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Cheshire East Health and Wellbeing Board

Agenda

Date:	**Tuesday, 29th May, 2018**
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 Municipal Year 2018/19.

2. **Appointment of Vice-Chairman**

   To appoint a Vice-Chairman for the Municipal Year 2018/19.

For requests for further information
Contact: Cherry foreman
Tel: 01270 686463
E-Mail: cherry.foreman@cheshireeast.gov.uk with any apologies

3. **Apologies for Absence**

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 5 - 8)

To approve the minutes of the meeting held on 27 March 2018 as a correct record.

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

In accordance with paragraph 2.32 of the Committee Procedural Rules and Appendix 7 to the Rules a period of 10 minutes is allocated for members of the public to address the meeting on any matter relevant to the work of the body in question. Individual members of the public may speak for up to 5 minutes but the Chairman or person presiding will decide how the period of time allocated for public speaking will be apportioned where there are a number of speakers. Members of the public are not required to give notice to use this facility. However, as a matter of courtesy, a period of 24 hours' notice is encouraged.

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

7. **Better Care Fund End of Year Report 2017/18** (Pages 9 - 46)

To consider the end of year report on the performance of the Better Care Fund.

8. **Improved Better Care Fund 2018 - 2010** (Pages 47 - 56)

To consider and endorse the iBCF schemes (1-7) and associated expenditure.

9. **Director of Public Health Annual Report 2017** (Pages 57 - 84)

To consider the Annual Report for 2017.

10. **Health and Wellbeing Strategy - Overview and Consultation** (Pages 85 - 104)

To consider the updated Health and Wellbeing Strategy.

11. **Health and Wellbeing Board Annual Report 2017/18** (Pages 105 - 116)

To approve this report on the annual work of the Board for 2017/18.

CHESHIRE EAST COUNCIL

Minutes of a meeting of the **Cheshire East Health and Wellbeing Board** held on Tuesday, 27th March, 2018 at Committee Suite 1,2 & 3, Westfields, Middlewich Road, Sandbach CW11 1HZ

PRESENT
Councillor R Bailey – Cheshire East Council (Chairman)
Councillor J Clowes - Cheshire East Council
Councillor J Saunders - Cheshire East Council
Louise Barry - Healthwatch
Jerry Hawker - Eastern Cheshire Clinical Commissioning Group
Mark Palethorpe - Cheshire East Council Acting Chief Executive and Director of People
Clare Watson - South Cheshire Clinical Commissioning Group

Non Voting:
Mike Larking - Cheshire Fire and Rescue Service
Caroline O'Brien - CVS Cheshire East
Kath O'Dwyer - Cheshire East Council Acting Chief Executive
Fiona Reynolds - Cheshire East Council Director of Public Health
Carla Sutton - NHS England

Observers
Councillor Joy Bratherton - Cheshire East Council
Councillor Liz Wardlaw - Cheshire East Council

Cheshire East Officers/Others in Attendance:
Hayley Doyle - Cheshire East Public Health Commissioning Support Manager
Guy Kilminster - Cheshire East Council Corporate Manager Health Improvement
Cherry Foreman - Cheshire East Council Democratic Services

49 APOLOGIES FOR ABSENCE

Apologies for absence were received from Tracey Bullock, Chief Inspector A Fairclough, Tom Knight and Dr A Wilson.

50 DECLARATIONS OF INTEREST

There were no declarations of interest.

51 MINUTES OF PREVIOUS MEETING

The minutes of the meeting held on 30 January 2018 were approved as a correct record.

52 PUBLIC SPEAKING TIME/OPEN SESSION

No members of the public wished to speak.

53 **PHARMACEUTICAL NEEDS ASSESSMENT AND CONSOLIDATION OF PHARMACIES REGULATIONS**

Consideration was given to this report giving an up to date statement of pharmaceutical needs. The Board had been given delegated authority to develop and produce a Pharmaceutical Needs Assessment (PNA) for the area every three years; NHS England was then responsible for using it, and any other relevant information, to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from a pharmacy.

Following a detailed consultation process the responses received had been reviewed together with additional information to check the findings presented within the PNA. The report had been shared with neighbouring authorities and vice versa in order to achieve as wide a view as possible of provision both in and around Cheshire East. Concerns regarding accessibility and provision in areas of planned housing growth had been addressed and the provision for the towns and villages of Cheshire East found to be adequate in terms of location, opening hours, and the services offered. No current or anticipated future need for new services had been identified.

In discussing the report and its findings it was agreed that the definition of 'adequate' should be added into the report. With reference to delivery services in rural areas it was requested that some research be carried out to ascertain both the reliability and satisfaction with the service; whilst this was outside the remit of the report it was agreed that this would be useful information and that it should be followed up. It was also agreed that the results of the current trial to place pharmacists in care homes should be shared with the adult social care team.

RESOLVED

1. That any pharmacy closures within neighbouring Health and Well-being Boards be considered in order to assess the potential impact on areas with already lower pharmacy:population ratios, and that this process be delegated to the Director of Public Health on behalf of the Board.

2. That continued consideration be made by NHS England, Clinical Commissioning Group (CCG) and local authority commissioners of the expertise within community pharmacies to case-find, deliver brief interventions, provide additional healthy lifestyle advice and signposting within the wider health system.

3. It be noted that Pharmacists need to ensure accessibility of their premises and to information materials such as leaflets and prescription labels and to review the dispensing process to understand the problems that are leading to general dissatisfaction of customers about long waiting times.

4. That more be done by the Clinical Commissioning Groups to promote the Minor Ailments Service more widely.

5. That the definition of 'adequate' be added into the report; that research be carried out into the efficacy of delivery services in rural areas; and the

results of the current trial to place pharmacists in care homes be shared with the adult social care team.

54 CARER'S MOU AND STRATEGY UPDATE

Consideration was given to progress to date against the five key priorities and the actions set out in the Carers Strategy Delivery Plan 2016/18 which continued to be a driver for change, focussing on the key areas that Carers said were important to them and would make a real impact upon improving their health and wellbeing.

The Strategy also led the approach for the re-commissioning of carers services to achieve improved outcomes for them whilst at the same time responding to both legislative requirements and budget restrictions. The Strategy also strengthened the partnership approach for the mutual benefit of the Council and the CCGs, both aligned to the Better Care Fund.

The Committee was advised that Encompass NW had been successful in its bid to provide a single point of contact service which, when introduced, would address one of the main needs identified during consultations. The Committee discussed the success of the Carer's Living Well Fund, through which 872 breaks had been provided since November 2017, and was informed that the service would continue to be offered via the Carers Hubs. The positive impact for young carers through the development of the Carers Hub was welcomed; the service was due to go live at the beginning of April and an update on this would be provided at the next meeting, to include details of their locations which were particularly important bearing in mind the lack of transport available to many young carers.

RESOLVED

That the report be noted.

55 CONNECTING CARE PROGRAMME UPDATE

Consideration was given to the progress of the Caring Together Programme since the last meeting. The report set out the achievements of the Programme which was now being closed down following the decision to establish the Central and Eastern Cheshire Health and Care Partnership. It was reported that a Memorandum of Understanding and governance arrangements were now being finalised for the new Partnership and it was envisaged there would be an Executive Group, a Stakeholder Forum and a Care Professional Advisory Group, all of which would report to a Joint Programme Board.

Work plans were being developed to identify the most appropriate configuration of services and organisational form to effectively meet the care needs of local people within the resources available; the aim was to retain as many services as possible locally and for care to be provided in the community. Detailed proposals would be shared with the Overview and Scrutiny Committee and key stakeholders prior to public consultation in 2018/19 for which a stakeholder analyses and communication strategy were being developed.

RESOLVED

That the report and plans to merge the two local transformation programmes, Connecting Care (NHS South Cheshire CCG and NHS Vale Royal CCG) and Caring Together (NHS Eastern Cheshire CCG) be noted and also that discussions are underway to agree the geography for the joint programme.

The meeting commenced at 2.00 pm and concluded at 3.00 pm

Councillor Rachel Bailey (Chairman)

Version Number: 3

Cheshire East Health and Wellbeing Board

Date of Meeting: 29 May 2018

Report Title: BCF Year-end report 2017/18

Portfolio Holder: Cllr. Janet Clowes (Adults Social Care and Integration)

Senior Officer: Linda Couchman, Interim Director of Adult Social Care and Health

1. Report Summary

1.1. The following is the year-end report for the Better Care Fund. The Better Care Fund provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and funding paid directly to local government for adult social care services – the Improved Better Care Fund.

1.2. The year-end report covers the performance of the BCF in Cheshire East over 2017/18. In appraising the performance of the BCF in 2017/18 there are a number of considerations which are detailed below.

2. Recommendation/s

2. DMT/HWB notes that:

2.1. The Better Care Fund in Cheshire East is making a significant difference to people's lives as evidenced by the highlights of scheme performance in section 1.4.

2.2. Notable improvements to Delayed Transfers of Care have taken place during the course of 2017/18.

2.3. At the same time the Better Care Fund plan covers a two year period 2017/19 and in 2018/19 there remains much to do as noted in next steps 1.17. The next steps include concluding the evaluation process, confirming schemes for 2018/19, the completion of number of self-assessments to better understand progress against 7 day working, integration and High Impact Care.

3. In appraising the performance of BCF in 2017/18 DMT/HWB has noted the following information:

- Vision, aims and objectives of BCF in Cheshire East (Appendix one)
- The aims of individual schemes (Appendix two)
- What will be different as a result of the 2017/18 BCF plan? As noted in 'Delivering the Better Care Fund in Cheshire East 2017-19'
- How individual schemes performed and what they achieved (Appendix three)

- How the plan performed against national metrics and Q4 performance (Appendix four)
- The evaluation process that has taken place to date and the results of that evaluation (Appendix five and six)
- The financial income and expenditure of the plan
- The next steps for the BCF in 2018-19

3. Reasons for Recommendation/s

3.1. The governance of the BCF through S75 agreements states that the progress against the delivery of plans will be shared and monitored by the Better Care Fund Governance Board and will also be provided to the Cheshire East Health and Wellbeing Board as required. This end of year report forms part of the monitoring arrangements for the Better Care Fund.

4. Other Options Considered

4.1. N/A

5. Background

3.1. The Better Care Fund provides a mechanism for joint health and social care planning and commissioning, bringing together ring-fenced budgets from Clinical Commissioning Group allocations, the Disabled Facilities Grant and funding paid directly to local government for adult social care services – the Improved Better Care Fund. The Spring Budget 2017 announced an additional £2 billion to support adult social care in England. This money is included in the Improved Better Care Fund grant to local authorities and will be included in local Better Care Fund pooled funding and plans.

3.2. Local Better Care Fund plans are subject to national conditions and guidance. Local plans are monitored through NHS England and there are strict timelines regarding submission of plans for both regional and national assurance of plans to take place.

3.3. National Conditions for 2017-19:

3.4. In 2017-19, NHS England required that Better Care Fund plans demonstrated how the area will meet the following national conditions:

- Plans to be jointly agreed
- NHS contribution to adult social care is maintained in line with inflation
- Agreement to invest in NHS commissioned out-of-hospital services, which may include 7 day services and adult social care
- Managing Transfers of Care *(Delayed Transfers of Care)*

1.1. Detailed Implementation Plans were developed as part of the '*Delivering the Better Care Fund in Cheshire East 2017-19,*' which was fully assured by NHS England on 21st December 2017. The progress against the delivery of these plans will be shared and monitored by the Better Care Fund Governance Board and will

also be presented to the Cheshire East Health and Wellbeing Board on a quarterly basis.

1.2. **What will be different as a result of the 2017/18 BCF plan?**

1.3. As part of 'Delivering the Better Care Fund in Cheshire East 2017-19' an articulation of what should be expected by the end of 2017/18 was produced, this along with a statement of progress is described in the table below:

By the end of 2017/18	Progress in 2017/18
Reablement services in Cheshire East will have become fully integrated to address both physical and emotional needs; the aim will be to provide more balanced provision including both proactive and responsive services for people with physical and/or mental health needs and thus an improved outcome for those in Cheshire East. This will be evidenced by an improved reablement score under National Metric 3.	There are currently different commissioning expectations and specifications (including some that are out of date) for each element of the Reablement service. Significant service changes have also been made in-year, which has diverted existing capacity from Community Support Reablement. Across Reablement, there is a single provider, one management structure, a shared electronic rostering system (Staffplan), a shared recording system (Liquid Logic), one centralised referral hub, one assessment system and a single recruitment and training programme. There are examples of joint case working and a flexible staffing system, where staff members move between teams to offer cover, to jointly manage complex cases and to respond to, and manage, increased demand. Service users with dual, or multiple, needs have a single care plan and a primary worker who co-works, or links, with staff from across the other elements of the reablement service to deliver a single holistic package of care. There is one manager for Mental Health and Dementia Reablement in each of the two teams, which ensures the services are operationally integrated where appropriate.
Carers' services will be integrated, providing a single solution for support, which supports wellbeing, de-escalates crisis and maintains quality of life for both the person caring and the person being cared for. This will be evidenced under an improved score under National Metric 3.	Carers services have been integrated through the introduction of the integrated carers hub which is due to go live in April 2018. This service replaces the current carers breaks provision with the Carers Living Well Fund.
Falls services will become streamlined	Work is still underway to ensure falls

across health and social care with a move towards joint commissioning arrangements and utilise assistive technology, in addition a Cheshire-wide project to widen use of assistive technology to support people in their own homes will be in progress. This will be evidenced by an improvement in National Metric 2.	services are streamlined across health and social care moving towards joint commissioning arrangements. In addition to this consideration will be given to the joint commissioning of assistive technology with CCG partners.
iBCF schemes provide increased capacity and capability in the community; this is evidenced by meeting the DTOC trajectory in a sustained way in addition to a reduction in those requiring residential and nursing home care particularly directly from acute care.	All but one of the iBCF schemes were implemented, the schemes have contributed to increased capacity and capability in the community and have contributed to improved performance in Q3 meeting the trajectory for DTOC performance. In the plans for January 2018 the total delayed days was projected as being 1,057, the actual was 897 so we are 160 days better than the target, equating to about 5.2 beds per day above target. Compared to projected target, the total for January was 34.1 beds per day, the actual was 28.9. Compared to the previous month the figure of 897 total days represents an increase of 81 days (9.9%). Since April 2017 the total number of delayed days is 12,393 (monthly average 1,239), days attributable to health 8,205 (monthly average 821) and days attributable to social care 4,156 (monthly average 416).
Improved use of data and evaluation locally will mean that the Better Care Fund planning will respond to trends much faster than previous, providing a much faster and evidence-based planning process.	The national metrics are reported on a monthly basis through the BCF Governance group. Work is underway to share partners KPI's as identified through the national CQC visits carried out as part of the local systems reviews. A programme enabler action will be to establish a position statement for information governance and to progress this where possible.

1.4. **How individual schemes performed and what they achieved**

A breakdown of scheme progress is shown in Appendix three, highlights from 2017/18 include:

- The pilot of a care sourcing team, sourcing 995 packages of care.

- Implementation of Care Package retention of 7 days scheme, utilising this on 413 occasions.
- Rapid return home scheme went operational
- Care Home Support fully went operational
- Funding in place to support discharge models which included having a locality manager and practice manager in post as well as having social workers available on weekends covering both Leighton and Macclesfield hospitals.
- A pilot scheme to test referrals to reablement from the acute setting over weekends was established.
- The establishment of a Rapid Return Home (Overnight) Service
- Clinical support to care Care Home Support
- Flexible non-acute bed capacity/Discharge to Assess Beds commissioned
- Increased support for community Matrons case-managing High Risk patients.
- Commenced Fair cost of care pricing review and consultation for Accommodation with Care.
- Completed market engagement on carers services and people with complex needs
- Specification for Care at Home and Accommodation with care completed.
- Live Well CE established, the site generated 16,000 page views per week and 5,700 individual user sessions.
- Management of steady increase to telecare usage from 1,926 monthly users in January 2016 to 2,531 monthly users in December 2017.
- Confirmed Carers wellbeing budgets for 872 people.
- 318 disabled people enabled to live independently through Disabled Facilities Grants.
- Service specifications in place for Support at Home Service – (British Red Cross to provide practical and emotional support at home over 7 days). Following this services were established.
- Community Support Reablement - the total number of hours provided is 2,140 hours per week across the North and South Teams
- 3175 safeguarding concerns were raised.

1.5. **How the plan performed against national metrics**

1.6. The BCF policy framework establishes the national metrics for measuring progress of integration through the BCF. Information on all four metrics is collected nationally. In summary these are:

a. Non-elective admissions (General and Acute);
b. Admissions to residential and care homes
c. Effectiveness of reablement; and
d. Delayed transfers of care;

1.7. **Non-elective admissions (General and Acute);**

The plan for 2017/18 was 39,768; whilst Q4 data is not yet available the forecast outturn is 41,775 which is 2,007 above the forecast

1.8. **Admissions to residential and care homes**

The plan for 2017/18 was 717 admissions to residential and nursing homes 65+ per 100,000 populations, the cumulative rate position in Q3 was 557; data for the Q4 position is not yet available.

1.9. **Effectiveness of reablement;**

The plan for 2017/18 was 88.4% in respect of the service user being at home 91 days after discharge to reablement/rehabilitation. The Q3 position states that 72.3% of service users were at home 91 days after discharge to reablement/rehabilitation. The data for Q4 is not yet available.

1.10. **Delayed transfers of care**

The plan for 2017/18 was 43 Delayed transfers of care from hospital per day, the Q3 position is 26 in December 2017. Data for Q4 is not yet available.

Partners worked together to develop schemes which would contribute towards unnecessary admission to hospital and care homes reducing Delayed Transfers of Care to meet national and locally agreed targets. The locally agreed targets were 3.5% by November 2017 for South Cheshire CCG and 5.2% for Eastern Cheshire CCG by March 31 2018. A number of the selected co-produced schemes were aligned to support the achievement of the High Impact Model.

1.11. Targets for reducing 'delayed transfers of care' (DToCs) were introduced this year by the Department of Health and Department for Communities and Local Government to encourage the NHS and local government to work better together to reduce the number of people remaining in hospital because of health-related delays or social-care related delays.

1.12. Each month, local authorities receive their ranking regarding health and social care partner working together to reduce DToCs. Cheshire East hospital patients are among the least likely in to be delayed being allowed home, according to national figures and we remain in the top quartile. This highlights how health staff and our care teams are working effectively together to improve outcomes for in-patients and freeing up vital beds for those awaiting hospital care.

1.13. A fuller overview of performance is show in Appendix four, the data in Appendix four is split by organisation and includes data definitions.

1.14. **The evaluation process that has taken place to date and the results of that evaluation**

1.14.1. The BCF plan includes some 16 schemes; of these 7 are Ibcf schemes. As part of the evaluation process scheme leads were asked to complete an evaluation of their scheme using a scoring sheet which is shown in appendix six. Evaluation commenced in March 2018 and is due to conclude by April 2018. Scheme leads were asked to identify how the scheme had performed against 6 domains: BCF aims, BCF metrics, High Impact Change model, Quality and effectiveness, Risk and Cost effectiveness. Each domain contained a number of lines of further enquiry. The scheme lead for each line of enquiry was asked to score the performance of the scheme between 1-5. Schemes could score up to 125.

1.14.2. Following on from the completion of the evaluation score sheet, scheme leads were asked to complete a presentation to the BCF Governance Group. The presentation included an overview of the score sheet, patient stories around how the scheme had changed the lives of its users, commissioner/operational recommendation, a SWOT analysis, implications of not extending the scheme along with partner views if applicable.

1.14.3. Appendix six gives a breakdown of scheme scores which ranged from 38 up to 110. All evaluation scores are due to be completed by the end of April 2018.

1.15. **The financial income and expenditure of the plan**

1.16. The total BCF budget in 2017/18 was £24.93 million. The total expenditure for the year was £24.82 million resulting in an underspend of £0.11m. This underspend of £110k will be carried forward for reinvestment in 2018/19.

