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Cheshire East Council

NHS
Eastern Cheshire
Clinical Commissioning Group

NHS
South Cheshire
Clinical Commissioning Group

Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 31st May, 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. **Appointment of Chairman**

   To appoint a Chairman for the 2016/17 municipal year.

2. **Appointment of Vice-chairman**

   To appoint a Vice-chairman for the 2016/17 municipal year.

3. **Apologies for Absence**

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

4. **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.

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

To approve the minutes of the meeting held on 15 March 2016 as a correct record.

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

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

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

7. **The Five Year Forward View for Mental Health** (Pages 13 - 96)

To consider the broad recommendations within the report, particularly those which require actions and support from the Board.

8. **The Mental Health Gateway** (Pages 97 - 104)

To consider the recommendation as set out in the report.

9. **Better Care Fund Update** (Pages 105 - 116)

To consider a briefing note providing the Board with an update on the plan for the Cheshire East Better Care Fund in 2016/17.

10. **Children and Young People's Improvement Plan Update** (Pages 117 - 156)

To consider a report updating the Board on the progress against the Children and Young People's Improvement Plan.

11. **Cheshire and Merseyside Sustainability and Transformation Plan**

To receive a verbal update from Jerry Hawker, Chief Officer, Eastern Cheshire Clinical Commissioning Group.

12. **Council Structure Update**

To receive a verbal update from Mike Suarez, Chief Executive, Cheshire East Council.

13. **The Cheshire Integrated Health and Care Pioneer Programme** (Pages 157 - 174)

To consider a report summarising last year's costs, achievements and challenges and setting out proposed budget requirements for 2016 - 17 and options for appointing to the post of Pioneer Director.

14. **Draft Alcohol Harm Reduction Position Statement and Forward Plan** (Pages 175 - 206)

To consider the recommendations as set out in the report in respect of the draft Alcohol Harm Reduction Position Statement and Forward Plan.

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CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 15th March, 2016 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT

Voting Members:
Councillor Rachel Bailey – Cheshire East Council
Councillor Janet Clowes – Cheshire East Council
Councillor Liz Durham – Cheshire East Council
Jerry Hawker – Eastern Cheshire Clinical Commissioning Group
Dr Paul Bowen – Eastern Cheshire Clinical Commissioning Group
Simon Whitehouse – Southern Cheshire Clinical Commissioning Group
Tina Long - NHS England
Jonathan Potter, representing Kath O'Dwyer - Director of Children's Services, Cheshire East Council
Peter Gosling, representing Brenda Smith – Director of Adult Social Care and Independent Living, Cheshire East Council
John Wilbraham, representing Tracy Bullock, Mid-Cheshire Hospitals NHS FT (Independent NHS Rep)
Kate Sibthorp - Healthwatch

Non Voting Members:
Mike Suarez – Chief Executive, CE Council

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

Cheshire East Council officers/others in attendance:
Guy Kilminster – Head of Health Improvement, CE Council
Julie North – Senior Democratic Services Officer, CE Council
Lucy Heath – Consultant in Public Health, CE Council
Robert Templeton, Cheshire East Safeguarding Adults Board Chair
Katie Jones - Adults Social Care and Independent Living, CE Council
Jacki Wilkes – Associate Director of Commissioning ECCG
Rachel Wood – Carer's Strategy Lead, NHS Eastern Cheshire CCG
Catherine Mills Clinical Projects Manager South Cheshire CCG

59 **APPOINTMENT OF CHAIRMAN**

Consideration was given to the appointment of Chairman, following recent changes in the membership of the Cheshire East Health and Wellbeing Board.

RESOLVED

That Cllr Rachel Bailey be appointed as Chairman.

60 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Dr Andrew Wilson, Kath O'Dwyer Brenda Smith, Heather Grimbaldeston and Tracy Bullock.

61 **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.

62 **MINUTES OF PREVIOUS MEETING**

RESOLVED

That the minutes be approved as a correct record.

63 **PUBLIC SPEAKING TIME/OPEN SESSION**

Ms Maeve Kelly, Friend of Cheshire East Children's Sure Start Centres, used public speaking time to ask the following question:-

At the February 25th Budget vote meeting I raised my concerns with changes to the children's centre provision increasing mental health issues. I would like to follow up on that point. Mental health issues are now some of the biggest killers of perinatal women in the UK (perinatal referring to the time before and after birth up to 5 years). A quarter of perinatal deaths are due to mental health issues with 1 in 10 being the result of suicide.

In recent weeks Cheshire East have said that the changes to the children centre structure of de-designating 4 children's centres in favour of a mobile service is due to reducing footfall and reaching rural families who cannot currently access the current situation. In a 2013 report from the Children's Society where they discuss the barriers of geography and low footfall, in their numerous recommendations, nowhere do they recommend a mobile service:

I would ask Cheshire East to confirm what research they have used to make the recommendation that footfall and geographical barriers will indeed be improved by the upcoming change to a mobile service? I would also ask that Cheshire East make available statistics over the last 5 years of both footfall and geographic location of families accessing children's centres (ie. urban, town, rural, etc.)? I would therefore ask for a commitment that if these numbers do not improve (and indeed continue to worsen) over an appropriate period that Cheshire East will un-de-designate the 4 centres?

In relation to mental health specifically, Tommy's the UK charity which researches pregnancy provided a report which examines perinatal mental

health. In this 2013 report they outlined that 1 in 7 women experience perinatal mental health problems, half of which say the main cause is isolation.

The Friends of Cheshire East Children's Sure Start Centres believe that the movement from central locations within towns to a mobile service will increase feelings of isolation by expectant and/or new mothers. I would ask for Cheshire East to provide me with details as to what underpins their assumptions that perinatal mental health will not be negatively impacted by the change to a mobile service? I would also ask that Cheshire East make available statistics over the last 5 years of all the relevant areas of perinatal mental health (suicides, postpartum psychosis, chronic serious mental illness, severe depressive illness, mild-moderate depressive illness and anxiety states, post-traumatic stress disorder, and adjustment disorders/distress). I would again therefore ask for a commitment that if these numbers do not improve (and indeed worsen) over an appropriate period that Cheshire East will un-de-designate the 4 centres?

The Chairman of the Board, Cllr Rachel Bailey, briefly responded to the points raised in the question and undertook to provide a written response.

Cllr Liz Durham,Children and Families Holder Portfolio Holder, responded as follows:-

The areas served by the four de-designated Children's Centres are large and contain significant rural areas – much of the delivery within these areas is already delivered away from the Children's Centre buildings via outreach groups and one to one family support rather than through the centres because the centres are not accessible to many families via public transport.
The commissioning of a mobile children centre is only one of a number of strategies to address these issues.
The mobile children's centre will be part (but only a part) of a new outreach team which as well as operating the vehicle will run sessions based around the borough in non – children's centre buildings.
The primary identification of post natal mental health issues is through the Health Visiting Service which has just moved to being commissioned by the local Authority (Oct 15).
As part of these changes Children's Centre staff, Early Years staff and Wirral Community Health staff are working together to develop better screening and pathways to address Post Natal mental health issues as part of a new integrated approach to Early Years called the Parenting Journey due to be launched later this year.
This will also include looking to spread the availability and supporting some of the outstanding parental support groups that are currently operating in parts of the borough and developing targeted joint groups through Children's Centres to support mothers with PND.
It has to be borne in mind that only a minority of parents of young children access Children's Centre services now so any strategy to support mother's mental health needs to be wider than just Children's Centres.

Mrs Sue Helliwell, representing Alsager Town Council, used public speaking time to speak about health profiles for individual wards and noted that Alsager had the highest figures in respect of excess weight in reception aged children. She asked that the Board to work with the Town Council in order to address this issue.

Mrs Helliwell also referred to hospitalisation figures for self harming and asked how many of these were children.

With regard to excess weight in reception aged children, Lucy Heath, Consultant in Public Health, Cheshire East Council responded to say that the service worked closely with Health Visitors and staff around healthy eating as part of the "patient experience" and that she would be happy to work with the Town Council with regard to this matter.

In respect of hospitalisation figures for self harming, she stated that there was data available which was broken down into the figures for adults and children and that the service was focusing on and trying to address this statistic.

The Chairman referred to a paper relating to fast food, which had been presented to the Town Council.

64 **BETTER CARE FUND 2016/17**

Consideration was given to a report is to providing the Board with an update on the proposals for the implementation and delivery of the Cheshire East Better Care Fund (BCF) in 2016/17.

The initial Cheshire East BCF plan for 2016/17 had been submitted to NHS England on 2nd March 2016. A second submission was due on 21st March 2016 followed by a final complete return, to be signed off by HWB, on 25th April 2016. The report included a number of recommendations including a request to the Board to advise how sign-off of the final return on 25th April be undertaken in the absence of HWB meetings between 15th March and 31st May 2016. It was agreed that the draft plan would be circulated electronically to Board members and that final sign off be delegated to the Chairman of the Board.

In 2015/16, the Cheshire East Health and Wellbeing Board endorsed progressing with two separate s75 pooled budget agreements locally, to support the delivery of the Better Care Fund plan and to be aligned with the respective health integration programmes Caring Together (Eastern Cheshire Clinical Commissioning Group(ECCCG)) and Connecting Care (South Cheshire Clinical Commissioning Group). Cheshire East Council would enter into a pooled budget arrangement with Eastern Cheshire Clinical Commissioning Group (CCG) and a separate s75 arrangement with South Cheshire Clinical Commissioning Group. It was proposed that this arrangement should continue into 2016/17.

With regard to the other options considered, as set out in paragraph 4 of the report, it was noted that the option to increase the pool across the HWB area was no longer relevant, as it had not been not agreed by ECCCG.

RESOLVED

1. That the final draft be circulated electronically to Board members and that final sign off be delegated to the Chairman of the Board.

2. That the continuation of the 2015/16 arrangements via two s75 Partnership Agreements from 1st April 2016 until 31st March 2017 be approved and that these arrangements to continue post April 2017 so long as there is a national requirement to operate the BCF as a s75 pooled budget agreement.

3. That the Board acknowledges that the continuation of the two s75 arrangements is proposed to reflect the local integrated care system programmes (Caring Together being led by Eastern Cheshire CCG and Connecting Care being led by South Cheshire CCG);

4. That the BCF Governance Group, which links to Caring Together and Connecting Care transformation programmes through its membership, be approved, to be the lead group to develop and agree returns prior to HWB sign-off.

65 **SAFEGUARDING ADULTS BOARD (SAB) ANNUAL REPORT**

Robert Templeton, Cheshire East Safeguarding Adults Board Chair, attended the meeting and gave a presentation in respect of the Safeguarding Adults Board Annual Report, including what Adult Safeguarding was, outlining some facts and figures, the Care Act and its context, making Safeguarding personal, what was happening nationally and what was happening in Cheshire East to make it real.

The CESAB was a multi-agency partnership which provided strategic leadership for the development of safeguarding policy and practice, consistent with national policy and best practice. Membership included representatives from Adult social care, fire, health, housing, police, probation and the third sector and service user representation.

The vision was outlined, which was to ensure that vulnerable adults living in Cheshire East felt safe and free from abuse and neglect. The service was based on the principles of prevention, protection, choice, self determination, independence and recovery and its mission was to ensure that adult safeguarding became everyone's business.

The legal context was outlined and it was noted that this was very complex. The Care Act 2014 placed a duty on local authorities to establish a SAB. The objective was to help and protect adults at risk of abuse or neglect and the SAB may do anything necessary or desirable to achieve this aim. The NHS and Police must nominate members with required skills and experience.

Guidance was about to be issued with regard to Making Safeguarding Personal. There had been a sector led initiative in response to findings from peer challenges, consultations and engagement, which had identified the need to develop an outcomes focus to safeguarding. Making Safeguarding Personal was about engaging with people about the outcomes they wanted at the beginning and middle of working with them and ascertaining the extent to which those outcomes were realised. To do this, a mix of responses was required, to enable people to achieve resolution or recovery and access to justice. Making Safeguarding Personal was an approach providing a different way of practicing safeguarding.

In practice, the fundamental shift revolved by putting the adult and their wishes and experience at the centre of safeguarding enquiries, which sought to enable people to resolve their circumstances, enabling them to recover from abuse or neglect and realise the outcomes that they wanted.

Examples of what some of the people who used the services were saying were outlined in the presentation. There was a vibrant user group in place and Katie Jones, who led the user group and was in attendance at the meeting, reported that some of the users felt “fenced in” and felt that decisions were being made for them. They wanted to be in control, make their own decisions and to be seen as the person, rather than being defined by the circumstances that they found themselves in.

Details of the new safeguarding principles were outlined. Safeguarding was to be done with and not to people, focusing on achieving meaningful improvement to people’s circumstances, rather than just on investigation and conclusion. All professionals involved in safeguarding should develop and utilise their skills, rather than by just putting people through a process and the difference safeguarding had made in outcomes for people should be measured. Business as usual was not an option. Partnership engagement would be vital and partner agencies needed to be kept well informed. The “Golden thread” from strategic to frontline services was to identify what outcomes were wanted or desired, how agencies would work together to make this happen and how the agencies would know that they had made a difference.

Details of what would be required to make this work locally were outlined. There would be key challenges for the Board and it was proposed to hold an Away Day, where it was hoped to present a business plan, showing the challenges and how it was proposed to go forward.

Discussion took place as to how the Board could engage in the process. Members of the Board also requested additional information in respect of the outcomes referred to which had been as result of the activities carried out.

Assurance was sought that there would be appropriate training for the Smart team and that there would be engagement with GPs and front line staff, in order to embed the value of safeguarding. It was agreed that there should be a report back to a future meeting on both these issues.

RESOLVED

That a report covering the above issues be submitted to future meeting of the Board.

66 **CARING FOR CARERS: A JOINT STRATEGY FOR CARERS OF ALL AGED IN CHESHIRE EAST 2016 - 2018**

Consideration was given to a report relating to a Joint Strategy for Carers of All Aged in Cheshire East for 2016 to 2018. Cheshire East Council had worked in partnership with carers, Eastern Cheshire Clinical Commissioning Group and South Cheshire Clinical Commissioning Group to develop a new two year strategy for carers. An evaluation of the previous strategy (2011-2015) had shown that some progress had been made to improve the health and well-being of carers in Cheshire East. A number of engagement events had been held over the previous two years to understand the stated needs of carers and review opportunities to meet those needs.

The publication of the 2014 Care Act had outlined specific changes to the offer of support for carers and the impact of these changes had been assessed and included in the Strategy. There were five priority areas outlined in the new Strategy, informed by carers and a delivery plan with detailed actions, timescales and clear lines of both organisational and individual officer accountabilities had been included for each area. An outcomes framework, with measures of success had been developed alongside the implementation plan and would be used to monitor progress. It was noted that this would be reported to the Board via the Joint Commissioning Leadership Team. The Board was asked to agree the Strategy for 2016-18.

Thanks were expressed to all those who had worked on the Strategy. It was noted that there had been a focus on experiential outcomes and that consideration needed to be given to the inclusion of measurable outcomes and bench marking evidence from carers.

It was noted that the table at para 5.13 of the report needed to include the financial plan for South Cheshire CCG, in addition to Eastern Cheshire CCG and that the total for carer breaks was a shared total for both CCGs. This would be included in the published document.

It was requested that additional information be included with regard to how the integrated teams worked with GPs to support carers. It was noted that co-production would be essential, in order to meet caring needs and that the inclusion of qualitative and quantitative information was important in order to measure this. The document would be updated to include the comments made and the Strategy would be given further consideration at a future informal meeting of the Board. An update report would be submitted to a future formal meeting of the Board.

RESOLVED

1. That the strategy for 2016-18 be agreed, in that it aligns to the Caring Together and Connecting Care vision and transformation agenda and as such is a key priority for Cheshire East Council, South Cheshire and Eastern Cheshire Clinical Commissioning Groups.

2. That it be noted that the Strategy has been endorsed by Eastern Cheshire CCG, but is yet to be endorsed by South Cheshire CCG.

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

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

5. That the Strategy be updated to include the comments made by the HWB and that further consideration be given to the Strategy at future informal meeting of the Board.

6. That an update report be submitted to a future formal meeting of the Board.

67 **CARING TOGETHER UPDATE**

Consideration was given to a report informing the Board on progress regarding the transformation of care services in Eastern Cheshire.

NHS Eastern Cheshire CCG was the lead partner of the Caring Together programme, the local health and care transformation programme in Eastern Cheshire. Since the last report to the Board, in November 2015, the Caring Together Programme Board had led the development of a new and refreshed strategic Local Delivery Plan (LDP) for the local care system. The new LDP built on existing work, providing greater clarity on the scale of change required and had been aligned to the guidance to establish a Sustainability and Transformation Plan across Cheshire & Merseyside. A summary version of the LDP was currently in production,

including a public summary leaflet to raise awareness of the changes to services being planned.
Aligned to the new Local Delivery Plan, governance arrangements for the Caring Together programme and associated implementation plans had been strengthened, with the appointment of a new independent chair, Dr Neil Goodwin. An update on the work already underway was provided. Thanks were expressed to all those who had been involved for their contribution.

In considering the report the Board agreed that it would be useful to hold a joint meeting of the Health and Wellbeing Boards in order to consider pan Cheshire projects.

RESOLVED

That the report be noted.

68 **NHS ENGLAND SUSTAINABILITY AND TRANSFORMATION PLANNING UPDATE**

An update was provided in respect of the NHS England Sustainability and Transformation Plan, which was due for submission on 11 April 2016, to be signed off on 26 June 2016.

The emphasis was on local delivery, with key themes being prevention and wellbeing, maternity services and the future sustainability of hospital services, to help ensure that all services were sustainable. There would need to be a Transformation Agreement for Cheshire and Merseyside, to include the six sub regions, to reflect a balance between planning at a large scale, for services such as, for example, neurological and specialist cancer services. It would also be necessary to appoint an accountable leader for the Plan.

It was recommended that partner organisations should include all 4 CCGS .It was noted that there was an established working group to consider this issue, comprising CCGs, Local Authority and public health representatives.

It was agreed that there should be a standing item included on the HWB agenda for future meetings and that an informal working group be established after 11 April to consider this issue.

RESOLVED

That the report be noted and that a standing item in respect of this matter be included the agenda for future meetings and that an informal working group be established after 11 April 2016 to consider this issue.

69 **TRANSFORMING CARE UPDATE**

Consideration was given to a report updating the Board with regard to the national, regional and local programme of work with regard to Transforming Care for people with Learning Disabilities.

As a result of the Winterbourne View Review: Concordat: Programme of Action (2012), NHS England was committed to improving the health and outcomes of people with learning disabilities and autism and transforming services to improve the quality of care throughout peoples' lives.

Transforming Care for People with Learning Disabilities - Next Steps, (July 2015) had outlined an ambitious programme of system wide change to improve care for people with learning disabilities and/or autism and behaviour that challenged learning disabilities.

There was now a single shared Transforming Care programme that recognised the scale of the change required, which it was hoped would ensure that the underlying causes of why so many people remained in and were continuing to be placed in hospital settings was addressed.

The Cheshire & Merseyside Learning Disability Network had undertaken much work from the Winterbourne View recommendations over the past 3 years. Discussions through this network had resulted in a consensus to progress developments via one Transforming Care Partnership across the Cheshire & Merseyside footprint to ensure commissioning at scale. There were three delivery hubs within the partnership area, which were outlined in the report.

In considering the report, Cheshire East Council Members commented that they felt that it would have been appropriate for there to be some Local Authority Executive representation at this stage, as well as at the implementation stage and the Chairman commented that she felt that the Council' s Cabinet should consider this matter and feed into the Plans.

RESOLVED

1. That the report be noted.

2. That the Board's support for the work being undertaken by the Cheshire and Merseyside Transforming Care Partnership and the sub-regional workstreams be noted.

3. That the arrangements for work to develop local services through the Cheshire and Wirral Delivery Hub be noted.
4. That the draft Cheshire and Merseyside Transforming Care Plans be noted.

5. That a further update on progress be submitted to the Board in September 2016.

70 **SUPPORTING THE MENTAL HEALTH OF CHILDREN AND YOUNG PEOPLE**

Consideration was given to two reports relating to supporting the mental health of children and young people and the Emotionally Healthy Schools Programme. The first report presented the "Supporting the Mental Health of Children and Young People" Strategy.
The Strategy was based on the findings of the Children and Young People's Joint Strategic Needs Assessment and the recommendations from the Annual Public Health Report 2015.

One of the priority areas was to "Put front-line mental health care and support into every community ". One of the key actions to deliver this objective was further development of the Emotionally Healthy Schools Programme. The second report submitted was in regard to this action.

The report described the Emotionally Healthy Schools Programme approach, progress with the initial pilot in six secondary schools was outlined and the evaluation approach shared. Investment and potential investment was described and recommendations made in order to secure this. Spend to date and the remaining available budget were also outlined. Options of how the available investment should be prioritised was provided.

Sustainability of the programme was outlined in the report, together with recommendations of how investment could be secured to facilitate this.

The Board accepted the recommendations, but considered that there needed to be an emphasis with regard to assurance in respect of how the funding would be spent and that there needed to be a process for review and regular monitoring of this.

RESOLVED

1. That the "Supporting the Mental Health of Children and Young People" Strategy be endorsed.

2. That the proposal for schools to be the setting for addressing the mental and emotional needs of children and young people be supported.

3. That it be noted that Cheshire East Council accepts the £85,000 from ECCCG and £176,000 from SCCCG to the Emotionally Healthy School Programme budget and supports the transfer of £400,000 from the 2015-16 Public Health ring fenced grant to a ring-fenced Emotionally Healthy School Programme budget hosted by Cheshire East Council. Members of the Health and Wellbeing Board sign up to an Memorandum of Understanding to allow this to happen.

4. That permission be granted to further roll out of the programme through coproduction with schools up to the value of the £1.2m funding available and that this is delegated to the Emotionally Health Schools Steering Group to undertake under the governance of the Children and Young People Joint Commissioning Group.

5. That a further report be submitted to a future meeting of the Board with regard to the assurance process in respect of how the funding would be spent, to include review and regular monitoring.

71 **HEALTH PROTECTION FORUM**

Consideration was given to a report concerning the establishment of Health Protection Forum, as a sub-group of the Health and Wellbeing Board, to be chaired by the Director of Public Health. The Board's support for this proposal was required. Draft Terms of Reference were appended to the report.

The Health Protection Forum would have responsibility for ensuring that plans were in place to protect the health of the population of Cheshire East. This would be done by identifying threats, assessing risks and reviewing health protection arrangements and plans that all associated organisations had in place. It would be able to provide assurance to the Board that there were safe and effective arrangements in place. In addition, the Forum would improve integration and partnership working on health protection between the Local Authority, NHS, Public Health England and other local services.

RESOLVED

That the creation of Cheshire East Council's Health Protection Forum be supported.

The meeting commenced at 2.00 pm and concluded at 4.35 pm

Councillor Rachel Bailey

REPORT TO: Health and Wellbeing Board

Date of Meeting: 31st May 2016
Report of: Sheena Cumiskey, Chief Executive, Cheshire and Wirral Partnership NHS Foundation Trust

Subject/Title: Mental Health Taskforce Five Year Forward Vision for Mental Health

1 Report Summary

1.1 To inform Health and Wellbeing Board members of the recently published Mental Health Taskforce Five Year Forward View report and recommendations.

2 Recommendations

2.1 The Health and Wellbeing Board is asked to note the recommendations with the report.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board is asked to consider the broad recommendations within the report, particularly those which require actions and support from Health and Wellbeing Board.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 This report supports a number of Council health priorities:

5 Background and Options

5.1 The Mental Health taskforce was commissioned by Simon Stephens NHS Chief Executive to undertake an independent review of mental health services in England. The taskforce examined the variation in the access to and quality of mental health care and support; looked at outcomes for people in receipt of services and those without, and considered ways to tackle the prevention of mental health problems.

As a result, the taskforce has produced an independent report setting out a ten year plan for transformation of mental health services. The report sets out

a number of recommendations for NHS bodies, government and wider stakeholders to help achieve the government's commitment to parity of esteem and to tackle the inequalities at local and national level.

There are 57 recommendations in the report; however in summary, the report proposes a three-pronged approach to improving care through prevention, the expansion of mental health care such as seven day access in a crisis, and integrated physical and mental health care.

The report specifically sets out a key role for Health and Wellbeing Boards to ensure that they have plans in place to promote good mental health, prevent problems arising and improve mental health services in their local area based on local data for risk factors, protective factors and levels of unmet need.

Public Health England Health are also asked to work with Health and Wellbeing Boards to develop a national Prevention Concordat programme that will support Boards and CCGs to put in place an updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

6 Access to Information

6.1 Five Year Forward View - https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

THE FIVE YEAR FORWARD VIEW FOR MENTAL HEALTH

A report from the independent Mental Health Taskforce to the NHS in England
February 2016

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FOREWORD

For far too long, people of all ages with mental health problems have been stigmatised and marginalised, all too often experiencing an NHS that treats their minds and bodies separately. Mental health services have been underfunded for decades, and too many people have received no help at all, leading to hundreds of thousands of lives put on hold or ruined, and thousands of tragic and unnecessary deaths.

But in recent years, the picture has started to change. Public attitudes towards mental health are improving, and there is a growing commitment among communities, workplaces, schools and within government to change the way we think about it. There is now a cross-party, cross-society consensus on what needs to change and a real desire to shift towards prevention and transform NHS care.

This independent report of the Mental Health Taskforce sets out the start of a ten year journey for that transformation, commissioned by Simon Stevens on behalf of the NHS. We have placed the experience of people with mental health problems at the heart of it. Over 20,000 people told us of the changes they wanted to see so that they could fulfil their life ambitions and take their places as equal citizens in our society. They told us that their priorities were prevention, access, integration, quality and a positive experience of care. Their voices are quoted in this report and their views are reflected in our recommendations.

First, we have made a set of recommendations for the six NHS arm's length bodies to achieve the ambition of parity of esteem between mental and physical health for children, young people, adults and older people.

Second, we set out recommendations where wider action is needed. Many people told us that, as well as access to good quality mental health care wherever they are seen in the NHS, their main ambition was to have a decent place to live, a job or good quality relationships in their local communities. Making this happen will require a cross-government approach.

Finally, we have placed a particular focus on tackling inequalities. Mental health problems disproportionately affect people living in poverty, those who are unemployed and who already face discrimination. For too many, especially black, Asian and minority ethnic people, their first experience of mental health care comes when they are detained under the Mental Health Act, often with police involvement, followed by a long stay in hospital. To truly address this, we have to tackle inequalities at local and national level.

We want to thank all the Taskforce members, and the tens of thousands of people who contributed to and helped to co-produce this report.

Paul Farmer, Chair

Jacqui Dyer, Vice-Chair

EXECUTIVE SUMMARY

THE CURRENT STATE OF MENTAL HEALTH

"The NHS needs a far more proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families, and to reduce costs for the NHS and emergency services".

Mental health problems are widespread, at times disabling, yet often hidden. People who would go to their GP with chest pains will suffer depression or anxiety in silence. **One in four adults** experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected and at any point in their lives, including new mothers, children, teenagers, adults and older people. Mental health problems represent the largest single cause of disability in the UK. The cost to the economy is estimated at £105 billion a year – roughly the cost of the entire NHS.

POLICY CONTEXT

There has been a **transformation in mental health** over the last 50 years. Advances in care, the development of anti-psychotic and mood stabilising drugs, and greater emphasis on human rights led to the growth of community based mental health services. In the 1990s, the Care Programme Approach was developed to provide more intensive support to people with severe and enduring mental illness. There was a new emphasis on promoting public mental health and developing services for children and homeless people. In 1999, the National Service Framework for Mental Health was launched to establish a comprehensive evidence based service. This was followed by the NHS Plan in 2000 which set targets and provided funding to make the Framework a reality. A National Service Framework for Children, Young People and Maternity Services was then launched in 2004.

In 2011, the Coalition government published a **mental health strategy** setting six objectives, including improvement in the outcomes, physical health and experience of care of people with mental health problems, and a reduction in avoidable harm and stigma. The strategy was widely welcomed. However, despite these initiatives, challenges with system wide implementation coupled with an increase in people using mental health services has led to inadequate provision and worsening outcomes in recent years, including a rise in the number of people taking their own lives.

Yet, over the last five years, public attitudes towards mental health have improved, in part due to the Time to Change campaign. In turn, this increased awareness has heightened understanding of an urgent need to act on improving the experiences of people with mental health problems, both within and beyond the NHS. There is now a need to **re-energise and improve mental health care across the NHS** to meet increased demand and improve outcomes.

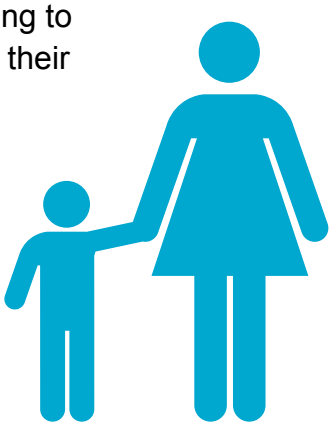
In this context, NHS England and the Department of Health **published Future in Mind** in 2015, which articulated a clear consensus about the way in which we can make it easier for children and young people to access high quality mental health care when they need it. This strategy builds on these strong foundations.

Mental health has not had the priority awarded to physical health, has been short of qualified staff and has been deprived of funds. We must provide equal status to mental and physical health, equal status to mental health staff and equal funding for mental health services as part of a triple approach to improve mental health care – a fresh mindset for mental health within the NHS and beyond.

MENTAL HEALTH PROBLEMS IN THE POPULATION

Half of all mental health problems have been established by the age of 14, rising to 75 per cent by age 24. **One in ten children** aged 5 – 16 has a diagnosable problem such as conduct disorder (6 per cent), anxiety disorder (3 per cent), attention deficit hyperactivity disorder (ADHD) (2 per cent) or depression (2 per cent). Children from low income families are at highest risk, three times that of those from the highest. Those with conduct disorder - persistent, disobedient, disruptive and aggressive behaviour - are twice as likely to leave school without any qualifications, three times more likely to become a teenage parent, four times more likely to become dependent on drugs and 20 times more likely to end up in prison. Yet most children and young people get no support. Even for those that do the average wait for routine appointments for psychological therapy was 32 weeks in 2015/16. A small group need inpatient services but, owing to inequity in provision, they may be sent anywhere in the country, requiring their families to travel long distances.

1 IN 10 CHILDREN AGED 5-16 YEARS HAVE A DIAGNOSABLE MENTAL HEALTH PROBLEM



One in five mothers suffers from depression, anxiety or in some cases psychosis during pregnancy or in the first year after childbirth. Suicide is the second leading cause of maternal death, after cardiovascular disease. Mental health problems not only affect the health of mothers but can also have long-standing effects on children's emotional, social and cognitive development. Costs of perinatal mental ill health are estimated at £8.1 billion for each annual birth cohort, or almost £10,000 per birth. Yet fewer than 15 per cent of localities provide effective specialist community perinatal services for women with severe or complex conditions, and more than 40 per cent provide no service at all.

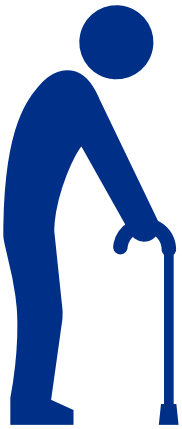
Physical and mental health are closely linked – **people with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people** – one of the greatest health inequalities in England. Two thirds of these deaths are from avoidable physical illnesses, including heart disease and cancer, many caused by smoking. There is also a lack of access to physical healthcare for people with mental health problems – less than a third of people with schizophrenia in hospital received the recommended assessment of cardiovascular risk in the previous 12 months.

In addition, **people with long term physical illnesses suffer more complications if they also develop mental health problems,** increasing the cost of care by an average of 45 per cent. Yet much of the time this goes unaddressed. There is good evidence that dedicated mental health provision as part of an integrated service can substantially reduce these poor outcomes. For example, in the case of Type 2 diabetes, £1.8 billion of additional costs can be attributed to poor mental health. Yet fewer than 15 per cent of people with diabetes have access to psychological support. Pilot schemes show providing such support improves health and cuts costs by 25 per cent.

Stable employment and housing are both factors contributing to someone being able to maintain good mental health and are important outcomes for their recovery if they have developed a mental health problem. Between 60–70 per cent of people with common mental health problems are in work, yet few employees have access to specialist occupational health services. For people being supported by secondary mental health services, there is a 65 per cent employment gap compared with the general population. People with mental health problems are also often overrepresented in high-turnover, low-pay and often part-time or temporary work. Common mental health problems are over twice as high among people who are homeless compared with the general population, and psychosis is up to 15 times as high. Children living in poor housing have increased chances of experiencing stress, anxiety and depression.

Only **half of veterans of the armed forces** experiencing mental health problems like Post Traumatic Stress Disorder seek help from the NHS and those that do are rarely referred to the right specialist care. NHS England is currently consulting on the future of mental health support for this group and it is essential that more is done to ensure their needs are identified early and they are supported to access specialist care swiftly.

One in five older people living in the community and 40 per cent of older people living in care homes are affected by depression. Diagnosing depressive symptoms can be difficult, and we know that some clinicians believe treatment for depression is less effective in older people, despite evidence to the contrary.



40 PER CENT OF OLDER PEOPLE LIVING IN CARE HOMES ARE AFFECTED BY DEPRESSION

People in **marginalised groups** are at greater risk, including black, Asian and minority ethnic (BAME) people, lesbian, gay, bisexual and transgender people, disabled people, and people who have had contact with the criminal justice system, among others. BAME households are more likely to live in poorer or over-crowded conditions, increasing the risks of developing mental health problems.

People of all ages who have experienced traumatic events, poor housing or homelessness, or who have multiple needs such as a learning disability or autism are also at higher risk.

As many as **nine out of ten people in prison** have a mental health, drug or alcohol problem.

Suicide is rising, after many years of decline. Suicide rates in England have increased steadily in recent years, peaking at 4,882 deaths in 2014. The rise is most marked amongst middle aged men. Suicide is now the leading cause of death for men aged 15–49. Men are three times more likely than women to take their own lives - they accounted for four out of five suicides in 2013. A quarter of people who took their own life had been in contact with a health professional, usually their GP, in the last week before they died. Most were in contact within a month before their death.

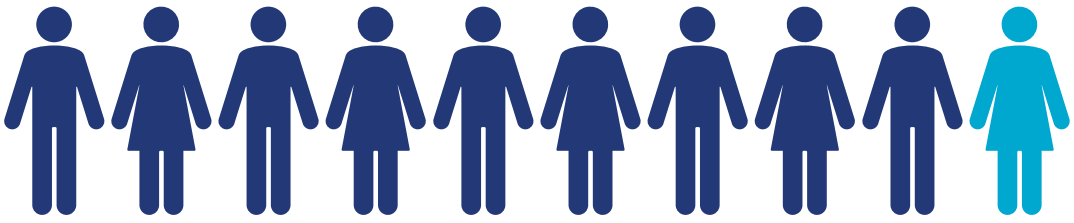
More than a quarter (28 per cent) of suicides were amongst people who had been in contact with mental health services within 12 months before their death, amounting to almost 14,000 people in the ten years from 2003-2013. However, suicides amongst inpatients in mental hospitals have significantly declined over the same period, as a result of better safety precautions.

CURRENT EXPERIENCES OF MENTAL HEALTH CARE

Nearly two million adults were in contact with **specialist mental health and learning disability services** at some point in 2014/15 – though we know little about the quality of their care and there remains extensive unmet need for mental health care. Three quarters of people with mental health problems receive no support at all. Among those who are helped, too few have access to the full range of interventions recommended by National Institute for Health and Care Excellence (NICE), including properly prescribed medication and psychological therapy.

Nine out of ten adults with mental health problems are supported in primary care. There has been a significant expansion in access to psychological therapies, following the introduction of the national IAPT programme (Improving Access to Psychological Therapies). However, there is considerable variation in services, with a waiting time of just over six days in the best performing areas and 124 days in the worst performing areas in 2014-15.

Of those adults with more **severe mental health problems** 90 per cent are supported by community services. However, within these services there are very long waits for some of the key interventions recommended by NICE, such as psychological therapy, and many people never have access to these interventions. One-quarter of people using secondary mental health services do not know who is responsible for coordinating their care, and the same number have not agreed what care they would receive with a clinician. Almost one-fifth of people with care coordinated through the Care Programme Approach (for people with more severe or complex needs) have not had a formal meeting to review their care in the previous 12 months.



NINE OUT OF TEN ADULTS WITH MENTAL HEALTH PROBLEMS ARE SUPPORTED IN PRIMARY CARE

In its recent review of **crisis care**, the Care Quality Commission found that only 14 per cent of adults surveyed felt they were provided with the right response when in crisis, and that only around half of community teams were able to offer an adequate 24/7 crisis service. Only a minority of hospital Accident & Emergency (A&E) departments has 24/7 cover from a liaison mental health service, even though the peak hours for mental health crisis presentations to A&E are between 11pm and 7am. Too often, people in mental health crisis are still accessing mental health care via contact with the police. The inquiry found that while adults were seen promptly where liaison mental health services were available in an A&E department and there were clear pathways through to community services, those aged under 16 were referred directly to children and young people's services but seen only when services were open during office hours. This could involve waiting a full weekend and lead to a significant variation in the quality of care on the basis of someone's age.

Admissions to **inpatient care** have remained stable for the past three years for adults but the severity of need and the number of people being detained under the Mental Health Act continues to increase, suggesting opportunities to intervene earlier are being missed. Men of African and Caribbean heritage are up to 6.6 times more likely to be admitted as inpatients or detained under the Mental Health Act, indicating a systemic failure to provide effective crisis care for these groups.

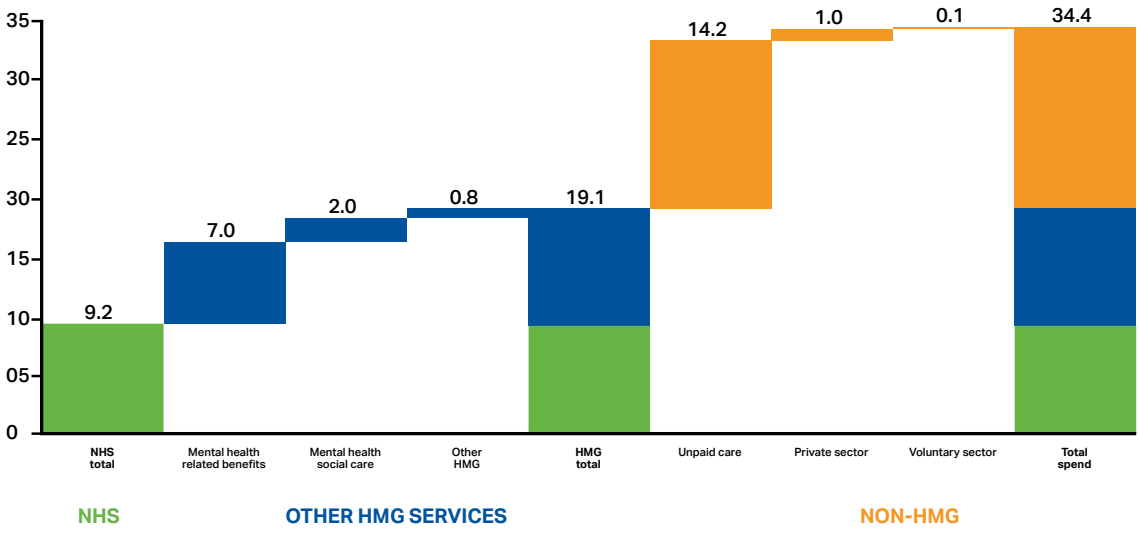
The number of adult inpatient psychiatric beds reduced by 39 per cent overall in the years between 1998 and 2012. For children and young people, average admissions per provider increased from 94 in 2013/14 to 106 in 2014/15. **Bed occupancy** has risen for the fourth consecutive year to 94 per cent. Many acute wards are not always safe, therapeutic or conducive to recovery. Pressure on beds has been exacerbated by a lack of early intervention and crisis care, and the resulting shortage leads to people being transferred long distances **outside of their area**.

Mental health accounts for 23 per cent of NHS activity but NHS **spending** on secondary mental health services is equivalent to just half of this. Years of low prioritisation have led to Clinical Commissioning Groups (CCGs) underinvesting in mental health services relative to physical health services but the degree of the disparity has largely been obscured by the way spending on mental health conditions is grouped together and reported, unlike spend on physical health care, which is disaggregated by specific conditions. Spending per capita across CCGs varies almost two-fold in relation to underlying need.

£34 BILLION EACH YEAR SPENT ON MENTAL HEALTH

Poor mental health carries an **economic and social cost of £105 billion a year** in England. Analysis commissioned by NHS England found that the national cost of dedicated mental health support and services across government departments in England totals £34 billion each year, excluding dementia and substance use [1].

Total cost of mental health support and services in England 2013/14 (£bn)



Note: this analysis aims to capture direct spend on services provided to support those with mental ill-health; it does not factor in second-order costs in other public services or wider society Source: Programme Budgeting, Departments' finance data, HSCIC, DWP spend on benefits

£19 billion of this is made up of government spend, though there is little or no national data available for how up to 67 per cent of mental health funding is used at a local level. Most of the remainder (£14bn) is for the support provided by unpaid carers, plus a relatively small share that is funded through the private and voluntary sectors.

Given chronic underinvestment in mental health care across the NHS in recent years, efficiencies made through achieving better value for money should be **re-invested to meet the significant unmet mental health needs** of people of all ages across England, and to improve their experiences and outcomes.

[1] NHS England internal analysis

WHAT NEEDS TO HAPPEN - A FRESH MINDSET

"We should have fewer cases where people are unable to get physical care due to mental health problems affecting engagement and attendance (and vice versa). And we need provision of mental health support in physical health care settings - especially primary care."

People told us that their mental health needs should be treated with equal importance to their physical health needs, whatever NHS service they are using – this is a fundamental principle of the Taskforce recommendations.

All too often people living with mental health problems still experience stigma and discrimination, many people struggle to get the right help at the right time and evidence-based care is significantly underfunded. The human cost is unacceptable and the financial cost to government and society is unsustainable.

Leaders across the system must take decisive steps to break down barriers in the way services are provided to reshape how care is delivered, increase access to the right care at the right time, drive down variations in the quality of care on offer, and improve outcomes.

Our ambition is to deliver rapid improvements in outcomes by 2020//21 through ensuring that 1 million more people with mental health problems are accessing high quality care. In the context of a challenging Spending Review, **we have identified the need to invest an additional £1 billion in 2020/21**, which will generate significant savings. It builds on the £280 million investment each year already committed to drive improvements in children and young people's mental health, and perinatal care.

PRIORITY ACTIONS FOR THE NHS BY 2020/21

1. A 7 day NHS – right care, right time, right quality

"If you feel unwell in the evening, during the night or at the weekends and bank holidays there is no choice but to go to A&E. There's no support out there during these times. It's crucial that this is changed for the benefit of service users, their families and carers."

People facing a crisis should have access to mental health care **7 days a week** and 24 hours a day in the same way that they are able to get access to urgent physical health care. Getting the right care in the right place at the right time is vital. Failure to provide care early on means that the acute end of mental health care is under immense pressure. Better access to support was one of the top priorities identified by people in our engagement work. Early intervention services provided by dedicated teams are highly effective in improving outcomes and reducing costs.

The Care Quality Commission (CQC) found that just half of Community Mental Health Teams (CMHTs) are able to offer a 24/7 crisis service today. By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme. **Out of area placements for acute care should be reduced and eliminated as quickly as possible.**

Good liaison mental health care is also needed in acute hospitals across the country, providing a 24/7 urgent and emergency mental health response for people attending A&E or admitted as inpatients to acute hospitals. Only a minority of A&E departments have 24/7 liaison mental health services that reach minimum quality standards, even though peak hours for people presenting to A&E with mental health crises are 11pm-7am. By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the 'core 24' service standard as a minimum.

People experiencing a first episode of psychosis should have access to a NICE-approved care package within 2 weeks of referral. Delay in providing care can lead to poorer clinical and social outcomes. The NHS should ensure that by April 2016 more than 50 per cent of this group have access to Early Intervention in Psychosis services, rising to at least 60 per cent by 2020/21.

People want care in the least restrictive setting that is appropriate to meet their individual needs, at any age, and is close to home. People living with severe mental health problems, such as schizophrenia or personality disorder, should not be held in restrictive settings for longer than they need to be. **The NHS should expand proven community-based services for people of all ages with severe mental health problems who need support to live safely as close to home as possible.**

More ‘step-down’ help should be provided from secure care, such as residential rehabilitation, supported housing and forensic or assertive outreach teams. By April 2017, population-based budgets should be in place for those CCGs who wish to commission specialised services for people of all ages, in partnership with local government and national specialised commissioners. The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve full community and inpatient care pathways.

A 7 DAY CRISIS RESPONSE SERVICE WILL HELP SAVE LIVES

Improving the 7 day crisis response service across the NHS will help save lives as part of a major drive to **reduce suicide by 10 per cent by 2020/21.** Every area must develop a multi-agency suicide prevention plan that demonstrates how they will implement interventions targeting high-risk locations and supporting high-risk groups within their population.

Some people experience unacceptably poor access to or quality of care. There has been no improvement in race inequalities relating to mental health care since the end of the 5-year Delivering Race Equality programme in 2010. **Inequalities in access** to early intervention and crisis care, rates of detentions under the Mental Health Act 1983 and lengths of stay in secure services persist.

National and local commissioners must show leadership in tackling unwarranted variations in care. The Department of Health should address race equality as a priority and appoint a new equalities champion to drive change.

