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Foreword
We are pleased to present the first Five Year Strategic Plan for NHS Eastern Cheshire Clinical Commissioning Group (CCG). This strategic plan covers the period 2014/15 to 2018/19 and has been developed in conjunction with our citizens, our partners and our stakeholders.

The NHS and local care services are needed by us all. They are valued and trusted, and in Eastern Cheshire we are proud of the services that are provided to its citizens. Our doctors, nurses, care workers and health professionals are doing all that they can to provide high quality care, but the way we need and want to access these services is changing. We are living longer; many people want to be treated in their own homes; and medical advances mean that the way hospital services are provided is evolving.

In Eastern Cheshire, we believe that our citizens should be put at the heart of decisions around local health and social care services. We need our citizens to be involved in helping us inform the design of services so that they are fit for the 21st century, and beyond, are able to respond to the changes in the way that we live and be able to provide the highest quality care.

Local GPs and consultants and other care professionals working in local practices, hospitals and care services hear stories from their patients, families and carers day in, day out about how good services are. However, there are cases when these experiences are not as good as they could be, and that is why we have looked at – and continue to look at - how we can respond better to meet the needs of all of our citizens.

We have already spent 18 months actively listening to citizen experiences, and as a result, we have a better understanding of the pressures in the current system. We know that citizens want to be able to make their own decisions over their care and they want access to a system where different health and social care services are more joined up. We also know that our staff want to be part of a health and social care system that allows them to do the best job they can do and deliver excellent care.

We have witnessed unprecedented support from local patients, carers, GPs, consultants, nurses, Allied Health professionals, council and social workers, all working in Eastern Cheshire, to help understand the opportunities we have and the risks of doing nothing. We all want high quality services, as local as possible, delivered by motivated, highly skilled and committed staff. We passionately believe that by understanding the issues that face our community as well as the opportunities we have to reshape services to meet our needs and prevent us from becoming ill, (and support us when we do), we can jointly define how services need to change.

Collectively we are keen to improve local services in Eastern Cheshire, including those on the Macclesfield hospital site and those from neighbouring hospitals used by our citizens. We know that to do this, services need to transform or change. The NHS is continuously evolving as care needs change, new standards introduced and care is moved from hospital to community settings. Without change, excellent will become average, and average will become poor. There is a point where this will affect us all – and accessing and receiving the highest quality, safest care will be threatened, resulting in poor health outcomes for our citizens.
This strategic plan helps to articulate in detail how we will achieve our vision “to inspire better health and wellbeing” amongst our citizens, partners and stakeholders. It also articulates how the CCG will lead and contribute towards achieving the collective vision of the Eastern Cheshire health and social care community “to join up care, improve outcomes and our citizen’s experiences of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England”

This strategic plan will continue to be an evolving story as NHS Eastern Cheshire CCG develops to meet the demands and challenges of the ever changing environment that it and its partners operate within.

We look forward to continuing to work in partnership with all those who wish to build a care system in Eastern Cheshire that is not only fit for the 21st Century but one that we are all proud of to say has been designed and delivered ‘Caring Together’.

Dr Paul Bowen BMBS MRCGP
General Practitioner, Chair

Jerry Hawker
Chief Officer
Chapter 1: Introduction
This document is the strategic plan for NHS Eastern Cheshire Clinical Commissioning Group (CCG) and covers the period 2014/15 to 2018/19. It responds to the Caring Together Five Year Strategy for the whole health and social care community and is designed to deliver our collective vision of a healthier population with fewer inequalities, and health and care services that are high quality, cost effective and sustainable.

The strategic plan has been based on a thorough analysis of the strengths and weaknesses of the local health and social care system and the needs of the changing population. It sets out a strategy for moving the CCG, and its partners in Eastern Cheshire, to a position where it can ensure the commissioning of health and social care services of the highest quality standards in all settings, whilst also delivering financial sustainability.

This plan is ambitious for our citizens (by which we mean our public, patients, families, carers and staff). It focuses on improving outcomes for older people, people with chronic diseases and those suffering from the consequences of health inequality. It focuses particularly on improving the access for these groups to urgent and emergency services, in order to help them avoid unnecessary hospital admissions.

NHS Eastern Cheshire CCG recognises the need to improve the quality of our citizens experiences of health and social care services. Our most significant improvement intervention is therefore focussed on integrating – or joining up - services around the patient/person - wherever possible pulling services closer to the person's home. This programme of work – known as Caring Together - will deliver improvements in the joining up of health and social care services and the joining up of people's physical and mental health care. It will deliver closer working between GP practices so that they can drive the joining up of primary, community, secondary and social care around the needs of our citizens.

In developing the five year strategic plan, the CCG has been an active partner in the south sector challenged health economy programme¹ and has fully considered the emergent thinking from this programme wherever possible whilst being cognisant that the work is still on-going and subject to approval by the relevant statutory and regulatory bodies.

As a consequence the CCG expects to develop further updates to this five year strategic plan in line with the emergent thinking of the south sector challenged health economy programme and the conclusion of the development of the Caring Together Five Year Strategy, due to be completed in July 2014.

Our Five Year Strategic Plan is summarised in Figure 1 on a ‘plan on a page’. The following chapters of this document provides the detail as to why and how we have developed our plan, specifically:

- the health and care needs, priorities and challenges facing our citizens and the Eastern Cheshire health economy
- the development, learning and performance of NHS Eastern Cheshire CCG and the Eastern Cheshire health economy over the last year
- the statutory responsibilities, national and local objectives
- the complexity, challenge and opportunities presented by transforming care in Eastern Cheshire
- the commissioning intentions that form our two year operational plan
- our five year financial plan and forecast
- the enablers for change.

Eastern Cheshire health economy is a system comprised of partners from across Eastern Cheshire who have come together to agree, refine and implement the CaringTogether Programme over the next five years.

Our shared vision is to join up care, improve outcomes and our citizens experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England.

To make affordable high value health services available to all to improve the health and wellbeing of our population.

**System Ambition One**
Increase the number of people having a positive experience of care

**Delivered through**
Utilisation of community assets and empowering people to effectively engage with a managed primary care delivery model in partnership with NHS England CWW Area Team and our 23 member practices to deliver 100% access to clinicians working in primary care

**System Ambition Two**
Reduce the inequalities in health and social care across Eastern Cheshire

**Delivered through**
The development of a new Integrated Community care model leading to a whole system partnership in Eastern Cheshire to deliver Risk stratification, neighbourhood teams, care planning, care co-ordination and case management. This is aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund

**System Ambition Three**
Ensure our citizens access care to the highest standards and are protected from avoidable harm

**Delivered through**
Community services supported by local hospital specialist enabled through the reconfiguration of acute care in partnership with healthier together programme and the challenged health economy initiative

**System Ambition Four**
Ensure that all those living in Eastern Cheshire should be supported by new, better integrated community services

**System Ambition Five**
Increase the proportion of older people living independently at home and who feel supported to manage their condition

**System Ambition Six**
Improve the health-related quality of life of people with one or more long term conditions, including, mental health conditions

**System Ambition Seven**
Secure additional years of life for the people of Eastern Cheshire with treatable mental and physical health conditions

**Delivered through**
A range of Productivity initiatives and continuous improvement plans delivered through our Operational plans and underpinned by the transformation programme

**Overseen through the following governance arrangements**
- Cheshire East Health & Wellbeing Board
- Caring Together Executive Board
- Healthier Together Committee in Common and the South Sector CCG partnership
- Challenged Economy Governance (TBA)

**Measured using the following success criteria**
- compliance against the emerging Caring Together and Healthier Together care standards
- delivery of the improvement metrics for each ambition (Two Year Operational plan)
- all organisations within the health economy report a financial surplus in 2018/19
- compliance against the NHS Outcomes framework and NHS Constitution

‘Caring together’: Joining up local care for all our wellbeing
Chapter 2: Eastern Cheshire context
Eastern Cheshire is located in the North West of England and includes towns such as Macclesfield, Knutsford, Wilmslow, Poynton and Congleton as well as many villages and rural areas. It has a population of 204,000 and most local people are classed as ‘white British’. The CCG area has 53% of the population of Cheshire East Council. With NHS South Cheshire CCG, the two CCG’s are co-terminous with the boundaries of the Council.

2.1 Eastern Cheshire health and care profile

The Cheshire East Joint Strategic Needs Assessment (JSNA)\(^2\) is the local “Big Picture” of health and care needs. It is a key tool by which the CCG accesses data that allows it to assess the health and care needs of and variations experienced by its citizens - the first step in the commissioning process and vital for determining our commissioning intentions. Data from the JSNA indicates the following for Eastern Cheshire.

Eastern Cheshire has the fastest growing over 65 and over 85 population in the North West\(^3\) with more than one in five people being over 65 (Figure 2). This ratio is higher than the national average, and will

**Figure 2:** Eastern Cheshire population age profile
become nearer to one in four people by 2021. The number of very elderly people is growing even more rapidly, with a higher estimated average annual growth rate when compared to England (2.7% vs. 2.3%). The overall population is forecast to grow by 28,000 (14%) by 2035. Although deprivation levels in Eastern Cheshire are lower than the national average, 4.5% (n9,180) of local people live in a Lower Super Output Area (LSOA) that is in the 20% most deprived in England. People living in these more deprived areas experience worse health than those living in those that are in the least deprived, and there are some startling differences in terms of life expectancy. On average, a woman living in Macclesfield Town South LSOA is likely to die almost 13 years earlier than a woman living a couple of miles away in Macclesfield Town Tytherington LSOA (Figure 2).

