Table Discussion Feedback Record

Commissioning and delivery of health and wellbeing	**How might we work together?**
Examples to provoke discussion: • Where might a consistent voice assist in delivering what we all want with providers that work across boroughs – where might there be strength in being more joined up, eg Allied Healthcare? • Commissioning services particularly for frailty and those with complex needs. • Market strength cohesion and sustainability • Collective understanding on action to make the best use of NHS funding to deliver local priorities (e.g. Tariff changes, new 10 year national strategy) • Learning from each other about what is working well in integrated services • Speaking with one voice to gain the best possible share of the wider health and social care resources and transformation funding • Commissioning mental health care services that work for local people •Public Health Services -Alcohol and Substance misuse; smoking; sexual health; NHS health checks / physical activity.	**Table One** • Happens on multiple levels - CCG/LA - the traditional statutory partners but also the link to geography and place and the opportunity and desirability of a pan – Cheshire approach through a common strategy. Mental health offers an opportunity as a high priority theme where there is scope to build on existing thinking • Emphasis on the need for a co-production approach with communities helping to drive the process. Don't make assumptions about what our communities want. Engagement is too soft a word - we need true co-production. Communities of interest as well as geography - people with specific or complex needs are not conveniently in clusters . This is often time consuming but is time well spent • Joint working is not just about the statutory sector. There are major players in the third sector, housing and in leisure and culture, for example. • Establishment of integrated care partnerships presents a new vehicle for co-production, commissioning and local delivery, including opportunities for sharing assets and funding. • Prevention and the role of public health in particular is critical, especially in the light of reductions in the public health budgets. It is short sighted to reduce such a key strand of preventative funding and others affecting the wider determinants – such as transport • Potential for a strategic approach. But there will be a need for an over-arching strategy with connecting sub-strategies such as mental health, learning disabilities, and starting well for children and young people. We need to "chunk it" to make it manageable. • The potential to share expertise and experience to trial different local approaches in different areas. What works and what is transferrable, running potentially to joint specifications and contracts • Noted the 17 care communities in Cheshire. All local interests need to be actively involved. We need to understand our localities, their networks, assets and dynamics and involve them in "bottom-up" planning • Our communities are very different - we shouldn't get hung up over structures. No one size will fit all in terms of how we engage - flexibility is key • Where are there synergies in terms of the potential for sub-regional and specific commissioning strategies? Noted work in regard to care at home; mental health; and public health • Commissioning around the individual is a key concept - personal need; personal aspiration; personal

Table Discussion Feedback Record

	responsibility. What do individuals need to make a real difference in how they live and keep well and independent? • Note that with commissioning also comes accountability. The importance of monitoring how things work and sharing evidence of what works well and why and what doesn't and why. Taking more of a test and learn approach and being willing to share the results. **Table Two** • MH - Place? ICP? C&W or Cheshire and Merseyside. Agree strategy and what action e.g. 100 day plan. • Integrated commissioning – are we serious? The total amount rather than individual services. Sharing best practice. • Integration in the Councils e.g. people and place? • Understanding markets and intelligence – predictive analytics • Public Health agenda – could do more across sub-region – wider determinants; but not a one size fits all. • Can we commit now to look to commissioning key areas together? CCGs are coming together. Are we spending our local pound well? • Do we know what we all spend and do we all agree these are our priorities? Can we share more? If we put these together we can maximise the limited resources. This could also attract funding streams from other areas. • Commissioning which is integrated e.g. Dom Care, Int care/DN's but all working to keep older people or people with learning difficulties at home and out of hospital when needed. • Trusted assessor model but not a hammer to hit a nail. Plus appetite for risk – who accepts this risk?

Table Discussion Feedback Record

	Older person living alone but is coping and wants to stay at home. • LD – more at sub-regional level – manage the market stop the arguments on continuing health care – better outcomes for people **Table Four** • Allied Healthcare issue demonstrated sector quite good at dealing with a crisis. ADASS shared plans. Different approaches by different councils. Slightly different legal advice. • Could be an opportunity to standardise local authority contracts taking best bits from each (in a similar way to the standard NHS contract). • Cost of dealing with the crisis – so do we pool funding? Could we top slice to create a fund at sub-regional level for crisis interventions? Can we better share data and intelligence regarding the sustainability of care providers in our area? • Opportunities to work collaboratively in our dealing with specialist providers. Certain providers used by lots of authorities but still naming their own price. Potential for a consortium approach to the commissioning of those providers. • Domiciliary care – economic conditions dictate availability and price so more likely to be a local solution and less benefits in trying to do across wider sub-region. • Sharing of best practice – e.g. getting the most of outcomes based domiciliary care services – could we do more to share contracts, scopes, specifications? • Public health – struggling with sexual health. Warrington had no interest in their service for the price being offered. Need to explore opportunities to commission on wider geographies. • Inequalities the three boroughs have agreed to work together to narrow the gap in educational outcomes.