Measures must be taken to ensure all deaths across NHS-funded inpatient mental health services are properly investigated, and learned from to improve services and prevent repeat events. By April 2017, the Department of Health should establish an independent system for the assurance of the quality of investigations of all deaths in inpatient mental health services and to ensure a national approach to applying learning to service improvement.

2. An integrated mental and physical health approach

"Making physical and mental health care equally important means that someone with a disability or health problem won't just have that treated, they will also be offered advice and help to ensure their recovery is as smooth as possible, or in the case of physical illness a person cannot recover from, more should be done for their mental wellbeing as this is a huge part of learning to cope or manage a physical illness."

People told us that mental health support should be made easily available across the NHS - for mums to be, children, young adults visiting their GP, people worried about stress at work, older people with long-term physical conditions and people receiving care for cancer or diabetes.

People with existing mental health problems told us that services should be integrated - for example, physical health checks and smoking cessation programmes should be made available for everyone with a severe mental illness.

The impact of mental health problems experienced by women in pregnancy and during the first year following the birth of their child can be devastating for both mother and baby, as well as their families. **By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period.** This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.

By 2020/21, at least 280,000 people living with severe mental health problems should have their physical health needs met. They should be offered screening and secondary prevention reflecting their higher risk of poor physical health. This will reduce the health inequalities gap. We know there is low take up of information, tests and interventions relating to physical activity, smoking, alcohol problems, obesity, diabetes, heart disease and cancer. In England there are over 490,000 people with severe mental illness registered with a GP. The proportion receiving an annual physical health check ranges from 62 per cent to 82 per cent (this data does not include any information about how many people are being supported to access evidence based interventions as a result of these checks). People with a long standing mental health problem are twice as likely to smoke, with the highest rates among people with psychosis or bipolar disorder. Current incentive schemes for GPs to encourage monitoring of physical health should continue and extra efforts should be made to reduce smoking - one of the most significant causes of poorer physical health for this group. Mental health inpatient services should be smoke free by 2018.

The provision of psychological therapies for people with common mental health problems has expanded hugely in recent years. But it is still meeting only 15 per cent of need for adults. NHS England should **increase access to evidence-based psychological therapies to reach 25 per cent of need so that at least 600,000 more adults with anxiety and depression can access care (and 350,000 complete treatment) each year by 2020/21.** There should be a focus on helping people who are living with long-term physical health conditions or who are unemployed. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

PEOPLE WITH A LONG STANDING MENTAL HEALTH PROBLEM ARE TWICE AS LIKELY TO SMOKE

3. Promoting good mental health and preventing poor mental health– helping people lead better lives as equal citizens

"If I'd had the help in my teens that I finally got in my thirties, I wouldn't have lost my twenties."

Prevention matters - it's the only way that lasting change can be achieved. Helping people lead fulfilled, productive lives is not the remit of the NHS alone. It involves good parenting and school support during the early years, decent housing, good work, supportive communities and the opportunity to forge satisfying relationships. These span across national and local government, so the Taskforce has a set of recommendations to build on the Prime Minister's commitment to a "mental health revolution."

Prevention at key moments in life

Children and young people are a priority group for mental health promotion and prevention, and we are calling for the Future in Mind recommendations to be implemented in full. Early intervention and quick access to good quality care is vital – especially for children and young people. Waiting times should be substantially reduced, significant inequalities in access should be addressed and support should be offered while people are waiting for care.

By 2020/21, at least 70,000 more children and young people should have access to high-quality mental health care when they need it. This will require a fundamental change in the way services are commissioned, placing greater emphasis on prevention, early identification and evidence-based care. NHS England should continue to work with partners to fund and implement the whole system approach described in Future in Mind, building capacity and capability across the system so that by 2020/21 we will secure measurable improvements in children and young people's mental health outcomes. We need to ensure that good quality local transformation

plans are put into action, invest in training to ensure that all those working with children and young people can identify mental health problems and know what to do, complete the roll-out of the Children and Young People's Improving Access to Psychological Therapies (CYP IAPT) programme across England by 2018 and develop an access standard for Child and Adolescent Mental Health Services (CAMHS) by the end of 2016/17. This should build on the standard for children and young people with eating disorders announced in July 2015.

BY 2020/21 AT LEAST 70,000 MORE CHILDREN AND YOUNG PEOPLE SHOULD HAVE ACCESS TO HIGH-QUALITY MENTAL HEALTH CARE

In addition, some children are particularly vulnerable to developing mental health problems - including those who are looked after or adopted, care leavers, victims of abuse or exploitation, those with disabilities or long term conditions, or who are within the justice system. The Departments of Health and Education should establish an expert group to examine their complex needs and how they should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.

The **employment rate for adults** with mental health problems remains unacceptably low: 43 per cent of all people with mental health problems are in employment, compared to 74 per cent of the general population and 65 per cent of people with other health conditions. Of people with 'mental and behavioural disorders' supported by the Work Programme, only 9.5 per cent have been supported into employment, a lower proportion than for some proven programmes. There is a 65 per cent point gap between the employment rates of people being supported by specialist mental health services who have more severe health problems and the general population.

Employment and health form a virtuous circle: suitable work can be good for your health, and good health means that you are more likely to be employed.

By 2020/21, each year up to 29,000 more people living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems and expanding access to Individual Placement and Support (IPS).

Employment is vital to health and should be recognised as a health outcome. The NHS must play a greater role in supporting people to find or keep a job. Access to psychological support must be expanded to reach at least a quarter of all people who need it. There must be a doubling of access to Individual Placement and Support programmes to reach an extra 30,000 people living with severe mental illness (so that at least 9,000 are in employment), and the new Work and Health Programme should prioritise investment in health-led interventions that are proven to work for people with mental health problems.

JUST 43%
OF PEOPLE WITH MENTAL HEALTH PROBLEMS ARE IN EMPLOYMENT

Creating mentally healthy communities

We heard from many people about the importance of the role of Local Government in the promotion and prevention agenda. Building on the success of local Crisis Care Concordat Plans, we recommend the creation of local Mental Health Prevention Plans, based on high quality evidence.

Housing is critical to the prevention of mental health problems and the promotion of recovery. The Department of Health, the Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

In relation to the proposed Housing Benefit cap to Local Housing Allowance levels, the Department of Work and Pensions should use evidence to ensure that the right levels of protection are in place for people with mental health problems who require specialist supported housing. The Ministry of Justice, Home Office, Department of Health, NHS England and Public Health England should work together to **support those in the criminal justice system experiencing mental health problems** by expanding- liaison and diversion schemes nationally, increasing support for Blue Light services, and for the 90 per cent of people in prison with mental health problems, drug or alcohol problems.

Ending the **stigma** around mental ill health is vital. The Department of Health and Public Health England should continue to help local communities build a grass roots social movement to raise awareness of good physical and mental health and support people to seek help when they need it.

Building a better future

"There should be even greater emphasis put on people's experience and how experts-by-experience can be seen as real assets to design and develop services."

The next five years will build the foundations for the next generation.

The UK should be a world leader in the development and application of new **mental health research**. The Department of Health, working with relevant partners, should publish a ten year strategy for mental health research one year from now including a co-ordinated plan for strengthening the research pipeline on identified priorities, and promoting implementation of research evidence.

A **data and transparency revolution** is required to ensure greater consistency in the availability and quality of NHS-funded services across the country. The information gathered by the NHS should reflect social as well as clinical outcomes – e.g. education, employment and housing - that matter to people with mental health problems. This requires better data linkage across the NHS, public health, education and other sectors, with absolute transparency on spending in relation to prevalence, access, experience and outcomes. **By 2020/21, CCGs should be required to publish a range of benchmarking data to provide transparency about mental health spending and performance.**

DELIVERING THIS STRATEGY

"Being both a junior doctor training in psychiatry, and a patient with mental health problems, enables me to experience both sides of the NHS, and I feel this gives me a great advantage and insight. Whilst a lot of the work I experience on both sides is very positive, I am frequently amazed by the heavy workloads of my colleagues and those treating me. And I know that for me, this can in fact contribute to deterioration in my own mental health."

Mental health services have been chronically underfunded. We know that the presence of poor mental health can drive a 50 per cent increase in costs in physical care. The Taskforce considers it a point of basic parity between physical and mental health that types of care and therapies shown to lead to improved mental health outcomes and found to be cost-effective should be made available to people with mental health problems. Without upfront investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse.

£1 BILLION
ADDITIONAL INVESTMENT NEEDED

Over the next five years additional funding should allow NHS England to expand access to effective interventions. The priority areas we have identified would require an additional £1 billion investment in 2020/21, which will contribute to plugging critical gaps in the care the NHS is currently unable to provide. Our expectation is that savings and efficiencies generated by improved mental health care e.g. through a strengthened approach to prevention and early intervention, and through new models of care, will be re-invested in mental health services.

To deliver these commitments and realise the associated savings NHS England must be able to target investment and ensure there is sufficient transparency and accountability for putting them into action. Both the current Mandate priorities and those set out in this report should specifically be reflected in the local Sustainability and Transformation plans that areas will need to produce by June 2016, in how those plans are assessed and in the processes for allocating and assuring funds.
We recommend eight principles to underpin reform:

- Decisions must be locally led
- Care must be based on the best available evidence

- Services must be designed in partnership with people who have mental health problems and with carers
- Inequalities must be reduced to ensure all needs are met, across all ages
- Care must be integrated – spanning people's physical, mental and social needs
- Prevention and early intervention must be prioritised
- Care must be safe, effective and personal, and delivered in the least restrictive setting
- The right data must be collected and used to drive and evaluate progress

We make specific recommendations on the need to develop and support the mental health workforce, making it a career option of choice across medicine, social care, the allied health professions and the voluntary sector. We encourage the further development of personalised care, giving people choice in their own care, and the expansion of peer support.

We make a series of fundamental recommendations to hardwire mental health into how care is commissioned, funded, and inspected, across the whole NHS. These should enable mental health to be fully embedded in NHS planning and operations for the duration of the Five Year Forward View.

Co-production with experts-by-experience should also be a standard approach to commissioning and service design, with Arm's Length Bodies (ALBs) leading by example and supporting this practice in local areas. We recommend the creation of a Mental Health Advisory Board reporting to the Five Year Forward View Board, publicly updating on progress against our recommended outcomes. We also encourage the Cabinet Office and Department of Health to put in place cross-government oversight of the wider actions we are recommending the Government should take, in addition to those being led by the NHS.

Conclusion

A summary of our recommendations can be found in the second annex of this report. Delivery of these recommendations is everybody's business - for the NHS, for health and social care professionals, for providers, employers, across government and communities.

But the critical element of success will be to put the individual with their own lived experience of mental health at the heart of each and every decision which is made. We have much to be proud of in the progress that has been made in empowering people to make their own decisions, and for services to be co-designed. We now have to go a step further and truly produce services which are led by the needs of the individual, not the system.

CHAPTER ONE:

GETTING THE FOUNDATIONS RIGHT: COMMISSIONING FOR PREVENTION AND QUALITY CARE

Every person with a mental health problem should be able to say:
I am confident that the services I may use have been designed in partnership with people who have relevant lived experience.

People with lived experience of mental health problems, carers and health and social care professionals told the Taskforce that prevention was a top priority. Specific themes raised included support for new mothers and babies, mental health promotion within schools and workplaces, being able to self-manage mental health, ensuring good overall physical and mental health and wellbeing, and getting help early to stop mental health problems escalating. Many people discussed the importance of addressing the wider determinants of mental health, such as good quality housing, debt, poverty, employment, education, access to green space and tough life experiences such as abuse, bullying and bereavement. It was suggested that while it is particularly important to recognise loneliness in older people, these issues can affect people of any age.

1.1 THE SYSTEM NOW

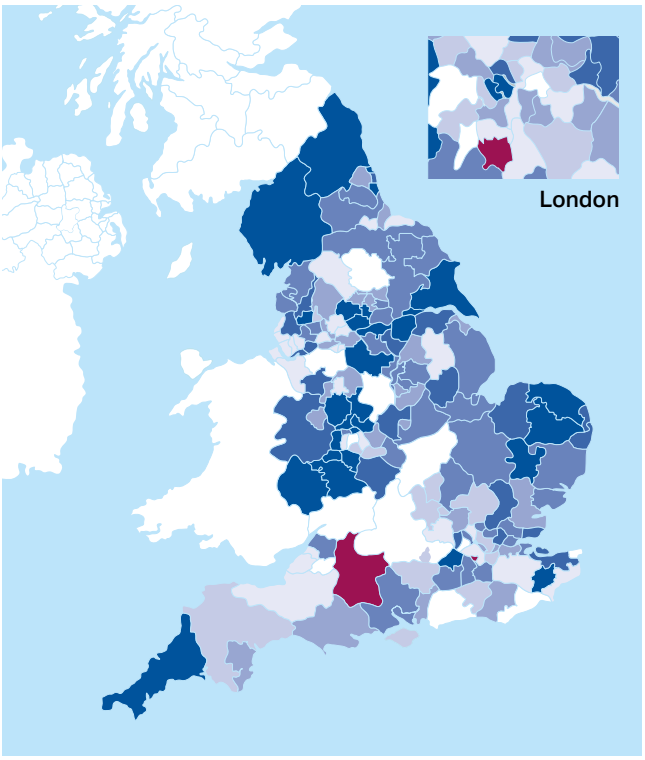
The quality of local mental health commissioning is variable. We found a twofold difference in apparent per-capita spend by CCGs, a more than threefold difference in excess premature mortality in people with mental health problems in England and a fourfold variation in mortality across local authorities. For children and young people there is wide variation in spend in both the NHS and local authorities. Detentions under the Mental Health Act continue to rise

steadily year on year. Similarly, we know that many adults cannot get the right care locally, a clear demonstration of poor quality commissioning and a lack of investment to meet local need. Reductions in local authority budgets are also leading to rising pressures on important components of mental health care e.g. social care and residential housing.

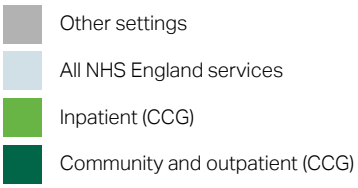
Up to ~2x variation in per-capita spend, even when adjusted

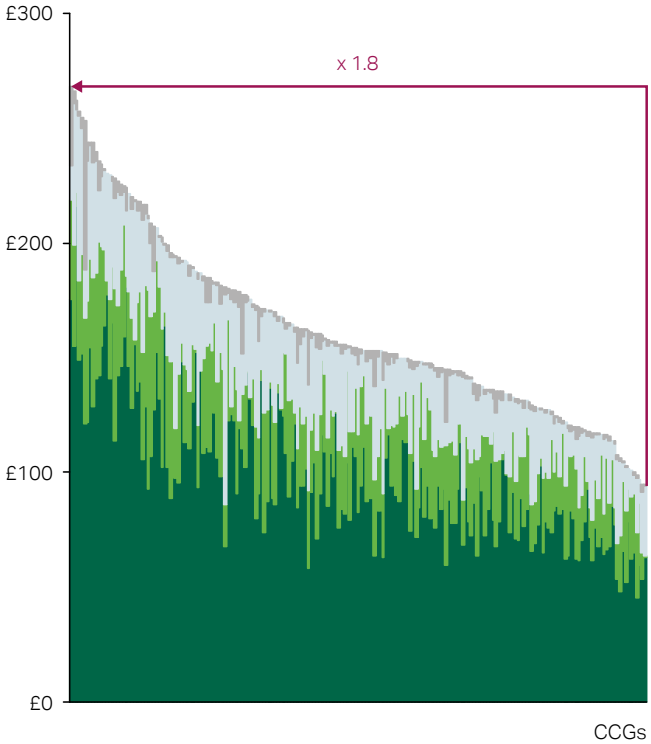
Unadjusted spend shows 5x variation

Spend per PRAMH-weighted capita by CCGs and NHS England on mental health 2013/14
PRAMH model weights the population based on age, sex, prevalence of mental health conditions, markers of severity (e.g. MHA), accommodation and employment status, ethnicity and length of contact with mental health services



Lowest spend — Highest spend — No Data





Note: Excludes 2 CCG; NHS England per capita expenditure varies by four regions (not by CCG). Source: Programme Budgeting 2013/14; Specialised Finance data; NHS England PRAMH weighted population

Commissioning of services is fragmented between CCGs, local authorities and the NHS. More needs to be done on prevention to reduce inequalities and there needs to be a greater focus on preventing suicide. There is increasing interest in “population-based” commissioning, either by pooling budgets or through joint decision-making with other commissioners, and a number of places are combining spending power across health and social care. The use of personal health budgets is increasing and other new models of care are being developed.

However, there is a long way to go to achieve integrated, population-based commissioning that is crucial for improving mental health outcomes, and incorporates specialised commissioning.

The Crisis Care Concordat action plans are promising as a model for integrated local commissioning. We also endorse the approach set out in Future in Mind as a model for wider system reform, which involves the NHS, public health, voluntary, local authority, education and youth justice services working together through Local Transformation Plans to build resilience, promote good mental health and make it easier for children and young people to access high quality care. This builds on a range of existing legislation that concerns children and young people and which requires agencies to take a coordinated approach. The plans are also important because they address the full spectrum of need, including children and young people who have a particular vulnerability to mental health problems.

Challenges remain to breaking down barriers between how services are commissioned across the country. Within the NHS, primary, secondary and tertiary care services should deliver integrated physical and mental health outcomes. Currently needs are addressed in isolation, if at all, which is not effective or efficient. CCGs need to ensure people with multiple needs do not fall through service gaps. For example, the commissioning of alcohol and substance misuse services has been transferred from the NHS to local authorities, leading to the closure of specialist NHS addiction inpatient units. Referral pathways have become more complex and many people with mental health and substance misuse problems no longer receive planned, holistic care.

On employment, the Department of Work and Pensions forecasts that it will spend £2.8 billion in total payments to contractors to help people into work under the Work Programme between June 2011 and March 2020. Yet fewer than one in 10 people with mental health problems have gained employment through the Work Programme. We know psychological therapies and Individual Placement and Support (IPS) services have proved highly effective – with around 30 per cent moving into jobs through IPS – but these are not being commissioned at scale. The Taskforce also welcomes the introduction of a Joint Unit for Work and Health, which is already piloting new approaches and recently secured significant new investment for an innovation fund.

Commissioners need support to analyse data, moderate demand, channel individuals to appropriate care and test their use of resources against their priorities. Co-production with clinicians and experts-by-experience to ensure services are accessible and appropriate for people of all backgrounds is also essential. Commissioners also need to understand what works, be adept at the use of financial and other levers, and be fully accountable for improving the mental health of their communities.

1.2 THE SYSTEM IN THE FUTURE

Local communities will be supported to develop effective Mental Health Prevention plans, and use the best data available to commission the right mix of services to meet local needs. Plans should focus on public mental health, including promoting good mental health, addressing the wider social determinants of mental health problems, local approaches to challenging stigma, and targeting at risk groups with proven interventions. This approach should blend healthcare, social care and user-led support.

By 2020/21, NHS commissioning will be underpinned by a robust understanding of the mental health needs of the local population, bringing together local partners across health, social care, housing, education, criminal justice and other agencies, with a clear recognition of the mental health needs of people treated for physical ailments and vice versa, and with greater integration across agencies to build stronger, more resilient communities. Commissioners will have the knowledge and skills to embed what is proven to work, and to work in partnership with people using services, carers, and local communities to develop and evaluate innovative new models in a range of settings.

The quality of services and outcomes will be assessed on the basis of robust data. There will be clear plans in place to prevent mental ill-health and suicide. More areas will have the freedom to work jointly across whole health and social care systems, following the examples of Manchester and West Midlands.

The Taskforce welcomes the invitation set out in NHS England Planning Guidance 2016/17 – 2020/21 for providers of secondary mental health services to manage budgets for tertiary (specialised) services, to reduce fragmented commissioning and improve care pathways. This is a significant change, which should be developed as a new vanguard programme, ensuring adequate inpatient resource is maintained while preparations are made to support people who are ready to transition into community based services. NHS England should also have established new models of care to trial this new approach for perinatal and CAMHS inpatient services.

Commissioners will:

- work in partnership with local stakeholders and voluntary organisations
- co-produce with clinicians, experts-by-experience and carers
- consider mental and physical health needs
- plan for effective transitions between services
- enable integration
- draw on the best evidence, quality standards and NICE guidelines
- make use of financial incentives to improve quality
- emphasise early intervention, choice and personalisation and recovery
- ensure services are provided with humanity, dignity and respect.

1.3 THE DELIVERY PLAN BY 2020/21

Health and Wellbeing Boards should have plans in place to promote good mental health, prevent problems arising and improve mental health services, based on detailed local data for risk factors, protective factors and levels of unmet need. These should specifically identify which groups are affected by inequalities related to poor mental health and be co-produced with local communities to generate innovative approaches to care and improving quality. Each local council should have Mental Health Champions, building on the 60 that already exist. Nationally, the Department of Health should lead continued work to tackle stigma.

Co-production with clinicians and experts-by-experience should also be at the heart of commissioning and service design, and involve working in partnership with voluntary and community sector organisations. Applying the 4PI framework of Principles, Purpose, Presence, Process and Impact developed by the National Survivor and User Network will help ensure services or interventions are accessible and appropriate for people of all backgrounds, ages and experience.

We expect rapid progress in the transformation of services for children and young people following investment of £1.4 billion over five years announced by the Government in 2014/15 (including additional money for eating disorders in children and young people). Plans are ready and these will be the first major programmes set out in this strategy to be delivered.

More people with common mental health problems should be supported into work through expanding integrated access to psychological therapies and employment support in primary care. Thousands more people accessing secondary mental health services should also be supported to find or keep a job through evidence based Individual Placement and Support services.

The NHS, local authorities, housing providers and other agencies should be working together locally to increase access to supported housing for vulnerable people with mental health problems. They should also be acting to share joint

plans and information between local partners so that mainstream housing services play a more active role in preventing mental health problems arising.

While joint working between the CCG commissioners and other partners has been accepted for children and young people, further work is required across adult services. This offers a means of tackling the difficulties arising from the fracturing of commissioning pathways and escalating demand for inpatient services. Work is also required across secure services and the criminal justice system.

These are the opportunities – but there are also risks. There will be uncertainty about the role and function of commissioning as local geographies change, responsibilities shift, and budgets come under pressure. NHS England and the ALBs must be clear what they expect of commissioners and ensure they are supported.

The transformation we envisage will take a number of years and without clear information about what the best care pathways look like and good data on current levels of spending, access, quality and outcomes, it will be hard to assess the impact of organisational change and ensure mental health services are not disadvantaged. Priority should also be given to tackling inequalities and routine data must be made available so that there is transparency about how local areas are addressing age, gender, ethnicity, disability and sexuality in their plans.

We recognise that the new models of care will not be operating nationwide by 2020/21. Providers currently carry much of the risk and responsibility for improvements in quality and outcomes, with too little scrutiny of commissioning. In an increasingly devolved system, commissioners must remain responsible for meeting the needs of their local populations and must be properly held to account.

Recommendation 1: NHS England should continue to work with Health Education England (HEE), Public Health England (PHE), Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping 70,000 more children and young people to access high quality mental health care when they need it. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.

Recommendation 2: PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated Joint Strategic Needs Assessment (JSNA) and joint prevention plans that include mental health and co-morbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.

Recommendation 3: The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, reviewed annually thereafter and supported by new investment.

Recommendation 4: The Cabinet Office should ensure that the new Life Chances Fund of up to £30 million for outcome-based interventions to tackle alcoholism and drug addiction through proven approaches requires local areas to demonstrate how they will integrate assessment, care and support for people with co-morbid substance misuse and mental health problems. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.

Recommendation 5: By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see Chapter Two) and doubling the reach of Individual Placement and Support (IPS). The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.

Recommendation 6: The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).

Recommendation 7: The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts.

Recommendation 8: NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.

Recommendation 9: NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17, NHS England should also trial new models through a vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements.

Recommendation 10: The Department of Health, Department of Communities and Local Government, NHS England, HM Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.

Recommendation 11: The Department of Work and Pensions should, based on the outcome of the "Supported Housing" review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.

Recommendation 12: The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community to contribute towards improving attitudes to mental health by at least a further 5 per cent by 2020/21.

CHAPTER TWO:

GOOD QUALITY CARE FOR ALL 7 DAYS A WEEK

Every person with a mental health problem should be able to say:
I have rapid access, within a guaranteed time, to effective, personalised care. I have a choice of talking therapy so that I can find one appropriate to me. When I need urgent help to avoid a crisis I, and people close to me, know who to contact at any time. People take me seriously and trust my judgement when I say a crisis is approaching. I can get help in a crisis, fast. Where I raise my physical health concerns, in any setting, they are taken seriously and acted on. If I am in hospital, staff on the wards can help with my mental as well as physical health needs. Services understand the importance to me of having friends, opportunities and close relationships.

The Taskforce heard that timely access to effective, good quality, evidence-based mental health pathways, with clear waiting times, is a primary concern. People also value having a choice of support, tailored to their specific needs, including access to a full range of psychological therapies. Access to treatment should be equal, and care should support people of all ages, regardless of the particular mental health problem they experience.

2.1 THE SYSTEM NOW

People who need physical health care – cancer care, for example – know what to expect and when to expect it. There are clear pathways of care, quality standards and maximum waiting times.

This is not always true of mental health care. Even though we know that the right care delivered in the right way at the right time improves and may save lives, mental health care has not benefited from the clear pathways and standards in place for secondary physical health care. Models of primary mental health care are also under-developed, and people with mental health problems are not always well supported in primary care with either their mental or physical health care needs.

The introduction of the first access and quality standards for mental health services therefore represents an important step forwards. Access to psychological therapies for common conditions such as anxiety and depression, as recommended by NICE, has increased. Work is in progress to improve services for people experiencing a first episode of psychosis, in perinatal care, crisis care and in children and young people's services, including for those with eating disorders.

What is lacking is a comprehensive set of standards – comparable to those for physical health care – and the supporting quality and outcomes data showing what works. Combined with under-investment, most people receive currently no effective care and too few benefit from the full range of NICE-recommended interventions.

Waiting times – for first appointments and for the right follow-on support – are unacceptably long. Basic interventions are in short supply, services are under pressure and thresholds for access are being raised. As a result, people's needs often escalate and they can become acutely unwell or experience a crisis, resulting in poorer outcomes and a reliance on higher cost care.

Crisis care is improving following the signing of the Crisis Care Concordat – but there is still a long way to go to match standards in urgent and emergency care for physical health needs. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, reported that the current reliance on acute beds means that it is often difficult for people to access care near home and that this is exacerbated by a lack of community services, particularly Crisis Response and Home Treatment Teams (CRHTTs). Only 14 per cent of adults experiencing a crisis feel they are provided with the right response and just over one third (36 per cent) feel respected by staff when they attend A&E. Less than half (48 per cent) of children and young people's services have a crisis intervention team. Too often people in crisis end up in a police cell rather than a suitable alternative place of safety.

Adult mental health services are under intense pressure. Less than half of CRHTTs have sufficient staff to provide 24/7 intensive home treatment as an alternative to admission, putting extra pressure on hospital beds. Delayed discharge and transfers of care are as high as 38 per cent in some areas, often linked to a lack of suitable housing or social care. Bed occupancy routinely exceeds 95 per cent and the CQC 'Right Here, Right Now' report found that many people have to travel long distances to be admitted.

Comprehensive liaison mental health services are currently available in only one in six (16 per cent) of England's 179 acute hospitals. The situation is better for paediatric mental health liaison, with 79 per cent of hospitals reporting cover, but these frequently do not operate out of hours.

Long stays in high cost secure hospitals and delayed discharge are common, often owing to the lack of recovery-focused care and suitable “step-down” services. Nine out of ten people in prison have a mental health or substance abuse problem – often together – but most do not receive the right care.

Some groups are disproportionately represented in detentions to acute and secure inpatient services, and are affected by long stays. For example, men of African Caribbean ethnic origin are twice as likely to be detained in low secure services than men of white British origin and stay for twice as long in those services on average. This suggests a failure to ensure equal access to earlier intervention and crisis care services.

Older people’s needs are also neglected, with many led to believe depression is a normal part of ageing.

People with mental health problems often also receive poorer physical health care. Those with severe mental illness die on average 15-20 years earlier than the general population. They are three times more likely to attend A&E with an urgent physical health need and almost five times more likely to be admitted as an emergency, suggesting deficiencies in the primary care they are receiving. The reverse is also true – people with long term physical health conditions do not routinely have mental health support included in their care package.

2.2 THE FUTURE: RIGHT CARE, RIGHT TIME, RIGHT QUALITY – 7 DAYS A WEEK

People with mental health problems, regardless of their age, ethnicity, or any other characteristic will have swift access to holistic, integrated and evidence-based care for the biological, psychological and social issues related to their needs, in the least restrictive setting and as close to home as possible.

By 2020/21, there will be a comprehensive set of care pathways in place and we expect at least a million more people will be able to get the help they need, improving outcomes and reducing reliance on acute care services. Services will provide clear data about access and waiting times and payment will be linked to the interventions delivered and the outcomes achieved.

There will be a 7 day NHS providing urgent and emergency mental health crisis care 24 hours a day, as there is for physical health, delivering 24/7 intensive home treatment and not just crisis assessment. Police cells will be used only in exceptional circumstances for people detained under the Mental Health Act. Good quality liaison mental health services will be available more widely across the country.

Mental and physical health support will be integrated. People with severe mental illness at highest risk of dying prematurely will be supported to access tests and screening to monitor their physical health in primary care. Mental health services will be delivered by multi-disciplinary integrated teams, with named, accountable clinicians, across primary, secondary and social care. They will include provision of care for substance misuse issues.

People with acute mental health needs will be able to access appropriate care, as inpatients or through community teams. Their housing, social care and other needs will be assessed on admission and the right support made available on discharge. Use of the Mental Health Act will be monitored, with a focus on Black and Minority Ethnic (BAME) groups.

People in the criminal justice system will also have their mental health needs assessed and the right care provided.

2.3 A DELIVERY PLAN FOR A 7 DAY MENTAL HEALTH SERVICE

Clinical standards, including maximum waiting times for NICE-recommended care based on the ambitions set out in Achieving Better Access to Mental Health Services by 2020/21 and the Five Year Forward View, should be rolled out nationwide. These must ensure that:

- waiting times are informed by clinical evidence and should be for effective care in line with NICE recommendations
- all services should routinely collect and publish outcomes data.

These are already in place for psychological therapies for common mental health problems, a waiting time standard for early intervention in psychosis will come into effect from April 2016 and one for children and young people with eating disorders the following year.

Urgent work is needed to establish comprehensive pathways and quality standards for the rest of the mental health system based on the timetable on page 36, which can then be implemented as funding becomes available. This programme must be co-produced with clinical experts and experts-by-experience. Work is already in happening to secure input on what robust standards for children and young people, crisis care for people of all ages, and perinatal care should look like. There should also be a referral to treatment access standard for acute care, including quality standards and outcomes measures for home treatment and inpatient care for people with acute mental health needs.

Where evidence about the effectiveness of interventions is robust and pathways are in place or are being developed there is a strong case for NHS England to invest to expand access. NHS England, the Department of Health and the Ministry of Justice should also start joint work to develop pathways across the criminal justice system.

Improved access to high quality inpatient services for children, young people and adults is needed, as highlighted by the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists which reported earlier this month.

Primary care (including Out of Hours services) should form a part of each of the relevant pathways within the new programme. There should also be a new focus in primary care on the physical health care of people with severe mental health problems, including psychosis, bipolar disorder and personality disorder.

Wherever it is provided care should be appropriate to people of all ages. Older people should be able to access services that meet their needs – bespoke older adult services should be the preferred model until general adult mental health services can be shown to provide age appropriate care.

Recommendation 13: By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, based on the timetable set out in this report. These standards should incorporate the relevant physical health care interventions and the principles of co-produced care planning.

Recommendation 14: NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting 20,000 people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.

Recommendation 15: By 2020/21, NHS England should support at least 30,000 more women each year to access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high quality services are in place across England.

Recommendation 16: The NHS should ensure that from April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.

Recommendation 17: By 2020/21, NHS England should ensure that a 24/7 community-based mental health crisis response is available in all areas across England and that services are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For adults, NHS England should invest to expand Crisis Resolution and Home Treatment Teams (CRHTTs); for children and young people, an equivalent model of care should be developed within this expansion programme.

Recommendation 18: By 2020/21, NHS England should invest to ensure that no acute hospital is without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals are meeting the 'core 24' service standard as a minimum.

Recommendation19: NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention.

Recommendation 20: PHE should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

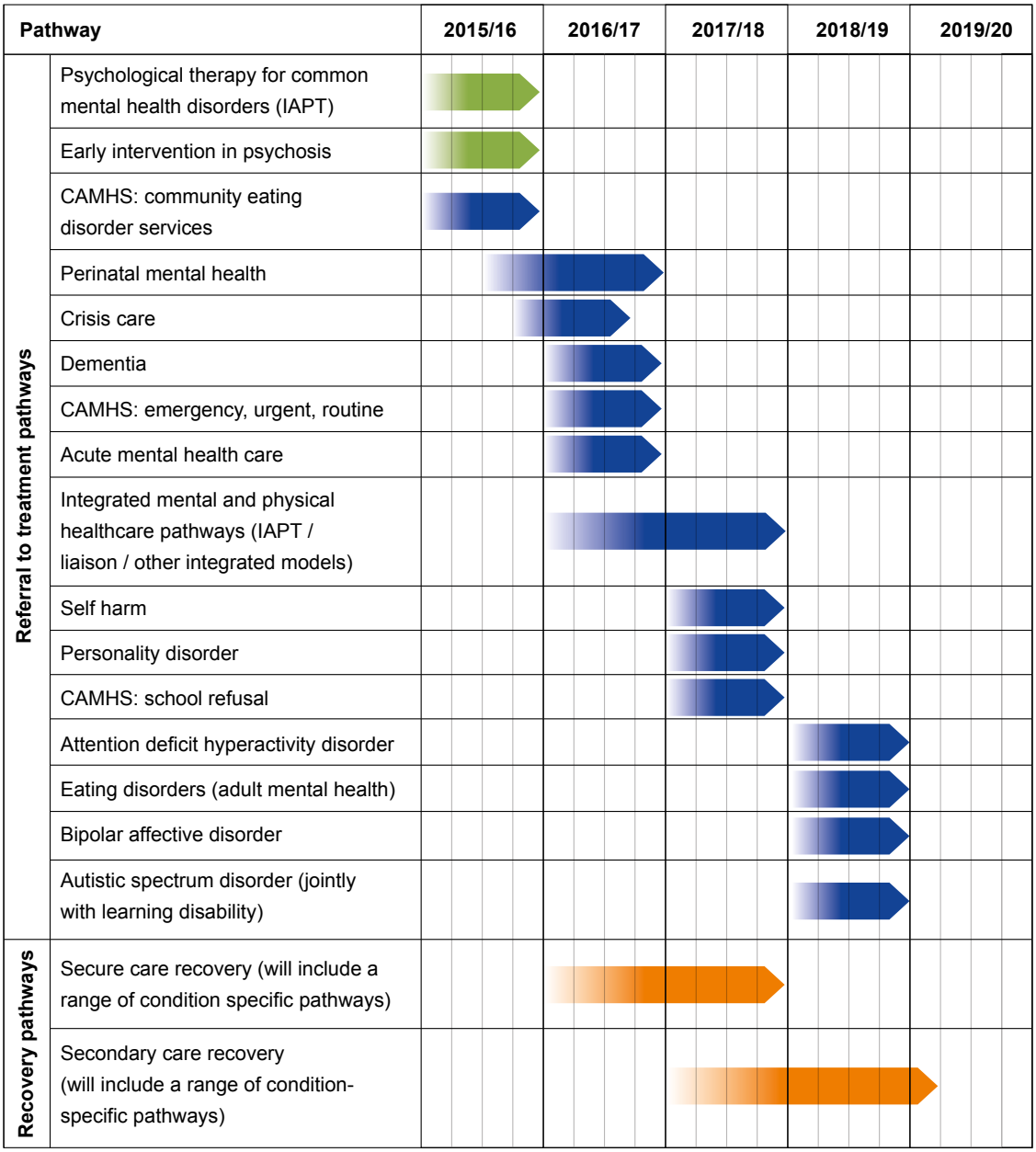
Recommendation 21: NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in the psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework or alternative incentive payments, and embedded through the Vanguard programmes.

Recommendation 22: In 2016, NHS England and relevant partners should set out how they will ensure that standards are introduced for acute mental health care, with the expectation that care is provided in the least restrictive way and as close to home as possible. These plans should include specific actions to substantially reduce Mental Health Act detentions and ensure that the practice of sending people out of area for acute inpatient care as a result of local acute bed pressures is eliminated entirely by no later than 2020/21. Plans should also include specific action to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups within detention rates. Plans for introduction of standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17.

Recommendation 23: NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and trial new co-commissioning, funding and service models.

Recommendation 24: The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed.

Proposed mental health pathway and infrastructure development programme



There are a number of different mental health conditions, and the guidelines and quality standards produced by NICE are structured in line with broad diagnostic categories such as ‘psychosis’. The aim of the existing mental health access and waiting time standards programme is to ensure that a greater number of people have timely access to the full range of interventions recommended by NICE and receive the ‘right care, first time’. The proposed new standards have broadly been framed in line with NICE guidelines and quality standards, unless this makes little practical sense. For example, the crisis care standards will cut across multiple conditions because the focus must be responding rapidly to people’s needs in the most appropriate setting (although the aim will still be to ensure that people in crisis have access to care in line with NICE recommendations). The proposed programme also includes work to ensure that people who are already receiving support get care that is fully NICE-concordant, including psychological therapy, as a core part of co-produced care plans that are recovery and outcome-focused.

CHAPTER THREE:

INNOVATION AND RESEARCH TO DRIVE CHANGE NOW AND IN THE FUTURE

3.1 BUILDING ON INNOVATION

Every person with a mental health problem should be able to say:
I am confident that the services I may use have been designed in partnership with people who have relevant lived experience. I can access support services without waiting for a medical referral. I am able to access a personal budget for my support needs on an equal basis to people with physical health problems for example, to help my recovery or to stay well. My mental and physical health needs are met together.

I am provided with peer support contact with people with their own experience of mental health problems and of using mental health services. I can find peer support from people who understand my culture and identity. Peer support is available at any point in my fluctuating health – in a crisis, during recovery, and when I am managing being well. I have a place I can call a home, not just 'accommodation'. I have support to help me access benefits, housing and other services I might need.

There were also concerns from people from BAME communities, who told us they had lost trust in services and wanted more support within the community. More widely, we heard that community and voluntary sector providers play a critical role in supporting groups that are currently poorly served by services, such as BAME communities, children and young people, older people, lesbian, gay, bisexual and transgender people, and people with multiple needs.

The Taskforce heard that there is a strong appetite for mental health research to be equitably funded and to have parity with other areas of health research. There was also support for much more research involving experts-by-experience, looking at what matters most to people in relation to prevention and care or support. Understanding the causes of mental ill health, including social and psychological factors, was considered a priority for research funding.

Delivering better care to more people not only requires increased investment. It also requires the development of new ways to improve the quality and productivity of services. We heard of many examples of approaches which had promise, but where further research was required.

This is already being applied: successful innovations, such as the Crisis Care Concordat, have led to the transformation of services, highlighting the importance of multi-agency partnerships and strong local leadership in implementing change. NHS Improvement should seek to stimulate other local initiatives building a broad pipeline of improvements from which others can learn.

Alongside new standards we need to see further innovation in three areas:

- **new models of care** to stimulate effective collaboration between commissioners and providers to develop integrated, accessible services for all - for example Integrated Personal Commissioning
- **expanding access to digital services** to enable more people to receive effective care and provide greater accessibility and choice - for example the digital initiative in London that will be operational later this year
- **a system-wide focus on quality improvement** to support staff and patients to improve care through effective use of data, with support from professional networks.

Innovation must be robustly evaluated as part of a strengthened approach to mental health research. NHS England should trial new approaches at scale, first in the 50 vanguard sites which are working to integrate health and social care, and second by creating an equivalent cohort of vanguard areas to pilot new approaches to delivering integrated specialist mental health care.

All new models must be developed in partnership with experts-by-experience, carers, and community and voluntary organisations. Psychological and social interventions, such as peer support and short-stay alternatives to hospital, are particularly valued by people with mental health problems and it is essential to demonstrate whether they also provide value for money.

We see a pivotal role for digital technology in driving major changes to mental health services over the next five years. There are already good examples of its use by NHS Choices, and there are a number of apps with a mental health theme. There is a large mental health community on social media and voluntary organisations report heavy demand on their digital services.

Provision must be increased so that:

- people can access services conveniently, have greater choice, and can network with peers to provide mutual support and guidance
- providers can deliver a more nuanced service, with contact through digital

media backed up by face-to-face interventions
- commissioners can improve outcomes through low-cost and easily scalable interventions
- providers can work securely to share patient data on electronic health records, where appropriate, to benchmark their performance and to test new service models
- people who use services, carers and the wider public can hold the system to account by using data across the entire pathway (from prevention and access through to productivity and outcomes) to scrutinise performance.

Our engagement activity brought home the critical role that people with experience of mental health problems, carers and staff can play in improving services. Yet we heard countless stories of promising ideas not being heard or taken forward. A whole-system approach is needed among the health ALBs to encourage constructive challenge.

Mental health problems account for a quarter of all ill health in the UK. Despite important new developments in mental health research it receives less than 5.5 per cent of all health research funding. Latest figures suggest that £115 million is spent on mental health research each year compared with £970 million on physical health research.

This disparity was highlighted by the Chief Medical Officer in her 2014 report. The biggest existing gaps include research into children's mental health, the promotion of good mental health and prevention of ill health, and the links between mental and physical health. One pound spent on mental health research realises an additional return of 37p each year, the same rate of return as for research on cancer and heart disease.

3.2 DELIVERING ON INNOVATION AND RESEARCH

We aim to create a simple pathway for innovation and research:
- identify areas of innovation and research promise
- invest in research programmes which include testing approaches at scale
- review research and embed it into care pathways and new models of care.

In future, new models of care will support people's mental health alongside their other needs, including physical health, employment, housing and social care and will have a greater emphasis on prevention, self-management, choice, peer support, and partnership with other sectors.

Specifically, new models of enhanced primary care and collaborative specialist care that meets the physical and mental health needs of people with severe mental illness will have been fully trialled.

People will also have greater choice and control over the services provided for them. They will be able to access good information, help and advice online, via live chat, email, text message and phone. Organisations will have the technology to collect data to improve their services. Mental health will be integrated into national and local transformation programmes and NHS commissioners supported to engage patients and staff in improving the quality and cost-effectiveness of care. There will be a more co-ordinated approach to research between government, private, public and philanthropic sectors over the long term and the involvement of people with lived experience of mental health problems as standard.

Mental health research should follow the roadmap set out in the ROAMER project, a collaboration of over 1,000 scientists, people using services, families, professional groups and industry representatives, published in September 2015, which identified the following priorities:

1. Preventing mental health problems arising, promoting mental health and focusing on young people
2. Focusing on the causal mechanisms of mental ill-health
3. Setting up international collaborations and networks for mental health research
4. Developing and implementing new and better interventions for mental health and wellbeing
5. Reducing stigma and empowering people with mental health problems and carers
6. Research into health and social systems.

3.3 NEW MODELS OF CARE

The new models of care being piloted by the vanguard sites offer opportunities to improve care for people with mental health problems by, for example:

- working with Primary and Acute Care Systems (PACS) to incorporate mental health screening and support within maternity pathways, and considering new payment models for integrating mental health care within tariff prices
- working with Multispeciality Community Providers (MCP) to provide integrated psychological support within wider primary care and community services provision, and supporting mental health inpatients more effectively to manage their physical health
- working with Urgent and Emergency Care (UEC) vanguards to ensure that sufficient liaison mental health and pathways to further care are available in acute hospitals to support those in mental health crisis.

NHS England should drive the development of new care models, starting with the implementation of NICE-recommended interventions. They should address current gaps in care and assess the work of relevant vanguards to benchmark how far mental health is reflected within their transformation plans to include:

- working with Jobcentre Plus, to expand access to IPS to help more people into employment
- trialling dedicated inpatient services for 16-25 year olds, as they transition to adulthood, following the model adopted for young cancer patients
- delivering extra training for primary care staff in supporting people with severe mental illness
- building a robust invest to save model for integrating psychological therapies into primary care through GP collaboratives
- developing new partnerships with the community and voluntary sector.

NHS England should support these innovations by working with current programmes to integrate commissioning across agencies, ensure commissioners and providers are confident to work in partnership with their communities, including people who use services and carers, and make more use of digital technology, as laid out in the National Information Board's strategy. A co-ordinated approach across ALBs, backed by experts in clinical improvement and good quality data, is essential to give local leaders effective support to implement necessary change.

Recommendation 25: The MCP, PACS, UEC Vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

Recommendation 26: The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now setting out a 10-year strategy for mental health research. This should include a coordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.

Recommendation 27: The Higher Education Funding Council for England (HEFCE) should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action

to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.

Recommendation 28: The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.

Recommendation 29: To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health and social work services.

Recommendation 30: NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards to guide them through options for their care and ensure they receive appropriate support. They should work with HEE to develop and evaluate this model.

Recommendation 31: NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with vanguard sites.

