address this.

RESOLVED

1. That the findings of the review as highlighted in the report be acknowledged.

2. That, in the interim, authority for developing joint commissioning governance be delegated to key members of HWB (namely CCG Chief Executives, Directors of Adults' and Children's Social Services and the Director of Public Health, or their nominees).

3. That the BCF governance be withdrawn from JCLT and managed via a discrete sub-group, comprising finance and commissioning leads from the CCGs and CEC. This group to provide assurance and monitoring prior to formal reports going to HWB for approval. (Reports to JCLT to be by exception).

4. That approval of the draft Terms of Reference for both JCLT and BCF Governance Group be deferred and that they continue to work under the existing arrangements .

41 **LOCAL TRANSFORMATION PLANS FOR CHILDREN AND YOUNG PEOPLE'S MENTAL HEALTH AND WELLBEING**

Consideration was given to a report regarding the requirement to develop a Local Transformation Plan for Children and Young People's Mental Health and Wellbeing, in order to access additional funding that was available to the Clinical Commissioning Groups (CCGs) to support the delivery of this plan.

The report presented the plans, proposed ongoing development and raised issues about the implementation of these plans. They are intentionally very similar.

The plans required sign-off by a representative of the Health and Wellbeing Board and, as agreed, at the September meeting of the Board, Cllr Janet Clowes, as Chairman, had provided the sign-off and the Plans had been submitted.

South Cheshire CCG and Eastern Cheshire CCG had both received letters from NHS England on 9th November, asking them to review two specific elements around eating disorder services and engagement and partnership. However, these elements were considered easy to adjust and therefore, the CCG would receive their allocated transformation funding in the November allocation.

It was recommended that the Health and Wellbeing Board note the two plans that have been successfully assured.

RESOLVED

1. That it be noted that the two plans that have been submitted.

2. That the ambition and future development of the plans be considered at a future meeting of the Board, and that the further development and implementation of the plans be delegated to the Children and Young People's Joint Commissioning Group.

42 **BETTER CARE FUND - UPDATE PAPER**

Consideration was given to a report providing an overview of 2015/16 Better Care Fund(BCF) Quarter 2 performance.

The Health and Wellbeing Board was responsible for the strategic oversight of the Better Care Fund plan and had significant influence in supporting partnership working across health and social care. The report provided the Board with an update on the progress and implementation of schemes and the expected outcomes and provided assurance to the Board on the delivery of the Cheshire East BCF plan and the BCF national conditions

NHS England would issue standard reports that would fulfil both local and national reporting obligations against the key requirements and conditions of the BCF Fund. The standard reports aimed to fulfil both the quarterly reporting and annual reporting requirements, to monitor the totality of the BCF at Health and Wellbeing Board level.

NHS England would be expecting quarterly updates on the progress of the BCF and the Board was required to review and sign off of these quarterly returns in line with the published timescales.

RESOLVED

That the NHS England 2015/16 Quarter 2 performance report be signed off, so that the NHS England reporting deadline of midday on 27th November 2015 can be met.

43 **THANKS**

Thanks were expressed by the Board Members to Cllr Janet Clowes for her chairmanship and contribution to the work of the Board over the past years.

The meeting commenced at 2pm and concluded at 4.30pm

Dr Andrew Wilson (Vice-chairman, in the chair)

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Better Care Fund Briefing Note for Health and Wellbeing Board

18th December 2015

This briefing note has been written for Health and Wellbeing Board members to update them on the emerging guidance for Better Care Fund (BCF) in 2016/17 and beyond. This guidance started to emerge during the spending review announcements on 24th November and further guidance was due week beginning 14th December[1]. The guidance will include requirements for metrics, pay for performance, national conditions amongst other detail.

The key headlines relating to the BCF are:

- For 2017/17, BCF plans will be submitted as part of mainstream CCG plans via UNIFY. The implication for this is that submitted plans will focus more on metrics and finance, and less on narrative than was seen in 2015/16. The deadline for this submission is **8th February 2016**.
- Narrative will be required locally to understand plans and the Health and Wellbeing Board will be required to sign off plans. These plans will be brought to the Cheshire East HWB meeting on **26th January 2016.**
- The existing six national conditions will remain but language may be tweaked.
- The performance fund element will be retained and will continue to be based on reductions in non-electives with arrangements simplified where possible (timetable aligned to other plans, consistent baselines and targets).
- Localities[2] to "commit to a fully integrated health and social care system" by 2020. Plans to detail how this will be achieved will be required by 2017. The model for these systems will not be prescribed, and localities will be able to choose from a "menu" of options, including:
    - Continuation of BCF plan
    - Devolution
    - Developing an accountable care organisation
    - Developing a lead commissioner model (e.g. NE Lincs Care Trust Plus model).
- There will be a BCF real terms increase of 1.9% in 2016/17. The detail of where this money will come from has not yet been provided.
- Extra £1.5bn for social care by 2020
- £500m extra for disabled facilities grant

Planned timescales in Cheshire East to complete this work are shown below:

Task	Outcome	Date	Leads
Planning workshop (1)	Consensus across commissioning partners on: • Priorities for 2016/17 • Agreement on schemes that will	5th January 2015	**CEC** Brenda Smith Patrick Rhoden

[1] At the time of writing on the afternoon of 18th December, this additional guidance had not yet been received.
[2] The geography of these localities has not been defined at the time of writing.

	be included in 2016/17 BCF, including any new / additional areas of pooled funding • Agreement on funding allocation per scheme • Agreement on some elements of S75 agreement for 2016/17		**ECCCG** Representative for Alex Mitchell Jacki Wilkes **SCCCG** Fiona Field Lynda Risk **BCF** Caroline Baines Louisa Ingham
Health & Wellbeing Board	• Agreement to Cheshire East BCF plans for 2016/17	26th January 2016	
Submission of BCF plans with CCG operational plans	• Submitted plans in line with national requirements	8th February 2016	
Planning workshop (2)	• Understanding across the commissioning partners of how joint commissioning is progressing locally and what actions are required to further improve • Agreement on all elements of S75 for 2016/17 • Agreement on how the 2020 plan will be developed and who will "own" the process	24th February 2016	**CEC** Ann Riley (for Brenda Smith) Patrick Rhoden **ECCCG** Alex Mitchell Jacki Wilkes **SCCCG** Fiona Field Lynda Risk **BCF** Caroline Baines Finance lead (TBA)
Sign-off of S75 agreements	• Signed agreements in line with national requirements	31st March 2016	
Implementation of BCF 2016/17 in line with agreed plans and s75 agreements.		1st April 2016 – 31st March 2017	
Begin development of plans for 2020		1st April 2016 – 31st March 2017	

Further information is available from:

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 26th January 2016
Report of: Guy Kilminster
Subject/Title: NHS Planning Guidance 2016/17 – 2020/21

1 Report Summary

1.1 Just before Christmas the NHS Planning Guidance for 2016/17 – 2020/21 was published (attached as Appendix One). There is a focus on place-based planning and the requirement to prepare five year local health system Sustainability and Transformation Plans (STP). These should be based upon an agreed 'transformation footprint' that has to be notified to NHS England by 29th January 2016. One year operational plans are also required, organisation based, but consistent with emerging STP

1.2 The Health and Wellbeing Board is asked to consider the most appropriate transformation footprints for the local health system(s) taking into account the different existing footprints (for example the Cheshire Integration Pioneer, Connecting Care, Caring Together and the Cheshire and Warrington devolution ambitions) and the factors that influence those.

2 Recommendations

2.1 That the Health and Wellbeing Board considers the options for local transformation footprints and the Sustainability and Transformation Plans to influence the decision and submission to meet the deadline of 29th January 2016.

3 Reasons for Recommendations

3.1 To ensure that the Board has considered the options for transformation footprints that might be appropriate and influenced the decisions made before 29th January 2016.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The Guidance states that the Sustainability and Transformation Plan '…must also cover better integration with local authority services, including but not

limited to, prevention and social care, reflecting local agreed health and wellbeing strategies'.

5 Background and Options

5.1 The Health and Wellbeing Board will be aware of the complicated and multi layered system geographies within Cheshire and Warrington, for example:

- Cheshire and Warrington sub-regional footprint (Local Enterprise Partnership, devolution bid, some elements of public service transformation for example the Complex Dependencies Programme and Community Safety Programme)
- Cheshire West and Chester / Cheshire East (Pioneer Programme, shared services, shared back office functions)
- Individual local authority geographies that mirror Health and Wellbeing Board geographies
- West Cheshire Way and Caring Together transformation programmes that match single CCG boundaries and are self contained within one local authority (although patient flows require cross boundary working)
- Connecting Care transformation programme that embraces two CCGs (although now working increasingly as a single entity) and spans the two local authorities (again with patient flows into a neighbouring authority).

5.2 Adding to this complicated picture is the Constabulary geography that includes Cheshire East, Cheshire West and Chester, Warrington and Halton, and as referenced above the patient flows and relationships within health that sees significant partnership work with organisations in Wirral, Greater Manchester and Staffordshire.

5.3 The Planning Guidance requires (by January 29th) decisions to be made (vague about who makes that decision but implies it's NHS (CCG) led but with 'Local Authorities engaged with these proposals') about the local health system transformation footprint. This is only the first step in the development of the Sustainability and Transformation Plans, but it is clearly an important one. However the guidance does warn us to '…focus energies on the content of the plans rather than have lengthy debates about boundaries.

5.4 There are a number of options for system leaders to consider in terms of the transformation footprint(s), for example:

a) Cheshire West, Cheshire East, Warrington and Wirral local authority areas as a combined transformation footprint;

b) Cheshire West, Cheshire East, Warrington as a combined transformation footprint;
c) The Cheshire Pioneer footprint embracing the Cheshire West and Chester and Cheshire East geographies;
d) A West Cheshire Way transformation footprint and a combined Connecting Care/Caring Together footprint;
e) West Cheshire Way, Connecting Care and Caring Together as separate transformation footprints.

5.5 Ironically the one that does not work because of the Connecting Care programme is a transformation footprint that matches the Health and Wellbeing/individual local authority boundaries of Cheshire West and Cheshire and Cheshire East.

5.6 Clearly the discussion and decision on the most appropriate transformation footprint(s) to submit for January 29th has to relate to the ongoing activity in health and care, the requirements of our Sustainability and Transformation Plan(s) to take heed of the nine 'National 'must dos' for 2016/17, 'set ambitions for seven day services' emphasise the development of new care models and respond to the 'national challenges':

- How will you close the health and wellbeing gap?
- How will you drive transformation to close the care and quality gap?
- How will you close the finance and efficiency gap?

5.7 The Guidance states that the STPs are about the 'holistic pursuit of the triple aim – better health, transformed quality of care delivery and sustainable finances' but that 'they also need to set out how local systems will play their part in delivering the Mandate.

5.8 The Health and Wellbeing Board has an opportunity to consider the options and issues related to the Sustainability and Transformation Plans and the agreement regarding transformation footprints, taking a 'whole system' view and to influence the thinking regarding decisions to be made before 29th January.

5.9 The full STPs are to be submitted by the end of June 2016. The draft one year Operational Plans have to be submitted by 8th February with final Plans submitted by 11th April.

6 Access to Information

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

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Delivering the Forward View: NHS planning guidance 2016/17 – 2020/21

December 2015

Delivering the Forward View: NHS planning guidance

2016/17 – 2020/21

Version number: 1

First published: 22 December 2015

Prepared by: NHS England, NHS Improvement (Monitor and the NHS Trust Development Authority), Care Quality Commission (CQC), Health Education England (HEE), National Institute of Health and Care Excellence (NICE), Public Health England (PHE).

This document is for: Commissioners, NHS trusts and NHS foundation trusts.

Publications Gateway Reference: 04437

The NHS Five Year Forward View sets out a vision for the future of the NHS. It was developed by the partner organisations that deliver and oversee health and care services including:

- NHS England*
- NHS Improvement (Monitor and the NHS Trust Development Authority)
- Health Education England (HEE)
- The National Institute for Health and Care Excellence (NICE)
- Public Health England (PHE)
- Care Quality Commission (CQC)

*The National Health Service Commissioning Board was established on 1 October 2012 as an executive non-departmental public body. Since 1 April 2013, the National Health Service Commissioning Board has used the name NHS England for operational purposes.

Introduction

1. The Spending Review provided the NHS in England with a credible basis on which to accomplish three interdependent and essential tasks: first, to implement the Five Year Forward View; second, to restore and maintain financial balance; and third, to deliver core access and quality standards for patients.

2. It included an £8.4 billion real terms increase by 2020/21, front-loaded. With these resources, we now need to close the health and wellbeing gap, the care and quality gap, and the finance and efficiency gap.

3. In this document, authored by the six national NHS bodies, we set out a clear list of national priorities for 2016/17 and longer-term challenges for local systems, together with financial assumptions and business rules. We reflect the settlement reached with the Government through its new Mandate to NHS England (annex 2). For the first time, the Mandate is not solely for the commissioning system, but sets objectives for the NHS as a whole.

4. We are requiring the NHS to produce two separate but connected plans:

   - a five year Sustainability and Transformation Plan (STP), place-based and driving the Five Year Forward View; and
   - a one year Operational Plan for 2016/17, organisation-based but consistent with the emerging STP.

5. The scale of what we need to do in future depends on how well we end the current year. The 2016/17 financial challenge for each trust will be contingent upon its end-of-year financial outturn, and the winter period calls for a relentless focus on maintaining standards in emergency care. It is also the case that local NHS systems will only become sustainable if they accelerate their work on prevention and care redesign. We don't have the luxury of waiting until perfect plans are completed. So we ask local systems, early in the New Year, to go faster on transformation in a few priority areas, as a way of building momentum.

Local health system Sustainability and Transformation Plans

6. We are asking every health and care system to come together, to create its own ambitious local blueprint for accelerating its implementation of the Forward View. STPs will cover the period between October 2016[1] and March 2021, and will be subject to formal assessment in July 2016 following submission in June 2016. We are asking the NHS to spend the next six months delivering core access, quality and financial standards while planning properly for the next five years.

Place-based planning

7. Planning by individual institutions will increasingly be supplemented with planning by place for local populations. For many years now, the NHS has emphasised an organisational separation and autonomy that doesn't make sense to staff or the patients and communities they serve.

8. System leadership is needed. Producing a STP is not just about writing a document, nor is it a job that can be outsourced or delegated. Instead it involves five things: (i) local leaders coming together as a team; (ii) developing a shared vision with the local community, which also involves local government as appropriate; (iii) programming a coherent set of activities to make it happen; (iv) execution against plan; and (v) learning and adapting. Where collaborative and capable leadership can't be found, NHS England and NHS Improvement[2] will need to help secure remedies through more joined-up and effective system oversight.

9. Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners including the independent and voluntary sectors, and local government through health and wellbeing boards.

10. As a truly place-based plan, the STPs must cover all areas of CCG and NHS England commissioned activity including: (i) specialised services, where the planning will be led from the 10 collaborative commissioning hubs; and (ii) primary medical care, and do so from a local CCG perspective, irrespective of delegation arrangements. The STP must also cover better integration with local authority services, including, but not limited to, prevention and social care, reflecting local agreed health and wellbeing strategies.

[1] For the period October 2016 – March 2017, the STP should set out what actions are planned but it does not need to revisit the activity and financial assumptions in the 2016/17 Operational Plan.

[2] NHS Improvement will be the combined provider body, bringing together Monitor and the NHS Trust Development Authority (TDA).

Access to future transformation funding

11. For the first time, the local NHS planning process will have significant central money attached. The STPs will become the single application and approval process for being accepted onto programmes with transformational funding for 2017/18 onwards. This step is intended to reduce bureaucracy and help with the local join-up of multiple national initiatives.

12. The Spending Review provided additional dedicated funding streams for transformational change, building up over the next five years. This protected funding is for initiatives such as the spread of new care models through and beyond the vanguards, primary care access and infrastructure, technology roll-out, and to drive clinical priorities such as diabetes prevention, learning disability, cancer and mental health. Many of these streams of transformation funding form part of the new wider national Sustainability and Transformation Fund (STF). For 2016/17 only, to enable timely allocation, the limited available additional transformation funding will continue to be run through separate processes.