2 Cheshire East Joint Strategic Needs Assessment www.cheshireeast.gov.uk/jsna
3 Cheshire East Joint Strategic Needs Assessment Sep 2012, population projections, 2010
4 21% vs. 18% 2011, 23 % in 2021, Office for National Statistics
5 Lower Super Output Area (LSOA) – a geographic hierarchy designed to improve the collection, analysis and reporting of small area statistics in England and Wales. An LSOA has an average population of 1,500 people

Figure 3: Life expectancy by lower super output area in Eastern Cheshire

![Figure 3: Life expectancy by lower super output area in Eastern Cheshire](image-url)

The overall health of the Eastern Cheshire population compares favourably with the North West and England as a whole. There are however, variations in premature mortality (death in under 75’s) - which is an important indicator of the distribution of health inequalities.

The Annual Report of the Director of Public Health 2012 - 2013 has described in more detail the distribution of premature mortality across the Cheshire East and Eastern Cheshire areas and the main drivers. Key headlines include:

- annually there are 545 premature deaths in Eastern Cheshire, with the main causes for both men and women attributed to cancer and then cardiovascular disease
- the four main causes of premature deaths - cardiovascular disease, late presentation cancers, lung disease and liver disease are avoidable.
- although premature deaths, in Cheshire East and Eastern Cheshire, spike in the 60-74 age range in both men and women, 48% of all premature deaths occur in people of working age (15-64 years). This premature mortality affects all communities across our area, but some areas experience and some populations experience more premature deaths than others. For example there is significant premature mortality among people with mental illness
- whilst overall health for all can be improved, the improvement needs to improve faster in those groups with the greatest need (‘proportionate universalism’)
- the greatest reduction in premature deaths are likely to have come from improvements in healthcare services and developments in medicine.

Through data from such sources at the JSNA and Annual Report of the Director of Public Health we are also aware of variations in health within our localities (such as higher than CCG average incidence of lung cancer in males and females in parts of Macclesfield) and where targeted approaches to improving outcomes may be necessary.

The CCG has a statutory duty to secure improvement in health and to reduce health inequalities and it is an underpinning theme of the CCGs strategy to commission effective quality services. As such, work directly related to reducing health inequalities or unwarranted variations in health is described throughout this document in its relevant sections, such as Chapter Five (Two Year Operational Plan) and Chapter Six (extended primary care).


2.2 The membership of NHS Eastern Cheshire CCG

NHS Eastern Cheshire CCG is a membership organisation made up of 23 Eastern Cheshire based GP practices, working within five town based locality per groups (Figure 4).

Figure 4: GP Practices and locality peer groups in Eastern Cheshire
Our five localities, known as General Practice Locality Peer Groups, are:
• Alderley Edge, Chelford, Handforth, and Wilmslow
• Bollington, Disley, and Poynton
• Congleton and Holmes Chapel
• Knutsford
• Macclesfield

The main purpose of the CCG is to commission (buy) the highest quality of health care services within available funds, and monitor the quality of these services. We are responsible for commissioning health services to meet all the reasonable requirements of our local population, with the exception of certain services commissioned directly by NHS England, health improvement services commissioned by Cheshire East Council, and health protection and promotion services provided by Public Health England.

Our main commissioning responsibilities include:
• elective hospital care
• rehabilitation care
• urgent and emergency care, including GP Out of Hours and NHS 111
• most community health services
• mental health and learning disability services
• prescribing and medicine optimisation
• emergency and patient transport ambulance services
• NHS continuing healthcare and NHS funded nursing care.

We also have the responsibility for commissioning emergency and urgent care services for the population within our boundaries as well as for commissioning services for any unregistered patients who live in our area.

2.3 Our statutory responsibilities
The CCG’s full statutory responsibilities are detailed within its constitution. The main responsibilities include:
• upholding the NHS Constitution, CCG Constitution and governance standards
• quality assurance and quality improvement of commissioned services
• quality improvement of GP services in partnership with NHS England
• safeguarding children and vulnerable adults
• reducing health inequalities
• Public Sector Equality Duty
• public involvement in CCG and promotion of choice
• training, innovation and research
• environmental sustainability
• delivering on relevant areas of the Governments mandate to NHS England and the NHS England planning guidance ‘Everyone Counts’
• achieving financial balance.

NHS Eastern Cheshire CCG is currently meeting its statutory duties.

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Figure 5: The CCG structure

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8  http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Pages/Overview.aspx
9  http://www.england.nhs.uk/everyonecounts/
2.4 Our structure

The CCG currently employs 40 staff who work alongside the clinicians and staff of the 23 practices to commission, plan and monitor health services. Throughout 2013/14 our workforce has been aligned to teams to deliver on the Corporate, Clinical, Business and Finance functions and requirements of the CCG. The management of the CCG was structured around these teams.

At the latter end of 2013/14 it became necessary to review and strengthen the CCG organisation to meet the increasing scale of the transformation challenge facing the local health economy. These transformation challenges include:

- Caring Together\(^{10}\) – our local transformation programme for improving care across the health and care system for the citizens of Eastern Cheshire
- Connecting Care across Cheshire\(^{11}\) – NHS Eastern Cheshire CCG together with its partner CCGs in Cheshire and the two Local Authorities were successful in becoming an integrated care pioneer site - one of only 14 nationally
- Healthier Together\(^{12}\) – the CCG is an associate to the Greater Manchester Healthier Together transformation programme which is aiming to raise standards of hospital care and integrated care across Greater Manchester
- South Sector Challenged Health Economy – an initiative sponsored by NHS England, Monitor and the NHS Trust Development Authority to develop plans to support the transformation of services across Eastern Cheshire, Stockport, South Manchester and Tameside and Glossop with a particular focus on establishing long term sustainable acute care.

An assessment of the current skill base and capacity of the CCG workforce has resulted in the CCG establishing a Commissioning Directorate and establishing a Transformation Directorate to support the CCG and the Governing Body in leading, supporting and delivering these substantial transformation programmes. These two directorates work alongside the Corporate Directorate (Figure 5).

The CCG, in addition, has developed a successful partnership with McKinsey and Carnell Farrar LLP\(^{14}\) to support its transformation work and contracted with the Cheshire and Merseyside Commissioning Support Service for a limited number of services that have supported the CCG in the delivery of its objectives and day to day operations.

10 http://www.caringtogether.info
11 https://www.easterncheshireccg.nhs.uk/About-Us/integration.htm
12 https://healthiertogethergm.nhs.uk/
13 http://carnallfarrar.com
14 https://healthiertogethergm.nhs.uk/
15 https://www.cheshiremerseysidecsu.nhs.uk/
2.5 Vision and Values
The vision of the CCG “inspiring better health and wellbeing” is a central tenet of its Constitution. It shapes the direction and behaviour of the CCG, its membership and its staff. This vision is embedded in all that we do and underpins all of the commissioning and business decisions that we undertake on behalf of our population. Our way of working is also guided by and measured against the values and principles of the CCG:

2.6 Values
• valuing people
• working together
• innovative
• quality
• investing responsibly.

Figure 6: Our vision and values

2.7 Principles
• clinical leadership
• local experts in health needs and improving health outcomes
• local leadership and community engagement
• expertise in local provider relations and quality improvement
• local assurance in finance, performance and governance.

2.8 Strategic Objectives
Our strategic objectives are:
• to lead the development of a shared vision for the health and social care economy
• to use the knowledge and experience of clinicians and managers to improve care
• to work effectively with our members
• to place patients at the centre of our commissioning decisions
• to commission safe, effective care that continues to improve patient experience
• to continue to develop the effectiveness of the organisation
• to ensure financial sustainability for the health economy.

2.9 Working in partnership
The CCG is a major partner with Cheshire East Council and neighbouring CCG’s (including NHS South Cheshire CCG and NHS Stockport CCG) in local (and sub-regional) work to improve both the health of and the care provided to the citizens of Eastern Cheshire. Examples include the successful achievement of being identified as one of 14 Integrated Care Pioneer sites within England, development of the Better Care Fund Plan16 and the development of the Joint Commissioning Board.

The CCG is a statutory member of the Cheshire East Health and Wellbeing Board and through its membership of the Board17, the CCG is responsible for the production and use of the Cheshire East Joint Strategic JSNA. The information and priorities identified by the JSNA inform the commissioning intentions and decisions of the CCG and were instrumental in helping us to determine our priorities for 2013/14 and for 2014/15.

The CCG has also continued to provide funding to Community Voluntary Services Cheshire East to undertake engagement work with the voluntary sector to help inform the JSNA through the qualitative experiences of the this sector.

The CCG, and its partners on the Cheshire East Health and Wellbeing Board, has also been responsible for the production of the Cheshire East Health and Wellbeing Strategy 2013/14. The CCG has influenced and contributes in its day to day operation and strategic delivery to the priorities of the strategy, which are:

Outcome One – starting and developing well
Children and young people have the best start in life; they and their families or carers are supported to feel healthy and safe, reach their full potential and are able to feel part of where they live and involved in the services they receive

Outcome Two – working and living well
Driving out the causes of poor health and wellbeing ensuring that all have the same opportunities to work and live well and reducing the gap in life expectancy that exists between different parts of the Borough

Outcome Three – ageing well
Enabling older people to live healthier and more active lives for longer

16 https://www.gov.uk/government/publications/better-care-fund
Further information on these three outcomes can be found in the full Health and Wellbeing strategy on the Cheshire East Local Authority website.

The CCG has encouraged and supported the development of Eastern Cheshire Community HealthVoice, the public/patient reference group for the CCG and which is a formal advisory committee to the CCG Governing Body. Members of this group play a proactive part in the development of CCG policies and strategies, have been instrumental in the prioritisation of the CCG commissioning intentions and provide public/patient representation on a variety of CCG meetings and groups, such as the Urgent Care Working Group and Caring Together Care Model Design Groups.