CHAPTER FOUR:

STRENGTHENING THE WORKFORCE

Every person with a mental health problem should be able to say:
Services and professionals listen to me and do not make assumptions about me. Those who work with me bring optimism to my care and treatment, so that I in turn can be optimistic that care will be effective. The staff I meet are trained to understand mental health conditions and able to help me as a whole person. Staff support me to be involved in decisions at the right level. They respond flexibly and change the way they work as my needs change. Wherever possible, there are people with their own experience of using services who are employed or otherwise used in the services that support me. As far as possible, I see the same staff members during a crisis.

My culture and identity are understood and respected when I am in contact with services and professionals. I am not stigmatised by services and professionals as a result of my health symptoms or my cultural or ethnic background. The strengths of my culture and identity are recognised as part of my recovery. My behaviour is seen in the light of communication and expression, not just as a clinical problem.

The Taskforce heard a strong message that staff across the NHS need to have training that equips them to understand mental health problems and to treat people with mental health problems with dignity and respect: treating 'the person, not the diagnosis'. This is critical in enabling people with mental health problems to play a more active role in making choices about all aspects of their care, based on a more equal and collaborative relationship between the person and professional(s). A number of people described encountering stigmatising attitudes from some staff within mental health services, as well as staff in the wider NHS (including GP surgeries and non-clinical staff). Developing a paid peer support workforce had considerable support. People also wanted clearer protocols for staff when they are working with carers.

Professionals and professional bodies wanted the NHS as an employer to pay greater regard to the health and wellbeing of NHS and social care staff, as an effective way to improve the quality of care at a time when staff are under increasing pressure.

4.1 THE PICTURE TODAY - STAFF WORKING HARD IN A TOUGH ENVIRONMENT

Building and maintaining a qualified workforce of committed staff is one of the greatest challenges facing the NHS - and it is most acute in mental health. Providing specialist care to people experiencing mental distress is difficult, demanding work and requires exceptionally dedicated, caring individuals. It calls for multi-disciplinary teams, including psychiatrists, mental health nurses, psychologists, occupational therapists and social workers. There are significant opportunities for increasing access to high quality, integrated care that rely upon an expanded workforce with the right skills, but recruitment is not easy in some areas.

Data from 2014 from Health Education England (HEE) indicate a 6.3 per cent vacancy rate for NHS consultant psychiatrist posts, and over 18 per cent of core training posts in psychiatry are currently vacant. Psychiatry has the slowest rate of growth and the highest drop-out rate of any clinical specialty.

Between 2013/14 and 2014/15, referral rates increased five times faster than the Child and Adolescent Mental Health Services (CAMHS) workforce. Some areas report one in ten appointments cancelled because of staff shortages, specialist CAMHS run by junior staff who lack the requisite skills and too few therapists with the necessary training.

According to the King's Fund report 'Under Pressure' almost half of community mental health teams surveyed had staffing levels judged to be less than adequate in 2013/14 and many more were unable to provide a full multi-disciplinary team. Demand for temporary mental health nursing staff has risen by two thirds since the beginning of 2013/14. Staff shortages have contributed to deaths on inpatient wards, according to the 2015 National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, and they have also been blamed for the rise in detentions.

Mind reported that in 2011/12, there were almost 1,000 incidents of physical injury following restraint in mental health services, with considerable variation between trusts. According to NHS Benchmarking, use of restraint has increased this year.

Workforce planning for mental health across the entire care pathway has not been developed and as a result opportunities are being missed to identify how changes in skill mix could help improve delivery, retain staff and tackle the highest vacancy rates.

A chink of light has appeared in the past year: there have been small increases in staffing on adult and older people's inpatient wards, driven by the safer

staffing initiative and new initiatives to increase social workers in mental health. However, bed occupancy rates have also risen.

In 2015, a five year plan began, led by NHS England and HEE, to set staffing levels to deliver high quality care under the existing standards programme. For example, to meet the access standard for Early Intervention in Psychosis, this has identified what staffing needs are required including psychologists, therapists, care co-ordinators, vocational workers and psychiatrists. Further work is needed by NHS England and HEE to expand this programme to put into action the full range of pathways and standards described in Chapter Two.

Staffing is not just a question of numbers. The resilience and wellbeing of staff is also critical. Morale varies widely across the system today, linked with pressure of work and level of training, according to the Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists. Yet the Royal College of Physicians found fewer than half of NHS trusts had a plan in place to promote staff wellbeing.

It goes without saying that people seeking NHS care need to be treated with compassion. But what is sometimes forgotten is that staff do too. The care they receive impacts on the care they are able to deliver. Ten million working days are lost each year to sickness absence in the NHS. Some 43 per cent of mental health staff cite work related stress as the cause, second only to ambulance trusts at 51 per cent. Findings from the British Psychological Society and New Savoy staff wellbeing survey for 2015 show that around half of psychological professionals surveyed report depression. Seventy per cent say they are finding their job stressful. Yet the quality of the NHS occupational health service is inconsistent and, in some cases, inadequate, according to the NHS Health and Wellbeing Review.

Despite the pressures, we heard many positive and inspiring stories about the quality of care provided by NHS staff for people with mental health problems. We also heard that some have poor attitudes to mental health. The CQC report ‘Right here, Right now’ found less than four in ten people (out of 316 surveyed) accessing A&E felt listened to, taken seriously and treated with warmth and compassion. Among those in touch with specialist mental health crisis services the response was only slightly more positive with half (of 748 surveyed) saying they were well treated. GPs, ambulance staff and the police were perceived as more caring and voluntary organisations as being the most caring of all.

Race discrimination is still perceived by some as a problem according to the CQC. The introduction of the NHS Workforce Race Equality Standard is welcome and must be monitored closely.

Primary care staff are not yet fully equipped to provide high quality mental health care. More than four out of five practice nurses have responsibilities for which they have not been trained, with 42 per cent having no training at all in mental health, according to the Royal College of GPs. The training of GPs could also be improved to ensure they are fully supported to lead the delivery of multi-disciplinary mental health support in primary care.

Drugs for mental health problems can have serious side effects, such as causing rapid weight gain, but standards in the prescribing of anti-psychotics and other medications are not consistently adhered to, according to the Prescribing Observatory for Mental Health.

Shared decision-making between the person being supported and their practitioner is known to improve the quality of care by increasing active involvement, self-management and confidence. Yet less than half (42 per cent) of people using community mental health services “definitely” have a care plan and only just over half (56 per cent) said they were “definitely” involved as much as they wanted to be. New models are appearing. In secure care services, an approach to collaborative planning has been developed called My Shared Pathway which should be robustly evaluated.

Carers have a unique role to play for some people with mental health problems, and are often responsible for navigating complex health and social care systems and providing support to help the person manage. This includes the children of parents with mental health problems, who are likely to provide a caring role. Mental health practitioners should have the knowledge and skill to involve carers appropriately, including working with the person using the service and carers to determine what information can be shared between the three parties.

Peer support is highly valued, especially by young people and BAME adults, and should be developed as a core part of the multi-disciplinary team.

4.2 THE WORKFORCE IN THE FUTURE - MENTAL HEALTH AS THE PROFESSION OF CHOICE

As public interest and awareness of mental health increases and stigma diminishes, many more people are considering a career in mental health. The Think Ahead programme, a “Teach First” approach for social workers in mental health, has had in excess of 2,000 applicants for its first 100 places. There is the potential to put in place an approach that encourages more young people to choose a career in mental health, and more peer support.

The right workforce with the right skills is the single most important component of good care. All frontline staff, including those in the criminal justice system, should have basic skills to provide mental health care. Urgent work to jointly develop robust health and social care workforce planning for mental health must start now to:

- identify and fill workforce gaps
- provide the right training and support
- involve carers, as appropriate
- provide annual projections for staff numbers and costs.

The ‘Public mental health leadership and workforce development framework’ has been published by Public Health England. It should be implemented in full. Staff should be trained to prevent ill health, working across traditional boundaries, in line with its recommendations. The need for access to effective social work as part of good quality mental health care should also be recognised through the routine inclusion of social workers in NHS commissioner and provider workforce planning.

Mental health staff should be trained to treat people with sensitivity, in the least restrictive way possible, prescribing in line with standards and using restraint only in exceptional circumstances. There should be a greater focus on mental health awareness for all front-line staff. This will involve cultural change and require strong leadership.

Staff should work in partnership with the people using services to develop plans based on the personal goals of the individual. Peer support should be offered from people who have had similar experiences and carers should be given help to play an appropriate role. Restraint will be used only as a last resort.

By 2020/21, measures to improve staff morale and wellbeing will be in place, backed by good data, and people with mental health problems will experience an improvement in staff attitudes. Training will have been strengthened and new models of care expanded. Most care should be provided in community and primary care settings.

Protecting the mental health of the workforce is also vital. NHS England has committed to helping staff make choices to improve their own health, and mental health is a key part of that. This should apply across the NHS – building on positive initiatives within ambulance trusts. Every NHS trust should become an ‘enabling’ environment, as recommended in the Francis Report, so people want to work there. Trusts should monitor the mental health of their staff and provide effective occupational health services.

Recommendation 32: HEE should work with NHS England, PHE, the Local Government Association and local authorities, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This must report by no later than 2016.

Recommendation 33: NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

Recommendation 34: NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.

Recommendation 35: NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.

Recommendation 36: The Department of Health and NHS England should work with the Royal College of GPs and HEE to ensure that by 2020 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.

Recommendation 37: The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding ‘Think Ahead’ to provide at least an additional 300 places.

Recommendation 38: By April 2017, HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, and take into account people’s personal preferences, including preventative physical health support and the provision of accessible information to support informed decision-making.

CHAPTER FIVE:

A TRANSPARENCY AND DATA REVOLUTION

The Taskforce heard from a range of stakeholder organisations that data and transparency are critical aspects of a system that delivers good outcomes. Work needs to happen to link data from different public services and agencies (the NHS, social care, education, criminal justice and others) to help identify and meet the full needs of people with mental health problems. Similarly, there should be more national support with the analysis and presentation of raw data to support good commissioning and local planning.

Organisations representing different communities emphasised the importance of equalities monitoring by providers for greater transparency about access, quality and outcomes for various groups. This should help ensure that the provisions of the Human Rights Act and the Equalities Act 2010 are being met. Several organisations also stated that there needs to be greater transparency in how resources are allocated to mental health across NHS settings, the quality of services provided and to what extent they are improving outcomes.

5.1 A "BLACK HOLE" OF DATA

Understanding how quickly people are able to access services, what sort of care they are receiving and what outcomes they are experiencing is vital to good care. Consistent and reliable data in mental health, however still lags behind other areas of health. There is good information available, but it is not co-ordinated or analysed usefully.

National data are collected through the Mental Health Services Data Set (MHSDS) by the Health and Social Care Information Centre (HSCIC) on behalf of the Department of Health. The MHSDS began operating on 1 February 2016 and its reporting capability is yet to be tested.

Prior to that point data reporting has been sporadic and the HSCIC has warned it will not be able to meet reporting needs quickly now the MHSDS is operational. Changes to the dataset can take more than 12 months which will limit the immediate usefulness of the MHSDS. For adults, data is also grouped together under 'clusters' which can inform how services are paid for but do not align with diagnosis or NICE guidelines so it not clear whether people are getting recommended interventions. The 'cluster' currency provides an indication of individual need and has demonstrated the ability of services to report high quality data (the cluster currency has been mandatory for providers since 2012). However, this approach still does not provide the right kinds of incentives i.e. across pathways of care or to promote good outcomes. It may even encourage perverse incentives, such as paying more where people move into crisis or become acutely unwell.

Some datasets are better quality than others – for example the national data on access to psychological therapies for common mental health problems are robust. Collection of data on children and young people has been subject to delays and the data itself lacks clarity. We also do not have ready access to local and national equalities data, showing us breakdowns in access and outcomes across groups protected by the Equality Act 2010.

The National Mental Health Intelligence Network (NMHIN), run by PHE, with support from NHS England and the Department of Health, presents data to help improve commissioning and service provision. In some areas, it is well developed, providing details on levels of access, spending and social care. But it lacks the analytical capacity of other health data networks. PHE publishes additional resources for children and young people on the Chimat website although it also lacks analytic power.

Financial reporting is an important indicator for scrutinising commissioning and provision. Yet it is not consistently available in mental health. Provider level data is also linked to care 'clusters' and reference costs for the clusters vary hugely across the country, partly due to lack of consistency in their use and partly to variations in the services provided. Clusters describe the needs that people present with but do not clearly align with the care that NICE recommends, making it difficult to establish the true funding picture. While CCG programme budgets for physical health are broken down by disease, there is only one category for mental health. Local information on investment in care, by condition, is therefore essential.

An important barrier to good care is the lack of appropriate data sharing to enable organisations to identify co-morbidities, anticipate problems and plan care in a holistic fashion. People with poor mental health may require primary care, secondary physical care and social care, as well as mental health services, but the lack of linked datasets hinders effective provision.

The Summary Care Record (SCR) is an attempt to address this by including key primary care information about an individual such as medication, allergies and adverse reactions. But it does not routinely include care plan information or allow access to mental health care records (or physical care records) which is a significant missed opportunity.

Good data are also necessary to allow people to make an informed choice of service. However, the information on mental health on 'myNHS' is limited to CQC ratings and clinical audits. Waiting times for care and the range of interventions on offer would be more relevant to choosing a provider.

5.2 A TRANSPARENCY REVOLUTION

The inadequacy of good national mental health data and the failure to address this issue until recently has meant that decisions are taken and resources allocated without good information, perpetuating a lack of parity between physical and mental health care.

This lack of transparency has also had a negative impact on confidence in mental health services - we heard that many people felt that additional resources didn't reach the front line. Data about outcomes and acceptable levels of variation are unclear, but we are encouraged by the work of the NHS Benchmarking Network.

In the future, the quality of mental health services and how well they are meeting the needs of the local population will be demonstrated through the provision of accurate, relevant, timely data which will be collected routinely for each person with mental health problems receiving care.

National datasets will include information on diagnosis, interventions and outcomes and be appropriately linked with other datasets, such as for physical health and social care. The Department of Health, NHS England and PHE will lead the transformation in mental health information, with changes to HSCIC data collection backed by new funding.

The NMHIN and Chimat will provide comprehensive data resources to inform good quality commissioning and allow services to be benchmarked against each other, highlighting best practice and ensuring resources can be targeted where they have most impact. Commissioners will be able to assess prevalence, predict incidence and plan provision and identify individuals repeatedly admitted to inpatient care in order to target them for preventive interventions.

Budget reporting will be aligned to specific mental health conditions, increasing transparency. Everyone will be able to assess the responsiveness of services to local population needs, including the needs of marginalised groups covered by equalities legislation.

People using mental health services will be able to make informed choices about their care and how their data is used. Care will be increasingly personalised and measures will capture how well it is helping them achieve their goals. Individuals will be able to rate services, holding commissioners and providers to account.

5.3 PUTTING IN PLACE DATA PLANS

Providing high quality mental health care requires the collection of the right kind of mental health data, at the right time. The National Information Board has been charged with delivering this ambition. Their task now should be a national stock take of mental health data to ensure it includes the most meaningful measures, which align with national priorities, and that collecting it does not place undue pressures on clinicians and service managers. Clinical system suppliers, mental health commissioners, providers and experts-by-experience should be involved.

The transition to the MHSDS provides an opportunity to reconsider which data should be collected and reported. The HSCIC should develop a package of support to solve problems related to getting, using or sharing data.

More work is needed to ensure data can be linked across public agencies, to promote integration of care and generate insight into where people are accessing different parts of the system and, ultimately, what their needs, preferences and outcomes are.

PHE should work with other national agencies to develop the NMHIN as the trusted national repository of robust and publicly available mental health data and intelligence over the next 5 years.

A review of national clinical audits and how they supplement mandated datasets should be carried out, including the Prescribing Observatory for Mental Health UK, the National Audit of Schizophrenia and NHS Benchmarking club data. ‘Future in Mind’ also identified significant gaps in data on children and young people’s mental health and these must be addressed.

Recommendation 39: The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to address the need for substantially improved data on prevalence and incidence, access, quality, outcomes, prevention and spend across mental health services. They should also publish a summary progress report by the end of 2016 setting out how the specific

actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.

Recommendation 40: The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Recommendation 41: The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health Five Year Forward View Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include employment and settled housing outcomes for people with mental health problems.

Recommendation 42: NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary.

Recommendation 43: During 2016 NHS England and PHE should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.

Recommendation 44: By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.

Recommendation 45: The Department of Health and HSCIC should advocate the adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Recommendation 46: The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every seven years.

CHAPTER SIX:

INCENTIVES, LEVERS AND PAYMENT

The Taskforce heard from a number of stakeholder organisations that the way services are contracted and paid for affects the quality of care people receive across settings. This includes a lack of transparency and accountability associated with the use of 'block contracts' which do not specify how many people will be supported by the service or the quality of care they should receive. The Taskforce also heard that the way services are currently paid for can prevent them from being integrated e.g. acute physical health services are not paid to include mental health support, even though this is good practice. Organisations said that the development of more effective payment models is heavily dependent on robust data about the quality of services.

6.1 THE CURRENT APPROACH TO AN UNEVEN PLAYING FIELD

Mental health services have been plagued by years of under investment. More than half of mental health trusts are paid using block contracts providing a fixed amount unrelated to how local needs are being met or the quality of care provided. This rewards those that deliver low cost interventions, regardless of outcome, and penalises those that increase access or deliver more costly interventions, even though they may improve outcomes. This payment method also affects the development of personalisation in mental health care, since without more detailed information about individuals receiving care, the costs of that care, or clear care pathways, it is difficult for funding to be released through Personal Health Budgets or integrated with social care funding to support Integrated Personal Commissioning (combined personal budgets).

Some areas are moving away from block contracts but mental health is being left behind and thus lacks the financial levers to drive change. National guidelines to reward quality and outcomes are being poorly implemented at local level. There is also a risk that new models of care will make greater use of block contracts, which is not currently appropriate for payment of mental health interventions where there is little transparency around quality and outcomes.

However, new payment approaches are being developed. Care clusters, mandated since 2012, which aim to describe a group of people with similar mental health needs, are being used by a number of providers as the basis for payment. They have been criticised for not easily mapping to diagnoses, missing the complexity of some populations and failing to incentivise outcomes but they have provided an indication of need. Very few providers have moved to contracts that reward quality and outcomes.

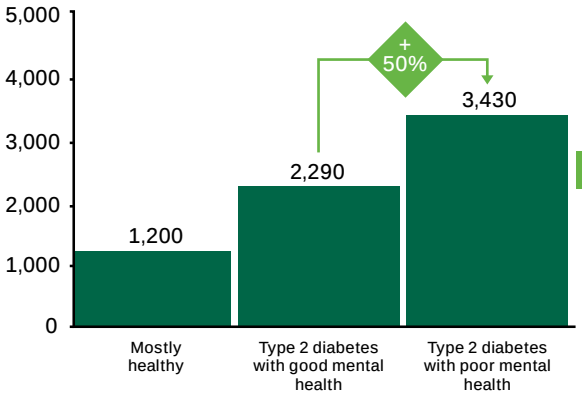
Two new payment models are proposed for adult care in 2016/17 (for 2017/18). One is based on the year of care or episode of care appropriate to each of the mental health care clusters. The second is a capitation-based payment tied to care clusters or similar data. Both link payment in part to quality and outcome measures. NHS Improvement and NHS England are asking commissioners and providers to adopt one of the two approaches.

Several of the vanguard sites are adopting the capitation model but are using historic spending to set annual budgets. This risks reinforcing previous underinvestment. Some CCGs are developing local outcomes-based contracts. This is also encouraging but without a national approach, opportunities to share evidence about which models deliver the best outcomes may be lost.

Presence of poor mental health drives a further 50% increase in costs

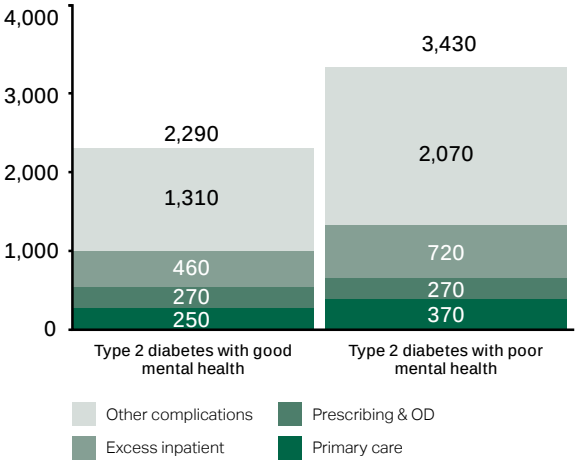
Physical healthcare costs 50% higher for type 2 diabetics with poor mental health

Annual physical healthcare costs per patient, 2014/15 (£)



Additional costs due to increased hospital admissions and complications

Annual physical healthcare costs per patient, 2014/15 (£)



Presence of poor mental health responsible for £1.8bn of spend on type 2 diabetes pathway

Note: Does not include spend on prescribing psychiatric drugs and other mental health services
Source: Hex et all, 2012; APHO Diabetes Prevalence Model for England 2012; Long-term conditions and mental health: The cost of co-morbidities, The King's Fund

Better integration with physical health is vital but payment models do not incentivise this. For example, payments for diabetes and cancer care do not routinely cover psychological interventions and payments for mental health care do not ensure physical health needs are met as standard.

There is one national CQUIN that rewards mental health providers for ensuring that the physical health needs of people with psychosis are met. This supports working relationships between specialist mental health providers and primary care which can avoid relapses and crises. Introduction of the CQUIN has seen physical care monitoring rise by a third, but performance is still well below target.

6.2 A FUTURE APPROACH TO A LEVEL PLAYING FIELD

In future, payments should incentivise swift access, high quality care and good outcomes, while deterring cherry picking of people who seem 'easiest-to-treat'. Payment models should include a range of capitated or population-based approaches. Wider levers include the NHS standard contract, CQUINs, quality premiums, sanctions and regulation, which should be used to encourage good performance. A full set of principles underpinning what the new approach to payment in mental health should look like is annexed.

Payments should incentivise provision of integrated mental and physical healthcare and be adjusted to account for inequalities. Funding decisions should be transparent and public, including those of the independent Advisory Committee for Resource Allocation (ACRA) for the NHS.

NHS England and NHS Improvement will need to provide robust support to providers and commissioners to introduce new payment approaches for adult mental health based on either capitated or episodic/year-of-care payment models and which reward improved outcomes, quality and access. Where progress is not being made, regulation, assurance and enforcement may be necessary. Similar changes are needed for children and young peoples' services and psychological therapy services, and to incentivise the provision of mental health care to people with physical health problems.

Physical health providers will need to be reimbursed for meeting mental health needs which may require re-classification of patient care described by Healthcare Resource Groups (HRGs), Treatment Function Codes (TFCs) and Office of Population Censuses and Surveys Classification of Surgical Operations and Procedures (OPCS) codes.

A new CQUIN to improve the recognition and treatment of depression in older people should be introduced, modelled on the dementia CQUIN. Since its introduction, the dementia CQUIN has raised the profile of the disease in

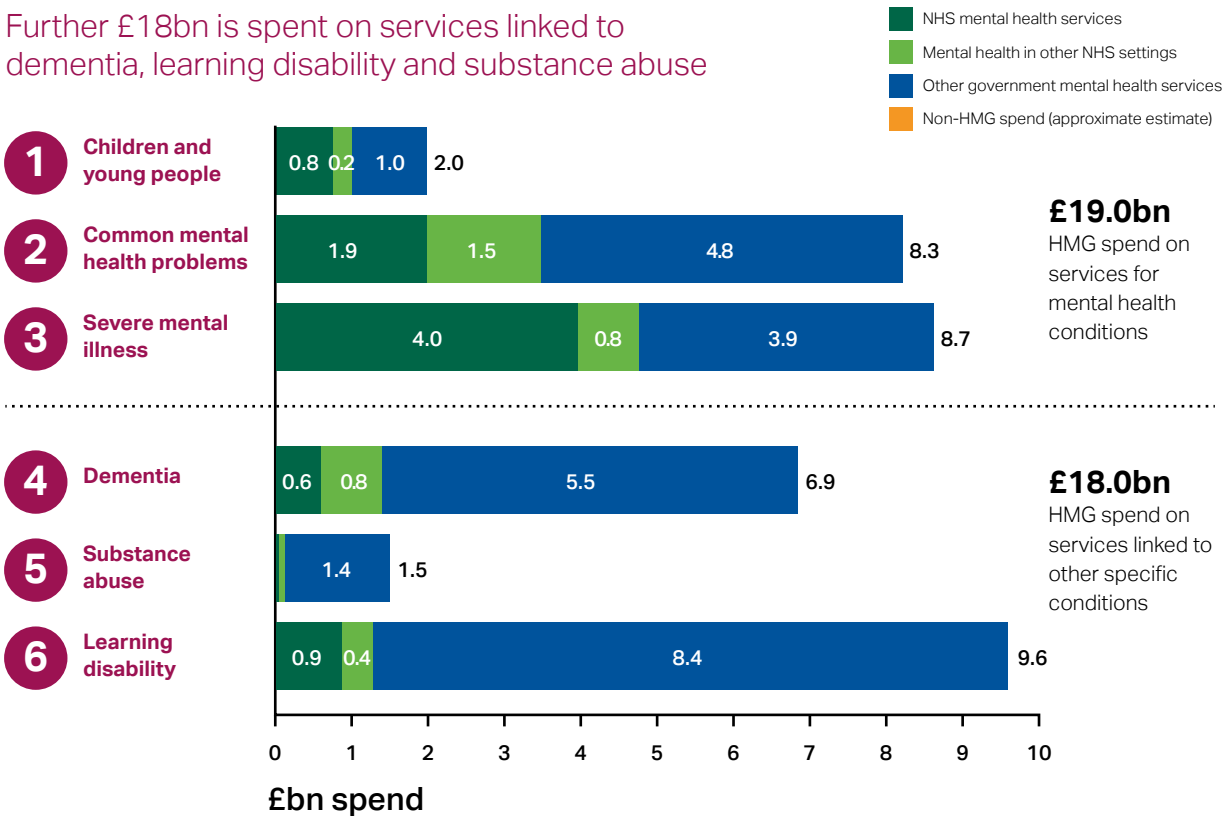
general acute hospitals, and is now finding 90 per cent of people with possible dementia.

NHS funding formulae must be reviewed by ACRA to ensure they support parity between mental and physical health. They should also be reviewed to ensure it correctly estimate the prevalence and incidence of conditions across the mental health spectrum.

In respect of the annual inequalities adjustment given to CCGs for people with the poorest access and outcomes in health, CCGs should also report how their spending is related to need, access and outcomes for mental health. Mental health funding should be allocated to individual conditions in the same way as physical health funding to make it easier to track. Good quality data will be needed to determine whether care is cost-effective and whether new approaches are more appropriate than existing ones.

£19bn is spent on services for mental health conditions

Further £18bn is spent on services linked to dementia, learning disability and substance abuse



Note: Dementia healthcare expenditure only includes spend on mental health services for dementia, not on physical health co-morbidities (e.g. diabetes), which would increase spend by £3bn

Recommendation 47: NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.

Recommendation 48: NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and primary care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and inequalities in access and outcomes.

Recommendation 49: ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

Recommendation 50: The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for children and Adolescent Mental Health Services, from 2017/8 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase.

CHAPTER SEVEN:

FAIR REGULATION AND INSPECTION

Every person with a mental health problem should be able to say:
I feel safe. My strengths, skills and talents are recognised and valued. I am treated as a person, not just according to my behaviour. My personal goals are recognised by support services. I choose who to consider the people 'close to me', who can support me in achieving mental wellbeing. I am able to see or talk to friends, family, carers or other people who I say are 'close to me' at any time. I can determine different levels of information sharing about me. I am confident that if I need care or treatment, timely arrangements are made to look after any people or animals that depend on me. I feel confident that my human rights are respected, protected and progressively realised in all systems of regulation and inspection.

If I raise complaints or concerns about a service these are taken seriously and acted upon, and I am told what has happened in response. If I do not have capacity to make decisions about my care and treatment, any advance statements or decisions I have made will be respected. I am supported to develop a plan for how I wish to be treated if I experience a crisis in future. As far as possible, people who see me in a crisis follow my wishes and any plan I have previously agreed. When I need medicines, their potential effects – including how they may react with each other – are assessed and explained.

7.1 THE SYSTEM TODAY: HIGH LEVELS OF SCRUTINY PAINTING A MIXED PICTURE OF EXPERIENCE

Many stakeholders believe that the legislative and regulation framework underpinning mental health care can be improved.

The Mental Health Act 1983 provides a legal framework for the detention of individuals with mental health problems in order to be assessed and treated (including with medication) for mental illness without regard to their mental capacity or their ability to give or withhold consent. This applies if they have

a mental illness which requires assessment or care in a hospital and they are detained because they are assessed as posing a risk to themselves or others.

The Mental Capacity Act 2005 makes no distinction between the mental and physical with regard to decisions about care. But the 2005 Act's provisions about having the mental capacity to consent to care can be over-ridden in the case of mental health care by the 1983 Act. We heard that this can act as a barrier to making parity of esteem a reality because it enshrines differences in the treatment of people with mental and physical health problems and frames care as a method of social control rather than a therapeutic intervention. The 1983 Act should therefore be reviewed as part of the continuing drive for greater parity with physical healthcare.

Commissioners, providers and the CQC should ensure that the full range of people's human rights are protected at a time when their capacity, autonomy, choice and control may be compromised. This is reinforced by the Care Act 2014. However, the number of people detained and the number subject to restrictive Community Treatment Orders (CTOs) requiring them to adhere to particular interventions, including medication, continue to increase. The use of CTOs is much higher than anticipated when they were introduced in 2008, yet findings from a recent Oxford University study show they are not effective for the majority of people.

The Health and Social Care Act 2012, as reflected in the NHS Constitution, provides rights to specialist care, including access to consultant-led treatment within 18 weeks of referral and a choice of provider. However, there is not yet parity between an individual's rights to physical and mental health care. Although the right to choice of provider has been extended to mental health there is no legal right to recommended interventions or maximum waiting times, as there is for physical health care.

The CQC has a robust approach to regulating the quality of NHS service provision. However, inspection of mental health support in primary and acute physical health care settings should be strengthened. We must also ensure psychological therapies are properly regulated.

The only detailed measure of people's experience of mental health care is through the CQC survey of community mental health services. But this is inadequate, as revealed by the CQC's special inquiry into crisis care which showed that people's experiences of mental health care across other settings were very mixed and should be tracked on a regular basis. There is also no measurement of people's experience of inpatient mental health care, including secure care, despite the nature of compulsory treatment and the potential vulnerability of those who are detained, in some cases for months or years.

The Taskforce heard that the experience for people who are marginalised needs to be improved, with particularly strong messages coming through from BAME groups. The Workforce Race Equality Standard is a welcome development in the NHS for those providing services. But there is no equivalent for those accessing them. The 5-year Delivering Race Equality programme concluded in 2010 that there had been no improvement in the experience of people from minority ethnic communities receiving mental health care. Data since shows little change. These inequalities must be prioritised for action, and we support the recommendations of The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists on this issue.

There were 198 deaths of people detained under the Mental Health Act in 2013/14, the majority of which were due to natural causes, including preventable physical ill health. Care providers must ensure that they take appropriate steps to prevent the avoidable deaths of people in inpatient care, including people of all ages who are deprived of liberty through detention under the Mental Health Act. However, unlike in prison or police detention, where every death is independently investigated, there is no independent pre-inquest process in place for investigating these deaths. Care organisations themselves carry out internal investigations. As highlighted by the recent findings within Southern Health NHS Foundation Trust, the quality of internal investigations can be poor and providers are not always able to demonstrate robustly how they have learned from them and made improvements.

There are no published death rates in individual units or by CCG area, no information on whether death has occurred in a public or privately run organisation, and no information on the number or nature of deaths that have occurred in specific settings. Patterns of deaths that merit closer examination may thus escape public scrutiny. In particular, there are questions about the over-representation of black people in mental health settings and the use of force that features in some of their deaths. There is also very limited information available nationally on the number of children who have died in mental health settings.

Measurement of wider social outcomes – such as finding a job and accommodation – is also a marker of the quality of services and varies across organisations. Yet these outcomes can be more meaningful than strictly clinical outcomes such as being “symptom free”.

THE SYSTEM IN THE FUTURE

The full range of regulatory levers will be used to address inequalities and improve the quality and experience of people receiving mental health care. The right to equal treatment in the least restrictive setting will be clearly enshrined

in legislation, and all providers will ensure they work in accordance with Human Rights legislation.

Strengthened inspection of mental health care by the CQC will be extended to all NHS-funded providers, including primary and acute physical health care. Measures of quality will show how services compare and specialist mental health services, including inpatient care, will include self-reported outcomes. Racial and other inequalities in rates of detention will be addressed and there will be greater transparency in the causes of deaths and how they can be prevented.

SYSTEM REFORMS BY 2020/21

It is essential that people's human rights to receive care in the least restrictive setting, to give or withhold consent, to use advance decisions and to maintain family life are respected and that inspections assess the extent to which these rights are supported. Individuals deprived of their liberty under the Mental Health Act should be offered information, advocacy and support. In the light of rising rates of detention and the high and potentially inappropriate use of CTOs, highlighted by research published by Oxford University in 2013, there is a strong case for considering whether the current legislative framework strikes the right balance between risk and consent. This should include consideration of how mental capacity legislation should be applied in the use of the Mental Health Act to detain a person for compulsory treatment. This is a fundamental aspect of ensuring parity between mental and physical health.

The whole NHS plays a role in preventing mental health problems and caring for people who suffer them. The inspection system should be updated to ensure it covers all aspects of mental health provision in all settings, and all physical and mental health pathways of care.

For children and young people, we support the recommendation in 'Future in Mind' that the CQC should work with Ofsted to develop a joint, cross-inspectorate view of how health, education and social care services are working together to improve their mental health.

In July 2015, the Secretary of State for Health announced the creation of a new Healthcare Safety Investigation Branch (HSIB). The Branch will be established from April 2016 and will provide support and guidance to NHS organisations on investigations, as well as carrying out certain investigations itself. It will also conduct national investigations into safety incidents and act as an exemplar. It will focus on incidents that signal systemic or apparently intractable risks within the local health care system. The Department of Health should ensure that the scope of the HSIB includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 51: The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of a individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Recommendation 52: The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated, to access to care within maximum waiting times).

Recommendation 53: Within its strategy for 2016–2020, the CQC should set out how it will strengthen its approach to regulating and inspecting NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups.

Recommendation 54: The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless they are provided within secondary mental health services.

Recommendation 55: The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.

Recommendation 56: The Department of Health should ensure that the scope of the Healthcare Safety Investigation Branch includes deaths from all causes in inpatient mental health settings and that there is independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement.

Recommendation 57: NHS Improvement and NHS England, with support from PHE, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements, are learned from, to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.

CHAPTER EIGHT:

LEADERSHIP INSIDE THE NHS, ACROSS GOVERNMENT AND IN WIDER SOCIETY

We have recommended an ambitious but deliverable strategy for mental health to realise improvements in prevention, access, outcomes and experience, backed by a strong clinical and economic case for investment. Implementing it will require robust leadership.

We commissioned a review by the Centre for Mental Health which identified 12 key elements necessary for the successful implementation of our vision:

1. **Leadership**: Effective national and local leadership is vital.
2. **Focus**: Strategies with a clear narrative and a set of widely supported, prioritised action points are more likely to succeed.
3. **Funding**: Funding for change and the associated double running costs is particularly important.
4. **Incentives**: Effective mental health strategies have benefited from close alignment with the incentives used in mainstream health policy.
5. **Workforce**: The most important changes are often the least amenable to policy-making and depend on the motivation of staff.
6. **Scrutiny**: Visible accountability for achieving a strategy's goals is essential to sustain implementation.
7. **Public opinion**: Strategies that enjoy support from the public and professionals are more likely to be implemented well.
8. **Partnerships**: Mental health policy relies on organisations working together.
9. Implementation: Robust, stable and supportive implementation infrastructure is vital.
10. **Innovation**: Policy cannot stand still but needs to facilitate innovation.
11. **Management**: Good quality programme and project management is essential.
12. **Time**: Changing practice takes longer than policymakers think. Policies need time to be implemented effectively.

Building on this evidence, a robust governance framework should be put in place to implement a 5-year programme to transform mental health care in

England. This strategy should be refreshed in 2019/20 in the light of new data that will emerge.

The key elements should be:

- **Establishing NHS England as the lead ALB** with responsibility for overall delivery of the strategy, led by the appointment of a new Senior Responsible Officer.
- **Embedding co-production** within the design and delivery of the programme, through the involvement of those with experience of mental health services and the organisations that represent them. This should include creating an independent external advisory board to provide independent scrutiny and challenge to the programme.
- **Establishing a new cross-ALB programme board** as a single coherent governance structure for delivering the strategy at a senior operational level, including defining the best approaches for local delivery.
- **Appointing an equalities champion,** with a specific remit to tackle mental health inequalities across the health system and through cross-government action.
- **Ensuring the necessary level of resource** within the national team overseeing day-to-day implementation.

The Department of Health, Cabinet Office and NHS England should put in place clear mechanisms for ensuring that the cross-government recommendations made in this report are implemented in full, and support continued action to combat stigma and discrimination in our society.

The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health. This should be given full consideration as quickly as possible as part of the remit of the new equalities champion.

Without additional investment it will not be possible to implement this strategy and deliver much-needed improvements to people's lives, as well as savings to the public purse. Funding is required in priority areas to help put the essential building blocks in place to improve the system over the long-term and to increase access to proven interventions that improve outcomes and deliver a return. We have identified that a minimum of £1 billion should be available in 2020/21. There should be a clear message that there is an expectation that more people are able to access NICE-evidenced services and that levels of investment in mental health should reflect this, across primary care, acute and mental health systems. Expenditure on mental health should be fully transparent.

Our proposals for investment are primarily targeted at expanding access to evidence-based care and scaling up effective programmes of work, supported by system reforms that are already happening and where the NHS can expand workforce capacity relatively quickly.

However, the Taskforce recognises the reality that reinvesting in services, planning for and recruiting into workforces that in many cases have been depleted in recent years, and initiating the essential system reforms required to support service expansion and transformation (e.g. relating to data and financial incentives) takes time.

Our proposals therefore focus on consolidating and expanding programmes for children and young people, for perinatal care and for Early Intervention in Psychosis 2016/17, in parallel to laying the ground for wider investment across the full range of priorities for action from 2017/18 onwards.

Securing new investment and realising the associated savings will require commissioners and providers, nationally and locally, to demonstrate that they are delivering high quality care and value for money within their budgets. This means implementing evidence-based standards, supporting quality improvement, improving data on outcomes and spend, a strong commitment to transparency, and integrating services at every level to meet the needs of their population. The transformation programme for Improving Access to Psychological Therapies for Children and Young People is a good example of how this can work. To make best use of new investment and ensure savings will materialise on the ground NHS England must also begin work now with ALB partners and local areas to trial new models of implementation.

We know that the scale of unmet mental health need is significant – hundreds of thousands of people go untreated each year at a cost of billions of pounds to our society and the economy. This investment would, however, make a start in plugging that gap, building on £1.4 billion of new funding over five years for children and young people's and perinatal mental health last year, including additional funding for eating disorders.

Mental health must remain a priority in a challenging financial climate for the NHS in the next five years, which is why we have set out specific recommendations to ensure that there is proper transparency and accountability for how money is spent. At a minimum, from 2016/17 we expect CCGs to be able to demonstrate how they will increase investment in mental health services in line with their overall increase in allocation each year or in line with the growth in recurrent programme expenditure.

Recommendation 58: By no later than Summer 2016, NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners, and the appointment of a new equalities champion for mental health to drive change.

ANNEX A:

PRINCIPLES UNDERPINNING PAYMENT APPROACHES IN MENTAL HEALTH

1. There must be no more unaccountable block contracts for mental health.

2. Providers should never entirely be rewarded for providing a number of days of care within a particular setting, but instead be rewarded for delivering whole pathways of care with achievement of defined outcomes or meeting local population need, as appropriate.

3. Both national and local outcome measures should be used as part of the payment system, these should be co-produced and developed by all stakeholders with a leading role taken by people with lived experience of mental ill health (and their families).

4. Where integrated care is needed, payment should similarly be integrated. For example, for urgent and emergency mental health care, the payment approach should be embedded within the wider urgent and emergency care payment approach, and payment for mental health care within physical care pathways should be similarly integrated.

5. Payment approaches should include access standards, where these are developed, to drive achievement of improved access to timely, evidence-based care with routine outcome measurement.

6. Payment approaches should be developed with experts-by-experience, reward engagement and delivery of access to excellent care for particular groups, where this is appropriate. This may include BAME populations and people with co-morbidities, such as substance misuse or diabetes.

7. Outcomes should be holistic and reward collaborative working across the system (e.g. stable housing, employment, social and physical health outcomes).

8. Payment systems must promote transparency and increased provision of high quality, relevant data that can drive improvement.

9. Payment systems should support improved productivity, value, efficiency and reduced costs, where possible.

10. Payment systems should support pathways through services, rewarding and incentivising step down to lower-intensity settings and a focus on care in the least restrictive setting. They should aim to reduce avoidable crises, admission and detentions, while protecting against any misalignment of incentives that might give rise to cherry-picking or other risks that might impact negatively upon those people with mental health problems who are 'hardest to reach'.

11. National guidance should support commissioners to commission effectively using appropriate payment approaches.

12. Additional support should be provided to commissioners to build leadership, capacity and capability in commissioning services, including for the use of new payment approaches that will necessarily require new skills and competencies.

ANNEX B:

FULL RECOMMENDATIONS

Recommendations are listed by lead or joint lead agency for the NHS arms-length bodies

NHS ENGLAND	Future in Mind	NHS England should continue to work with HEE, PHE, Government and other key partners to resource and implement Future in Mind, building on the 2015/16 Local Transformation Plans and going further to drive system-wide transformation of the local offer to children and young people so that we secure measurable improvements in their mental health within the next four years. This must include helping at least 70,000 more children and young people each year to access high-quality mental health care when they need it by 2020/21. The CYP Local Transformation Plans should be refreshed and integrated into the forthcoming Sustainability and Transformation Plans (STPs), which cover all health and care in the local geography, and should include evidence about how local areas are ensuring a joined up approach that is consistent with the existing statutory framework for children and young people.
	Access standards and care pathways	By 2020/21, NHS England should complete work with ALB partners to develop and publish a clear and comprehensive set of care pathways, with accompanying quality standards and guidance, for the full range of mental health conditions based on the timetable set out in this report. These standards should incorporate relevant physical health care interventions and the principles of coproduced care planning, balancing clinical and non-clinical outcomes (such as improved wellbeing and employment). Implementation should be supported by: • Use of available levers and incentives to enable the delivery of the new standards, including the development of aligned payment models (NHS England and NHS Improvement) • Alignment of approaches to mental health provider regulation (NHS Improvement and CQC) • Comprehensive workforce development programmes to ensure that the right staff with the right skills are available to deliver care in line with NICE recommendations as the norm (HEE) • Ensuring that the relevant public health expertise informs the development of the new standards and that they are aligned with the new co-existing mental health and alcohol and/or drug misuse services guidance being developed for commissioners and providers of alcohol and/or drug misuse services. (PHE)

NHS ENGLAND	Perinatal mental healthcare	NHS England should invest to ensure that by 2020/21 at least 30,000 more women each year access evidence-based specialist mental health care during the perinatal period. This should include access to psychological therapies and the right range of specialist community or inpatient care so that comprehensive, high-quality services are in place across England.
	Psychological therapies for people with long term conditions	NHS England should invest to increase access to integrated evidence-based psychological therapies for an additional 600,000 adults with anxiety and depression each year by 2020/21 (resulting in at least 350,000 completing treatment), with a focus on people living with long-term physical health conditions and supporting people into employment. There must also be investment to increase access to psychological therapies for people with psychosis, bipolar disorder and personality disorder.
	Employment support	By 2020/21, NHS England and the Joint Unit for Work and Health should ensure that up to 29,000 more people per year living with mental health problems should be supported to find or stay in work through increasing access to psychological therapies for common mental health problems (see above) and doubling the reach of Individual Placement and Support (IPS). NHS England should seek to match this investment in IPS by exploring a Social Impact Bond or other social finance options.
	Early Intervention in Psychosis	NHS England should ensure that by April 2016 50 per cent of people experiencing a first episode of psychosis have access to a NICE–approved care package within two weeks of referral, rising to at least 60 per cent by 2020/21.
	Crisis services	By 2020/21, NHS England should expand Crisis Resolution and Home Treatment Teams (CRHTTs) across England to ensure that a 24/7 community-based mental health crisis response is available in all areas and that these teams are adequately resourced to offer intensive home treatment as an alternative to an acute inpatient admission. For children and young people, an equivalent model of care should be developed within this expansion programme.
	Acute liaison	By 2020/21 no acute hospital should be without all-age mental health liaison services in emergency departments and inpatient wards, and at least 50 per cent of acute hospitals should be meeting the ‘core 24’ service standard as a minimum.