13. The most compelling and credible STPs will secure the earliest additional funding from April 2017 onwards. The process will be iterative. We will consider:

    (i) the quality of plans, particularly the scale of ambition and track record of progress already made. The best plans will have a clear and powerful vision. They will create coherence across different elements, for example a prevention plan; self-care and patient empowerment; workforce; digital; new care models; and finance. They will systematically borrow good practice from other geographies, and adopt national frameworks;

    (ii) the reach and quality of the local process, including community, voluntary sector and local authority engagement;

    (iii) the strength and unity of local system leadership and partnerships, with clear governance structures to deliver them; and

    (iv) how confident we are that a clear sequence of implementation actions will follow as intended, through defined governance and demonstrable capabilities.

Content of STPs

14. The strategic planning process is intended to be developmental and supportive as well as hard-edged. We set out in annex 1 of this document a list of 'national challenges' to help local systems set out their ambitions for their populations. This list of questions includes the objectives set in the Mandate. Do not over-interpret the list as a narrow template for what constitutes a good local plan: the most important initial task is to create a clear overall vision and plan for your area.

15. Local health systems now need to develop their own system wide local financial sustainability plan as part of their STP. Spanning providers and commissioners, these plans will set out the mixture of demand moderation, allocative efficiency, provider productivity, and income generation required for the NHS locally to balance its books.

Agreeing 'transformation footprints'

16. The STP will be the umbrella plan, holding underneath it a number of different specific delivery plans, some of which will necessarily be on different geographical footprints. For example, planning for urgent and emergency care will range across multiple levels: a locality focus for enhanced primary care right through to major trauma centres.

17. The first critical task is for local health and care systems to consider their transformation footprint – the geographic scope of their STP. They must make proposals to us by Friday 29 January 2016, for national agreement. Local authorities should be engaged with these proposals. Taken together, all the transformation footprints must form a complete national map. The scale of the planning task may point to larger rather than smaller footprints.

18. Transformation footprints should be locally defined, based on natural communities, existing working relationships, patient flows and take account of the scale needed to deliver the services, transformation and public health programmes required, and how it best fits with other footprints such as local digital roadmaps and learning disability units of planning. In future years we will be open to simplifying some of these arrangements. Where geographies are already involved in the Success Regime, or devolution bids, we would expect these to determine the transformation footprint. Although it is important to get this right, there is no single right answer. The footprints may well adapt over time. We want people to focus their energies on the content of plans rather than have lengthy debates about boundaries.

19. We will issue further brief guidance on the STP process in January. This will set out the timetable and early phasing of national products and engagement events that are intended to make it much easier to answer the challenges we have posed, and include how local areas can best involve their local communities in creating their STPs, building on the 'six principles' created to support the delivery of the Five Year Forward View. By spring 2016, we intend to develop and make available roadmaps for national transformation initiatives.

20. We would welcome any early reactions, by Friday 29 January 2016, as to what additional material you would find most helpful in developing your STP. Please email england.fiveyearview@nhs.net, with the subject title 'STP feedback'. We would also like to work with a few local systems to develop exemplar, fast-tracked plans, and would welcome expressions of interest to the above inbox.

National 'must dos' for 2016/17

21. Whilst developing long-term plans for 2020/21, the NHS has a clear set of plans and priorities for 2016/17 that reflect the Mandate to the NHS and the next steps on Forward View implementation.

22. Some of our most important jobs for 2016/17 involve partial roll-out rather than full national coverage. Our ambition is that by March 2017, 25 percent of the population will have access to acute hospital services that comply with four priority clinical standards on every day of the week, and 20 percent of the population will have enhanced access to primary care. There are three distinct challenges under the banner of seven day services:

(i) reducing excess deaths by increasing the level of consultant cover and diagnostic services available in hospitals at weekends. During 16/17, a quarter of the country must be offering four of the ten standards, rising to half of the country by 2018 and complete coverage by 2020;

(ii) improving access to out of hours care by achieving better integration and redesign of 111, minor injuries units, urgent care centres and GP out of hours services to enhance the patient offer and flows into hospital; and

(iii) improving access to primary care at weekends and evenings where patients need it by increasing the capacity and resilience of primary care over the next few years.

23. Where relevant, local systems need to reflect this in their 2016/17 Operational Plans, and all areas will need to set out their ambitions for seven day services as part of their STPs.

The nine 'must dos' for 2016/17 for every local system:

1. Develop a high quality and agreed **STP**, and subsequently achieve what you determine are your most locally critical milestones for accelerating progress in 2016/17 towards achieving the triple aim as set out in the **Forward View**.

2. Return the system to **aggregate financial balance**. This includes secondary care providers delivering efficiency savings through actively engaging with the Lord Carter provider productivity work programme and complying with the maximum total agency spend and hourly rates set out by NHS Improvement. CCGs will additionally be expected to deliver savings by tackling unwarranted variation in demand through implementing the RightCare programme in every locality.

3. Develop and implement a local plan to address the **sustainability and quality of general practice**, including workforce and workload issues.

4. Get back on track with **access standards for A&E and ambulance waits**, ensuring more than 95 percent of patients wait no more than four hours in A&E, and that all ambulance trusts respond to 75 percent of Category A calls within eight minutes; including through making progress in implementing the urgent and emergency care review and associated ambulance standard pilots.

5. Improvement against and maintenance of the NHS Constitution standards that more than 92 percent of patients on non-emergency pathways wait no more than 18 weeks from **referral to treatment**, including offering patient choice.

6. Deliver the NHS Constitution **62 day cancer waiting standard**, including by securing adequate diagnostic capacity; continue to deliver the constitutional two week and 31 day cancer standards and make progress in improving **one-year survival rates** by delivering a year-on-year improvement in the proportion of cancers diagnosed at stage one and stage two; and reducing the proportion of cancers diagnosed following an emergency admission.

7. Achieve and maintain the **two new mental health access standards**: more than 50 percent of people experiencing a first episode of psychosis will commence treatment with a NICE approved care package within two weeks of referral; 75 percent of people with common mental health conditions referred to the Improved Access to Psychological Therapies (IAPT) programme will be treated within six weeks of referral, with 95 percent treated within 18 weeks. Continue to meet a **dementia diagnosis** rate of at least two-thirds of the estimated number of people with dementia.

8. Deliver actions set out in local plans to transform care for people with **learning disabilities**, including implementing enhanced community provision, reducing inpatient capacity, and rolling out care and treatment reviews in line with published policy.

9. Develop and implement an affordable plan to make **improvements in quality** particularly for organisations in special measures. In addition, providers are required to participate in the annual publication of **avoidable mortality** rates by individual trusts.

24. We expect the development of new care models will feature prominently within STPs. In addition to existing approaches, in 2016/17 we are interested in trialing two new specific approaches with local volunteers:
    - secondary mental health providers managing care budgets for tertiary mental health services; and
    - the reinvention of the acute medical model in small district general hospitals.

Organisations interested in working with us on either of these approaches should let us know by 29 January 2016 by emailing england.fiveyearview@nhs.net

Operational Plans for 2016/17

25. An early task for local system leaders is to run a shared and open-book operational planning process for 2016/17. This will cover activity, capacity, finance and 2016/17 deliverables from the emerging STP. By April 2016, commissioner and provider plans for 2016/17 will need to be agreed by NHS England and NHS Improvement, based on local contracts that must be signed by March 2016.

26. The detailed requirements for commissioner and provider plans are set out in the technical guidance that will accompany this document. All plans will need to demonstrate:

- how they intend to reconcile finance with activity (and where a deficit exists, set out clear plans to return to balance);
- their planned contribution to the efficiency savings;
- their plans to deliver the key must-dos;
- how quality and safety will be maintained and improved for patients;
- how risks across the local health economy plans have been jointly identified and mitigated through an agreed contingency plan; and
- how they link with and support with local emerging STPs.

The 2016/17 Operational Plan should be regarded as year one of the five year STP, and we expect significant progress on transformation through the 2016/17 Operational Plan.

27. Building credible plans for 2016/17 will rely on a clear understanding of demand and capacity, alignment between commissioners and providers, and the skills to plan effectively. A support programme is being developed jointly by national partners to help local health economies in preparing robust activity plans for 2016/17 and beyond.

Allocations

28. NHS England's allocations to commissioners are intended to achieve:

- greater equity of access through pace of change, both for CCG allocations and on a place-based basis;
- closer alignment with population need through improved allocation formulae including a new inequalities adjustment for specialised care, more sensitive adjustments for CCGs and primary care, and a new sparsity adjustment for remote areas; and
- faster progress with our strategic goals through higher funding growth for GP services and mental health, and the introduction of the Sustainability and Transformation Fund.

29. In line with our strategic priorities, overall primary medical care spend will rise by 4-5 percent each year. Specialised services funding will rise by 7 percent in 2016/17, with growth of at least 4.5 percent in each subsequent year. The relatively high level of funding reflects forecast pressures from new NICE legally mandated drugs and treatments.

30. To support long-term planning, NHS England has set firm three year allocations for CCGs, followed by two indicative years. For 2016/17, CCG allocations will rise by an average of 3.4 percent, and we will make good on our commitment that no CCG will be more than 5 percent below its target funding level. To provide CCGs with a total place-based understanding of all commissioned spend, alongside allocations for CCG commissioned activities, we will also publish allocations for primary care and specialized commissioned activity.

    NHS England will in principle support any proposals from groups of CCGs, particularly in areas working towards devolution who wish to implement a more accelerated cross-area pace-of-change policy by mutual agreement.

31. Mirroring the conditionality of providers accessing the Sustainability and Transformation Fund, the real terms element of growth in CCG allocations for 2017/18 onwards will be contingent upon the development and sign off of a robust STP during 2016/17.

Returning the NHS provider sector to balance

32. During 2016/17 the NHS trust and foundation trust sector will, in aggregate, be required to return to financial balance. £1.8 billion of income from the 2016/17 Sustainability and Transformation Fund will replace direct Department of Health (DH) funding. The distribution of this funding will be calculated on a trust by trust basis by NHS Improvement and then agreed with NHS England.

33. NHS England and NHS Improvement are working together to ensure greater alignment between commissioner and provider financial levers. Providers who are eligible for sustainability and transformation funding in 2016/17 will not face a double jeopardy scenario whereby they incur penalties as well as losing access to funding; a single penalty will be imposed.

34. Quarterly release of these Sustainability Funds to trusts and foundation trusts will depend on achieving recovery milestones for (i) deficit reduction; (ii) access standards; and (iii) progress on transformation. The three conditions attached to the transitional NHS provider fund have to be hard-edged. Where trusts default on the conditions access to the fund will be denied and sanctions will be applied.

35. Deficit reduction in providers will require a forensic examination of every pound spent on delivering healthcare and embedding a culture of relentless cost containment. Trusts need to focus on cost reduction not income growth; there needs to be far greater consistency between trusts' financial plans and their workforce plans in 2016/17. Workforce productivity will therefore be a particular priority as just a 1 percent improvement represents £400 million of savings. All providers will be expected to evidence the effective use of e-rostering for nurses, midwives, Health Care Assistants (HCAs) and other clinicians to make sure the right staff are in the right place at the right time to ensure patients get the right hours of care and minimum time is wasted on bureaucracy. This approach will enable providers to reduce their reliance on agency staffing whilst compliance with the agency staffing rules will also reduce the rates paid. In addition, providers will need to adopt tightly controlled procurement practices with compliance incentives and sanctions to drive down price and unwarranted variation. For example, all providers will be expected to report and share data on what they are paying for the top 100 most common non-pay items, and be required to only pay the best price available for the NHS.

36. Capital investments proposed by providers should be consistent with their clinical strategy and clearly demonstrate the delivery of safe, productive services with a business case that describes affordability and value for money. Given the constrained level of capital resource available from 2016/17, there will be very limited levels of financing available and the repayment of existing and new borrowing related to capital investment will need to be funded from within the trust's own internally generated capital resource in all but the most exceptionally pre-agreed cases. Trusts will need to procure capital assets more efficiently, consider alternative methods of securing assets such as managed equipment services, maximize disposals and extend asset lives. In January, the DH will be issuing some revisions to how the PDC dividend will be calculated and a number of other changes to the capital financing regime.

Efficiency assumptions and business rules

37. The consultation on the tariff will propose a 2 percent efficiency deflator and 3.1 percent inflation uplift for 2016/17 (the latter reflecting a step change in pension-related costs). This reflects Monitor and NHS England's assessment of cost inflation including the effect of pension changes. To support system stability, we plan to remain on HRG4 for a further year and there will also be no changes to specialist top- ups in 2016/17; the specialised service risk share is also being suspended for 2016/17. We will work with stakeholders to better understand the impact of the move to HRG4+ and other related changes in 2017/18. For planning purposes, an indicative price list is being made available on the Monitor website. The consultation on the tariff will also include the timetable for implementing new payment approaches for mental health.

38. As notified in Commissioning Intentions 2016/2017 for Prescribed Specialised Services, NHS England is developing a single national purchasing and supply chain arrangement for specialised commissioning high cost tariff excluded devices with effect from April 2016. Transition plans will be put in place prior to this date with each provider to transition from local to national procurement arrangements.

39. The 2 percent efficiency requirement is predicated upon the provider system meeting a forecast deficit of £1.8 billion at the end of 2015/16. Any further deterioration of this position will require the relevant providers to deliver higher efficiency levels to achieve the control totals to be set by NHS Improvement.

40. For 2016/17 the business rules for commissioners will remain similar to those for last year. Commissioners (excluding public health and specialised commissioning) will be required to deliver a cumulative reserve (surplus) of 1 percent. At the very least, commissioners who are unable to meet the cumulative reserve (surplus) requirement must deliver an in-year break-even position. Commissioners with a cumulative deficit will be expected to apply their increase in allocation to improving their bottom line position, other than the amount necessary to fund nationally recognised new policy requirements. Drawdown will be available to commissioners in line with the process for the previous financial year. CCGs should plan to drawdown all cumulative surpluses in excess of 1 percent over the next three years, enabling drawdown to become a more fluid mechanism for managing financial pressures across the year-end boundary.

41. Commissioners are required to plan to spend 1 percent of their allocations non-recurrently, consistent with previous years. In order to provide funds to insulate the health economy from financial risks, the 1 percent non-recurrent expenditure should be uncommitted at the start of the year, to enable progressive release in agreement with NHS England as evidence emerges of risks not arising or being effectively mitigated through other means. Commissioners will also be required to hold an additional contingency of 0.5 percent, again consistent with previous years.

42. CCGs and councils will need to agree a joint plan to deliver the requirements of the Better Care Fund (BCF) in 2016/17. The plan should build on the 2015/16 BCF plan, taking account of what has worked well in meeting the objectives of the fund, and what has not. CCGs will be advised of the minimum amount that they are required to pool as part of the notification of their wider allocation. BCF funding should explicitly support reductions in unplanned admissions and hospital delayed transfers of care; further guidance on the BCF will be forthcoming in the New Year.

43. Commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall expenditure increase. Where CCGs collaborate with specialised commissioning to improve service efficiency, they will be eligible for a share of the benefits.

44. NHS England and NHS Improvement continue to be open to new approaches to contracting and business rules, as part of these agreements. For example, we are willing to explore applying a single financial control total across local commissioners and providers with a few local systems.

Measuring progress

45. We will measure progress through a new CCG Assessment Framework. NHS England will consult on this in January 2016, and it will be aligned with this planning guidance. The framework is referred in the Mandate as a CCG scorecard. It is our new version of the CCG assurance framework, and it will apply from 2016/17. Its relevance reaches beyond CCGs, because it's about how local health and care systems and communities can assess their own progress.

Timetable

Timetable	Date
Publish planning guidance	22 December 2015
Publish 2016/17 indicative prices	By 22 December 2015
Issue commissioner allocations, and technical annexes to planning guidance	Early January 2016
Launch consultation on standard contract, announce CQUIN and Quality Premium	January 2016
Issue further process guidance on STPs	January 2016
Localities to submit proposals for STP footprints and volunteers for mental health and small DGHs trials	By 29 January 2016
First submission of full draft 16/17 Operational Plans	8 February 2016
National Tariff S118 consultation	January/February 2016
Publish National Tariff	March 2016
Boards of providers and commissioners approve budgets and final plans	By 31 March 2016
National deadline for signing of contracts	31 March 2016
Submission of final 16/17 Operational Plans, aligned with contracts	11 April 2016
Submission of full STPs	End June 2016
Assessment and Review of STPs	End July 2016

Please note that we will announce the timetable for consultation and issuing of the standard contract separately. A more detailed timetable and milestones is included in the technical guidance that will accompany this document.