1.17. The table below shows the final outturn for 2017/18. This demonstrates the size of the fund and the fact this has met the conditions with regard to the total funds pooled as required by central government. After accounting for any individual scheme variances (both over and underspends) in line with the agreed Section 75 agreements, the final bottom line position is an underspend of £1104k. Cheshire East Council has carried forward this underspend into 2018/19 and the deployment of these funds will be agreed with all BCF partners following the methodology set out in Schedule 3 of the S75 agreements that govern the operation of the Pooled Fund.

1.18. In broad terms this means bolstering existing provision, funding an additional scheme that will contribute towards the aims of the BCF, funding a planned procurement where this is a commitment in the following year and in the event of all these options having been exhausted, return of funds to the Partner who provided them.

2017/18 Better Care Fund	Total BCF	Total variance
Assistive technology	743,000	138,581
Early Discharge Schemes	243,000	18,079
Combined Re-ablement	4,401,000	(243,832)
Social Care Act	390,000	0
Programme Enablers	226,522	(34,380)
Home First - East	8,378,000	0
Home First - South	7,427,000	0
Carers Assessment and Support	319,000	0
Carers Live Well Fund	376,000	11,050
Discharge to Assess initiatives – East	260,000	0
Discharge to Assess Initiatives - South	240,000	0
Disabled Facilities Grant	1,931,000	0
TOTAL	24,934,522	(110,502)

1.19. **The next steps for the BCF in 2018-19**

- Conclude scheme evaluation process for 2017/18
- Confirm final income and expenditure for the BCF for 2017/18
- Confirm Q4 data against performance measures.
- Confirm the schemes which will be continuing in 2018/19.

- The Improved Better Care Fund plan (IBCF) for 2018/19 will be shared with partners for agreement and approval.
- System leadership event to refine view of integration
- 7 day working self-assessment
- High Impact Care self-assessment
- Developing Cheshire East approach to integration scorecard
- Imbedding learning from the local systems reviews which have been carried out by CQC
- Independent review of schemes conducted for (2018/19)

6. Implications of the Recommendations

6.1. Legal Implications

6.1.1. This is in line with the Care Act 2014, and The Better Care Fund Policy Guidance and the Local Government Act 2003 for adult social care.

6.1.2. The Better Care Fund Governance Group continues to have oversight and responsibility for reviewing the delivery of the agreement. Under Section 75 of the National Health Service Act 2006, NHS bodies may enter into arrangements with local authorities in relation to NHS functions and the health functions of local authorities.

6.1.3. S141 of the Care Act 2014 provides for the Better Care Fund Pooled Funds to be held under and governed by an overarching s75 National Health Service Act 2006 Partnership Agreement.

6.2. Finance Implications

6.2.1. Financial implications stated in the body of the report.

6.3. Policy Implications

6.3.1. The ageing population in Cheshire East and associated pressures on the home care market is central to the planning behind the iBCF schemes and core Better Care Fund schemes which have been developed for Cheshire East Better Care Fund.

6.4. Equality Implications

6.4.1. As the leaders for our local health and social care economy, all BCF partners in Cheshire East are conversant and complaint with the Equality Act 2010.

6.5. Human Resources Implications

6.5.1. Any impact for Cheshire East employees will be as a result of the need for greater integration in care delivery and commissioning in terms of restructures or changes to job roles. These will be dealt in accordance

with the Councils policy and procedures. This could be due to a number of factors- seven day working policy, change in terms and conditions, geographical location of staff. Any identified implication will have a full impact assessment completed and assurance that all employment legislation is adhered to.

6.6. **Risk Management Implications**

6.6.1. Risk of the consequence of failing to achieve proposed changes in activity levels and a plan to mitigate these with respect to the BCF in 2018-19.

6.7. **Rural Communities Implications**

6.7.1. There are no direct implications for rural communities.

6.8. **Implications for Children & Young People**

6.8.1. Some children and young people are classed as carers, and it is important that these individuals are recognised and supported through the existing better care fund.

6.9. **Public Health Implications**

6.9.1. The Better Care Fund has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

6.9.2. Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system

6.9.3. The Better Care Fund has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

6.9.4. Health and care that supports better health and wellbeing for all, and a closing of health inequalities.

7. Ward Members Affected

7.1. The implications are borough wide.

8. Consultation & Engagement

8.1. Consultation and engagement with CCG partners through the BCF Governance Group has taken place and will continue to take place.

9. Access to Information

9.1. 2017-19 Integration and Better Care Fund Policy Framework (DoH, DCLG 2017)
9.2. Delivering the Better Care Fund in Cheshire East 2017-19
9.3. Integration and Better Care Fund planning requirements for 2017-19

10. Contact Information

10.1. Any questions relating to this report should be directed to the following officer:

Name: Alex Jones

Job Title: BCF Programme manager

Email: Alex.t.jones@cheshireeast.gov.uk

Appendix one – BCF vision, aims and objectives

Our vision:

The Cheshire East vision is to achieve the "Delivery of a fully integrated health and social care commissioning function by 2020 supporting the delivery of Accountable Care across Cheshire".

- Centre all care around the empowered individual, their goals, communities and carers
- Have shared decision-making and supported self-care, family and community care as integral components to all care
- Teams built around a person's needs and journeys, jointly accountable for outcomes and joint responsibility for continually improving care
- Focus its attention on health promotion, pro-active models of care and population level accountability and outcomes
- Continue to tackle health inequalities, the wider causes of ill-health and need for social care support e.g. poverty, isolation, housing problems and debt
- Have a strong clinically led primary care and community care system offering a comprehensive modern model of integrated care at scale
- Be delivering fully integrated and co-ordinated care, 7 days a week, close to home with a focus on the frail elderly and those with complex care needs

Our aims:

- System re-design of care – co-produced with our public and our workforce
- Strengthened and renewed primary care
- Shared information systems across health and social care so that people will only ever have to tell their 'story' once
- New contracting approaches that facilitate costs being moved from the acute sector to the community and that promote collaborations across multiple providers
- Joint commissioning utilising the Better Care Fund and other approaches
- A range of new roles to support models of care across traditional providers in the public, private and voluntary sector

Our Objectives:-

- Improve health outcomes and the wellbeing of local people.
- The recipients of care services and the staff providing them have a positive experience of care.
- Care is person centred and effectively coordinated.
- Services are commissioned and delivered in the most effective and efficient way.
- People are empowered to take responsibility for their own health and wellbeing.
- People spend the appropriate time in hospital with prompt and planned discharge into well organised community care when needed.
- Carers are valued and supported
- Staff working together, with the person at the centre, to proactively manage long term physical and mental health conditions.
- Expansion of 'out of hospital' offer
- Accountable care

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Appendix two – BCF scheme aims

Scheme name	Aims
1. Care home assessments at the weekend (iBCF)	• Work has been undertaken with the care home sector to ensure that any individual who is fit for discharge over the weekend period can be assessed and returned to their care home. This will form part of our contracts with care homes. This meets the requirements of the 'High Impact Change Model' for managing Transfers of Care in particular seven day working and reducing the pressure on the NHS.
2. Care Package retention of 7 days	• Cheshire East Council have an agreement with extra care housing schemes and Dom care providers to pay a retainer to the care provider in order to keep the care provision open whilst the individual is absent for a period of time, e.g., in hospital. The retainer ensures that individual's existing care provider is kept available for a period of up to 7 days to resume the existing care package when the person is fit or ready to return home. If the person is in hospital this should facilitate a timelier/appropriate discharge.
3. Innovation and Transformation Fund	• In order to support the 'Caring Together' and 'Connecting Care' transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East. • NHS Eastern Cheshire CCG - This forms part of the work to implement assessment and care outside of hospital as appropriate. There is the need for a range of options and discharge destinations to ensure that wherever possible people are supported to remain at, or return to, their usual place of residence - 'Home First'. The elements of the Winter Plan for 2017/18 are: • Flexible capacity to match different needs of patients reviewed throughout winter • Implement the Caring Together model through the 'Home First Winter Plan' developments • Integrate and connect care and services wherever possible based on a person-centred journey • Co-production - through a joint commissioner/ provider 'action group' to implement and manage • Identify, manage and escalate risks e.g. a lack of beds/staffing capacity to implement initiatives • Support Care Homes to ensure their sustainability The additional/enhanced interventions we will deliver are targeted towards: • People currently living independently who experience a sudden change in their needs • People who are already in receipt of existing care in response to an escalation of their needs • Frequent callers/attenders (A&E, GP Practices, NWAS, Social Care) iBCF funded Home First Winter Plan Services delivering these aims: • Rapid Return Home (Overnight) Service • Care Home Support • Flexible non-acute bed capacity/Discharge to Assess Beds • Increased support for community Matrons case-managing High Risk patients. NHS South Cheshire CCG Schemes • Increased Rapid Care Support • Clinical Support to care Homes

	• Dedicated Support for D2A Implementation
4. Funding for additional social care staff to support Discharge to Assess initiatives (iBCF)	• Funding of additional staff to support the local transformation programmes Caring Together and Connecting Care in implementing a 'Discharge to Assess' model. This builds on the existing initiative with Eastern Cheshire where funding is being targeted at continuing to provide a team manager, social worker and occupational therapist, plus the roll out across Mid-Cheshire.
5. Increasing capacity in the Care Sourcing and Social Work Team over Bank Holidays and weekends (iBCF)	• This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven day period.
6. Sustain the capacity, capability and quality within the social care market place (iBCF)	• In order to sustain and stabilise both the domiciliary care markets and care home markets. This means transforming the care and support offer to ensure Cheshire East has greater capacity and an improved range of services. Local partners will jointly commission the new offer and include: Discharge to Assess beds, step up/step down beds, more specialist provision for complex needs and care at home services that promote quality of care under the system beds programme.
7. The use of Live Well online information and advice resource (iBCF)	• Cheshire East Council has embarked on a programme to deliver a new online resource to the public: Live Well Cheshire East. Both Clinical Commissioning Groups have expressed a desire to utilise this platform and expand the offer to create a community infrastructure that maps all existing assets for use of professional staff alongside members of the public
8. Assistive Technology	• Reduce the demand on health and social care services over the longer term by ensuring access to assistive technology and telecare solutions to people with eligible needs to maintain independence in a community setting. • Increase the independence of people living with long term conditions and complex care • Support for carers to maintain their caring role. • Improved access to the right service at the right time is the overall aim of this scheme.
9. Carers Breaks / Integrated Carers Hub	• The aim of the scheme is during 2017/18 to replace the current carers breaks provision with the Carers Living Well Fund.
10. Disabled Facilities Grants	• The Disabled Facilities Grant (DFG) contributes to preventing non-elective admissions and DTOC in Cheshire East through the provision of adaptations that enable independence at home, and reduce falls and the risk of injury to disabled people and their carers. It is anticipated that 800 people will benefit from adaptations to their home over the period of the BCF plan.
11. Home First (NHS Eastern Cheshire CCG)	1. Proactive care: • Risk stratification of the population is enabling services to be targeted to the people who need them most. It identifies the top 20% of the population who are most at risk of experiencing poor health and empower them to live more independently. We are currently targeting top 5% and working towards 20%. • These people will receive a single assessment focused on their lifestyle, goals and care needs using a joint assessment across

	health and social care • For those most at risk, a care co-ordinator will be identified from within an integrated community team • A care plan will be created jointly with the person to include goals, required interventions, provider details, and information on who to contact in case of change or crisis. For less complex needs, this may simply be a crisis plan • Services are being put in place to empower the person and their carers and meet their needs. The integrated community team and care co-ordinator (as appropriate) will then undertake case management to empower the person to follow the care plan and make sure that care takes place • Specialists will provide support in the community for professional care staff and patients • Education and training will be delivered across all care settings and involve the whole workforce in a rolling evidence-based training and mentoring programme. • Services already in place supporting this which are included in BCF: Nursing Home MDT staff (Dietician and Speech and Language Therapist); NIMO medicines support; Community Matrons case-managing highest risk and frail patients; Telehealth 2. Rapid Response in Crisis and Management of the Patient Journey • Comprehensive assessment on attendance at A&E or Admission to Acute Assessment Unit (Frailty Service) . Turn patients around prior to admission and if not possible, minimise inpatient stay (Home First). Link to existing care plans via Cheshire Care Record and live access to Primary, Community and Social Care records as appropriate. • Schemes to enable rapid return home via increased nursing and therapy support to A&E and outreach into community. • Schemes to enable rapid return home by providing transport and "settling back home". • Comprehensive bed-based service for patients able to be discharged from acute setting or requiring temporary step-up of care. • Community intermediate care to enable recovery at home. • In-hours GP visiting service for End of Life patients enabling timely access and increasing number of deaths in preferred place. • Services already in place supporting this which are included in BCF: Intermediate Care Beds and community service; additional evening staffing in A&E; Therapy support at front end; Transport home from A&E at night; Acute Visiting Service (3 GP teams).
12. Home First (NHS South Cheshire CCG)	• Develop system wide service review to enable rapid timely access to urgent care across Central Cheshire that will bring together existing service providers together to shift the balance from acute bed based services to community step up and home based health and social care to support improved patient outcomes and experience. • Review existing models of intermediate care and social care reablement that create system wide efficiencies through single assessment and increase capacity to support more people closer to home and reduce duplication of assessments with demonstrable improved outcomes in relation to reduce the length of stay in acute care and emergency department attendances that also demonstrate value for money. • Explore and identify opportunities to work in collaboration with the wider health and social care economy, such as voluntary sector, pharmacy services and primary care to create more of an emphasis on enablement and self-empowerment to meet health and social care needs. • Scope the potential financial impact on reducing emergency admissions as part of the redesign, with greater emphasis on medical responsibility being maintained in primary care, with support from specialist services. • Streamline the assessment process of patients that supports safe transfer of care and improves patient experience, utilising a comprehensive geriatric assessment to outline future management plans and reduce the risk of readmission or long term care

	placement. There is a need to quantify potential impact on readmission rates and CHC reduction costs based on national data if possible • Target a reduction in delays in transfers of health and social care with the development of the trusted assessor framework. • Develop a discharge to assess model that improves timely discharge from acute care of frail older people to their normal place of residence as soon as the acute treatment is complete with an assessment that have agreed personalised goals agreed in conjunction with the person and carers. • Improve utilisation of commissioned community bed stock to meet patient need rather than service need.
13. Support at Home Service – (British Red Cross to provide practical and emotional support at home over 7 days) NHS Eastern Cheshire CCG	• The aim of the service is to provide short-term (up to 2-weeks) support over 7 days for individuals who are at risk of being admitted to hospital and for people who are being discharged from hospital in the Cheshire East area. • This support should provide practical and emotional support for individuals to help them to regain their confidence, maintain their confidence and avoid any future crisis, with a focus on enabling a person to become confident in self-management, or know how to access support and information, if required, to help them keep well.
14. Programme Enablers	• To provide enabling support to the Better Care Fund programme, through programme management and other support, as required • To develop and maintain adherence to governance arrangements including the s75 agreement and commissioning capacity • The delivery of the Better Care Fund relies on joint commissioning plans already developed across the Cheshire East Health and Social Care economy. it is recognised that additional capacity is required in the interim in the following key roles: • Programme management • Governance and finance support to develop S75 agreements; cost schemes and cost benefit analysis • Financial support • Additional commissioning capacity might be required to develop business cases and to assist with the procurement of alternative services.
15. Reablement Services	• The current service has three specialist elements delivered across two teams (North and South): • Community Support Reablement (CQC-registered) - provides a time-limited intervention supporting adults with physical, mental health, learning disabilities, dementia and frailty, from the age of 18 to end of life, offering personal care and daily living skills to achieve maximum independence, or to complete an assessment of ongoing needs. • Dementia Reablement - provides up to 12-weeks of personalised, post-diagnostic support for people living with dementia and their carers. The service is focused on prevention and early intervention following a diagnosis of dementia. • Mental Health Reablement - supports adults age 18 and over with a range of mental health issues and associated physical health and social care needs, focusing on coping strategies, self-help, promoting social inclusion and goal-orientated plans.
16. Care Act	• Ensure compliance with Care Act 2014 responsibilities. • Provider Quality Reports (BCF Social Care Act Allocation) • Safeguarding Adults Boards • Maintaining minimum care eligibility thresholds • Continuity of care for people moving into areas

	• Assessment of Social Care in prisons • Disregard for armed forces Guaranteed Minimum Income • Training social care staff in Social Care Act

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Appendix three – Scheme progress made to date

Scheme name	Scheme progress/highlights
1. Care home assessments at the weekend (iBCF)	• Business case produced • Partner meeting to discuss business case • Discussions have taken place with providers via provider forums regarding this scheme and what the current blockages are to enabling existing residents to return back to their care home over the weekend. • Providers stated that the discharge process has been better recently, providers Also been getting better notice from hospital before discharge. • Providers weren't opposed to facilitating discharges at a weekend but stated that often hospital weren't able to provide the necessary paperwork or equipment needed to ensure a safe discharge, i.e. assessments; care plans have not been updated. • Providers not confident that they can trust the information being sent over is correct which is why they insist on caring out their own reassessments before the resident can return to the care home. • Discussed using a Trusted Assessor role, providers not against this model but concerns that the hospitals need to ensure this role is done correctly so they can trust the information being provided
2. Care Package retention of 7 days	LHT • Number of admissions = 170 • Under 7 days = 78 • Under 14 days = 70 (Discharged between of 7-13 days = 32) • 14 days and over = 98 MDGH • Number of admissions = 198 • Under 7 days = 38 • Under 14 days = 101 (Discharged between 7-13 days = 23) • 14 days and over = 92 OTHER (i.e. any other hospital listed or admissions where no hospital is listed) • Number of admissions = 45 • Under 7 days = 7 • Under 14 days = 12 (Discharged between of 7-13 days = 5) • 14 days and over = 32
3. Innovation and Transformation Fund	• 'Soft' procurement for additional bed capacity from January 2018 set in train. • Rapid return home scheme operational • Care Home Support fully operational
4. Funding for	• Locality Manager in post

additional social care staff to support Discharge to Assess initiatives (iBCF)	• Practice Manager for hospital team in post • Weekends covered in February from existing staff group in both hospitals • Weekend referrals to reablement pilot commenced • Completion of MADE event with health colleagues & supported by NHSE
5. Increasing capacity in the Care Sourcing and Social Work Team over Bank Holidays and weekends (iBCF)	• Rota of volunteers from IDT & Intermediate Care team completed for December 2017 including Christmas and New Year period • Basis for weekend working agreed & shared with team • Information shared with health partners The Care Sourcing team has proven its value over the previous twelve months and has achieved the following:- • Increased productivity for front line social care staff due to them not having to spend time sourcing packages of care. • Has full oversight of the market place and the issues, blockages and capacity issues which are fed into the commissioners. • Held the contract price wherever possible when sourcing care. • Reduced care package costs as worked with the Local Area Co-Ordinators to find alternatives to traditional care services. • Has integrated and collaborated well with partners working within the Smart Teams, Community Mental Health Team (CHMT) and the Hospital integrated Health and Social Care team. • Facilitated prompt hospital discharges. Community and third sector links. • Developed the relationship between the Council and providers. Packages sourced: • January 2017 – 85 • February 2017 – 74 • March 2017 – 95 • April 2017 – 82 • May 2017 – 98 • June 2017 – 77 • July 2017 – 69 • August 2017 – 56 • September 2017 – 96 • October 2017 – 59 • November 2017 – 68 • December 2017 – 41 • January 2018 – 55

	Total: 955
6. Sustain the capacity, capability and quality within the social care market place (iBCF)	• Commenced Fair cost of care pricing review and consultation • Paper written on hard to serve areas and working up a pilot to try and improve capacity in these areas • Quality team putting a lot of input into a number of failing homes to ensure we can maintain admissions • Commenced market engagement on carers services and people with complex needs • Focused the care sourcing team on DTOCS • Joint approach to Preventing Lyme Green Nursing home from urgent closure • Commissioning of accommodation of care and care at home progressing well • Specification and advert for D2A beds for East CCG completed • Work has taken place with CCG colleagues around a number of joint posts. • Notice was received for Weston Park closure. • The Care fees review is coming to a closure • The final draft specification for care at home and accommodation with care.
7. The use of Live Well online information and advice resource (iBCF)	• Live Well CE currently has approximately 16,000 page views per week and 5,700 individual user sessions (session = a single user interaction). (In Sep 2017 the figures were approximately 10,000 pages views / 3,000 sessions). Since May 2017 to date there have been 48,000 new unique users to Live Well CE. In the same period there have been 140,000 user sessions. In November 2017 to January 2018: • 76% of traffic was on the CEC website and 24% on the OCC Marketplace. • 60% of source traffic to LWCE is from Google searches and a total of 67% of all traffic is now from all organic searches (Google/Bing/Yahoo etc). • Users are viewing 2.5 Pages per session on average. In this quarter, compare to the last: • Direct traffic has increased by 37%. • Page views have increased by 37%. • Social media traffic has increased by 182%.
8. Assistive Technology	• Meeting held with Community Equipment Service Partners where agreement took place that this service would be considered as part of a wider review of our offer to residents. • Ongoing research taking place as part of general review of the offer the service provides • Contract meeting to be held with Peaks and Plains to get their perspective on service provision • Initial data compiled on AT usage • Discussion with Peaks and Plains on service provision • New Manager appointed to support AT review • Falls prevention group held with CCGs which will also consider elements of AT • Review continuing of AT service • Core project group to consider current AT situation + review • Terms of reference agreed for core falls prevention group. Membership of wider group compiled. Audit completed by CCGs/LA of falls

provision at moment. Recommendations from falls group to feed into AT Strategy.