Table Discussion Feedback Record

	• Could we explore working closer together across domestic abuse, align contracts? • There's a need for transformation capacity to help commissioners work more effectively together. But it's not a Health and Wellbeing board issue. • Joint strategy work only worthwhile on issues that are of common concern. These need identifying. **Table Five** What – how – why? Adult and Social Care focus as opposed to wellbeing 1. Police focus mental health, early intervention, offender management (key gap). Need integrated/linked pathways, shared understanding, consistent models of delivery. CYP not yet in contact with justice Does health own the mental health of offenders? Plus mental health, substance misuse and alcohol Points of contact/communication. More support if there is a family / parent connection Need for greater focus on community prescribing – focus is distracted by acute. 2. Seek to align commissioning = spreadsheets. Leaders need to mandate joint commissioning. Focus on prevention vs evidence vs national dictat. 2a. Warrington – democratic stewardship of the resources (Local); collective compact /contract with the voluntary sector providers. Connectedness to local communities. #Shared learning event. 2b. HWBB: wider determinants. Pooling of budgets – commissioning sub-groups Reduce the tribalism – who owns the problem? Who owns the solution? Governance Shared geographies; place based; appropriate to specialist 2c. Clarity needed on focus and brief of HWBBs and Integrated Care Partnerships. #Shared learning event.

Table Discussion Feedback Record

Working together to address issues that affect the public's health	**How might we work together?**
Examples to provoke discussion: • Addressing collectively issues such as childhood obesity. • Ensuring early help is there for children with mental health challenges across all services? • Working with the Local Enterprise Partnership around wider determinants of health, skills and education, industry, planning, housing for example • Leadership and accountability – local democracy and the role of the elected Members. • Minimum unit pricing of alcohol	**Table Two** Prevention and the voluntary, community and faith sector. - MoU at Greater Manchester – co-production - Need as a core resource - Don't make the CVS sector like local government – see the parable of the blobs and squares on You Tube https://www.youtube.com/watch?v=C107PQ3h8Kk **Table Four** • With any issue need to start at a Place level and review if there is an opportunity to work at a sub-regional or Cheshire and Merseyside level. • Different themes / issues being dealt with through different local delivery systems, eg Warrington stroke patients go to Whiston. The Place is different according to the condition so frailty is local but stroke moves you out of your local place. • Need to review and work together on data. If the data demonstrates a common need then there's potential to work across the geographies. Right Care can help with this They use CCG populations as basis for their data. • So an action could be to bring together the data, intelligencer Right care analysis together to identify the unwarranted variation, common needs and help t identify areas for focus.

Table Discussion Feedback Record

Workforce	**How might we work together**
Examples to provoke discussion: • How can we work together to ensure we have the best possible multi-skilled workforce to deliver health and wellbeing? For example, making every contact count. • How can we collectively make ourselves attractive in a competitive recruitment market? Housing, quality of life, transport, good places to work, joined up services. • Can we do more to develop and promote "grow our own "opportunities? • Can one voice help us get our fair share of training and development resources? • Development of a joint sense of purpose and culture. • Equality of opportunity • How do we ensure we are connected to the workforce workstream of the Cheshire and Merseyside Health and Care Partnership?	**Table Two** • How do we make it a career of choice and have value? • Health and social care academy for this workforce **Table Four** • Low paid workfocre • Pecking order eg nurse – hospital, community, care homes. For care workers its care homes, assisted living and domiciliary care. • Need to raise the esteem of the workforce. • Idea of a Care Academy being explored. Needs to be done at scale and pace. • Need clarity re. the model for delivery to allow for the appropriate workforce planning to take place. Necessary skills mix needs clearly defining. • Potential to explore opportunities to work together across recruitment, retention, skills, training development etc.