Annex 1: Indicative 'national challenges' for STPs

STPs are about the holistic pursuit of the triple aim – better health, transformed quality of care delivery, and sustainable finances. They also need to set out how local systems will play their part in delivering the Mandate (annex 2).

We will publish further guidance early in 2016 to help areas construct the strongest possible process and plan.

We will also make available aids (e.g. exemplar plans) and some hands-on support for areas as they develop their plans.

The questions below give an early sense of what you will need to address to gain sign-off and attract additional national investment.

We are asking local systems first to focus on creating an overall local vision, and the three overarching questions – rather than attempting to answer all of the specifics right from the start. We will be developing a process to offer feedback on these first, prior to development of the first draft of the detailed plans.

A. How will you close the health and wellbeing gap?

This section should include your plans for a 'radical upgrade' in prevention, patient activation, choice and control, and community engagement.

Questions your plan should answer:

1. How will you assess and address your most important and highest cost preventable causes of ill health, to reduce healthcare demand and tackle health inequalities working closely with local government?

   - How rapidly could you achieve full local implementation of the national Diabetes Prevention Programme? Why should Public Health England (PHE) and NHS England prioritise your geographical area (e.g. with national funding to support the programme)?

   - What action will you take to address obesity, including childhood obesity?

   - How will you achieve a step-change in patient activation and self-care? How will this help you moderate demand and achieve financial balance? How will you embed the six principles of engagement and involvement of local patients, carers, and communities developed to help deliver the Five Year Forward View?

2. How will you make real the aspiration to design person-centred coordinated care, including plans to ensure patients have access to named, accountable consultants?

3. How will a major expansion of integrated personal health budgets and implementation of choice – particularly in maternity, end-of-life and elective care – be an integral part of your programme to hand power to patients?

4. How are NHS and other employers in your area going to improve the health of their own workforce – for example by participating in the national roll out the Healthy NHS programme?

B. How will you drive transformation to close the care and quality gap?

This section should include plans for new care model development, improving against clinical priorities, and rollout of digital healthcare.

Questions your plan should answer:

1 What is your plan for sustainable general practice and wider primary care? How will you improve primary care infrastructure, supported in part through access to national primary care transformation funding?

2. How rapidly can you implement enhanced access to primary care in evenings and weekends and using technology? Why should NHS England prioritise your area for additional funding?

3. What are your plans to adopt new models of out-of-hospital care, e.g Multi-specialty Community Providers (MCPs) or Primary and Acute Care Systems (PACS)? Why should NHS England prioritise your area for transformation funding? And when are you planning to adopt forthcoming best practice from the enhanced health in care homes vanguards?

4. How will you adopt new models of acute care collaboration (accountable clinical networks, specialty franchises, and Foundation Groups)? How will you work with organisations outside your area and learn from best practice from abroad, other sectors and industry?

5. What is your plan for transforming urgent and emergency care in your area? How will you simplify the current confusing array of entry points? What's your agreed recovery plan to achieve and maintain A&E and ambulance access standards?

6. What's your plan to maintain the elective care referral to treatment standard? Are you buying sufficient activity, tackling unwarranted variation in demand, proactively offering patient choice of alternatives, and increasing provider productivity?

7. How will you deliver a transformation in cancer prevention, diagnosis, treatment and aftercare in line with the cancer taskforce report?

8. How will you improve mental health services, in line with the forthcoming mental health taskforce report, to ensure measureable progress towards parity of esteem for mental health?

9. What steps will your local area take to improve dementia services?

10. As part of the Transforming Care programme, how will your area ensure that people with learning disabilities are, wherever possible, supported at home rather than in hospital? How far are you closing out-moded inpatient beds and reinvesting in continuing learning disability support

11. How fast are you aspiring to improve the quality of care and safety in your organisations as judged by the Care Quality Commission (CQC)? What is your trajectory for no NHS trust and no GP practice to have an overall inadequate rating from the Care Quality Commission (CQC)?

12. What are you doing to embed an open, learning and safety culture locally that is ambitious enough? What steps are you taking to improving reporting, investigations and supporting patients, their families and carers, as well as staff who have been involved in an incident?

13. What plans do you have in place to reduce antimicrobial resistance and ensure responsible prescribing of antibiotics in all care settings? How are you supporting prescribers to enable them issue the right drugs responsibly? At the same time, how rapidly will you achieve full implementation of good practice in reducing avoidable mortality from sepsis?

14. How will you achieve by 2020 the full-roll out of seven day services for the four priority clinical standards?

15. How will you implement the forthcoming national maternity review, including progress towards new national ambitions for improving safety and increased personalisation and choice?

16. How will you put your Children and Young People Mental Health Plan into practice?

17. How quickly will you implement your local digital roadmap, taking the steps needed to deliver a fully interoperable health and care system by 2020 that is paper-free at the point of care? How will you make sure that every patient has access to digital health records that they can share with their families, carers and clinical teams? How will you increase your online offer to patients beyond repeat prescriptions and GP appointments?

18. What is your plan to develop, retrain and retain a workforce with the right skills, values and behaviours in sufficient numbers and in the right locations to deliver your vision for transformed care? How will you build the multidisciplinary teams to underpin new models of care? How ambitious are your plans to implement new workforce roles such as associate nurses, physician associates, community paramedics and pharmacists in general practice?

19. What is your plan to improve commissioning? How rapidly will the CCGs in your system move to place-based commissioning? If you are a devolution area, how will implementation delivery real improvements for patients?

20. How will your system be at the forefront of science, research and innovation? How are you implementing combinatorial innovation, learning from the forthcoming test bed programme? How will services changes over the next five years embrace breakthroughs in genomics, precision medicine and diagnostics?

C. How will you close the finance and efficiency gap?

This section should describe how you will achieve financial balance across your local health system and improve the efficiency of NHS services.

Questions your plan should answer:

1. How will you deliver the necessary per annum efficiency across the total NHS funding base in your local area by 2020/21?

2. What is your comprehensive and credible plan to moderate demand growth? What are the respective contributions in your local system of: (i) tackling unwarranted variation in care utilisation, e.g. through RightCare; (ii) patient activation and self-care; (iii) new models of care; and (iv) urgent and emergency care reform implementation?

3. How will you reduce costs (as opposed to growing income) and how will you get the most out of your existing workforce? What savings will you make from financial controls on agency, whilst ensuring appropriate staffing levels? What are your plans for improving workforce productivity, e.g. through e-rostering of nurses and HCAs? How are you planning to reduce cost through better purchasing and medicines management? What efficiency improvements are you planning to make across primary care and specialised care delivery?

4. What capital investments do you plan to unlock additional efficiency? How will they be affordable and how will they be financed?

5. What actions will you take as a system to utilise NHS estate better, disposing of unneeded assets or monetising those that could create longer-term income streams? How does this local system estates plan support the plans you're taking to redesign care models in your area?

Annex 2: The Government's mandate to NHS England 2016/17

The table below shows NHS England's objectives with an overall measurable goal for this Parliament and clear priority deliverables for 2016-17. The majority of these goals will be achieved in partnership with the Department of Health (DH), NHS Improvement and other health bodies such as Public Health England (PHE), Health Education England (HEE) and the Care Quality Commission (CQC). It also sets out requirements for NHS England to comply with in paragraph 6.2.

Read the full Mandate to NHS England

1. Through better commissioning, improve local and national health outcomes, particularly by addressing poor outcomes and inequalities.	
1.1 CCG performance	**Overall 2020 goals:** • Consistent improvement in performance of CCGs against new CCG assessment framework.
	2016-17 deliverables: • By June, publish results of the CCG assessment framework for 2015-16, which provides CCGs with an aggregated Ofsted style assessment of performance and allows them to benchmark against other CCGs and informs whether NHS England intervention is needed. • Ensure new Ofsted-style CCG framework for 2016-17 includes health economy metrics to measure progress on priorities set out in the mandate and the NHS planning guidance including overall Ofsted-style assessment for each of cancer, dementia, maternity, mental health, learning disabilities and diabetes, as well as metrics on efficiency, core performance, technology and prevention. • By the end of Q1 of 2016-17, publish the first overall assessment for each of the six clinical areas above.

2. To help create the safest, highest quality health and care service.	
2.1 Avoidable deaths and seven-day services	**Overall 2020 goals:** • Roll out of seven-day services in hospital to 100 percent of the population (four priority clinical standards in all relevant specialities, with progress also made on the other six standards), so that patients receive the same standards of care, seven days a week. • Achieve a significant reduction in avoidable deaths, with all trusts to have seen measurable reduction from their baseline on the basis of annual measurements. • Support NHS Improvement to significantly increase the number of trusts rated outstanding or good, including significantly reducing the length of time trusts remain in special measures. • Measurable progress towards reducing the rate of stillbirths, neonatal and maternal deaths and brain injuries that are caused during or soon after birth by 50 percent by 2030 with a measurable reduction by 2020. • Support the NHS to be the world's largest learning organisation with a new culture of learning from clinical mistakes, including improving the number of staff who feel their organisation acts on concerns raised by clinical staff or patients. • Measurable improvement in antimicrobial prescribing and resistance rates.
	2016-17 deliverables: • Publish avoidable deaths per trust annually and support NHS Improvement to help trusts to implement programme to improve from March 2016 baseline. • Rollout of four clinical priority standards in all relevant specialties to 25 percent of population. • Implement agreed recommendations of the National Maternity Review in relation to safety, and support progress on delivering Sign up to Safety. • Support the Government's goal to establish global and UK baseline and ambition for antimicrobial prescribing and resistance rates.

2.2 Patient experience	**Overall 2020 goals**: • Maintain and increase the number of people recommending services in the Friends and Family Test (FFT) (currently 88-96 percent), and ensure its effectiveness, alongside other sources of feedback to improve services. • 50-100,000 people to have a personal health budget or integrated personal budget (up from current estimate of 4,000). • Significantly improve patient choice, including in maternity, end-of-life care and for people with long-term conditions, including ensuring an increase in the number of people able to die in the place of their choice, including at home.
	2016-17 deliverables: • Produce a plan with specific milestones for improving patient choice by 2020, particularly in maternity, end-of-life care (including to ensure more people are able to achieve their preferred place of care and death), and personal health budgets. • Building on the FFT, develop proposals about how feedback, particularly in maternity services, could be enhanced to drive improvements to services at clinical and ward levels.
2.3 Cancer	**Overall 2020 goals:** • Deliver recommendations of the Independent Cancer Taskforce, including: o significantly improving one-year survival to achieve 75 percent by 2020 for all cancers combined (up from 69 percent currently); and o patients given definitive cancer diagnosis, or all clear, within 28 days of being referred by a GP.
	2016-17 deliverables: • Achieve 62-day cancer waiting time standard. • Support NHS Improvement to achieve measurable progress towards the national diagnostic standard of patients waiting no more than six weeks from referral to test. • Agree trajectory for increases in diagnostic capacity required to 2020 and achieve it for year one. • Invest £340 million in providing cancer treatments not routinely provided on the NHS through the Cancer Drugs Fund, and ensure effective transition to the agreed operating model to improve its effectiveness within its existing budget.

3. To balance the NHS budget and improve efficiency and productivity	
3.1 Balancing the NHS budget	**Overall 2020 goals**: • With NHS Improvement, ensure the NHS balances its budget in each financial year. • With the Department of Health and NHS Improvement, achieve year on year improvements in NHS efficiency and productivity (2-3 percent each year), including from reducing growth in activity and maximising cost recovery.
	2016-17 deliverables: • With NHS Improvement ensure the NHS balances its budget, with commissioners and providers living within their budgets, and support NHS Improvement in: o securing £1.3 billion of efficiency savings through implementing Lord Carter's recommendations and collaborating with local authorities on Continuing Healthcare spending; o delivering year one of trust deficit reduction plans and ensuring a balanced financial position across the trust sector, supported by effective deployment of the Sustainability and Transformation Fund; and o reducing spend on agency staff by at least £0.8 billion on a path to further reductions over the Parliament. • Roll-out of second cohort of RightCare methodology to a further 60 CCGs. • Measurable improvement in primary care productivity, including through supporting community pharmacy reform. • Work with CCGs to support Government's goal to increase NHS cost recovery up to £500 million by 2017-18 from overseas patients. • Ensure CCGs' local estates strategies support the overall goal of releasing £2 billion and land for 26,000 homes by 2020.

4. To lead a step change in the NHS in preventing ill health and supporting people to live healthier lives.	
4.1 Obesity and diabetes	**Overall 2020 goals:** • Measurable reduction in child obesity as part of the Government's childhood obesity strategy. • 100,000 people supported to reduce their risk of diabetes through the Diabetes Prevention Programme. • Measurable reduction in variation in management and care for people with diabetes.
	2016-17 deliverables: • Contribute to the agreed child obesity implementation plan, including wider action to achieve year on year improvement trajectory for the percentage of children who are overweight or obese. • 10,000 people referred to the Diabetes Prevention Programme.
4.2 Dementia	**Overall 2020 goals:** • Measurable improvement on all areas of Prime Minister's challenge on dementia 2020, including: o maintain a diagnosis rate of at least two thirds; o increase the numbers of people receiving a dementia diagnosis within six weeks of a GP referral; and o improve quality of post-diagnosis treatment and support for people with dementia and their carers.
	2016-17 deliverables: • Maintain a minimum of two thirds diagnosis rates for people with dementia. • Work with National Institute for Health Research on location of Dementia Institute. • Agree an affordable implementation plan for the Prime Minister's challenge on dementia 2020, including to improve the quality of post-diagnosis treatment and support.

5. To maintain and improve performance against core standards	
5.1 A&E, ambulances and Referral to Treatment (RTT)	**Overall 2020 goals:** • 95 percent of people attending A&E seen within four hours; Urgent and Emergency Care Networks rolled out to 100 percent of the population. • 75 percent of Category A ambulance calls responded to within 8 minutes. • 92 percent receive first treatment within 18 weeks of referral; no-one waits more than 52 weeks.
	2016-17 deliverables: • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for A&E. • Implement Urgent and Emergency Care Networks in 20 percent of the country designated as transformation areas, including clear steps towards a single point of contact. • With NHS Improvement, agree improvement trajectory and deliver the plan for year one for ambulance responses; complete Red 2 pilots and decide on full roll-out. • With NHS Improvement, meet the 18-week referral-to-treatment standard, including implementing patient choice in line with the NHS Constitution; and reduce unwarranted variation between CCG referral rates to better manage demand.
6. To improve out-of-hospital care.	
6.1 New models of care and general practice	**Overall 2020 goals:** • 100 percent of population has access to weekend/evening routine GP appointments. • Measurable reduction in age standardised emergency admission rates and emergency inpatient bed-day rates; more significant reductions through the New Care Model programme covering at least 50 percent of population. • Significant measurable progress in health and social care integration, urgent and emergency care (including ensuring a single point of contact), and electronic health record sharing, in areas covered by the New Care Model programme. • 5,000 extra doctors in general practice.

	2016-17 deliverables: • New models of care covering the 20 percent of the population designated as being in a transformation area to: o provide access to enhanced GP services, including evening and weekend access and same-day GP appointments for all over 75s who need them; and o make progress on integration of health and social care, integrated urgent and emergency care, and electronic record sharing. • Publish practice-level metrics on quality of and access to GP services and, with the Health and Social Care Information Centre, provide GPs with benchmarking information for named patient lists. • Develop new voluntary contract for GPs (Multidisciplinary Community Provider contract) ready for implementation in 2017-18.
6.2 Health and social care integration	**Overall 2020 goals:** • Achieve better integration of health and social care in every area of the country, with significant improvements in performance against integration metrics within the new CCG assessment framework. Areas will graduate from the Better Care Fund programme management once they can demonstrate they have moved beyond its requirements, meeting the government's key criteria for devolution. • Ensure the NHS plays its part in significantly reducing delayed transfers of care, including through developing and applying new incentives.
	2016-17 deliverables: • Implement the Better Care Fund (BCF) in line with the BCF Policy Framework for 2016-17. • Every area to have an agreed plan by March 2017 for better integrating health and social care. • Working with partners, achieve accelerated implementation of health and social care integration in the 20 percent of the country designated as transformation areas, by sharing electronic health records and making measurable progress towards integrated assessment and provision. • Work with the Department of Health, other national partners and local areas to agree and support implementation of local devolution deals. • Agree a system-wide plan for reducing delayed transfers of care with overall goal and trajectory for improvement, and with local government and NHS partners implement year one of this plan.