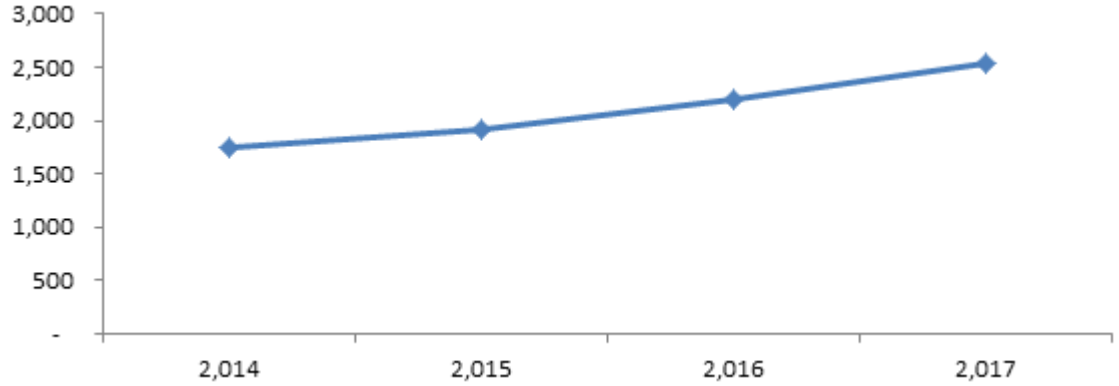
- Review continuing of AT service. Needs assessment once complete to be followed by AT Strategy.

Table 2: Telecare Usage over time

	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEPT	OCT	NOV	DEC
2014				1,503	1,520	1,554	1,590	1,631	1,644	1,652	1,707	1,749
2015	1,756	1,743	1,817	1,837	1,862	1,862	1,881	1,919	1,912	1,936	1,929	1,925
2016	1,926	1,927	1,917	1,929	1,940	1,994		2,032	2,061	2,105	2,161	2,193
2017	2,228	2,259	2,057	2,306	2,135	2,384	2,407	2,406	2,466	2,594	2,531	2,531

There has been a general trend of increased telecare usage over time although numbers have increased relatively steadily. This is illustrated in the graph below which show numbers of telecare users in December each year.

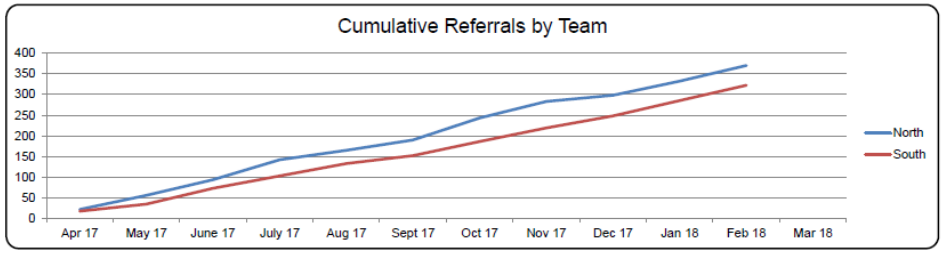
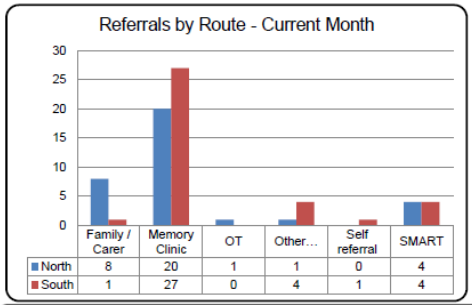
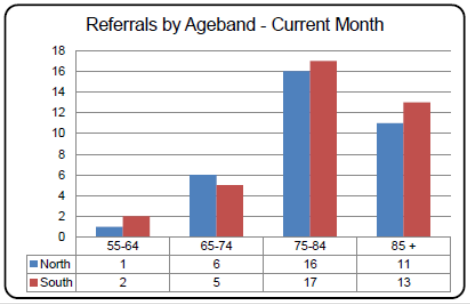
Graph 1: Telecare Take Up

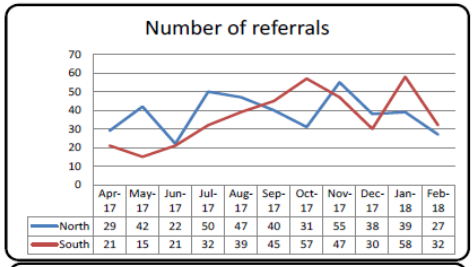
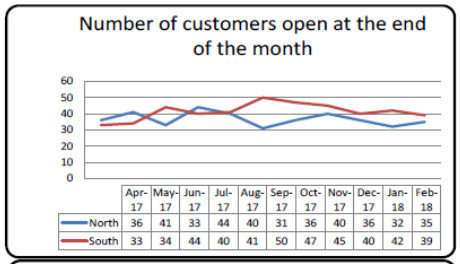
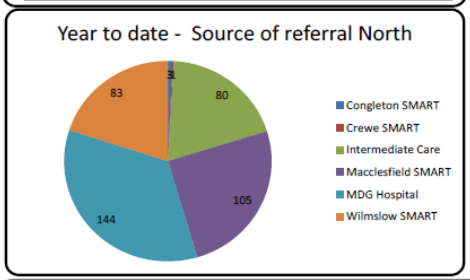
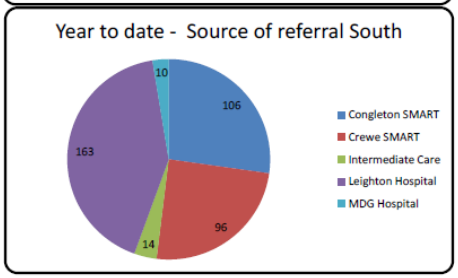
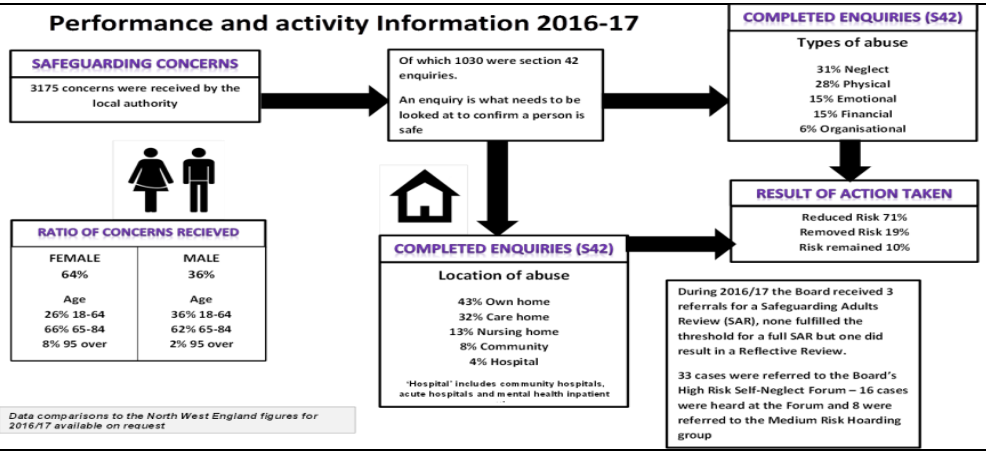


9. Carers Breaks /	• Total number of carers wellbeing budgets confirmed for this period = 872

Integrated Carers Hub	Carers Living Well statistics Nov 2017 to March 2018 inclusive:- • Total spend East CCG: £152,250 • Total Budgets completed East CCG: 364 qty • Total spend South CCG : £233,000 • Total Budgets South CCG: 508 qty • Total Spend to date= £385,250.
10. Disabled Facilities Grants	• 318 disabled people enabled to live independently in 2017-18 • Grants ranged from £836 to £30,000 – average of £4,384 per grant
11. Home First (NHS Eastern Cheshire CCG)	• Short term action group established on behalf of the operational resilience group to agree and implement the initiatives to support the Home First Winter plan – key commissioners and operational leads from across Eastern Cheshire • At the Transforming Older People's Service Steering Group on Monday 27 November 2017 it was agreed that a joint commissioner and provider meeting would be established. The focus of this meeting is to bring together the CEC and CCG commissioners and provider organisations to: • Review the transformation work underway; • Identify any gaps in delivery (based on the Fusion48 final report); and • Reduce duplication across Eastern Cheshire. • The joint commissioner and provider meeting has been planned for Monday 18 December 2017. The Short Term Action Group members have been invited to this meeting.
12. Home First (NHS South Cheshire CCG)	• Redesign of Community Matron role and function complete. New role and pathway agreed by CCICP Partnership Board. • Review of Complex Case Practitioner and Care Facilitator roles complete • Alignment of community services staff to Care Communities complete. • Care Communities senior management structure complete. All vacancies appointed • Roll out of Advanced Community Practitioner complete. Community Matrons in all areas now working as Advanced Community Practitioners, delivering the rapid response pathway • Vision for frailty developed, based on national framework. Test site for community frailty pathway live • Rockwood Score being recorded by Advanced Community Practitioner, Complex Care Practitioners and as part of the Social Care assessment • Work commenced to combine the function of Intermediate Care therapy and community therapy into one coordinated rehab service /function, to support patients both within intermediate bed based services and at home • Falls Rapid Response pilot live. The 'Green Car' is operational 7 days a week, with AHPs from community rehab involved as part of the rapid response • Intermediate care accepting forms 1 & 2 to support discharge to assess pathway • "Community redesign • Redesign of Community Matron role and function complete. New role and pathway agreed by CCICP Partnership Board.

	• Review of Complex Case Practitioner and Care Facilitator roles complete • Alignment of community services staff to Care Communities complete. • Care Communities senior management structure complete. All vacancies appointed • Roll out of Advanced Community Practitioner complete. Community Matrons in all areas now working as Advanced Community Practitioners, delivering the rapid response pathway • Vision for frailty developed, based on national framework. Test site for community frailty pathway live • Rockwood Score being recorded by Advanced Community Practitioner, Complex Care Practitioners and as part of the Social Care assessment • Work commenced to combine the function of Intermediate Care therapy and community therapy into one coordinated rehab service /function, to support patients both within intermediate bed based services and at home • Falls Rapid Response pilot live. The 'Green Car' is operational 7 days a week, with AHPs from community rehab involved as part of the rapid response • Intermediate care accepting forms 1 & 2 to support discharge to assess pathway • Hone first steering group in place • Community Matrons covering the care communities • Initial scoping of intermediate care completed • MSK triage commenced 1/2/18 • OOHrs and primary care streaming now linked more closely with CCICP
13. Support at Home Service – (British Red Cross to provide practical and emotional support at home over 7 days) NHS Eastern Cheshire CCG	• Service Specification developed • Service specification agreed with the Red Cross. • Demand and capacity modelling has been completed with the Red Cross. • Additional models for Winter Resilience have been shared. • Service Specification agreed by CCG representatives and The British Red Cross • Service Specification developed • Agreement regarding revised specification now in place. Previous activity 272 people per year. • Agreement to establish data capture for the revised specification in place.
14. Programme Enablers	• Q2 LGA monitoring is completed and was submitted on the 2oth of October 2017 • Implement recommendations • Cabinet report

	• IBCF Cabinet report • End of year report for HWB • Finalise s75
15. Reablement Services	• Weekly meetings now operational to take forward reablement redesign • Proposals, based on best practice from Norfolk and Wolverhampton underpinned by NICE guidelines are being brought together as part of a Business Case that will be taken to Cabinet and CCG Governing Body's. • The Business Case will focus on a model which brings together reablement with intermediate care, and will involve a number of partners namely, Cheshire East Council, NHS South Cheshire CCG, NHS Eastern Cheshire CCG, East Cheshire Trust, CCICP, Macclesfield District General Hospital and Mid-Cheshire Hospitals Foundation trust. • High level paper has now been drafted which has been shared with all operational partners (CCGs and acute trusts). **Dementia Reablement**    Between April 16 and February 17 640 referrals were recieved for the DRS, this has increased in the period April 17 to February 18 to 692. The largest source for referrals in February 2017 was the memory clinic and this remains the same in 2018. People in the 75-84 age group were the most frequently referred in February 2017 and this is the same in February 2018.

	Domiciliary Care/ Community Support Reablement     Across the 2 teams in February 2017 43 referrals were recieved, this has increased to 57 for February 2018. At the end of February 2017 69 customers were open to Reablement and this slightly higher with 74 in February 2018. At this point last year Intermediate Care was the largest referral source for the North, MDG Hospital is the biggest referral source this year. The largest referral source for the South was the Crewe SMART team, so far this year Leighton Hospital is the largest referral source.
16. Care Act	**Performance and activity Information 2016-17** 

Appendix four – Cheshire East Better Care Fund Year End Position (2017/18)* Cheshire East & Q4 performance

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance					
			Q1	Q2	Q3	Q4	Outturn	Variance from Plan
Non-elective admissions	**40,199**	**39,768**	**10,218**	**9,993**	**10,663**	***10,901 (forecast)***	***41,775 (forecast)***	***+ 2,007 (forecast)***
Delayed transfers of care from hospital per day	**58** (Mar 2017)	**43** (Mar 2018)	**47** (Jun 2017)	**42** (Sep 2017)	**26** (Dec 2017)	**Data not yet available**	**Data not yet available**	
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	**610**	**616**	**Cumulative Admissions: 188** (Q1 - 188)	**Cumulative Admissions: 355** (Q2 – 167)	**Cumulative Admissions: 479** (Q3 – 124)	**Data not yet available**	**Data not yet available**	
Admissions to residential and nursing homes 65+ per 100,000 population	**723**	**717**	**Cumulative Rate:** 219	**Cumulative Rate:** 413	**Cumulative Rate:** 557	**Data not yet available**	**Data not yet available**	
Effectiveness of reablement (at home 91 days after discharge to reablement / rehabilitation **	**82.3%**	**88.4%**	**82.0%**	**77.0%**	**72.3%**	**Data not yet available**	**Data not yet available**	

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

** The figures up to Quarter 3 only include Intermediate Care and do not include reablement due to data not being available. Quarter 4 data, which is the period used for the BCF and national Adult Social Care Outcomes Framework (ASCOF) measure, will include the reablement element.

Cheshire East Better Care Fund Year End Position (2017/18)*

Eastern Cheshire CCG

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance					
			Q1	Q2	Q3	Q4	Outturn	Variance from Plan
Non-elective admissions	**17,602**	**-**	**4,480**	**4,297**	**4,604**	**Data not yet available**	**Data not yet available**	**-**
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	**292**	**-**	**Cumulative Admissions: 115** (Q1 - 115)	**Cumulative Admissions: 187** (Q2 – 72)	**Cumulative Admissions: 248** (Q3 – 61)	**Data not yet available**	**Data not yet available**	-
Admissions to residential and nursing homes 65+ per 100,000 population	**622**	**-**	**Cumulative Rate:** 240	**Cumulative Rate:** 391	**Cumulative Rate:** 518	**Data not yet available**	**Data not yet available**	-

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

Cheshire East Better Care Fund Year End Position (2017/18)*

South Cheshire CCG

Outcome description	Baseline 2016/17	2017/18 Plan	2017/18 Performance					
			Q1	Q2	Q3	Q4	Outturn	Variance from Plan
Non-elective admissions	**22,597**	**-**	**5,738**	**5,696**	**6,059**	**Data not yet available**	**Data not yet available**	**-**
Injuries due to falls, persons 65+								
People who feel supported managing long term conditions								
Admissions to residential and nursing homes 65+	**318**	**-**	**Cumulative Admissions: 73** (Q1 - 73)	**Cumulative Admissions: 168** (Q2 – 95)	**Cumulative Admissions: 231** (Q3 – 63)	**Data not yet available**	**Data not yet available**	**-**
Admissions to residential and nursing homes 65+ per 100,000 population	**851**	**-**	**Cumulative Rate:** 192	**Cumulative Rate:** 442	**Cumulative Rate:** 607	**Data not yet available**	**Data not yet available**	**-**

* These are provisional figures and may change as final data returns are compiled. The population figure used to calculate the 2017/18 rate is based on ONS population projections.

Data descriptions

Non-elective admissions

- Description: Total number of specific acute (replaces General & Acute) non-elective spells per 100,000 population.
- Data definition: A Non-Elective Admission is one that has not been arranged in advance. Specific Acute Non-Elective Admissions may be an emergency admission or a transfer from a Hospital Bed in another Health Care Provider other than in an emergency.

- Rationale: Effective prevention and risk management of vulnerable people through effective, integrated Out-of-Hospital services will improve outcomes for people with care needs and reduce costs by avoiding preventable acute interventions and keeping people in non-acute settings.

- Outcome sought: A reduction in the number of unplanned acute admissions to hospital.

Delayed transfers of care from hospital per day

- Description: Delayed transfers of care from hospital per 100,000 population

- Data definition: Total number of DToCs (delayed days) per 100,000 population (attributable to either NHS, social care or both)*
    - A DToC occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.
    - A patient is ready for transfer when:
    - a clinical decision has been made that the patient is ready for transfer AND
    - a multi-disciplinary team decision has been made that the patient is ready for transfer AND
    - the patient is safe to discharge/transfer.

- Rationale: This is an important marker of the effective joint working of local partners, and is a measure of the effectiveness of the interface between health and social care services. Minimising delayed transfers of care (DToCs) and enabling people to live independently at home is one of the desired outcomes of social care. The DToC metric reflects the system wide rate of delayed transfers and activity to address it will involve efforts within and outside of the BCF.

- Outcome sought: Effective joint working of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults.

Admissions to residential and nursing homes 65+

- Description: Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes, per 100,000 population

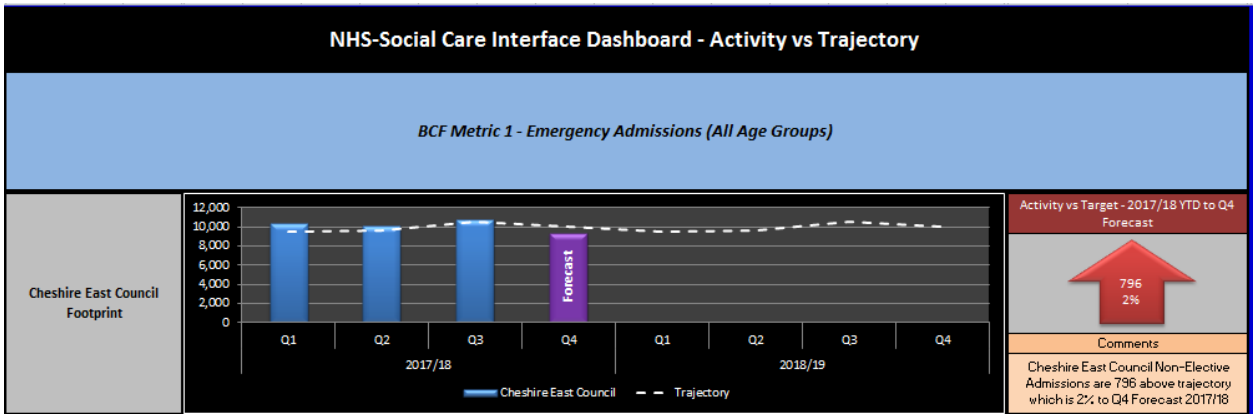
- Data definition: Annual rate of older people whose long-term support needs are best met by admission to residential and nursing care homes.