NHS ENGLAND	Least restrictive acute care	In 2016, NHS England and relevant partners should set out how they will ensure that standards – co-produced with experts by experience, clinicians, housing and social care leads – are introduced for acute care services over the next five years. Integral to the standards should be the expectation that acute mental health care is provided in the least restrictive manner and as close to home as possible, with the practice of sending people out of area for acute inpatient care due to local acute bed pressures eliminated entirely by no later than 2020/21. Plans for introduction of the standards should form part of a full response to the Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, by no later than end 2016/17. NHS England and NHS Improvement should also ensure that use of the Mental Health Act is closely monitored at both local and national level, and rates of detention are reduced by 2020/21 through the provision of earlier intervention. Plans should include specific actions to substantially reduce Mental Health Act detentions and targeted work should be undertaken to reduce the current significant over-representation of BAME and any other disadvantaged groups in acute care.
	Secure care pathway	NHS England should lead a comprehensive programme of work to increase access to high quality care that prevents avoidable admissions and supports recovery and 'step down' for people of all ages who have severe mental health problems and significant risk or safety issues in the least restrictive setting, as close to home as possible. This should seek to address existing fragmented pathways in secure care, increase provision of community based services such as residential rehabilitation, supported housing and forensic or assertive outreach teams and identify new co-commissioning, funding and service models. This work should also tackle inequalities for groups shown to be over-represented in detentions and lengthy stays, and seek to ensure that out of area placements are substantially reduced. The programme should identify where and how efficiencies could be realised within the system and reinvested, and include recommendations on the wider reforms required to make this happen, including changes to legal processes. NHS England should also roll out the proven model of teams delivering community forensic CAMHS and complex need services nationally from 2016.
	Using and sharing data	By 2020/21, NHS England and NHS Improvement should work with the HSCIC and with Government to ensure rapid using and sharing of data with other agencies. The Department of Health should hold the HSCIC to account for its performance, and consult to set minimum service expectations for turning around new datasets or changes to existing datasets by no later than summer 2016.
	Vanguards	MCP, PACS, UEC vanguards and the Integrated Personalised Commissioning programme should be supported to ensure that the inclusion of payment for routine integrated care adequately reflects the mental health needs of people with long-term physical health conditions within new care model programmes. Vanguard sites should also provide greater access to personal budgets for people of all ages, including children and young people who have multiple and complex needs, to provide more choice and control over how and when they access different services.

NHS ENGLAND	Physical health outcomes in people with mental illness	NHS England should undertake work to define a quantified national reduction in premature mortality among people with severe mental illness, and an operational plan to begin achieving it from 2017/18. NHS England should also lead work to ensure that by 2020/21, 280,000 more people living with severe mental illness have their physical health needs met by increasing early detection and expanding access to evidence-based physical care assessment and intervention. This will involve developing, evaluating and implementing models of primary care whereby GPs and practice nurses take responsibility for delivering the full suite of physical care screenings, outreach, carer training and onward interventions or referrals, in line with NICE guidelines. This model should include outreach workers or carer training to support people to access primary care because many people with psychosis struggle to access services, and give GPs and practice nurses the training and time they need to deliver NICE-concordant screening and care.
	Older age specialist services	NHS England should ensure that people being supported in specialist older-age acute physical health services have access to liaison mental health teams – including expertise in psychiatry of older adults – as part of their package of care, incentivised through the introduction of a new national CQUIN or alternative incentive payments and embedded through the vanguard programmes.
	Trialling population based budgets	NHS England should ensure that by April 2017 population-based budgets are in place which give CCGs or other local partners the opportunity to collaboratively commission the majority of specialised services across the life course. In 2016/17 NHS England should also trial new models through a Vanguard programme that allow secondary providers of these services to manage care budgets for tertiary (specialised) mental health services to improve outcomes and reduce out of area placements. We recommend testing this at scale, with a particular focus on secure care commissioning, perinatal and specialised CAMHS services.
	Co-production evaluation	NHS England should work with NHS Improvement to run pilots to develop evidence based approaches to co-production in commissioning by April 2018.
	CCG inequalities – funding	NHS England should disaggregate the inequalities adjustment from the baseline funding allocation for CCGs and Primary Care, making the value of this adjustment more visible and requiring areas to publicly report on how they are addressing unmet mental health need and mental health inequalities.
	NHS staff mental health	NHS England should ensure current health and wellbeing support to NHS organisations extends to include good practice in the management of mental health in the workplace, and provision of occupational mental health expertise and effective workplace interventions from 2016 onwards.

NHS ENGLAND	Navigators	NHS England and NHS Improvement should encourage providers to ensure that 'navigators' are available to people who need specialist care from diagnosis onwards, to guide them through options for their care and ensure they receive appropriate information and support. In parallel, NHS England and HEE should work with voluntary and community sector organisations, experts-by-experience and carers to develop and evaluate the role of 'navigators' in enabling more people-centred care to be provided.
	Trialling acute care models or 16-25s	NHS England should work with CCGs, local authorities and other partners to develop and trial a new model of acute inpatient care for young adults aged 16–25 in 2016, working with Vanguard sites. This should evaluate: developmentally and age-appropriate inpatient services for this group; supporting young people in an environment that maximises opportunities for rehabilitation and return to education, training or employment; viewing the young person within their social context; and enlisting the support of families or carers. This should build on the existing trials of new models of 'transitional' services for those aged 0–25.
	NHS staff awareness	NHS England should develop and introduce measures of staff awareness and confidence in dealing with mental health into annual NHS staff surveys across all settings.
	Staff health & wellbeing	NHS England should introduce a CQUIN or alternative incentive payment relating to NHS staff health and wellbeing under the NHS Standard Contract by 2017.
	Data stocktake	NHS England and the HSCIC should work to identify unnecessary data collection requirements, and then engage with NHS Improvement to prioritise persistent non-compliance in data collection and submission to the MHSDS, and take regulatory action where necessary. For the most important data items (including inequalities data), commissioners should use NHS standard contract sanctions (financial penalty) for a data breach where there is persistent non-return of data. Commissioners should be required to use national data flows where they exist and not place undue pressure on providers by asking for local data that duplicates national data.
	Payment system	NHS England and NHS Improvement should together lead on costing, developing and introducing a revised payment system by 2017/18 to drive the whole system to improve outcomes that are of value to people with mental health problems and encourage local health economies to take action in line with the aims of this strategy. This approach should be put in place for children and young people's services as soon as possible.
	Governance	NHS England, the Department of Health and the Cabinet Office should confirm what governance arrangements will be put in place to support the delivery of this strategy. This should include arrangements for reporting publicly on how progress is being made against recommendations for the rest of government and wider system partners.

Public Health England	Mental Health Intelligence Network	During 2016 NHS England and Public Health England should set a clear plan to develop and support the Mental Health Intelligence Network over the next five years, so that it supports data linkage across public agencies, effective commissioning and the implementation of new clinical pathways and standards as they come online.
	Preventing poor physical health outcomes	Public Health England should prioritise ensuring that people with mental health problems who are at greater risk of poor physical health get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to 'stop smoking' services. As part of this, NHS England and PHE should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.
	Preventing mental ill health	PHE should develop a national Prevention Concordat programme that will support all Health and Wellbeing Boards (along with CCGs) to put in place updated JSNA and joint prevention plans that include mental health and comorbid alcohol and drug misuse, parenting programmes, and housing, by no later than 2017.
Care Quality Commission	Integrated regulation of CYP services	The CQC should work with Ofsted, Her Majesty's Inspectorate of Constabulary and Her Majesty's Inspectorate of Probation to undertake a Joint Targeted Area Inspection to assess how the health, education and social care systems are working together to improve children and young people's mental health outcomes.
	Quality inspection across settings	The CQC should develop regulation and inspection of NHS-funded services to include mental health as part of its planned approach to assessing the quality of care along pathways and in population groups, beyond the inspection of providers. Within its strategy for 2016–2020, the CQC should also set out how it will strengthen its approach to: • How it inspects primary medical services, acute and adult social care services, so that it assesses whether these services are providing high-quality care for people with mental health problems • Inspect providers on the quality of co-production in individual care planning, carer involvement and in working in partnership with communities to develop and improve mental health services (drawing on good practice such as the 4PI principles) • Ensure that, from 2016, inspections of all specialist mental health services reflect the extent to which the provider ensures that people have an outcomes-focused recovery path that includes discharge and future planning and is integrated with other services, incorporating housing and other social needs · Ensure (with support from the Department of Health) that data captured about experience of inpatient mental health services is represented in a form which allows comparison and improvement monitoring at national level • Incorporates good practice in information sharing with other providers and with mental health carers, to address complex issues relating to how patient confidentiality rules apply in the care of people with mental health problems.

NHS Improvement	Learning from deaths by suicide	NHS Improvement and NHS England, with support from Public Health England, should identify what steps services should take to ensure that all deaths by suicide across NHS-funded mental health settings, including out-of-area placements are learned from to prevent repeat events. This should build on insights through learning from never events, serious incident investigations and human factors approaches. The CQC should then embed this information into its inspection regime.
Health Education England	Workforce planning and development across settings	HEE should work with NHS England, PHE, professional bodies, charities, experts-by-experience and others to develop a costed, multi-disciplinary workforce strategy for the future shape and skill mix of the workforce required to deliver both this strategy and the workforce recommendations set out in Future in Mind. This review should address training needs for both new and existing NHS-funded staff and should report by no later than the end of 2016. This workforce strategy should include: • Clear projections for required staff numbers to 2020/21 and what action will be taken to plug any gaps • Core training in basic mental health awareness and knowledge, understanding of mental health law, public mental health, compassion and communication skills • For professions involved in the care and support of people with mental health problems, tailored curricula with competencies in dealing with the common physical health problems people may present with, shared decision-making, mental health prevention (including suicide), empowering people to understand their own strengths and self-manage, carer involvement and information sharing. Drawing on the best available evidence, this should also ensure that professionals are equipped to provide age-appropriate care and reduce inequalities. HEE and PHE should develop an action plan so that by 2020/21 validated courses are available in mental health promotion and prevention for the public health workforce (including primary care).
	Prescribing standards	HEE should work with the Academy of Medical Royal Colleges to develop standards for all prescribing health professionals that include discussion of the risks and benefits of medication, take into account people's personal preferences, include preventative physical health support and the provision of accessible information to support informed decision-making. This should be completed in collaboration with relevant stakeholders by April 2017 and subject to regular review.

RECOMMENDATIONS FOR GOVERNMENT

Cabinet office	Co-morbid mental health and substance misuse problems	The Cabinet Office should ensure that the new Life Chances Fund of up to £30m for outcomes-based interventions to tackle alcoholism and drug addiction requires local areas to demonstrate how they will integrate assessment, care and support to people with co-morbid substance misuse and mental health problems, and make a funding contribution themselves. It should also be clear about the funding contribution required from local commissioners to pay for the outcomes that are being sought.
Department of Health	Research	The UK should aspire to be a world leader in the development and application of new mental health research. The Department of Health, working with all relevant parts of government, the NHS ALBs, research charities, independent experts, industry and experts-by-experience, should publish a report one year from now, setting out a 10-year strategy for mental health research. This should include a co-ordinated plan for strengthening and developing the research pipeline on identified priorities, and promoting implementation of research evidence.
	Equalities	The Department of Health should appoint a new equalities champion with a specific remit to tackle health inequalities amongst people with mental health problems and carers across the health and social care system and through cross-government action. This role should include responsibility for advising on operational activity within the NHS to reduce discrimination for people found to be at particular risk, including but not limited to those with characteristics protected by the Equalities Act. The Independent Commission on Acute Adult Psychiatric Care, established and supported by the Royal College of Psychiatrists, makes a recommendation that a Patients and Carers Race Equality Standard should be piloted in mental health and this should form part of the remit of the new role-holder.
	Suicide prevention	The Department of Health, PHE and NHS England should support all local areas to have multi-agency suicide prevention plans in place by 2017, contributing to a 10 per cent reduction in suicide nationally. These plans should set out targeted actions in line with the National Suicide Prevention Strategy and new evidence around suicide, and include a strong focus on primary care, alcohol and drug misuse. Each plan should demonstrate how areas will implement evidence-based preventative interventions that target high-risk locations and support high-risk groups (including young people who self-harm) within their population, drawing on localised real time data. Updates should be provided in the Department of Health's annual report on suicide.
	Mental Health Act	The Department of Health should work with a wide range of stakeholders to review whether the Mental Health Act (and relevant Code of Practice) in its current form should be revised in parts, to ensure stronger protection of people's autonomy, and greater scrutiny and protection where the views of individuals with mental capacity to make healthcare decisions may be overridden to enforce treatment against their will.

Department of Health	Social work	The Department of Health should continue to support the expansion of programmes that train people to qualify as social workers and contribute to ensuring the workforce is ready to provide high quality social work services in mental health. This should include expanding 'Think Ahead' to provide at least an additional 300 places.
	Supported housing	The Department of Health, Communities and Local Government, NHS England, HM-Treasury and other agencies should work with local authorities to build the evidence base for specialist housing support for vulnerable people with mental health problems and explore the case for using NHS land to make more supported housing available for this group.
	Health and Justice care pathway	The Ministry of Justice, Home Office, Department of Health, NHS England and PHE should work together to develop a complete health and justice pathway to deliver integrated health and justice interventions in the least restrictive setting, appropriate to the crime which has been committed. This should build on the national roll out of Liaison and Diversion schemes (including for children and young people) across England by 2020/21 and the increased uptake of Mental Health Treatment Requirements (diversion through court order to access community based treatment) as part of community sentences for everyone who can benefit from them. It should also improve mental health services in prison and the interface with the secure care system, with continuity of care on release, to support offenders to return to the community.
	Data improvement	The Department of Health, NHS England, PHE and the HSCIC should develop a 5-year plan to: address the need for substantially improved data on prevention, prevalence, access, quality, outcomes and spend across mental health services; set out responsibilities for each agency in providing the necessary legal, commissioning, and quality and safety information required; design and develop new datasets, linking physical health, mental health, social care and employment datasets, while ensuring that information governance adequately protects people's rights; include mental health measures in all physical care datasets, including emergency care. The HSCIC should act as a data system leader and set new minimum service expectations for turning around new datasets or changes to existing datasets. The Department of Health, NHS England, HSCIC and NHS Improvement should publish a summary progress report by the end of 2016 setting out how the specific actions on data, information sharing and digital capability identified in this report and the National Information Board's Strategy are being implemented.
	Children and Young People metrics	The Department of Health should develop national metrics to support improvements in children and young people's mental health outcomes, drawing on data sources from across the whole system, including NHS, public health, local authority children's services and education, to report with proposals by 2017.

Department of Health	Greater transparency	The Department of Health, HSCIC and MyNHS, working with NHS England, should improve transparency in data to promote choice, efficiency, access and quality in mental health care, ensuring that all NHS-commissioned mental health data are transparent (including where data quality is poor) to drive improvements in services. The CCG Performance and Assessment Framework should include a robust basket of indicators to provide a clear picture of the quality of commissioning for mental health. To complement this, NHS England should lead work on producing a Mental Health FYFV Dashboard by the summer of 2016 that identifies metrics for monitoring key performance and outcomes data that will allow us to hold national and local bodies to account for implementing this strategy. The Dashboard should include health and social outcomes including employment and settled housing outcomes for people with mental health problems.
	Prevalence surveys	The Department of Health should commission regular prevalence surveys for children, young people and adults of all ages that are updated not less than every 7 years.
	CCG transparency	The Department of Health and NHS England should require CCGs to publish data on levels of mental health spend in their Annual Report and Accounts, by condition and per capita, including for Children and Adolescent Mental Health Services, from 2017/18 onwards. They should require CCGs to report on investment in mental health to demonstrate the commitment that commissioners must continue to increase investment in mental health services each year at a level which at least matches their overall allocation increase. For children and young people, this should be broken down initially into spend in the community, on emergency, urgent and routine treatment, and for inpatient care.
	Parity for mental health in Health & Social Care Act regulations	The Department of Health should carry out a review of existing regulations of the Health and Social Care Act to identify disparities and gaps between provisions relating to physical and mental health services. This should include considering how to ensure that existing regulations extend rights equally to people experiencing mental health problems (e.g. to types of intervention that are mandated or to access care within maximum waiting times).
	Deaths in inpatient settings	The Department of Health should ensure that the scope of the new Healthcare Safety Investigation Branch includes a clear focus on deaths from all causes in inpatient mental health settings, including independent scrutiny of the quality of investigation, analysis of local and national trends, and evidence that learning is resulting in service improvement. This should include the involvement of families, and build on the models and experiences of the Independent Police Complaints Commission and the Prisons and Probation Ombudsman. The Department should also work with the CQC to establish a methodology for inspecting the quality of learning from all deaths in inpatient mental health services, including introducing greater transparency around the cause of deaths within each provider.

Department of Health	Challenging stigma	The Department of Health should work with PHE to continue to support proven behaviour change interventions, such as Time to Change, and to establish Mental Health Champions in each community, to contribute to improving attitudes to mental health by at least a further 5 per cent by 2020/21.
	Innovation fund for devolved areas	The Department of Health and the Department for Work and Pensions, working with NHS England and PHE, should identify how the £40 million innovation fund announced at the Spending Review and other investment streams should be used to support devolved areas to jointly commission more services that have been proven to improve mental health and employment outcomes, and test how the principles of these services could be applied to other population groups and new funding mechanisms (e.g. social finance).
	Digital	The Department of Health, through the National Information Board, should ensure there is sufficient investment in the necessary digital infrastructure to realise the priorities identified in this strategy. Each ALB should optimise the use of digital channels to communicate key messages and make services more readily available online, where appropriate, drawing on user insight. Building on trial findings, NHS England should expand work on NHS Choices to raise awareness and direct people to effective digital mental health products by integrating them into the website and promoting them through social marketing channels from 2016 onwards.
	New GPs	The Department of Health and NHS England should work with the RCGP and HEE to ensure that by 2020/21 all GPs, including the 5,000 joining the workforce by 2020/21, receive core mental health training, and to develop a new role of GPs with an extended Scope of Practice (GPwER) in Mental Health, with at least 700 in practice within 5 years.
	Regulation of psychological therapies	The Department of Health should consider how to introduce the regulation of psychological therapy services, which are not currently inspected unless provided within secondary mental health services.
	Better Care Fund	To drive and scale improvements in integration, the Department of Health and relevant partners should ensure that future updates to the Better Care Fund include mental health. This might include making an element of payment for outcomes contingent on reducing acute admission through requiring all hospitals to comply with Crisis Care Concordat and NICE standards on liaison and crisis mental health care.
	Summary Care Records	The Department of Health and HSCIC should advocate adoption of data-rich Summary Care Records that include vital mental health information, where individuals consent for information to be shared, by 2016/17.

Department for Work & Pensions	Employment support	The Department for Work and Pensions should ensure that when it tenders the Health and Work Programme it directs funds currently used to support people on Employment Support Allowance to commission evidence-based health-led interventions that are proven to deliver improved employment outcomes – as well as improved health outcomes – at a greater rate than under current Work Programme contracts. The Department of Work and Pensions should also invest to ensure that qualified employment advisers are fully integrated into expanded psychological therapies services.
	Housing Benefit cap	The Department of Work and Pensions should, based on the outcome of the "Supported Housing" review in relation to the proposed Housing Benefit cap to Local Housing Allowance levels, use the evidence to ensure the right levels of protection are in place for people with mental health problems who require specialist supported housing.
Department for Education / Department of Health / Department for Work and Pensions	Parenting programmes and support for children with complex needs	The Departments of Education and Health should establish an expert group to examine the needs of children who are particularly vulnerable to developing mental health problems and how their needs should best be met, including through the provision of personalised budgets. The Government should also review the best way to ensure that the significant expansion of parenting programmes announced by the Prime Minister builds on the strong-evidence base that already exists and is integrated with Local Transformation Plans for Children and Young People's mental health services.
HEFCE	Research	HEFCE should review funding requirements and criteria for decision-making to support parity through the Research Excellence Framework and take action to ensure that clinical academics in mental health (including in psychiatry and neuroscience) are not disadvantaged relative to other areas of health research, starting in 2016/17.
ACRA	Inequalities and funding allocation formula	ACRA should review NHS funding allocation formulas, including the inequalities adjustment, to ensure it supports parity between physical and mental health in 2016/17. They should also be reviewed to ensure they correctly estimate the prevalence and incidence of conditions across the mental health spectrum. Membership of ACRA should be revisited with the specific goal of ensuring that mental health expertise is adequately represented across the disciplines involved, e.g. clinical, academic, policy and providers.

The Mental Health Taskforce
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CHESHIRE EAST COUNCIL

REPORT TO: Health and Well-being Board

Date of Meeting:	31 May 2016
Report of:	Director of Adult Social Care and Independent Living
Subject/Title:	Mental Health Gateway
Portfolio Holder:	Councillor Janet Clowes

1.0 Current Position

1.1 Mental health services are currently provided jointly by the local authority and the Cheshire and Wirral Partnership (CWP) Trust.

1.2 The current route for referrals of people with mental ill health in the East of the Borough is via a Single Point of Access (SPA). This is made up of 3.5 (FTE) social workers and 3.75 (WTE) Community Psychiatric Nurses, with a Nurse Manager, supported by two administrative staff. This team screens referrals and makes decisions about urgency and will arrange an assessment of need. This assessment determines whether the individual meets the criteria for secondary care services (in a Recovery team) or would benefit from primary care services (in which case a referral is made to the GP or to the Psychological services (IAPT). Some residents are provided with a short term intervention by the SPA team, others are referred to the Recovery team and are likely to have significant needs and pose greater risks to themselves or others. Some residents will be referred to the primary care services as a result of mild mental health issues. People requiring assessment under the Mental Health Act are referred directly to the relevant social work team who arrange for an assessment by an Approved Mental Health Professional (AMHP).

1.3 Some of the current issues are:

- Lack of capacity in primary care interventions for people with milder mental health issues
- Delay in people accessing primary care services
- Timeliness of the assessment in the SPA
- Proportionality of the assessment undertaken by the SPA
- Duplication of assessments
- Multiple referral pathways

2.0 Key elements of a mental health service

2.1 The local authority requires the following key elements in a mental health service:

The service must be accessible to all adults over the age of 18 who are regarded by others or themselves as in need of assessment and support in relation to mental ill health.

A referral point to access a mental health social care assessment must be able to be accessed by any referrer who has concern for a person in need of mental health assessment. This will include self-referrals.

The service will have a range of health and social care professionals available to undertake assessments of individuals and their carers providing them with the appropriate service to best meet their needs in inclusive, flexible and diverse ways. People should be able to choose the support they want to achieve the outcomes they want.

The service will foster excellent partnership arrangements with a range of other professionals and organisations to promote a more socially inclusive style of service by using a range of community resources to appropriately meet the needs of those seeking help and to support them in their communities wherever possible.

Whilst adopting the approach of “No wrong door”, for those individuals who require or request an alternative service, the service seeks to assist people to access the appropriate level of support. There should be no barriers to people moving between levels of care to meet their needs.

Having regard to the requirements of the Care Act the service will need to focus on the well-being of individuals entering the service and seek to provide holistic and preventative services by linking with a range of key partners including all care sector provision, community and other council services.

The new national eligibility threshold for access to a personal care budget will be used to make a determination about eligibility for publically funded care and support where this is deemed appropriate.

There will be a clear pathway to secondary care services in the form of the integrated mental health teams who will deal with individuals with more complex and long term mental health problems. Such services will be recovery focussed.

In addition there will be a clear and fast track route to the AMHP service which will be available throughout the twenty-four hour period for those service users who require this level of assessment or for carers who request an assessment under the Mental Health Act 1983.

The service will be required to fulfil the statutory duties in responding to safeguarding concerns and must be in a position to uphold the principles and best practice of safeguarding and thereby ensure maximum protection for those individuals who use the service in line with Making Safeguarding Personal principles.

3.0 Proposed Gateway model

3.1 The Gateway model that has been developed by Cheshire and Wirral Partnership NHS Foundation Trust in response to health commissioners seeks to address the concerns about people with mental ill health accessing primary care services in a timely way. It provides a single point of referral into mental health services for adults living in the area of the Connecting Care integration programme (therefore including some services operated by Cheshire West). It is understood it will be used primarily (but not exclusively) by GPs as referrers. Having received a referral and undertaken a screening assessment, the service will offer one of the following:

- Signposting to an appropriate provider
- Provision of a brief intervention
- Referral to specialist services

3.2 The service comprises Community Psychiatric Nurses who will offer assessments, brief interventions, practical support and signposting to services for people with mild to moderate mental health problems. People with more severe mental health problems will be referred on to secondary care mental health teams for more in-depth assessment.

4.0 Issues and concerns about the Gateway model

4.1 The Council recognises and welcomes the significant additional capacity to provide primary care mental health interventions within the new service development and acknowledges that this is an attempt to provide a better service for this group of people and to streamline access into mental health services for General Practitioners in particular. However, the proposed Gateway model poses a fundamental problem for the Adult Social Care services in the Council:

The move from a multi-agency to a single agency approach to receiving and responding to referrals is a move away from integrated services and will not fulfil the statutory duties of the Local Authority at the point of referral.

4.2 The Local Authority cannot be confident that social care needs will be identified and responded to appropriately in this single agency approach using a medical model. There is a high level of risk that people's rights to an assessment under the Care Act 2014 may not be recognised and responded to appropriately by a health only staff team. There is no evidence of the criteria the team will apply to determine the need for social care assessment and intervention and there are serious concerns that this proposal does not take sufficient account of the local authority's responsibilities.

4.3 In addition, the development of the gateway means a move away from the SPA as the multi-agency referral point for all residents of Cheshire East and would require the authority to operate two different models for accessing mental health services. In the Caring Together integration programme, the intention is to move the resources currently in the SPA in to the community integrated teams.

5.0 Options appraisal

5.1 We have not been able to reach a consensus as a partnership about this proposed change and how it might be implemented in a way that addresses the health priority of residents accessing primary care services in a timely way and the Local Authority concern about moving from a multi-agency process for screening referrals to a single agency process.

5.2 There are a number of possible options which are summarised in appendix 1 with a brief description of the benefits and risks of each.

5.3 Options 1 and 2 are the local authority's preferred options and have been discussed with health colleagues but there is no agreement.

5.4 Options 5 and 6 would assert the role and significance of adult social care but would probably cause confusion and damage working relationships with health colleagues.

5.5 Option 4 does not provide a multidisciplinary approach to the screening of mental health referrals and therefore poses a significant risk that service users will not gain prompt access to the service they require.

5.6 Option 3 poses some significant practical issues, particularly in the timescale suggested for the introduction of the Gateway service, but it protects the key feature of a multi-agency approach to the screening of referrals and provides a safeguard that there will be a 'social care' view taken on referrals received. This is not the preferred option for the local authority as it may present Adult Social Care with significant risks. It is however being explored further with health colleagues to see if it is a viable option for both parties.

6.0 Conclusion

6.1 We have all invested considerable time and effort in seeking to resolve this issue in a way that addresses the aims and aspirations of all parties but have not been able to reach a successful conclusion. Partners'' perception of the risks of this service development are at significant variance and the anxieties of the local authority about the model are not shared by health colleagues.

6.2 The development of this service has taken some time and is a welcome development in many ways. It is absolutely understandable that, given the acknowledged capacity issues in primary care mental health services, health colleagues are keen to proceed with this service development. However, the move from a multi-agency to a single agency approach to the management of

referrals is a retrograde step and is not in keeping with the stated wishes across the health and social care system to develop more integrated working arrangements and is not in the spirit of partnership working.

6.3 We believe that the development of the proposed Gateway has a potentially significant impact on a large number of people. As such it constitutes a substantial development or variation (SDV) under the Health and Social Care Act 2012 (section 23 of the 2013 Regulations) and should have been referred to the Health Scrutiny function by the responsible person (in this case South Cheshire CCG).

7.0 Recommendation

7.1 As this service development is no longer a proposal but is in the process of being implemented, we are clearly well beyond the point at which this matter should have been referred to the Scrutiny Committee. Given the unresolved concerns of the Council and the fact that we believe that due process has not been followed, the Health and Well Being Board is invited to take a view on this issue. A delay in full implementation, if agreed, would allow time for a formal scrutiny meeting to review the proposals and for all options to be reconsidered.

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

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Appendix 1

Option	Benefits	Risks
1. Retain the current SPA team as is and have a referral pathway from the SPA to the Gateway service for people requiring primary mental health services.	This would support the SPA by providing access to increased capacity in primary mental health but would retain the multidisciplinary approach to screening/ triage.	Health colleagues have rejected this option as they feel that people with low level needs are 'over-assessed' and given the numbers of referrals to the SPA anticipated, this would become unmanageable, resulting in delays to people accessing primary care. The model would therefore not address the current concerns about people accessing primary care.
2. Merge the current SPA team and the Gateway resources and this revised service to deal with all mental health referrals.	This removes the additional step in the process introduced by the Gateway and adds significant capacity to primary mental health at the first point of contact. This option retains the multidisciplinary approach to screening/ triage.	Health colleagues have rejected this option as they feel that people with low level needs are 'over-assessed' and given the numbers of referrals to the SPA anticipated, this would become unmanageable, resulting in delays to people accessing primary care. The model would therefore not address the current concerns about people accessing primary care. There is no SPA in Cheshire west and this model is therefore not one that would work across the whole of the Connecting care programme.
3. Given the anticipated reduction in demand on the existing SPA by the introduction of the Gateway, move some of the current social worker resource from the SPA to the Gateway.	Would retain the multidisciplinary approach to first point of contact. Might be a step towards the disaggregation of resources into the integrated community teams. Could be used to strengthen referral pathways to the mental health reablement service.	Would need to be linked to an agreement about the screening processes to ensure social care needs identified and responded to appropriately. Social worker resource in SPA very small and may make social care capacity in both Gateway and SPA unviable. Would not fit easily with model developed across two local authorities. Would mean operating two different systems across Cheshire East.
4. Allow trial of Gateway model	Concerns could be tested in trial period.	Individuals may be delayed in accessing the (social

		care) services they need and consequently be at risk. Would require staffing resource for careful monitoring.
5. Separate referral pathway for 'social care' referrals	Clear route for referrers identifying social care issues.	Confusion for referrers resulting in delays for people to access services. Damage to working relationships with health colleagues. Loss of credibility with key stakeholders which may affect other 'integration' discussions. Likely that GPs will use Gateway service anyway with no 'controls' or monitoring in place.
6. Withdraw from integrated arrangements for mental health services with CWP; separate line management arrangements for Adult Social Care staff; separate referral pathway for social care referrals (see above)	Clear route for referrers identifying social care issues. ASC priorities addressed more effectively. ASC staff feel better supported.	See above. At time of greater integration, feels counter-intuitive. Management capacity within ASC?

Cheshire East Council

Health & Wellbeing Board

Date of Meeting: **31 May 2016**

Report of: **Sue Redmond (Interim Director of Adult Social Care)**

Subject/Title: **Better Care Fund 2016/17**

Portfolio Holder: **Cllr Janet Clowes (Adults and Integration)**
Cllr Paul Bates (Communities and Health)

1.1 The purpose of this briefing note is to provide Health & Wellbeing Board with an update on the plan for the Cheshire East Better Care Fund (BCF) in 2016/17.

1.2 On 27th April 2016, Cheshire East submitted the third of three BCF planning submissions, in the form of an Excel template and a Word narrative document. These are provided along with this paper.

1.3 At the time of submission, the only outstanding area of clarity was the need for finance colleagues across all the partners develop the final expenditure plan. Work has been underway since submission to rectify this, and at the time of writing a plan has been agreed by coleagues and awaits executive level agreement.

1.4 However, additional issues have arisen since submission that may cause further changes to be made to the expenditure plan. In particular the CCGs' intentions to potentially withdraw funding from carers' breaks. At the time of writing, a confirmed position regarding this is pending.

1.5 Formal feedback from NHS England is expected by the end of May 2016. This had not been received at the time of writing but the expectation, based on informal feedback, is that Cheshire East will be "approved with support". The implications of this being that additional work will be required on plans by the end of June to ensure they can be "fully approved". Failure to do this will result in escalation to national level. Initial feedback has been received through ADASS. Most Key Lines of Enquiry (KLOEs) were assured with some suggestions for improvement. These have been addressed in the attached drafts. No formal conditions are therefore expected to be attached to Cheshire East's BNCF plan for 2016/17. However, at the time of writing this was yet to be formally confirmed.

1.6 The areas requiring attention are likely to be the spending plan, the lack ofa DTOC plan for South Cheshire CCG and assurance that DTOC is a standing item on SRG agendas.

1.7 The total pooled budget submitted was £25,825,383, some way over the £24,236,470 minimum. This incorporates the additional areas of Cheshire Care Record, Mental Health Reablement, Carers and Community Equipment Scheme, as well as those in the 2015/16 BCF.

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

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(Copies of the embedded documents referred to in this document are available on request from the person listed at the foot of the agenda).

Cheshire East Health & Wellbeing Board BCF Plan 2016/17

Narrative Submission – 25TH April 2016

This document has been developed to meet the requirement for 2016/17 BCF plans to have a short jointly agreed narrative that includes details of how local partners, through the Health & Wellbeing Board (HWB), are addressing the national conditions. It is not a requirement to confirm, describe or demonstrate compliance with all KLOEs[1] (key lines of enquiry) within the documents. Instead plans should either include the information required to meet the KLOE or set out where this information is already available within existing strategies, plans or other documents. Referencing to these documents is encouraged rather than duplicating any narrative.

There is no national template for the narrative. Therefore, this document has been developed based on a regionally recommended template (developed by colleagues in St Helens), amended to meet local needs. The narrative is in tabular form with four columns:

- **Headings**
  This column details the BCF national conditions that need to be met
- **Supporting Evidence**
  This column details any supporting evidence as to how the area is meeting / plans to meet the national requirement through other strategies, initiatives, etc.
- **Narrative**
  This column details additional information required above and beyond that in the previous columns to either add context to the previous and/or demonstrate further evidence to meet the minimum required KLOEs

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Assurance of BCF 1617

This narrative has been signed off by the HWB through delegated authority to Cllr Rachel Bailey, who is Chair of the HWB and Leader of Cheshire East Council.

Headings		Supporting Evidence	Narrative[2]
1	**Local Vision for health and social care services**	• CE HWB BCF planning template for 15/16  6. BCF Cheshire East Part 1 28112014 revi • Connecting Care Model and Delivery Programme (please note this is the latest draft and future iterations will be produced)  Connecting Care Model - latest draft a: • Caring Together Local Delivery Plan  CARING TOGETHER Local Delivery Plan V6	The CE vision for health and social care services can be seen in our 2015/16 plan (p.4-5) and is based on evidence from the JSNA and JHWS as well as consultation with service users and the general public (p.5-17). The BCF plan for Cheshire East (CE) has been developed collectively across partners, and the final return has been signed off by the Health & Wellbeing Board (HWB) via delegated authority to the Chair of the Health & Wellbeing Board. The key drivers for implementing the FYFV and the move towards fully integrated health and social care services by 2020 in Cheshire East are via the pre-existing transformation programmes (Caring Together in Eastern Cheshire CCG and Connecting Care in South Cheshire CCG). These programmes work closely with health and social care providers to achieve the best outcomes for local people. This largely means shifting care from acute and reactive provision to home/community-level and proactive joined-up planned care. The impact is likely to eventually mean closure of some hospital wards, with a need for additional community-based health and social care staff. Self-care and self-management (via the empowerment of individuals, carers, families and communities) is also a key part of our model and vision. The STP for the area is at a Cheshire & Merseyside level with Transformation Programme (CCG) level sub-plans. The BCF supports transformation by providing a valuable vehicle across the HWB (local authority) footprint. During 15/16 our housing leads have been working more closely with social care leads to join-up service user pathways from

[2] Based on published KLOEs in March 2016 document "Approach to regional assurance of Better Care Fund plans"

Headings		Supporting Evidence	Narrative[2]
			universal access to low level support through to major home adaptations funded by DFG. We will continue and progress these new ways of working to improve services for local people. Our submission pools more than the minimum required amounts for 16/17, which demonstrates progress from 15/16 when only minimum mandatory amounts were pooled. This demonstrates an increasing commitment amongst partners to joint working and increasing levels of trusting meaningful working relationships.
2	**An evidence base supporting the case for change**	• CE HWB BCF planning template for 15/16 (p.18-28)	The case for change is still line with that submitted for 15/16. Key developments that add to the case are the emerging recent decreases in DTOC and falls in the over 65s – potentially linked to transformation of service delivery. Deteriorating performance in non-electives has been seen in SCCCG and is a key priority, whilst improving trends are evident in ECCCG. The full implementation of integrated teams across the HWB area is expected to improve these performance areas, and others, across CE. Performance metrics for 16/17 have been set to be challenging but realistic in light of performance in 2015/16. Population risk stratification has been undertaken through the pre-existing transformation programmes and is being used to target preventative interventions to reduce the future demand for costly, intensive health and social care provision.
3	**A coordinated and integrated plan of action for delivering that change**	• CE HWB BCF planning template for 15/16 (p.29-33) • HWB Paper from November 2015 that summarises the findings of the review and provides terms of reference for two key governance groups overseeing BCF	A review of BCF governance structures took place in 15/16 and a slightly amended structure put in place to ensure BCF gets the due attention needed whilst not distracting partners from other joint commissioning priorities. The "JCLT review paper" attached to the left demonstrates how BCF is governed and managed locally in the context of wider joint commissioning work from our BCF Governance Group (comprised of executive leads from each partner and BCF programme staff) through to our Joint

Headings			Supporting Evidence	Narrative[2]
			 JCLT Review Paper - Nov 2015 • BCF risk log  BCF Risk Log 270116	Commissioning Leadership Team and ultimately Health & Wellbeing Board. Each partner ensures BCF key decisions are taken through organisational governing bodies (CCGs) and cabinet / overview and scrutiny (LA). A series of such papers are available as evidence if required. In update to the 2015/16 plan, additional work areas have been proposed to come into the BCF for 2016/17. These areas have been agreed on against two criteria: 1) Good existing joint working in place between CCGs and LA 2) Provides a more cohesive and meaningful delivery of services commissioned under pooled budgets (e.g. bringing in Community Equipment Schemes as DFG, assistive technology, universal access to low-level support are already in the pool, and together these all form a service user pathway). Bringing schemes together under BCF in 15/16 has demonstrated that this can be helpful in further co-ordinating and integrating seamless delivery. A comprehensive risk log is maintained and discussed at monthly BCF Governance Group meetings with all partners. This contains mitigating actions to manage risks and responsible senior leads. An example of this is attached to the left.
4a	**A clear articulation of how our plan will meet each national condition**	1) Signed off by H&WB and other CCG/LA committees	• CE HWB BCF planning template for 15/16 (p.34-46) • Minutes of meetings including: ○ CCG Governing Bodies ○ Cabinet  Cabinet report - BCFPaper for 080316 ○ HWB	Our 16/17 plan pools more than the minimum required amounts, which demonstrates progress from 15/16 when only minimum mandatory amounts were pooled. This demonstrates an increasing commitment amongst partners to joint working and increasing levels of trusting meaningful working relationships. The plan for 16/17 has been developed by reviewing 15/16 BCF schemes and performance utilising the NHSE tool and discussion of potential additional areas that could be brought into the pool for 16/17.

Headings			Supporting Evidence	Narrative[2]
			BCF Paper for HWB - 150316	The decision was taken not to drop anything form BCF as it was felt that this would be a retrograde step in light of emerging requirements for STPs, and fully integrated health and social care by 2020. During 15/16 our housing leads have been working more closely with social care leads to join-up service user pathways from universal access to low level support through to major home adaptations funded by DFG. We will continue and progress these new ways of working to improve services for local people. Once agreed by the BCF Governance Group (executive level group that oversees CE BCF), the proposals were taken through the partners' governance processes culminating in CCG governing bodies (7/4/16 for SCCCG and 30/3/16 for ECCCG) and LA cabinet (8/3/16). Throughout this process, HWB has been kept up to date on developments and discussed the plans and process (most recently on 15/3/16) and will ultimately signoff the final submission ahead of the deadline of 25/4/16 via delegation to the Chair. Evidence of these papers and processes are attached to the left.
4b		2) A demonstration of how the area will maintain the provision of social care services in 2016/17	• CE HWB BCF planning template for 15/16 (p.47-52) • Carers' Strategy (this is a near final draft and was approved by HWB on 16/3/16). Carers Strategy	Local adult social care services will continue to be supported within the 16/17 plan in a manner consistent with 15/16. Partners are agreed on the level of protection contained within the submission, and do not envisage that this level of protection will destabilise the health and social care system. The 2% additional funding via increased council tax is being applied across Cheshire East charge, and will provide additional protection of social care services. The local proportion of the £138 million for the implementation of new Care Act duties is £834,000. In 16/17, CE partners have agreed to pool all of their spending,

Headings			Supporting Evidence	Narrative[2]
				including on young carers, to allow a truly joined-up approach to delivering the Cheshire East Carers Strategy for 2016/18. The strategy includes national and local context, need, consultation and delivery plans.
4c		3) Confirmation of agreement on how plans will support progress on meeting 2020 standards for 7 day services, to prevent unnecessary non-elective admissions and support timely discharge	• CE HWB BCF planning template for 15/16 (p.53-54)	Our plan, continuing from 15/16, contains the implementation of integrated teams, working 7 days a week across the health and social care system to prevent unnecessary admissions and facilitate timely discharge. These teams did not go fully live in 15/16 as planned but they will be fully delivered during 16/17. A strategic review of early discharge schemes is taking place up to end of June 2016 to ensure they are truly meeting local need. Recommendations will be implemented by October 2016. In addition, SCCCG is part of the prime minister's challenge fund initiative and has increased the availability of GP appointments during evenings, weekends and early mornings.
4d		4) Better data sharing between health and social care, based on the NHS number	• CE HWB BCF planning template for 15/16 (p.54-57) • CCR update report  CCR Update	The Cheshire Care Record (CCR) is instrumental to achieving 100% of coverage using NHS number as the universal identifier across the health and social care system. Good progress has been made in 15/16 against this and we expect full rollout to be achieved in 16/17. To the left is an update report as of March 2016. Implementation plans by each partner organisation are available if required. Appropriate IG controls are in place and open APIs are being pursued. In recognition that much of the successful integration of health and social care hinges on effective systems with good IG control, partners have agreed to bring the CCR into BCF for 16/17. NHS number is used as a consistent identifier in primary care and hospitals with plans to introduce this across other settings in 2016/17. Staff can retrieve relevant information about a service

Headings			Supporting Evidence	Narrative[2]
				user from their local system using the NHS number in primary care, hospitals, community care and mental health. There are plans to have this in place across social care (currently partially available) and palliative care by the end of 2016/17.
4e		5) A joint approach to assessments and care planning and ensure that where funding is used for integrated packages of care there will be an accountable professional	• CE HWB BCF planning template for 15/16 (p.57-58) • Connecting Care Plan (please note this is a latest draft and future iterations will be produced)  Connecting Care Model - draft as of 16 • Supporting information regarding Connecting Care Integrated Community Teams  SCCCG Integrated Community Teams • Caring Together "ramp up plan"  CT ramp up plan	In SCCCG, during 16/17, 40% of the frail elderly group under the integrated care teams would have case management/care coordinator. The current Integrated Care Teams' plan to have joint assessment of patients' needs using EMIS as the basic data sharing platform. The plan is for all Integrated Care Teams to be in place for April 2017 across SC and VR CCGs footprint. By May 2016, each GP Practice cluster will have an identified team of professionals in place to manage the needs of the local population. A number of additional roles will be in place within these Teams with recruitment ongoing to further support those individuals who have been identified through risk stratification and Multi-Disciplinary Team (MDT) Meetings. The roll-out of these meetings has commenced and will continue throughout 2016. Equivalents for ECCCG through the Caring Together transformation programme are still in negotiation with the provider collaborative, so a signed off activity plan is not available at the time of submission, although a meeting is taking place on 21/3/16 that may mean this alters by the final submission of 25/4/16. The attached high level "ramp up plan" is being worked to at present with additional detail to follow. Dementia services are identified as a particularly important priority for better integrated health and social care services, as demonstrated through our dementia reablement scheme.
4f		6) Agreement on the	• CE HWB BCF planning template for 15/16 (p.62-68)	The BCF Governance Group, on reviewing achievement in 15/16, identified that this agreement was needed at a Pioneer

Headings			Supporting Evidence	Narrative[2]
		consequential impact of changes on the providers that are predicted to be substantially affected by the plans		(Cheshire & Warrington) level rather than a HWB level due to the patient/population flows. Consequently this has been deferred to the Pioneer board for discussion, agreement and action.
4g		7) Agreement to invest in NHS commissioned out of hospital services, or retained pending release as part of the local risk sharing agreement	• Scheme specifications for integrated teams, CBCC and STAIRRS	The risk sharing arrangements for over and underspends is directly linked to each scheme specification and the lead commissioning organisation will be responsible for the budget management of the pooled fund allocated to the each individual scheme. The risks of overspends for the schemes included in the BCF plan are currently limited to the funding contribution. A variation schedule has been included in the partnership agreement to provide the lead commissioner with the escalation process to raise issues and concerns. All partners agree to investing in NHS-commissioned out of hospital services. These are a continuation from our 2015/16 work, form the bulk of our BCF spend and can be seen under the lines "STAIRRS", "Community-Based Co-ordinated Care" and "Integrated Community Teams" in the Excel template on tab 4: HWB Expenditure Plan". There has been a delay in fully mobilising some of these schemes and consequently, we were not successful in achieving a reduction in NELs in 15/16 sufficient to release performance funding (ECCCG did for some periods but it agreed not to release funding due to increased acuity).
4h		8) Agreement on a local action plan to reduce delayed	• DTOC action plan for ECCCG  TDA Initial Scoping Exercise Final Report	In December 2015, the TDA conducted a scoping exercise to understand East Cheshire Trust resources and process in relation to bed management, patient flow and delayed transfers of care. The final report provided 31 recommendations (p.9-10 in the

Headings			Supporting Evidence	Narrative[2]
		transfers of care (DTOC) and improve patient flow		attached) and points to consider in connection with the findings of the scoping exercise. Leads have been allocated to each recommendation to ensure they are implemented accordingly. SCCCG does not have a plan for DTOC reduction as this has not been an issue locally in 2015/16. However, there is a plan to investigate the reason for high levels of NEL admissions (particularly those less than 12 hours) and then to put in place plans to reduce this activity in 2016/17.
5	**An agreed approach to financial risk sharing and contingency**		• Insert financial risk sharing and contingency arrangements in 16/17 S75 draft	None of the pooled fund is being put under a risk share agreement as we are investing more than the minimum required in NHS-commissioning out of hospital services. The key risks to CE are: • Not reducing non-electives by enough to allow resources to be moved from the acute trust into the community. (This risk is very much an issue for the South Cheshire area rather than the Eastern Cheshire area) • Increasing financial pressures and deficits in acute trusts and CCGs. (This risk is more of an issue in the Eastern Cheshire area rather than the South Cheshire area) Mersey Internal Audit has highlighted the robust financial risk sharing and contingency arrangements in place in our 2015/16 S75 agreements. Therefore we propose to continue these in 2016/17. The S75s have been reviewed by all parties and minor amends made to update. These are at final draft stage at the time of writing.