	2016-17 requirements: • NHS England is required to: o ring-fence £3.519 billion within its allocation to CCGs to establish the Better Care Fund, to be used for the purposes of integrated care; o consult the Department of Health and the Department for Communities and Local Government before approving spending plans drawn up by each local area; and o consult the Department of Health and the Department for Communities and Local Government before exercising its powers in relation to failure to meet specified conditions attached to the Better Care Fund as set out in the BCF Policy Framework.
6.3 Mental health, learning disabilities and autism	**Overall 2020 goal:** • To close the health gap between people with mental health problems, learning disabilities and autism and the population as a whole (defined ambitions to be agreed based on report by Mental Health Taskforce). • Access and waiting time standards for mental health services embedded, including: o 50 percent of people experiencing first episode of psychosis to access treatment within two weeks; and o 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks.
	2016-17 deliverables: • 50 percent of people experiencing first episode of psychosis to access treatment within two weeks. • 75 percent of people with relevant conditions to access talking therapies in six weeks; 95 percent in 18 weeks. • Increase in people with learning disabilities/autism being cared for by community not inpatient services, including implementing the 2016-17 actions for Transforming Care. • Agree and implement a plan to improve crisis care for all ages, including investing in places of safety. • Oversee the implementation of locally led transformation plans for children and young people's mental health, which improve prevention and early intervention activity, and be on track to deliver national coverage of the children and young people's Improving Access to Psychological Therapies (IAPT) programme by 2018. • Implement agreed actions from the Mental Health Taskforce.

7. To support research, innovation and growth.	
7.1 Research and growth	**Overall 2020 goals:** • Support the Department of Health and the Health Research Authority in their ambition to improve the UK's international ranking for health research. • Implement research proposals and initiatives in the NHS England research plan. • Measurable improvement in NHS uptake of affordable and cost-effective new innovations. • To assure and monitor NHS Genomic Medicine Centre performance to deliver the 100,000 genomes commitment.
	2016-17 deliverables: • Implement the agreed recommendations of the Accelerated Access Review including developing ambition and trajectory on NHS uptake of affordable and cost-effective new innovations.
7.2 Technology	**Overall 2020 goals:** • Support delivery of the National Information Board Framework 'Personalised Health and Care 2020' including local digital roadmaps, leading to measurable improvement on the new digital maturity index and achievement of an NHS which is paper-free at the point of care. • 95 percent of GP patients to be offered e-consultation and other digital services; and 95 percent of tests to be digitally transferred between organisations.
	2016-17 deliverables: • Minimum of 10 percent of patients actively accessing primary care services online or through apps, and set trajectory and plan for achieving a significant increase by 2020. • Ensure high quality appointment booking app with access to full medical record and agreed data sharing opt-out available from April 2016. • Robust data security standards in place and being enforced for patient confidential data. • Make progress in delivering new consent-based data services to enable effective data sharing for commissioning and other purposes for the benefit of health and care. • Significant increase in patient access to and use of the electronic health record.

7.3 Health and work	**Overall 2020 goal:** • Contribute to reducing the disability employment gap. • Contribute to the Government's goal of increasing the use of Fit for Work.
	2016-17 deliverables: • Continue to deliver and evaluate NHS England's plan to improve the health and wellbeing of the NHS workforce. • Work with Government to develop proposals to expand and trial promising interventions to support people with long-term health conditions and disabilities back into employment.

#FutureNHS

Health and Wellbeing Board

Date of Meeting: 26 January 2015

Report of: Heather Grimbaldeston / Steph Cordon

Subject/Title: Sustainable Community Strategy and Health and Wellbeing Strategy Refresh

1. Report Summary

1.1. It has become apparent that there is work currently in hand to refresh both the Health and Wellbeing Strategy and the Sustainable Community Strategy. This offers an opportunity to consider bringing the two together to form the key strategic focus for the future. The Council's MGB and Cabinet (informally) are supportive of this approach and the Health and Wellbeing Board's views are now sought to determine the next steps.

1.2. The recent NHS Planning Guidance has also introduced the requirement to draft Local health system Sustainability and Transformation Plans and their relationship to the Sustainable Community Strategy and Health and Wellbeing Strategy needs to be determined.

2. Recommendation

2.1. That the Health and Wellbeing Board consider and support the proposal to merge the Health and Wellbeing Strategy and the Sustainable Community Strategy

3. Other Options Considered

3.1. The alternative option is to retain two separate strategic documents.

4. Reasons for Recommendation

4.1. 'Ambition for All' was launched in 2010 and provides the overarching strategic view of the Council and partner's ambitions for the communities of Cheshire East over a 15 year period until 2025. Its purpose was "to set out how, over the next 15 years, we will ensure that Cheshire East continues to prosper for the benefit of all residents, businesses and visitors."

4.2. Since the launch of 'Ambition for All' there have been a number of significant changes in the external environment which have both had an impact on the delivery of priorities and will strongly influence future priorities. The strategic direction of Cheshire East in terms of becoming a commissioning council also needs to be incorporated into further development of our future Community Strategy.

4.3. ‘Ambition for All’ was produced following comprehensive and inclusive consultation with partners and residents and so it does provide a framework which could be refreshed to include current direction and new priorities.

4.4. ‘Ambition for All’ has seven priorities which are ambitious and continue to be relevant. It was intended that these priorities would be revisited and would change over the life time of the strategy, as would supporting delivery plans. The priorities are:

- Nurture strong communities
- Create conditions for business growth
- Unlock the potential of our towns
- Support our children and young people
- Ensure a sustainable future
- Prepare for an increasingly older population
- Drive out the causes of poor health

4.5. ‘Fair Society, Healthy Lives’ The Marmot Review of Health Inequalities, 2010 identified that reducing health inequalities would have economic and social benefits, but that action on health inequalities required action across all the social determinants of health. It identified the social gradient in health – the fact that the lower a person’s social position the worse his or her health.

4.6. Six policy objectives were identified as requiring action:

- Give every child the best start in life;

- Enable all children, young people and adults to maximise their capabilities and have control over their lives;

- Create fair employment and good work for all;

- Ensure healthy standard of living for all;

- Create and develop healthy and sustainable places and communities;

- Strengthen the role and impact of ill health prevention.

4.7 Within the detail the Review’s Policy recommendations included:

- Supporting families to achieve progressive improvements in early child development;

- Providing good quality early years education and childcare proportionately across the social gradient;

- Reducing social inequalities in life skills;

- Increasing access and use of quality lifelong learning opportunities across the social gradient;

- Prioritising active labour market programmes to achieve timely interventions to reduce long term unemployment;

- Improving the quality of jobs;

- Developing greater security and flexibility in employment;

- Develop and implement standards for minimum income for healthy living;

- Prioritise policies and intervention that reduce both health inequalities and mitigate climate change;

- Fully integrate planning, transport, housing, environmental and health systems to address the social determinants of health;

- Support local developed and evidence based community regeneration programmes;

- Prioritise investment in ill health prevention and health promotion

4.8 This demonstrates that the connectivity between improving health outcomes and reducing health inequalities links very strongly with the priorities being addressed within 'Ambition for All' the Sustainable Community Strategy.

4.9 For completeness sake the current Health and Wellbeing Strategy priorities are below:

What we want to achieve for 2014-2015	**What we need to focus on**
Outcome one - Starting and developing well… *Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive.*	Children and young people feel and are kept safe Children and young people experience good emotional and mental health and wellbeing - Reduce the levels of alcohol use / misuse by Children and Young People - Reduce the numbers of children and young people self harming. Children and young people who are disabled or who have identified special education needs have their aspirations and hopes met

	Targeted prevention interventions to reduce children and young people's obesity[1]
Outcome two - Working and living well… *Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough.*	Reducing the incidence of alcohol related harm. Reducing the incidence of cancer. Reducing the incidence of cardiovascular disease. Ensuring the health and wellbeing of carers to enable them to carry out their caring role Better meeting the needs of those with mental health issues, in particular to focus upon improving the physical health of people with serious mental illness[2]. Seven day care services provision
Outcome three - Ageing well… *Enabling older people to live healthier and more active lives for longer:*	Improving the co-ordination of care around older people, in particular those with dementia, and supporting independent living (including falls prevention and interventions to reduce social isolation and loneliness).[3] Providing high quality palliative care service Supporting older people, their families and carers, to prepare for the rest of their lives.

[1] Following a review of obesity levels in children and young people during 2013, it has been identified that although Cheshire East overall is below the national average, there are some parts of the Borough where rates are significantly higher than that average. This is where activity will be targeted.
[2] The Director of Public Health's report 2012 – 2013 has identified that Cheshire East has one of the highest excess mortality rates for adults under 75 with a serious mental illness.
[3] The Board has recognised the impact upon health and wellbeing of loneliness and social isolation (Holt-Lunstad et al, 2010 Social Relationships and Mortality Risk: A Meta-analytic Review) and with the growing older population of the area identified this as a new priority.

5. Background/Chronology

5.1. Using the rationale of the Marmot Review Policy Objectives and recommendations, there is an opportunity to bring together the re-drafting of the Health and Wellbeing and Sustainable Community Strategies to create a single strategic vision and ambition for Cheshire East. This would tie together a number of priorities for the Authority that, in effect, strengthens the health and wellbeing of the people of our area, ensuring the sustainability of our communities.

5.2. Key issues that are of significance across the system include reducing dependency and demand upon services; early intervention and prevention and enhanced community capacity (including the development of Community Hubs). A single Strategy may also facilitate the ambition to be a commissioning Council, with collaborative or joint commissioning opportunities being more clearly evident as a result of a combined strategic approach.

5.3. A combined Strategy could provide a means of establishing a more effective golden thread through the Authority and its partners signed up to by the Leaders' Board and the Health and Wellbeing Board.

5.4. In addition the recently published NHS Planning Guidance 2016/17 – 2020/21 has introduced the requirement to draft 'Local health system sustainability and transformation plans'. There needs to be consideration given as to how these relate to the Sustainable Community and Health and Wellbeing Strategies.

6. Wards Affected and Local Ward Members

6.1. All

7. Risk Management & Implications of Recommendation

7.1. There is a risk, if we continue with separate strategies of duplication of effect and a strategic disconnect. Combining the work to inform a single Strategy would make better use of capacity and avoid potentially confusing stakeholder and public engagement and consultation.

8. Access to Information

8.1. N/A

9. Contact Information

Contact details for this report are as follows:-

Name: Guy Kilminster Corporate Manager Health Improvement and Kirstie Hercules Principal Manager - Partnerships and Communities

Email: guy.kilminster@cheshireeast.gov.uk and kirstie.hercules@cheshireeast.gov.uk

REPORT TO: Health and Wellbeing Board

Date of Meeting: 26th January 2016
Report of: Kath O'Dwyer, Director of Children's Services/Deputy Chief Executive
Subject/Title: Update on the Children and Young People's Improvement Plan

1 Report Summary

1.1. This report updates the Health and Wellbeing Board on developments in relation to the children and young people's improvement plan.

2 Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a) Note the contents of this report, including the revised governance model at Appendix 1, the summary improvement plan for professionals at Appendix 2 and the letter from the Minister lifting the improvement notice at Appendix 3; and
b) Agree the development plan for the Board set out at Appendix 4.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board is the accountable body for the children and young people's improvement plan and will be kept updated on progress against the plan.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The children and young people's improvement plan has been developed to address the areas of improvement identified by Ofsted and will need to align closely with the Health and Wellbeing Strategy.

5 Background and Options

5.1 The Board received reports in October and November 2015 on the outcome of Ofsted's inspection of children's services and the proposed improvement plan to address Ofsted's recommendations. Members endorsed the proposal for the Health and Wellbeing Board to become the accountable body to monitor, scrutinise and challenge progress against the improvement plan.

5.2 To ensure that arrangements are in place to address the recommendations from Ofsted, the local authority was required to submit an action plan to the Department for Education and Ofsted by 22 December 2015. The Board endorsed the draft plan in November. However, Members felt that there needed to be clarity around the governance arrangements, particularly below the Health and Wellbeing Board, as to accountability and who the various bodies were accountable to. The amended governance information is attached at Appendix 1. This was included in the final improvement plan, which was submitted to Ofsted and DfE ahead of the deadline; a summary of the plan, developed for professionals, is attached at Appendix 2.

5.4 On 16th December 2015 Cheshire East received a letter from Sam Gyimah, MP, confirming that the improvement notice, issued to Cheshire East on 12th September 2013, is now lifted. A copy of the letter is attached at Appendix 3. This means that the Improvement Board, that was the accountable body for the previous improvement plan, has been disbanded and this responsibility passes to the Health and Wellbeing Board. The Board will receive updates on progress against the improvement plan, with the first update planned for March 2016.

5.5 Very positive feedback has been received from the DfE in relation to our improvement plan. Indeed the DfE have sought the councils agreement to sharing the Cheshire East improvement plan with other LA's as a model of good practice.

5.6 Cheshire East is one of the first local authorities to come out of improvement since the new DfE ongoing monitoring arrangements were introduced in November this year. This means that Cheshire East will continue to receive support and supervision up until September 2016 to ensure that improvements are being sustained.

5.7 In affirming its commitment to become the accountable body for the improvement plan, the Health and Wellbeing Board identified the need to improve the knowledge and understanding of Board Members in relation to the areas of the improvement plan. An outline development plan is attached at Appendix 4 for endorsement by members.

6 Access to Information

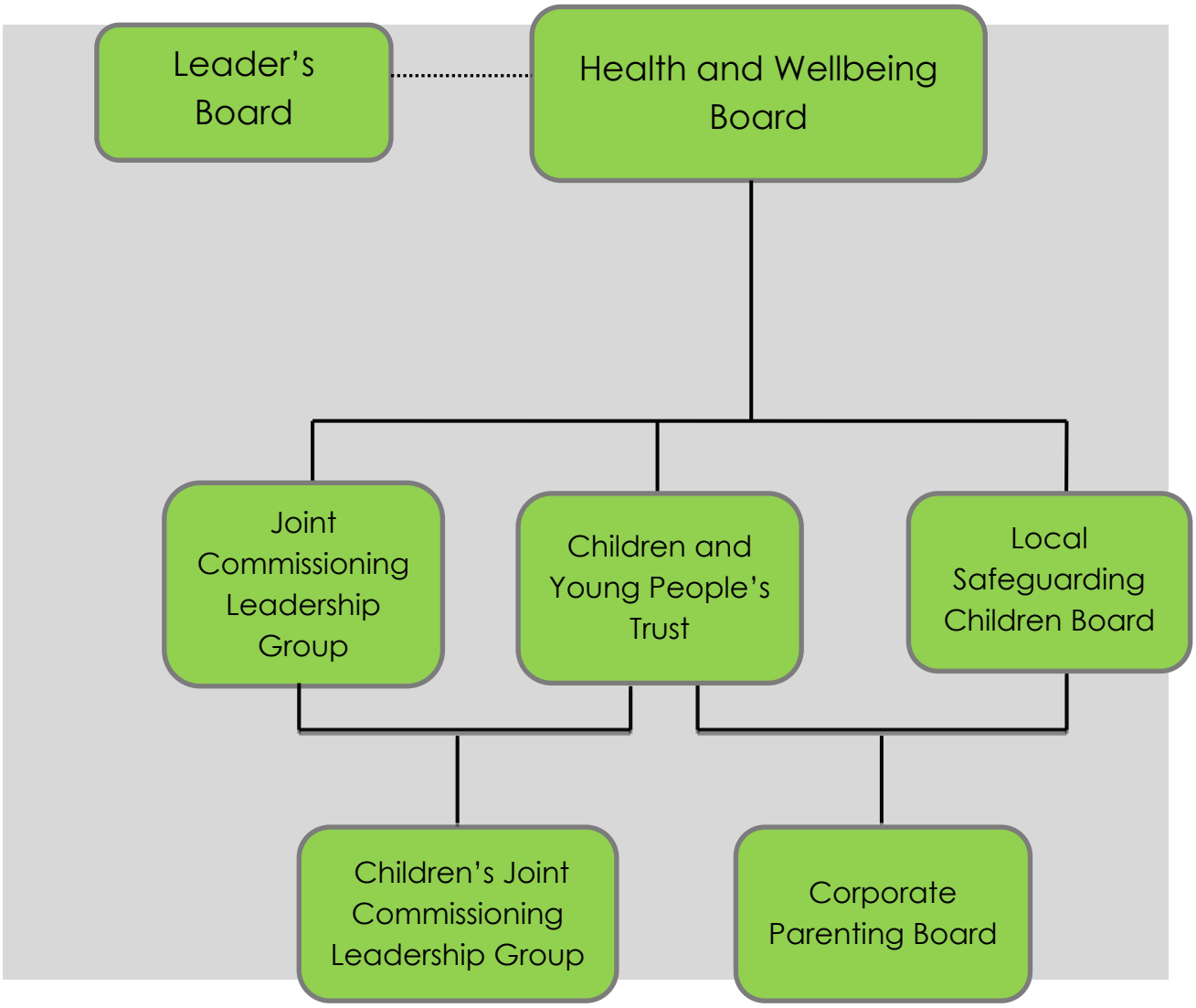
6.1 Cheshire East's Ofsted Inspection Report is available on the website http://reports.ofsted.gov.uk/local-authorities/cheshire-east

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

Name: Kath O'Dwyer
Designation: Director of Children's Services/Deputy Chief Executive
Tel No: 01270 3 71105
Email: Kath.O'Dwyer@cheshireeast.gov.uk

Appendix One

Governance for the Improvement Plan



The above structure sets out the key partnership governance around the improvement plan. The Council's Scrutiny Committees and the management accountability structures within the Council will also play key roles in monitoring, scrutinising and challenging progress of the plan. Further details of these arrangements are set out on the following pages.