- Rationale: Avoiding permanent placements in residential and nursing care homes is a good measure of delaying dependency, and the inclusion of this measure in the framework supports local health and social care services to work together to reduce avoidable admissions. Research suggests that, where possible, people prefer to stay in their own home rather than move into residential care. However, it is acknowledged that for some client groups that admission to residential or nursing care homes can represent an improvement in their situation.

- Outcome sought: Reducing inappropriate admissions of older people (65+) in to residential care

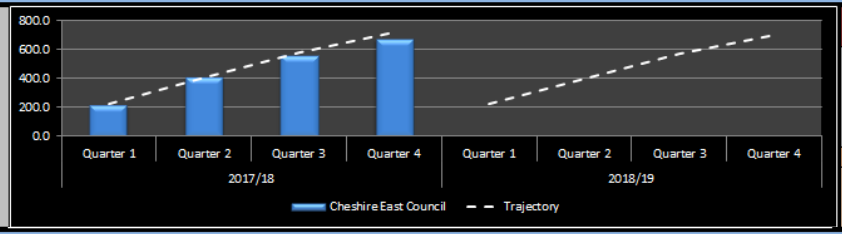
Effectiveness of reablement (at home 91 days after discharge to reablement / rehabilitation

- Description: Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement / rehabilitation services
- Data definition: The proportion of older people aged 65 and over discharged from hospital to their own home or to a residential or nursing care home or extra care housing for rehabilitation, with a clear intention that they will move on/back to their own home (including a place in extra care housing or an adult placement scheme setting), who are at home or in extra care housing or an adult placement scheme setting 91 days after the date of their discharge from hospital.
- Rationale: Improving the effectiveness of these services is a good measure of delaying dependency, and the inclusion of this measure in the scheme supports local health and social care services to work together to reduce avoidable admissions. Ensuring that the rate at which these services are offered is also maintained or increased also supports this goal.
- Outcome sought: Increase in effectiveness of these services whilst ensuring that those offered service does not decrease



BCF Metric 2 - Long-term support needs of older people (aged 65 and over) met by admission to residential and nursing care homes (per 100,000)

Cheshire East Council Footprint



Activity vs Target - 2017/18 to Q4 (Provisional)

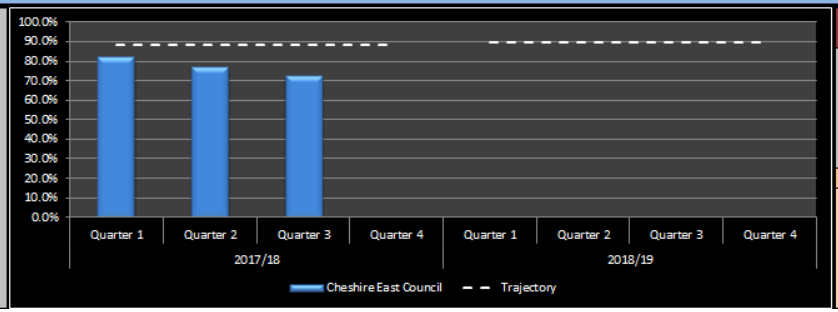
(37.2)
(5.2%)

Comments

Cheshire East Council permanent admitssion rate per population (65+) is 37.2 below plan which is 5.2% to Q4

BCF Metric 3 - Proportion of older people (65 and over) who are still at home 91 days after discharge

Cheshire East Council Footprint



Activity vs Target - 2017/18 to Q3 Only

(16.1)

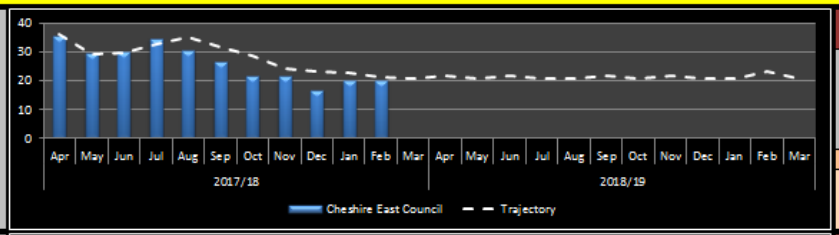
Comments

Cheshire East Council proportion of older people who are still at home 91 days after discharge to rehabilitation or reablement is 16.1 percentage points below plan. N.B. Current figures only include Intermediate Care and not Reablement

BCF Metric 4 - DTOCs

Delayed transfers of care - DTOCs per day

Cheshire East Council Footprint



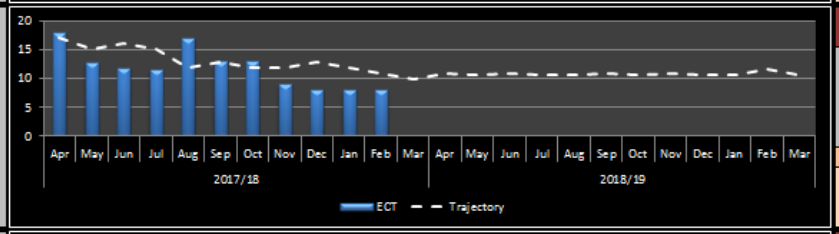
Activity vs Target - 2017/18 (Apr - Feb only)

(30)
(9.4%)

Comments

Cheshire East Council DTOC's Per day are 30 below trajectory which is 9.4% for year to date 2017/18

ECT



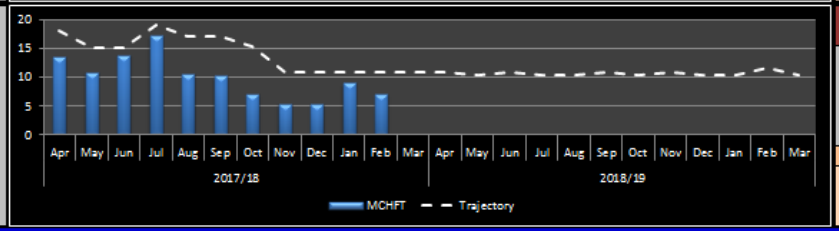
Activity vs Target - 2017/18 (Apr - Feb only)

(18)
(12.1%)

Comments

ECT DTOC's Per day are 18 below trajectory which is 12.1% for year to date 2017/18

MCHFT



Activity vs Target - 2017/18 (Apr - Feb only)

(50)
(31.3%)

Comments

MCHFT DTOC's Per day are 50 below trajectory which is 31.3% for year to date 2017/18

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Appendix five – overview of the evaluation conducted

2018 BCF SCHEME EVALUATION CRITERIA - SCORE SHEET

SCHEME LEAD(S):

	Score / Factor	1	2	3	4	5	Your Score	Add notes for the rationale behide your score
1.1	Health and social care integration by 2020	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
1.2	Focus on Prevention and Recovery	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
						Sub-total	**0**	
2.1	Preventing or reducing non-elective admissions (NELs)	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
2.2	Long Term Admissions to Care Homes	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
2.3	Effectiveness of Reablement	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
2.4	Reducing Delayed Transfers Of Care	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
						Sub-total	**0**	
3.1	Early discharge planning	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.2	Systems to monitor patient flow	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.3	Multidisciplinary/multi-agency discharge teams	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.4	Home First / Discharge to Access	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.5	Seven Day Service	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.6	Trusted Assessors	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.7	Focus on choice	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
3.8	Enhancing health in Care Homes	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
						Sub-total	**0**	
4.1	**Strength of Evidence:** What is the strongest evidence that the proposed service / intervention has a positive effect?	Lower evidence, e.g.	Some evidence that service	Modest evidence, e.g.	Significant evidence, e.g. at	Major evidence, e.g. More		
4.2	**Quality of Life:** E.g. disability reduction, independence, pain reduction, improving social relationships	No improvement or not	Some improvement	Moderate improvement , e.g.	Significant improvement	Compelling life changing		
4.3	**Access and Equity:** Enables more equitable access to health care and/or reduces health inequalities	No effect or not applicable	Some effect	Moderate effect	Significant effect	Major effect		
4.4	**Prevention:** the proposal significantly reduces ill health and/or need for further health and care services	No contribution or not	Some contribution	Moderate contribution	Significant contribution	Major contribution to		
						Sub-total	**0**	
5.1	**Risk of not achieving target:** e.g. national requirements or joint "must do's"	Minimum contribution	Some contribution to	Moderate contribution to	Significant contribution to	Major contribution to		
5.2	**Financial risk:** what is the risk if the project does not go ahead?	Minimum risk and impact if	Some risk and impact if	Moderate risk and impact if	Significant risk and impact if	Major risk and impact if		
5.3	**Political / reputational risk:** what is the risk if the project does not go ahead?	Minimum risk and impact if	Some risk and impact if	Moderate risk and impact if	Significant risk and impact if	Major risk and impact if		
5.4	**Clinical risk:** what is the risk if the project does not go ahead?	Minimum risk and impact if	Some risk and impact if	Moderate risk and impact if	Significant risk and impact if	Major risk and impact if		
5.5	**Impact on other services:** What is the impact on other services or providers if the service goes ahead?	Major negative impact on	Some negative impact on	No impact on other service	Some positive impact on	Service gap identified. Will		
						Sub-total	0	
6.1	No savings or unknown	£0-£50,000	>£50,000-150,000	>£150,000-£500,000	>£500,000	>£500,000		
6.2	No financial return on investment	>3 years	Between 1 and 3 years	Between 6 months and 1 year	Less than 6 months	Less than 6 months		
						Sub-total	0	
						TOTAL	0	

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Appendix six – scheme evaluation scores

	Health and social care integration by 2020	Focus on Prevention and Recovery		Preventing or redcuing non-elective admissions (NELs)	Long Term Admissions to Care Homes	Effectiveness of Reablement	Reducing Delayed Transfers Of Care		Early discharge planning	Systems to monitor patient flow	Multidisciplinary/ multi-agency discharge teams	Home First / Discharge to Access	Seven Day Service	Trusted Assessors	Focus on choice	Enhancing health in Care Homes		Strength of Evidence: What is the strongest evidence that the proposed service / intervention has a	Quality of Life: E.g. disability reduction, independence, pain reduction, improving social relations	Access and Equity: Enables more equitable access to health care and/or reduces health inequalities	Prevention: the proposal significantly reduces ill health and/or need for further health and care services		Risk of not achieving target: e.g. national requirements or joint "must do's"	Financial risk: what is the risk if the project does not go ahead?	Political / reputational risk: what is the risk if the project does not go ahead?	Clinical risk: what is the risk if the project does not go ahead?	Impact on other services: What is the impact on other services or providers if the service goes ahead?		No savings or unknown	No financial return on investment		Total score
1. Care Home assessments at the weekend (iBCF)																																
2. Care package retention of 7 days (iBCF)	4	3	7	4	3	4	4	15	5	5	5	4	5	4	5	2	35	4	4	3	4	15	4	4	4	4	4	20	2	2	4	96
3. Innovation and transformation fund (iBCF)																																
4. Funding of additional social care staff to support D2A	4	4	8	3	3	3	5	14	5	4	5	5	2	2	4	1	28	5	4	4	4	17	5	5	5	5	4	24	1	2	3	94
5. Increasing capacity in Care Sourcing Team and Social	3	2	5	2	2	1	3	8	2	2	3	3	4	2	2	1	19	2	1	3	2	8	3	2	3	2	2	12	1	1	2	54
6. Sustain the capacity, capability and quality within	0	0	0	5	1	1	5	12	5	1	1	1	5	5	5	5	28	2	2	2	2	8	3	5	5	5	5	23	5	5	10	81
7. The use of Live Well online information and advice	3	5	10	2	2	3	2	30	1	1	3	2	4	2	5	1	40	3	2	5	1	10	4	5	5	1	5	20	1	5	10	110
8. Assistive Technology	5	3	10	3	3	4	4	30	4	4	4	4	5	3	4	3	40	3	4	4	4	10	3	3	3	3	4	16	2	2	10	76
9. Integrated Carers Hub	3	3	6	N/A	N/A	N/A	N/A	0	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	0	1	2	2	3	8	3	2	4	4	3	16	3	5	8	38
10. Disabled Facilities Grants	1	5	6	4	2	2	2	10	1	1	1	1	1	1	3	1	10	4	5	4	4	17	5	5	5	2	5	22	5	4	9	74
11. Home First (NHS Eastern Cheshire CCG)																																
12. Home First (NHS South Cheshire CCG)	4	4	8	4	4	4	4	16	4	3	4	5	3	2	4	3	28	4	4	4	4	16	5	5	5	5	5	25	4	3	7	100
13. Hospital Discharge (East and South Cheshire)	5	5	10	5	4	4	5	18	4	4	4	5	5	2	4	3	31	4	4	4	4	16	5	5	5	5	5	25	3	4	7	107
14. Programme Enablers																																
15. Reablement Services																																
16. Care Act	5	5	10	2	4	3	3	12	2	2	2	2	2	2	5	5	23	5	4	4	5	18	5	5	5	5	5	25	1	1	2	90

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Version Number: 3

Cabinet

Date of Meeting: 22 May 2017

Report Title: Improved Better Care Fund (iBCF) 2018 to 2020

Portfolio Holder: Cllr. Janet Clowes (Adults Social Care and Integration)

Senior Officer: Linda Couchman, Interim Director of Adult Social Care and Health

1. Report Summary

1.1. This report describes the areas of activity and the proposed expenditure for the grant money being received directly by Cheshire East Council in 2018/19 through the Improved Better Care Fund (iBCF) monies for 2018 to 2020.

1.2. It identifies a number of schemes and presents the rationale of how they meet the needs and demands of the local care and health economy.

1.3. iBCF monies can be used to support existing adult social care services, as well as investing in new services. These proposals include investment in a combination of new and existing services essential in managing demand, maintaining Care Act compliance, protecting existing key services, maintaining the adult care statutory duties whilst also enhancing NHS community and primary care services to facilitate hospital discharges. These proposed schemes will help to promote the sustainability of adult social care and other care services within the care economy as a whole.

1.4. The grant can be spent on three care purposes:

- Meeting adult social care needs
- Reducing pressures on the NHS, including supporting more people to be discharged from hospital when they are ready
- Ensuring that the local social care provider market is supported

1.5. With particular reference to ensuring the local social care provider market is supported, these proposals will stabilise the market. Councils have the ability to decide if they spend part or all of the funding on this purpose.

1.6. These schemes will support the outcomes of the joint strategic needs assessment JSNA Cheshire and Merseyside Sustainability and Transformation Plan (STP).

2. Recommendation/s

2.1. That Cabinet endorses the iBCF schemes (1-7) and associated expenditure outlined in paragraphs 5.4-5.19.

3. Reasons for Recommendation/s

3.1. These proposed schemes contribute towards avoiding unnecessary admission to hospital and care homes, reducing Delayed Transfers of Care to meet the 3,5% target and support the implementation of the High Impact Change Model.

4. Other Options Considered

4.1. Do Nothing- This is clearly not an option as Social Care is under constant pressure to meet the needs of our communities both in transition and older people.

4.2. Use the money to mitigate growth- this has not been done. The money is to be used to transform services whilst at the same time dealing with current demand/pressure and support system resilience across Cheshire East.

5. Background

5.1. At the 2017-18 Government budget a total of £2.021 billion was announced as supplementary funding to the improved Better Care Fund (iBCF). This is to be distributed as £1.01 billion in 2017-18, £674 million in 2018-19 and £337 million in 2019-20 and will be given to councils in England over the next 3 years for adult social care.

5.2. The Grant allocation for Cheshire East Council for 2017/18 totals £4.7m in 2017/18. This is be paid directly to the council under section 31 of the Local Government Act 2003 for adult social care.

5.3. The Government has made it clear that part of this funding is intended to enable local authorities to quickly provide stability and extra capacity in the local care systems. Local Authorities are therefore able to spend the money, commission care subject to the grant conditions set out in the determination. The Council can undertake this as soon as plans for spending the grant have

been locally agreed with Clinical Commissioning Groups involved in agreeing the Improved Better Care Fund plan.

5.4. **Scheme 1** - 7 day retainer (£0. 100m) National Metric 4: Grant Condition Criteria 1/2/3/4 – Cheshire East Council have an agreement with extra care housing schemes and domiciliary care providers to pay a retainer to the care provider in order to keep the care provision open whilst the individual is absent for a period of time, for example in hospital. The retainer ensures that the individual's existing care provider is kept available for a period of up to 7 days to resume the existing care package when the person is fit or ready to return home. If the person is in hospital this should facilitate a timelier and appropriate discharge.

5.5. **Scheme 2** - Increased weekend capacity for social workers (£0. 159m) National Metric 2/3/4: Grant Condition Criteria 1/3/4: - Increased capacity in the Social Work Team over Bank Holidays and weekends. This is to ensure patient flow and assisting in reducing the pressure on the NHS can be maintained over a seven day period. Cheshire East will provide 2 social workers and 2 care arrangers (split between the 2 hospitals) that cover the weekends and bank holidays. Working on a 62 week year (to cover holidays etc.) that would be 124 days for the weekends and another 8 days for bank holidays giving 132 days each per year at a cost of £159k per year.

5.6. **Scheme 3** - Care Sourcing team- moving to 8-8 model (£0. 215m) National Metric 2/3/4: Grant Condition Criteria 1/3/4: The scheme sees the continuation of funding for the Care Sourcing Team following on from a successful 12 month pilot; the service provides a consistent approach to applying the brokerage cycle and in turn, makes best use of social worker time. The Care sourcing team undertake all aspects of the Brokerage cycle: enquiry, contact assessment, support planning, creation of support plan, brokering, putting the plan into action as well as monitor and review of the support. The service operates 8am till 2pm / 2pm till 8pm, Monday to Sunday. The Care Sourcing Team comprises of a range of employees including: team and deputy manager, admin, care sourcing officers as well as a social care assessor. This funding is to enable an 8 till 8 operation.

5.7. The model is fully compliant with the Care Act 2014 as it provides information and advice, prevention, assessment, review, safeguarding, carers, market management and shaping, charging, support planning, personalisation and arranging care and support.

5.8. **Scheme 4** - Live well (£0.106m) National Metric 1/2: Grant Condition Criteria 1/2/3 - The use of 'Live Well' Online information and advice resource:

National Metric 1/2: Grant Condition Criteria 1/2/3. Cheshire East Council embarked on a programme to deliver a new online resource to the public: Live Well Cheshire East. It is designed to give citizens greater choice and control by providing information and advice about care and support services in the region and beyond. This new digital channel went live in June, initially offering information and advice and a directory of local services in one place covering Adult, Children, Community and Public Health services. Both Clinical Commissioning Groups have expressed a desire to utilise this platform and expand the offer to create a community infrastructure that maps all existing assets for use of professional staff alongside members of the public. This will be a project under the Better Care Fund. Cheshire East will continue to maintain and update the platform at an approximate cost of approximately £106k per year.

5.9. **Scheme 5** - Funding for additional social care staff to support Discharge to Assess initiatives (iBCF) (£0.290m) National Metric 1/2/3/4: Grant condition 1/2/3 - Funding of additional staff to support the local transformation programmes Caring Together and Connecting Care in implementing a 'Discharge to assess' model. This builds on the existing initiative with Eastern Cheshire where funding is being targeted at continuing to provide a team manager, social worker and occupational therapist, plus the roll out across mid Cheshire at an approximate cost of £290k per year.

5.10. **Scheme 6** - Innovation and Transformation Fund (£0.500m) National Metric 1/2/3/4: Grant Condition Criteria 1/3/4 - In order to support the 'Caring Together' and 'Connecting Care' transformation plans. Cheshire East Council will create a fund that the NHS and partners can access to support initiatives that promote the move towards integrated working (community teams) to achieve better outcomes for the residents of Cheshire East.