REPORT TO: Health and Wellbeing Board

Date of Meeting: 31st May 2016
Report of: Kath O'Dwyer, Director of Children's Services and Deputy Chief Executive
Subject/Title: Children and Young People's Improvement Plan Update.

1 Report Summary

1.1. This report updates the Health and Wellbeing Board on the progress against the children and young people's improvement plan.

2 Recommendations

2.1 The Health and Wellbeing Board is recommended to:

a) Note the update on progress and performance against the improvement plan set out at Appendix 1 and 2, respectively; and
b) Endorse the next steps to sustain and embed progress as set out in these documents.

3 Reasons for Recommendations

3.1 The Health and Wellbeing Board is the accountable body for the improvement plan and has a responsibility to ensure that sufficient progress is being made to address the 25 recommendations for improvement identified by Ofsted in its 2015 inspection report of Children's Services.

4 Background and Options

4.1 The improvement action plan was endorsed by the Health and Wellbeing Board in November 2015 and subsequently approved by the Department for Education. Work has been underway to implement the actions within the plan and Appendix 1 summarises activity to date and proposed next steps against each recommendation. Appendix 2 sets out the key quantitative (how much we did) and qualitative (how well we did it) measures to assess impact of the plan.

4.2 Progress against the plan is set out under the four key objectives below.

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

- Ensuring frontline practice is consistently good, effective and outcome focused
- Improving senior management oversight of the impact of services on children and young people
- Ensuring the partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East

4.3 In summary, whilst significant activity has taken place since Ofsted's inspection of children's services to address their recommendations, further improvement is still needed in most areas to ensure services reach the 'good' level achieved by the Adoption Service.

4.4 Good progress continues to be made around the recruitment and retention of quality Social Workers, which is key to good practice. There are also many other examples of good practice, but the challenge is to ensure that there is consistently good practice for all children and young people. Working together as a partnership to safeguard children is a key factor. Whilst evidence suggests that it can take a significant period for inadequate authorities to get to good; of the 17 local authorities judged inadequate in the same year as Cheshire East, only one that became inadequate for the first time is currently judged as good by Ofsted (a small London borough authority).

4.4 There are some areas of performance where data is not currently available or less reliable due to the system and work is underway to address this or to look at alternatives.

5 Access to Information

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

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Appendix 1

Cheshire East
Children and Young People's Improvement Plan
to meet the Ofsted Recommendations

Creating a great place to be young

Improvement Action Plan Monitoring March 2016

Contents

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

Ensuring frontline practice is consistently good, effective and outcome focused

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

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

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

15. Ensure that learning from complaints leads to clear action plans and that these are implemented, tracked and reviewed to inform and improve practice.

Background to the recommendation:

- Analysis of complaints did not consistently result in effective action to improve practice.
- Recommendations from complaints did not sufficiently explore the underlying issues, and did not result in a reduction to the number of complaints received.

Activity, current position and impact: A learning action plan has been developed to address the themes from complaints and is presented and agreed at Service Managers' meetings. Progress against this is tracked and monitored to ensure effective action is taken.

29 complaints to children's social care were received in quarter 4. The vast majority of formal complaints (and other more informal comments/ feedback) are from parents. Only 5 of the complaints received in quarters 3 and 4 were from children and young people. The number of complaints received has remained fairly stable over the past 2 years.

The mains themes from complaints are:

- poor communication, including phone calls not being returned, minutes of meetings and copies of assessments not being sent out.
- Attitude, conduct and comments from staff
- Factual errors and inaccuracies in reports or information given
- Delays in receiving reports, assessments, or minutes, or in arranging placements
- Meetings being cancelled at short notice.

The theme from children and young people's complaints is poor communication.

These themes are consistent over time and reflect that our practice requires improvement. Practice reminders have been sent to social workers regarding the importance of good, timely communication. Action has been taken appropriately regarding professional conduct through individual supervision and line management. Service and senior managers continue to reinforce the standards expected, and challenge poor performance at Practice Challenge Sessions. Good practice is also celebrated at Practice and Performance Workshops to ensure staff recognise the hallmarks of good practice and the impact this has on children, young people and families. Action has and is being taken to improve frontline practice, such as developing a core training offer for social workers and managers, making the child's record system more user friendly and making social workers more accountable and answerable to their own performance through Performance Challenge Sessions. These actions are all discussed in more detail in later sections.

The number of compliments received this year has increased from 42 in 2014-15 to 61 in 2015-16 which is very positive. As at 8th April 2016, 20 out of 25 complaints had been resolved and closed at Stage 1, which is positive as this indicates that the

complainant was satisfied with our response and that they felt they had been listened to. Work is currently ongoing with the other 5, including meetings, to try and resolve these at Stage 1. None have yet been escalated to Stage 2 which is a positive step.

We recognise that we need to develop and embed a positive, responsive culture that puts children and young people first across all of the children's workforce. There is a plan in place on how we will put this into action, an overview of which is given in the next steps.

Themes from compliments and complaints are communicated to staff through Practice and Performance Workshops. Engagement with staff on changes to practice as a result of findings from complaints is done through these workshops or the Practice Champions Group. Changes to policy has been made in response to complaints, such as the Children with Disabilities Policy which was developed in response to parents and carers complaints that they were unclear on the process for assessments for children and young people with disabilities.

Children, young people, parents and carers' views are actively sought so that they can inform service planning. Children and young people, parents and carers are invited to take part in the children in need (CiN) and CP feedback survey, which is completed at the last core group meeting as cases are closed to children's social care to ensure a good level of responses. The results of this survey have been very positive; the survey showed that 88% families felt that the social workers' explanation for why they had got in touch with them was "very clear", and over 90% agreed or strongly agreed that the allocated social worker was easy to talk to, listen to their views and understood their situation. When asked about the reliability of their social worker, 98% were reliable or very reliable at returning calls, 95% were reliable or very reliable at doing what they said they would do and 88% were reliable or very reliable at turning up on time. The learning points from this survey were that while most families felt supported, some felt that communication could sometimes be better and that everyone should get a copy of the assessment, which echoes the feedback through comments and complaints from families.

Children, young people, and parents' views are also sought on the quality of their support through audit, and the findings from these are communicated to all staff through the audit newsletter and are explored with the individuals involved in casework through the audit process. In the last audit, children, young people and parents expressed that they wanted social workers to open and honest with them, and that this was really important to them.

Children and young people are aware of their right to complain. Cared for children receive information on how to do this in their 'Coming into Care' Pack and the interactive handbook on the website.

The Improvement Plan Quality Assurance Framework has been based on the quadrant model, which involves gaining the views of children, young people, parents and carers and using this to continually improve services. Children and young people's views are represented at the key partnership boards and drive and inform strategic planning and decision making.

Next steps – how we will sustain and embed progress: In order to develop a culture of putting children and young people first across all of children's services, we are:

- Developing participation training and skills development based on the views, needs and experiences of three teams from each directorate
- Developing a kite mark/ recognition scheme for good quality participation that services can apply for. This will raise the profile of good work in this area, and will be based on the Participation Standards developed by young people.
- Ensuring there is a participation champion from every service who is actively involved in the Participation Network, which will grow the network and ensure practice, skills, training, techniques and standards for participation are disseminated and championed within every department.
- Developing a participation 'toolkit' of resources to support engagement with children and young people for multi-agency workers.
- Putting children and young people first will be a key part of recruitment, selection and induction to ensure we have the right people working with us in Cheshire East who are committed to our values.

Progress against the learning action plan will continue to be tracked and themes will continue to be communicated to staff to continue to improve our service. Feedback from children, young people and parents will continue to be sought and mechanisms to do this promoted in order to enable their views to shape our development.

Ensuring frontline practice is consistently good, effective and outcome focused

2. Ensure the challenge provided by child protection chairs and independent reviewing officers (IRO) addresses drift and improves planning for children

Background to the recommendation:

- In the inspection, a sample of the CP cases open over 15 months showed that there was drift and delay in making progress on plans for some children and young people.
- Child protection review conferences were not always held within timescale, with 11% taking place later than planned.
- Independent Reviewing Officers' (IROs') Practice Alerts were not having sufficient impact on the overall quality of assessment and planning for cared for children.

Activity, current position and impact: Following the inspection, all plans open over 12 months were reviewed to ensure these cases had a robust plan in place. Where there were concerns about drift or delay this was addressed directly.

Performance tracking mechanisms are in now place to prevent delays, such as Safeguarding Performance Challenge Sessions, which scrutinises the cases open over 12 months to ensure there is not drift or delay for these children and young people. The CP IRO Manager is also held to account for progress on all cases open over 12 months in her supervision.

There has been a need to improve working together between the Safeguarding Unit and Children's Social Care and a focus on developing relationships at the frontline.

These services are now aligned under the same Director, and closer working relationships are being supported and developed. Service Managers and IRO Managers are now having regular team meetings and also specific tracking meetings, which is ensuring a shared focus to prevent delays and improve planning, and is improving working relationships.

IRO's are raising issues appropriately through Practice Alerts, but the quality and consistency with which they do this still needs improvement. IROs are required to discuss the Practice Alerts they have raised that month in each supervision to embed good practice and challenge.

More good practice alerts have been made than those that challenge gaps in practice (157) which is positive, and shows that there is evidence of good practice and that this is being recognised.

CP conferences are now being held within timescales, performance was at 92% in quarter 4. This relates to initial conferences as well as CP and review conferences. All review and CP conferences were held within timescales. These initial conferences that were out of timescale were due to delayed notifications. There is some performance information that demonstrates improvement in practice in reducing delay, such as the percentage of children subject to a plan for 15 months or over, where the target is to be under 15% and our current performance is 6%. However, there needs to be evidence of improvement in practice more consistently to show sustained impact. We have launched a new model for CP conferences which should help to support and embed improved practice.

Next steps – how we will sustain and embed progress: The right mechanisms are in place, such as the Practice Alert Tracker, focus on challenge in supervision, and Safeguarding Performance Challenge Sessions. We will continue to focus on embedding good practice around these and developing good working relationships between the IROs and social care teams.

The impact of the IRO's is also dependent on the responsiveness of the operational service and this is still inconsistent. The improvement in planning is linked to the larger requirement to improve the quality of practice across all partners, the action which is being taken to improve both these areas is discussed elsewhere in this report under the relevant sections.

3. Ensure that supervision is reflective, challenging and consistently focuses on continual professional development.

Background to the recommendation:

- Social Workers felt supported by their Managers and received regular supervision, but they could not describe how their practice was monitored or challenged through supervision.
- Managers were not consistently using personal development plans to drive practice improvement through supervision.
- It was difficult for inspectors to see what impact training was making on improvements to practice as explicit links were not made to continual professional development needs.

Activity, current position and impact: Monthly supervision file audits by Service Managers have been introduced and are embedding. The last report for quarter 3 showed that for the Social Workers' supervision files audited, 57% were critically reflective, and 64% evidenced CPD. Performance in these areas needs to significantly improve, but we do now have good scrutiny of the quality of supervision which will support driving up standards in this area. In the social work staff survey in July 2015, 72% said that their manager actively supported them to address their development or training needs, so the proportion of supervisions covering CPD may in fact be higher and the supervision audits may reflect a recording issue. 69% children's services staff had a Personal Development Plan (PDP) in place at the end of the year, which is in line with the wider Council which had a 71% uptake. We will be aiming to improve on this this year.

A core training offer for Social Workers and Managers has been developed and published. This maps expectations against grades of Social Workers and is tied into the grade progression process. Effective supervision training for both supervisors and supervisees is part of the core Social Worker and Manager training offer. The Children's Social Care Practice Standards have been updated and clarify management responsibilities and expectations about supervision. These have been communicated to all staff and compliance with these standards will continue to be measured and evaluated through audit.

The practice coaching audits include reflective discussions with social workers on all the cases that have been audited (around 40 cases), with the option to discuss an additional case chosen by the Social Worker or Team Manager. The additional case could be a particularly complex one or one that would benefit from an independent view/ reflection. This audit model supports Social Workers to develop their reflective skills and their practice overall, and is highly valued by Social Workers.

Next steps – how we will sustain and embed progress: A workshop on PDPs will be delivered in the Practice and Performance Workshops in June 2016 to engage and support staff and managers in the PDP process. Evaluation of compliance and the quality of supervision from the supervision audits in May 2016 will inform further actions. Evaluation of the take up of the core training offer will be evaluated in July 2016, along with its impact on the quality of practice through audit.

4. Ensure that where children do not meet the threshold for social work intervention their circumstances are considered promptly and they receive appropriate and timely early help.

Background to the recommendation: Some contacts that were identified for early help were not progressed as quickly as they could be at the front door as cases for referral to social care were prioritised.

Activity, current position and impact: The Early Help Brokerage Service has been established and went live in October 2015. This service is a dedicated team, with increased capacity, to ensure the swift allocation of early help cases. This ensures timely referrals to early help, and identifies the best service to meet the needs of the child or young person and their family.

There has been a very significant increase in referrals in the North Locality and demand has outweighed our capacity within early help services. Remedial actions are underway to address the significant increase in demand in the north locality. Incoming new service requests are routinely checked (daily) and re-prioritised. All open cases have been reviewed to identify those appropriate for closure/step down to universal services and those cases that can be managed through other services.

The brokerage service has just undergone a business review, to identify opportunities for streamlining this service with Cheshire East's Consultation Service (ChECS) and complex dependencies.

Next steps – how we will sustain and embed progress: Early Help is now supported on the child's record system, and work is underway to build the reporting structures to support effective performance monitoring around referral to and support through early help. Performance information has just become available on the timeliness of decision making in the brokerage service, and a case sample will be undertaken to understand the child's journey, including any delays for cases which are out of timescale and inform necessary action to improve this.

Work around Cheshire East's Parenting Journey will strengthen the early help offer by providing a universal integrated early help pathway and programme of support for children under 5 and their families who live in Cheshire East.

The improvements from the business review to streamline the process for children and families are being implemented. Recommendations for improvement to the referral and allocation systems at the front door will now be implemented through a task and finish group. This group will also scope the full range of early help services across Cheshire East partners with a view to enhancing and improving the range of provision across the continuum of need.

5. Ensure that strategy meetings and decisions are informed by relevant partner agencies.

Background to the recommendation:

- In the majority of cases seen, strategy discussions were telephone conversations between a practice manager and the Police, without the involvement of other agencies, such as health, so decisions did not consistently take account of all relevant information.
- Agencies were not always asked to contribute so not all the relevant information informed decisions.

Activity, current position and impact: Multi-agency Practice Standards have been developed and launched across all agencies in February 2016. These standards set clear expectations in relation to strategy meetings and discussion, i.e., that all agencies and professionals that have a contribution to make to strategy discussions should be invited, and that they should challenge children's social care if they are not included. Work has been completed through the Safeguarding Children Operational Group (SCOG) of partnership frontline managers to raise awareness of

this expectation. Standards for Section 47 enquires and a clear timeline to follow have been issued to support Social Workers.

An IRO themed audit on strategy discussions completed soon after referral was carried out in January 2016. This considered the case notes for 16 families relating to 26 children. The audit found that the recording of the rationale for decision making by managers needs to significantly improve as in 44% cases, based on the referral information, auditors felt that the child or young person had not or was not likely suffer significant harm.

The audit also found that in 75% (12) of the cases, the strategy discussion was held on the same day as the referral, and no significant contact was made with the family or to partner agencies prior to the discussion so referral information was not placed in any wider context. This audit showed that the decision to hold a strategy discussion was often made with too little information, and practitioners were felt to be erring on the side of caution rather than having a clear rationale for why they believed these cases might result in a s47 enquiry, which is an area for further work and development.

The audit also showed that the majority of strategy discussions taking place still only involve social care and the police, with only 1 discussion being truly multi-agency and 1 other including midwifery (13%), so there has not yet been improvement in performance in this area.

Next steps – how we will sustain and embed progress: An action plan has been developed in response to these audit findings. In the exceptional circumstances when a strategy discussion is held only between children's social care and the police, the reason for this is to be clearly recorded on the strategy discussion document held on the child's file. It is expected that this type of strategy discussion would only occur when a child was at imminent risk of significant harm. This will act as a prompt to Team Managers about the need to invite other agencies and will identify themes and issues for further quality assurance activity and the identification of any obstacles that need to be challenged in achieving multi-agency strategy discussions.

The Police Public Protection Unit (PPU) will gate keep requests for a strategy discussion and will challenge children's social care when they feel that the request is made without sufficient information, or when other agency information is not available, or that the team manager/Emergency Duty Team worker is erring on the side of caution without sufficient evidence to suggest risk of significant harm. The PPU will record this gatekeeping activity to allow themes and issues to be identified and for consistent thresholds to be introduced.

An audit of strategy discussions will be repeated in September 2016 to evaluate the impact of this further work and the awareness raising and Multi-agency Practice Standards.

6. Improve the quality of recording so that all key discussions and decisions about children and their families, including management oversight, are clearly recorded.

Background to the recommendation:

- Not all CAF assessments recorded children and young people's views.
- The rationale for closing CAF plans was not always clearly recorded, making it difficult to evaluate the effectiveness of the help received.
- Historical information considered in decision making on contacts was not always recorded in as much detail as it needed to be, which led to delays as Practice Managers needed to request further information to make a decision.
- There was not always a clear rationale recorded on contacts for why the decision had been made to proceed without consent for information-sharing.
- Practice Managers' oversight of casework was not clear in most of the cases seen, and there was little evidence of direction, challenge or support where plans for children had not progressed or work had not been completed in a timely way.
- Key discussions and decisions were not always fully recorded on the child or young person's record. This made it difficult to follow the child's story, to evaluate if further work could have prevented the child or young person becoming cared for, and could mean important information could be missed by new workers to the case.
- The work presented to courts was of variable quality.
- Recording was not always detailed enough to show the benefits of contact with families for cared for children and young people.
- Information recorded on return home interviews was not always comprehensive.

Activity, current position and impact: A core training offer for Social Workers and Managers has been developed to embed expectations around the quality of practice and ensure that the whole workforce has the skills they need to deliver this level of service.

Performance Challenge Sessions now take place on two levels; Senior Managers challenge Service Managers on their service's performance, and the sessions have also been extended to Team Managers and Social Worker Pod Teams, which are challenged by the Service Manager. IRO Managers also have Performance Challenge Sessions for their IRO Teams. This process is embedding well. These sessions focus on quality of practice, down to individual performance level, including caseloads, timeliness of assessment and plans, supervision and management oversight, and are successfully continuing to drive improvements to practice and embed accountability.

Research has been undertaken on good practice models in other authorities and options to develop one way of working/ operating model across all social work teams in Cheshire East are being explored. Project work, to inform the operating model for Children's Social Care, is about to commence.

Sharing and celebrating good practice is now established at Practice and Performance Workshops and Practice Champions meetings. Social Workers and Team Managers present examples of their own good practice to increase recognition and understanding of the features of good practice.

The quality of recording continues to be evaluated through audit and the practice coaching audits continue to support workers to reflect on the quality of their work and where they can improve and develop. 76% (57) files audited in quarter 3 met the practice standard for recording management decisions, which shows this is an area that still requires improvement.

Overall, all of the audit streams showed that the majority of practice is judged to require improvement, with some inadequate cases (although these are reducing) and some good cases. Requires improvement is a broad category in terms of the quality of work it covers, and it is positive that inadequate practice is reducing, however we are aiming that all casework is good or outstanding. This will take time to establish and embed.

Despite the quality of practice not yet being at the level of quality we want it to be, children and young people are safe in Cheshire East, and the last Practice Manager audit supports this which showed that in all cases (of 9 cases) social workers were judged to have taken the right action at the right time to protect children and young people, and in 89% (8) cases there was evidence that the work had improved outcomes for the child.

The themes for improvement that have been identified through audit are:

- Assessments need to be updated to reflect changing circumstances
- Plans need to be SMART and tailored to each child's individual needs
- Recording needs to be clear and fully reflect the work undertaken, this includes recording the rational for management decisions
- Chronologies and family history need to be used to inform decision making and planning.

Next steps – how we will sustain and embed progress: We will evaluate attendance on and impact of the core training programme. The focus on standards expected and individual accountability will continue through the Performance Challenge Sessions. Practice coaching audits will continue to focus on supporting the quality of recording and case work. This, and evaluation of the impact of core training offer will inform the next steps. Whilst not a quick fix, the development of a Cheshire East model for social work does has the potential to have a significant impact on the quality of recording and decision making.

A review of the processes for centrally monitoring and tracking CAFs will take place. In addition, a performance management framework will be refreshed and a quality assurance framework developed for all early help cases.

7. Strengthen frontline practice to ensure effective action is taken to support children at risk of child sexual exploitation and those who go missing.

Background to the recommendation:

- The findings from return home interviews were not always being used to inform on-going work with children and young people, or to explore wider issues such as links with other missing young people.

- The response to children going missing from care was variable, the recording of return home interviews was not always comprehensive, and there were delays in these being sent to Social Workers.
- Tools to assess the risk of child sexual exploitation were being used, however there was not enough skilled, sensitive work completed with children and young people to understand their individual vulnerability and risk.
- Some Social Workers had not had training in recognising and responding to the signs of child sexual exploitation due to the high turnover of staff.

Activity, current position and impact: A Missing from Home Team was established in 2012. This was extended to include CSE in April 2014. Other agencies; police and health, have become part of this team during this period. This service supports workers on an individual case by case basis through consultation, guidance, resources and case direction/ supervision. This specialist service should improve the quality and coordination of CSE and missing from home and care (MFH&C) work. An active CSE Champions Group is in place and this is driving improvements to practice through feedback from frontline practitioners and children and young people.

The relationship between the CSE and Missing from Home and Care Service and the new Early Help Brokerage service has continued to grow. Sharing of information has been extremely beneficial in making decisions on what service will best meet the needs of children and families. The service has also been able to draw on the expertise and provide consultations and resources for those children who are already involved with some of Catch22's other services in Cheshire East, including the Family Focus (Troubled Families) workers, Project Crewe Child in Need Team and the services for those not in education, employment and training (NEET) and Drug services. The service has worked closely with the workers involved with these services to ensure appropriate planning and support around Missing from Home is included in their ongoing plans for children and families.

The Integrated Team were joined by a MFH/CSE Nurse Specialist during this quarter and this has provided wider consideration for young people who are high risk Missing From Home individuals, and has widened the amount of immediate information and joint working within the local authority. It is hoped that going forward, health services will become more involved in planning for these children.

The Missing From Home Case Workers continue to be part of the CHAPS (Care Homes and Police) Operational Group and these meetings have been key in establishing links between young people from different care homes and sharing information between police and care homes. Importantly, all children and young people supported through this service reported that they felt safer following this support.

A multi-agency audit of the quality of the use of the CSE screening tool in February 2016 by the CSE Champions Group found that 63% (10) were good, 25% (4) required improvement, and 13% (2) were inadequate. However, this audit also showed that the quality of work recording the views of children and young people was variable, and this was an area that was identified for improvement.

The forums through which practice with children who are at risk of CSE are monitored, and the recent multi-agency CSE audit, shows that children are not yet

always being identified early enough and the quality of assessment planning and intervention can still be improved.

Tools and training to support social workers with direct work have been developed and delivered through Practice and Performance workshops. A range of training around CSE has been provided, and CSE and Missing from Home and Care is a mandatory training course for all Social Workers. A session on CSE and MFH&C was also given at the Practice and Performance workshops in December 2015 to social workers and managers. The CSE/MFH team have offered a number of sessions to provide every social worker with the opportunity to have basic CSE training. The new core training offer was launched in March 2016 and take-up and impact of training will be closely monitored this year. A considerable number of social work staff are now registered to attend this training. An e-learning module on CSE is also available.

71% return home interviews were completed following an incident of missing from home or care this quarter. Return home interviews are sent to social workers and the timescales for this are performance managed. Social workers also get a follow-up call to ensure they are aware of the issues, and where there are high level concerns, these children are discussed first and the recording is prioritised. There has been an improvement in return home interviews being placed on the child's file by social workers, but this still needs further improvement.

There is inconsistency in the use of return home interviews to inform the understanding, assessment and plan for the child. This is linked to the wider need to improve the quality of practice. To assist and support improvement in this, the return home template has been changed so that it clearly identifies the immediate risks to children and young people in a separate section which social workers can use to inform assessment and planning.

Next steps – how we will sustain and embed progress: The Missing from Home and CSE Team will be visiting social work teams to identify specific issues that workers have and how best to support best practice. This will also form a key element of the business plan for this service.

Work is underway to develop best practice standards for CSE conferences, including good practice examples of the use of screening tools, reports, meetings and interventions. This will ensure that it is clear what a good standard of service looks like and will make expectations clear for practitioners.

The multi-agency audit of CSE work will be repeated in 6 months to evaluate impact on practice. Evaluation of the uptake and impact of the core training offer will be completed in 6 months time.

8. Ensure assessments for children in need of help and protection and children looked after are timely, consistently consider the full range of children's needs, contain thorough analysis and are routinely updated to reflect changes in circumstances.

Background to the recommendation:

- Not all assessments were of a sufficient quality

- Not all assessments demonstrated that the risks to children and young people from domestic abuse, parental mental health problems or substance misuse were fully considered and understood and Adult Social Care was not routinely involved in assessments where factors for adults were present.
- The specific needs of each child or young person within the family were not always differentiated.
- Issues of diversity and cultural needs were not consistently well explored or responded to. Assessments did not fully explore issues of race and gender and how they impact on children and young people's experiences within their own family.
- Assessments were not consistently updated in response to a change in circumstances.
- When children and young people returned home from care an updated assessment was not always undertaken to inform this decision and identify the appropriate level of support needed.
- In some cases, contact with families for cared for children and young people was not always rigorously risk assessed.
- Where cared for children were living with friends or relatives, assessment of those connected persons was not always sufficiently robust.
- Timescales for completion of assessments were not always adhered to.

Activity, current position and impact: As detailed above work is underway to develop a single operating model for Children's Social Care in Cheshire East. The assessment framework and practice standards have been reissued to ensure the standards for assessment are clear to all staff. This includes what constitutes a good assessment. A range of activity is taking place to support the development of good quality practice, as detailed under section 6. Improvements to the quality of supervision will also impact on practice, and this is detailed under section 3.

However, currently, the majority of practice still requires improvement, and ensuring assessments are routinely updated and consider the full range of children's needs remains an area we need to improve which has been shown through the audit findings from quarter 3.

Next steps – how we will sustain and embed progress: We will continue with our focus on the supporting the quality of assessments through audit, and will continue to drive improvements to timeliness through the Performance Challenge Sessions.

Exemplars for social workers will be produced through the Practice Champions Group to demonstrate what a good assessment and plan looks like and how children's views and lived experience should be captured.

Recent audit and performance has revealed the need to review the workflow for combined assessments, care plans and pathway plans, to make the process and requirements clearer for social workers. The workflow will be reviewed to ensure that this supports effective practice and is easy and intuitive to use.

9. Ensure that plans to help children in need of help and protection, looked after children, and care leavers, are specific, clear, outcome-focused and include timescales and contingencies so that families and professionals understand what

needs to happen to improve circumstances for children. This includes improving the clarity of letters before proceedings so that the expectations of parents are clear.

Background to the recommendation:

- Child Protection Plans and Child in Need Plans were not always specific to individual children, and not always of a good enough quality.
- Plans lacked timescales and contingencies.
- Plans were not consistently underpinned by a full understanding of whether changes were sustainable.
- Direct work with children and young people was not always informed by the assessment or the plan so lacked focus.
- Some Social Workers were too slow to respond to the lack of progress against plans for children and young people; some Child Protection Plans showed delays and drift and some children experienced delays with their permanence plans. Some cases took too long to step up to Child Protection.
- Not all partners were as involved in planning as they could be. Adult service Social Workers and Housing Providers were less involved, and this meant that there was not always a coordinated multi-agency response.
- The quality of Personal Education Plans (PEPs) has improved, but some were not detailed enough and did not contain precise enough targets.
- The majority of pathway plans did not have clear and specific targets and actions to help or encourage young people to secure employment, education or training.

Activity, current position and impact: A new model for Child Protection Conferences has been introduced which 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 helps 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. Improved understanding and engagement with the plan and agencies delivering it should lead to improved outcomes for children, young people and families. We are in the process of carrying out a mid-point review of the model. Anecdotally, it appears that the model has been well received as an improvement in addressing the issue of drift and improving planning.

The core training offer for Social Workers and Managers will support workers to develop the skills to produce and support strong assessments and plans. Training on delivering direct work with children and young people has been delivered to ensure that this is of a good quality and is informed by assessment, analysis and planning. The impact of this will be reviewed in 6 months time.

The Practice Champions Group have designed and developed tools to support direct work, and these were produced into a 'tool kit' which was given to all social workers, and there is an area in each of the social work offices which features these tools. Training on direct work has also been delivered through the Practice and Performance Workshops.

A new quality assurance process for Personal Education Plans has been developed, which includes local Head teachers providing external scrutiny on the quality and challenge to schools. This will help to embed standards and drive up the quality of practice. Best Practice examples of PEPs are on the Cheshire East Virtual School

website, and this has been communicated to schools. These best practice examples are shown to new Designated Teachers as examples of effective PEPs as part of their induction.

A new post of designated Service Manager for Care Leavers has been created and appointed to, which will provide additional capacity, management oversight and focus on improving outcomes for Care Leavers. This specialist care leavers' service allows specialist support, expertise and focus on the particular needs of these young people as a group.

Performance on the timeliness of plans has improved, the last audit found 67% CIN plans were completed within 35 days, but this is still an area requiring further improvement. As discussed in previous sections, the quality of practice requires improvement and planning is still a key area that we need to improve.

The number of children and young people subject to a plan for emotional abuse has risen. A recent dip sample in January 2016 of child protection plans for the category of emotional abuse showed that this category is sometimes incorrectly used, and that deeper analysis needs to made and evidenced in conference discussions to ensure that the reason the plan is needed and the impact on the child or young person is correctly identified. Without this it is difficult for parents to understand why professionals are concerned and what they need to do to reduce these concerns.

This audit highlighted that we need to ensure planning is more solution based and family focused; plans need to cover how parents will be supported differently to achieve the aims in the plan that they were unable to achieve at CAF or CIN level. This will be address through the new conference model, but at this point in time it is too early to evaluate the model's impact.

Next steps – how we will sustain and embed progress: Work is underway to develop a multi-agency framework to support professionals working with substance misusing parents. We will continue with our focus on the supporting the quality of plans through audit, and will continue to drive improvements to timeliness through the Performance Challenge Sessions. A mid review of the child protection conference model will be carried out in June 2016.

A model for IRO's systematically auditing child in need cases has been introduced in April 2016. The first quarter will focus on auditing all plans over 12 months. The model also encompasses some observation of CIN meetings. The model will focus on auditing a sample of CIN cases open over 6 months to assess the quality of this work. A repeat audit of new plans under the category of emotional abuse will be undertaken in August 2016 to evaluate improvements in practice in this area.

10. Ensure that decisions to step down or close cases are appropriate and that management rationale to do so is clearly recorded.

Background to the recommendation: Inspectors saw a number of cases that had been closed to children's social care and stepped down too soon, where not

enough progress had been made, and change had not been sustained to secure improved outcomes.

Activity, current position and impact: The policy on Step Up and Step Down has been reviewed, updated and relaunched. Managers chair Step Down meetings so that they have oversight of the case and ensure the arrangements around step down are robust. Training on Chairing Meetings effectively is part of the core mandatory training programme for managers to ensure they have the skills to chair more complex meetings. All actions to address the recommendations from the LSCB multi-agency audit on Step Down have been completed.

In the last audit, only one case audited was stepped down. However this case showed that there are still issues with robust arrangements for stepping down, as this case was closed from CIN and the decision was made that support at CAF level was not needed. The auditors queried this decision and it was accepted that support should be given at CAF to ensure continued support was offered. However, the auditors did agree that this was the right time to close the case at CIN.

Next steps – how we will sustain and embed progress: We will continue to monitor progress through audit that the decision to step down or close cases is appropriate and the management rationale for this is clearly recorded. Step down of cases is proposed to be a thematic area for the LSCB to revisit in its audit programme in 2016-17 which will give an in-depth picture of progress in this area.

11. Improve the implementation of delegated authority so that carers are clear about what decisions they can make and children do not experience delays.

Background to the recommendation: All foster carers spoken to in the inspection were aware of the delegated decision making process, but they felt that Social Workers still have to complete too many forms for decisions foster carers could make.

Activity, current position and impact: The Foster Carers' Handbook has been reviewed and revised along with the policy on delegated authority to ensure the guidance is clear and consistent for Social Workers and Foster Carers. A simple checklist has been produced on delegated authority, setting out what areas carers can make decisions on, which Social Workers make decisions on, and which need to be agreed and specified in the plan; this is included within the Foster Carers' Handbook. Awareness raising of delegated authority has been carried out at the Practice and Performance Workshops, Foster Carers' Forum and through the Foster Carers' newsletter.

Next steps – how we will sustain and embed progress: Work is necessary to improve the forms on the child's record system to support improved practice. This involves a potential new Care Plan document which puts delegated authority in a clearer format. Work is underway reviewing this. The Foster Carer's survey will be carried out this year and will assess whether carers are clear on delegated decisions.

12. Improve the timeliness of initial health assessments so that children who become looked after have their own health needs assessed within the expected timescales.

Background to the recommendation:

- Most cared for children had an assessment of their health needs, but there were delays in some initial health assessments taking place.
- Only 30% of initial health assessments for cared for children and young people in were completed within timescale in 2014-15 due to delays in Social Workers requesting assessments.
- Review health assessments were timely.

Activity, current position and impact: The process for requesting initial health assessments has been streamlined and a new pathway has been developed and is in place. The process is now prompted in the child's record system to support timely requests and completion. The impact of these changes have not yet been realised in the performance measure and this area continues to be under scrutiny by the Corporate Parenting Board and the LSCB, both having received detailed reports around the issues. A case example was also presented to the Corporate Parenting Board in March 2016 for detailed analysis. The Health and Wellbeing Board has also received a report on the health of cared for children, which highlighted this issue.

For performance to improve, it is critical that there is an early and timely request for the initial health assessment from the social worker, as the assessment needs to be completed within 20 working days to be within timescale.

During quarter 4, 20% requests for initial health assessments were received within 48 hours of the child or young person coming into care, which needs significant improvement. As a result, there has not yet been an improvement in the number of initial health assessments that were completed within 20 days.

All Social Workers and Team Managers have been reminded of the pathway and procedure for requesting these, and the expectation that requests for these assessments are made within 2 working days of the child or young person coming into care. A new process has been put into place to ensure timely referrals are made and this becomes embedded. The placements service are notifying the Head of Service when a child or young person comes into care, and the Head of Service will track compliance with the standard and will report any exception to the Director of Children's Social Care. The Cared for Nurses have attended the Practice and Performance workshops to raise awareness of the health assessment pathway, and the Designated Doctor will raise this issue again with the relevant paediatricians.

A Health app for cared for children and young people has been developed and launched to support them to get advice about health issues and where to go and what to do to meet their health needs.

Next steps – how we will sustain and embed progress: Performance to remain under scrutiny by the Head of Service and key partnership Boards until improvement in performance is sustained. The Director of Children's Social Care will challenge requests out of timescale to embed timeliness.

Work is underway to look at the current processes to see if health professionals can be involved earlier in the process to provide up to date and relevant health information to inform assessments and plans.

17. Ensure later-in-life letters provide details of all known information, are written in plain English, and are accessible to children so that they understand their stories.

Background to the recommendation: Later in life letters were variable in quality.

Activity, current position and impact: The production of later-in-life letters has been allocated to the Adoption Team, to ensure consistency of approach. All later-in-life letters are quality assured by Team Managers, and this is overseen by the Service Manager for Adoption. This has established a good quality standard and letters are being produced to a good standard. Consultation with care leavers has taken place on what constitutes a good later-in-life letter and this has informed the production of good practice exemplars.

Next steps – how we will sustain and embed progress: Team Managers will continue to monitor the quality of the letters, and there is a tracker in place to ensure the timeliness of these.

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

1. Strengthen senior managers' oversight and monitoring of:

- ***complex cases where there are historic drift and delay in taking decisive action***
- ***private fostering and connected persons' arrangements to ensure that these arrangements are suitable and comply with regulations***
- ***care leavers who are homeless***

Background to the recommendation:

High Risk cases:

- In the inspection, inspectors saw two cases where drift and delay (across CIN/CP and cared for) had impacted on the child or young person's safety and progress, but this had not been alerted to senior managers. Inspectors suggested one of example of how this might be addressed through a high risk panel.

Private Fostering and Connected Persons Arrangements:

- Service Manager's oversight of private fostering and connected person arrangements needed to be strengthened. Private Fostering cases sampled during the inspection showed delays in responding to notifications, disclosure and barring (DBS) checks, visits and decision-making. There was no evidence of management oversight identifying or challenging these delays.
- Where cared for children or young people live with relatives or friends, assessments of connected persons were not always sufficiently robust, timescales for completion were not always adhered to, and it was not clear in all cases if assessments had been signed off by Group Managers.

Care Leavers who are Homeless:

- Group Manager's oversight of care leavers who are homeless needed to be strengthened. At the time of the inspection 6 care leavers were refusing appropriate accommodation, all of them had multiple problems, including drug and alcohol misuse, risk of or actual offending behaviour, and emotional health problems. Personal Advisors were making concerted efforts to engage them with services and reduce the risks, however outcomes for these care leavers were uncertain due to the complexity of the needs. Senior managers did not have sufficient oversight of these care leavers who are homeless, and did not routinely monitor the individual circumstances for these highly vulnerable young people.

Activity, current position and impact: The multi-agency professional dispute resolution (escalation) process has been reviewed, revised and relaunched to ensure it is explicit about the criteria for raising concerns where drift or delay are impacting on the child's safety or progress. The resolution workflow has been incorporated into the child's record system to ensure that the process is systematic and the pace of resolution can be tracked and monitored. This is currently in the final stage of testing. Drift and delays are being challenged by IROs through the Practice Alert process. Criteria for a protocol on notifying all tiers of management on high risks cases is being developed.

A tracking system for all privately fostered cases has been established and is managed by the lead IRO. The Placement Service seeks confirmation at the time of referral about the exact arrangements for the child's placement, and where relevant, the allocated IRO ensures that issues pertinent to connected person's assessment, particularly any identified risks, as well as the support package, are scrutinised during the preparation for the first (20 days) review. 93% (14 of 15) private fostering visits were completed within timescale in quarter 4, and the one which was outside of timescales could not have been foreseen, so this is very good performance and is a considerable improvement on performance during the inspection in quarter 2 which was 67%.

This year we have nearly doubled the number of privately fostered children and young people we are aware of in Cheshire East, from 6 to 11 new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases. All the reg. 24 assessments were presented to the fostering panel within statutory timescales in quarter 4.

A monthly permanence case tracking meeting, chaired by the Head of Service for Cared for Children, has been introduced to ensure clear senior management oversight and drive for permanence. The tracker for care leavers who are homeless

has been strengthened and is being used to effectively track and monitor these young people, and this is overseen by the Service Manager.

Next steps – how we will sustain and embed progress: A protocol that sets out when and how all tiers of management up to the Director of Children's Services will be informed about a case based on the risks to the child or young person will be developed. Mechanisms to track these young people and ensure senior management oversight are now in place and we will continue to evaluate the impact of these measures on outcomes for children and young people. A multi-agency stocktake of private fostering cases will be carried out in June 2016.

13. Ensure audit arrangements have a sharper focus on looked after children.

Background to the recommendation: Some of the audit programme was focused around the performance and quality of services for child in need and child protection, as these services had been inadequate. Plans were in place to extend the current audit programme to cared for children but this had not taken place at the time of the inspection.

Activity, current position and impact: The audit programme for children in need and child protection has been extended to cover cared for children's services, so this now reviews the quality of casework across the whole service; from contact at the front door to leaving care. Audits are completed and reported on a quarterly basis, and cover 57 cases.

The main themes from audit are given under section 6.

The impact that the findings are having on practice is not yet evident across all areas for our cared for children, but there are indications that some areas show improvement e.g. recording of management decisions being recorded on the child's record, and statutory visits in timescales. However, practice for cared for children generally requires improvement.

Next steps – how we will sustain and embed progress: The audits will continue to reflect and report on the compliance and quality of practice for Cared for Children in Cheshire East, to supplement other performance information to managers. The improvement in practice will be reflected as other areas for action make progress.

14. Ensure that comprehensive and clear data and performance information are provided to managers and strategic leaders to enable them to better understand, oversee and scrutinise performance. This includes ensuring the accuracy of the information provided through the electronic recording system so that managers have effective oversight of frontline practice.

Background to the recommendation:

- There was no annual performance report for children's services to outline and explain our progress compared with previous years against national performance and statistical neighbours, which would assist political leaders, partners and staff

to understand and follow the improvement journey and demonstrate what performance means for children and young people.
- The electronic recording system for Children's Social Care was replaced with a modern case management system to support effective social work practice.
- The migration of data from the old system to the new one resulted in some anomalies and unreliable data. As a result, managers were not always confident about what the data was telling them, and managers were unable to readily identify the right data without a time consuming check of individual records or audits of casefiles. This made it difficult for managers to understand and manage performance in their services and teams.

Activity, current position and impact: A performance scorecard for the whole of children's services has been developed, the annual version of this will be received by Children and Families Scrutiny Committee to support them to determine the areas of focus for the year.

Work has been completed to develop performance monitoring across teams and to ensure a range of reporting suites are available on children in need and child protection, cared for children and care leavers. As at the end of March 2016, there are 61 live reports in the live reporting environment that can be run by Managers and staff to complement the reports that are readily available from the live electronic recording system. Live performance profiles are also available for each team manager to run which shows their team's performance against the key areas, such as timeliness.

An additional 5 reports are currently in development. The key areas for development are adoption and fostering reporting suites, and the implementation of the Early Help module and the supporting reporting infrastructure.

Training has been provided to all managers around running and extracting reports to support performance management. In addition, requests are received by the Business Intelligence teams to provide reports to support performance monitoring. Use of these by managers is still not routine but this is improving substantially.

Performance Challenge data is produced and sent to managers on a fortnightly basis to supplement readily available reports. Performance Challenge Sessions now take place on two levels; Senior Managers challenge Service Managers on their service's performance, and the sessions have also been extended to Team Managers and Social Worker Pod Teams, which are challenged by the Service Manager. All performance, including individual performance is scrutinised through the performance challenge sessions, which is helping to embed accountability and the expectations on practice. These sessions are also supporting development of a culture of performance monitoring and challenge from team managers.

The Performance Challenge sessions have substantially improved the timeliness and accuracy of data loaded into the system. Any areas of concern are highlighted at challenge sessions or with specific managers.

Specific performance areas are also explored through various monthly tracking meetings, such as cared leavers in unsuitable accommodation, and a range of trackers are kept to facilitate detailed scrutiny on performance in these areas.

It has been 18 months since the launch of the new child's record system, and the quality of data due to migration is no longer a significant issue as it was at the time of the inspection. The quality of the data is becoming better and better as time progresses and new records are loaded onto the system. Monthly case management development sessions are held with LiquidLogic to support developments to the system.

Next steps – how we will sustain and embed progress: We will continue to develop the suite of live reports available and support good frontline practice and recording to ensure the quality and integrity of the data. The Business Intelligence Team has a list of reports requested and those currently in development, and these are discussed at the monthly case management systems meeting in terms of priority for development. Performance will continue to be closely monitored to drive improvements through the Performance Challenge Sessions.

16. Strengthen commissioning arrangements to ensure that services meet the needs of families and children in need of help and protection and children looked after by:

- ***Reviewing the use of foyer accommodation for 16-17 year olds***
- ***Ensuring that rigorous risk assessments are undertaken before the placement of young people in foyer or hostel accommodation, and review the practice of using this provision***
- ***Ensuring sufficient health provision for older looked after children and care leavers***
- ***Improving the use of family group conferences so that all possible options for children are consistently explored***
- ***Increasing the capacity of advocacy services to support children and young people identified as in need.***

Background to the recommendation:

- There was no joint commissioning strategy in place.
- Foyer accommodation was used as a last resort for young people who are not yet adults. Providers of this accommodation completed risk assessments on all young people under the age of 18 at the start of the placement, but did not routinely complete them on older care leavers who could be equally vulnerable.
- Assessments for these young people were not detailed enough, and did not specifically address the potential impact of the setting on the young person.
- The 16+ Cared for Young People's Nurse post had been vacant since April 2015, and although this post was covered, it was not always provided by the same person which reduced consistency.
- There was no specialist health resource for care leavers over the age of 18.
- Family Group Conferencing was not used well and its impact was not known.
- Not all children in need were offered advocacy.
- Some cared for children experienced delays in being matched with an independent visitor.