Appendix One

Partnership Governance

Health and Wellbeing Board

The **Health and Wellbeing Board** provides the vision and coordinated drive to address the health and wellbeing needs of the local population of Cheshire East to reduce unacceptable and avoidable variations in health and healthcare. Services for children, young people and their families come under the 'Starting Well' and 'Living Well' priorities of the Health and Wellbeing Board. This Board will hold the other children and young people's partnerships to account for their delivery of the improvement plan.

Leader's Board

The **Leader's Board** is responsible for joint commissioning and integrated delivery. The members of this Board are high level representatives from the Council, Police and Crime Commissioner, the Chair of the Health and Wellbeing Board, and Fire Authority. Any issues or risks to the implementation of the improvement plan that cannot be resolved by the other partnership boards will be escalated to the Leader's Board, in particular, where these issues relate to partners not represented on the Health and Wellbeing Board.

Local Safeguarding Children Board

The **Local Children's Safeguarding Board (LSCB)** is an independently chaired statutory partnership board that works together to ensure that where children are harmed, or at risk of harm, all agencies actively cooperate to safeguard them and promote their welfare. The LSCB is supported by an LSCB Executive Group and a number of sub-groups that progress separate work streams of the LSCB Business Plan. The LSCB will monitor and challenge partnership progress against the improvement plan.

Children and Young People's Trust

The **Children and Young People's Trust** is a partnership Board that aims to improve outcomes for all children and young people in Cheshire East through strategic leadership and decision making, determining joint priorities, joint planning, and ensuring integrated working. The Trust is responsible for ensuring that the Children, Young People's Plan, and the wider partnership supports the improvement plan.

Joint Commissioning Leadership Group

The **Joint Commissioning Leadership Group** co-ordinates joint commissioning across the partnership for children's and adults' services to ensure this is joined up and the partnership works effectively together to meet the needs of people within Cheshire East.

Children's Joint Commissioning Leadership Group

The **Children's Joint Commissioning Leadership Group** is focused on joint commissioning arrangements for children's services to ensure these are prioritised. It co-ordinates joint commissioning across the partnership for to ensure this is joined up

and the partnership works effectively together to meet the needs of children and young people within Cheshire East.

Corporate Parenting Board

The **Corporate Parenting Board** is mainly made up from officers from across the Council's services and partners that can impact on outcomes for cared for children and young people. The Board will be responsible for ensuring delivery of the improvement plan areas for cared for children and young people.

Other Key partnership input to the improvement plan

It is proposed that a **Partnership Chair's Group,** made up from the Chairs of the children and young people's partnership boards and relevant officers, will meet quarterly. This group will use information from other groups to assess progress against the Improvement Plan as a whole. They will inform the quarterly progress reports to the Health and Wellbeing Board. This group will also ensure that cross-partnership issues are effectively aligned.

There are a range of other partnerships that will also help to deliver and monitor the effectiveness of this improvement plan. These include the **Cheshire East Domestic Abuse Partnership Board** that co-ordinates the shared work of all key statutory and voluntary sector communities to keep people safe from domestic abuse and the **Local Safeguarding Adults Board** that will need to ensure that adult safeguarding arrangements are effective in prioritising the needs of children and young people.

Council Member Governance

Overview and Scrutiny Committee

The **Children and Families Overview and Scrutiny Committee** and the **Health and Adult Social Care Overview and Scrutiny Committee** form part of the Committee structure of the Council and will carry out the overview and scrutiny functions of the improvement plan on behalf of the Council. These committees will make recommendations to the Council's **Cabinet** where they identify areas that need to improve.

Council Officer Governance

Management Group Board

The Council's **Management Group Board** brings together Chief Officers from across Council departments and oversees delivery of the improvement plan across Council services. The Board will also deal with risks and issues that need to be resolved at a wider council level.

Children and Families Senior Leadership Team

The **Children and Families Senior Leadership Team** are senior managers from across the Council's Children's Services and is responsible for ensuring delivery of the improvement plan at a service level. The team will monitor, challenge and ensure appropriate reports are presented to other bodies in respect of the improvement plan.

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APPENDIX 2

SHORT GUIDE FOR PROFESSIONALS
Cheshire East
Children and Young People's Improvement Plan
to meet the Ofsted Recommendations
November 2015-2016

Creating a great place to be young

What is the Children and Young People's Improvement Plan?
Our Improvement Plan sets out how children's services in Cheshire East, as a partnership, will continue to improve outcomes for children and young people by ensuring that **all our services are good or better**. The plan addresses the recommendations from the Ofsted Inspection in July 2015.

What do we want to achieve?
We want to make Cheshire East a **great place to be young**, where children and young people are happy, heathy, safe, and have lots of opportunities to enjoy life, learn and develop.

We want all children and young people in Cheshire East to:
- **Be safe, and protected from harm**
- Have a **loving, caring and stable environment** where they can grow and develop
- Have a **permanent home as soon as possible** when they need to become cared for by the local authority
- **Achieve to their full potential**
- Have a range of opportunities for and the **right support to go into employment, further education or training** when they reach adulthood

Children, young people and parents have told us they want:

- **To be listened to**
- **To be included in their plans**, and **understand what the concerns are** and why they need a plan
- For **professionals to be clear with them** about what is going to or could happen

We have achieved significant improvements to services over the past two years, and we do have good quality practice in Cheshire East. This plan is about ensuring that **all our practice is consistently good or better** so that we can ensure that all children, young people and families experience good outcomes, and get the right service they need at the right time.

APPENDIX 2

How will make it happen?

Our plan focuses on developing a culture of good practice, which means that all professionals **put children and young people first** – making sure we find ways to hear their views, that we consider what it's like to be them, that we champion their best interests, and that we put them at the heart of all our decision making.

We will develop **a culture of continual learning, support and challenge**, where everyone supports each other to get the best outcomes for children and young people.

We will invest in and recognise the skills of our staff. We have very passionate, committed and creative professionals in Cheshire East, we will cultivate these people and make the most of their skills, and continue to attract new highly qualified people excited to work with us.

What will we do?

Our plan has four priorities that we will concentrate on:

1. Embedding listening to and acting on the voice of children and young people throughout services

We know that children, young people and parents experience better outcomes when they understand what professionals are doing, how and why. We will involve children, young people, parents and carers in decision making from the outset, as they are the people best placed to know what works for them.

We will:

- **Strengthen the use of feedback from complaints** to drive improvements to services
- **Use feedback** from children, young people, parents and carers for all services **to evaluate how well we are performing**.

"The participation of children and young people is a real strength in Cheshire East. Political and senior leaders create meaningful opportunities for young people to join them in strategic thinking and planning."

APPENDIX 2

2. Ensuring frontline practice is consistently good, effective and outcome focused

Overall, practice needs to be more consistent to provide a good service to children and young people. We will support managers to be leaders for good practice, and we will continue with our successful recruitment programme attracting the right people to work with our families in Cheshire East.

We will:

- **Develop one way of working across children's social care services** and deliver training to support this so that the support provided throughout the child's journey is consistently good.
- **Produce clear guidance so all professionals know what is expected of them**, what good practice looks like, and feel confident to challenge and support others where this is not happening. This includes the Multi-agency Practice Standards, Cheshire East Social Work Practice Standards, Missing from Home and Care Protocol, Policy on step up and step down, and revising the Escalation Process.
- **Support practitioners through a comprehensive training programme** from the LSCB Multi-agency training, and launch a new mandatory core training offer for Social Workers and their Managers.
- **Strengthen supervision** through delivering training on effective supervision to Social Workers and Managers, introducing minimum standards and completing monthly audits on the quality of supervision.
- **Share and celebrate good practice** to increase recognition and understanding of the features of good practice.
- **Introduce the Safer Children Model for Child Protection Conferences.** This model focuses on ways to include the family in planning, and focuses on the strengths of the family as well as the areas that need to improve, which will help to engage children, young people and families in the planning process. It also helps families to understand why the plan is in place and what needs to happen to achieve it.
- **Establish the Early Help Brokerage Service,** which will ensure timely referrals to early help, and will identify the best service for the child or young person and the family's needs.
- **Increase management capacity and appoint a newly designated lead Group Manager and Practice Manager for Care leavers**
- **Hold sessions on specific areas in Practice and Performance Workshops to raise awareness and understanding**, including on Private Fostering and Connected Persons Arrangements, Child Sexual Exploitation, and Missing from Home and Care.

"Children's views and ideas are included in assessments and recorded on case files. Social workers see children regularly and speak warmly about them."

APPENDIX 2

4. Improving senior management oversight of the impact of services on children and young people

We will improve how we measure the impact of services on children and young people so that we have a clear picture, and a joined up approach for all our services. This will help us to effectively target our efforts on the areas that need it most, and help us to learn from the services we know are working really effectively. We will ensure that all managers have the information they need to know how effectively their service is operating in order to drive improvements day to day within their teams.

We will:

- **Develop an overarching performance monitoring framework** for children's services
- **Develop performance reporting** for all children's services
- **Introduce a system for regular reporting on services to senior managers and partnership boards**

3. Ensuring the partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East

We need to unite our services and continue to develop partnership working by developing one way of working. This will make it clear what is expected from each person's role, and will ensure that everyone is focused on achieving the best outcome for children and young people. We will improve links between the strategic decision-making partnership boards, and we will involve practitioners across the partnership in driving changes to services. This will help us to continually improve our services and will make sure that our partnership services are joined up.

We will:

- **Establish a multi-agency Missing from Home and CSE Team**. This will improve joint working and information sharing and will provide a specialist resource for advice and support for practitioners.
- **Launch a new campaign around the neglect strategy** to embed the use of the graded care profile, a tool to help practitioners assess the impact of neglect.
- **Continue to work with practitioners across the partnership to embed ownership, challenge, reflection and support** through LSCB communications and partnership forums such as the Safeguarding Children Operational Group.

APPENDIX 2

How will we know we are making a difference?

We are improving our services so that children and young people experience better outcomes. To assess the impact of our improvements on children and young people, we will use information from four different sources.

Performance

An up to date, month by month picture, showing a clear trajectory of progress. Allowing us to set targets and evaluate our performance against our statistical neighbours.

Feedback from Children and Young People, Parents and Carers

What children and young people, parents and carers want and is important to them, what their experience is of our services.

Qualitative Information

Detailed information on what is working well and areas for improvement for specific services, including what the causes of issues are.

Feedback from Staff

What staff know would help them to work with families, what is working well, and what could work better.

This will allow us to triangulate the evidence so that we know what impact improvements are making. We think it is important to have a continual learning and self-improvement culture, and we will use information from these sources to continually evaluate and improve our services throughout the year. We will continue to communicate the findings of this activity to staff, children and young people, partners, and other key stakeholders through our e-newsletters, staff forums, and partnership Boards.

The Health and Wellbeing Board will receive quarterly updates on progress against the actions in our plan, performance and quality assurance information to ensure that we achieve our goals.

This plan is focused on activity to improve services over the next year as part of a larger improvement programme over three years. A new Improvement Plan will be developed in September 2016 for the next stage in our improvement journey.

Feedback

If you have any thoughts or views on this plan, or how well we are progressing, please do contact us at **C&FSpeakUp@cheshireeast.gov.uk**

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Sam Gyimah MP
Parliamentary Under Secretary of State for Childcare and Education

Sanctuary Buildings 20 Great Smith Street Westminster London SW1P 3BT
tel: 0370 000 2288 www.education.gov.uk/help/contactus

Councillor Michael Jones
Leader of the Council
Cheshire East Unitary Authority
Town Hall
Macclesfield
SK10 1EA

16th December 2015

Dear Michael

I am writing further to my letter of 1 October 2015. I have considered the Ofsted report, the report from the independent chair of the Improvement Board, Helen Denton, and advice from my officials.

It is clear that Cheshire East Council has made progress in consolidating improvements since the previous inspection and clear that the service provided to children, young people and their families has significantly improved. However, some challenges and priorities remain which will require a continued sharp focus. I understand that these are captured in your revised improvement plan.

As a result of this improvement, the Improvement Notice which was issued to the council on 12 September 2013 is now lifted. However, Cheshire East Council will now enter a period of supervision and support until September 2016. This will enable me to be assured of the sustainability of the improvements which have taken place. Going forward this approach will be the norm for all councils leaving intervention following an Ofsted judgement of 'requires improvement'. Officials will contact you directly to discuss what this means in practice.

Finally, I would encourage you and your officers to continue to work

with neighbouring authorities – especially those who find themselves facing similar challenges – in order to share the lessons you have learned, and the good practice you have developed on your improvement journey.

Councillor Rachel Bailey (Children and Young People Portfolio), Mike Suarez (Chief Executive), Kath O'Dwyer (Director of Children's Services and Deputy Chief Executive) and Helen Denton (Chair of Cheshire East Improvement Board).

Sam Gyimah MP
Parliamentary Under Secretary of State for Childcare and Education

Health and Wellbeing Board Development Opportunities

Re: Children and Young People's Improvement Plan

The Health and Wellbeing Board (HWBB) has a statutory responsibility to improve the health and wellbeing of the children, young people and their families in Cheshire East, reduce health inequalities and promote the integration of services. As the 'accountable body' for the children and young people's improvement plan, it is important that members of the HWBB feel that have the skills, knowledge and ability to monitor, scrutinise and challenge progress against the plan.

Proposed Areas for Development

The following areas have been identified as key areas of knowledge and expertise for the HWBB to enable it to robustly assess progress against the Children and Young People's Improvement Plan:

- Knowledge of the framework for governance, planning, monitoring and signing off action plans
- Knowledge of the role and plans of key partnership forums – The Local Safeguarding Children Safeguarding Board (LSCB), Corporate Parenting Board and The Children and Young People's Trust
- Familiarity with the Quality Assurance Framework – impact around performance (measures) and quality (audit) and participation and engagement (feedback)
- Information on and awareness of Ofsted findings re key features of inadequate authorities
- Familiarity with Frontline practice - Children in need and child protection
- Familiarity with Frontline practice - Cared for children and care leavers
- Familiarity with Role of the Independent Reviewing Officers and Child Protection Chairs
- Familiarity with Cheshire East Consultation Service (ChECS)

Development Opportunities

It is recommended that HWBB members engage in some or all of the following development opportunities which can be arranged dependant on need and the requests of the H&WB membership:

- Frontline visits to key teams – Children in Need/Child Protection/C4C/CHeCs/Independent Reviewing Officers/Child Protection Chairs
- Light bite events – 15/30 minute focussed sessions before/after the HWBB
- Attending/shadowing key board meetings – LSCB, Corporate Parenting Board
- Board development sessions
- Attend existing multi-agency training
- Shadowing the Audit process
- Speed dating on core elements of the elements of the improvement plan
- Access to help, support and advice on specific children and families issues via the Children's Improvement generic email – all queries will be routed through the relevant Officer within the service.

NB. It is expected that members of the HWBB prioritise these development opportunities and complete them within the next 6 months (Jan-June 2016)

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Health and Wellbeing Board

Date of Meeting:	**26 January 2016**
Report of:	Caroline Simpson. Executive Director of Economic Growth & Prosperity.
Subject/Title:	Key Worker Accommodation: Gathering intelligence for demand and location to support the development of a Supplementary Planning Document.
Portfolio Holder:	Councillor Ainsley Arnold. Housing and Planning.