5.11. This forms part of the work to implement assessment and care outside of hospital as appropriate. There is the need for a range of options and discharge destinations to ensure that wherever possible people are supported to remain at, or return to, their usual place of residence –

5.12. Home First'. iBCF funded Home First Winter Plan Services delivering these aims:

5.13. NHS Eastern Cheshire CCG Schemes

- Rapid Return Home (Overnight) Service
- Care Home Support
- Flexible non-acute bed capacity/Discharge to Assess Beds
- Increased support for community Matrons case-managing High Risk patients.

5.14. NHS South Cheshire CCG Schemes

- Increased Rapid Care Support
- Clinical Support to care Homes
- Dedicated Support for D2A Implementation

5.15. **Scheme 7** - Sustain the capacity, capability and quality within the social care market place (£4,224m) National Metric 2/3/4: Grant Condition Criteria 1/2/3/4: Cheshire East Council has a duty under Section 5 of the Care Act to promote the efficient and effective operation and sustainability of a market in services for meeting the care and support needs of individuals. There are increasing financial pressures on the social care market, for example National Living Wage, recruitment and retention issues which is resulting in a rise in care costs. Cheshire East Council is undertaking a review of fees to ensure capacity and capability in the marketplace.

5.16. The demand for care services will be significant over the next few years, and as a result of this and the need to ensure the transfers of care are undertaken in a timely manner to meet NHSE targets of 3.5%; therefore will be a requirement for investment into community resources and increases in care packages, in order to sustain and stabilise both the domiciliary care markets and care home markets. This means transforming the care and support offer to ensure Cheshire East has greater capacity and an improved range of services. It is intended that the CCGs together with Cheshire East Council jointly commission the new offer and include: discharge to assess beds, step up/step down beds, more specialist provision for complex needs and care at home services that promote quality of care under the system beds programme.

5.17. The joining up of commissioning and contracting will provide partners with an opportunity to promote and champion a single and shared view of high-quality care and support. With our partners we need to ensure that health and social care services provide people with safe, effective, compassionate, high quality care and that as partners we encourage care services to improve, this may include quality payment premiums to providers.

5.18. Funding to support stabilise the social care market includes fee uplifts for both Care at Home and Accommodation with care. As part of the commissioning process for Care at Home, bidders have been invited to submit bids between £14 to £18 per hour for each geographical patch of the Borough they opt to bid for. This approach allows for cost variations between urban and rural/hard to serve areas of the Borough to be taken into account alongside the differing business models of provider organisations. As part of

the commissioning process for Accommodation with care, a 6% increase to contract rate has been proposed.

5.19. **Scheme 8 -** Electronic Call Monitoring (ECM) (£0.389m) – Care at Home (domiciliary care) is one of the largest contracted service areas that the Council commissions in the external market, with the Council currently spending in excess of £13.5 million per annum on generic Care at home services commissioned via the Council. In order to support the effective operation of the care at home this scheme will see the purchase of an ECM solution. The ECM solution will bring greater transparency to the delivery of care at home. Typical benefits realised from the implementation of ECM include increased quality within care at home services as well as increased safeguarding.

5.20. **Scheme 9 -** Care home assessments at the weekend (iBCF) (0.017m) - Work has been undertaken with the care home sector to ensure that any individual who is fit for discharge over the weekend period can be assessed and returned to their care home. This will form part of our contracts with care homes. This meets the requirements of the 'High Impact Change Model' for managing Transfers of Care in particular seven day working and reducing the pressure on the NHS.

6. Implications of the Recommendations

6.1. Legal Implications

6.1.1. This is in line with the Care Act 2014, and The Better Care Fund Policy Guidance and the Local Government Act 2003 for adult social care.

6.1.2. Under Section 75 of the National Health Service Act 2006, NHS bodies may enter into arrangements with local authorities in relation to NHS functions and the health functions of local authorities.

6.1.3. S141 of the Care Act 2014 provides for the Better Care Fund Pooled Funds to be held under and governed by an overarching s75 National Health Service Act 2006 Partnership Agreement.

6.1.4. On 13 March 2018 Cabinet:

6.1.5. Approved the Council entering into agreements with NHS Eastern Cheshire Clinical Commissioning Group and NHS South Cheshire Clinical Commissioning Group for the period of one year (2018-2019);

6.1.6. Delegated authority to the Executive Director of People to decide to extend for a further period of one year (subject to there being a continuing national requirement to operate the Better Care Fund and the Improved Better Care Fund as a s75 pooled budgets agreement for that period); and

6.1.7. Delegated to the Executive Director of People to make decisions and agreements on behalf of the Council in relation to the commissioning of schemes funded by the Better Care Fund.

6.1.8. The Better Care Fund Governance Group continue oversight and responsibility for reviewing the delivery of the agreement.

6.2. **Finance Implications**

6.2.1. The allocation for 2017/18 for the Cheshire East Council is £4.69 million; however this is subject to performance over the next two years. In 2018/19 the Improved Better Care Fund allocation is £6.0m.

6.2.2. The Council takes responsibility for the collation and consolidation of standardised financial and reporting information for the Cheshire East Health and Wellbeing board.

6.2.3. Planned expenditure on the schemes is as follows:

Scheme	Scheme name	Amount
Scheme 1	7 day retainer	100,000
Scheme 2	Increased weekend capacity for social workers	159,000
Scheme 3	Care Sourcing team- moving to 8-8 model	215,000
Scheme 4	Live well	106,000
Scheme 5	DTOC additional staff	290,000
Scheme 6	Transformation	500,000
Scheme 7	Sustainability of market	4,224,000
Scheme 8	Electronic call monitoring	389,000
Scheme 9	Care home assessments at the weekend (iBCF)	17,000
	Total	6,000,000

6.3. **Policy Implications**

6.4. The ageing population in Cheshire East and associated pressures on the home care market is central to the planning behind the iBCF schemes.

6.5. **Equality Implications**

6.6. As the leaders for our local health and social care economy, all BCF partners in Cheshire East are conversant and complaint with the Equality Act 2010.

6.7. **Human Resources Implications**

6.7.1. Any impact for Cheshire East employees will be as a result of the need for greater integration in care delivery and commissioning in terms of restructures or changes to job roles. These will be dealt in accordance with the Councils policy and procedures. This could be due to a number

of factors- seven day working policy, change in terms and conditions, geographical location of staff. Any identified implication will have a full impact assessment completed and assurance that all employment legislation is adhered to.

6.8. **Risk Management Implications**

6.8.1. Increased pressures and demands across both the health and social care economy creating instability in the system.

6.8.2. Risk of not reducing the delayed transfers of care.

6.8.3. Risk of market failure and/or disruption due to increasing care costs.

6.8.4. Risk that all funded proposals are not approved within the NHS England framework.

6.8.5. That the strategic priorities of all partners are not met.

6.8.6. Risk that the schemes lead to an increase in the number of admissions to residential and care homes.

6.8.7. Manage the risk to the clinical commissioning groups of sustaining services where the hospital trusts face significant financial pressures.

6.8.8. There is a risk in the ability to achieve integration in the current provider landscape and there will need to be careful market management and ensuring capacity in the whole system.

6.8.9. Risk of the consequence of failing to achieve proposed changes in activity levels and a plan to mitigate these.

6.9. **Rural Communities Implications**

6.10. A risk identified for the rural communities is in maintaining and incentivising care and support agencies to pick up packages of care. Care agencies are reporting difficulty in the recruitment and retention of care workers specifically in the rural areas.

6.11. **Implications for Children & Young People**

6.11.1. There are no direct implications for children and young people. Some children and young people are classed as carers, and it is

important that these individuals are recognised and supported through the existing better care fund.

6.12. **Public Health Implications**

6.12.1. Reducing the demand for health and care services, by enabling people to enjoy a healthy and active life within their communities, is a key priority for the NHS and social care system

6.12.2. The Better Care Fund has been created to improve the lives of some of the most vulnerable people in our society, placing them at the centre of their care and support, and providing them integrated health and social care services, resulting in an improved experience and better quality of life.

6.12.3. Health and care that supports better health and wellbeing for all, and a closing of health inequalities.

7. Ward Members Affected

7.1. The proposal will affect all wards.

8. Consultation & Engagement

8.1. Consultation and engagement with CCG partners through the BCF Governance Group has taken place and will continue to take place.

9. Access to Information

1.1. 2017-19 Integration and Better Care Fund Policy Framework (DoH, DCLG 2017)
1.2. NHS Five Year Forward View (2014)
1.3. Next Steps on the NHS Five Year Forward View (NHS 2017)
1.4. Care Act (DoH 2014)
1.5. High impact Change Model – Managing transfers of care between hospital and home (LGA 2017).

2. Contact Information

2.1. Any questions relating to this report should be directed to the following officer:

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Job Title: BCF Programme manager

Email: Alex.t.jones@cheshireeast.gov.uk

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livewell Cheshire East

Public Health Annual Report 2017

Contents

Working for a brighter future together

Foreword

By Fiona Reynolds, Director of Public Health

Welcome to the public health annual report for 2017 which features a summary of all the work to improve the health and well being of everyone who lives in the Cheshire East Borough.

I was pleased to join Cheshire East Council in spring 2017, with work already well underway on much of what it shared in this report and involving many teams from across the Council and local NHS, health, community and voluntary organisations. Helping the whole community to be as healthy as possible requires us all as to do what we can to take care of our own health and well being.

A major step forward to support people to do this in Cheshire East is the new 'Live Well' (**www.cheshireeast.gov.uk/livewell**), free website that lists over 3,000 services and activities available across the area including everything from care services to sports and walking clubs - there really is something for everyone.

Cheshire East is a great place to live with general indicators showing a good quality of life for the majority of residents. People are also living longer and this is a long term trend that thankfully is set to continue.

Looking at 2017 month by month, this report shares outcomes from several case studies and projects, as well as some of the day to day work that we're involved in.The report should be read with the Compendium of Statistics which provides the data and detail. We hope you find it informative and interesting and please do get in touch if you would like to know more about anything in this report and public health at Cheshire East Council (**publichealtheast@cheshireeast.gov.uk**).

Fiona Reynolds
Director of Public Health

JANUARY

Alcohol Strategy

Key Statistics

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 2015 admissions increased by 27%. In 2014-15 there were 7550 alcohol related hospital admissions.

Alcohol-related harm affects many of the residents and businesses of Cheshire East. The impacts are estimated to cost the public sector and businesses in Cheshire East over £136 million. This includes health and crime associated costs and lost productivity.

The variety of issues that stem from alcohol-related harm have led to overstretched ambulance, Police and hospital accident and emergency departments dealing with alcohol-related incidents and to subsequent delays in responding to the needs of other people.

Individuals, families, communities and business suffer harm as a result of excessive consumption, both in the short term through for example anti-social behaviour, incidents of domestic violence and drink–driving, but also in the long term for example through relationship breakdowns, longer term health impacts and addiction.

Cheshire East Health and Wellbeing Board approved an Alcohol Harm Reduction Plan in March 2017. This is designed to be an over-arching strategy for partners to use to more effectively join up interventions designed to help people engage in safe, sensible and social drinking.

Drink Less Enjoy More

The Drink Less Enjoy More (DLEM) campaign has been through a partnership across Cheshire and Merseyside. **It is targeted at**:

- 18-30 year olds visiting the night time economy (NTE) with the intention of getting drunk;
- Bar staff, who could be personally fined for serving someone who is clearly drunk;
- Bar owners, who could lose their licence for serving those who are clearly drunk.

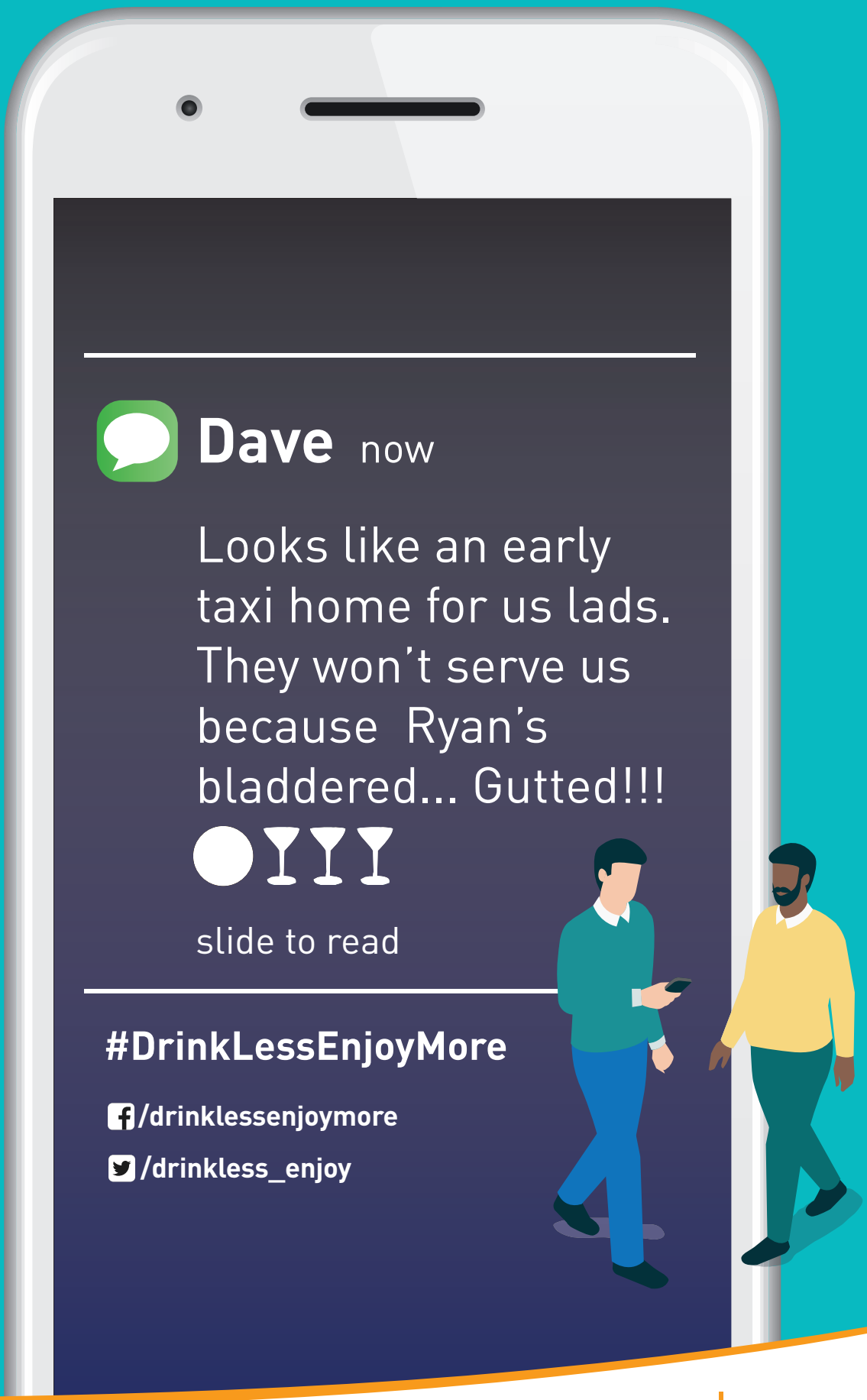
The campaign is raising awareness that:

- People won't get served if they are clearly drunk;
- It's illegal to buy alcohol for someone (e.g. a friend) who is clearly drunk;
- It's illegal for bar staff to serve someone who is clearly drunk.

A toolkit of campaign materials and tried and tested branding (co-produced with people aged 18-30) has been developed.

A number of teams collaborated to deliver this campaign including public health, communications, licensing and community safety. Face to face engagement with a number of local licensed premises was undertaken with evening visits and attendance at Pub Watch meetings.

A number of bar owners took branded t-shirts for their staff to wear to show support for the campaign and share key messages. Social media was the main channel used for the campaign to reach the 18-30 year old target audience with some on-street advertising near to nightclubs and bars.



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FEBURARY

Community Cohesion

Key Statistics

Data collected from the Cheshire East Schools Census (2017) provides a recent and detailed breakdown of migrant population based on the registered children in formal education. The Schools Census also helps with mapping of migrant population dispersal including their nationalities.

The Cheshire East Schools Census shows that:

- Children from migrant families make up **5.9%** of **52,820 children and young people** in education
- There are **102 languages** spoken in Cheshire East
- A significant migrant population is in Crewe with some schools having between **25-50%** of their registered children with English as an additional language. Other areas of higher migrant population identified are Wilmslow, Knutsford and Macclesfield.
- The main minority languages identified are Polish, Slovakian, Romanian, Urdu, Malayalam and Bengali.

It is important to note that these figures are based on the number of children in formal education and excludes other migrants who may not have any children or whose children are not in formal education. For example, we have identified a significant population of young East Timorese economic migrants in Crewe and recently young migrants from Middle Eastern countries.

The main issues that contribute to health inequalities among migrant communities in Cheshire East are:

- Lack of knowledge of available services and how to access them
- Language barrier leading to isolation and loneliness and poor health outcomes.

One of the most challenging issues with language barriers is isolation and loneliness. A lack of language comprehension affects the individuals' confidence leaving them feeling disempowered. As a result, they are isolated and unable to access services or engage with any social activities in their areas. It has a substantial impact upon their health and well being.

Community Connectors

The Community Connectors are part of our asset based approach to community development, cohesion and integration.

They are volunteers recruited from diverse communities in Crewe and have established community networks, knowledge and experience of their locality needs. Their role is to work in partnership with Cheshire East Council and other statutory partners to provide feedback of areas of concern in their communities which helps inform priority areas.

The Connectors are a bridge between these individuals and wider support networks. They are able to use their resources and networks to get the individual connected with other people within their community and also support them in accessing services.

The Connectors have also been involved in raising awareness about different Public health initiatives, e.g. Public Health's 'Stay well this winter' campaign has been translated into four languages.

Because of increased needs in the communities, we are in process of recruiting our next cohort.

MARCH

Community Resilience

Key Statistics

Cheshire East Council has taken part in a Department of Communities and Local Government (DCLG) national pilot project called Delivering Differently in Neighbourhoods.

This project assessed how communities can become more engaged in service delivery and policy and how this can influence priority and budget setting.

At the heart of this has been an innovative approach to providing and enabling services to be delivered at the right time, by the right people and at the right place through community facilities which are seen as hubs by local communities.

Working with neighbourhood partnerships to ensure local need is matched with the correct services being delivered from our Connected Communities Centres is the key to supporting residents with preventative interventions.

Delivering Differently

Macclesfield was chosen as a pilot area to test and implement this programme. It has provided an opportunity to engage intensively with the communities on the four estates in Macclesfield (Moss, Weston, Hurdsfield and Upton Priory).

The focus is on intensive engagement with communities, upskilling residents and supporting local resident led initiatives, enabling local communities to become stronger.

The programme has worked to a set of 4 key principles:

Working in collaboration

Community based neighbourhood partnerships were set up with key stakeholders in recognised priority areas to work collaboratively to tackle issues brought forward in these areas.

Tackling local priorities

Residents and partners united under the branding and have used it in various ways to show how they are all working together on the ground to address local issues. The project has engaged with over 750 local people through local events and consultations, as part of a comprehensive engagement programme.

Supporting resident led initiatives

The services initiated in the 12 month period were as follows:

- Smoking Cessation
- Cognitive Behavioural Therapy Support Group
- Tiny Tearaways – (mums and tots with health theme)
- Life Programme – (support addictive behaviours and socially isolated)
- Mental Health Awareness Training
- The Green in the Corner Dementia Café
- Weston Memories - (Local community group based on reminiscence and local history)

Coordinating service delivery

The community based neighbourhood partnerships have a responsibility in supporting the social franchise model for Connected Communities Centres to ensure the right services are delivered in the right places.

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APRIL

Recovering from alcohol and drug misuse

Key Statistics

People in Cheshire East receiving help with alcohol and drug misuse spend longer in treatment than the national average.