2.10 Engaging with our citizens and partners to improve services

A comprehensive, planned approach to communication and engagement with our citizens and our partners is essential for NHS Eastern Cheshire CCG to achieve its vision of “inspiring better health and wellbeing”. We recognise that we will only be able to achieve this vision by working collaboratively with our citizens and partners to co-design and co-produce the changes needed. Communication and engagement has a crucial role helping us realise our aims and objectives as well as our development as an organisation.

The Health and Social Care Act 2012 sets out statutory duties for CCGs with regard to patient and public involvement.

It supports two distinct new legal duties on NHS Commissioners.

The first is for NHS commissioners to promote the involvement of patients, carers and members of the public in planning, managing and making decisions about their own care and treatment:
- Friends and Family Test (FFT) – e.g. the capture, collation and analysis of patient experience insight including FFT
- Information for patients e.g. ensuring targeted support to enable patients to be more in control of their health
- Personalised care planning e.g. when a person is eligible, having the option of a personal health budget
- Shared decision making e.g. involvement in decisions about individual episodes of care and/or longer term care
- Self-care and self-management e.g. providing support to better manage health and prevent illness.

The second relevant statutory duty places a requirement on NHS Commissioners to ensure public involvement and consultation in commissioning processes and decisions. It includes involvement of the public, patients and carers in:
- planning of commissioning arrangements, which might include consideration of allocation of resources, needs assessment and service specification
- proposed changes to services which may impact on patients.


The communications and engagement strategy sets out our responsibilities and how we will demonstrate meaningful engagement with our patients, carers and their communities. We understand that our success is based on the effectiveness of our organisation to communicate and engage with our communities. The key to our success lies in the continued fostering of relationships with our citizens, member practices, locality peer groups, Patient Participation, Eastern Cheshire Community HealthVoice and any groups that represent the voice and interests of our citizens.

The communications and engagement strategy sets out how we will involve, communicate with, engage with and listen to our citizens and partners whose interests or work contribute to the health and wellbeing of the citizens of Eastern Cheshire. It sets out our aims and objectives to ensure that we have effective, open and transparent communication and engagement mechanisms to develop the work of the CCG and to enable our citizens in Eastern Cheshire to have the opportunity to influence our commissioning decisions. Effective communication is an integral part to effective engagement which will contribute to the success of the CCG.

The communications and engagement strategy outlines how we will involve, communicate with, engage with and listen to our citizens and partners whose interests or work contribute to the health and wellbeing of the citizens of Eastern Cheshire. It sets out our aims and objectives to ensure that we have effective, open and transparent communication and engagement mechanisms to develop the work of the CCG and to enable our citizens in Eastern Cheshire to have the opportunity to influence our commissioning decisions. Effective communication is an integral part to effective engagement which will contribute to the success of the CCG.

The communications and engagement strategy sets out our responsibilities and how we will demonstrate meaningful engagement with our patients, carers and their communities. We understand that our success is based on the effectiveness of our organisation to communicate and engage with our communities. The key to our success lies in the continued fostering of relationships with our citizens, member practices, locality peer groups, Patient Participation, Eastern Cheshire Community HealthVoice and any groups that represent the voice and interests of our citizens.

We have a real desire to make a difference to the communities of Eastern Cheshire by enabling opportunities for individuals and organisations to be involved within healthcare decision making. We want to ensure that we become a listening organisation, responding to the needs of our communities and becoming an organisation which our member practices, patients, carers, staff, partner organisations and the public can feel proud of.

We value the importance of our members of the public, member practices, Patient Participation Groups and Eastern Community HealthVoice in helping us to achieve our vision of ‘inspiring better health’ and through this five year strategic plan we demonstrate our commitment to ensuring that this becomes a reality for our citizens across Eastern Cheshire.

The CCGs approach is to ensure that citizens are fully included in all aspects of service design and change (co-design and co-production) and that all our citizens are fully empowered in their own care. Our early initiatives include:

- the CCG has encouraged and supported the development of Eastern Cheshire Community HealthVoice, the public/patient reference group for the CCG and which is a formal advisory committee to the CCG Governing Body. Members of this group play a proactive part in the development of CCG policies and strategies, have been instrumental in the prioritisation of the CCG commissioning intentions and provide public/patient representation on a variety of CCG meetings and groups, such as the Urgent Care Working Group, Caring Together Care Model Design Groups
- the CCG has also continued to provide funding to Community Voluntary Services Cheshire East to undertake engagement work with the voluntary sector to help inform the JSNA through the qualitative experiences of this sector
- the CCG promotes transparency in local health services in a number of ways. Senior CCG meet both formally and informally with the medical and nursing directors of its major providers to discuss key issues to ensure potential clinical concerns can be raised and intelligence shared between organisations
- the CCG patient advice and liaison service are publicised to enable people to contact the CCG to discuss aspects of healthcare
- the CCG produce a Quality and Performance report which is discussed at the CCG Quality and Performance Committee and is available to our public through our Governing Body meetings.

2.11 The Eastern Cheshire Healthcare Economy

Appendix A provides a summary of key facts about the Eastern Cheshire healthcare economy, described in further detail within this section.

2.11.1 Healthcare spend

Health and social care spending on the citizens of Eastern Cheshire is around £346 million per year (Figure 7). Around a third of this is spent on hospital care, a thirteenth on GP practices (Primary Care), one sixth on community care, one seventh on social care, one twentieth on mental health and the rest on other services such as prescribing and specialist care.

It is also acknowledged that a range of health services are also commissioned by the local Public Health department of the council which span across and contribute to the local primary care, mental health and community care services e.g. NHS health checks, drugs and alcohol services and school health services. These elements are provided across

**Figure 7: Healthcare spend in Eastern Cheshire**

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<th>Service Type</th>
<th>Amount</th>
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<tr>
<td>Social Care</td>
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<tr>
<td>Other (Specialist Care)</td>
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<td>Mental Health</td>
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<td>16</td>
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<tr>
<td>Acute Care</td>
<td>16</td>
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1 Community/Acute estimate for commissioner has been based on spend at ECT (this estimate will be tend to overstate community component)
2 Includes CHC, NHS funded care, CCG running costs and ‘other’ (<£2m)
3 Numbers received 13.12.13
4 CWP spend (total - no breakdown available for NHS Eastern Cheshire CCG residents)
5 Numbers received 13.12.13
6 2012/13 spend on social care allocated to Eastern Cheshire CCG based on pro-rata CEC spend
more than one CCG footprint and have not been included above.

2.11.2 Access to services

In Eastern Cheshire there are 38 Pharmacies, 42 Dentists and 48 Opticians. There is one District General Hospital in Macclesfield and two community hospitals (Congleton and Knutsford), run by East Cheshire NHS Trust. The hospitals and community health services (e.g. District Nurses who visit patients in their homes) are also managed by East Cheshire NHS Trust. Mental Health services are managed by the Cheshire and Wirral Partnership NHS Foundation Trust.

The proximity of Eastern Cheshire to Greater Manchester provides Eastern Cheshire citizens with significant access and choice of general acute hospital services and access to a range of specialist care providers, for example the population in the north of the CCG access hospital services across Greater Manchester. There is already an innovative model of providing specialist services locally with larger, specialist hospitals, like The Christie Hospital NHS Foundation Trust, enabling chemotherapy to be administered at East Cheshire NHS Trust, and a number of other locally delivered services such as:

<table>
<thead>
<tr>
<th>Mid Cheshire Hospitals</th>
<th>Ophthalmology</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Foundation Trust</td>
<td>Pathology</td>
<td></td>
</tr>
</tbody>
</table>

| University Hospital     | Vascular Services | Oral Surgery |
| South Manchester NHS    | University Hospitals Foundation Trust | Ear, Nose and Throat |
| Foundation Trust        | Pathology        | Neurology   |

| Salford Royal NHS       | Urology         | Orthodontics |
| Foundation Trust        | Neurosurgery    |            |

| Stockport NHS Foundation | Neurology |
| Trust                   |          |

Some specialist paediatric services are also delivered by Alder Hey Children’s NHS Foundation Trust Hospital or Central Manchester University Hospitals NHS Foundation Trust. It is also not unusual for patients to travel to other hospitals like The Christie, or even further afield for specialist services or access to medical or surgical specialists.

The CCG has a commitment to ensuring compliance with choice and competition statutory duties; including ensuring that we have an active provider market, seeking to secure the highest quality of care whilst recognising the need to ensure local access to services commensurate with an ageing population.

For the populations of NHS Eastern Cheshire CCG, and the neighbouring NHS South Cheshire CCG, local authority services, including Children, Families and Adult social care, are provided in the main by Cheshire East Council. NHS England also commissions a range of services, such as pharmacy, optometry and dentistry.

2.12 Convenient access for everyone

The CCG already generally performs very well against key national access measures. However we recognise that demand for services is both growing and changing. The schemes identified, both through the Caring Together Programme and the two year operational plan have been designed following a thorough assessment of CCG performance in comparison to peers and best practice standards.

2.13 Forward view - Transforming Care in Eastern Cheshire

People now live for longer in Eastern Cheshire than they have ever done before; which is a cause for celebration. An ageing population is also a hugely significant challenge because older people are more likely to develop long term conditions such as diabetes, heart disease and breathing difficulties, and are more at risk of strokes, cancer and other health problems – which all means people tend to need more care and more treatment as they get older.