1. Report Summary

1.1. Strategic Housing continually works and innovates to support the councils' successful job-led economic regeneration and drive for Best Place to Live in the Northwest. Such local economic success highlights the need for access to affordable housing and the ability to attract and retain key workers in our communities.

1.2. This briefing note clarifies the work to date, the strategic link with the Local Plan and informing intelligence led policy for the provision of key worker affordable housing need and location. An approach which works to help deliver the councils' Resident First Outcomes and 4 Year Plan 2016 to 2020.

1.3. To support such a strategic approach, it is necessary to ensure we fully compliment the Local Plan, through a clear evidence based assessment of particular housing need. As such, commissioning a borough wide survey into potential demand for key worker housing allows Strategic Housing to contribute to Spatial Planning's' emerging planning guidance.

1.4. Strategic Housing have previously obtained Cabinet approval for an interim policy approach in December 2014, this paper now informs a formal policy approach which will be established within a Supplementary Planning Document

1.5. Initial contact with our partner agencies employing key workers, such as qualifying staff working in both NHS Trusts; Cheshire Police and Cheshire Fire and Rescue Service, has proven very positive, so Strategic Housing now seek to gather evidence of potential affordable housing need for key workers within Cheshire East, through primary qualitative research by conducting an online key worker affordable housing needs survey.

2. Recommendation

2.1. That The Board support Strategic Housing's conducting of a survey within the borough with partner agencies, to gain valuable intelligence into potential key workers affordable housing needs, which will in turn supplement the Cheshire East Council Local Plan and inform the development of a Supplementary Planning Document.

3. Other Options Considered

3.1. Extensive work has been carried into developing the most appropriate method in which to obtain intelligence of key worker affordable housing need within Cheshire East and support the development of a SPD.

3.2. Direct contact has been made with relevant partner organisation's in the borough, such as both NHS Trusts; Cheshire Police and Cheshire Fire and Rescue Service into the most effective method of communication, in which due to the diversity of shift and work patterns, an online survey was seen as the most efficient and effective technique in communication within a large number of workers.

4. Reasons for Recommendation

4.1. Affordable housing in Cheshire East plays a fundamental role in supporting Cheshire East Councils' successful job-led economic regeneration and commitment to provide a mix of accommodation to meet identified needs. It is clear, that if we are to attract and retain a vibrant workforce, then we have to provide adequate housing provision including accommodation for key workers, who may struggle in some of our higher value and rural areas to access affordable housing.

4.2. If Strategic Housing are to fully support the attraction and retention of key worker within our communities, it is important that access to affordable housing is available of the right type and in the right location.

4.3. Strategic Housing obtained Cabinet approval in December 2014 to;

a) Utilise an interim approach for key workers, including definition

b) Carry out the primary research to establish the need for Key worker provision

c) The need for key worker provision once established to be incorporated into the development of a Supplementary Planning Document

4.4. To inform such an approach, evidence of need for such provision is required to inform strategic decisions, most particularly the Local Plan Strategy.

4.5. The Local Plan creates a vision for the future which is to deliver jobs-led growth and sustainable vibrant communities. The detailed policies, which need to be clearly linked to the Plan, will be provided through the development of Supplementary Planning Documents (SPD). The SPD will

be informed by research and evidence and will enable us to have sound, defensible policies including a Policy for the provision of Key Worker Accommodation. To ensure contact is made with all relevant key partner agencies with Cheshire East, effective dialogue is in progress with appropriate contacts within organisations, which highlights the approach and raises the profile of online survey, seeking to capture a wide range of responses from a wide range of key workers across the borough.

5. Background / Chronology

5.1. The definition of key worker within Cheshire East is defined in accordance with Central Government's Key worker Scheme, taking into account the local position. Staff employed on a permanent basis within the following public sector roles;

a) NHS workers (e.g. nurses and junior doctors)
b) Teachers
c) Police
d) Prison Officers
e) Probation Service
f) Local Authority (e.g. social workers)
g) Fire Fighters
h) Ministry of Defence

5.2. The Local Plan Strategy specifies under Policy SC4 – Residential Mix that the mix of housing will be expected to include properties for key workers and for those who wish to self build. The Strategy states that how this will be taken forward will be set out in a Supplementary Planning Document and the Site Allocations and Development Policies Document.

5.3. The approach sought by Strategic Housing must be informed by the Local Plan. As such, appropriate links have been made with Spatial Planning to ensure the approach is defined by the contents of the Local Plans, which is initially to gain intelligence about potential affordable housing need within Cheshire East.

5.4. The Project Plan [Appendix 1] details steps to be undertaken for the delivery of a successful outcome are detailed specified in Table 1.

Table 1: Project Plan Steps

Project Set-up	Research and Consultation	▪ Agree scope / contents of survey ▪ Set up survey, including questions ▪ Discuss preferred method of communication with key partner agencies	
	Web Team	▪ Online survey access arrangements, ease of access online ▪ Introduction page [s] to detail aims and objectives ▪ Shortened URL / QL Code – to allow ease of access	
	Publicity	▪ Press release [Media and Communication] – to raise awareness ▪ Leaflet print / distribution	
Key Communication	Partner public sector employing organisations	▪ Linked with Media and Communication Managers / teams to obtain buy-in ▪ Scoped raising awareness / best method of communicating through existing processes – website link; social media and poster / leaflets	
	Cheshire East Council services	Education Spatial Planning Social care	▪ Raise awareness / appropriate communisation methods ▪ Poster / leaflets campaign
Survey	Lead up	▪ Poster / Leaflet print off / distribution by Housing Policy Officer ▪ Press release issued ▪ Web links set up ▪ Social media – raise awareness	
	Online	▪ Availability setup for agreed period	
Project Closure	Survey Report	▪ Results analysis ▪ Report: Findings / Recommendations ▪ Project sign	

6. Wards Affected and Local Ward Members

6.1. All wards

7. Risk Management & Implications of Recommendation

7.1. Cheshire East has a strong and resilient economy, which has been enormously successful in creating and maintaining business growth and local jobs. Access to affordable housing for key workers, working and living in our communities is fundamental to such economic success.

7.2. Strategic Housing have worked extensively with Spatial Planning to ensure strong contribution is made to the Local Plan, in terms of planning guidance for site allocation of key worker housing through a SPD. This contribution needs to be evidenced by primary research into key worker housing need, the qualitative data obtained from a survey of partner organisations is essential to inform future policy decisions.

7.3. In light of such evidence of need, it is remains crucial that such planning guidance is available, to inform potential developers and support the councils continued drive for a job-led economic regeneration and attract key workers to be able to access affordable housing.

8. Access to Information

8.1. Cabinet approval in December 2014 [Ref CE 14/15-22] – Link HERE

8.2. Draft Cheshire East Council Strategic Housing Key Worker Survey – link HERE

9. Contact Information

Contact details for this report are as follows:-

Name: Caroline Simpson
Designation: Executive Director of Economic Growth & Prosperity
Tel. No: 01270 686640
Email: caroline.simpson@cheshireeast.gov.uk

Appendix 1: Project Plan

	Key Deliverables	Start Date	End Date	Lead / Owners	% Comp	Plan/ Actual	Nov-15					Dec-15				Jan-16				Feb-16					Mar-16			
	Keyworkers Survey: Gaining intelligence of affordable housing need	Mon 02/11/15	Mon 28/03/16	Karen Carsberg	30%	Monday	02	09	16	23	30	07	14	21	28	04	11	18	25	01	08	15	22	29	07	14	21	28
						Friday	06	13	20	27	03	11	18	25	01	08	15	22	29	05	12	19	26	04	11	18	25	01
	Project Set-up																											
1	Research and Consultation	Mon 02/11/15	Fri I 01/01/16	GB	25%	Planned																						
						Actual																						
2	Web Team	Mon 02/11/15	Fri 03/12/16	GB	25%	Planned																						
						Actual																						
3	Publicity	Mon 30/11/15	Fri 01/04/16	GB / Comms	25%	Planned																						
						Actual																						
	Key Communication																											
4	Mid Cheshire NHS	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
5	East Cheshire NHS	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
6	Cheshire Fire and Rescue Service	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
7	Cheshire Police	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
8	British Transport Police	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
9	HMP Styal	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
10	CEC Education	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
11	CEC Spatial Planning	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
12	CEC Social Care	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
13	Cheshire Probation [Public]	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
14	Cheshire Probation [Private]	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
15	Help to Buy Northwest	Mon 30/11/15	Fri 01/04/16	GB		Planned																						
						Actual																						
	Survey																											
16	Lead-up	Mon 30/11/15	Fri 03/12/15	GB		Planned																						
						Actual																						
17	Online	Mon 07/12/15	Fri 19/02/16	GB		Planned																						
						Actual																						
	Project Closure																											
18	Results Analysis	Mon 22/02/16	Fri 18/03/16	Research / Consultation		Planned																						
						Actual																						
19	Report: Findings / Recommendations	Mon 21/03/16	Fri 01/04/16	KC		Planned																						
						Actual																						
	Project Sign-Off			KC		Planned																						
						Actual																						

REPORT TO: Health and Wellbeing Board

Date of Meeting: 26th January 2016
Report of: James Morley, Scrutiny Officer
Subject/Title: Memorandum of Understanding between Health & Wellbeing Board, Health & Adult Social Care, and Children & Families Overview and Scrutiny Committees, and Healthwatch Cheshire East

1 Report Summary

1.1 This report provides a brief overview of the relationship between Overview and Scrutiny, the Health and Wellbeing Board and Healthwatch together with a Memorandum of Understanding (MoU) that has been proposed to support the work of the four bodies.

2 Recommendations

2.1 That the MoU be taken to the four bodies to be discussed and a final version agreed

3 Reasons for Recommendations

3.1 The purpose of the MoU is to provide a guidance to the four bodies as to how they should work together, to ensure their activities are complimentary (whilst avoiding duplication), and contribute towards achieving the strategic health and care outcomes of the Borough.

3.2 Limited time and resources makes it difficult for each body to achieve the objectives of the Borough individually. Also each body has specific powers and remit that the others should not duplicate unnecessarily.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The MoU may help to develop relationships between the bodies that allow each to focus on particular issues, producing better quality work and enabling the bodies as a whole to achieve more.

5 Background

5.1 The Centre for Public Scrutiny (CfPS) has produced a variety of guidance regarding health scrutiny and the relationships between Health and Wellbeing

Boards, Health Scrutiny and Healthwatch. The guidance has been useful in considering ways to improve working, such as developing protocols and having regular dialogue.

5.2 HASCOSC has developed good relationships with the individual members of the HWB. However there hasn't been much progress in terms of establishing a cohesive relationship between the Committee and the Board. At the same time, whilst there has been work to develop a relationship between officers of Scrutiny and Healthwatch, there is little relationship between the HASCOSC and HWCE.

5.3 Children and Families Overview and Scrutiny Committee is also included because HWB often considers issues in relation to children's health which it has an interest in and needs to be considered alongside Health Scrutiny.

5.4 It is important that there is joint working however it is also necessary to avoid over complicating governance arrangements. It is suggested that the purpose of the MoU should be similar to that of the Health Scrutiny Protocol. The Protocol is a guide that should be referred to when needed however collaborative working should rely on good communication and mutual agreement rather than forced by strict procedure.

6 Access to Information

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

Name: James Morley
Designation: Scrutiny Officer
Tel No: 01270 6 86468
Email: james.morley@cheshireeast.gov.uk

Memorandum of Understanding between Cheshire East Health and Wellbeing Board, Healthwatch Cheshire East, Health and Adult Social Care Overview & Scrutiny Committee and the Children and Families Overview & Scrutiny Committee

Introduction

1. This Memorandum of Understanding (MoU) sets out a simple framework for the working relationship between Cheshire East Health & Wellbeing Board (CEHWB), Healthwatch Cheshire East (HWCE), Health and Adult Social Care Overview & Scrutiny Committee (HOSC), and the Children and Families Overview & Scrutiny Committee (CFOSC).

2. All organisations recognise that there are distinct and unique relationships between them. Accordingly, the framework set out in this MoU takes account of these relationships and specifies the ways in which all bodies will work together in delivering their respective statutory functions (See Annex I).

3. This MoU cannot override the statutory duties and powers of any of the organisations, and is not enforceable in law. However, all organisations agree to adhere to the principles set out in this MoU and will show regard for each other's activities.

4. The MoU sets out the principles that the organisations will follow in the course of day-to-day working relationships. The MoU is supported by the Cheshire East Health and Social Care Overview and Scrutiny Protocol and other guidance documents which advice on working relationships from providers such as the Department of Health and Centre for Public Scrutiny (CfPS).

Principles of cooperation

5. CEHWB, HWCE, HOSC and CFOSC agree that their working relationship will be guided by the following principles:
   I. The need to make decisions which promote the safety health and wellbeing of the Cheshire East population
   II. Respect for each organisation's independence
   III. The need to maintain public confidence
   IV. The need to use resources efficiently and effectively.
   V. The Seven Principles of Public Life (Nolan Principles): Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty and Leadership

Collective Responsibilities

6. The CEHWB, OSCs and HWCE recognise collective responsibility in improving the health and wellbeing of people in Cheshire East. As such the bodies will work

together to both support each other and to provide appropriate challenge to ensure that the potential to improve the health and wellbeing of the population is maximised. The bodies will ensure that their work programmes are complementary and contribute towards the strategic needs of the Borough and that outcomes from pieces of work reinforce each other, avoiding duplication or contradiction.

7. The CEHWB, OSCs and HWCE understand the importance of engaging with our population, and the requirement to incorporate patient/public feedback and/or engagement in all our planning and commissioning cycles. While understanding patient experience and acting as 'consumer champion' is a key function of Healthwatch Cheshire East, there is a collective responsibility to ensure that all mechanisms for consultation and engagement are effective and efficient.

8. Decisions taken by the CEHWB, OSCs and HWCE must work to promote the sustainability and efficiency of services and work to promote the implementation of the prevention agenda and to reduce inequalities in Shropshire.

9. CEHWB, OSCs and HWCE must ensure the smooth transition of appropriate information across organisations. This will be facilitated by (Quarterly) informal meetings between key members of CEHWB, OSCs and HWCE and regular communication between support officers of all bodies.

Relationships

Cheshire East Health and Wellbeing Board and Healthwatch Cheshire East

10. As per legislation (Health and Social Care Act 2012), a representative of HWCE will sit on CEHWB and have a full voting power.

11. HWCE will produce reports to and advise CEHWB on the issues and needs of the local population in order to better inform the Board's decisions and support their engagement with the population of Cheshire East.

Cheshire East Health and Wellbeing Board and Health and Adult Social Care Overview & Scrutiny Committee

12. The CEHWB and HOSC will maintain dialogue, as relevant, with each other about the issues, risks and challenges involving health and wellbeing of the local population as well as health and social care in Cheshire East.

13. HOSC will share with the CEHWB relevant recommendations and/or information following the scrutiny of local health and social care services, which CEHWB will use to support partners and to inform future priorities. CEHWB will provide a response to HOSC on recommendations which are presented to it within an agreed timeframe

14. HOSC will monitor the performance of CEHWB and will act as a critical friend to the Board's activity and hold the Board to account on the delivery of its statutory obligations.

15. CEHWB will consult HOSC on analysing and evaluating performance of services against the JSNA and JHWS to inform future strategy development

Cheshire East Health and Wellbeing Board and Children and Families Overview & Scrutiny Committee

16. CEHWB and CFOSC will maintain dialogue with each other, as relevant, about the issues, risks and challenges involving wellbeing of children and young people in Cheshire East.

17. CFOSC will share with the CEHWB relevant recommendations and/or information following the scrutiny of local children's services, which CEHWB will use to support partners and to inform future priorities.

Health and Adult Social Care Overview & Scrutiny Committee and Healthwatch Cheshire East

18 HWCE will regularly communicate with HOSC and feed into their work programme referring issues to the Committee as per the legislation

19 HOSC may commission HWCE to undertake specific investigations or research, co-opt representative of HWCE onto task and finish groups where appropriate.