People who spend a long time in treatment are more likely to stay in treatment. Evidence shows that it is important to make recovery visible to those being treated, helping people to really see themselves getting better and to see the benefits of the treatment. One effective way to do this is to develop 'Recovery Communities' and creating peer support and volunteer opportunities for those undergoing treatment.

Our public health and communities team have worked together to develop a recovery community in Cheshire east and to challenge the stigma of people who are receiving treatment for alcohol and drug misuse. As part of this work, we held two events encouraging community and voluntary organisations and the people they help to share their experiences, make connections and raise awareness locally of services and support on offer.

Speaking at the event were

Acorn Recovery provide a range of innovative drug and alcohol rehabilitation services across the North West, including treatment, reduction and motivation programmes, support accommodation, and social enterprise.

Representatives from Acorn Recovery talked how stigma and perceptions of people getting treatment for substance misuse can be barriers to recovery. Families of people in treatment can feel ashamed and isolated when a loved one suffers from an addiction and are not sure how to best support their family member. This can lead to breakdown of communication and relationships which can hamper successful recovery from substance misuse.

"Love, support and connecting is what an addict needs, what we all need." – Acorn Recovery

Emerging Futures provide a range of accommodation based support for people with a housing support need, and who require support with drugs and alcohol. This could be anything from help to claim the correct benefits, and life skills such as budgeting, to more complex support with things like drug and alcohol support.

Speaking at the event, the Team from Emerging Futures shared their experiences of supporting the community around where they have homes where people stay who are recovering from drug abuse. They also shared the challenges around finding new suitable properties so they can help more people. Integrating recovering addicts back into the community is a big step forward to their sustained recovery. "Describing drug and alcohol addicts as 'these people' is not helpful." – **Emerging Futures.**

People in recovery spoke at both of our events and told their painful and powerful stories. **Some quotes from the day included**:

- "Walking into that place to get help literally saved my life."
- "I have friends that understand me."
- "Helping others has given me confidence."
- "I have hope for the future."

Recommendations for improvement:

- Increased peer support and mutual aid – re-commissioning of the substance misuse services
- Identify more volunteering opportunities for people in recovery
- Stronger links between substance misuse services and local voluntary organisations
- Building a sustainable 'recovery community' through the re-commissioning of the substance misuse services.

MAY

Protecting vulnerable people from consumer scams

Key Statistics

- On a scale of 1 to 10, with 10 being the worst, **50%** of people who were the victims of a scam rated the negative impact on their lives as between 6 and 10
- **23%** said it had affected their health
- 38% said it had resulted in reduced confidence generally
- **26%** said it had left them feeling down or depressed (National Trading Standards survey 2014/15)
- **53%** of people aged 65+ have been targeted by scams and criminals (Action Fraud)

Scams affect the lives of millions across the UK. People (specifically the elderly and consumers made vulnerable by their circumstances) who are scammed experience loneliness, shame, social isolation, deteriorating health and loss of self-confidence, alongside the obvious financial loss.

These also give rise to additional financial costs on the health and social care sector.

Vulnerable adults defrauded in their own home become susceptible to repeat crime and are 2½ times more likely to go into residential care, than their non-defrauded older adult neighbours.

In 2017, Cheshire East launched the Friends Against Scams initiative which aims to protect and prevent people from becoming victims of scams by empowering communities to take a stand against scams.

Friends Against Scams

The Friends Against Scams initiative has been created to tackle the lack of awareness by providing information about scams and those who fall victim to them. This information enables communities and organisations to understand scams, talk about scams and cascade messages throughout communities about scams-prevention and protection.

Recommendations

- Educate those in the public health sector about the harms of scams.
- Work with home care and service providers to help those visiting the elderly and vulnerable to spot signs of financial abuse and be able to report it.
- Partnership with Royal Mail, educating staff in Royal Mail depots on identifying scam mailings and potential victims.
- Utilise call blocking technology.

Increase community and service presentations and events (including SCAMchampions), empowering people to look for the tell tale signs of a victim of this intrusive crime and educating them to know where to report the issue to is a priority for the service.

Anybody can join **Friends Against Scams** and make a difference in their own way.

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JUNE

Men's Health Week and One You

Key Statistics

- One man in five dies before the age of 65.
- **75%** of premature deaths from heart disease are male.
- **67%** of men are overweight or obese.
- Middle-aged men are twice as likely to have diabetes as women.
- Four out of five suicides are male.

Men are more likely to:

- Smoke (and smoke more)
- Eat too much salt and red meat
- Eat too little fruit and veg,
- Drink alcohol to dangerous levels (men are twice as likely to have liver disease)

(Source: Men's Health Forum 2017)

On average, more than one in five men are still dying between the ages of 16 and 65, and more than two in five before the age of 75 – with death rates amongst men in the poorest areas of the country even worse.

This year's theme for Men's Health Week 2017 was belly fat. Belly fat is a problem because it lurks not just beneath the surface but also surrounds your vital organs and men are more likely to have it.

Regardless of your overall weight, a large amount of belly fat increases your risk of:

- Cardiovascular disease
- Insulin resistance and type 2 diabetes
- Colorectal cancer
- Sleep apnoea
- Premature death from any cause
- High blood pressure

Men's Health Week (11-17 June)

Public Health staff teamed up with Everybody Sport and Recreation (ESAR) to offer free health checks to male Council staff.

We had 40 men attend on the day to benefit from:

- Two lifestyle coaches from ESAR did a range of fitness and health checks including taking blood pressure readings.
- A free healthy lunch
- A Man Manual from the Men's Health Forum to take away with them.
- Staff also provided relevant health information and promoted other work that Public Health were involved in.

The event was a huge success and it was also promoted via the Cheshire East social media pages which also shared and re-tweeted several posts from Men's Health Forum during the week.

JULY

Change4Life Play Day

Key Statistics

- **Almost 20%** of 4-5 year olds in Cheshire East are overweight.
- **Almost 30%** of 10-11 year olds in Cheshire East are overweight.

(Source: PHE Public Health Outcomes Framework)

Change4Life

Change4Life is a national programme to encourage everyone to eat more healthily and be more active. 'Modern life' can mean that we're a lot less active. With so many opportunities to watch TV or play computer games, and with so much convenience and fast food available, we don't move about as much, or eat as well as we used to.

The Communities Team held a summer Play Day to show-case a variety of play experiences within Queens Park Crewe, highlighting play and activities that can be done on a shoestring.

Approximately 600–700 people attended the day which brought together 20 public, private and community organisations: including Active Cheshire, Cheshire East Council Fostering Team, Homestart, OneYou, Everybody Sport and Recreation, the Children's Centres, Community Recycle Cycles, Cheshire Fire Service, We Make Footballers, Motherwell, Creative Crewe and others.

The event was successful in helping connect families to local services and summer activities and 500 Change4Life Shake Up Packs were distributed.

More information can be found at the Change4Life visit: **www.nhs.uk/change4life**

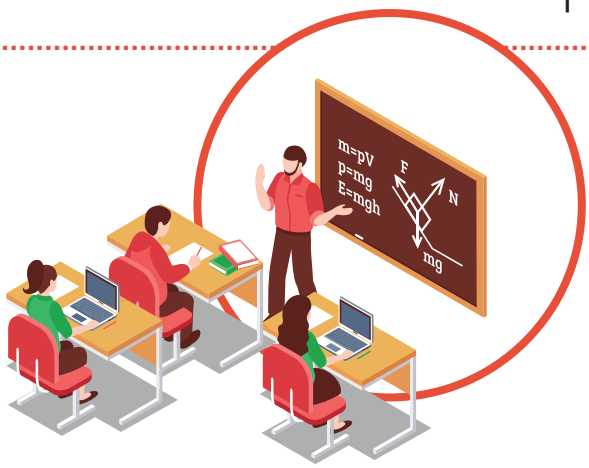
Case Study

Play Day outcomes:

- encouraging families to get outdoors and find out what's on offer locally and for free or low cost
- creating opportunities for physical activity
- offering ideas of play that could be easily replicated at home
- improve knowledge of other services and organisations for their benefit
- crafting improved relationships between family focused service providers


bar vista
EMOTIONALLY HEALTHY SCHOOLS
EMOTIONALLY HEALTHY SCHOOLS
EMOTIONALLY HEALTHY SCHOOLS

AUGUST



August – Emotionally Healthy Schools

Key Statistics

- **Around 695,000** children aged 5-16 years suffer from a clinically significant mental health illness
- **1 in 10 children** aged 5-16 suffer from a diagnosable mental health illness

The Cheshire East Emotionally Healthy Schools Project (EHS) is an innovative partnership model, committed to enhancing the capacity of schools to promote positive emotional health and wellbeing in school and to develop stronger working relationships with agencies outside of the school environment.

The project provides a mix of whole school and targeted interventions for children and young people, underpinned by access to mental health and wellbeing training, consultation and reflective practice sessions for school staff.

EHS will reach all schools and colleges by March 2019. The project aims to tackle the challenges out lined in the Public Health Annual Report 2015 which focused upon 'Supporting the Mental Health of Children and Young People'. Our data and consultation with children and young people and their parents and carers had identified significant issues in relation to their mental health and wellbeing.

Following a successful phase 1 pilot, and as part of Cheshire East's Local Transformation Plan, in partnership with the two CCGs, Phase 2 of the Emotionally Healthy Schools (EHS) Programme has been launched.

Emotionally Healthy Schools Phase 2 has three component parts;

- Schools Leadership Programme
- LINK Programme working across all primary, secondary, special and private schools and General Practice across the Cheshire East footprint in order to support training and learning.
- Tools For Schools

The Emotionally Healthy Schools launch took place on Friday 29th September 2017 further developing cluster based training and support for schools across the Borough. This event provided information about international research into emotional health and wellbeing, as well as giving delegates the opportunity to take part in workshops, reflective of the EHS offer and to network with colleagues from agencies who are able to offer additional support and/or advice to schools.

Recommendations for improvement:

- Funding for the Emotionally Healthy Schools Programme is time limited, further work on sustainability plans would be beneficial.
- Engagement with children, young people and their families could be further developed, the Programme could be improved with further work in co-producing, co-delivering and co-evaluating the programme with children young people and their families.
- Promotion of other services within the programme could be improved, particularly around the promotion of the Live Well community website to support professionals and families Visit: **cheshireeast.gov.uk/livewell**

SEPTEMBER

Suicide prevention

Key Statistics

4820 people are recorded as having died by suicide in England in 2015 but the true figure is likely to be higher.

Suicide disproportionately affects men, accounting for around three quarters of all suicides, but rates are rising in women.

In 2015 (the most recent data available) in Cheshire & Merseyside 17 children and young people aged 10-19 years and 16 aged 20-24 years died by suicide. Of these, seven had a history of self-harm and 10 had previously attempted suicide (Cheshire and Merseyside Zero Strategy 2017).

Suicide is preventable, yet in England 13 people take their own lives every day. The impact on family, friends, workplaces, schools and communities can be devastating; it also carries a huge financial burden for the local economy and contributes to worsening inequalities.

Acting to eliminate preventable deaths is a public health concern. There is no single cause and no single solution to suicide, but a requirement for joint, collaborative effort utilising evidence-based interventions, intelligence and a drive to eradicate this preventable death. (Zero Strategy 2017).

Cheshire East is a partner in the Cheshire and Merseyside Zero Strategy. This strategy is an all-age suicide prevention strategy, recognising that suicide and suicidal risk varies across the life course and that prevention and age-appropriate interventions are particularly important.

Gatekeeper training

Cheshire and Merseyside Public Health Collaborative Gatekeeper Suicide Prevention Training Programme

Suicide prevention training was identified as a key component of the Cheshire Merseyside 'No More: Zero Suicide' Strategy (Cheshire and Merseyside Public Health Collaborative (Champs) 2015) and is also a requirement within the national strategy 'Preventing suicide in England' 2012.

In Cheshire East there have been 257 people trained through the Gatekeeper Training programme since February 2017. **Participants have attended from the following organisations and teams:**

- Cheshire Police
- Fire and Rescue
- The Richmond Fellowship
- National Probation Service Crewe.
- Wulvern Housing (Guiness Partnership), Neighbourhood Workers, Sheltered Housing Co-ordinator, Tenancy Support Workers
- Plus Dane Housing, Sheltered Housing Officers, Tenancy Management Advisors, Tenancy Management Officers, Homeless Support Advisor Floating Support Officer, Tenancy Enforcement Officers Housing Officers.
- Cheshire Without Abuse (CWA)
- Cheshire East Council staff including the benefits team, Care4CE support workers, council tax, social care assessors, customer advisors, customer services team leader, revenues assistants, approved mental health and social workers, re-ablement team, intermediate care team, SMART team, civil enforcement team, youth engagement, mental health and learning disabilities team, community impact manager – partnerships, health and safety advisors, prevention of homelessness and money advice officer, post 16 tutor – virtual school.

Feedback from the courses

The feedback has indicated that the course offers a good mix of information, insight and stimulating exercises with valuable tips to improve awareness of the subject. Participants found the group work and role-play useful and has prepared them to identify someone who may be thinking of taking their own life and how to ask appropriate questions in a sensitive manner. The risk assessment tool was found useful and the information on local services was a useful signposting tool. One participant said, "the entire training session was brilliant" and that the course "delivered knowledge and skills in how to deal with difficult disclosures". Another said that the course left you "Knowing where to turn and what to do".

The participants are also given an opportunity to feedback on the areas of improvement which are needed for future service improvement, which was welcomed by all. Key issues which were highlighted and feedback to commissioners. To date there are over 1500 gatekeepers which have been trained across Cheshire and Merseyside since January 2017


maketime
When was the last time...
you got up and out?
Being active isn't all about looking good, it helps us feel good too. Something as simple as going outside for a walk can make a positive difference to our mood. Discovering something you really like doing is the most important bit. When will the next time be?

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OCTOBER

Seasonal Flu

Key Statistics

An average of 600 people in the UK die every year from complications associated with seasonal flu. This number can be as high as 10,000 or more during a bad flu season. (ref: vaccine knowledge http://vk.ovg.ox.ac.uk/influenza-flu)

During the 2016/17 flu vaccination season over 101,700 eligible residents across Cheshire East were vaccinated as part of the free NHS vaccination programme.

- **63,500 people** aged 65 and over
- **22,000 people** under 65 in at risk groups
- **2000** pregnant women.

There were seven flu outbreaks in care homes in 2016/17, with vaccine uptake among care staff generally low.

The national flu immunisation programme offers protection to as many eligible people as possible, especially those most at risk.

Across Cheshire East our uptake rates are consistently higher than the England average, and the highest uptake across Cheshire and Merseyside for most eligible groups.

Eligible group	Target	Cheshire East uptake	England average
Aged 65 and over	75%	76.2%	70.5%
Under 65 at risk	55%	53.8%	48.6%
Pregnant women	55%	50.9%	44.9%

Children spread flu infection easily and have been part of the universal vaccination programme since 2012. Uptake for eligible children was within the 40-65% target range. This varied from 44.7% for four year olds to 65.7% five year olds. Our uptake is consistently better than the England average.

Case Study – vaccinating frontline staff

All local community pharmacies were invited to apply to offer flu vaccination to front line staff employed by Cheshire East Council. In total 50 pharmacies have signed up, which provides a good spread across the borough and four clinic sessions have been arranged at some of the main council buildings. Vaccination at local pharmacies will be available until the end of February 2018.

The new system will be reviewed, particularly in terms of uptake but also asking teams and managers for suggestions as to any changes for future years.

NOVEMBER

Mental well being – Youth Connect 5

YOUTH CONNECT 5
Supporting the emotional wellbeing of young people

Key Statistics

In Cheshire:

- **13.1% or nearly 24,300 children and young people** aged between 0-24 years are estimated to have a mental health disorder including:
- **7.7% (about 2,900 children)** aged 0-4 years
- **7.7% (nearly 3,600 children)** aged 5-10 years
- **11.5% (about 5,400 young people)** aged 11-16 years
- **19.9% (about 12,400 young people)** aged 17-24 years

In Cheshire East:

- **439 children and young people** registered with Xenzone Kooth, an on-line free, confidential, safe and anonymous counselling service for 11-25 year olds, during 2014/2015 with **1189 active users** across the year.
- **93% of active users** were aged between 13-18, with 14 and 15 year olds forming the majority.
- **Nearly 4.5 times more females (84%, 357)** registered with the service than males (16%, 82).
- **The proportion of registrations from black and minority ethnic groups is 7% (30),** which is higher than the proportion within the general population (3.3%). 30% of registrations were from the Crewe area and nearly 7% from rural areas.

Visyon works in various locations in Cheshire East and North Staffordshire, providing a range of services to support the emotional health and wellbeing of children, young people between the ages of 4 and 25 and their families.

There were 739 referrals during 2014/15 for under 25s, 46% were for counselling. The split between males and females is more even (55% females) with a small number of transgender. Where ethnicity is recorded (28%), 96% are white, in line with proportions in the general population (BME 3.3%).

In Cheshire East, the 2016 figures highlighted that the annual referral figures were as follows:

Service	Provider	Age Group	Number of Referrals
Children Adolescent Mental Health Service	Cheshire and Wirral Partnership Trust	0-24 years	2857
Mental Health Adult Service	Cheshire and Wirral Partnership Trust	Under 25 years	1278
Visyon		0-24 years	563

For further information on Children and Young Peoples Mental Health and Wellbeing go to:
www.cheshireeast.gov.uk/JSNA

Case Study – Youth Connect 5

Children and young people's emotional health is receiving a lot of attention. (See the section on Emotionally Healthy Schools on pages 17 and 18). One of the factors of low wellbeing is when children experience weak and uncaring relationships with their family or carer.

Parents and carers play a pivotal role in promoting the knowledge, skills and environment that can help children cope with adversity. Supporting families has a dual role of strengthening parents' and children's resilience.

The Youth Connect Five (YC5) programme takes a prevention approach by upskilling families and carers: those closest, most trusted and the first point of support for children and young people. Family and school contact frequently reduces as children move from primary to secondary school and there is a recognised lack of training programmes directed to this target group.

The programme targets those not covered by school or Child and Adolescent Mental Health Services (CAMHS) programmes, providing skills and tools to families with sub-threshold symptoms and recognising that only 30% of those with a diagnosable condition access services. Although flexible, the target age range is family and carers of those 8-18 years.

A pilot has been developed with funding from Health Education England with Cheshire and Merseyside Public Health Collaborative Service (ChaMPs) overseeing the development and delivery of the project.

During the pilot there were 16 train the trainers courses delivered by Merseyside Youth Association to 241 trainers. **The YC5 programme was then delivered across 83 courses to 461 parents over the nine Local Authorities. This equates to a total of 99 courses and 702 individuals across the whole programme.**

Cheshire East has **delivered 10 programmes to 81 parents.**

The trainers were asked if the course was excellent to which 67.7% agreed, 32.3% agreed the course was good.

Early indications from parents undertaking the course are positive and have shown an improvement in understanding, confidence and resilience.

Wellbeing outcomes were captured pre and post the course, using the validated Short Warwick-Edinburgh Mental-Wellbeing Scale (SWEMWBS). This consists of seven questions about wellbeing. Parents rated how often they felt optimistic about the future, felt relaxed, dealt with problems well, thought clearly, felt close to other people and felt able to make their own mind up about things.

Early indications show that there was an improvement in wellbeing for parents.

Other outcomes reported include a change in parent's behaviour, children's behaviour and the family dynamic. A number of parents have continued to meet up and provide peer support to one another following the completion of the YC5 programme.

A full evaluation is currently underway by Liverpool John Moores University and a final report will be published in Spring 2018.


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Trading Standards protecting health and safety – counterfeit goods

Key Statistics

- Counterfeit goods cost the UK economy **£17.3bn** in 2016 alone, **destroying 72,000 jobs** in the process. (Cebr Report)
- Cigarettes, clothing and alcohol remain as the most investigated products. (IP Crime Report 2015/16)
- Top three crimes linked to IP crime remain benefit fraud, money laundering and organized criminal networks. (IP Crime Report 2015/16)
- Recent counterfeit cigarettes seized contained **160% more tar, 80% more nicotine and 133% more carbon monoxide** than genuine cigarettes.