There are over 2,000 people in nursing homes in Eastern Cheshire, up from 1,500 in 2001 and national data suggests more than half of people aged over 60 have at least one long term health condition. For example, an ageing population
means increasing incidence of dementia – there are already 1,545 people in Eastern Cheshire with dementia, a figure set to double by 2030\(^2\) – and it is believed that the real scale of this condition could be almost twice as large as those figures, with up to half of those actually with dementia not diagnosed.

In Eastern Cheshire we also know that around half of hospital expenditure\(^2\), and around half of spending on adult social care\(^2\), is used for people aged over 65, even though they represent only one fifth of the population. So it is important to make sure that what money the CCG receives is spent well.

Over the last 18 months local commissioners and providers have united behind a common vision and purpose of transforming care services in Eastern Cheshire. This has been driven by a shared desire to join up care, improve outcomes and our citizen’s experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest growing over 65 and over 85 population in the North West.


\(23\) Communal establishments residents 2001/2011

\(24\) GP practice profiles 2011; DH Long term conditions compendium of information, 3rd edition (58%)

\(25\) Cheshire East Joint Strategic Needs Assessment Sep 2012 (using data from PANIS, POPPI and QOF - 100% in Cheshire East (from 2010 to 2030)

\(26\) Payment by result spend – Hospital Episode Statistics 2012/2013

\(27\) Cheshire East Council social care data (November 2013) and Hospital Episode Statistics 2012/2013
2.14 A modern model of integrated care

Caring Together (Chapter 4) is the programme that will enable the development of a new integrated community care model leading to a whole system partnership in Eastern Cheshire to deliver risk stratification, neighbourhood teams, care planning, care coordination and case management. This is aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund.

Community provided care will be the nucleus of the new model of care and create a common view of patients to drive improvements in care by identifying those most at risk and most vulnerable. This will be supported by a care coordination service to provide a central point of contact for patient information, coordinate a faster more effective referral process and manage the use of technologies to monitor some health conditions remotely.

This proposal will enable the majority of care to be provided locally in the community and specialist consultants working more closely with GPs and community services.

The Caring Together Five year strategic plan is in development and will be shared with partners and NHS England once completed in July 2014 having taken considerable consideration the conclusion of the south sector challenged health economy programme.

2.15 Our commitment to quality

NHS Eastern Cheshire CCG views quality as the golden thread that runs through everything that we do. Ensuring the delivery of compassionate, high quality care focused on achieving positive patient centred and beneficial outcomes is at the very heart of our clinical values. By establishing a shared understanding of quality and a commitment to place it at the centre of everything we do, the aspiration of high quality of care for all of our commissioned services will be achieved.

The NHS defines quality as effectiveness, safety and the provision of an excellent patient experience. High quality care encompasses all three aspects with equal importance being placed on each.

We see high quality care as: “When patients are ill they will receive care that is as safe as we can make it, care that is based on the best clinical evidence that ensures they have the best outcome and that this care is delivered in an integrated and holistic way. Patients and their families will be treated with dignity and respect during the delivery of this care and involved in care decisions. Patients will have a positive experience of care.”

As a CCG this means we hold the interests of the patient at the centre of everything we do and seek out and listen to what they are telling us and what they need. We ensure that the services we commission for patients are as safe as possible, in line with best practice, in order to achieve the best reasonable outcomes for these patients and a good patient experience.

The CCG has developed innovative processes to capture feedback from patients (including views from seldom heard groups), clinicians, the CCG Governing Body Sub-committee – the Quality and Performance Committee, and Governing Body and ensures that this feedback is utilised to continuously improve services. This information includes complaints, concerns, compliments or safeguarding concerns received either directly from service users, from other NHS commissioners and regulators or from health care professionals involved in co-ordinating or delivering care.

2.15.1 Quality Strategy Development

The NHS Constitution sets out the key principles that guide the NHS and the values we should be working to. This is one of the key documents considered when developing the NHS Eastern Cheshire CCG Quality Strategy, especially in relation to our responsibilities as NHS staff as we commission care. National guidance sets out the responsibility CCG’s have in relation to improving quality in primary care. NHS Eastern Cheshire CCG sees this as a fundamental part of developing care in Eastern Cheshire, in order to achieve the aims of proactive integrated care.
our commissioning strategic priorities, and the NHS Eastern Cheshire CCG Quality Strategy.

The NHS Eastern Cheshire CCG Quality Strategy works to ensure that the services we commission are safe, effective and provide a positive patient experience.

The Quality Strategy enables the CCG to ensure improvements in quality throughout the patient journey. When developing the strategy equal consideration was given to:

- local and national quality improvement priorities
- priorities identified within the Cheshire East Joint Health and Wellbeing Strategy and Cheshire East JSNA
- safeguarding children
- safeguarding vulnerable adults
- equality, diversity and human rights
- learning from a range of reports including Francis, Berwick, Winterbourne and Keogh.

The Clinical Quality and Performance Committee oversee the implementation of the CCG quality priorities which are identified in the annual plan.

2.15.2 Ensuring and improving quality throughout the patient journey

The CCG uses a range of evidence to identify local quality improvement priorities such as pressure ulcers and serious incidents. The specific objectives and initiatives that underpin this aim are included in Chapter 4.

2.15.3 Compassionate high quality care

NHS Eastern Cheshire CCG is committed to supporting compassionate and high quality care as advocated by the Chief Nursing Officer for England through Compassion in Practice 28 - a strategy that aims to achieve excellent health and wellbeing outcomes. It builds on the existing NHS Constitution and the 6C’s (which details six values):

- Care
- Compassion
- Communication
- Courage
- Competency
- Commitment.

Towards demonstrating our commitment we have created a NHS Eastern Cheshire NHS Staff pledge:

“We will care with compassion, ensuring we communicate effectively, have the necessary competence to understand your health and social care needs and the courage to speak up for you. We will demonstrate our commitment by working together, combining our knowledge, skills and expertise to maximise opportunities for innovation and excellence.”

The CCG has committed to developing and embedding the 6C’s in all of its work and has taken an active role nationally and locally in its promotion, including an innovative scheme to share best practice between local care homes.

2.15.4 Implementing “Compassion in Practice”

The CCG will work alongside GPs to support implementation of ‘Compassion in Practice’ the Vision and Strategy for Nursing, Midwifery and Care Staff29. This will further assure NHS England of quality improvement, support practices in preparation for the Care Quality Commission (CC) quality inspections and, most importantly, address the recommendations outlined following the Francis Report, specifically:

‘Foster wholeheartedly the growth and development of all staff, especially with regard to their ability and opportunity to improve the processes within which they work’.

2.15.5 Working in partnership to improve quality

Partners include the nursing homes sector where the CCG continues to invest to support continuous improvement. These initiatives include implementation of enhanced primary care services (GP) and the on-going development of a quality framework for care homes.


The Cheshire East Health and Wellbeing Board also binds the two CCGs and Cheshire
East Council into a partnership arrangement, with joint aims and objectives around quality identified through the JSNA and articulated through the joint health and wellbeing strategy.

2.15.6 Quality premium
The ‘quality premium’[30] was established to reward CCGs for improvements in the quality of the services that they commission and for associated improvements in health outcomes and reducing health inequalities. The quality premium payment for achieving in 2013/14 will be invested locally during 2014/15. A summary of the position to date for 2013/14 is shown below in Figure 8.

2.16 Safeguarding
The CCG is committed to ensuring that safeguarding is embedded within the organisation and in the services commissioned from all of its providers. However, we also recognise that our responsibilities extend well beyond our local statutory duties and boundaries and have been an active member of the Cheshire East Multi-agency Safeguarding hub working alongside NHS South Cheshire CCG, Cheshire East Council and Cheshire Police. The CCG Executive Nurse and safeguarding team have worked closely with the Cheshire East Children’s and Cheshire East Adult’s safeguarding boards to continuously improve the way we work and ensure safeguarding policies, frameworks are embedded in everything we do.

2.16.1 Adult Safeguarding
One of the biggest developments this year for Adult Safeguarding is the reform of the law and the publication in May 2014 of the Care Act[31] which now clearly states care and support for adults and the law relating to support for carers:
• to make provision about safeguarding adults from abuse or neglect
• to make provision about care standards; to establish and make provision about Health Education England
• to establish and make provision about the Health Research Authority
• to make provision about integrating care and support with health services.

This change will fully support the work that the Caring Together programme is striving for in Eastern Cheshire, keeping the patients at the heart of the services that they use.

As part of our five year planning processes the CCG will be working closely with the local authority to establish and implement a range of Adult safeguarding priorities. These will include:
• improving the quality and standards of care within nursing homes
• ensuring that the CCG responds fully to new guidance regarding Mental Capacity Act/Deprivation of Liberty Safeguards (MCA/DoLS).

2.16.2 The Local Safeguarding Children Board
The Local Safeguarding Children Board (LSCB) is the key mechanism for agreeing how the relevant organisations in each local area will co-operate to safeguard and promote the welfare of children and for ensuring the effectiveness of their work. The CCG support the Boards through attendance at Board meetings and actively supporting the sub groups.