20 HOSC will contribute to the HWCE's work programme and will scrutinise its outcomes via its annual report.

Children and Families Overview & Scrutiny Committee and Healthwatch Cheshire East

21 HWCE will regularly communicate with CFOSC and feed into their work programme on children's issues.

22 CFOSC may commission HWCE to undertake specific investigations or research.

Children and Families Overview and Scrutiny Committee and Health and Adult Social Care Overview and Scrutiny Committee

23 CFOSC and HOSC will liaise on issues that overlap their remits and agree which committee will lead on them through the Council's Corporate Overview and Scrutiny Committee.

24 The committees will share information and attend each others meetings to observe any work which is relevant to both committees.

25 When appropriate the committees will make arrangements for cross committee/joint meetings or task and finish groups.

Resolution of disagreement

26 Any disagreement between CEHWB, HWCE, CFOSC and HOSC will, wherever possible, be resolved at working level. If this is not possible, it will be brought to the attention of the MoU managers and/ or signatories who will then be jointly responsible for ensuring a mutually satisfactory resolution.

SIGNATORIES

……..
Chair of Cheshire East
Health & Wellbeing Board

……..
Chair of Healthwatch
Cheshire East

……..
Chair of Children & Families
Overview & Scrutiny Committee

……...
Chair of Health and Adult Social Care
Overview & Scrutiny Committee

ANNEX I

1. STATUTORY FUNCTIONS OF HEALTH & WELLBEING BOARDS

The Health and Social Care Act 2012 gives health and wellbeing boards specific functions. These are a statutory minimum and further functions can be given to the boards in line with local circumstances. The statutory functions are:

- To prepare Joint Strategic Needs Assessments (JSNAs) and Joint Health and Wellbeing Strategies (JHWSs), which is a duty of local authorities and clinical commissioning groups (CCGs).
- A duty to encourage integrated working between health and social care commissioners, including providing advice, assistance or other support to encourage arrangements under section 75 of the National Health Service Act 2006 (ie lead commissioning, pooled budgets and/or integrated provision) in connection with the provision of health and social care services.
- A power to encourage close working between commissioners of health-related services and the board itself.
- A power to encourage close working between commissioners of health-related services (such as housing and many other local government services) and commissioners of health and social care services.
- Any other functions that may be delegated by the council under section 196(2) of the Health and Social Care Act 2012. For example, this could include certain public health functions and/or functions relating to the joint commissioning of services and the operation of pooled budgets between the NHS and the council. Such delegated functions need not be confined to public health and social care. Where appropriate, they could also, for example, include housing, planning, work on deprivation and poverty, leisure and cultural services, all of which have an impact on health, wellbeing and health inequalities.

Health and wellbeing boards A practical guide to governance and constitutional issues – LGA/ ADSO 2013)

2. STATUTORY FUNCTIONS OF LOCAL HEALTHWATCH

As part of the Health and Social Care Act 2012 and Regulations, the functions of Local Healthwatch are:

Function One: Gathering views and understanding the experiences of patients and the public

- Ensure systematic and ongoing engagement with all sections of the local population so that a wide cross-section of views are represented in respect of local health and social care.
- Seek the community's views about the current provision of health and social care and use this to identify the need for changes or additions to services.
- Demonstrate an ability to analyse and channel high quality user feedback and public views on services to relevant commissioners so that they can inform the whole commissioning cycle

Function Two: Making people's views known

- Communicate the local community's views to health and social care commissioners and providers.
- Represent local people's views through its membership on the Health and Wellbeing Board.
- Present regular reports, on the local views and concerns and its activities, as required, to Healthwatch England, a committee of Care Quality Commission.

Function Three: Promoting and supporting the involvement of people in the commissioning and provision of local care services and how they are scrutinised

- Give input to new or proposed services.
- Act as a critical friend to commissioners and providers of services to help bring about improvements.
- Exercise their "Enter and View" powers judiciously by working collaboratively with other inspection regimes.
- Cooperate with and feed into the County Council's Overview and Scrutiny functions and work programmes.

Function Four: Recommending investigation or special review of services via Healthwatch England or directly to the Care Quality Commission (CQC)

- Making recommendations for special reviews or investigations to the Care Quality Commission through Healthwatch England based on robust local intelligence.

Function Five: Providing advice and information (signposting) about access to services and support for making informed choices

- Influence or provide information (signposting) services to ensure that all sections of the local population have access to good quality impartial advice and advocacy relating to health and social care services available to them.

Function Six: Making the views and experiences of people known to Healthwatch England (and to other local Healthwatch organisations) and providing a steer to help it carry out its role as national champion

- Ensure local intelligence gathering systems complement those established by Healthwatch England.
- Develop/ abide by protocols to ensure effective and efficient information sharing with other local Healthwatch organisations.

3. STATUTORY FUNCTIONS OF HEALTH SCRUTINY

The statutory powers of health scrutiny are the powers to:

a) review any matter relating to the planning, provision and operation of health services in their area;
b) request information from health bodies and relevant health service providers;
c) require attendance of NHS staff and members of relevant health service providers at scrutiny meetings;
d) make reports and recommendations to NHS bodies, relevant health service providers and the local authority, and expect a response where one is requested within 28 days;
e) respond to consultations by NHS bodies and relevant health service providers on matters of substantial variations or developments to health services. They must publish timescales for making such responses;
f) refer contested service changes to Secretary of State on specific grounds. They must provide robust evidence in support of this and publish clear timescales within which the referral will be made;
g) co-opt representatives onto their health scrutiny arrangements;
h) delegate health scrutiny powers to another local authority, or to a joint committee of a number of local authorities;
i) delegate health scrutiny powers to a HOSC, where one is retained under s244 (as amended). *In Warwickshire these powers have been delegated to ASC&HOSC;*
j) delegate some health scrutiny functions where a HOSC has not been retained in favour of an alternative mechanism such as a s101 committee;
k) form joint scrutiny arrangements with other local authorities. This is mandatory in relation to proposals for substantial service change.

All commissioners and providers of publicly funded healthcare and social care are covered by these powers, along with health and social care policies arising from the Joint Strategic Needs Assessment (JSNA) and the Joint Health and Wellbeing Strategy.

ANNEX II

CONTACTS

Health & Wellbeing Board	Chair: Cllr Email: @cheshireeast.gov.uk Coordinator: Guy Kilminster Email: guy.kilminster@cheshireeast.gov.uk Tel: 01270 686560
Healthwatch Cheshire East	Chair: Email: Chief Executive Officer: Email: Tel:
Children and Families Overview & Scrutiny Committee	Chair: Cllr Email: @cheshireeast.gov.uk Coordinator: Mark Nedderman Email: mark.nedderman@cheshireeast.gov.uk Tel: 01270 686459
Health and Adult Social Care Overview & Scrutiny Committee	Chair: Cllr Email: @cheshireeast.gov.uk Coordinator: James Morley Email: james.morley@cheshireeast.gov.uk Tel: 01270 686468

ANNEX III

Local Healthwatch, health and wellbeing boards and health scrutiny – Roles, relationships and adding value – CfPS 2012

http://cfps.org.uk/domains/cfps.org.uk/local/media/downloads/L12_693_CFPS_Healthwatch_and_Scrutiny_final_for_web.pdf

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REPORT TO: Health and Wellbeing Board

Date of Meeting: January 2016
Report of: Brenda Smith Director of Adult Social Care and Independent Living (Cheshire East Council)
Sally Rogers Lead Nurse Community and Safeguarding/Registered Nurse, Governing Body Member (NHS Eastern Cheshire Clinical Commissioning Group)
Judith Thorley, Chief Nurse and Director of Quality & safeguarding (NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups)
Subject/Title: **Ensuring and Improving quality and choice in residential and nursing home provision.**

1 Report Summary

1.1 The report provides an update for the Health and Wellbeing Board on the progress and developments to establish a task and finish group, under the auspices of the Health and Wellbeing Board, to review current residential and nursing home provision and consider what might be required to ensure that it is fit for purpose in the future.

2 Recommendations

2.1 The Health and Wellbeing Board is asked:

1. To note the establishment of the Task and Finish Group;

2. To note the proposed structure and content of the strategy;

4. To note the proposed engagement with stakeholders to inform the development of the strategy;

5. To receive a draft report at the Health and Wellbeing Board meeting in April making recommendations for the Health and Wellbeing Board's consideration.

3 Reasons for Recommendations

3.1 As colleagues are aware from previous meetings Health and Wellbeing Board agreed to the establishment of a Task and Finish Group to review current residential and nursing home provision and consider what might be required to ensure that it is fit for purpose in the future. There continues to be steady

progress with the work plan overall together with a number of milestones having been met:

The report covers:

(i) Scoping process
(ii) Establishment of a Task and Finish group
(iii) Draft outline for the strategy
(iv) Proposed engagement
(v) Next Steps

3.2 An initial scoping meeting was held in October attended by Brenda Smith Director of Adult Social Care and Independent Living, Sally Rogers Lead Nurse (NHS Eastern Cheshire Clinical Commissioning Group) and Judith Thorley, Chief Nurse and Director of Quality & Safeguarding (NHS South Cheshire and NHS Vale Royal Clinical Commissioning Groups).

3.3 In November the output from this group was shared with officers within the respective organisations with a request to establish a Task and Finish Group to progress the work as outlined.

3.4 The first meeting of the Task and Finish Group was held in December. This group has continued to meet on a weekly basis and is attended by representatives from Strategic Commissioning, Clinical Commissioning Groups and Social Care. We are actively seeking to widen the membership of the group to include representatives from the wider health economy, provider organisations and service users and carers.

3.5 A draft outline for the strategy has been developed and is attached at Appendix 1. It is proposed that the draft outline will be shared widely for comments and feedback and we welcome the views of the Health and Wellbeing Board on the proposed content.

3.6 Leads from the Task and Finish Group have been identified as being responsible for different elements of the strategy and it is proposed that they will seek wider engagement on each section of the strategy linking into existing groups and expertise as appropriate.

3.7 We are also proposing to hold a workshop to secure wider engagement in development of the strategy. We held a similar event before commencing the joint work to quality assure care services which was well attended and received. Such an event will provide an opportunity to update attendees on the achievements to date regarding the improvement of quality within care services (details of which can be found in the Cabinet Report at Appendix 2) as well as providing stakeholders with the opportunity to shape and influence

the strategy going forward. It is proposed that this event will be held in February.

3.8 It is proposed that the Health and Wellbeing Board will then receive a copy of the draft strategy in April together with recommendations for the Board's consideration.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The 'Ageing Well' priority within the Health and Wellbeing Strategy is focussed upon enabling older people to live healthier and more active lives for longer. This includes when circumstances require them to move into a care environment.

5 Background and Options

5.6 The Joint Strategic Needs assessment will be reviewed to determine what information it might provide to assist with the review.

5.7 The ongoing work being undertaken by Red Quadrant, to review the fair price of care and make recommendations for future costs, will also be considered.

6 Access to Information

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

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CHESHIRE EAST COUNCIL
Cabinet

Date of Meeting: 8 December 2015
Report of: Director of Adult Social Care and Independent Living
Brenda Smith
Subject/Title: The Quality Assurance of Care Services in Adult Social Care

Portfolio Holder: Cllr Janet Clowes – Care and Health in the Community

1.0 Report Summary

1.1 This Council is committed to providing a range of excellent local care and support services for the residents of Cheshire East. We are proud of the care and support services provided to citizens who need both short and long-term care in the community. To support the development of the care market and to ensure that care and support services are of a high quality for our citizens this Council has invested additional resources in the development of a new Quality Assurance function. To this end the Council is delivering on its commitment to ensure residents are supported to live well for longer and to remain as independent as possible.

1.2 The Contract Management and Quality Assurance Team is hosted by Cheshire East Council (CEC) and is supported by input from NHS East Cheshire Clinical Commissioning Group (ECCCG) and NHS South Cheshire Clinical Commissioning Group (SCCCG). The team have strong links with the Care Quality Commission (CQC). It is now twelve months since the new function was established. Regular updates have been provided to Overview and Scrutiny Committee. This report is intended to update Cabinet on the work of the unit over the last year and to seek approval for continued investment in this function**.**

1.3 There is a large market for care and support provision that responds effectively to the needs of the residents in Cheshire East. The majority of the Adult Social Care services currently commissioned are focused on meeting eligible care needs utilising the national eligibility criteria. These services include residential and nursing care, domiciliary care services, day services and supported tenancy schemes. Services are provided across the public, private and voluntary care sectors.

1.4 The Contract Management and Quality Assurance Team is responsible for the quality monitoring of the adult social care market for care and support

with a view to establishing and maintaining standards, minimising risk and ensuring continuous improvement. In addition the team has oversight and management of provider and market failure on behalf of the Council. Recruitment to the new team was completed in December 2014. Appointments to date include a Commissioning Manager, Quality Assurance Manager and five Quality Assurance Officers. The new officers have been recruited from different service backgrounds including contracts, social care and provider services and are supported by colleagues from health when undertaking quality assurance visits to nursing homes.

1.5 An annual programme of reviews of all registered social care providers is in place and is supported by a Framework and Toolkit for the Contract Management and Quality Assurance of Commissioned Services. The primary purpose of the contract monitoring and quality assurance visit is to ensure that commissioned services are meeting the standards and requirements of their contracts, to review the safety, quality and effectiveness of services commissioned by CEC, SCCCG, and ECCCG and to ensure continuous improvement.

1.6 The review is also an opportunity for commissioners to engage with customers of care services. When reviewing care homes the reviews provide the opportunity to observe interaction between staff and residents, view the physical environment of the home and to talk to relatives and staff about services and to seek their views about their experiences. As well as ensuring that providers are meeting their contractual obligations, the quality of the providers care provision is also monitored in line with the 6+1 C's as outlined within the Compassion in Practice Three Year Strategy for Nursing, Midwifery and Care Staff which was launched in December 2012 by Jane Cummings, the Chief Nursing Officer for England and the CQC 5 Key Lines of Enquiry. The 6+1 C's are Care, Compassion, Competence, Communication, Courage, Commitment and Culture. The CQC 5 Key Lines of Enquiry are Safe, Effective, Caring, Responsive and Well Led.

1.7 At the conclusion of a review visit officers will share initial observations and findings and if required agree immediate actions as appropriate. Following completion of the visit the Contract Management and Quality Assurance Team collate all review findings and populate a standardised report template. The report details the purpose of the review and visit, the methodology, findings and any required actions. The report is sent to the provider within two weeks. Where actions and improvements are required an action plan is produced detailing the area that needs to be remedied. The provider is required to update and return the action plan to the commissioners within two weeks detailing how and by when they intend to address the actions required.

Copies of the report are shared with other relevant professionals as required. The progress of the provider is then monitored against the agreed action plan and timescales until the actions have been completed to a satisfactory level.

1.8 The Skilled Multi Agency Response Teams (SMARTs) are responsible for the management of safeguarding investigations and they are represented by a Senior Manager in all governance meetings. As safeguarding investigations may be an indication of poor quality care the Contract Management and Quality Assurance Team work closely with the front line social work teams to identify when this is the case. Officers from the Contract Management and Quality Assurance Team are informed of safeguarding investigations involving independent sector care providers and attend planning meetings as required. The number and nature of safeguarding investigations are reviewed by the Contract Management and Quality Assurance Team as part of the quality assurance process to help inform and prioritise visits. The Commissioning Manager for the Contract Management and Quality Assurance Team attends the Adults Safeguarding Governance Meeting to share findings on contracts and quality assurance.

1.9 The work of the Contract Management and Quality Assurance Team is supported by joint governance arrangements with our health commissioners. Lower level concerns and intelligence regarding commissioned services are discussed at a multidisciplinary Contract Management and Quality Assurance Planning Meeting. This meeting is held every fortnight and provides a robust system of co-ordination and sharing of intelligence for all agencies including, but not limited to: health, social care, palliative care, Healthwatch and infection control. The Contract Management and Quality Assurance Team also communicate regularly with CQC to share intelligence on Providers and findings from inspections and quality assurance visits.

1.10 More serious concerns regarding commissioned services, which require consideration by senior management, are raised at the Joint Quality Assurance Governance Meeting. This meeting is held monthly and is attended by senior managers from CEC, ECCCG, SCCCG and CQC. The group makes recommendations in relation to suspensions on placements, contract defaults and, in exceptional circumstances, contract termination. These recommendations are then presented to the respective Directors of each commissioning body for approval.