As well as a known link between the trafficking of illicit goods and transnational organised crime, often being created in a 'sweatshop' in violation of child labour and employment laws and basic human rights, counterfeiting also takes profit away from genuine business. More importantly counterfeiters are not concerned with ensuring important safety checks and compliance testing are within a product to ensure they are safe, putting people's health at risk.

This highlights the significance of counterfeit goods as not only an intellectual property and trade problem, but also as an unrecognised public health problem with particular consequences in the area of injury mortality and morbidity.

UK wide children and adults are experiencing injuries, harm and death associated with counterfeit goods.

Real Deal for Markets

Markets are unregulated and a known hub for counterfeit trade. This is a national markets charter (introduced across Cheshire East) to regulate markets to trade legally, prevent counterfeit goods being offered and sold and a commitment to safe and fair trading at their local market. The work is to:

- Reduce health incidents linked to counterfeit and illicit goods and associated costs.
- Increase health and safety of consumers.
- Improve the formal economy and protect honest business.

Recommendations for improvement

- Further awareness with health partners to change behaviour of consumers that counterfeiting is a 'victimless' crime. Efforts to protect public health from injury associated with counterfeit goods can complement and augment strategies to protect intellectual property rights.
- Deploy a health communications strategy around counterfeit goods.

Contact Us

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NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

REPORT TO: Health and Wellbeing Board

Date of Meeting: 29th May 2018
Report of: Fiona Reynolds (Director of Public Health)
Subject/Title: Health and Wellbeing Strategy – Overview of the Consultation

1 Report Summary

1.1 The aim of Cheshire East's Health and Wellbeing Board is to improve health and wellbeing for all by building on the strengths of people and communities in towns and villages across the borough. We want to help people be happier, healthier and independent for longer so they can live the best lives possible in Cheshire East.

1.2 The Health and Wellbeing Strategy has been updated to take a place-based approach, based on discussions held by the Board over the last year.

1.3 The draft strategy was consulted on across the Borough with events and an online survey. The findings are summarised here.

1.4 The Strategy is included as an appendix.

2 Recommendations for the Implementation of the Strategy:

2.1 Reduce the number of priorities in the refreshed Health and Wellbeing Strategy, identified by the Joint Strategic Needs Assessment.

2.2 Partners ensure that actions discussed at the Health and Wellbeing Board are followed up in each organisation – acknowledging that the Board has a strategic role and implementation occurs outside the Board.

2.3 Strengthen links with subregional working via expanded membership to include the Cheshire East Council Executive Director of Place.

2.4 Expand the agenda of the Health and Wellbeing Board to include Place issues (e.g. Crewe Masterplan).

3 Reasons for Recommendations

3.1 These recommendations were made during the June 2017 workshop – identified and endorsed by members. These actions will strengthen the effectiveness of the Health and Wellbeing Board and reframing action in terms

of Place/Geography will support improvements in health and wellbeing in the Borough.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The Consultation has shaped the final draft of the Board's third Health and Wellbeing Strategy.

5 Consultation

5.1 Invitations to workshops held on 5th (Crewe) and 15th (Macclesfield) January 2018 asked people if they could help Cheshire East Health and Wellbeing Board to deliver a 'Health and Wellbeing New Year Resolution' and were worded in order to encourage attendance by people from a wide range of backgrounds.

5.2 It was explained in the invitation that the refreshed Joint Health and Wellbeing Strategy 2018-2021 has the exciting vision to enable people to live well for longer; independently and enjoying the place where they live. Whilst we recognise that having support from family, friends and the local community is important for improving overall health, other factors such as education levels, a healthy working environment, access to green spaces and comfortable housing are equally as important.

5.3 An overview of the intelligence and ideas that had informed the Strategy, the health needs of Cheshire East was presented to focus the discussions and the participants were asked to consider the goals, principles, priorities and indicators. Questions focused on:

- Do they feel relevant to me/my organisation?
- What do my organisation need to change or implement to help meet them?
- Are there any other goals that the H&WB strategy could be working towards – is there anything missing?
- Practicalities, are CEC and our partners already delivering against these outcomes?
- How can we improve on this through system leadership?
- How can we work better together and what ideas do we have to achieve better joint approaches?
- What additional support is needed?

5.4 Goals and Principles – Crewe

1) What does my organisation need to change or implement to help achieve the goals?

- Communication e.g. CEC/CVS Communication role to support key messages going out widely and helping organisations to see their role
- Partnership working e.g. Pathways into programmes need creating and partnership working groups formed, which focus on specific themes. CEC joined up working across directorates / services must improve – outcome focussed rather than service specific.
- Strategic alignment e.g. cross referencing priorities across strategy development including place-making strategies
- Accessibility e.g. – not just a 9-5 service – delivered in the community in the right place at the right time

2) Are there other goals that the H&W Strategy could be working towards? Is there anything missing?

- Nothing about children's social care outcomes
- Goals are right but challenge to implement them – rurality and transport issues. Need outlier services.
- Working lifestyle groups need to be created which focus on strategy goals so key agencies can work together.
- Focus on health in early years, children's centres; healthy schools – smoking under 11s target
- More building of neighbourhood partnerships, sharing information and working together

3) Do they feel relevant to my organisation?

- Everybody Sport and Recreation is a key partner for the strategy managing 15 leisure facilities across Cheshire east and having a wellbeing and lifestyle service. We want to be more involved and ensure our programmes are made aware of and firmly on the health pathways
- Yes (CVS) volunteering, fits with prevention and early help.
- Yes (CEC) across all services (not just people/health/social care). Place making can have big impact on wider health determinants
- Feels terrific – so much to do and cracking social isolation is key. Needs in Alsager – we know there are difficulties eg food bank. Communication – do people know what support is there?

5.5 Goals and Principles – Macclesfield

1) What does my organisation need to change or implement to help achieve the goals?

- Communication e.g. Shared communication is key – between various organisations, ability to signpost to appropriate services and know where to go e.g. Live well.
- Partnership working e.g. Collectively promoting the benefits of health interventions from all partners to show the affects on real individuals. Place-based interventions - multi-agency approaches bringing together different skill sets
- Strategic alignment e.g. Lobbying NHS England to allow Doctors to make changes i.e. social prescribing to reduce medicine prescribing
- Accessibility e.g. Clear choices for individuals, concentrate on what people can do rather than what they can't

2) Are there other goals that the H&W Strategy could be working towards? Is there anything missing?

- Dementia friendly communities essential to our ageing demographic and their health and wellbeing
- Empowering individuals to do things for themselves – first conversation flipping perceptions e.g. social workers don't help they assess – but people need help first.
- Safeguarding – level of meaning in context of the Strategy queried. Would be a top principle for some organisations. Differing definitions of vulnerability needs consideration
- Nothing about adults and no loneliness indicator shown. Is the outcome unachievable and need softening 'people do not feel lonely or isolated' change to 'less people feel lonely or isolated'?
- Co-location – potential to develop initiatives to increase accessibility

3) Do they feel relevant to my organisation?

- Every part of Cheshire East is different. Need place based approach.
- Link between social isolation and mental health. Lots of different ways of addressing – doesn't have to about going to the gym.
- Need people to do shared planning throughout lives so it becomes the norm
- Third sector and local communities are better placed to serve rural/isolated communities
- Individuals must feel empowered and able to inform us where and what they need themselves

5.6 Priorities and Outcomes – Crewe

- Needs integration and collaboration from all groups e.g. neighbourhood partnerships for rural areas (who have disparate groups) need to come together.
- Need to share information and look at potential to collaborate. Community based services working out of community based venues eg children's centres
- Gap identified between strategy and delivery of commissioned services. Commissioners to gather collectively, align plans, avoid duplication. Gap in clarity re. accountability
- Remove activity based payments and reward improved outcomes instead. Hold everyone to account on Strategy indicators
- Consider governance as jointly holding to account communities (8 LAPS?) to achieve outcomes.
- Jointly set the right conditions and contracts (outcomes focussed) to promote partnerships/innovation.
- No flavour of community diversity in Strategy – must not ignore changing communities
- Integration – organisations need to let go, counter the negative voices, focus on the positive, give permission and confidence so people take their own action.

5.7 Priorities and Outcomes – Macclesfield

- Improve mental health and wellbeing - connect the wider determinants of health; co-ordinate not duplicate; dementia – needs specific recognition
- Statutory outcomes that we have to deliver - some NHS and PH outcomes are based on deprivation models which doesn't suit CE
- If H&W Board and this Strategy is going to be of the highest impact it needs the widest representation
- Need one core service in place to co-ordinate - a mental health service hub? Too many silos, need one service – link to connected communities centres and JSNA?
- Aligning services to the same configurations e.g. GP clusters so they can work together
- Need to work on commitment first – then build relationships after cultural shift and culture change

- Capture case studies from success stories when things are changed that people didn't want i.e. Peatfields closure and move to Macclesfield where people attending had improved lives following the change
- Cross cutting leadership i.e. housing outside adult social care, but working with same clients – need to improve ways of working together – carer's hub
- Allow senior management time to come together to share knowledge and build on working relationships to understand other's work areas – what forum can we use?
- Use Connected Communities centres to ensure services are relevant for individuals and adapt as needed
- Is there an early intervention health and wellbeing MOT (e.g. linking health and financial advice / wider determinants).

5.8 Pledges were also connected from attendees and these will contribute to shaping the action plans for the Health and Wellbeing Strategy.

5.9 Changes to the Health and Wellbeing Strategy

5.10 A number of people requested that specific conditions be named within the strategy. The approach taken in developing this version has been based on the recommendation that focusing on specific conditions can distract from broad prevention interventions that would benefit several. For example, action

to reduce smoking will support improvements in health in cardiovascular disease, cancer and dementia.

5.11 The following changes have been made – emphasising that action is required across the life course, i.e. poor mental health is an issue that affects older people, not only children and young people. We've also taken into consideration the fact that many groups did want to see conditions named so we have included some of these as examples of the conditions that would benefit from various actions. We've also included a number of key deliverables:

- Ensure that health and wellbeing considerations are at the heart of all work related to spatial planning, transport, housing, skills and employment.
- Develop a Supplementary Planning Document for Health and Wellbeing.
- Deliver our responsibilities in ensuring that Cheshire and Merseyside achieve Suicide Safer Status – demonstrating work to reduce rates of suicide.
- Assess the levels of isolation across the borough.
- Deliver four collaborative health and wellbeing campaigns across all partners per year.
- Deliver a physical activity programme in schools not currently participating in a programme.
- Develop a falls prevention strategy.

5.12 Feedback also included the need for clarity on outcomes and these will be developed through action plans.

5.13 Next Steps

5.14 A great deal of feedback included enthusiasm and willingness to be involved from a number of partners and the suggestion that we create implemention/ action groups in order to enable the Health and Wellbeing Board to deliver the actions.

- Identify existing networks that could deliver the Health and Wellbeing Strategy Action Plans and which will be best suited to delivering key themes of work.
- Each network will develop an action plan, with measurable outcomes.
- The Board will be updated on progress.

6 Access to Information

6.1 LGA: *The Power of Place (2017)*

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

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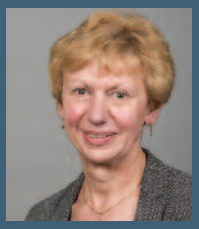
livewell Cheshire East

The **Joint Health and Wellbeing Strategy**

for the **Population of Cheshire East 2018-2021**



A Message from

Pictured l-r: **Councillor Rachel Bailey**
Chair of the Health and Wellbeing Board

Dr Paul Bowen
Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group

Dr Andrew Wilson
Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group

This is the third Joint Health and Wellbeing Strategy for Cheshire East which has been produced in collaboration with Health and Wellbeing Board partners. Much has changed since we published the first Strategy in March 2013, and there is significant pressure in the health and care system and the public sector more widely because of increasing demand and reducing capacity. This makes it more important than ever that as system leaders we agree a small number of priority areas that will be our focus of attention over the next three years and lead the transformation required to ensure better outcomes, but within a system that is financially sustainable in the long term. Early intervention and prevention has to be at the heart of this, to reduce demand and improve outcomes for individuals, families and communities.

Working for a brighter future together

The Health and Wellbeing Board is attended by members from different organisations and our intention is to deliver the Strategy through a place-based approach. We will improve health and wellbeing in the Borough by building on the distinctive strengths and characteristics of the towns and villages within Cheshire East. The key motivation for us is that we are **"working in the interests of our population."**

We are now part of the Cheshire and Merseyside Health and Care Partnership. We also need to ensure that economic growth creates opportunities for our residents, working with our neighbours in the sub-region (Cheshire West and Chester and Warrington). Our starting point will always be focused on improving the health and wellbeing of the population of Cheshire East. To do this we have reviewed the Joint Strategic Needs Assessment and the data from sources such as the Public Health England Health Profiles.

This document represents a commitment by the NHS, the Local Authority and our other partners on the Health and Wellbeing Board to collaborate to tackle the complex, difficult and inequitable health and wellbeing issues together.

The Health and Wellbeing Strategy provides an overarching framework that will influence the commissioning plans of the local NHS, the Council, and other organisations in Cheshire East. It will be a driver for change, focussing upon those key areas that will make a real impact upon improving the health and wellbeing of all our communities.

The Cheshire East Health & Wellbeing Board will work together to reduce health inequalities and make a positive difference to people's lives, through a partnership that understands and takes action to improve the health and wellbeing of the population now and in the future.

The Board will do this by:

- **Providing strategic system leadership**
- **Demonstrating improved outcomes within a broad vision of health and wellbeing**
- **Enabling people to be happier, healthier, and independent for longer**
- **Making the connections between wellbeing and economic prosperity**
- **Supporting people to take personal responsibility and make good lifestyle choices**
- **Engaging effectively with the public**

Councillor Rachel Bailey -
Chair of the Health and Wellbeing Board

Dr Paul Bowen – Chair and GP Lead of the NHS Eastern Cheshire Clinical Commissioning Group

Dr Andrew Wilson – Chair and GP Lead of the NHS South Cheshire Clinical Commissioning Group

Board Membership

There are two Clinical Commissioning Groups in Cheshire East, the NHS Eastern Cheshire Clinical Commissioning Group and the NHS South Cheshire Clinical Commissioning Group (CCGs). Representatives from these two organisations, together with Councillors, the Director of Public Health and senior managers from Cheshire East Council and a patient representative (from Healthwatch), form the core membership of the Health and Wellbeing Board. NHS England, the Police, Fire and Rescue Service and voluntary and community sector are also represented.

Ambition

Our ambition is to enable people (individuals and communities) to live well for longer; independently and enjoying the place where they live.

Meaningful engagement with our communities, patients and carers continues to inform all that we do and we will commission to improve health and social care services for our local populations and to lead the integration agenda around the needs of individuals. Co-production and collaboration with the community, faith and voluntary sector will be key to improving health and wellbeing. The Health and Wellbeing Strategy sits alongside the Cheshire East Sustainable Community Strategy and the Cheshire East Industrial Strategy.

The Board and its members will:

- Ensure action is centred around the individual, their goals, and the communities where they live
- Have shared planning, decision-making with our residents and supported self-care, for families in communities
- Focus our attention on health improvement and creating environments that support and enable people to live healthily
- Continue to tackle health inequalities, the wider causes of ill-health and the need for social care support e.g. poverty, isolation, housing problems and debt

Health and Wellbeing in Cheshire East: Where are we now?

In general, the health and wellbeing of the residents of Cheshire East is good. However there are still very significant challenges that need to be addressed.

Amongst these are:

- Increasing the number of people who enjoy a healthy lifestyle – e.g. are physically active, have good mental wellbeing etc;
- Preparing for an ageing population (by 2029 the numbers of people aged 65 or over will increase by more than 50% to 108,000 and those aged 85 or over will more than double to 20,000);
- Improving the mental health and emotional wellbeing of residents;
- Addressing some stark differences across Cheshire East. For life expectancy there is a noticeable difference of around 13 years between the lowest rates in Crewe Central and the highest in Gawsworth for females. For males, there is an 11 year gap between the lowest rate, again in Crewe Central, and the highest in Wilmslow East.

Highest:

Female Life Expectancy: Gawsworth: 89.5
Male Life Expectancy: Wilmslow East 84.1

Lowest:

Female Life Expectancy: Crewe Central: 76.3
Male Life Expectancy: Crewe Central 72.7

There is existing good practice to build upon that will help us to address these challenges. There are effective NHS / local authority / wider partners' joint working and innovative projects already in place and these are focused on identifying local bespoke – i.e. using the individual strengths of our towns and villages to support health and wellbeing. We do recognise that more needs to be done and the Board, through the Strategy will drive improvement in health and wellbeing.

As stated we also recognise the link between health and wellbeing and economic growth. The latter is essential to provide the infrastructure and opportunities for employment that help people to live well and flourish.

The Joint Health and Wellbeing Strategy is an evolving document, responding to the changes that occur through these new ways of working and to new challenges that we may face in the future, the priorities will modify over time. The Strategy is informed by and underpinned through the evidence of the Joint Strategic Needs Assessment which continues to be refreshed and updated.

Our Priorities: What we want to achieve between 2018 and 2021

The priorities we have selected are focused on supporting everyone in Cheshire East, from childhood through to older age. We have provided a list of indicators that we will use to demonstrate our progress. These are published by Public Health England through the Public Health Outcomes Framework – this will enable everyone to see the progress being made.

Outcome One: Create a place that supports health and wellbeing for everyone living in Cheshire East

While there are many things we can do as individuals to improve our health and wellbeing, the places where we live, attend school, play, work…spend our daily lives are where we spend the majority of our time. There are a number of interlinked factors that shape the place and our lives – with the potential to improve our health and wellbeing:

- Our local communities are supportive with a strong sense of neighbourliness
- People have the life skills and education they need in order to thrive
- Everyone is equipped to live independently
- People have access to good cultural, leisure and recreational facilities
- Homes for all people
- Supporting key employment sectors and local supply chains
- Rural economy

Indicators for Success

We want to:

- Maintain the low numbers of 16-17 year olds not in education, employment or training (NEET) or whose activity is not known
- Increase the percentage of people aged 16-64 in employment
- Reduce the number of people who are killed or seriously injured on the roads
- Increase the number of people who use outdoor space for exercise/health reasons
- Further reduce the number of households that experience fuel poverty

Key Deliverables

- Ensure that health and wellbeing considerations are at the heart of all work related to spatial planning, transport, housing, skills and employment
- Develop a Supplementary Planning Document for Health and Wellbeing

Outcome two: Improving the mental health and wellbeing of people living and working in Cheshire East

Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act. It also helps determine how we handle stress, relate to others, and make choices. Mental health is important at every stage of life, from childhood and adolescence through adulthood. We want to ensure that:

- Our children, young people and adults have improved emotional wellbeing and mental health thanks to a focus on prevention and early support
- People do not feel lonely or isolated

Indicators for Success

We want to:

- Increase the numbers of adults who report good wellbeing
- Reduce the levels of depression in adults
- Increase the numbers of children and young people who report good wellbeing
- Increase the proportion of adult social care users who have as much social contact as they would like*
- Increase the proportion of adult social carers who have as much social contact as they would like*
- Increase the proportion of adults in contact with secondary mental health services living independently
- Increase the proportion of adults in contact with secondary mental health services in employment
- Reduce the suicide rate

*While the other indicators are available through the Public Health Outcomes Framework, these indicators are gathered through biannual surveys.