Statutory Membership of the LSCB is set out in ‘Working Together to Safeguard Children’[32]. As part of our five year planning processes the CCG will be working closely with Cheshire East Council to establish and implement a

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**Figure 8: 2013/14 Position against the Quality Premium**

<table>
<thead>
<tr>
<th>National/Local</th>
<th>Measure</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Emergency Admissions</td>
<td>Achieving</td>
</tr>
<tr>
<td>National</td>
<td>Clostridium Difficile</td>
<td>Achieving</td>
</tr>
<tr>
<td>National</td>
<td>Friends and Family Test</td>
<td>Achieved</td>
</tr>
<tr>
<td>National</td>
<td>Potential Years Life Lost</td>
<td>Data September 14</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Readmissions</td>
<td>Failed</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Primary Mental Health</td>
<td>Achieved</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Feeling Supported to manage my long term condition</td>
<td>Data July 14</td>
</tr>
</tbody>
</table>

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range of children's safeguarding priorities. These will include:

- working closely with Cheshire East Council to develop a new strategic plan
- continuing to develop the multi-agency working board
- strengthen the range of qualified clinicians supporting the safe guarding of children.

2.17 Patient experience

The CCG is committed to a continuation and improvement of its use of patient experience information. Local schemes include:

- the CCG already has a working group who monitor information gathered from complaints, incidents and the Patient Advisory Liaison Service. This group uses this information to generate service change. As an example the CCG is currently re-procuring a community diagnostics service in light of patient feedback around the quality of the current provider
- as part of the empowered person work stream of the Caring Together programme, the CCG is exploring a range of service developments which both improve public access and experience of public services. For example how choose and book is used across our local health economy
- the friends and family test rollout will be continued with the CCG using this information as a driver for change
- a programme of service visits will take place during the year to ensure the CCG hears directly from service users and clinicians.

2.18 Promoting innovation and research

The CCG is a founding member of the Greater Manchester Academic Science Research Network and has worked closely with them in their formative year and in ensuring the network supports active innovation and clinical research across Eastern Cheshire. The CCG is also part of a European project called “Stop and Go” looking to increase the innovation, development and implementation of new Assistive Technologies.

The CCG has previously been involved with Keele University working on research in MSK (musculoskeletal) conditions. More recently we have had discussions with Keele University (Prof. Carolyn Chew-Graham) about research into the effectiveness of Non-Traditional Providers (NTP) in the elderly with depression. This links in with the work we are currently undertaking with Health and Wellbeing Coordinators (employed through Age UK), who are working within our multi-professional neighbourhood teams.

In April 2014 we also became a partner in the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care for Greater Manchester (GM CLAHRC) - projects being pursued in the first two years include patient centred care (facilitating a holistic and coordinated approach to patients and mental multi-morbidity & Improving patient access to information and care), primary care (Improving vascular health in primary care and using research in practice) and community services (wound care and End-of-life care).

The CCG’s leadership of the Caring Together programme and its involvement in the pioneer integration programme will continue to provide the CCG with significant opportunities to develop and share innovative approaches to new care systems, locally, regionally and nationally.

2.19 Promoting Education and Training

As a CCG, we have a duty when exercising our functions, to have regard to the need to promote education and training for our employees (Section 14Z NHS Act 2006). We actively encourage our staff to attend organisational and personal development opportunities. We have adopted an annual appraisal system in order to support performance and development of our staff, which is further underpinned by regular 1-1’s between line managers and their staff.
2.20 Progress against agreed targets

NHS Eastern Cheshire CCG is proud of the improvements that have been made in the period 2013/14 – our first full year in operation as a statutory NHS body - and it is a positive reflection of the commitment of our members and staff to focus on the need for both short term continuous improvement in the quality and access to care whilst leading substantial long term transformation programmes.

The CCG recognises that more needs to be done to address those areas where the CCG has yet to achieve the improvement we have set ourselves. These will become the areas of additional focus during 2014/15.

Figure 9 indicates the progress the CCG has made to date (March 2014) against these measures.

For the small number of areas where we did not achieve our targeted level of improvement for the year, we have identified within our 2014/15 operational plan, clear priority areas for improvement. These are:

- **Readmission** – local quality premium initiative for this year
- **Pressure Ulcers** – forms part of a harm free care scheme that is included in our quality and improvement programme
- **IAPT** – improving waiting times for IAPT is a key strand of our mental health programme

NHS Eastern Cheshire CCG is committed to ensuring that its local population has access to services that are fully compliant with the standards set out in the NHS Constitution. Through our five year strategic plan we will maintain the same focus shown in 2013/14 in the years ahead working in partnership with our providers.

**Delivering against the NHS Constitution.**

NHS Eastern Cheshire CCG has delivered the NHS Constitutional targets consistently well across all indicators (Figure 10). The only exceptions are:

- “Diagnostics within six weeks of referral” where the CCG fell 0.05% below the 99% standard. This dip in performance was influenced by issues with provision of a community ultrasound service. The CCG responded promptly to address these issues and sourced additional capacity to rectify the issue in the short term whilst undertaking a procurement process to address this in the longer term
- during the year the CCG worked closely with our main provider of services, East Cheshire NHS Trust, to ensure that improved performance was achieved in both 18 weeks Referral to Treatment and four hour wait in A&E were achieved. This resulted in a successful year of performance for the CCG.
<table>
<thead>
<tr>
<th>National/Local</th>
<th>Measure</th>
<th>Status</th>
<th>Target</th>
<th>Performance</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>National</td>
<td>Emergency Admissions</td>
<td>Achieving</td>
<td>5% reduction by March 2016</td>
<td>3.46% reduction in year 1</td>
<td>The CCG is on target to achieve its three year objective</td>
</tr>
<tr>
<td>National</td>
<td>Clostridium Difficile</td>
<td>Achieving</td>
<td>27% reduction on 2012/13</td>
<td>48.4% reduction</td>
<td>The CCG achieved a significant reduction ahead of the national expectation</td>
</tr>
<tr>
<td>National</td>
<td>Friends and Family Test</td>
<td>Achieved</td>
<td>Rollout to national timetable</td>
<td>Rollout complete within timeframe</td>
<td>FFT was rolled out to A&amp;E, Inpatient Wards and Maternity</td>
</tr>
<tr>
<td>National</td>
<td>Potential Years Life Lost</td>
<td>Awaiting</td>
<td>3.2% reduction by March 2014</td>
<td>Awaiting data</td>
<td>Data not available until September 2014</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Readmissions</td>
<td>Failing</td>
<td>5% reduction by March 2014</td>
<td>4.62% increase</td>
<td>Levels did not fall by the 5% projected remaining consistent with the levels in the previous year (until spike in Feb/March)</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Primary Mental Health</td>
<td>Achieved</td>
<td>15% Increase by March 2014</td>
<td>15.86% increase</td>
<td>15% more people gained access to IAPT[^36] and CAMHS[^37]</td>
</tr>
<tr>
<td>Local Priority</td>
<td>Feeling Supported</td>
<td>Awaiting</td>
<td>55% of people feeling managed to support condition</td>
<td>Awaiting data (last survey 53.5%)</td>
<td>Data not available until July 2014</td>
</tr>
<tr>
<td>Other Local</td>
<td>Pressure Ulcer Reduction</td>
<td>Failed</td>
<td>30 % decrease on 12/13 by March 2014</td>
<td>17.9% increase</td>
<td>The CCG did not see the level of reduction planned for, although this may be partially due to “improved reporting”</td>
</tr>
<tr>
<td>Other Local</td>
<td>Falls Reduction in Hospital</td>
<td>Part Achieved</td>
<td>7.5% reduction on 12/13 in falls and falls with harm</td>
<td>All Falls = 9.16% reduction falls with harm= 3.78%</td>
<td>Although there were reductions in “all falls” and “falls with harm” the rate of reduction was lower than planned in the “falls with harm” category. Reporting was targeted leading to improved staff “awareness” and reporting</td>
</tr>
<tr>
<td>Other Local</td>
<td>Emergency Cancer Presentation</td>
<td>Achieving</td>
<td>30% reduction by March 2015</td>
<td>20.5% reduction</td>
<td>The CCG is on target to achieve its 2 year objective</td>
</tr>
<tr>
<td>Other Local</td>
<td>IAPT Waiting Times</td>
<td>Failed</td>
<td>15% reduction in people waiting more than 28 days by March 2014</td>
<td>67.1% increase</td>
<td>Whilst the headline performance looks poor significant improvements were made in the later part of 2013-14</td>
</tr>
<tr>
<td>Other Local</td>
<td>Alcohol “brief interventions”</td>
<td>Achieved</td>
<td>80% of appropriate staff by March 2014</td>
<td>Over 80% staff trained</td>
<td>East Cheshire NHS Trust and Primary Care trained the planned clinical staff to deliver “IBA”[^38]</td>
</tr>
</tbody>
</table>

[^36]: IAPT - Improving Access to Psychological Therapies
[^37]: CAMHS - Children’s and Adults Mental Health Services
[^38]: IBA - Identification and Brief Advice

Figure 9: 2013/14 progress against agreed objectives (as of March 2014)
**Figure 10: Our performance against the NHS constitution measures**