1.11 CQC, as a statutory regulator of care provision, is required to undertake regular inspections of all registered health and social care services. CQCs approach to inspections changed in October 2014 and all care providers are now inspected under the 5 Key Lines of Enquiry. Following a CQC Inspection

the findings are published on CQCs public website. There is often a delay of several months between the Inspection Visit and the report being published, during which time the Contract Management and Quality Assurance Team will have already worked with the Provider to address the areas of concern. The rating will also remain in place until the provider is re-inspected. This can result in inspection reports being published on the CQC website which show Providers rated as 'Inadequate' by the regulators when the Council feels that the Provider has already resolved the areas of concern and are continuing to contract with them. This can lead to mixed messages regarding the quality of care being provided locally and has been raised as an issue for CQC to address. In addition CQC also have their own independent alert processes and can call a 'Management Review' meeting with a Provider at any time if they have any serious concerns.

1.12 As a result of this work there has been continuous improvement in the quality of care and support provision in Cheshire East. The support to providers as a result of the teams' intervention has resulted in a reduction in the number of cases of serious concern. The number of providers who had been assessed as being at high risk of provider failure has reduced from eight in September 2014 to none in December 2015. All providers have responded positively to the Council's intervention and have continued to raise their performance by remedying any defaults identified within their action plan within the required timescale. The improvement in the quality of care and support services has directly benefited the users of care services in Cheshire East.

2.0 Recommendations

It is recommended that;

2.1 Cabinet note the work of the Contract Management and Quality Assurance Team, hosted by Cheshire East Council (CEC) within the Adult Social Care Strategic Commissioning Business Unit.

2.2 Cabinet approve the continued investment in the Contract Management and Quality Assurance Team.

Sourcing local care and support services for customers remains integral to the Council's plans. This proposal will ensure that the quality of the care and support services commissioned from the independent sector will continue to be monitored by the Contract Management and Quality Assurance Team.

3.0 Reasons for Recommendations

3.1 The Care Act has introduced a requirement for Local Authorities to encourage a diverse range of high quality care providers. Local authorities therefore have a duty to stimulate the care provider markets so that individuals have a range of options to choose from.

3.2 This proposal will assist the Council to meet this duty by continuing to support the availability of a range of high quality provision in a range of locations across Cheshire East so that people can choose support in the location that works best for them and from a provider who can deliver to their personal requirements.

3.3 As a result of this work there has been continuous improvement in the quality of care and support provision in Cheshire East. The support to providers as a result of the team intervention has resulted in a reduction in the number of cases of serious concern. The number of providers who had been assessed as being at high risk of provider failure has reduced from eight in September 2014 to none in December 2015. All providers have responded positively to the Council's intervention and have continued to raise their performance by remedying any defaults identified within their action plan within the required timescale.

3.4 The continued improvement of the quality of care and support services in Cheshire East is of direct benefit to the users of these services, their relatives and carers. This includes the many residents who purchase their own care independently of Adult Social Care services.

3.5 The establishment of the new function by Cheshire East Council has also resulted in strengthened joint commissioning arrangements between the Council, NHS East Cheshire Clinical Commissioning Group (ECCCG) and NHS South Cheshire Clinical Commissioning Group (SCCCG). An excellent working relationship with the statutory regulator of care provision - Care Quality Commission (CQC) has also been established.

4 Wards Affected

4.1 All wards will be affected by this proposal.

5 Local Ward Members

5.1 All ward members will be affected by this proposal.

6 Policy Implications

6.1 This proposal is in keeping with the requirements of the Care Act 2014.

7 Financial Implications

7.1 It is proposed that the existing investment of £354k is maintained in this activity.

7.2 This represents less than 0.5% of the overall spend on externally commissioned services.

7.3 This is within the existing affordability envelope and no changes are proposed to next years budget as part of the Pre-Budget Report which is currently out to consultation.

8 Implications for Rural Communities

8.1 The proposal will support those in rural communities to access high quality provision in a range of locations across Cheshire East.

9.0 Legal Implications

9.1 The proposals support the Council's ability to demonstrate its fulfilment of its duties under the Care Act, in particular in relation to market-shaping and commissioning activity; and the Council's clear focus on the key issues of outcomes and wellbeing; promoting quality services; supporting sustainability; ensuring choice; and co-production with partners.

10 Risk Management

10.1 Ensuring adequate services in the independent sector market to meet current and future needs of local residents is critical. Carefully planned work to secure quality care and support in the independent sector should mitigate this risk, both for the Council and residents. The Contract Management and Quality Assurance Team will continue to ensure that residents can access quality care. This team provides the Council with additional assurance that residents' needs can be appropriately met.

10.2 The Council is aware of its responsibilities in relation to the Equality Act 2010. Our priority is to ensure that no groups are disadvantaged. We are proud of what we do to ensure that we uphold the rights of our citizens.

11 Background and Options

11.1 Work commenced in November 2014 with a joint stakeholder event to agree the shared priorities of the new function. The event, held at Sandbach Town Hall, was well supported with attendees including General Practitioners, health employees, council employees, Care Quality Commission and Councillors. Care providers and service users were also consulted on the proposals for the new function. Support for the Contract Management and Quality Assurance Team from these stakeholders has continued to date.

11.2 Sourcing local care and support services for customers remains integral to the Council's plans. This proposal will ensure that the quality of the care and support services commissioned from the independent sector will continue to be monitored by the Contract Management and Quality Assurance Team.

12 Access to Information

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

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REPORT TO: Health and Wellbeing Board

Date of Meeting: 26th January 2016
Report of: Brenda Smith, Director of Adult Social Care and Independent Living
Subject/Title: The Care Act - The first 6 months

1 Report Summary

1.1 The Care Act 2014 was implemented on 1st April 2015 across England. This report outlines the impacts of the first 6 months of The Care Act 2014 and the changes implemented by Adult Social Care as a response to the new legislation. The request for an update on implementation and impacts of the first 6 months of The Care Act 2014 in Cheshire East Council resulted from a presentation on the closure of the Care Act Implementation project.

2 Recommendations

2.1 To note the content of this update report.

3 Background and Options

3.1 The Care Act is divided into three main parts. Part One deals with the reform of adult social care and supporting legislation. Part Two seeks to improve care standards by putting people and their carers in charge of their care and support. Part Three establishes health Education England and the Health Research Authority.

3.2 The underlying principle of the Care Act is for Local Authorities to promote the well being of the population and in doing so to ensure that people have access to advice and information to assist them to access the right help and to focus on prevention and early intervention services.

3.3 The Care Act was intended to be implemented in two phases. Phase One was implemented on 1st April 2015. Phase One implementation of the Act involves the key elements of the legislation which are detailed in Appendix 1.

3.4 Phase Two was to be implemented from April 2016 and includes the elements of the new legislation which governs the financial elements of care including

revised capital limits, the care cap and care accounts. This phase of the Act has been deferred by Government until April 2020.

3.5 The main areas which Adult Social Care departments were required to deliver through this major amendment to social care legislation are summarised at Appendix 1 along with progress and initial analysis of impact at the 6 month post implementation stage.

4 Access to Information

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

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Item No	Care Act Duty	Cheshire East Council, Adult Social Care and Independent Living position statement - September 2015	Impacts to date
1	A duty to promote people's wellbeing and to prevent need for care and support.	• Adult Services have updated the Council website to promote care and support, and signposted services. • We have a workforce who understand Care Act duties to promote wellbeing, supported by the Principal Social Worker role and a number of professional lead staff. • The Community Agents service commissioned primarily to support older people in rural areas also identify carers who can benefit from support. Through direct face to face contact they can provide people with information and support to access appropriate agencies, whilst helping them to make informed choices. They link in closely with Cheshire East Councils Local Area Co-ordinators in identifying local day opportunities and support groups. • Social Care Local Area Coordinators have developed strong links with community hubs and cross feed information and advice developments regularly as well as collating information on alternative services in the community to underpin prevention and assist individuals with their wellbeing needs. • Think Local, Act Personal events have taken place to promote relationships and public engagement on social care issues. • Work with health colleagues planning for integrated teams has improved connections around wellbeing. • Adult Social Care have improved links with Public Health in promoting physical and emotional well being. • The Life Links project delivered by Peaks and Plains is a planned, preventative outreach service, targeting people and their carers, who may be on the brink of physical dependence or social isolation. By giving advice	During the first 6 months of the Care Act a total of 6,135 adult social care assessments were completed and of these 4,343 individuals met the eligibility threshold for care and support, showing that a number of individuals were assessed for support in their wellbeing needs. There has been an average of 71 carers accessing the Carer Wellbeing Fund against a target of 63 in each of the SMART teams with an average £270 awarded per carer to support them in maintaining their caring role.

		and making referrals to local non-statutory services (including commissioned services) they look to improve health and wellbeing, therefore preventing unnecessary access to health and social care services.	
2	A duty to provide an information and advice service about care and support	• Our Care Act Help Line and dedicated Care Act Advisors are available through the third sector organisation Advice Cheshire East , which along with the Cheshire East Council improved website and revised factsheets provide information and advice. • A directory of resources has been published for those needing guidance on care, health and wellbeing services. • Plans are underway to ensure we have a fully connected ICT marketplace in the new year. • A number of public consultation events have been facilitated around the Care Act and social care charging policies. • Local Area Coordinators draw together knowledge of community resources and assist in the development of such services for individuals	There has been approximately 700 enquiries to the Care Act Help Line in relation to universal services between April 2015 and September 2015 with the majority being visted face to face. Other methods of enquiry included telephone and email with an additional 784 web hits suggesting an element of self help.
3	A requirement to carry out an assessment of both individuals and carers wherever they have needs, including people who will be "self-funders", meeting their own care	• Adult Social Care has updated its policy documents, assessment documents and trained all staff through e-learning and dedicated, focused training sessions to ensure all staff apply the national minimum eligiblity threshold for support. • A Transition Coordinator has been appointed whose role is to ensure that transition for children and young people with disabilities from Childrens Service into Adult Services, is as smooth as possible. • Policy and practice guidance on transition has been reviewed and revised. A factsheet on transition is being developed. The Transition Coordinator is involved in delivering training to social care staff on young carers. An E-learning mobile on transition is also available to staff.	6,135 individuals were assessed and a further 832 Carers received a Carers Assessment in their own right during the first 6 months. 19 carers received funding support through a Direct Payment in order to support them in their caring duties. The Council currently commissions care services for approximately 200 self funders which supports their choice.

	costs.	• Practice guidance for staff has been written which sets out the offer to carers and what is available at each stage of the assessment process. This includes information about accessing early intervention and prevention services, the carers' reablement service, carer support groups and Direct Payments for carers. • Joint events for social care staff and carer support services have been held at which the offer to carers has been promoted and developed. • A review on carers assessments practice and processes as well as promotional information has been undertaken to inform improvements on engagement with Carers during the second half of the year. A Carers Panel has been established to consider carers funding requests and to ensure links are robustly made with universal services or reassessment needs for the person requiring care and support services. • Adult Social Care had expected a larger number of carers to come forward for assessment, and steps are being taken to address this through further training, care provider events, improved communications, engagement with community support groups, the Carers Reference Group. • A dedicated Mental Health worker is undertaking carer assessments within the mental health services. We are piloting this specialist role for carers' assessments to see if this offers greater consistency and value to carers. Early indications are that this approach is successfully identifying an increased number of carers but this initiative will be evaluated properly at the end of this financial year.	

4	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 fails.	• A consultation with the care market has begun to address issues facing the market such as the introduction of the national living wage, pension reforms and recruitment and retention challenges within the care sector. • Adult Social Care has developed a joint approach with the CCG's for contract monitoring and quality assuring commissioned services to ensure services are meeting peoples needs. • Adult Social Care and the CCGs have also developed joint procedures and processes for provider failure. Adult Social Care also liaise closely with the CQC on any concerns regarding registered provider services to ensure a joined up response. In addition there is a focus on developing effective preventative and early intervention services to reduce the reliance on traditional commissioned services to allow people more choice with a focus on reablement to support individuals to maintain their independence.	CEC has established a dedicated team to undertake quality assurances visits to all contracted care providers, but with an initial focus on the care home market. As a result CEC is now undertaking regular visits to care providers. Providers have a minimum of one quality assurance visit a year. Where improvements / actions are required more visits will be undertaken. The visits are part of a CEC'S proactive approach to quality assurance and contract monitoring and allows CEC to work jointly with care providers to identify issues and areas of concern before they escalate into something more serious. This approach also allows CEC to work with providers to address any concerns that may be identified as part of their CQC inspection and to offer assurances to senior managers, residents and family members that where there are concerns that appropriate actions are being taken to address them. Since the introduction of the QA Team the number of providers in default and at risk of closure or contract termination has reduced from eight in September 2014 to none in December 2015 and there has been no further closures in this time.

5	A duty to apply the national minimum eligibility threshold for support – a minimum level of need which will always be met in every council area	• Adult Social Care has updated policy and trained all staff through e-learning and through dedicated, focused training sessions to ensure all staff apply the national minimum eligiblity threshold for support which extends into addressing moderate needs and promoting preventative support. • Staff have access to robust information and dedicated reference resources to ensure practice changes in line with legislation.	There will be a focussed piece of work on reassessment in the first 3 months of 2016 with a remit to strengthen practice and promote personalised approaches across the services.
6	A requirement to offer a universal "deferred payment" scheme, where people can defer the costs of care and support set against the value of a home they own	• Cheshire East Council, Adult Social Care offered a deferred payment scheme for people wishing to offset some of their care costs against their property assets prior to the introduction of the Care Act. The Departments' Deferred Payment Policy has been reviewed and consulted on. There were 150 existing customers who had entered into a deferred payment arrangement with the Council pre April 2015 and a further 23 have subsequently deferred their payments under the Care Act at 30 September 2015.	All customers wishing to defer charges, not just the 23 new users under The Care Act are provided with regular information on their deferred charges and interest charge figures. One individual has been able to access the Council's discretionary policy to defer charges for community based services.
7	A duty in some cases to arrange "independent advocacy" to facilitate the involvement of an adult or carer in assessing needs and planning for	• 18 referrals have been processed for Advocacy Services provided through the Council's contracted services to support individuals with their assessment and support planning • A further 335 advocacy support services have been provided via general advocacy services including support around debt, financial issues, legal issues, medication, mental health issues not directly related to peoples assessment and support planning processes at 30th September 2015. • There is a rolling programme of Advocacy training for social care staff as part of the Practice Excellence Programme and a "One Minute Guide" has	353 individuals have been supported through advocacy services. However, due to the lower threshold under The Care Act for advocacy support a higher number was anticipated. Work is being undertaken to better understand this.

	care.	been issued to support front line staff in application of advocacy services.	
8	A duty to provide social care support to people in Prisons and bail hostels	• Cheshire East Council has one prison within its boundaries at Styal. Adult Social Care has undertaken 14 social care assessments at 30 September 2015 and one individual with significant care and support needs has been found to be eligible. Some prisioners have also been eligible for equipment or information and advice services. The Carers Federation have been commissioned to provide prisoners Care Act Advocacy as part of the sub regional Healthwatch Advocacy contract for which Liverpool Council are the lead commissioner.	The Council funds services in Styal prison which provides care and support to a number of prisoners both with eligible needs and with identified wellbeing needs. The Carers Federation are continuing to work with Styal in order to promote access to this service for prisoners.
9	A duty to strengthen Safeguarding Adults Boards and to make safeguarding 'personal'	• Adult Social Care have introduced an independent Safeguarding Board Chairperson. • Training has been extensive through professional leads to ensure the social care workforce fully understands and applies in practice the requirements of Making Safeguarding Personal. • Policy and processes have been reviewed and implemented, including the introduction of a practitioner toolkit and regular multi-agency safeguarding forums and governance meetings.	722 safeguarding enquiries have been dealt with from April to September 2015.
10	A responsibility to embed the right to choice through care plans and personal budgets	• Adult Social Care has updated policy and practice guidance on support planning and personal budgets, as well as developing a comprehensive carers offer. • Support is available for individuals wishing to direct their care and support services themselves through Cheshire Centre for Independent Living. • Eligible individuals requiring community based social care are offered the opportunity to take control of their care services through a direct payment. The department recognises that Direct Payment numbers are lower than would be hoped for. Whilst early interventions and	The Local Area Coordinator role has been identified as a key resource to ensure that community assets are maximised. Additional LAC resources have been introduced to build on choice and support independence.

		preventative services may be positively impacting resulting in reduced need for care and support the option of a Direct Payment for individuals will feature strongly in the reassessment work planned during January to March 2016.	

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