Activity, current position and impact: A Children's Joint Commissioning Strategy has been drafted. This was discussed at Children's Senior Leadership Team in February 2016 and will be considered by the Health and Wellbeing Board in May.

Cheshire East is adopting the ignition approach, which is based on the voice of individual young people directly influencing decisions about their 16+ accommodation and support. The approach assesses the full range of accommodation offer (including Foyer) to ensure the most appropriate placement decisions. A robust risk assessment tool is now in place for use with YMCA/ foyer accommodation.

The 16+ and transition nurse post has been advertised to cover Cheshire East's 16-25 year old young people. Interviews are planned for April 2016. A Nurse Specialist for Cared for Children has taken up this post working 2 days alongside the Designated Nurse for Cared for Children. The CCGs are reviewing the provision of cared for children's health services to ensure that this is effective across all service areas.

The use of Family Group conferencing has been reviewed. Family Group Conferencing will be brought in house and will be integrated as part of the new model for children's social care to improve consistency and support for families.

The take up of advocacy and independent visiting services has been reviewed and target priorities have been set through negotiation with commissioned provider, The Children's Society. The contract has been amended to ensure the advocacy service is offered to children and young people on a CSE plan, and all children subject to a plan prior to their first review.

71 children and young people were accessing advocacy in quarter 4. 94% young people were pleased with the service they received. The Independent Visiting Coordinator and the Service Coordinator have promoted the service to social workers at the Practice and Performance workshops in June 2015. New leaflets have been produced to promote the service, which social workers share with children and young people. Young people have developed a short animation for young people to explain the role of an advocate and an independent visitor which will also be used to promote the service to children and young people.

Next steps – how we will sustain and embed progress: We will continue to work with Crewe YMCA to improve the foyer offer. We will continue to track and monitor all care leavers deemed to be in unsuitable accommodation to actively seek alternatives that meet their needs. We will inform the review of the provision for cared for children's health services. We will continue to monitor the up take and quality of advocacy and independent visiting. We will develop one model of working within children's social care which includes Family Group Conferencing.

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

151: Complete work to develop the performance management framework so that service effectiveness can be evaluated rigorously across all agencies

Background to the recommendation: Use of performance data to analyse and scrutinise partnership performance was not fully developed. More work was needed in order to reach an agreement on which data should be included within the LSCB

performance scorecard in order to ensure robust oversight and scrutiny of safeguarding practice.

Activity, current position and impact: The LSCB scorecard has been further developed and strengthened; it covers a range of measures from all partners and has been aligned with the areas of focus for the LSCB and the partnership from the Ofsted Inspection Report. It now gives a robust oversight of safeguarding practice across the partnership. The LSCB Quality and Outcomes Sub Group is effectively scrutinising and challenging partnership performance, and is driving improvements to partnership working. This includes identifying risks to improving outcomes across the partnership that are subsequently added to the LSCB's risk register where they are monitored and challenged until progress is made.

A range of quality assurance activity supports performance monitoring. Arrangements for this are robust, and support and supplement partnership performance monitoring. This includes the LSCB multi-agency audit programme, LSCB frontline visits, and the annual LSCB Children and Young People's Challenge and Evidence Panel. The Challenge and Evidence Panel is run by young people, who challenge LSCB members on the key safeguarding issues that are important to children and young people in Cheshire East. This is informed by the themes highlighted in the Children and Young People's Safeguarding Survey.

LSCB audits have shown that further work is needed to improve SMART planning, and ensuring that the progress against plans is evaluated and tracked in meetings. In the last LSCB thematic audit on parental mental health, 60% plans were considered to be clear, but all other indicators of a SMART plan were considerably lower with 54% considered to be outcome focussed, 58% focussed on risk and need, 56% clear about professional roles, and with contingency arrangements outlined in just 37%. In response to this, all LSCB multi-agency training now includes references to SMART planning, and the Safeguarding Children Operational Group (SCOG) are reviewing and updating the one minute guide on SMART planning so this can be communicated widely across the partnership to support good practice. Improvements to SMART planning and the quality of plans are also being driven through Children's Social Care which is discussed in detail in section 9.

Findings from LSCB audits are driving improvements to practice. The need to improve communication between GPs and the safeguarding unit so that GPs are aware of the concerns and inform child protection planning was a recurring theme from the last two LSCB audits. The named GP has visited the visited the majority of GP practices in Cheshire East completing direct work with the practice managers to improve their processes and arrangements. Work has been completed between the safeguarding unit and the named GP which has resulted in strengthened data reporting. Quarterly reporting has now been established to monitor the impact of the work to improve communications. As a result of this work, the percentage of initial case conferences informed by GP reports has improved from 35% in quarter 2 to 62% in quarter 3. This still needs to improve and further work is being carried out to ensure progress in this area continues to be made. Quarterly updates are received and scrutinised by the LSCB Quality and Outcomes Group to drive and monitor the progress in this area. Work is underway within Children's Social Care to ensure GPs are notified of children in need (CIN).

LSCB frontline visits have shown that there is commitment to engage children and young people in service planning across the partnership, and some good examples of this were found such as children and young people's participation in developing the new child protection conference model. Frontline staff welcomed the feedback from LSCB audits through the staff newsletter and said they used this to improve their practice. Most organisations provided examples of how they have learned from SCRs and this was cascaded well throughout the teams via team meetings and bulletins. Most staff felt confident in raising a challenge and some have experienced their service challenging another agency or partner agency challenging them. However, staff were unclear on the policy and procedure for resolving professional disagreements. This policy and procedure has now been reviewed and strengthened, and the resolution process has been incorporated within the child's record system. Awareness raising of the new policy and procedure has been completed with frontline managers through the Safeguarding Children Operational Group (SCOG) and through the Multi-agency Practice Standards.

Next steps – how we will sustain and embed progress: The LSCB quality assurance framework will be revised in April/ May 2016 in line with the production of the LSCB annual report and the review of the LSCB Business Plan priorities. The LSCB multi-agency audit process will be reviewed as part of this process to align with the business plan priorities and key areas for partnership improvement in the Ofsted inspection report. A multi-agency audit on the toxic trio will take place in May 2016 to complete the current LSCB audit cycle. The findings from this will be used to drive improvements and to evaluate progress.

The LSCB frontline visits and LSCB Challenge Sessions are both effective, established methods of scrutinising partnership practice. These two methods will be dovetailed to allow evidence from service managers and the frontline to be triangulated with performance information around the LSCB's key priority areas.

IROs will attend the GP level 3 safeguarding training In April 2016 to cover what makes a high quality conference report and to remind GPs of the process for case conference. The named GP is currently undertaking targeted practice visits to those practices that appear to not be submitting reports consistently to ensure they have robust processes in place. Reports on progress in this area will continue to be received by the LSCB Quality and Outcomes Sub Group.

152: Provide regular scrutiny of services for looked after children. Monitor and review the application by partner agencies of the threshold framework and take appropriate action where necessary.

Background to the recommendation:

- The focus of the LSCB's work and scrutiny had been on child in need and child protection services, as these had been inadequate.
- Cared for children's services had not received the same level of scrutiny and challenge on the quality of their service provision.
- Consideration and scrutiny of early help services was not sufficiently embedded in the strategic oversight and work of the LSCB.
- There were inconsistencies in stepping down to lower levels of intervention.
- Escalation processes were underused.

Activity, current position and impact: The business support functions for the LSCB and the Corporate Parenting Board have been aligned within the same team which is ensuring that both boards are sighted on the key issues and are informed of the activity of one another. Key reports on the quality of cared for children's services have already been received by the LSCB, Executive and relevant subgroups and further reports are scheduled for receipt by the LSCB over the year. The LSCB also receives regular updates on progress against the Improvement Plan, including areas relating to cared for children.

An Early Help Challenge session was carried out in November 2015 where the LSCB scrutinised and challenged the quality of early help provision across the partnership. This session found that early help services need to be more joined up, including with adult services, and that monitoring and evaluation of the quality of work needs to be strengthened. Since this session, a LSCB Early Help Sub Group has been established to drive improvements to the quality of early help services, and this sub group reports to the LSCB Executive.

Reports on the application of the threshold framework are received and reviewed by the LSCB to ensure this is applied consistently across the partnership and this is considered through the LSCB audits and LSCB frontline visits. The LSCB frontline visits completed in quarter 3 found that most practitioners had a clear understanding of thresholds and that this is supported through training and advice available.

The professional dispute process has been revised and relaunched to make it clearer in response to staff feedback received through the LSCB audit and frontline visits as outlined above.

Next steps – how we will sustain and embed progress: Reports on the quality of cared for children's services and the Improvement Plan will continue to be received regularly by the LSCB.

Evaluation of the application of thresholds will be included within the revised LSCB multi-agency audit process. The application of thresholds will be a key focus at the LSCB's Leadership Summit in May.

The Early Help Sub Group will continue to drive and coordinate improvements to early help services across the partnership and this will be monitored by the LSCB and LSCB Executive to ensure that the recommendations from the Early Help Challenge are met. The CAF audit process is currently being reviewed and revised to strengthen this as a form of evaluation, and these audits will be reported to the Sub Group.

The application and use of the professional disagreement and resolution policy will be evaluated and reviewed to ensure it is resulting in the desired impact.

153. Evaluate the impact of the neglect strategy and disseminate the findings to help agencies improve their practice.

Background to the recommendation:

- In response to high numbers of children and young people subject to child protection plans due to neglect, the LSCB launched a neglect strategy in January 2015.
- The graded care profile was not being used consistently to assess neglect cases.
- Plans were in place to undertake further work to embed use of the tools, and then to audit to assess the impact of the strategy early in 2016, but this had not taken place at the time of the inspection.

Activity, current position and impact: A new LSCB multi-agency training programme on neglect was launched in January 2015, and 235 practitioners have received the training so far. This is not yet having sufficient impact on practice, as graded care profiles are still not being used routinely to assess and evaluate the extent of neglect.

In order to address this, the Neglect Strategy Task and Finish Group has been reinstated, led by Nigel Moorhouse Director for Children's Social Care, to drive the relaunch of the strategy and use of the graded care profile. A neglect scorecard has been developed that contains the key measures set out in the strategy and is being used to inform the LSCB on impact of the strategy. Graded care profile training is now a mandatory training course for all ASYEs (Social Workers in their assisted and supported year of employment).

Key strategic managers from children's social care are attending all the Ofsted 'Getting to Good' seminars on neglect to learn from best practice and share with relevant staff. All partners will report on progress against the LSCB business plan priorities in their annual reports, including progress against reducing and tackling neglect.

Next steps – how we will sustain and embed progress: The Task and Finish Group will review the impact of the strategy through the reporting mechanisms that have now been developed and will drive the actions to embed use of the graded care profile, including a relaunch of the strategy and tools.

A multi-agency audit will be conducted to evaluate the impact of this on frontline practice as part of the LSCB audit programme.

154. Develop links with the Local Family Justice Board so that CESCB can monitor how well the needs of children in public and private law proceedings are met.

Background to the recommendation: The LSCB had no oversight of or connection to the Local Family Justice Board, so it could not assure itself that young people's needs were being met in relation to public and private proceedings.

Activity, current position and impact: A report from CAFCASS was given to the LSCB Board in January 2016, and the Board agreed focussed areas for scrutiny in terms of performance. Performance measures are included on the LSCB performance scorecard which are scrutinised every quarter. CAFCASS performance will be reviewed in the LSCB Business Plan and Annual Report.

Nigel Moorhouse, Director of Children's Social Care, is the named link with the Family Justice Board and identifies any issues that need to be brought to the attention of

the LSCB. Update from the Family Justice Board is a standing item on the LSCB Executive and LSCB Board agendas. Regular meetings taking place between area managers and CAFCASS, and there is established and regular communication between CAFCASS and IRO managers.

Next steps – how we will sustain and embed progress: Reports from CAFCASS are on the forward plan for scrutiny from the LSCB Board and LSCB Quality and Outcomes Sub Group.

155: Review the arrangements for monitoring the quality of private fostering work.

Background to the recommendation: The arrangements for case management of private fostering were not sufficiently robust. Private Fostering cases sampled showed delays in responding to notifications, DBS checks, visits and decision making.

Activity, current position and impact: Awareness raising is now routinely carried out and recorded. Materials and posters have been used to support a publicity campaign and are included in a pack which is provided to all social work teams.

Data on compliance with DBS Checks has been compiled to inform the LSCB, which revealed that there are still significant delays in obtaining DBS checks. The lead IRO for Private Fostering is developing a process for obtaining timely DBS checks and management sign off which will be formalised in the Private Fostering policy and procedure.

This year we have nearly doubled the number of privately fostered children and young people we are aware of in Cheshire East, from 6 to 11 new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases.

The LSCB Private Fostering Sub Group has sought previously privately fostered young people's views on service to inform service evaluation and development. The three young people interviewed were very positive about the support they had received from their social workers "They wanted to know what was going on for me, I felt listened to", and reported that they felt cared about and safe. They were all visited very quickly following the initial referral, however the first visit was not used to full effect in that a lot of information sharing and gathering at that point was missed out. All three young people felt this was important they wanted to know they could stay as quickly as possible. Two of the young people expressed concerns about the financial implications their care had on their carers, and said that they didn't like to ask for things like toiletries and make-up and this caused them stress. The young

people felt that process for receiving additional monetary support needed to be dealt with far quicker and advice in this area should be improved. An action plan to improve services based on this feedback has been developed to address these areas.

Performance on Private Fostering is monitored through the LSCB scorecard and a progress report from the Chair of the Sub Group is received by the LSCB Executive.

Next steps – how we will sustain and embed progress: A multi-agency stocktake of private fostering arrangements will be carried out, which will inform the development of a focused Private Fostering Strategy. A multi-agency audit of the quality of casework will be carried out in June and this will inform further service development.

The LSCB Private Fostering Sub Group will respond to any areas for development identified through the multi-agency audits. The private fostering annual report will be scrutinised by the Quality and Outcomes Group and areas for further development will be identified.

156: Improve the influence of CESCB in the work of the Health and Wellbeing Board to ensure that safeguarding is embedded within its priorities.

Background to the recommendation: Strategic links between the LSCB and the Health and Wellbeing Board were not explicit. As a joint adults and children's Board, the children's agenda within the Health and Wellbeing Board was not given sufficient priority.

Activity, current position and impact: The Health and Wellbeing Board (HWBB) is the accountable body for the Children and Young People's Improvement Plan and have received a number of reports on the outcome of the Ofsted inspection and the improvement plan. They have also received a presentation on the LSCB Annual report 2014-15 and business plan for 2015-16.

Key updates from Children's services have been scheduled on the forward plan for the Health and Wellbeing Board to ensure they have strategic oversight and scrutiny of the quality of children's services and the key issues for children and young people in Cheshire East. Other reports around children's issues, including a report on the health of cared for children have been considered by the HWBB.

The Health and Wellbeing Strategy is currently being refreshed, and this will align with the areas of the Cheshire East Children and Young People's Plan, which is already aligned with the Corporate Parenting Strategy and LSCB Business Plan.

A development plan for Health and Wellbeing Board Members has been developed, which includes observing and meeting with key teams and groups. Members of the Board have been canvassed for their training and development needs relating to children's services and responses are currently being collated and will inform the training and development offer to the Board to ensure all members have the necessary knowledge and context to effectively scrutinise the quality of children's services and whether they are meeting the needs of children and young people in Cheshire East.

Next steps – how we will sustain and embed progress: The HWBB will continue to receive regular updates on progress against the improvement plan. The LSCB Annual Report for 2015-16 and Business Plan for 2016-17 is on the forward plan to be discussed at the Health and Wellbeing Board in July. Other reports relating to children's issues are scheduled to go to the board in 2016-17. This will ensure that children's issues continue to be championed at the HWBB and that they are informed and scrutinise key issues in relation to children's services.

157: Develop and implement a coordinated strategy in relation to female genital mutilation so that the impact of multi-agency work within Cheshire East can be evaluated and understood.

Background to the recommendation: The work in relation to female genital mutilation was not yet coordinated. Health agencies recorded the prevalence of incidents but this was not formally reported to the Board.

Activity, current position and impact: It was agreed that this work would be best progressed on a pan-Cheshire basis. A LSCB task and finish group, led by the Named GP, working in partnership with local hospital trusts, has been established to agree and monitor a FGM pathway as part of a Pan Cheshire co-ordinated strategy. The procedure for FGM is currently out for consultation.

Next steps – how we will sustain and embed progress: Launch the FGM strategy across the pan-Cheshire area and evaluate its impact after 6 months.

158: Implement a protocol that outlines when the National Panel should be notified about SCRs and incidents in order to strengthen scrutiny of decision-making.

Background to the recommendation: There were no serious case reviews (SCRs) commissioned in the last four years; those cases considered for SCR had not been referred to the National Panel. This meant that there had not been any external monitoring of the thresholds to undertake a SCR.

Activity, current position and impact: A notification process for when the National Panel should be notified about SCRs and incidents has been developed and launched and is on the LSCB website. The online procedures for SCRs are currently under review on a pan-Cheshire basis.

Next steps – how we will sustain and embed progress: Revision of the online procedures for SCRs to ensure these are clear for practitioners. Plans are underway to commission an independent review of the application of the threshold for cases in Cheshire East and the notification process to critically assess its effectiveness, however this may be subject to change following the Government's review of the LSCB functions including Serious Case Reviews; this is expected in April 2016.

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Quarterly Improvement Performance Scorecard - March 2016

No	Rec	Rec Summary	Measure	What it Shows	Thresholds			Q1	Q2	Q3	Q4	Comment/Additional Information
					Requires Improvement	Good	Outstanding					
Listening to and acting on the voice of children and young people												
1	15	Learning from complaints	Percentage of complaints resolved at stage 1	If complaints are resolved at stage 1 this shows that we have listened to the complainant and that they have been responded to appropriately.	75-84	85-93	95-99	80%	94%	100%	80%	Q4 - As at 8 April 2016, 20 out of 25 complaints had been resolved and closed at Stage 1, equalling 80%. Work is ongoing with the other 5 - including meetings - to try and resolve these at Stage 1. None have yet been escalated to Stage 2.
Frontline practice is consistently good, effective and outcome focused												
2	2	CP Chairs and IROs address drift and improve planning	Number of Practice Alerts made	Practice Alerts being raised demonstrates that IROs are challenging practice				58	60	28	*11*	This data is taken currently from the safeguarding sharepoint which is incomplete for February and March as it is compiled from manual reports from the IROs. An accurate figure will only be available at the end of the month.
3			Percentage of Practice Alerts addressing drift	This demonstrates that IROs are challenging and addressing drift				3%	7%	4%	2%	There are issues with the accuracy of the reporting. These figures represent formal alerts where concerns about drift have not been responded to and issues could not be resolved at an informal level. It is diffcult to make a judgement about the figure other than there are still children where drift is needing to be addressed. You would exepct fluctuation dependent on the children reviewed that quarter.
4			Percentage of cases alerted due to drift where this was addressed before escalation beyond formal stage 1	This indicates if drift is addressed promptly in response to Practice Alerts	75-84	85-94	95-100		75%			This is a new measure - data is currently being collected to report on this
5			Percentage of Practice Alerts resolved at formal stage 1 or before	Response to Practice Alerts within timescale shows that challenge is being acted on to improve practice.	75-80	81-85	86-90	100%	100%	100%	100%	All practice alerts were resolved before formal stage 1 which is positive.
6			Percentage of Child Protection Conferences held within timescale	Child Protection Conferences should be held within timescale to ensure progress is made against the plan, and that there aren't delays for children and young people.	85-89	90-94	95-100	82%	92%	98%	92%	Whilst every effort is taken to ensure that all CP conferences are held within timescales occassionally delays are unavoidable. There is a weekly report that sets out the delays, the reasons why and which team these were from. 100% of CP and review conferences were held within timescale for quarter 4. The initial case conferences that were out of timescale were due to late notification from social workers.
7			Percentage of Child Protection Plans open for more than 15 months	Child Protection Plans should not remain open for more than 15 months in the majority of cases.	16-20	10-15	Below 10	11%	6%	6%	6%	All CP plans open over 12 months are scutinised closely by Safeguarding and frontline teams to ensure plans are appropriate and are achieving their aims in a timely fashion. 16 children and young people (from 7 families) have currently been on a plan for 15 months or more. All these cases have been scrutinised to ensure there is not delay for these children and young people
8			Percentage of children and young people's views that are heard at Child Protection Conferences	Children and young people's views are represented at child protection conferences to ensure these are considered by all professionals.	70-80	81-90	91-100	87%	94%	95%	90%	Children and young people's views are presented at conference in a variety of ways either through attendance, evidence from visits and reports presented at conference. Whilst every effort is made to obtain the views of individuals there will be times when they refuse to speak to Social Workers. there is an advocacy service at first review for all children subject to a plan but the commissioned service is struggling to provide this. this is being addressed with them.
9	4	Timely Early Help	Percentage of decisions made within 1 working day	Timeliness of decision making	70-80	81-90	91-100					System reporting has just been established for this service, but is not yet reliable for reporting performance. We will be sampling from cases to understand the child's journey and to assess the quality of the data reporting.
10			Maximum time taken from contact to referral to Early Help Services	The greatest time taken for a decision on what service is right for the child/ young person.	5 working days	3 working days	1 working day					
11			Maximum time taken from referral to receiving Early Help Services	The longest time is has taken for a family to receive a service	7 working days	5 working days	2 working days					Currently we have no way to report on this measure, we are looking at ways to build this into the reporting system so that we can clearly identify how swiftly families receive services and consider how we can improve their experience. We are aware that demand is currently outweighing our capacity so some families do wait to receive a service.
12	7	Strengthen frontline practice for CSE and MFH	Percentage of cases where return interviews have been completed following missing from home or care (Individuals)	Return home interviews are important to ensure the risks and reasons for the young person going missing are understood, however these are voluntary. A high percentage shows good engagement with young people.	70-75	76-80	81-90		71%	69%	71%	The agreement for the independent service to conduct an return interview is voluntary. Some individuals have declined to completed a return interview. The decline can be from the parent or carer or from the child or young person. All declines are scrutinised via the MFH/CSE Sub group and performance reviews of the commissioned service. Where the young person or parents have declined a return interview from the independent service and they have a social worker or lead professional via a CAF, contact is made with these professionals and Social Workers are made aware of their duty to complete the return interview in line with the Pan Cheshire Protocol; while the statistics don't reflect this, there may have been a higher number completed.
13	8	Quality of assessments	Percentage of children and young people seen within 10 days of the combined assessment start date	Children and young people's views and experiences are considered from the start of the assessment.	75-84	85-94	95-100	29%	54%	59%	65%	Although improving there still remains some issues with recording and linking in the correct visit date to assessments, which means this measure is under-reporting activity. In Q4 from reviewing cases there was clear evidence in 90% of cases that children were seen as part of the assessment. This recording issue has been raised at Practice and Performance sessions and performance is improving.
14	9	Quality of plans	Percentage of children and young people subject to a child protection plan for a second or subsequent time (cumulative)	The amount of children which have had support from children's social care were there was a high level of concerns, but then need this again at a later date. Demonstrates how well families are able to maintain the changes they have made – a low percentage is an indicator of good performance.	15-20	10-14	5-9	23%	21%	21%	19%	This measure considers repeat plans from any time period, eg if a child had a plan when they were 3 years old and then has one again at 15. If we limit repeat plans to within the last 2 years (so more likely to be due to similar cirumstances and issues), then performance is at 10%.
15	10	Appropriate step down or closure	Percentage of repeat referrals (cumulative over a 12 Month Period)	The amount of children which have had support from children's social care, but then need this again at a later date. Demonstrates how well families are able to maintain the changes they have made – a low percentage is an indicator of good performance.	25-30	20-24	Below 20	25%	22%	22%	22%	There is robust audit activity around both repeat referrals and contact activity to ensure that risk assessment and decision making is appropriate. This is also used to inform multi-agency training around information required at referral stage.
Senior management oversight of the impact of services on children and young people												
16	1	Senior managers' oversight of connected persons	Percentage of Reg 24 assessments presented to the fostering panel in statutory timescales	The correct process is being followed within timescale for connected persons	80-89	90-94	95-100	NA	100%	66%	100%	There is a small number in this cohort. There is increased confidence that all Reg 24 assessments are presented to panel, although some timescales need to be tightened around extensions.
17			Percentage of Private Fostering cases visited in timescales	Visits for Private Fostering cases are timely	80-89	90-94	95-100	100%	67%	83%	93%	There were six private fostering arrangements open during this period, so this figure is based on 15 potential private fostering visits within this quarter, 14 were completed within timescales - the one visit missed was unforseeable as young person had left country to return home for funeral, so this is good performance

18	1/155	Senior managers' oversight of private fostering	Percentage of Private Fostering cases that are reviewed by the ADM within 45 working days of notification	Private Fostering cases are appropriately overseen within timescale.	80-89	90-94	95-100	0%	0%	0%	0%	Two private fostering arrangements should have been signed off in February 2016, these were not seen by ADM within timescales. Both were delayed by the completion and receipt of DBS checks. There were three other private fostering arrangements in Quarter 4 however these all ended prior to the 45 days. In the current process, the ADM does not review case until DBS, PFAAR and the CIN Plan are in place. Practice standards and current procedures for Private Fostering will be review and updated in April 2016 to improve performance in this area.
19	1	Senior managers' oversight of YP in unsuitable accomodation	Number of care leavers recorded as homeless	Number of care leavers who are homeless or in unsuitable accommodation						3	3	Out of 184 care leavers within the 18th, 19th, 20th & 21st birthday cohorts, there are 3 in unsuitable accommodation. Two of these are considered unsuitable as they are in custody/prison and one is unknown, but not engaging
20	16	Strengthen commissioning arrangements	Number of children and young people using advocacy	Advocacy is being offered and used				41	39	46	71	Of the 71 cases, 51 are Child Protection cases
21			Number of children and young people using advocacy that are at risk of CSE	Advocacy is being offered and used by young people at risk of child sexual exploitation				0	1	1	3	7 referrals for Child Protection Advocacy with CSE risk came in during this quarter. 1 opted out, 3 have been offered the advocacy service but have not confirmed as of yet as to whether they wish to use the service and 3 are using the service this quarter
22			Number of children who agreed to access advocacy services who did not receive the service prior to the first Child Protection review.	Children and young people are being encouraged to access advocacy services to get their voice heard				0	3	1	0	All children who agreed they wanted the service received a service prior to their first Child Protection review .
23			Average time young people wait to be matched with an independent visitor	The delay children and young people experience in being matched with independent visitors				5-6 months	4-7 months	3 months	2 months	There were 3 referrals in Q4. Of these three, two were matched within 2 months, and 1 other is still awaiting a match.
The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.												
24	153	Impact of the neglect strategy	Percentage of children and young people on child protection plans due to neglect	The prevalence of neglect in Cheshire East	2% reduction	5% reduction	10% reduction	56%	48%	47%	44%	The latest IRO sample audit on CP plans for emotional abuse shows that the correct category of plans is not also used so this percentage may not be reflective.
25			Percentage of plans for neglect which have had a previous plan for neglect	The proportion of children and young people who need more support from children's social care, following intervention where changes were made.	20% - 16%	15%-10%	Below 10%	11%	16%	13%	17%	As at 31/3/2016 there were 35 individuals on a plan for neglect that had been subject to a plan previously. Of these, 20 has been subject to a previous plan for neglect.

Audit Improvement Scorecard - March 2016

NB: Measures relate to audits that commenced prior to the improvement plan (Q3 includes cared for audit findings, where appropriate)

No.	Audit Measure	Q1	Q2	Q3	Q4	Direction of Travel	Comment/Additional Information
1	% of case files meeting the standard for management decision making and recording	78%	66%	76%		↑	In this last cohort, auditors requested a management review in 13 cases, which shows that management decision making and recording is still an area that requires improvement.
2	% of children seen within 24 hrs of a Section 47 decision	42%	62%	67%		↑	9 cases in the last audit were appropriately the subject of S47 enquiries. Of those, 6 (67%) were seen within 24 hours. Of the 3 cases where the children were not seen within 24 hours two children were seen within 3 days. Neither constituted an immediate risk to the child .The third child was seen 7 days after the strategy meeting. The allegation was made by an older sibling who was seen in school within the 24 hour timescale, however all of the children within the family should have been seen within the 24 hour timescale.
3	% of Child in need (CIN) cases where there should have been a Section 47	100%	97%	100%		↑	There were no missed S47s in the last cycle.
4	% of CIN reviews with an appropriate recommendation for a change of plan including those reviewed by the Independent Reviewing Officer.	100%	88%	80%		↓	There were 5 cases where there was a change of plan - 1 was step down and 4 were step up. Of the 5 changes of plan, the Auditors queried 1 of the decisions. The Auditor did not disagree with the decision for Children's Social Care to close the case, but considered that a CAF should be put into place to provide continued support for the family. Following a discussion with the relevant Manager, a CAF was subsequently put into place.
5	% of CIN and child protection (CP) cases which meet the practice standard for incorporating and recording the views and wishes of children and young people.	77%	79%	86%		↑	Of the 22 cases audited, 19 (86%) evidenced children's wishes and feelings being incorporated, but the recordings of this were of a variable standard.
6	% of children who have a CIN plan after 35 days	42%	59%	67%		↑	This standard applied to 18 cases. 12 (67%) had a plan within 35 days, leaving 6 (33%) with a plan outside of the 35 day standard.
7	% of cases in which practice standard is met for regularity of visits by a social worker	79%	78%	67%		↓	Analysis of the data shows that the performance for CIN cases has improved, whilst there has been a dip in relation performance in CP cases. Performance challenge sessions are addressing individual and team practice in this area

Annual Improvement Performance Scorecard - March 2016

No	Rec	Rec Summary	Measure	What it Shows	Thresholds: Requires Improvement	Thresholds: Good	Thresholds: Outstanding	Annual Figure 2015-2016	Additional Information
Listening to and acting on the voice of children and young people									
1	15	Learning from complaints	Number of compliments received to Children's Social Care	The number of compliments should increase as we improve services	High is good			61	The number of compliments received this year has exceeded last year's figure of 42.
2			Number of complaints around particular themes.	The number of complaints on specific themes should reduce as these themes are addressed.				99	The number of complaints received last year in 2014-15 was 98, therefore the amount of complaints has stayed more or less the same.
Frontline practice is consistently good, effective and outcome focused									
3	2	CP Chairs and IROs address drift and improve planning	Number of good Practice Alerts made	Good Practice Alerts show that there is good practice and this is being recognised by IROs.				195	More good practice alerts have been made than those that challenge bad practice (157) which is positive, and shows that there is evidence of good practice and that this is being recognised.
4	3	Supervision is reflective, challenging and focused on CPD	Percentage of PDPs in place (ensuring gaps in practice identified through supervision are addressed)	All staff in post over 6 months should have a personal development plan (PDP) in place.	70-79	80-89	90-100	69%	This is in line with the wider Council's performance which overall has 71% of plans in place. However, this does also include a large proportion of new starters, who would not have a PDP until they had completed their 6 month probation period, so performance on this measure is higher than this figure suggests. We will be working to increase our performance in this area and a workshop will be given to social work staff and managers at the Practice and Performance workshops in June on PDPs to improve engagement with process and the quality and continued use and evaluation of development plans.
5	7	Strengthen frontline practice for CSE and MFH	Percentage of Social Workers who have been trained in using the CSE tools for assessment and intervention	The amount of Social Workers who have had the training to support them to work effectively with children and young people at risk of child sexual exploitation.					The core training offer for social workers has been launched in March 2016, which includes CSE training. The takeup of this offer will be closely monitored and evaluated over the next 6 months, and reporting will be available against this measure. Sessions on CSE have been provided to social work staff through the Practice and Peformance workshops in December 2015. CSE training is also available through e-learning.
6			Percentage of children and young people reporting that they feel safer at the end of the intervention for CSE	Children and young people feel safer as a result of the work that was completed to address the CSE risks	70-79	80-89	90-100	100%	This quarter saw an increase in engagement from teenage boys aged between 13 and 16. Prior to this quarter it was largely girls being worked with in this age bracket. The girls coming to the attention of the service have been largely very young or in the 17-18 year old bracket with a smaller percentage being in the 13-16 age range. The service has further strengthened partnerships with other agencies and service in this quarter which has had an impact on the offer of support available to young people and more seamless safeguarding.
7	8	Quality of assessments	Percentage of assessments completed within 15 days **Threshold only up to 50% as any higher would not be considered outstanding*	The amount of assessments completed within the target of 15 days to drive improvement to timeliness for assessments.	20-24	25-29	30-50*	28%	This measure is used to drive progress and ensure there is not unnecessary delay for children and young people. Performance on this measure is good, but we know form audit that the quality of assessments still require improvement overall.
8			Percentage of assessments completed within 35 days	The amount of assessments that are completed in line with Cheshire East's practice guidance.	65-70	71-75	76-100	78%	This shows that assessments are being completed in a more timely fashion and that the majority of children and young people don't experience delays, however we know that the quality of assessments are not at the level we want them to be.
9	11	Implementation of delegated authority	Percentage of Foster Carers that are clear on what decisions are delegated to them (Foster carer annual survey)	Foster carers are clear on the decisions they can make so this does not cause delays for children and young people	70-79	80-89	90-100		The Annual Foster Carer's survey has not been carried out yet but is planned to take place this year before July 2016.
Senior management oversight of the impact of services on children and young people									
10	1/155	Strengthen senior managers' oversight of private fostering	Number of open Private Fostering cases	Private Fostering is identified				14	The Annual Figure last year 2014 - 2015 was 6, this year we have nearly doubled this figure with eleven new arrangements and 3 carried forward from 2014-2015. We can attribute this to the awareness raising efforts of the LSCB Private Fostering Sub Group who have ensured that Private Fostering Recognition is on the agenda in Cheshire East. In particular we have seen an increase in education referrals regarding Private Fostering. In September 2016 a Private Fostering Refresher presentation was delivered at the quarterly Practice and Performance Workshop which impacted on the new referrals in Quarter 3. In addition to this, lots of work has been completed to improve the links and communication between the Safeguarding and Quality Assurance Unit and the CIN/CP Teams which has resulted in regular informal discussions regarding potential private fostering arrangements and requests for information and support on existing cases.
11	1	Strengthen senior managers' oversight of YP in unsuitable accomodation	Percentage of care leavers in homeless accommodation that have an appropriate risk assessment which references the risk presented by older residents	Risk assessments are being completed which consider the risks from other residents in order to protect young people	80-89	90-94	95-100		A newly revised risk assessment tool is being implemented from April 2016, as this has just been implemented reporting is not yet available for this measure. The new risk assessmenr tool has been sent out to every Personal Advisor and Social Worker working with these young people, and we are in the progress of re-assessing them using this new tool. Outcomes for all of these young people are being monitored by the Service Manager.
12	16	Strengthen commissioning arrangements	Number of young people placed in foyer accommodation	Young people in foyer accommodation are identified and monitored				11	We know how many young people are placed at Foyer accomodation. As of the first week of April this was 11, 5 of which are care leavers. Those that are care leavers have personal advisors who are risk assessing their placements using the new risk assessment tool. This risk assessment tool is also being rolled out to other parts of the service to ensure consistency of risk assessments for all young people placed in Foyer accomodation. A tracker reviews all young people placed at the Foyer on a monthly basis.
13			Percentage of children and young people that were pleased with the advocacy or independent visiting service they received	Children and young people felt that the service met their needs and their views were represented	75-79	80-89	90-100	94	We carried out 39 Outcome wheels with children and young people and under Having my Say there was an increase in score in 37 of them. We also carried out a National Service User satisfaction survey in December, we had 30 returns 21 were very happy and 9 were happy. We are looking at doing this every quarter rather than twice a year and splitting it into Issue based Advocacy, CP Advocacy and Independent Visitor to give more accurate results
The partnership effectively protects and ensures good outcomes for all children and young people in Cheshire East.									
14			Number of FGM cases identified in any age group that are recorded on the FGM enhanced dataset	Evidence that healthcare professionals are identifying and recording FGM					This information is being collated from GP practices and hospitals and will not be available until the end of April

15		FGM Strategy	Number of FGM cases identified in young people undr 18 reported to Cheshire Police via 101	Professionals are reporting FGM in accordance with the Serious Criome Act (2015)			This information will be available later in April.
16			Number of Police investigations following reported cases of FGM	Female Genital Mutilation is responded to and investigated			This information will be available later in April.
17	158	National Panel is notified about SCRs	Number of cases referred to Ofsted	Cases are referred to Ofsted		0	There have been 0 cases referred to Ofsted this year.
18			Number of cases referred for consideration for a case review	Cases are considered for case reviews		3	3 referrals were received but not met the criteria for a SCR
19			Number of single agency case reviews held	Number of cases meeting this level of review		1	1 case (SAR001) was reviewed this year on a single agency basis.
20			Number of reflective reviews held	Number of cases meeting this level of review		3	3 reflective reviews have been held and lessons learnt have been disseminated through LSCB communications and the Sfaeguarding Children Operational Group (SCOG)
21			Number of serious case reviews held	Number of cases meeting this level of review		0	There have been no serious case reviews held as no cases this year met the criteria.
22			Number of ‘True for Us’ reviews held	Number of opportunities for learning we have used to develop services in Cheshire East		1	City and Hackney true for us exercise completed and reviewed for learning
23			Number of cases referred to the National Panel	Compliance with the protocol and that cases are referred to the National Panel		1	1 case which did not meet the criteria for SCR was notified to the NPE for verification by LSCB Chair.

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REPORT TO: Health and Wellbeing Board

Date of Meeting: May 31st 2016
Report of: Guy Kilminster, Cheshire Pioneer Interim Director
Subject/Title: The Cheshire Integrated Health and Care Pioneer Programme

1 Report Summary

1.1 The Cheshire Integrated Health and Care Pioneer is now in its third year. There is a need to revisit the aspirations and running of the Programme in the light of the requirement to draft Sustainability and Transformation Plans and with developments in Caring Together, Connecting Care and the West Cheshire Way over the last three years. Similarly we need to determine that the partners through the Cheshire East and Cheshire West and Chester Health and Wellbeing Boards are willing to reaffirm their support to continue as a Pioneer area and the commitment of resources to support its implementation for the remainder of the Programme.

1.2 The Report summarises last year's costs, achievements and challenges, sets out proposed budget requirements for 2016 - 17 and options for appointing to the post of Pioneer Director.

2 Recommendations

2.1 That the Health and Wellbeing Board notes the background to, achievements and costs of the Programme for 2015 – 2016.

2.2 That the Health and Wellbeing Board reaffirms its commitment to retaining Pioneer status as part of the transformation of health and care across Cheshire Programme and recommends to the Partner organisations that they support the budget commitments for 2016 – 2017.

2.3 That the Health and Wellbeing Board considers and agrees the preferred arrangements for the post of Director.

3 Reasons for Recommendations

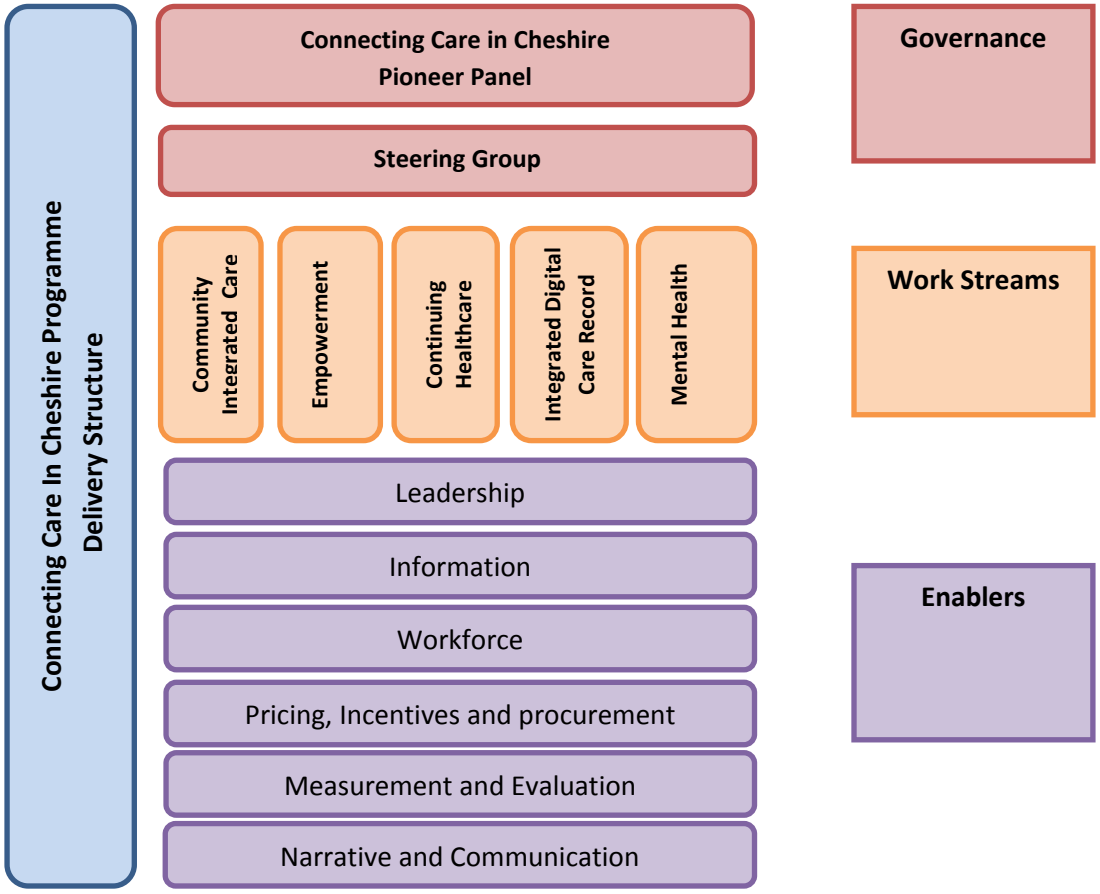
3.1 To ensure that the Cheshire Integrated Health and Care Pioneer can continue to add value to the Health and Care transformation activity across Cheshire.

4 Background and Options

4.1 NHS England launched the Pioneer initiative in 2013 and Cheshire East and Cheshire West and Chester's Health and Wellbeing Boards agreed to submit a combined bid to become a Pioneer area (See Appendix One). This was successful and the Pioneer Programme went live in April 2014.

4.2 The underpinning principle of the Pioneer submission was that the Cheshire Pioneer would support the three local health and care transformation Programmes, **The West Cheshire Way, Caring Together** and **Connecting Care**, where it was sensible to do something once across all three Programmes. It would also facilitate sharing and learning across the local programmes.

4.3 The Pioneer Programme work-stream model is illustrated below:



4.4 Key achievements in 2015 – 2016 were the work to deliver the Cheshire Care Record, an integrated digital care record allowing clinicians and social workers to access patient/client data. This went live in April and will have all relevant data flowing into it by July. The Mental Health Commissioning Review is making good progress with a joint strategic needs assessment developed by the two Public Health Teams, a Service Mapping workshop held and the Children's Strategy drafted. We have also been progressing a number of workforce related projects with external funding secured to develop a Career and Engagement Hub and a

Connecting, Learning and Improvement Academy. In addition support from Skills for Care, Skills for Health and the Local Government Association was secured to facilitate the Pioneer's use of the Workforce Repository and Planning Toolkit and to develop the narrative for change to use with the workforce as part of the conversations about transformation and doing things differently. Finally we have utilised support from the Leadership Centre to review and improve systems leadership across the Cheshire Pioneer. This is ongoing.

4.5 The Pioneer Panel agreed in May 2015 to an operational budget for the Pioneer Programme of £113,111, based on the costs of the Programme Director and administrative support, with a 10% additional amount for activity costs. The total costs incurred for the year were £72,483 (the difference being due to the Director leaving in October and there not being any recharge made from Cheshire East for the interim Director's time (see para 4.6 below)). These costs have been covered by a one off grant of £100,000 from NHS England received in December 2015 to be used towards Pioneer costs in 2015-2016, so no costs have been incurred by partner organisations.

4.6 It should be noted that the Director role has only been covered on a three day a week basis since the end of October 2015. The cost of this to the year end (2015 – 2016) was £15,950. However, Cheshire East Council's Director of Public Health agreed not to recharge the Pioneer partners for any contributions to this cost, nor to recover it from the NHS England monies. This was conditional on the Pioneer Panel agreeing that the resultant underspend on the £100,000 is used to support the Workforce Development work-stream (up to £9,500) and the Mental health commissioning review work (up to £18,000), which the Panel agreed at its meeting on 9th March 2016.