<table>
<thead>
<tr>
<th>Referral to Treatment Waiting Times</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>90%</td>
<td>91.83%</td>
</tr>
<tr>
<td>Non-admitted patients to start treatment within a maximum of 18 weeks from referral</td>
<td>95%</td>
<td>97.14%</td>
</tr>
<tr>
<td>Patients on incomplete non-emergency pathways (yet to start treatment) should have been waiting no more than 18 weeks from referral</td>
<td>92%</td>
<td>94.56%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diagnostic waiting Times</th>
<th>Target</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waiting for a diagnostic test should have been waiting less than 6 weeks from referral</td>
<td>99%</td>
<td>98.95%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A &amp; E Waits</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients should be admitted, transferred or discharged within 4 hours of their arrival at an A&amp;E department</td>
<td>95%</td>
<td>95.25%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer Waits – 2 Week Wait</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with suspected cancer by a GP</td>
<td>93%</td>
<td>97.67%</td>
</tr>
<tr>
<td>Maximum two-week wait for first outpatient appointment for patients referred urgently with breast symptoms (where cancer was not initially suspected)</td>
<td>93%</td>
<td>95.68%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer Waiting – 31 days</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum one month (31-day) wait from diagnosis to first definitive treatment for all cancers</td>
<td>96%</td>
<td>98.06%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is surgery</td>
<td>94%</td>
<td>99.50%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where that treatment is an anti-cancer drug regimen</td>
<td>98%</td>
<td>100%</td>
</tr>
<tr>
<td>Maximum 31-day wait for subsequent treatment where the treatment is a course of radiotherapy</td>
<td>94%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer waits – 62 days</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum two month (62-day) wait from urgent GP referral to first definitive treatment for cancer</td>
<td>85%</td>
<td>86.94%</td>
</tr>
<tr>
<td>Maximum 62-day wait from referral from an NHS screening service to first definitive treatment for all cancers</td>
<td>90%</td>
<td>91.57%</td>
</tr>
<tr>
<td>Maximum 62-day wait for first definitive treatment following a consultant's decision to upgrade the priority of the patient (all cancers)</td>
<td>No standard set</td>
<td>94.29%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Category Ambulance Calls</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 1</td>
<td>75%</td>
<td>75.90%</td>
</tr>
<tr>
<td>Category A calls resulting in an emergency response arriving within 8 minutes - Red 2</td>
<td>75%</td>
<td>77.40%</td>
</tr>
<tr>
<td>Category A calls resulting in an ambulance arriving at the scene within 19 minutes</td>
<td>95%</td>
<td>95.80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mixed Sex Accommodation Breaches</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimise Breaches</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancelled Operations</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice.</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Programme Approach (CPA): The proportion of people under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care during the period</td>
<td>95%</td>
<td>Q1: 96.3%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q2: 96.6%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q3: 95.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Q4: 97.1%</td>
</tr>
</tbody>
</table>
2.22 Risk Management and principal risks

NHS Eastern Cheshire CCG adopts an embedded risk management framework, as detailed in the annual governance statement in the NHS Eastern Cheshire CCG Annual Report and Accounts 2013/14. The annual governance statement identifies the following key risks and uncertainties together with related controls:

- Caring Together Programme
- business information systems
- underlying financial deficit and delivery of QIPP plans
- delivery of the operational plan.
- capacity of mental health services
- capacity of local dermatology services
- appointment of a new designated doctor for safeguarding of children.

The CCG has developed systems to identify, assess and monitor risk with mitigating action plans developed and implemented at an operational level with oversight through the Governing Body and its subcommittees.

2.23 Sustainability report

NHS Eastern Cheshire CCG intends to develop and implement a CCG Sustainability Development Management Plan which will be put forward mid 2014 for consideration by the Governing Body. Consideration will be given with regards to how CCG policies and strategies, such as flexible working, lease car policies and Information and Communication Technology strategy can contribute towards meeting our sustainability obligations.

As a new organisation, the CCG will work towards ensuring that it meets its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. The CCG is also progressing towards setting out its commitments as a socially responsible employer.

The CCG recognises that its biggest impact can be made with regards to how it commissions and procure services. The CCG is committed to ensuring that within all of its commissioning and procurement processes that it asks all of its providers to ensure that they are committed to delivering the sustainability agenda, as detailed by NHS England and the NHS Sustainable Development Unit.

Meeting the needs of today without compromising the needs of tomorrow is a key driver of the Caring Together Programme. This programme of change typifies the CCGs approach to commissioning for sustainable development in that end goals include saving money, saving resources and benefiting staff and patients.

2.24 Equality and Diversity

We understand that certain communities face disadvantages in relation to accessing health and wellbeing services and some experience unequal outcomes and the CCG will ensure that we consider the needs of our population when making commissioning decisions through a variety of mechanisms including:

- a NHS Eastern Cheshire CCG Equality and Human Rights Plan underpinning our approach to the agenda
- setting equality objectives which are specific and measurable and which can be updated on an annual basis. Our current equality objectives are:
  - to ensure accessibility to services and information
  - to develop joint consultation and engagement
  - to ensure the equality of opportunity in employment and training provision
  - to improve the JSNA to provide a greater understanding of the Eastern Cheshire population
  - using the Equality Delivery System (EDS) to enable us to measure our own performance on equality and diversity and support us to set Equality objectives. The CCG is currently undertaking EDS2 for 2014/15 and are looking at developing innovative and continuous models of assessment
  - to monitor the performance of our providers through robust contractual requirements via the quality contract schedule
  - undertaking Equality Impact Assessments across a range of key functions
  - consulting and engaging with communities across the populations we serve
  - ensuring our staff are fully engaged.

NHS Eastern Cheshire CCG has commissioned Pathways Community Interest Company to undertake community development work with our Black, Minority and Ethnic
communities to help us understand how our population access services, and what support is needed to promote positive health and wellbeing. The CCG has also sought specific advice in relation to consultation processes in order to ensure we apply both our statutory duties and best practice.

Key sources of information about population outcomes and experience of care used by the CCG are:

- Cheshire East JSNA
- the Annual Report of the Director of Public Health
- patient experience of care from Friends and Family test, patient related outcome measures and patient surveys (for planning new services). Further, HealthWatch and East Cheshire’s HealthVoice feedback directly to the local Health and WellBeing Board and to the CCG Governing Body respectively
- ‘Commissioning for Value’ and CCG Outcomes Packs information about outcomes at CCG level
- Quality Outcomes Framework Primary Care Data

The CCG commissioning intentions and two year plan are produced with regard to the above information.

It is recognised that reducing inequalities in outcomes requires a multiagency effort. For example, the local public health department commission smoking cessation services and NHS Health Checks, whilst NHS England commission screening programmes for breast, cervical, colorectal cancers, and for aortic aneurysm. The CCG contributes to this whole system effort both through its direct commissioning responsibilities, and by working with partners as part of the Health and Wellbeing Board.

Towards this end the CCG commissions or plans to commission (not exhaustive):

- providers to deliver a ‘Every Contact Counts’ approach thus maximising opportunities for people to take a fuller preventive approach to looking after their health
- secondary prevention for post-myocardial infarction, and for stroke and Transient Ischaemic Attack
- brief advice intervention for alcohol use
- provides Macmillan funded...
training for practice nurses on early recognition and staging of cancer

• implement a system to identify and recall patients with serious mental health or learning disability for health checks

• redesign our primary care mental health service specification to improve access, develop outcomes whilst providing best value for money

• and, although not the direct commissioner of primary care, the CCG recognises it has a local leadership role as a federation of GP practices and is therefore in a key position to advocate for and lead more optimal cardiovascular disease prevention in primary care where improvements can still be made e.g. for sub-optimal blood pressure control, and management of atrial fibrillation to prevent strokes.

2.26 Examples of Outcomes Measures

The CCG will use a range of outcome measures and relevant comparison groups to monitor progress in reducing health inequalities in premature mortality, examples include:

• potential Years of Life Lost from causes amenable to healthcare

• one year survival (lower Gastrointestinal cancer)

• one year survival (lung cancer)

• one year survival (breast cancer)

• people with severe mental illness who have received a list of physical checks

• excess under 60 mortality rate in adults with a learning disability (national outcome measure, data not yet available).

Some CCG outcome measures will be joint indicators with the Public Health outcome and social care outcome indicators and so also offers the joint opportunity to address any inequalities in outcomes where these exist.

2.27 Mental Health Services and meeting the Parity of Esteem health inequalities in our population

NHS England has established a Parity of Esteem Programme in order to focus effort and resources on improving clinical services and health outcomes for those that need access to Mental Health services. Parity of Esteem means:

“My family and I all have access to services which enable us to maintain both our mental and physical wellbeing.”

“If I become unwell I use services which assess and treat mental health disorders or conditions on a par with physical health illnesses.”

Parity of Esteem is important because:

• mental illnesses are very common

• among people under 65, nearly half of all ill health is mental illness

• mental illness is generally more debilitating than most chronic physical conditions

• mental health problems impose a total economic and social cost of over £105bn a year

• only a quarter of all those with mental illness such as depression are in treatment

• we tend to view physical and mental health treatment in separate silos in health services

• people with poor physical health are at higher risk of experiencing mental health problems

• people with poor mental health are more likely to have poor physical health.

As we look to improve the health services for Eastern Cheshire we recognise the importance of ensuring parity of esteem for mental health, not only in the services that are commissioned specifically for the treatment of mental health but also by ensuring parity of accessibility to physical health services for those with mental health conditions.

In order to ensure parity of esteem for mental health we aim to address the 25 areas identified in ‘Closing the Gap: priorities for essential change in mental health47. This information, together with the Eastern Cheshire specific information that will be contained within the Eastern Cheshire Mental Health Strategy, (draft due to be completed summer 2014), will allow commissioners to ensure that commissioning decisions are informed by local context and the drive to ensure parity of esteem for Mental Health. Further details on our plans can be found in Chapter Four.

The Eastern Cheshire parity of esteem programme is currently being developed through discussions with stakeholders but we have identified three areas as initial priorities for urgent focus as part of our five year strategic plan. These are:

• Improving Access to Psychological Therapies (IAPT) – this is a national programme to roll out access to talking therapies for people
suffering from depression and anxiety disorders. Whilst we have made good progress in this area we also know that there is more to provide good access to these invaluable therapies which help patients manage their conditions and improve their quality of life. We have a national ambition by end March 2015 to increase access so that at least 15% of those with anxiety or depression have access to a clinically proven talking therapy services, and that those services will achieve 50% recovery rates.