Key Deliverables

- Deliver our responsibilities in ensuring that Cheshire and Merseyside achieve Suicide Safer Status – demonstrating work to reduce rates of suicide.
- Assess the levels of isolation across the borough

Outcome three: Enable more people to Live Well for Longer

The evidence shows that we need to focus on the root causes of illhealth (e.g. alcohol, obesity, smoking) rather than focusing on named diseases, because these factors contribute to multiple diseases and illnesses (e.g. smoking contributes to heart disease, stroke, lung cancer and vascular dementia).
We also want to take action across the life-course – from childhood to older age, focusing on prevention and early intervention. So we will be taking action to address:

- Alcohol and substance misuse
- Smoking
- Physical activity
- Healthy easting

Indicators for Success

- Increase the breastfeeding rates
- Reduce the numbers of children with tooth decay
- Reduce the numbers of 4-5 and 10-11 year olds who are overweight or obese
- Increase the numbers of people meeting the recommended "5-a-day" at age 15
- Reduce the number of adults that smoke
- Reduce the number of adults who are overweight or obese
- Increase the number of adults that are physically active
- Reduce the number of alcohol related admissions to hospital
- Increase the number of people who successfully complete alcohol or drug treatment
- Increase the numbers of people meeting the recommended '5-a-day' on a 'usual day'
- Increase the number of people who are offered and accept a NHS Health Check
- Improve health related quality of life for older people
- Reduce the numbers of older people who fall and need to be admitted to hospital

Key Deliverables

- Deliver four collaborative health and wellbeing campaigns across all partners per year
- Deliver a physical activity programme in schools not currently participating in a programme
- Develop a falls prevention strategy

How are we going to achieve this?

There is significant demand and need for services, high costs to the system and local demographic pressures which, coupled with the impact of preventable premature morbidity and mortality and reduced funding, will continue to put pressure on the Cheshire East health and care system.

There is already a great deal of work taking place and this is summarised briefly in Appendix 1 Making It Happen. We want to ensure greater collaboration and connection between programmes of work and strategies to achieve improved health and wellbeing. Our consultation for this strategy also showed great willingness and enthusiasm from partners to create themed networks to support the delivery of the Health and Wellbeing Strategy – we will be establishing these.

The term place-based health is becoming more commonly used and this means to ensure that we are focusing on support and services for communities and close to home. It's also about acknowledging the vital importance of education, jobs and housing in shaping people's health and wellbeing – more so than health and social care services. We want to enable people to take greater control over their own lives and to take greater responsibility for their health outcomes.

We want to focus on individuals, supported by families and friends within their local communities. All resources and assets in places must be used to support the wider determinants (e.g. education, jobs, housing etc) of health and improve health and wellbeing outcomes. There needs to be a shift towards prevention and early intervention which will require services to organise and professionals to behave in very different ways. We also want to work more collaboratively with all partners including the voluntary, community and faith sector.

Every community in Cheshire East is different and local solutions will reflect local challenges. But our action will be united around the four shared commitments:

Integrated and empowered communities: Individuals will be enabled to live healthier and happier lives in their communities with minimal support. This will result from a service approach 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.

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 co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and a single key worker.

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, reablement, mental health services, drug and alcohol support and housing with support options.

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. Prevention to support people from needing health or care interventions will be a priority as will addressing the wider determinants of health that are significant contributors to ill health.

How are we going to achieve this?

Equality and fairness

Provision of services meet need, reduce health outcome variations, and are targeted to areas which need them the most. **Proportionate universalism** will be a key tenet – the idea that health inequalities can be reduced across a community through universal action, but with a scale and intensity that is proportionate to the level of disadvantage.

Accessibility

Services are accessible to all, with factors including geography, opening hours and access for disabled people and other vulnerable groups considered.

Integration

To jointly commission services that fit around the needs of residents and patients, encouraging providers to collaborate to create integrated services where appropriate. This will maximise the benefits of delivery through the Health and Wellbeing Board.

Quality

The strategy is based on sound evidence and reasoning, and focuses on quality, within our resources.

Sustainability

Services are developed and delivered considering environmental sustainability and financial viability.

Safeguarding

Services and staff prioritise keeping vulnerable people of all ages safe. There will be proactive and effective relationships with the Safeguarding Children and Adults Boards.

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NHS South Cheshire Clinical Commissioning Group
NHS Eastern Cheshire Clinical Commissioning Group
Cheshire East Council

REPORT TO: Health and Wellbeing Board

Date of Meeting: 29.05.2018
Report of: Fiona Reynolds (Director of Public Health)
Subject/Title: Health and Wellbeing Board – Annual Report 2017/18

1 Report Summary

1.1 The Health and Wellbeing Board has a duty to provide an annual report on its business and activities. This draft report will also be submitted to Overview and Scrutiny Committee. The report is being brought to the Health and Wellbeing Board for comment, amendments and sign-off before it is published.

1.2 Recommendations

2.1 The recommendation is that the Board:

Approves this paper as the annual report of the Health and Wellbeing Board's work in 2017/18.

2 Reasons for Recommendations

3.1 The report enables residents to hold the Health and Wellbeing Board to account for its actions. It is a summary of the previous year's work and a mechanism to promote the role of the Board and improve understanding of the work.

4 Impact on Health and Wellbeing Strategy Priorities

4.1 The report is a record of the Board's activity to address Health and Wellbeing priorities and also captures the work undertaken to develop the 2018-21 Health and Wellbeing Strategy. This report does not capture every issue discussed at each meeting – this is a summary of the variety of work that has been undertaken by the Board.

5 Background

5.1 Health and Wellbeing Boards bring together key leaders from not only the local health and care system, but also partners from wider services that are responsible for shaping our environment. This enables us to work together to improve the health and wellbeing of our residents and reduce health inequalities through:

- developing a shared understanding of the health and wellbeing needs of our communities;
- providing system leadership to secure collaboration to meet these needs more effectively;
- having a strategic influence over commissioning decisions across health, public health and social care; and
- involving councillors and patient representatives in commissioning decisions.

5.2 2017/18 has seen a number of substantial changes for Cheshire East's Health and Wellbeing Board. We have examined and expanded our membership. We've also reviewed our priorities against the recommendations of the Local Government Association's *The Power of Place* report to support the development of the 2018-21 Health and Wellbeing Strategy. This will transform the approach that we take to improve health and wellbeing. The range of issues and projects that we have provided support and advice to has diversified and we also developed the Pharmaceutical Needs Assessment which is a statutory duty to support the commissioning of pharmacy services across the Borough.

5.3 Membership Review

5.3.1 The membership was reviewed and there are three new members of the Board from Cheshire Police, Cheshire Fire and Rescue and CVS Cheshire East.

5.3.2 All three organisations are actively involved in work that is contributing to improving health and wellbeing. Very often this is in partnership with existing members of the Health and Wellbeing Board. However, there is an opportunity to improve the strategic engagement of the three organisations and to ensure a more effective and coordinated response to our collective efforts by their joining the Board.

5.3.3 The membership is now:

Organisation	Role	Post holder
Voting members		
Cheshire East Council	Leader of the Council (Chairman)	Cllr. Rachel Bailey
Cheshire East Council	Adult Social Care and Integration Portfolio Holder	Cllr. Janet Clowes
Cheshire East Council	Children and Families Portfolio Holder	Cllr. Jos Saunders
Cheshire East Council	Acting Exec Director of Adults and Health	Linda Couchman
Cheshire East Council	Acting Executive Director of People	Mark Palethorpe
South Cheshire CCG	Accountable Officer	Clare Watson
South Cheshire CCG	GP Lead	Dr Andrew Wilson
Eastern Cheshire CCG	Accountable Officer	Jerry Hawker
Eastern Cheshire CCG	GP Lead (Vice chairman)	Dr Paul Bowen
Healthwatch	Healthwatch Rep	Louise Barry
Mid Cheshire Hospitals NHS FT	CEO Mid Cheshire Hospital Trust (representing NHS Providers)	Tracy Bullock
Non-voting members		
Cheshire East Council	Acting Chief Executive	Kath O'Dwyer
Cheshire East Council	Director of Public Health	Fiona Reynolds
Cheshire East Council	Executive Director-Place and Acting Deputy Chief Executive	Frank Jordan
NHS England	Nominated Rep NHS England	Tom Knight
Cheshire Fire and Rescue Service	Cheshire Fire and Rescue Service Rep	Mike Larking
Cheshire Police	Cheshire Police Rep	Chief Inspector Alan Fairclough
CVS	CVS Rep	Caroline O'Brien
Other members		
Cheshire East Council	Health Portfolio Holder (Observer)	Cllr. Liz Wardlaw
Cheshire East Council	Adults, Health and Communities Scrutiny Committee Chair (Observer)	Cllr. Stewart Gardiner
Cheshire East Council	Observer	Cllr. Joy Bratherton

5.4 Reviewing Priorities

5.4.1 The key finding from the 2017 Local Government Association report "The Power of Place" was that Health and Wellbeing Boards should undertake an annual self-

assessment review to examine the progress that they had made and that this should focus on: place (i.e. linking wider determinants and health improvement); leadership; collaborative working and making the geography work.

5.4.2 A workshop was held at the June informal meeting of the Board details of this are available here. The key outcomes of this discussion were:

- The Health and Wellbeing Strategy refresh would consider place-based approaches as a key priority
- Partners ensure that actions discussed at the Health and Wellbeing Board are followed up in each organisation – acknowledging that the Board has a strategic role and implementation occurs outside the Board;
- Links be strengthened with sub regional working via expanded membership to include the Cheshire East Executive Director of Place;
- The agenda of the Health and Wellbeing Board be expanded to include Place issues (e.g. Crewe Masterplan).

5.4.3 It was also confirmed that the Executive Director of Place membership of the Board would be as a non-voting associate member.

5.5 Developing the Health and Wellbeing Strategy

5.5.1 The Board's draft Health and Wellbeing Strategy was consulted on from December to January using an online survey and community events.

5.5.2 Invitations to workshops held on 5th (Crewe) and 15th (Macclesfield) January 2018 asked people if they could help Cheshire East Health and Wellbeing Board to deliver a 'Health and Wellbeing New Year Resolution' and were worded in order to encourage attendance by people from a wide range of backgrounds.

5.5.3 Feedback included strong support for all three priorities (Place based approach, mental wellbeing and people living well for longer). A number of people requested that specific conditions be named within the strategy. The approach taken in developing this version has been based on the recommendation that focusing on specific conditions can distract from broad prevention interventions that would benefit several. For example, action to reduce smoking will support improvements in health in cardiovascular disease, cancer and dementia.

5.5.4 The following changes have been made – emphasising that action is required across the life course, i.e. poor mental health is an issue that affects older people, not only children and young people.

5.5.5 Feedback also included the need for clarity on outcomes and a selection of indicators have been added that are publicly accessible through the Public Health Outcomes Framework to ensure transparency.

5.5.6 A great deal of feedback included enthusiasm and willingness to be involved from a number of partners and the suggestion that we create implemention/ action groups in order to enable the Health and Wellbeing Board to deliver the actions.

5.6 Refreshing the Joint Strategic Needs Assessment (JSNA)

5.6.1 The purpose of the Cheshire East JSNA is to provide the evidence base to support commissioning, decision making and service development, in order to help improve outcomes for our residents. The Cheshire East JSNA is not a standalone report but a collection of 'products' that includes themed reports, dashboards and summaries. It brings together local intelligence into a coherent collection in one place, telling the 'story' of health and wellbeing - in its widest sense – in our borough.

5.6.2 The JSNA is the joint responsibility of the local authority and NHS. It is accessed online and the webpages have recently been restructured to facilitate easier navigation for the user. A 'life course' approach has been taken to organise the information and data are categorised into the following thematic areas:

- Starting and developing well
- Living well, working well
- Ageing well

5.6.3 The JSNA is accessed online via the Council website. The JSNA provides the evidence base to direct the work of the Health and Wellbeing Board.

5.6.4 It is important that everyone can use the data we collect – and this data is available to communities who can shape their own health actions. The JSNA has been used to develop the Health and Wellbeing Strategy and shapes the priorities of the Health and Wellbeing Board. It is also key to supporting the commissioning plans of the partner organisations.

5.6.5 This year, we have refreshed the following sections.

- Tobacco
- Special Educational Needs and Disabilities
- Winter Health (Excess Winter Deaths)
- Autism Spectrum

- Mental Health – Focus: Employment
- Mental Health – Focus: People who are Lesbian, Gay, Bisexual and/or Transgender

5.6.6 The JSNA work programme for 2018/19 is included in Appendix 1.

5.7 Pharmaceutical Needs Assessment

5.7.1 The pharmaceutical needs assessment was a key programme of work linked to the JSNA and looks at the current provision of pharmaceutical services across Cheshire East and how well needs for pharmaceutical services are being met. Once the PNA has been finalised, NHS England is required to use it to consider applications to open a new pharmacy, move an existing pharmacy or to commission additional services from a pharmacy.

5.7.2 Under current regulations, Health and Wellbeing Boards are required to produce a PNA at least every three years. The current PNA for Cheshire East was published in March 2018 and is available here.

5.8 Emotionally Healthy Schools

5.8.1 The Board considered the evaluation of the pilot phase of the Emotionally Healthy Schools Project – the purpose of which was to assess the impact of the Project to help us plan for Phase 2 of the roll out of the scheme to all schools in Cheshire East. The evaluation was carried out by the University of Salford.

5.8.2 The Emotionally Healthy Schools project is a multi-agency project; providing a mixture of whole school and targeted interventions for children and young people, underpinned by access to mental health and wellbeing training, consultation and reflective practice sessions for school staff.

5.8.3 It is aligned to the Health Promotion and Illness Prevention outcomes for children and young people in the Public Health Outcomes Framework. This programme aims to acknowledge the vital role played by schools in promoting and supporting the emotional wellbeing of their pupils, and seeks to build knowledge, expertise and quality; and to strengthen relationships between schools and wider services.

5.8.4 The Emotionally Healthy Schools Project will reach all schools and colleges by March 2019. More information is available here.

5.9 Adult Social Care and Public Health Three Year Commissioning Plan

5.9.1 The Board advised on and supported the Three Year Commissioning Plan (2017/2020), entitled “People Live Well for Longer”. The vision is for responsive and modern care and support in Cheshire East, promoting people’s independence, choice and wellbeing. Through People Live Well for Longer, people will be enabled to live well, prevent ill health and postpone the need for care and support. This will put people in control of their lives so that they can pursue opportunities, including education and employment, and realise their full potential.

5.9.2 The plan will enable Cheshire East residents, as a population, to understand how important resources were in the delivery of preventative change over the next three years, working with a wide range of private and third sector providers, partners from across the health and social care economy, with a specific focus on the voluntary community and faith sector taking a significant role in the delivery of prevention.

5.10 The *improved* Better Care Fund (iBCF)

5.10.1 The Health and Wellbeing Board Partners have also been working to deliver the aims and objectives of the iBCF. All partners are committed to maximising the opportunities afforded by the iBCF to further integrate health and social care, to promote health and wellbeing and improve the health outcomes of the local population.

5.10.2 We are using the iBCF to address those areas identified as requiring immediate improvement to enable more people to remain independent and effectively cared for in the community as an appropriate alternative to hospital admission and to support the timely discharge of anyone who is admitted to hospital with a focus on Home First.

5.10.3 The Delivering Better Care in Cheshire East (2017-10) Plan aligns with the Health and Wellbeing Board priorities for adult social services around:

- Having available information, advice and signposting to enable people to access information about staying well (prevention) and where to get the right help if they need it (early intervention). This will be supported via the iBCF scheme LiveWell (which is outlined in the full version of the plan).
- Developing community services across all sectors to ensure care can be provided at home wherever possible (reducing admissions to residential care and avoidable visits to A&E and hospital). This will be supported by a number of the iBCF schemes namely improving capacity and capability in the social care sector and core services such as the Integrated Reablement services.

- Ensuring a range of accessible services and support for people, who take on a caring role, to maintain their health and wellbeing. This priority is supported by the development of the integrated Carers' Hub (which the Board heard an update on in March 2018).
- Ensuring our services are developed to provide joined up care from health and social care services. This is central and underpins all of the schemes within the plan.
- Ensuring that people in rural communities can access the same types of support services and activities as those in more urban areas.

5.11.1 Community Cohesion and Integration

5.11.2 There is substantial work taking place in relation to community cohesion in Cheshire East which is important for improving health outcomes for our migrant communities. There has been a rise in both the migrant population and its diversity, with the most up to date evidence being drawn from the Cheshire East Schools Census (January 2017) showing 102 languages were spoken and 5.9% of pupils who not have English as their first language.

5.11.3 A Cheshire East Cohesion Strategy is to be developed from evaluation work on the Crewe Cohesion Action Plan and that it will address the challenges in accessing and navigating health care services or community based support by people who are isolated and do not speak English.

5.11.4 The Board endorsed the recommendations of:

- Cultural Competency training for all staff
- Member organisations to commit to working with multi-agency groups in the south and east Cheshire CCG geographies with an agreed Memorandum of Understanding
- Fully utilising the diversity of the health and social care workforce
- Reviewing of existing on line methods of education and sharing information and develop better mechanisms to engage with under represented migrant groups.

6 Access to Information

6.1 The minutes and papers of the Health and Wellbeing Board's meetings, which informed this report are available on the Cheshire East Council website.

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Appendix 1: JSNA Workplan (2018/19)

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JSNA Work Programme - 2018/19
Last updated 01/05/18

JSNA Section	New or update existing?	Opportunity to support planned projects/priorities	JSNA Content Sponsor / Sign-Off	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Carried forward from 2017/18															
Carers	New	Inform carer services commissioning and refresh of carers strategy.	Hayley Doyle		△										
Air Quality	Update/ expand	Development and implementation of Air Quality Action Plan.	Nick Kelly	△											
Childhood maltreatement	Update/ expand	Neglect strategy and focus of task and finish group.	Nigel Moorhouse		△										
Adults mental health	New	Redesign of adults and older people's specialist mental health services.	Fiona Reynolds/ Helen Bromley	To be determined											
Suicide	Update/ expand	Inform work programme of Cheshire East Suicide Prevention and Self Harm Group.	Fiona Reynolds		△										
Cancer	Update/ expand	Setting SC CCG cancer work plan for 2018/19.	Tracey Wright		△										
Childhood Immunisations	Update	Inform Immunisation Steering Group priorities.	Matt Tyrer			△									
Sexual health	Update/ expand	Inform service review, recommissioning and Ddvelopment of sexual health strategy. JSNA to be published April 2019.	Jo Sutton												
End of life care for adults	Update/ expand	To be determined - scoping discussion at Strategic Collaborative Cheshire meeting - 22nd May.	Tracey Wright											△	
Planned developments															
Alcohol and drug misuse	Update/ expand	Geographical analysis to support mobilisation of Treatment and Recovery Service.	Shelley Brough/ Hayley Doyle						△						
Falls prevention (and mobility needs)	New	Development of falls prevention strategy.	Nik Darwin										△		
Veterans Community JSNA	Update	Inform substance misuse service delivery and Armed Forces Network bids for funding.	Tbd - CEC Armed Forces Champion?									△			
Domestic abuse	Update	Specialist domestic abuse services recommissioning.	Tbd - Judith Gibson/Liz Smith?						△						
Excess weight in adults (expand excess weight in children section or update both as separate sections?)	New / update	One You recommissioning.	Tbd - Nik Darwin?				△								
Tobacco	Update	One You recommissioning.	Nik Darwin				△								
Demographics	Update/ expand	Scene setting for business cases and other JSNA sections.	Sara Deakin												△
Infectious diseases	New	Recommissioning Infection Prevention Control Service.	Nik Darwin				△								
JSNA sections to inform 0-19 healthy child programme recommissioning - to be determined	Update/ expand	0-19 healthy child programme recommissioning and review of parenting journey. JSNA to be published in 2019/20.	Hayley Doyle												
Potential developments															
Children in care and care leavers	Update/ expand	Refresh of corporate parenting strategy. 0-19 healthy child programe recommissioning?	Nigel Moorhouse	To be determined											
Learning disability	New / update	Development of all age LD strategy.	Tbd - Mark Hughes / Dave Leadbetter?	To be determined											
Autism spectrum	Update/ expand	Development of autism strategy and action plan. Streamlining diagnostic pathways.	Ian Donegani	To be determined											
Children and young people's mental health	Update/ expand	Children and young people's mental health review and recommissioning.	Tbd	To be determined											
Experiences and inequalities in accessing health and social care services	New	To be determined (Tbd)	Tbd						To be determined						
Preparatory work for future JSNA sections															
SEND	Update/ expand	SEND Sufficiency work (for 16-25 year olds and then 0-4 year olds). JSNA to be published in 2019/20.	Ian Donegani / Dave Leadbetter												

Key
- Planned work
- △ Current publication deadline
- Original publication deadline
- ★ JSNA section published

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