4.7 For 2016 – 2017 the Director arrangement needs to be reviewed given that the seconded Programme Director post-holder left in October 2015 and the interim cover from Cheshire East Council was initially agreed to the end of March 2016. The tables below summarises the budget implications for partners based on i) a full time Director and ii) a three day a week Director.

i) Full Time Director

		2016/17 Pioneer Budget – Full Time Director & Administrative Officer + 10% Contingency			
Partner Organisation	**Approximate Population**	**Cost of 50% of Total**	**Cost of Population Element**	**Plus 10% for General Expenditure**	**Total 2016/17 Contribution**

					by Partner
Cheshire East Council	370,100	£8,569	£13,308	£2,188	£24,065
Cheshire West and Chester Council	330,200	£8,569	£11,874	£2,044	£22,487
NHS Eastern Cheshire CCG	201,000	£8,569	£7,228	£1,580	£17,376
NHS South Cheshire CCG	173,000	£8,569	£6,221	£1,479	£16,269
NHS Vale Royal CCG	102,500	£8,569	£3,686	£1,225	£13,480
NHS West Cheshire CCG	253,000	£8,569	£9,098	£1,767	£19,433
Proposed Total		**£51,414**	**£51,414**	**£10,283**	**£113,111**
		£102,828			

ii) Part Time Director (3 days a week)

Partner Organisation	Approximate Population	Cost of 50% of Total	Cost of Population Element	Plus 10% for General Expenditure	Total Estimated 2016/17 Contribution by Partner
Cheshire East Council	370,100	£5,505	£8,550	£1,405	£15,460
Cheshire West and Chester Council	330,200	£5,505	£7,628	£1,313	£14,446
NHS Eastern Cheshire CCG	201,000	£5,505	£4,643	£1,015	£11,163
NHS South Cheshire CCG	173,000	£5,505	£3,996	£950	£10,452
NHS Vale Royal CCG	102,500	£5,505	£2,368	£787	£8,660
NHS West Cheshire CCG	253,000	£5,505	£5,845	£1,135	£12,485
Proposed Total		**£33,030**	**£33,030**	**£6,606**	**£72,666**

4.8 The current interim Director arrangement needs to be revisited for 2016 – 2017 and a decision made as to whether or not a Programme Director is to be appointed on a full time basis for the remaining three years of the Pioneer initiative. The Administrative Assistant's existing secondment arrangement runs until the end of March 2017. The options are:

A – Recruit a full time Programme Director
B – Recruit a part time Programme Director
C – Continue or revisit an interim arrangement
D – Explore the potential for the sub-regional Programme Office to pick up the responsibilities of the Programme Director.

All of the above options will require partners to continue to contribute to the costs on the basis of the population split in the table above.

4.9 A critical issue related to this decision is the need to review the commitment of all partners to retaining Pioneer status and utilising the Programme to add value to the Transformation programmes (West Cheshire Way, Connecting care and Caring Together) and the relationship of the Pioneer to the discussions regarding devolution and more recently the requirement to prepare sustainability and transformation plans. At the Pioneer Panel meeting on 9th March it was agreed that the aspirations of the Pioneer bid as submitted in 2013 need reviewing to ensure that they are still relevant.

4.10 With the pressures in the system faced by all partners, there is evidently an issue regarding the capacity of some to engage in the Pioneer work-streams. This is hampering progress and puts at risk our ability to report to NHS England on Pioneer achievements (as opposed to individual Transformation Programme achievements). However working on a Pioneer footprint (or 'Pioneer Plus' – see 4.12 below) offers significant opportunities to join things up more effectively and efficiently and provide alternative transformation solutions to those feasible within individual CGG footprints.

4.11 The Board's view on our future commitment to being a Pioneer would be welcomed and a decision on whether we remain committed to the aspirations of being a Pioneer when the bid was submitted. The Pioneer Steering Group considered the question at its meeting on 6th April and those present agreed that there is still value in working as a Pioneer, in particular in relation to the Integrated Community Teams, Empowerment, Workforce transformation (and we have financial resources allocated to facilitate this) and Digital Services development. Some Pioneer initiatives such as the roll out of the Cheshire Care Record and the Mental Health Commissioning Review also need ongoing support through to their conclusion.

4.12 If a commitment remains, there is the opportunity to explore engaging with Warrington and Wirral to explore a 'Pioneer Plus' arrangement, whereby Warrington and Wirral colleagues join in some of the work-stream activity where it is helpful / useful for them to do so. Already there has been some engagement with the Workforce Development work-stream from Warrington Council and with the Mental Health Review work-stream from Warrington CCG.

4.13 Assuming an ongoing commitment to the Pioneer Programme, the Panel are asked to consider the above and determine their preferred way forward in relation to the role of the Director and in consequence the budget arrangements for 2016 – 2017.

5 Access to Information

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

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Designation: Corporate Manager Health Improvement/Interim Director Cheshire Pioneer
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Email: guy.kilminster@cheshireeast.gov.uk

Connecting Care Across Cheshire

Expression of interest to be an Integrated Care Pioneer

Submitted on behalf of West Cheshire Health & Wellbeing Board and East Cheshire Health & Wellbeing Board

June 2013






OUR PROPOSAL: Within three years the residents of Cheshire will enjoy a better standard of health and wellbeing and place less demand on more costly public services through the implementation of groundbreaking models of care and support based on integrated communities, integrated case management, integrated commissioning and integrated enablers. The main focus will be those cohorts such as older adults with long term conditions and complex families and that are currently not well served by models of care and require a seamless solution. This radical approach as well as benefiting local residents can be replicated, adopted and adapted in other localities.

Cheshire West and Chester

NHS Eastern Cheshire Clinical Commissioning Group

NHS South Cheshire Clinical Commissioning Group

NHS Vale Royal Clinical Commissioning Group

NHS West Cheshire Clinical Commissioning Group

Cheshire East Council

1. An Introduction to Cheshire

Who are we? The following expression of interest covers the geographic area of Cheshire, as covered by the Cheshire East and Cheshire West Health and Wellbeing Boards. It is fully supported by the two Local Authorities of: Cheshire West and Chester Council and Cheshire East Council, along with the four Clinical Commissioning Groups working in the Borough, including; NHS Eastern Cheshire CCG, South Cheshire CCG, Vale Royal CCG, and West Cheshire CCG. These areas are covered by our hospitals: Countess of Chester NHS Foundation Trust, East Cheshire NHS Trust, Mid Cheshire NHS Foundation Trust, Cheshire and Wirral Partnership NHS Foundation Trust. With an estimated combined health and social care budget of £1.3 billion, there is a clear commitment from all partners including providers and third sector agencies to work together in a joined up way.

The document outlines our shared commitments across Cheshire but also sets out our detailed plans on a locality basis covering West Cheshire, Mid Cheshire, and East Cheshire.

What are our shared challenges?: The area includes approximately 700,000 residents, with a rich diversity of urban centres such as Chester, Crewe and Macclesfield, alongside market towns and rural communities. Whilst the area is relatively affluent it does face a number of local challenges. The population of West Cheshire is ageing, with the number of people aged 65 and over forecast to increase by 19,500 (26%) from 2010 – 2020, and the number of residents over 85 estimated to grow by 3,000 (41%). This challenge is mirrored in East Cheshire which has the fastest growing demographic of residents over 65 and 85 in the North West of England. This translates into a financial growth pressure of £19.1million in West Cheshire over the coming five years, and for East Cheshire organisations the financial challenge is in excess of £36million over the coming three years. In broad terms, this cohort represents approximately 30% of the population, but consumes 70% of the total Health and Social Care spend. Local residents over the age of 85 often require support with long-term conditions, but are confronted with a system of care that can be fragmented, disjointed, and designed to be acute based and episodic. In addition, organisations across Cheshire are working to address the challenge that around 1,100 families with complex needs place on the public purse, estimated at £83.3million annually. This group would benefit significantly from early and integrated support services covering mental health, physical health, public health, social care, housing and other key agencies. Quite simply, the current configuration of services does not meet the needs of individuals, families and communities in a coherent way, and certainly will not meet the collective financial challenges now and in the future, unless we implement radical reform.

Why do we want to collaborate across Cheshire? Both Health and Wellbeing Boards have ambitious plans in place that will deliver better outcomes through integration. Partners, however, have recognised the opportunity to work together across the patch for the following four reasons:

1. ***Patient flows across the health economy*:** The boundaries that exist across organisations in Cheshire do not reflect the flow of patients and residents when interacting with services. This application across Cheshire presents the opportunity to address the transfers, referrals, and movement of services users in the area.
2. ***Capacity to make it happen:*** By pooling together the talent and expertise of four CCGs, two Local Authorities and a range of providers we are more likely to achieve results with greater scale and pace.
3. ***A track record of partnership working across the geography*:** The County of Cheshire has a long-history of working in partnership, formally a single County Council, with a number of partners such as police, Fire and Rescue, Cheshire and Wirral Partnership Trust, and Job Centre Plus already working to a wider Cheshire geography.
4. ***The opportunity to showcase an area with similarities to many communities across the UK*:** The County of Cheshire reflects a number of challenges that will exist elsewhere in the UK, as it contains urban areas, market towns, and rural communities.

What does integrated care mean to us? Integrated care is about people not process. Through the vast engagement that partners have conducted across Cheshire and the results of National Voices programme we are able to use this adapted case study to describe the changes that will be made from the perspective of service users, staff and communities:

Charlie and Marie (older residents living in Nantwich): *Our care makes sense to us. Our key worker Sue sorts out all the things we said we needed to live at home and always keeps us up to date. She's treated us like adults and by bringing everything together quickly we have been helped to achieve our goal of staying together after Charlie was diagnosed with dementia.*

Sue (social worker from Winsford): *I've always worked closely with colleagues in health and housing but things now are so much more easier to get sorted. It now happens by design rather than accident. I work in a joint case management team where all agencies agree a joint plan for the individuals and families that used to get passed from pillar to post. I feel supported by my organisation and other partners to use my professional judgement to make things happen and I've learned a huge amount by understanding how we all play a part. Its common sense really – if we all work together we avoid falling over each other, we make our budgets go further and we deliver a better service for the most vulnerable members of our community.*

Carol (daughter of Charlie and Marie): *My mum and dad live over in a rural area of Nantwich but are well looked after in their community. The services in the area have all clubbed together to fund a volunteering scheme which means that mum and dad always have someone to help them with little things like the shopping and the ironing. They also have been told about all the things that are available in the area and they really appreciate the new friends they have made. As well as being good for them I really value the support network that has grown around them.*

This narrative is taken from individuals receiving services in Cheshire and will be communicated widely to describe the purpose of our approach. This will inform a number of guarantees outlining the changes for our communities.

We believe our expression of interest is worth consideration for the following five reasons:

- **Learning for other localities**: The commitment to take a locally sensitive approach across the varying communities of Cheshire will generate a range of proposals which will be applicable to most localities across the U.K.
- **A commitment to scale and pace**: Our shared ambition to deliver radical change across Cheshire will cover an area of 700,000 citizens and £1.3 billion of health and social care expenditure
- **A proven track record**: We have a large number of examples of delivering transformation, collaborative leadership and integrated care
- **Clarity on our plans**: We have already begun to scope what we will deliver through this opportunity and how we can combine the capability and expertise of four CCGS and two Local Authorities to make it happen
- **A clear ask to Whitehall**: We also have clarity on the technical support that will help us achieve our vision with real scale and pace

2. A Compelling Vision for 2015

We are committed to ensure that individuals in Cheshire stop falling through the cracks that exist between the NHS, social care and support provided in the community, and we will avoid:

- duplication and repetition of individuals experience, with people having to re-tell their story every time they come into contact with a new service
- people not getting the support they need because different parts of the system don't talk to each other or share appropriate information and notes;
- the "revolving door syndrome" of older people being discharged from hospital to homes not personalized to their needs, only to deteriorate or fall and end up back in A&E
- home visits from health or care workers are not coordinated, with no effort to fit in with people's requirements
- delayed discharges from hospital due to inadequate coordination between hospital and social care staff.

We will move away from commissioning costly, reactive services and commission those that will develop self-reliance, improve quality of care, reduce demand and take cost out of the system for re-investment into new forms of care. Across Cheshire we are aligning our commissioning approaches and where relevant jointly commissioning services to deliver consistency and integration in the wider service landscape.

By 2015, the communities of Cheshire will experience **world class** models of care and support that are **seamless**, high quality, cost effective and locally sensitive. **Better outcomes** will result from working together with:

- **Better experiences** of local services that make sense to local people rather than reflecting a complex and confusing system of care
- More individuals and families with complex needs are able to **live independently and with dignity** in communities rather than depending on costly and fragmented crisis services
- **Enhanced life chances** rather than widening health inequalities

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

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

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

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

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

   We recognise that the current position of rising demand and reducing resources make the **status quo untenable**. Integration is at the heart of our response to ensure people and communities have access to the care and support they need.

3. A blueprint for whole-system integration

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

Pan-Cheshire

Our Commitment	What does this mean?	Key Stakeholders
Integrated communities	• Delivering a joint investment plan for the voluntary community sector prioritising investment in activity which reduces demand for longer term demand on acute and specialist services; • Implementing a joint information and advice strategy to help individuals make informed choices about their care • Rollout of personal health and social care budgets to enhance local choice, independence and local microenterprises; • Jointly commissioned initiatives to encourage volunteering such as time banks and community coordinators, particularly to tackle issues around social isolation; • Integrated support for carers across health and social care. • A suite of interventions that tackle the causes of unhealthy lifestyles • Rolling out timebanks to attract volunteers and mutual support networks • Rolling out the Paramedic Pathway programme and further development of developing community pathways, bridging the liaison between health and social care, at the same time avoiding A/E attendances and promoting self care models	• All residents across Cheshire • The voluntary and community sector • Public Health • All health and social care services • Wider health and social care providers • North West Ambulance Service
Integrated case management	• A single point of access into services in each area. • A risk stratification tool to identify target populations requiring joined-up support • Real and virtual case management teams each working with patient populations of between 30,000 and 50,000. • A common assessment tool to support the sharing of information across professionals with joint information systems to support collaboration. • Care coordinators and lead professionals who will hold the case, step up and step down the appropriate interventions and help the individual and family navigate the system. • Develop a Multi-Agency Safeguarding Hub covering both Adults and Children's that will enable strategic safeguarding leads to work closer together	• Complex families (as per locally defined troubled families cohort) • Individuals with mental health issues • Older adults with long terms conditions • All health and social care services • Vulnerable Children and Adults • Ambulance service
Integrated commissioning	• A redesigned model of bed-based and community-based intermediate care to enable demand for long term care to be better managed. • A full package of interventions which support older adults to live in their own home including assistive technology, admission avoidance/hospital discharge schemes and reablement. • Scaled-up plans for Supported Housing to maximise independence within an additional supported environment. • Evidence-based interventions to support families requiring additional support including triple P and Family Nurse Partnership. • A jointly commissioned community equipment service • A jointly commissioned offer for children in care • A jointly commissioned offer for children with disabilities • Jointly commissioned drug and alcohol services across health and social boundaries. • Move towards a coalition approach to co-ordinated care. • An Integrated Wellness Service that addresses the root causes of poor health outcomes alongside other partners outside of Health and Social Care.	• Clinical Commissioning Groups and Local Authority Commissioners • Transitional care providers • Strategic Housing and Planning • Emergency Services
Integrated enablers	• A joint approach to information sharing • Development of a single case management ICT system • A new funding contracting model to ensure that incentives are in place to shift activity from acute provision to community based care (likely to include capitation or cap and collar supported by new contracting models such as prime provider models, joint ventures or accountable care organisations)	• All health and social care services • Acute Foundation Trusts • Community Health Providers • Monitor • Information Commissioner

1. West Cheshire (West Cheshire CCG, Cheshire West and Chester Council and key partners)

This area covers a population of approximately 250,000 people and includes key urban areas such as Ellesmere Port, Chester, and a number of rural communities. The main providers of care in this locality are the Countess of Chester Hospital, Cheshire and Wirral Partnership Trust, and Cheshire West and Chester Council, with 37 GP practices based in this area. The area participated in the Whole place community budget programme as one of four national pilots that developed robust business cases for integration. These plans are currently being implemented and are reflected below:

Our commitment	What does this mean?
Integrated communities	• Investment in time banking models to foster community delivery and create a closer link between residents and their neighbourhoods. • Extension of of telecare and telehealth to support residents to be safely supported to live independently in their own homes for longer. This approach supports the Department of Health's 3million lives campaign which is based on the principle that if implemented effectively as part of a whole system redesign of care, telehealth and telecare can alleviate pressure on long term NHS costs and improve people's quality of life through better self-care in the home setting • A new third sector strategy jointly agreed across partner agencies, setting out an investment plan for voluntary and community sector support • Extension of personal health and social care budgets
Integrated case management	• A single point of access to health, social care and other key services • Delivery of an integrated early support case management team to support complex families (currently operational in a testing phase with partners working together from health, local authority, police, probation, job centre plus) • Further rollout of 7 integrated care management teams (two early adopters already in place with staff from health and social care aligned to GP surgeries) • Mental health joint case management teams are already in place. Programme budgeting will also enhance and support joined up service provision for both Mental Health and Learning Disabilities
Integrated commissioning	• A multi-agency approach to introducing a single Falls Pathways across West Cheshire • Extra Care Housing • A joint specification for Care Homes for all long stay including residential, nursing, dementia for older people, learning disabilities, mental health and physical disabilities. Undertaking a review of transitional care with partner agencies looking at both community and bed based services • Explore the scale up of the successful Hospital at Home project • Review End of life care to ensure provision **o**f 24/7 community palliative care nursing for both children and adults. • The planning and development of the Integrated Provider Hub for mental health commissioning, which has provided opportunities to identify and pilot different ways of commissioning contracting and funding services. Using this learning there are plans to identify opportunities to use these principles for the commissioning of learning disability services. • There is a joint commissioner post for mental health and learning disabilities across the Local Authority, West Cheshire CCG and Vale Royal CCG
Integrated enablers	• Workforce development plan to compliment joint working • Information sharing agreements between GP practices and community services • A new funding and contracting model for the acute sector and community care is being scoped to review opportunities to move toward outcomes based commissioning. • In 2013/14 the CCG has used contracting levers with the Countess of Chester NHS Foundation Trust to support transition arrangements aimed at improving capacity, demand, patient experience and quality thereby supporting the whole system approach. • The CCG is working alongside Chester University in developing and implementing specific learning set modules for the Integrated Teams.

2. Mid-Cheshire (including Vale Royal Clinical Commissioning Group, South Cheshire Clinical Commissioning Group, Cheshire West and Chester Council and Cheshire East Council)

This locality has a population of approximately 278,500, and includes 30 GP practices (18 in South Cheshire CCG, 12 in Vale Royal CCG). This area covers a proportion of Cheshire East, and Cheshire West and Chester Council. The two Clinical Commissioning Groups share a management team to provide efficiencies. Patient flows to the DGH have illustrated that 92% are from people living within the boundaries of the two Clinical Commissioning Groups. There are significant financial pressures that exist within the health and social care geographies in this locality, and this is due in part to a relative lack of deprivation against national benchmarking making it difficult for local organisations to individually draw resources to create the headroom for innovation.

The local Partnership Board recognises the work that is already taking place with regards to developing integrated services to meet the needs of the local communities. Our approach so far has been to deliver integrated services locally, led by empowered staff groups and with a clear focus on improving outcomes and reducing health inequalities. This has engaged frontline health and social care staff, clinicians, patient groups, the voluntary sector and commissioners. The Partnership Board has now acknowledged the

need for further work to produce an integrated plan that will ensure the 'bottom up' approach is coordinated and meets the needs of the local HWB strategies to achieve real scale and pace.

Our commitment	What does this mean?
Integrated communities	• Investment in time banking models to foster community delivery and create a closer link between residents and their neighbourhoods. • Extension of schemes such as Street Safe and Nominated Neighbourhoods that promote social inclusion, supporting older people to feel safe within their communities. • Deliver Falls Awareness training to all frontline staff through online learning, and develop and implement a new approach to Community Transport Grants that support local transport initiatives. • Partners in Vale Royal are currently working with the Systems Leadership Pilot to develop and deliver a fully costed plan to tackle social isolation. • Extension of telecare and telehealth to support residents to be safely supported to live independently in their own homes for longer. • A new third sector strategy jointly agreed across partner agencies, setting out an investment plan for voluntary and community sector support . • Extension of personal health and social care budgets
Integrated case management	• The integration that has already taken place regarding the creation of Mulit-Agency Neighbourhood Teams provides a strong foundation for local partners to build on. Within this project there are in-built review dates that will enable partners to monitor the progress to-date, and capture the lessons learnt so that this model could potentially be extended to new areas, and improved as it develops. • Integrate secondary care clinicians (particularly community physicians and geriatricians) and GPs as part of the integrated care model • Delivery of an integrated early support case management team to support complex families (currently operational in a testing phase with partners working together from health, social care, police, probation, job centre plus) • There is a pooled budget for Learning Disabilities with Cheshire East Council and we have developed our approach through a a Learning Disability Life Course service review which includes both Children's and Adults.
Integrated commissioning	Jointly commissioned interventions covering: • Falls • Extra Care Housing • Community Equipment • Transitional care (South Cheshire CCG and Vale Royal CCG are investing resources in intermediate care to address a gap in the provision of services that previously failed patients in a community setting. Following a point prevalence study it was found that 32% of admissions could be avoided, and 39% of patients could be discharged with the appropriate community support. In reaction to this research the two CCGs have committed approximately £1.6million to develop integrated intermediary care) • Learning Disabilities • The 'First Steps Pathway' developed with Mid Cheshire Hospital Trust will ensure that any child aged 0 - 2.5 years with a complex 'stable or unstable' health condition will experience a planned and robust transition from Secondary Care to Community Provision through a provider partnership that includes CEC and CWAC Children's Services, Community Nursing, Secondary Care Clinicians and Community Paediatrics. This process ensures any child that leaves the area to attend a Specialist Children's Hospital will remain the responsibility of the Local Paediatric Consultant and that they will ensure a smooth transition back into local services. This programme helps to inform local commissioners of information on complex cases at the earliest possible moments, and promotes health and care that is centred on the need of local residents and families. This programme was funded through a CQUIN programme within Mid Cheshire Hospital Trust agreed with South and Vale Royal CCGs.
Integrated enablers	• Workforce development plan to compliment joint working • Deliver measurable goals to improve patient experience. • Develop patient orientated standards for integrated care. • A new funding and contracting model will be developed to ensure the funding of support shifts from acute setting to community based care. The Clinical Commissioning Groups are in dialogue with other partners around this agenda and are committed to a feasibility study to identify alternative models and the opportunities for risk share. This will include a system of payments for specialists and GPs working in community settings in integrated teams, incentivising their organisations to keep people well and out of long term care. Potential issues with competition law will require technical support and advice to ensure any barriers are addressed within the current legislative framework.

3. **East Cheshire** (including NHS Eastern Cheshire CCG and Cheshire East Council)

This area covers a population of approximately 201,000 residents, and includes the urban areas of Macclesfield, Congleton, and Knutsford. Whilst life expectancy is above the national average, there are significant disparities between areas. The main causes of premature death are circulatory and respiratory disease, cancers, and diseases of the digestive system, with particular links back to lifestyle issues of obesity and alcohol consumption. This area includes 23 GP practices, and works closely with the Local Authority of Cheshire East.

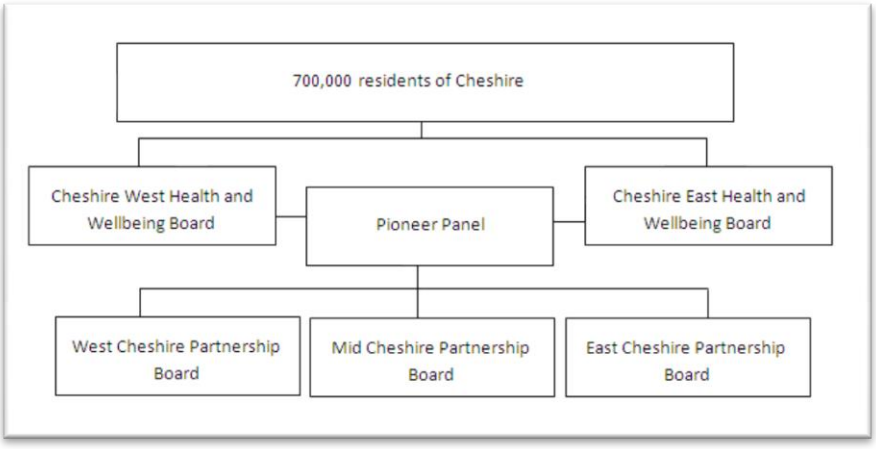
A partnership of health and social care organisations have developed a shared vision across Eastern Cheshire that is called 'Caring together' – joined up local care for all our wellbeing. This is aimed at bringing about a radical shift in care from a reactive hospital based approach to a proactive community based care model. Our approach is patient-centred and will use a new and enhanced primary care approach as the foundation. The notion of the empowered person is at the starting point of great care. The model builds out from this using a locality team approach and specialist in-reach to support primary and community care more effectively.

The vision in this area was developed in partnership between professionals and the public, and is clinically driven, incorporating the National Voice Principles. In Eastern Cheshire we believe that integration cannot be delivered by one organisation working alone in isolation, but must be delivered through genuine collaboration.

Our commitment	What does this mean?
Integrated communities	• Introduce supported self management techniques; a proposal being supported by AQuA and the Talking Health Programme • A commitment to deliver the 3 Million Lives Project as one of the NHS Fast Follower pilots • The launch of the Engagement HQ to capture public and staff experiences and ideas, and use of social media, to link people together and to ensure experienced based co-design of services • A campaign strategy to promote the vision, values and principles of caring together and messages to increase momentum • Extension of personal health and social care budgets
Integrated case management	• **Caring Together** Community Teams that are structured around clusters of GP practice, and include professionals from across health and social care (Doctors, Nurses, Social Care Workers and Mental Health Professionals). These teams promote more integrated services across organisations, creating tailored packages and avoiding repetition in the system. • A **care co ordination hub** supporting case management will support the community based approach, providing a central point of contact and information for patients and coordinate a faster, more effective referral process and manage the use of new technologies to monitor some health conditions remotely.
Integrated commissioning	• **Reducing Hospital readmissions:** Local organisations are working in partnership with; Healthcare Management Financial Association, Health Care Services, and Net Orange with the ambition to reduce hospital admissions by 25%. The success of this programme over the past 18 months has seen the programme supported by NHS England to create a strategic plan by August 2013 to extend this work, including economic modelling, systems design and impact assessments. This will ensure a full business case and a five- year implementation plan will be agreed by December 2013. Moreover, a draft evaluation framework has been developed to take this work forward. • **Learning Disabilities:** Building on the recent submission for a community budget pilot we will pursue a whole-life course approach to the integration of LD services
Integrated enablers	• Workforce and leadership development to ensure new skills and competencies • Introduction of service improvement methodologies, focusing on measurement • Develop patient orientated standards for integrated care. • A new funding and contracting model will be developed to ensure the funding of support shifts from acute setting to community based care..

4. A strong commitment to integrate and support across the breadth of relevant stakeholders

Partners across Cheshire are committed to a model of collaborative leadership, through which shared visions and outcomes will allow organisations to establish a common direction of travel and make joint decisions. A pioneer panel with representatives from both Health and Wellbeing Boards will be in place to help coordinate activity across the areas where appropriate. It is recognised that that all local organisations and partnerships will maintain their governance processes and structures to ensure continuity of existing sovereignty to stability.



The role of service users and their carers is vitally important and will feed in via Health Watch and

other local arrangements such as the Older Peoples Network, Healthwatch, the Parent Partnership, and Patient Participation Groups.

5. The capability and expertise to deliver successful transformation at scale and pace

Cheshire is in a strong position to deliver this agenda, building on a strong track record of serious transformation. For example,

Track record	Evidence
Developing robust business cases for change with Whitehall	• **Whole Place Community Budgets:** West Cheshire and Vale Royal CCG worked alongside Cheshire West and Chester Council and other key partners to develop six business plans for integrated services. Collectively these plans will deliver financial benefits of £106m to local services over the next five years as well as and enhancing outcomes for vulnerable members of the community. These plans have been subject to scrutiny by the Treasury and the National Audit Office. The programme continues to involve strong working relationships with Whitehall Departments and demonstrated the ability for partners to move beyond fine words to credible plans for integration based on evidence and robust financial modelling.
Delivering structural and cultural change	• **Developing two new Unitary Authorities**: In 2009, Cheshire West and Chester Council and Cheshire East Council were formed through the integration of the County Council and six District Councils. This transformation was completed to required timescales and has resulted in total cashable saving of £150m across the area. It also involved a number of shared services arrangements where the two local authorities developed a joint approach to payroll, transactional finance and ICT. • **Delivering clinical leadership –** the new clinical commissioning groups have all formed with clinicians leading on local commissioning decisions • **Provider Services Mutual** – Cheshire West and Chester are implementing a business case which involves 'spinning out' provider services in Adult Social Care such as home care into a mutual. Working closely with the Cabinet Office this approach is seen as leading practice with staff engagement seen as a real strength. • **Developing connected Safeguarding and Quality Assurance:** Cheshire East with it's partners are developing a Multi-Agency Safeguarding Hub (MASH). This will connect and co-locate Police, Health, Children and Families and Adult safeguarding services within the Council as one integrated team. • **Public Health Integration** – Public Health have embedded into the local authority and are a key partner to support the Clinical Commissioning Groups. The additional resource and development of the Joint Strategic Needs Assessment (JSNA) adds significantly to the ability to use intelligence to inform commissioning and delivery of services in an efficient and effective way.
Transforming Learning Disability Services	• Health and Social Care **Learning Disability Teams** have been co-located at the Countess of Chester Health Park to further facilitate integration and joint working. This enables shared access to cases, the development of joint approaches and systems to case management. • Cheshire East Council, working in partnership with its Clinical Commissioning Groups are one of a reducing number of areas that have retained **pooled budget** arrangements for Learning Disabilities. This equates to a joint investment that is worth approximately £43 million.
Transforming Mental Health Services	• **Community Mental Health Teams** are in operation across Cheshire bringing together health and social professionals under single line management. This will support and inform our wider approach to integrated care management across Cheshire. • **Transitions**: A Multi-Agency policy and protocol is developing between the Vale Royal, South Cheshire East Cheshire CCGs and Cheshire East Council relating to the transition of young people from children's to adult services, including input from the voluntary and community sector. This provides information on statutory services, and broader services such as benefits, equipment, carer support, and the Mental Health Act.
Developing aligned financial incentives	• West Cheshire CCG has introduced a system-wide **Ageing Well CQUIN** which is based on timely communication across agencies following admission, prior to discharge and following discharge to support case management; volunteers befriending/supporting the frail elderly during and after an admission; and risk stratification of patients likely to be readmitted. These incentives have been introduced across the Acute and Community providers. • **Programme budgeting for mental health** – using prime provider models to manage integrated services for mental health with joint investment across the health economy.
Reducing demand on crisis services	• An integrated crisis and **reablement** team has had a significant impact in West Cheshire, providing short-term and intensive support to older people, adults with learning disabilities, people with physical disabilities, and individuals with mental illness. This team provides support up to a maximum of six weeks in order to maximise independence and avoid admissions to long-term care. The team consists of qualified nursing staff, health care assistants, social care supervisors and care staff, and has been operational in this co-operative and multidisciplinary manner for just over 18 months. On average 30% of people completing a period of reablement no longer require ongoing domiciliary support. In addition, this has achieved £250,000 of efficiencies savings through integration of health

	and social care, whilst providing a high quality and consistent model of care. • West Cheshire's **Hospital at Home** service operates 24/7 and is a GP-led service with a skill mixed team including advanced nurse practitioners (independent prescribers) and health care assistants. The service has the capacity to manage twelve patients at any one time at home, depending on clinical conditions, with a proposed average length of stay of three days. The service is accessed by GPs and Community Matrons for those patients who require additional care but who do not necessarily require an acute bed. The service has continued to develop and also supports the early discharge of patients from the acute sector. • **Integrated OOH Social Care in A&E:** The project was designed to prevent avoidable hospital admissions/ re-admissions through pro-active and fully integrated health and social care assessment in A&E. A Social Worker based in A&E, works side by side in partnership with nursing and medical staff to deliver a multidisciplinary approach to crisis intervention, and admission/re-admission avoidance. And evidence from this programme has indicated that it has saved 549 bed days, equating to nearly £140,000. • **Early Supported Discharge**: Cheshire and Wirral Partnership NHS Foundation Trust, the Countess of Chester Hospital and Cheshire West and Chester Council committed to provide a stepped care model for patients in Western Cheshire. The model supports commissioners' aims to integrate care across the continuum of complexity for residents with long term conditions, so that we can maximise the appropriate skills of patients, carers, clinicians, specialists and the third sector. The integrated early supported discharge service provides co-ordinated rehabilitation and specialist care for patients discharged early from hospital in order to relieve the pressure on acute hospital beds. • **Long Term Conditions Service Integration:** Both Vale Royal and South CCGs have delivered a number of integrated patient pathways including, Respiratory Care Pathway, Diabetes Care Pathway and Cancer Pathway. Pathway development has incorporated integration with statutory and VCF sector to deliver excellent patient care. • **Award Winning Integrated Care Home Support**: integrated work across Vale Royal and South Cheshire CCGs is in place with Nursing and residential homes, community services and the acute hospital to improve standards or care and patient experience including GP-led home-based ward rounds to avoid inappropriate hospital admissions. Recognised nationally as an innovative service development to improve the coordination of care form some of our most vulnerable patients. • **Multi-Systemic Therapy Programme:** This is an intensive family, and community based treatment programme that focuses on addressing all environmental systems that impact chronic and violent juvenile offenders (housing, relationships, education, and neighbourhoods). MST recognises that these issues require integrated solutions, and this programme has been successful in keeping a number of young residents in a family environment. • **Family Nurse Partnership Programme:** The family nurse partnership is an intensive, structured, home visiting programme which is typically offered to first time parents under the age of 20. Through this programme a specially trained family nurse visits the mother regularly from early pregnancy to the child turning two. The have been high-levels of take up with this programme, and we have received positive feedback from parents.
Building community capacity	• Public Health integration into local government has enabled closer working with partners linking in synergies between health and wellbeing, stronger communities and supporting sustainable self-care models. • Across Cheshire we have worked with colleagues in Public Health in addressing **Excess Winter Deaths** and have jointly rang Keep Well Keep Warm This Winter campaigns during 2012/13 and going forward into 2013/14. This provides a systematic approach to health and social care interventions to vulnerable communities/patient groups. • West Cheshire CCG has worked with Public Health colleagues in commissioning the **Hospital Alcohol Liaison Service** within the Countess of Chester NHS Foundation Trust and have collaborated on the production and commissioning of the Health Checks Local Enhanced Service in primary care. • East Cheshire Health and Wellbeing Board have an **ageing well programme** in place to capture the voice of service users and support the connection of and investment in low-level community interventions. Reporting to the Health and Wellbeing Board and , to date this programme has seen 266 people attending *Be Steady, Be Safe exercise classes* to help reduce their risk of falls; 350 people trained as *Info Link* Champions and accreditation of the *Info Link* scheme; Arts and dementia activities rolled out across the borough; Nantwich Museum and Bridgend Heritage Centre currently developing memory box resources and service for dementia sufferers; delivery of the winter warmth campaign; the provision of a central, accessible and safe meeting place for social activities and regular lunch clubs. • **Every Contact Counts** - Development of an 'Every Contact Counts' approach so that we empower and facilitate other organisations, communities and individuals to become part of a wider public health network of health champions • **Dementia:** Partners in West Cheshire have worked closely together on the redesign of Dementia Services with the establishment of a new memory service. This work has led to a shifting of funding into the Third sector to develop

	a more responsive service provision that meets the needs of local residents. • **Springboard:** Cheshire Fire and Rescue Services are working in partnership with Age UK, Health Partners, and Local Authorities to identify unmet needs of older adults through the extension of Home Safety Assessments. Traditionally, home safety visits would assess for potential fire hazards and provide safety advice; however, this new model of partnership working has enabled partners to investigate the needs of over 65 residents. This involves unique data sharing agreements, with the NHS providing core information to enable Cheshire Fire and Rescue to assess the broader needs of those most at risk, conducting over 40,000 visits with older residents in the past three years. • **Clever Together Programme:** Cheshire East Council and East Cheshire Clinical Commissioning Group ran a joint campaign, engaging with residents to suggest, develop and prioritise initiatives to enhance the experience of using services through improved integration. This resulted in 246 contributions in three weeks, resulting in 10 quick wins and 5 strategic initiatives to improve integration. From this programme, changes included the alignment of Team boundaries, joint training, joint workforce planning and a new integrated, family-centered approach to service redesign. • **Healthy Living** - Investment into 2 Healthy Living Centres in Blacon and Ellesmere Port (areas with significant deprivation and health inequalities) to target healthy interventions – cookery skills, benefits uptake, mental health and recovery services, smoking cessation, weight management, employment skills and parenting courses including breastfeeding.

Following selection as a pioneer site, partners have committed to:

- Establishing a **virtual redesign team and redesign budget** with three programmes coming together to cooperate where needed. Individuals from these teams will include commissioners, clinicians, business analysts, project managers and finance support.
- Ensuring that the three programmes are connected through the application of the **Managing Successful Programmes** methodology including clear scopes, roles and responsibiles, risk management and programme planning.
- Ensuring all staff involved in the programme are fully trained in **cost-benefit analysis methodology** in line with HM Treasury Green Book principle
- Ensuring a **Senior Responsible Owner** is in place for each of the reform proposals

6. Sharing our Learning:

We are committed to sharing our learning and believe the diverse nature of Cheshire will yield different models of integration that could be adopted and adapted across the country. This will be enabled through:

- A **dedicated website** providing regular updates, project documentation and opportunities to interact in one place.
- Use of **social media** to extend communication and engagement across a range of partners
- Using **existing networks** through the NHS Confederation, ADASS, the Kinds Fund, the newly established Public Service Transformation Network, the Early Intevention Foundation, and existing regional peer organisations such as I-Network to share learning
- Commitment to at least **two major conferences** to bring health and social care leaders together to hear about our plans and progress with implementation

This openness to share learning and invite dialogue from other localities is clearly in evidence in our current activites. For example:

- West Cheshire's involvement in the **Whole Place Community Budget Programme.** Through this programme Cheshire West and Chester Council have met with representatives from a range of geographies and organisations to share lessons learnt, including peer to peer meetings with Shropshire's Public Services Board and Tri-Boroughs Whole Base Community Budget Team; presentations at Halton's Local Strategic Partnership, and a number of one to one meetings with Local Authorities such as Stoke and Wirral. Further to these meetings, partners have regularly provided presentations and talks on the national stage, as reflected through Councillor Mike Jones (Leader of Cheshire West and Chester Council) speaking at the national launch of community budgets, and Dr Huw Charles Jones (Chair of the West Cheshire Clinical Commissioning Group) addressing the 2013 Local Government Association Conference on Public Service Transformation. This has been further reflected in the relationships that have been formed between local partners and trade-press publications that have taken an interest in the innovation that is taking place in Cheshire.
- There are also a number of links that have been formed between local organisations and academic institutions, as reflected through the work between Cheshire East and East Cheshire CCG working to develop a local evidence base through their involvement with the **King's Fund and the Nuffield Trust** through the **Advancing Quality Alliance's Integrated Care Discovery Programme**
- Based on the joint partnership approach and system wide leadership, Cheshire West and Chester Council, West Cheshire CCG, and Vale Royal CCG have been successful in applying for the **System Leadership programme** which allows collaboration between Public Health England, National Skills Academy for Social Care, NHS Leadership Academy, Virtual Staff College, Local Government

Association and the Leadership Centre. This opportunity would help partners to build upon and further improve leadership across public sector partners.

7. A Robust Understanding of the evidence base

All of our plans to date have been based on an ability to engage with a national and local evidence base. The Whole Place Community Budget programme required a fully-costed model of change based on the best available evidence. This involved working with academic, national policy leads, Whitehall Departments including the Department of Health, and Treasury Analysts. It was clear from this process that national evidence for integration is not comprehensive and continues to develop. The challenge therefore will be to ensure a local evidence base for integration is captured and evaluated. This will build on our established benefits realisation process which involves:

- Setting clear outcomes and measures
- Establishing the baseline
- Ensuring processes are in place to monitor data on a regular basis
- Monetising improvements in outcomes
- Establishing causality through techniques such as logic-chain analysis and randomised control groups

A dedicated budget for evaluation has also been identified to enable external evaluation to compliment this approach.

8. The Added Value of Pioneer Status:

The inclusion of Cheshire as an Integrated Health Pioneer would have a number of significant benefits for services and organisations in the local area, and would facilitate the delivery of improved services for local residents. We would like to work with the Integrated Care Pioneers on the following issues:

- **Technical support on developing a new funding and contracting model:** Local partners are committed to the importance of developing new funding and contracting methods to facilitate the movement of resources from acute to community services, and across organisational boundaries. This could be supported through this programme through access to technical advice and guidance, and facilitating a mature conversation with Government regarding potential methods.
- **Advice on financial modelling and benefits realisation:** The impact of changes in services and interventions will have natural consequences across the whole-system of public services, and we believe that this programme could provide support on modelling the long-term impact of proposals, and developing the methods to accurately track and measure the impact of reform.
- **Leadership brokerage:** This programme would provide external impetus and figures that could broker local discussions and provide neutral advice on contentious decisions as they arise.
- **Access to a well developed evidence base to inform joint commissioning:** The implementation of successful joint commissioning is largely dependent upon the use of accurate evidence. Local partners hope that this programme would provide access to useful models, metrics and measures to inform commissioning across the partnership, and we believe that we are well placed to contribute in this field.
- **Support the development of processes to track the impact of reform on providers:** The need to provide stability to local providers is important in supporting the delivery of high quality care, but also in securing a strong economic context for Cheshire. We would hope that this programme would provide evidence and models that would allow local partners to have a mature dialogue with local providers regarding the direction of travel for services.

9. Conclusion

In summary, we believe our proposals have the potential to deliver **better outcomes** for our customers many of which are vulnerable, a transformational **reduction in demand** and the ability to **meet needs with reducing resources**. Our expression of interest is worth consideration for the following five reasons:

- **Learning for other localities**: The commitment to take a locally sensitive approach across the varying communities of Cheshire will generate a range of proposals which will be applicable to most localities across the U.K.
- **A commitment to scale and pace**: Our shared ambition to deliver radical change across Cheshire will cover an area of 700,000 citizens and £1.3 billion of health and social care expenditure
- **A proven track record**: We have a large number of examples of delivering transformation, collaborative leadership and integrated care
- **Clarity on our plans**: We have already begun to scope what we will deliver through this opportunity and how we can combine the capability and expertise of four CCGS and two Local Authorities to make it happen
- **A clear ask to Whitehall**: We also have clarity on the technical support that will help us get achieve our vision with real scale and pace

Pictured top left to right:
Dr Paul Bowen, Chair of NHS Eastern Cheshire Clinical Commissioning Group, Cllr Janet Clowes, Chair of Health & Wellbeing Board (Cheshire East), Cllr Brenda Dowding, Chair of Health & Wellbeing Board (Cheshire West and Cheshire)

Bottom left to right:
Dr Jonathan Griffiths, Chair of NHS Vale Royal Clinical Commissioning Group, Dr Huw Charles Jones, Chair of NHS West Cheshire Clinical Commissioning Group, Dr Andrew Wilson, Chair of NHS South Cheshire Clinical Commissioning Group

REPORT TO: Health and Wellbeing Board

Date of Meeting: May 31st 2016
Report of: Guy Kilminster, Cheshire Pioneer Interim Director
Subject/Title: Reducing Alcohol Related Harm in Cheshire East, a Position Statement and Forward Plan

1 Report Summary

1.1 Alcohol related harm affects many of the residents and businesses of Cheshire East, and there is a significant cost to the public purse in dealing with its impacts. The Position Statement and Forward Plan has been drafted to support the many organisations working to reduce levels of consumption and promote safe, sensible and social drinking.

1.2 The Draft Position Statement and Forward Plan is about to be shared with stakeholders as part of an engagement and consultation process. The Board are invited to offer comments on the document and in relation to the process of consultation and engagement.

2 Recommendations

2.1 That the Health and Wellbeing Board considers and comments upon the Draft Reducing Alcohol Related Harm in Cheshire East Position Statement and Forward Plan.

2.2 That the Health and Wellbeing Board offers advice to ensure a meaningful and thorough engagement and consultation process is undertaken.

3 Reasons for Recommendations

3.1 To ensure that the draft Reducing Alcohol Harm Reduction Position Statement and Forward Plan provides clarity on a strategic approach to tackling alcohol harm and can be signed up to by all key partners.

4 Background and Options

4.1 The impacts of excessive alcohol consumption cause harm to residents and businesses within Cheshire East, both directly and indirectly. From a health and a

community safety perspective there are negative impacts. The cost to the public purse in dealing with alcohol related harms is estimated to be over £119 million.

4.2 The Position Statement and Forward Plan has been drafted to bring together a summary of current activity, and to provide clarity on initiatives underway or planned to reduce levels of harm. There are five priorities identified:

- To reduce alcohol related health harms
- To reduce alcohol related hospital admissions
- To reduce alcohol related crime, anti-social behaviour and domestic abuse
- To support a diverse, vibrant and safe night time economy
- To improve our co-ordination / partnership work to ensure that all of the above are met in an efficient and affordable way.

4.3 Both the current Health and Wellbeing Strategy and the Community Strategy identify reducing alcohol related harm as a priority. There is a lot of activity underway, but there has not been an overarching approach to ensure connectivity across commissioners and in delivery on the ground. With the wide range of partners involved in different aspects of trying to reduce alcohol related harms, it is critical that a more joined up approach is taken to allow an appropriate focus on key interventions.

4.4 The Draft Position Statement and Forward Plan has been prepared through a multiagency working group. It is intended that there will be engagement and consultation through the networks of the partner agencies. This will inform an Implementation Plan that will respond to the ‘What needs to be done?’ sections of the Forward Plan (once they have been agreed through the engagement and consultation process). The structure of the Plan is based around the themes of Prevention, Protection, Treatment, Recovery, Enforcement and Control.

4.5 The engagement and consultation will be taking place over from the end of June. It is intended to launch the final Plan in the early Autumn.