- Improving diagnosis and support for people with Dementia – we are committed to making considerable progress towards diagnosis, treatment and care of people with dementia by 2015. We recognise that key to this is a diagnosis as this can unlock access to support services. We have a national ambition for two thirds of people with dementia to have received a formal diagnosis and be accessing care and support by end March 2015. We are also working with NHS Choices to provide additional support for people who are newly diagnosed with dementia and their carers, with a new information and webchat service to guide people in the early stages.

- Improving awareness and focus on the duties within the Mental Capacity Act – Concerns have been raised that there is a low level of appreciation of the duties and expectations of CCGs explicit in the Mental Capacity Act, a concern that spans patient groups such as those with enduring mental illness and people with dementia. The Act is of central importance in delivering healthcare. Where difficult decisions may need to be made in balancing the patients’ rights to make decisions about their care and treatment with the right to be protected from harm, and requiring others to act in the patient’s ‘best interests’ where they lack capacity for a particular decision.

45 Public Health Outcomes Framework http://www.phoutcomes.info/
Chapter 3: 
Developing our five year strategic plan
3.1 National and local factors driving our planning process

NHS Eastern Cheshire CCG is committed to radically reshaping the delivery of care with the aim is to improve the health and wellbeing of the citizens of Eastern Cheshire and the quality and experience of the care they receive, and to do so with the resources available. In defining what this means the CCG reviews the national and local drivers which influence our planning processes (Figure 11).

**Figure 11: Summary of local and national factors driving our planning process**

<table>
<thead>
<tr>
<th>National Drivers</th>
<th>Local Drivers</th>
<th>Operational Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Citizen Participation and Empowerment</td>
<td>Statutory Responsibilities</td>
<td>Our Statutory Duties</td>
</tr>
<tr>
<td>Wider Primary Care provided at scale</td>
<td>Better Care Fund</td>
<td>Proactive and Urgent Care</td>
</tr>
<tr>
<td>A modern model of integrated care</td>
<td>Changing Demographic</td>
<td>Mental Health</td>
</tr>
<tr>
<td>Access to the highest quality urgent and emergency care</td>
<td>Improving Health Outcomes</td>
<td>Quality of Services and Pathways</td>
</tr>
<tr>
<td>A step change in the productivity of primary care</td>
<td>Financial Sustainability</td>
<td>Learning Disability</td>
</tr>
<tr>
<td>Specialised services concentrated in centres of excellence</td>
<td>Levels of Access</td>
<td>Children, Young People and Transition</td>
</tr>
<tr>
<td></td>
<td>Quality and Safety of Services</td>
<td>QIPP</td>
</tr>
<tr>
<td></td>
<td>Levels of Patient and Public Satisfaction</td>
<td></td>
</tr>
</tbody>
</table>

Caring Together

- Transformation of primary care
- Development of a new integrated community care
- Reconfiguration of acute care
- A range of productivity initiatives to underpin the transformation programme
3.2 Implementation Timeline

**Figure 12:** Implementation timeline for the Caring Together, Better Care Fund and our Two Year Operational Plans
4.1 Introduction
The Caring Together Programme is at the heart of NHS Eastern Cheshire’s five year strategic plan to support and inspire a radical reshape of how care will be delivered to the citizens of Eastern Cheshire, to provide better, more joined-up consistent, effective and efficient care, which meets their needs and keeps them independent. The Empowered Person sits at the centre of this programme.

The Eastern Cheshire health economy is a system comprised of partners (including NHS Eastern Cheshire CCG, East Cheshire NHS Trust, Cheshire East Council, Cheshire & Wirral Partnership Mental Health Trust, Vernova CIC, North West Ambulance Service and the 23 practices) from across Eastern Cheshire who have come together to agree, refine and implement the Caring Together Programme over the next five years.

Our shared vision is to “join up care, improve outcomes and our citizens experience of care whilst responding to increasing clinical and financial sustainability challenges within an environment of one of the fastest ageing populations in England”.

Caring Together is aiming to transform health and care for all the residents of Eastern Cheshire. However, the effects of the programme will be most focused on the very high risk, high risk, and moderate risk people in the populations. In addition, while children are in scope of the programme, they have not been the focus in this phase and will be incorporated into future phases of work.

Figure 13: Caring Together programme governance structure
4.2 Governance

The “Caring Together” programme has an established governance arrangement and its own risk management framework which support the CCG in delivering its Transformational programme as outlined in the CCGs five year strategic plan. The governance structure shown below shoes how the programme links the programme management structure to the “Caring Together” Executive Board, the CCG Governing Body and the Cheshire East Health and Wellbeing Board.

4.3 Process

Four Care Model Design Groups (CMDGs) were set up to develop the case for change, quality standards and ambitions, and design different parts of the care model. The four CMDGs are:

- Empowered person
- Community-based services
- Primary care
- Acute and specialist.

These groups included clinicians, patient representatives, social services and managers and met fortnightly from January to June 2014. An overarching Care Professionals’ Board co-ordinated the work of the groups and brought the work together into the overall care model.

A Finance and Investment Group comprising Directors of Finance of the Caring Together partners also met fortnightly between January and June to review and agree the affordability analysis.

The Caring Together Executive Board, comprising Chief Executives and Medical Directors of partner organisations, has led the programme and developed the plan.

A series of engagement events with patients and the public, each attended by over 100 participants, have informed the work throughout.

During the life of the programme so far, a linked programme of work has been undertaken in partnership with other CCGs and Trusts to review acute and specialist services across the South Sector. This work has been integrated into this plan although options for the location of acute services have not yet been agreed (these will be incorporated into the plan once agreed, but the plan is not dependent on them).

Caring Together will incorporate three key components:

- the delivery of integrated care in the community
- securing high quality local and regional specialist acute care, through collaboration with the Healthier Together Programme
- delivering increased efficiency and productivity across the local health and care economy, to ensure future financial sustainability.

4.4 Caring Together Vision

The vision of an integrated – or joined up - care system in Eastern Cheshire has existed for some time. The understanding that radical change must be made to the care system to ensure that the provision of care is sustainable was further informed through international experience and evidence that is being used to inform a new approach to health and social care system and service design. This has included visits to Kaiser Permanente, USA and Jönköping, Sweden. The overall vision for the Caring Together programme is:

Joining up local care for all our wellbeing.

For people this means: “I am supported to live well and stay well because I can access joined up care and support when I need it.”

For care staff this means: “Supporting people to live well. By supporting people to access joined up care when it is needed, we support them to stay well”.

Caring Together programme
4.5 Caring Together Values
The Caring Together programme incorporates the following values:
• promote self-care and management, health promotion, education and individual responsibility where appropriate, and for care workers and people and their carers to work together with access to the required support and facilities to make this happen
• ensure collaborative working between health and social workers and colleagues in the private, voluntary and third sector to meet the needs of people, and respecting the needs of staff to achieve this
• promote innovation, and encourage new ideas from local people and carers and staff.

4.6 Caring Together Principles
Our care system should:
• be organised around the needs of individuals (patient-centred)
• focus always on the goal of benefiting service users
• be evaluated by its outcomes, especially those which service users themselves report
• include community and voluntary sector contributions
• be fully inclusive of all communities in the locality
• be designed together with the users of services and their carers
• deliver a new deal for people with long term conditions
• respond to carers as well as the people they are caring for
• be driven forwards by the commissioners
• be encouraged through incentives
• aim to achieve public and social value, not just to save money
• last over time and be allowed to experiment.

4.7 Caring Together Ambitions
We have worked together with our citizens, clinicians, care professional to develop a clear set of ambitions for how care services will be provided in Eastern Cheshire in the future. These ambitions are fully supported by the CCG and all its partners in the Caring Together programme. Against each of our ambitions we have developed and agreed a set of overarching quality standard statements which in the eyes of a citizen will demonstrate how we are delivering our ambitions. To deliver these ambitions and quality standards our five
year strategic plan will require the future care model to be commissioned to achieve each of the following

• wider primary care provided at scale: Utilisation of community assets and empowering people to effectively engage with a managed primary care delivery model in partnership with NHS England CWW Area Team and our 23 member practices to deliver 100% access to clinicians working in primary care

• a new model of integrated care: The development of a new Integrated Community care model leading to a whole system partnership in Eastern Cheshire to deliver Risk stratification, neighbourhood teams, care planning, care coordination and case management. This is aligned to the Connecting Care across Cheshire Pioneer programme and the Better Care Fund

• transformed Acute Care: Community services supported by local hospital specialist enabled through the reconfiguration of acute care in partnership with healthier together programme and the challenged health economy initiative

• a range of productivity initiatives and continuous improvement plans delivered through our Operational Plans and are under pinned by the transformation programme.

4.8 The Future – What would great services look like in Eastern Cheshire?

Over the last 18 months we have worked with our citizens and care professionals to establish what great services will look like in the future. We do not have predetermined solutions at this stage but we have established the Caring Together framework and aspirations from which a new model of care will be developed.

Based on this feedback the local clinical, health and social care leaders believe that all those living in Eastern Cheshire should:

**Have access to more information**

• in ‘plain English’ and other languages, delivered with compassion and humanity with a treatment plan, including when specific treatments will happen, what they are to be and what effect is expected

• providing guidance on a healthy and active lifestyle, and on how to best use local services when they are needed

• to be actively listened to, as a patient, parent, child, partner or carer.