5 Access to Information

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

Name: Guy Kilminster
Designation: Corporate Manager Health Improvement/Interim Director Cheshire Pioneer
Tel No: 01270 686560

Email: guy.kilminster@cheshireeast.gov.uk

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Reducing Alcohol Related Harm in Cheshire East: A Position Statement and Forward Plan

V2.0 Consultation Draft 12112015

Approval/Amendment History:

Version	Date	Author	Amendment History
V1.0	15.10.2015	Callum Helman/Guy Kilminster	First consultation draft
V2.0	11.11.2015 12.11.2015 17.11.2015	Guy Kilminster	First consultation draft amended to incorporate exec summary and amends from Lucy Heath, Gerard Buckley, Shelley Brough.

Executive Summary

Alcohol related harm affects many of the residents and businesses of Cheshire East, both directly and indirectly. The impacts of alcohol related harm cost the public sector and businesses in Cheshire East over £119 million. This includes health and crime related costs and lost productivity. The variety of issues that stem from alcohol related harm have led to overstretched Ambulance, Police and Accident and Emergency departments dealing with alcohol related incidents and to subsequent delays in responding to the needs of other people.

The facts about our levels of alcohol consumption and the negative impacts that it has, demonstrate that action needs to be taken:

Locally -

- Young people in Cheshire East have suggested that, among other things, more needs to be done to raise awareness of the problems that alcohol causes young people.
- Alcohol specific hospital admissions in under 18s are high in Cheshire East compared to other areas of the country
- Levels of regular binge drinking amongst Cheshire East 14-17 year olds increased from 11% in 2013 to 17% in 2015 and there has been a reduction in the percentage who are worried about the long term health effects of drinking alcohol
- There are increasing numbers of adults in Cheshire East being admitted to hospital every year as a result of their alcohol use. Between 2008 and 2014 admissions increased by 26%.

Nationally -

- Alcohol consumption is the second biggest cause of cancer (after smoking) in people aged 35 and over[1]
- 70% of night time and 40% of daytime admissions to A&E are caused by alcohol[2]
- 10% of accidental deaths have alcohol as a contributory factor[3]
- 33% of fatal fires involve alcohol[4]
- Alcohol plays a part in 30% of domestic abuse cases, 40% of child protection cases and 74% of child mistreatment cases;[5]

The Position Statement and Forward Plan has been drafted to support the actions of many organisations working to reduce levels of consumption and promote safe, sensible and social drinking. It brings together national policy and local aspiration and sets a direction for activity across Cheshire East over the next three years. This document has been structured around five key themes that encompass the diverse areas that are affected by alcohol related harm. By focusing on Prevention, Protection, Treatment, Recovery, and Enforcement and Control this paper will demonstrate the excellent work that is already happening and set out clear ideas and plans for improvement.

As a 'Residents First' Council, we are working with a wide range of partners to focus upon activity that will bring positive outcomes to the families, communities and businesses of Cheshire East.

Our priority outcomes are:

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[1] House of Commons Health Committee on Alcohol – First report of session 2009-10, Volume 1, p.24
[2] House of Commons Health Committee on Alcohol – First report of session 2009-10, Volume 1, p.28
[3] Institute of Alcohol Studies website, Alcohol and Accidents
[4] Institute of Alcohol Studies website, Alcohol and Accidents
[5] Institute of Alcohol Studies website, Alcohol, Domestic Abuse and Sexual Assault

- To reduce alcohol related health harms
- To reduce alcohol related hospital admissions
- To reduce alcohol related crime, anti-social behaviour and domestic abuse
- To support a diverse, vibrant and safe night time economy
- To improve our co-ordination/partnership work to ensure that all the other priorities are met in an efficient and affordable way

The Plan will be overseen by the Cheshire East Health and wellbeing Board, but with a reporting line for information to the Cheshire East Community Safety Partnership.

Delivering on Outcomes

As alcohol impacts across a wide range of policy and service priorities, developing a robust partnership approach is essential to the successful delivery of the plan. The various policy and structural changes within public services over the last few years and the continued financial pressures accentuate the need for a cohesive approach.

Decisions around investment and commissioning intentions across the system will be considered within this partnership approach. Decisions will be evidence based and represent value for money.

The Position Statement and Forward Plan will be supported by a delivery plan outlining a partnership programme of actions to support defined outcomes and will be reviewed yearly to ensure that it remains current and is responsive to changing need, changes in national policy, legislation and evidence.

Delivery of the plan will be overseen by the Health and Wellbeing Board but with a reporting line for information to the Cheshire East Community Safety Partnership. The Board will provide leadership and influence other strategic agendas and programmes as appropriate. They will monitor and manage performance of the plan and address challenges and barriers to delivery. The overall implementation will be co-ordinated by the local authority with engagement from all key partners.

Needs Assessment

Alcohol misuse is often a symptom rather than a cause of vulnerability among people. Many people have broader difficulties that are compounded by drugs and alcohol that need addressing at the same time. It is difficult to accurately record drinking behaviours and levels of alcohol consumption but the following sections indicate Cheshire East levels of alcohol use.

Starting and Developing Well

Pregnancy:
Applying the 2010 national infant feeding survey to Cheshire East[6] estimates that:

- 1,500 women drank during pregnancy and 112 drank more than two units per week
- Mothers aged 35 or over (52%), from managerial and professional occupations (51%) or from a White ethnic background (46%) were more likely to drink during pregnancy
- Over 9,000 women are admitted to hospital each year for miscarriages caused by alcohol.

Young people:
In February 2014, 1,595 11 - 18 year olds took part in the Make Your Mark ballot. Young people in Cheshire East highlighted their top concerns locally which included drugs and alcohol. They suggested that more needs to be done to raise awareness of the problems that alcohol and drugs cause young people.

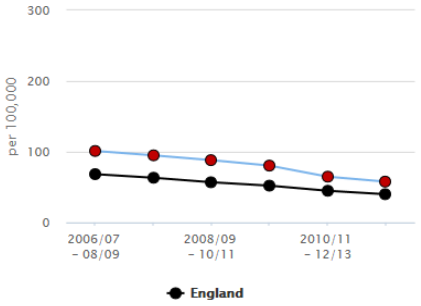
The evidence suggests that higher numbers of young people (aged 14-19) in Cheshire East compared to nationally or the North West are drinking to harmful levels.

Alcohol specific hospital admissions in under 18s are high in Cheshire East compared to other areas of the country. Although these are decreasing, 2011-14 rates were still significantly higher in

[6] National Infant Feeding Survey 2010 applied to Cheshire East birth data 2013-14

Cheshire East (57.8 admissions per 100,000) than England (40.1 admissions per 100,000). Alcohol-specific conditions include those conditions where alcohol is causally implicated in all cases of the condition; for example, alcohol-induced behavioural disorders and alcoholic liver cirrhosis.

5.01 - Alcohol-specific hospital admission - under 18s Cheshire East — Crude rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North West	England
2006/07 - 08/09	●	235	101.2	88.6	115.0	115.6	68.4
2007/08 - 09/10	●	220	95.0	82.8	108.5	104.2	63.3
2008/09 - 10/11	●	200	88.2	76.4	101.3	94.9	56.9
2009/10 - 11/12	●	180	80.5	69.2	93.0	85.5	52.2
2010/11 - 12/13	●	145	64.8	54.7	76.2	71.9	44.9
2011/12 - 13/14	●	130	57.8	48.3	68.7	60.4	40.1

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates

The 2015 North West young person's alcohol and tobacco survey received responses from 334 young people in Cheshire East. Key findings include:

- The percentage of 14-17 year olds who drink alcohol at least once a week has fallen since 2013, although the rates are slightly higher in Cheshire East (15%) compared to the North West region results (12%).
- Since 2013 there has been a 6% increase in the number of 14-17 year olds in Cheshire East regularly binge drinking. It now stands at 17% compared to 12% for the North West.
- A third of young people in Cheshire East (33%) are not really worried about the long term health effects of drinking alcohol (down from 43% in 2013).
- 47% of young people aged 14-17 in Cheshire East claim never to have drunk alcohol, which is similar to the North West rate of 46%. This has increased from 19% in the 2013 survey, possibly due to the lager proportion of 14 year old respondents; over half of Cheshire East respondents were 14 years old in 2015.
- Perhaps also reflecting the younger sample profile, there is a decrease in the percentage claiming to drink in pubs/clubs (from 26% down to 14%), but a slight increase in the percentage drinking outside
- The proportion of young people in Cheshire East drinking alone has increased from previous years to 11%
- The proportion of 14-17 year olds in Cheshire East claiming to be aware of drinking dens or party houses in their local area, has increased from 19% in 2013 to 28% in 2015

[NB The results of the What About Youth Survey will be incorporated into the final version of the document if published in time.]

Living Well

In relation to adult drinking behaviour, guidance from the National Institute for Health and Clinical Excellence (NICE)[7] suggests population benchmarking estimates of

- **Hazardous drinkers (where drinking increases someone's risk of harm) -** 24.2% of people aged 16 years and above. This equates to 73,658 hazardous drinkers in Cheshire East.

[7] https://www.nice.org.uk/guidance/cmg38/chapter/6-Commissioning-and-benchmarking-tool

- **Harmful drinkers (where alcohol consumption causes directly related health problems)-** 3.8% of people aged 16 years and above. This equates to 11,566 harmful drinkers in Cheshire East.
- **Alcohol dependence –** 2.6% of people aged 16 years and above. This equates to 7,914 dependent drinkers in Cheshire East

Modelled estimates of binge drinking from 2006-08 suggest that 22% of over 16 year olds binge drink[8] (compared to 17% of Cheshire East 14-17 year old survey respondents). 22% equates to 68,000 people in Cheshire East.

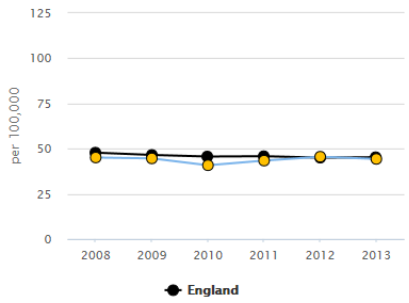
During 2013/14, 559 over 18s were in specialist treatment for alcohol misuse. Of those accessing treatment for alcohol, 47% successfully completed their treatment[9].

Whilst it is not possible to fully quantify the impact of alcohol misuse across Cheshire East a number of indicators provide evidence of harm.

Alcohol-related mortality

The number of deaths from alcohol related conditions has remained relatively stable in Cheshire East between 2008 and 2013. Approximately 170 people each year die from alcohol related conditions.

4.01 - Alcohol-related mortality (Persons) Cheshire East — Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North West	England
2008		163	45.1	38.4	52.6	58.3	47.8
2009		166	44.6	37.9	51.9	57.0	46.5
2010		153	40.8	34.5	47.8	54.6	45.7
2011		165	43.4	37.0	50.6	55.8	45.8
2012		174	45.6	38.9	52.8	54.8	45.0
2013		173	44.3	37.9	51.4	54.7	45.3

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) from the Office for National Statistics (ONS) Annual Death Extract Public Health Mortality File and ONS Mid Year Population Estimates

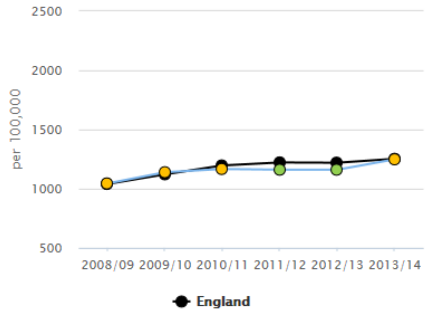
Alcohol attributable hospital admissions

There are increasing numbers of people in Cheshire East being admitted to hospital every year as a result of their alcohol use. Between 2008 and 2014 admissions increased by 26%.
Further investigation into the specific conditions shows that Cheshire East benchmarks poorly compared to England for admission episodes for:

- Alcohol related mental and behavioural disorders due to alcohol condition in males and females
- Alcohol-related alcoholic liver disease conditions in females

[8] Cheshire East JSNA Overview: http://www.cheshireeast.gov.uk/pdf/social-care-and-health/ce-lh-indicators-quintile-analysis.pdf
[9] http://fingertips.phe.org.uk/profile/local-alcohol-profiles/

7.01 - Alcohol-related hospital admission (Broad) (Persons) Cheshire East — Directly standardised rate - per 100,000



Period		Count	Value	Lower CI	Upper CI	North West	England
2008/09		3,800	1,045	1,012	1,079	1,291	1,040
2009/10		4,182	1,140	1,105	1,175	1,403	1,122
2010/11		4,335	1,167	1,132	1,203	1,471	1,197
2011/12		4,360	1,161	1,127	1,197	1,484	1,222
2012/13		4,417	1,161	1,127	1,196	1,491	1,220
2013/14		4,786	1,249	1,213	1,285	1,546	1,253

Source: Calculated by Public Health England: Knowledge and Intelligence Team (North West) using data from the Health and Social Care Information Centre - Hospital Episode Statistics (HES) and Office for National Statistics (ONS) - Mid Year Population Estimates.

Alcohol related recorded crime

- During 2014/15 there were 838 alcohol related crimes of violence recorded in Cheshire East; there has been an average of 68 crimes per month since April 2012, predictably ranging from 34 to 104 per month[10].
- There were 537 drink driving arrests and 281 drunk and disorderly arrests during 2014/15[11] and alcohol was a consistent feature in around 30% of domestic offences and incidents.[12]

Benefit claimants

- In 2014 there were 103.9 per 100,000 people claiming incapacity, severe disablement allowance or employment and support allowance due to alcoholism. This is lower than the rates in other areas of the North West and the England rate.

Ageing Well

- Approximately 11,000 older people drank more than the recommended amounts.[13]
- Alcohol has been identified as one of the three main causes of falls. There were 1,720 injuries due to falls in people aged 65 years and over in Cheshire East in 2013-14.[14]

[10] Monthly data supplied by Cheshire East Police

[11] Monthly data supplied by Cheshire East Police

[12] CHESHIRE EAST DOMESTIC ABUSE PARTNERSHIP ANNUAL REPORT 2014-15

[13] IAS (2013) Older people and Alcohol Factsheet applied to 2011 census data

[14] www.phoutcomes.info

Our Approach

A Summary of what we are already doing in Cheshire East:

- **Integrated Lifestyle and Wellness Support System – Alcohol**
  Lifestyle and wellness services are accessed using a variety of different routes. This can be confusing both to members of the public and professionals who work with them to improve their health and wellbeing. Our aim is to do things in a new way by introducing an 'Integrated Wellness and Lifestyle Support System'. This will give local people more control over how they access services, and more choice over the services they access. The 'Integrated Support System' will have a range of components such as:
    - Assessment and Co-ordination help, advice and support
    - Lifestyle and Wellness Support including: Physical Activity, Holistic Lifestyle Coaching, **Alcohol Harm Reduction**, Tobacco Control & Stop Smoking, Healthy Eating, and some Sexual Transmitted Infection

- **Stepping Stones Specialist Substance Misuse Service**
  Cheshire and Wirral Partnership NHS Foundation Trust (CWP) are the lead provider for the Cheshire East Substance Misuse Service 'Stepping Stones' for which the contract was awarded in November 2014 by Public Health. Stepping Stones takes a life-course approach, supporting adults and young people with substance misuse problems. CWP have also subcontracted to a number of voluntary and community sector organisations to deliver interventions to support individuals to achieve recovery such as employment training, school based support and mutual aid.

- **Business Advice courses for local businesses about licensing law**
  These courses are voluntary and catered to the individual businesses and the concerns they have. They are designed to offer an easy way for businesses to ensure that they comply with the relevant legislation. This saves money and time in the long run as any potential issues are fixed before they develop into something more problematic.

- **Test purchasing with underage volunteers**
  This approach is intelligence led and used to target businesses that are believed to be selling alcohol to underage people.

- **Children's alcohol & tobacco survey**
  This is done every two years and assesses our young people's relationship with alcohol and tobacco. The information garnered from such surveys can indicate areas for improvement in our approach. 334 responses were received in the 2015 survey.

- **Enforcement against counterfeit alcohol**
  Ensuring that any alcohol sold is licensed and genuine is vitally important in ensuring that our areas alcohol supply can be monitored and kept in the hands of adults. It is also important in minimising the harm caused by alcohol as counterfeit alcohol can damage people's health far more acutely than legal equivalents

- **Community Alcohol Network (CAN)**
  The CAN is a newly formed partnership organisation that was born out of the successful pilot of the CAP (community Alcohol Partnership) in Crewe South. It is a Council-wide initiative designed to bring together several council departments, the police and community safety teams. It is designed to offer a universal approach to problem premises with multiple issues. It has already had some notable success.

- **Working to Introduce the Cardiff Model of data sharing**
  The Cardiff Model of data sharing is a mechanism for sharing information between the Police, Accident and Emergency departments and local Council Licensing departments. It has been proven to reduce the numbers of alcohol related incidents in a town or city centre that result in either an arrest or a presentation at an A&E Department.

- **TWISTA peer mentoring scheme**
  This is a scheme aimed at vulnerable and at risk young people. The idea was to ensure they got support in a way that benefitted them without having to go through more formal routes. In this programme, a volunteer becomes the peer-mentor of a young person and helps with the pastoral side of their care.

- **Recovery based accommodation**
  This is a plan to better utilise the housing facilities already being used by some residents at the moment. It became clear that the service we provided did not cater for those with complex needs and was not co-ordinated enough to give the best results. It is hoped that by restructuring our current service we can provide a more coherent service that reduces the number of readmissions and radically improves the number of people recovering and becoming independent again.

- **ACPO Alcohol Harm Reduction Week**
  This is an event, run by the police, that raises awareness of licensing procedures that need to be followed.

- **High Profile visits to hotspot premises**
  This is a form of deterrence that demonstrates an awareness of the local environment. It also acts as a great tool for ensuring that any problems are not related to the premises serving the alcohol.

- **Operation Americas**
  This is an initiative led by Neighbourhood Policing Units. It involves running licensing focused weekends.

- **ARC Angel**
  ARC angel is a multi-agency approach to tackling alcohol related crime that utilises powers given to the police by the Anti-Social Behaviour, Crime and Policing Act 2014. It is a

standards based approach aimed at improving community relationships with alcohol and using enforcement where appropriate.

- **Operation ARC**
  This scheme offers 1st time offenders an alternative to on the spot fines. If you are caught being drunk and disorderly for the first time you can pay £20 and attend a multi-agency presentation on the damages of alcohol instead of the standard fine.

- **School Liaison Visits**
  This work is carried out by the police in order to help prevent alcohol harm in the future. It involves talking to school children about the use and damage of alcohol.

- **NAVIGATE Scheme**
  This scheme aims to target persistent offenders who pose their greatest threat to the safety and confidence of their community. Many of these have substance misuse issues, including alcohol.

- **CCTV service**
  Utilised as a form of deterrent for a whole host of crimes and is placed in hot-spot areas throughout town centres in Cheshire East. It also provides evidence for further action on specific people, premises or establishments.

- **Community Warden Service**
  The Community Warden Service was established to address public concerns in relation to crime and disorder and tackle issues in relation to anti-social behaviour. This is achieved by working in partnership with the local community and its partners to provide a safer environment in which to live, work, and visit. The provision of a uniformed community patrol offers and promotes community reassurance leading to a reduction in crime and, most importantly, the community's perception of crime.

- **Multi-Agency Action Groups**
  The MAAG process is a relatively new one which has developed from Safer Cheshire East Partnership's "Tasking and Co-Ordination" (T&C) process. It involves a range of issues and problems that arise from time to time via regular analysis of current trends and nominations of specific issues (which are assessed) from agencies which are members of the Group.

- **Street Pastors**
  Street pastors are trained volunteers from local churches who care about their community. They patrol in teams of men and women, usually from 10pm – 4am on a Friday and Saturday night, to care for, listen to and help people who are out on the streets. Street pastors engage with people on the streets to care for them, listen to them and help them. They work together with other partners in the night-time economy to make communities safer.

- **Manchester Mediation Service**
  This is a commissioned company who deliver mediation intervention for neighbour disputes around anti-social behaviour and other such things.

- **Anti-Social Behaviour Team**
  The Safer Cheshire East Anti-Social Behaviour Team work with partnership agencies to tackle this sort of behaviour, and draw up and amend standards of practice to make sure ASB is tackled as effectively as possible within Cheshire East. They utilise multiple tools and measures to help reduce the amount of anti-social behaviour across Cheshire East. These tools include, letters to parents, acceptable behaviour contracts, referral to preventing offending panel, community protection notices etc.

Our Ambition

There are a number of priority areas that we intend to focus upon over the next two years to build upon the good work already underway, but to help to co-ordinate even more effectively the efforts of partners to reduce alcohol related harms.

Goals for the future

- Minimum Unit Pricing (MUP) – working with Cheshire and Merseyside authorities to support the introduction of MUP, subject to the outcome of the alcohol industry legal challenge to the introduction of an MUP in Scotland. The Advocate General of the European Court of Justice has offered the opinion that the Scottish Alcohol Minimum Unit Price does not contravene European Law (3rd September 2015), but that it would only be legal if it can be demonstrated that no other mechanism exists to achieve the same desired outcome. The introduction of MUP would need to demonstrate "additional advantages or fewer disadvantages by comparison with the alternative measure". This has been welcomed by both supporters and opponents of MUP. The European court is expected to take at least a further six months to issue its final ruling, before the case is referred back to the Court of Session in Edinburgh.

- A coherent multi-agency approach with an effective action plan that covers all services – The main purpose of this work, and the main ambition of those involved, is to create an effective framework for encouraging multi-agency approaches to dealing with the issues surrounding alcohol related harm. Bringing services together in such a way will help us to improve outcomes and create a more efficient and personalised service for residents.

- Improved engagement with local alcohol retailers in order to promote responsible retailing.

- Working closely with the Clinical Commissioning Groups and Acute Hospitals to further develop Hospital Alcohol Liaison Services.

- Single brand message around alcohol across services – development of a consistent brand and concise and clear messaging, that all organisations would use in any promotional activity related to reducing alcohol harm. Development of a coordinated alcohol communications plan agreed by all partners.

- To undertake further work to better understand capacity and demand for treatment within the borough.

- Develop the wider use of identification and brief advice across the borough by non-specialist universal services and within other commissioning areas including Healthchecks, and the Integrated Lifestyle and Wellness Support System.

- Embedded 'Recovery' in communities across the borough. We need to have a clear understanding of our local recovery assets and where they can be developed further. By

taking an 'Assets Based Community Development' (ABCD) approach we can build recovery in our communities. Developing local our assets to enable individuals to engage in meaningful community based activities; we want to enable individuals to build their recovery capital through volunteering, education, training, employment, housing, family, friends, and wider health services. Local examples include: the development of a volunteering opportunities through a network of visible 'Recovery Champions' through our specialist substance misuse service, and our recovery based accommodation pilot.

- We have an ambition to develop some recovery accommodation in the area. The provision of such a service would offer people with complex needs a safe place to come and receive the help and support they need. The accommodation would also act as the perfect vessel to utilise effective multi-agency working to improve outcomes and keep the work cost effective. The recovery based accommodation pilot will be jointly commissioned by public health and housing, to provide sustainable accommodation and recovery at a community level.

- A shift from long term treatment to prevention and recovery within our Specialist substance Misuse service, with clear seamless pathways between treatment and recovery.

- Licensing Review - The Council is currently considering whether it is appropriate to implement a Late Night Levy (LNL) or Early Morning Restriction Orders (EMRO) together with other powers at our disposal to protect residents from crime, anti-social behaviour and noise nuisance caused by irresponsible licensed premises and irresponsible drinkers and to promote the reduction in the levels of alcohol use/misuse by Children and Young People and the incidence of alcohol related harm. Specific consideration must be given to whether a LNL or EMRO is a proportionate and reasonable response to the problems in our night-time economy or whether alternative measures can be considered. This may include a Cumulative Impact Policy for certain areas or supporting business led best practice schemes (eg Purple Flag or Best Bar None). Our ambition is to ensure that the residents of this area are provided with the best solution for them regarding licensing.

Prevention

Overview

'Prevention', through evidence-based interventions, aims to delay the first use of alcohol, deter people from developing drinking problems and reduce the harm of alcohol use. In addition to the harmful impact of alcohol misuse on health and wellbeing, the 'hidden harm' caused by alcohol misuse can also lead to unemployment, domestic violence and child neglect.

Alcohol prevention is multifaceted with various factors at different levels, from individual behaviour and choice, which can be combined with wider community, environmental, social, cultural and economic influences.

Effective prevention helps to reduce or remove individual and community level risk factors such as family conflict, parental or sibling alcohol use or economic deprivation. While enhancing protective factors such as strong family bonds, strong support structures, self-efficacy, problem solving skills, conventional, constructive interests and activities.

Cheshire East Council Public Health have recently commissioned a Substance Misuse Service (SMS) for young people and adults, which was awarded to Cheshire and Wirral Partnership NHS Trust (CWP) as the 'Lead Provider' to coordinate the delivery of SMS across a number of providers. The integrated SMS is called 'Stepping Stones' and it aims to reduce the harm to people misusing alcohol.

Evidence suggests that higher numbers of young people (aged14-19) in Cheshire East are drinking to harmful levels compared to nationally. Therefore 'Early Intervention' and a 'Life-course' approach are also key to prevention. Stepping Stones provides targeted interventions for Young People and their families and also offers interventions within schools. There is a strong evidence base supporting the influence of protective factors such as parents/carers and schools play a key role in preventing young people from developing alcohol problems. The Integrated Lifestyle and Wellness Service will also deliver universal prevention for Young people in these areas. Parents/carers can also be a risk factor in terms of the health and safeguarding impact on children who live with parents who drink to harmful levels.

There is also a need to enable and educate young people and adults to make healthy lifestyle choices that don't include harmful behaviour, such as excessive drinking. Again the Integrated Lifestyle and Wellness Service will provide a choice of help, advice and support in a range of ways.

What needs to be done?

We need to reduce the high levels of harmful drinking in Cheshire East compared to the national picture. This will be achieved through alcohol prevention interventions targeted at various levels from individuals, families and wider communities, across the life course.

Key priorities for alcohol prevention in Cheshire East include:

- Reducing the number of Young People who are drinking to harmful levels.

- Reducing the number of alcohol-related hospital admissions in Cheshire East compared to the national picture.

- Redressing the balance from treatment to prevention – Local alcohol services need to shift from focus on the treatment of alcohol misuse, towards prevention

- Assets Based Community Development to build on the protective factors of individuals and communities to prevent alcohol misuse

- Evidence based behaviour change interventions through a choice of help, advice and support services; more specifically an alcohol 'Identification and Brief Advice' (IBA) service as part of the Cheshire East Integrated Lifestyle & Wellness Support System. The Brief Advice also needs to focus on the impact of parental drinking on children and young people, to prevent and delay young people from drinking and alcohol.

- The Cheshire East Local Safeguarding Children Board have recommended that we need to raise awareness of the hidden harm and safeguarding implications of children living with parents/carers who are drinking to harmful levels.

Protection

Overview

Public services have a responsibility to work together to safeguard and promote the wellbeing of children and young people and vulnerable adults. This Impact Area focuses on reducing the harmful use of alcohol by young people and reducing the number of children affected by parental alcohol misuse.

Alcohol misuse among young people can have serious consequences. There are strong links between high levels of consumption and other risk factors such as offending, teenage pregnancy, truancy, school exclusion and illegal drug misuse.

Data will be available from the What about Youth? survey which is to be published in December on alcohol consumption in young people.

Cheshire East benchmarks well pupil absence and teenage pregnancy. Cheshire East is similar for England on first time entrants to the criminal justices system. The What about Youth? Survey will provide data for drug use.

Parental alcohol misuse and related domestic violence can adversely affect the physical, mental and psychological development and wellbeing of young people and lead to a range of poor outcomes.

Maternal alcohol misuse during pregnancy is linked to a number of mental and physical disabilities that can affect infants into childhood.

Improvements in the evidence has helped raise awareness and understanding of these issues and informed responses at both the national and local level. Parental alcohol misuse is now firmly established as a risk factor that needs to be addressed within child protection and safeguarding work within the borough.

What needs to be done?

A programme of education and awareness raising needs to be in place to ensure that parents are aware of the consequences and potential harms of alcohol use among young people. Parents must also be aware of the possible impact of their alcohol use on their children. This includes ensuring that parents are aware of the risks of supplying young people with alcohol.

The progress made through the Early Intervention and Prevention work already done in Cheshire East needs to be built upon. This will improve access for families to engage with Childrens centres and ensure that Parenting Programmes have capacity to work with families where alcohol misuse is a key issue. It will also improve access and engagement of parents requiring treatment for alcohol misuse including those where there are child protection concerns.

Cheshire East is developing a Parent Journey through integrated working between Children's Early Help services and Public Health commissioned 0-19 services. This will include systematic assessment of 0-5s and their parents. The assessment will include the AUDIT C. It will also include systematic promotion of healthy lifestyles including appropriate alcohol consumption.

Responses to young people's alcohol misuse must be integrated within other initiatives to improve outcomes for children and young people. Specialist services must be in place for those young people who need them.

Cheshire East is developing an emotionally healthy schools programme targeting secondary schools. We are part of two national pilots: a CAMHS school link pilot and an extension to vulnerable children. The extension to vulnerable children will involve systematic identification of vulnerable children in the school footprint, systematic assessment of need and multiagency appropriate responses. This will include young people who misuse alcohol.

All key services working with parents and their children need to be equipped to identify parental alcohol abuse.

In 2014-15 alcohol misuse of a parent/carer was identified in 427 out of 3,627 children's assessments. Only 76 of these parents were involved in alcohol and drugs services. A bid has been made to the Complex Dependency programme to support a deep dive to understand the needs of these different families and whether the appropriate parents are reaching services.

Links between specialist alcohol services and domestic violence services must be improved to promote collaborative and integrated service provision. Support must be in place for children and young people affected by parental alcohol misuse and domestic violence. The Complex Dependencies bid also includes links with Domestic Abuse.

Alcohol and Drugs, Mental Health and Domestic Abuse are three key causes of children's social care involvement in families. The LSCB offers comprehensive training around domestic abuse. We are exploring how we can deliver mental health training. We need to also find a way to deliver alcohol and drugs training to the wider safeguarding audience.

Treatment

Overview

'Treatment' of alcohol misuse generally involves three evidence based steps, identification and brief intervention/second level psycho-social interventions, detoxification and recovery.

The first phase of treatment for those who are **dependent** on alcohol is controlled and supervised detoxification. Detoxification is then followed by a recovery programme, which can include a number of interventions such as counselling, psychosocial support (behaviour change), prescribing, mutual aid, peer support, building on assets/strengths/protective-factors, information, advice and education. Treatment can be provided via inpatient supported treatment accommodation or while the individual lives in the community.

Stepping Stones delivers specialist treatment services for dependant drinkers in Cheshire East, offering harm reduction and appropriate health assessment for blood borne viruses and sexually transmitted disease, to help with recovery from addiction, behaviour change, and support to withdraw and become alcohol free. Stepping Stones provides 'step up and step down' treatment and support that is seamless, co-ordinated and monitored, with follow up review arrangements post service exit to monitor achievements of a life free from alcohol, and learning from relapse. At the end of March 2015 there were a total of 458 dependent drinkers receiving treatment from Stepping Stones.

In order to prevent adults from becoming dependent on alcohol and to therefore reduce the demand for specialist treatment, it is important to also target interventions to those who are **Hazardous drinkers** (Hazardous drinking usually refers to drinking above the recommended lower-risk levels but without, yet, showing evidence of harm to health) and also **Harmful drinkers** (Harmful drinking refers to those already experiencing or showing evidence of health harms, but not if just showing evidence of alcohol dependence).[15]

What needs to be done?

Improve commissioning with CCG Acute Hospitals regarding further development of hospital alcohol Liaison service.

The development of an effective alcohol treatment and referral pathway between GPs and the specialist substance misuse service.

To undertake further work to better understand capacity and demand for treatment within the borough.

Develop wider use of identification and brief advice across the borough by non-specialist universal services and within other commissioning areas including Healthcheck, and the Integrated Lifestyle and Wellness Support System.

The principles of prevention and recovery need to be embedded within our treatment workforce. Clear, visible pathways between treatment and recovery will enable individuals, families and

[15] NHS Choices, Alcohol misuse http://www.nhs.uk/conditions/Alcohol-misuse/Pages/Introduction.aspx

communities to engage and to provide the recovery networks that are needed to achieve the benefits of recovery in communities.

Recovery

Overview

'Recovery' includes giving people the support they need to move towards being alcohol free and to maintain this ideally for life. Key contributing factors for recovery are having a home, employment / volunteering, and supportive networks. Effective recovery planning is essential and needs to embrace these factors in addition to treatment and wider health and wellbeing considerations.

Alcohol misuse services in Cheshire East have been predominantly focussed on specialist treatment, therefore the newly commissioned Substance Misuse Service (SMS) 'Stepping Stones' aims to concentrate more on progress towards recovery, particularly for those in long term treatment. The partnership approach delivered by Stepping Stones aims to make it easier for people who may use more than one service and or require different interventions at times within their 'recovery journey' from alcohol misuse, or at relapse.

To support individuals to achieve their journey towards recovery, Stepping Stones makes good use of asset based community development, promoting self-care and actively supporting the development of and linkage with mutual aid. Some of the recovery based, behaviour change interventions and mutual aid delivered by community based organisations through Stepping Stones include, Catch 22, Acorn Recovery (RAMP and DEEP), Intuitive Thinking Skills training such as Skills-Tu Employment, Expanding Futures, Emerging Horizons and Changing Lanes.

What needs to be done?

To redress the balance from treatment to prevention and recovery – local Alcohol services have been predominantly focussed on the specialist treatment of alcohol misuse. Stepping Stones aims to shift the focus more towards reducing the harm of alcohol misuse (Prevention) and supporting people to become alcohol free (recovery). Stepping Stones has been developed to be more oriented towards recovery, to reduce the number of individuals who have historically remained in long term treatment, also to ensure that new entrants to treatment are able to move onto recovery and abstinence. We also need to ensure that wider providers and settings have a responsibility for supporting recovery.

To develop an 'Assets Based Community Development' approach, that aims to build on our local community strengths and therefore the key contributing factors in recovery.

There is a lack of local suitable stable accommodation, which is a significant risk to an individual's ability to achieve and sustain their recovery. We need to commission an appropriate accommodation model which provides a safe temporary home to enable Cheshire East residents without accommodation and currently using alcohol in an uncontrolled manner to recover to the point where they can start to work towards maintaining an independent tenancy. In addition we need to work with the Registered Providers to ensure a co-ordinated approach to supporting individuals at risk of losing their accommodation because of alcohol related causes and we need to respond to the needs of people who continue to use alcohol despite losing access to rented accommodation, for example through Housing Options.

Details of the existing Service offer and other resources are contained in Appendix One.

Enforcement and Control

Overview

We are committed to securing the safety and amenity of communities within the Cheshire East area, whilst facilitating a sustainable alcohol and entertainment industry. We also recognise that our residents deserve a safe and desirable environment in which to work and live. We recognise the importance of well-run licensed premises in a vibrant and diverse local economy. We will do all we can to promote the safety of our residents and visitors.

We intend to work proactively with the Cheshire Police and other enforcement agencies. This will include intelligence led late night visits and the monitoring of problem premises.

Proportionate targeting of agreed problem and high-risk licensed activities needing greater attention will be applied. A corresponding lighter touch for well run, lower risk premises will also be applied.

The Review of licences or certificates provides a key protection for the community where the Licensing Objectives are being undermined. The Licensing Authority will provide advice to members of the public and responsible authorities on the review process.

Strategic use of local information can be employed to target specific crime 'hot spot' areas. In particular, hospital Emergency Departments can make a significant contribution to reducing community violence through working with their local Community Safety Partnership to share data about alcohol related violence.

What needs to be done?

Enforce

All the relevant tools and powers must be used to address alcohol related crime and anti-social behaviour with a specific emphasis on early intervention. Cheshire East should work with national and regional partners to engage in new and emerging programmes where there is evidence of effectiveness.

Through the use of Mandatory Licensing Conditions we will be able to utilise a whole host of measures that act as a strong deterrent to breaching the conditions; warnings, cautions and prosecutions can be utilised against premises that breach their licensing conditions. It is also worth noting that very similar punishments are available for people who are in the possession of fake identification documents.

People who commit alcohol related crime must be supported to engage with relevant alcohol services. First time offenders attending court as a result of their alcohol misuse should be offered early interventions to reduce re-offending and address alcohol concerns early. For more persistent and chaotic offenders a CBO must be employed to address alcohol related offending and alcohol misuse.

All agencies responsible for commissioning alcohol treatment services for offenders must work together to ensure a full ranges of interventions can be provided to the residents of Cheshire East.

It is vitally important that we look at the effect alcohol has on incidents of domestic abuse. Last year we have conducted one Domestic Homicide Review and contributed to a second. In both of these incidents alcohol use by the perpetrator played a significant role in the antecedents to the murders.

We are currently working under the guidance and action plans set out in the Domestic Abuse Strategy 2014-16 document. Our provision for Domestic Abuse vision is realised under six key priorities. They are Prevention and Early Intervention, Protection, Provision, Partnership, Participation, and Performance. The strategy offers a holistic approach to tackling domestic abuse through the encouragement of partnership work and inter-service co-operation.

Control

We will work closely with Cheshire Police and other enforcement agencies to ensure that businesses and individuals comply with the relevant legislation. This will include a number of different measures being utilised to ensure positive outcomes for our residents.

Regular visits to licensed premises will be included to ensure that they are being operated in accordance with the terms of their respective licenses. There will also be intelligence led late night visits and regular monitoring of problem premises to ensure that the area is constantly providing a thriving but safe night time economy.

A programme for test purchasing, guided by intelligence gathered from multiple reputable sources, will be instigated with the help of underage volunteers. This form of test purchasing plays an integral role in our area's ability to protect young people from the harm caused by excessive alcohol consumption.

Through the Trading Standards team, there is also scope for ensuring that alcohol labelling and measurements are compliant with relevant legislation. Trading standards also offer Business Advice packs that are catered individually to businesses that use them. They can cover any topic that the business owners are unsure about; be it licensing conditions, spotting real identification or other similar issues. This is an important preventative tool in our arsenal as we do not want to unfairly target businesses who are trying to comply with all the relevant legislation.

Cross Cutting Enablers

Communication

Effective communication across partners and with the community, will support further development and implementation of the plan. Through the Cheshire East Community Safety Partnership and the Health and Wellbeing Board, communication with individuals, communities and businesses will be undertaken to raise awareness of the work underway to reduce alcohol related harms. We will seek their views on how alcohol impacts them, how we can improve our responses and how they can support action to address these issues. We will communicate with a wide range of partners and stakeholders, including local councillors, local businesses and service providers in the public and third sector, to ensure the successful delivery of the plan. A multi agency Communications Strategy will be developed.

Workforce Development

We need to ensure that all organisations and services engaged in the implementation of the plan have sufficient staff with the knowledge and skills required to deliver the relevant services. This includes skills around Identification and Brief Advice and the safeguarding of young people and vulnerable adults affected by alcohol. We need to ensure that we promote workforce development through regular training and opportunities for skill sharing and exchange throughout the system.

Improving Understanding

We are committed to improving our understanding of how alcohol misuse impacts Cheshire East.

We will collect and utilise data to inform our approaches in Cheshire East. We will evaluate new services and approaches to improve the evidence about what works in reducing alcohol related harm.

Relevant National Policy

It is vitally important that this Position statement and Forward Plan is based on, responds to and incorporates, current policy and legislation. The most significant influencers on our thinking have included:

- **Licensing Act, 2003;** *HM Government*
  This legislation has been the cornerstone of Alcohol Licensing legislation since its introduction in 2003. Its primary goal was to replace the nation's outdated laws with what was deemed to be a 21st Century licensing system.

- **Communication from the Commission to the Council, the European Parliament, the European Economic and Social Committee and the Committee of the Regions: An EU strategy to support Member States in reducing alcohol related harm, 2006;** *Commission of the European Communities*
  This policy document was written in 2006 and offers a clear outline of areas that could be tackled to reduce the harm caused by alcohol. It was roundly criticised for its lack of industry

focused policy but given the scope of this local strategy it offers a useful, in-depth analysis of the different areas of our services that alcohol can have an impact upon.

- **Selling Alcohol Responsibly: the new mandatory licensing conditions, 2010;** *Home Office*
  This guidance outlines new mandatory licensing conditions and allows for a local approach to age verification policies and price promotions.

- **Drug Strategy – Reducing Demand, Restricting Supply, Building Recovery, 2010;** *HM Government*
  This approach is aimed primarily at ensuring people who are dependent on any substance, like alcohol, are cared for throughout their progression from vulnerability to independent living. It focuses on improving these outcomes to reduce alcohol related admissions to hospital - better for the individual and reducing costs to the health service.

- **Breaking the Cycle – Effective Punishment, rehabilitation and sentencing of offenders, 2010;** *Ministry of Justice*
  It proposes that by tackling dependencies, such as alcohol dependency, in prison populations the number of reoffenders, and prison numbers as a whole, would drop. By breaking this cycle the number of prisoners and the number of crime and health incidents related to alcohol would reduce.

- **Healthy Lives Healthy People – Our Strategy for public health in England, 2010;** *Dept. of Health*
  Published as part of the preparation for the Health and Care Act (2012), its focus was to make public health more community orientated so that it could shape its work around the needs of local people. The main outcome was the shift of public health into local authorities. Other elements of the Act introduced the local Health and Wellbeing Boards and Clinical Commissioning Groups.

- **Police Reform and Social Responsibility Act, 2011;** *HM Government*
  This piece of legislation was brought in to support the Licensing Act of 2003 by giving local areas new powers including tools such as a late-night levy and the ability to restrict opening hours in problem establishments.

- **No Health without Mental Health: a cross-government mental health outcomes strategy for people of all ages, 2011;** *Dept. of Health*
  This outlines a framework for improving the diagnosis and treatment of mental health in people, particularly those who already have other needs being addressed within the system. This approach aims to offer a more holistic approach to care and hopes to get practitioners to join the dots between mental health concerns and substance dependence more regularly. It is also hoped that such an integrated approach would lead to better outcomes for those involved.

- **Government Alcohol Strategy, 2012;** *HM Government*

This document signalled a new approach to alcohol consumption and the culture of "irresponsible drinking". Its focus was primarily aimed at reducing binge drinking and reducing alcohol related crime and alcohol related health issues. It also includes the drinks industry in plans to help combat these important issues.

- **The Troubled Families Programme – Financial Framework for Payment by Results Scheme for Local Authorities, 2012;** *Dept. for Communities and Local Government*
  This is another approach designed to tackle those with multiple needs and provides a framework for providing local interventions to families. This has a direct link to those who are affected by alcohol misuse and dependency.

- **Improving Outcomes and Supporting Transparency; a public health outcomes framework for England 2013-2016, 2012;** *Dept. of Health*
  The suggested framework is designed to help public health departments become more effective at delivering and supporting local action against certain local health issues such as specific sicknesses, domestic abuse, premature mortality or health improvement.

- **Health first: An evidence based alcohol strategy for the UK, 2013;** *Alcohol Health Alliance UK et al.*
  This is an ambitious document that sets out a range of initiatives that would allow the focus of Alcohol Harm Prevention work to move towards a treatment based service and away from the criminal aspects. It highlights desires to introduce a 50p minimum unit price, lower the limit for drink driving in England to 50mg/100ml, which would bring it in line with Scotland's law, and restrictions on alcohol advertisement and sales among a whole host of other ideas to help prevent harm caused by alcohol.

- **Anti-Social Behaviour, Crime and Policing Act, 2014;** *HM Government*
  This act provides the police with new powers to tackle crime and anti-social behaviour. They now have dispersal powers requiring people causing disorder or committing an act of anti-social behaviour to leave the area. They also have closure powers that can be used against problem premises and Criminal Behaviour Orders that can be used to restrict the night time activity of those involved in anti-social behaviour if they have previously been convicted of a criminal offense. They can also be required to attend an alcohol rehabilitation course.

- **From Evidence into Action: Opportunities to protect and improve the nation's health, 2014 (Priority 3 - Reducing Harmful Drinking);** *Public Health England*
  The Public Health priorities of the newly formed Public Health England include reducing harmful drinking through a number of planned actions that centres on using Alcohol as a trailblazer for a new, whole system approach. The goal is a system that works and offers a return of investment so that organisations can invest in evidence-based policy with confidence. The priorities detail ways in which current tools and approaches can be integrated with new frameworks and initiatives to offer the best, most cost-effective methodology for reducing alcohol related harm.

- **Service user involvement: A guide for drug and alcohol commissioners, providers and service users, 2015;** *Public Health England*
  Service users' involvement in the design and delivery of services has contributed significantly to the evolution of effective drug and alcohol treatment systems. This guide builds on guidance published by the National Treatment Agency (NTA) in 2006, 1 looking at the evidence base, the different levels of involvement, and the impact of involvement on service users and treatment effectiveness.

APPENDIX ONE

Current Commissioned Recovery Services

http://www.cwp.nhs.uk/services/2540-cheshire-east-substance-misuse-service

http://www.acornrecovery.org.uk/

http://www.catch-22.org.uk/

http://www.intuitivethinkingskills.co.uk/

http://www.expandingfutures.co.uk/

http://www.emerginghorizons.org/training-courses/recovery-and-substance-misuse/

Changing Lanes 24 Hour Helpline: 07980 053810

Stepping Stones branding / logo

Case Studies are available via CWP and partner agencies if needed.

Further Comments

Suggested forward steps

In some of the feedback there has been reference to steps that should be taken going forward. These include:

- **A survey that is sent to all our partners on alcohol services to inform us about what the sector feels they need in terms of improved provision.**
- **There must be improved training on alcohol and harm reduction as a single issue and as one of the key complexities for families**

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