**Be supported by new, better community services**

• such as ‘wellness services’, helping people to live healthy and active lifestyles, reduce social isolation and loneliness, and provide support for carers

• such as friendly, helpful, listening and supportive care staff across community and social services, GP practices and hospitals, who treat people as individuals

• with a flexible appointment system to suit needs, advise and signpost accordingly

• acting with compassion, empathy and respect, putting the patient and their family / carers at the centre

• with care staff sharing information between themselves and with the patient, carer and their family, to build a trusting, well-informed relationship and stop patients having to repeat their story over and over again

• and know that the implications of a Registered Lasting Power of Attorney – which covers health and welfare – are understood and acted upon by all staff who deal with the public, and that all staff and public information documents cover this.

**Have access to improved specialist services**

• including the very best specialist care, 24 hours a day, seven days a week

• with senior hospital doctors and specialist nurses working more closely with their GP and primary care colleagues

• and could be assured of excellent, early and constructive care, to prevent the worst aspects of long-term conditions from impacting on the lives of sufferers and their carers.

To achieve this, we will need to:

• promote self-care and management, health promotion, education and individual responsibility where appropriate, and for professionals and patients, carers and services users to work together with access
4.9 A future model of care in Eastern Cheshire

The Caring Together Framework set out aspirations for a new integrated health and social care system underpinned by four pillars, or environments, of care:

• **The empowered person:** Proactive empowerment of individuals to take responsibility for their own health

• **Community provided care:** Fully integrated and coordinated community care provided by a multi-professional team

• **Local specialist care:** High quality specialised care delivered within a reasonable distance from people’s home

• **Regional specialised care:** Highly trained specialists delivering world-class care on a regional level.

Caring Together shifts care from reactive and acute care to proactive community based care.

Through the Caring Together programme and the South Sector challenged health programme we are nearing completion of our understanding of what a future care model might look like in Eastern Cheshire.

Figure 15 illustrates how care will be centred on the individual with the vast majority of services delivered as close to home as possible with a range of specialist services delivered in centres of excellence.

The CCG five year strategic plan is committed to commissioning as many services as possible to be delivered close to a person’s home. For all services it is important to commission them to achieve the best possible health outcomes for our local population. It will be important in the future to ensure that services are developed around levels of activity which are sufficient to maintain clinical competence, sustainability and patient safety.

**Figure 15:** Caring Together draft model of care centred around the individual

- A&E
  - Assess
  - Stabilise
  - Observe
  - Treat
  - Transfer

**Priority areas of focus**
- Maternity
- Critical Care
- Acute Surgery
- In-patient Paediatrics
The diagram (Figure 15) represents the approach being taken in Eastern Cheshire. The areas highlighted in blue have been identified by the CCG and the clinicians across Eastern Cheshire as areas that require further review to determine whether they can be commissioned and delivered safely and to the quality standards set out in our ambitions within the boundaries of Eastern Cheshire.

The outer circle shows the type of services where specialist skills are required. These types of services are already commissioned from regional centres of excellence and the CCG will continue to expand this approach in order to ensure safe, sustainable, clinical services and better patient outcomes.

Figure 15 is supported by significant national evidence about how this kind of care can be achieved based on the experiences of service users and research evidence. National Voices states that this kind of best practice, integrated care should:

- be organised around the needs of individuals (patient-centred)
- focus always on the goal of benefiting service users
- be evaluated by its outcomes, especially those which service users themselves report
- include community and voluntary sector contributions
- be fully inclusive of all communities in the locality
- be designed together with the users of services and their carers
- deliver a new deal for people with long term conditions
- respond to carers as well as the people they are caring for
- be driven forwards by the commissioners
- be encouraged through incentives
- aim to achieve public and social value, not just to save money
- last over time and be allowed to experiment”.

4.10 Critical Success factors

- designing and delivering choice, a quality patient and carer experience and public involvement
- understanding the problem as a key to providing the solution
- benefits realization – against agreed outcomes
- managing risk
- culture change through organisational development, engagement and communication activities
- governance arrangements
- Information Management and Technology
- effective mobilisation and implementation.

In achieving this new care system, the CCG expects through its five year strategic plan to see a significant shift in how and where care is provided. In our planning assumptions we expect to see the following significant changes:

- reduction in emergency (non elective) admissions by 25 – 30%
- reduction in planned (elective) admissions by 7 – 12%
- reduction in outpatient appointments by 5- 13%
- reduction in accident & emergency (A&E) attendances by 7-17%
- a significant increase in care provided in the community setting and in the home.

4.11 The Caring Together Programme High Level Implementation plan

Figure 16 outlines the investment and the activity shift forecasted over the next five years.
**Figure 16: The Caring Together programme high level five year timeline**

**Ramp-up plan to 2018/19**

**Consistent investment in signposting and self-care resources to empower individuals**

**Workforce development and estates investment**

**Establishment of prerequisites to deliver Caring Together**

- Planning phase
- Creating service and job specifications
- Business case development

**Focus on core areas that will create a base to release savings**

- Care coordination: begin assigning
- Care planning: all VHR and HR have one
- Risk stratification: all of population is risk stratified
- IT investment is started
- Ensure all eligible have a named GP

**Expand core areas to cover all targeted groups**

- Care coordination: all VHR, HR, and 30% of MR have a care coordinator
- Care plans are for top 20% of risky patients
- Risk stratification lists are reviewed
- Invest in MDTs
- Rapid response team put in place for those with care coordinators
- Ramp-up of IT investment

**Continue to expand core components; begin investment in new innovations**

- Care coordinators, care plans, and risk stratification functioning
- Rapid response teams in each locality available to whole population
- Discharge support teams operation in each locality
- Begin investment in SPA and short-term care
- Ensure MDTs running regularly

**Expand innovative programmes while consistently improving core elements of care**

- Expand short-term care and SPA to be available to whole population where relevant
- Ensure all core elements running in a fully integrated way
- Integrated IT system working across the patch for the whole population
- Full implementation of specialists inputing into the community
- Comprehensive performance review of progress in the system thus far

<table>
<thead>
<tr>
<th>Year</th>
<th>Investment</th>
<th>Activity Shift</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>£0M</td>
<td>0%</td>
</tr>
<tr>
<td>2015/16</td>
<td>24%</td>
<td>10%</td>
</tr>
<tr>
<td>2016/17</td>
<td>24%</td>
<td>30%</td>
</tr>
<tr>
<td>2017/18</td>
<td>26%</td>
<td>70%</td>
</tr>
<tr>
<td>2018/19</td>
<td>26%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Figures shown are for low investment scenario.

HR – high risk  VHR – very high risk  SPA – single point of access  MDT – multi-disciplinary team
Chapter 5:
NHS Eastern Cheshire CCG
Two Year Operational Plan
2014/15 to 2015/16
5.1 Developing the Two Year Operational Plan

5.1.1. Commissioning Intentions

In developing the CCG commissioning intentions the CCG considered not only the nationally defined priorities included in the “Everyone Counts” planning guidance, but also a range of local and nationally sourced information. Within the Everyone Counts guidance the five outcome domains and seven ambitions, set by NHS England, have been carefully reviewed and considered when developing our commissioning intentions. The seven ambitions include:

- securing additional years of life for the people of England with treatable mental and physical health conditions
- improving the health related quality of life of the 15 million+ people with one or more long-term condition, including mental health conditions
- reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital
- increasing the proportion of older people living independently at home following discharge from hospital
- increasing the number of people with mental and physical health conditions having a positive experience of hospital care
- increasing the number of people with mental and physical health conditions having a positive experience of care outside hospital, in general practice and in the community
- making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care.

The local sources reviewed to form the commissioning intentions include Joint Strategic Needs Assessment, Cheshire East Health and Wellbeing Strategy, Annual Report of the Director of Public Health, feedback from Locality Practices and Eastern Cheshire Community HealthVoice, Quality Outcomes Framework Primary Care data and intelligence drawn from our contracts with existing providers.

A set of tools have also been issued nationally to benchmark the CCG performance against a range of outcomes, including CCG Outcomes Pack, Atlas of Opportunity, “Any town health system” guides, “Commissioning for Prevention” and Commissioning for Value Packs. These packs have allowed the CCG to identify the greatest opportunities for improvement.

Following assessment of all these data sources the CCG was able to produce a long list of initiatives which is then prioritised using a prioritisation matrix which has been developed for the CCG by Cheshire East Council Public Health, and which was also used to develop our previous year’s priorities. This prioritised list has then been validated by the CCG, clinical leads, Cheshire East Council Public Health Team and Eastern Cheshire Community HealthVoice.

5.1.2 Outcome Measures

NHS England included within the Everyone Counts guidance indicators from the NHS Outcomes Framework which are grouped around five domains. These set out the high level national outcomes that the NHS should be aiming to improve. For each domain, there are a small number of overarching indicators followed by a number of improvement areas. They focus on improving health and reducing health inequalities.

Whilst the CCG performs well against many of the nationally measured indicators compared to our peer CCGs, there does remain opportunities to improve in many areas. The CCG has set itself challenging improvement trajectories against all these indicators as well as a range of locally identified improvement areas.

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5.1.3 Eastern Cheshire CCG Improvement trajectories against national outcome priorities

Figures 17 to 21 and Appendix B show the five year projections for improvement against the national outcomes in Eastern Cheshire. In developing these projections, the CCG considered our baseline performance, as well as the ambition of our trajectory, in comparison to the ten CCG’s across England who are most similar to us in terms of demographic composition.

**Figure 17:** Our ambition for securing additional years of life from conditions considered amenable to healthcare

<table>
<thead>
<tr>
<th>Year</th>
<th>PYLL (per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1743.20</td>
</tr>
<tr>
<td>2014/15</td>
<td>1730.10</td>
</tr>
<tr>
<td>2015/16</td>
<td>1717.10</td>
</tr>
<tr>
<td>2016/17</td>
<td>1697.90</td>
</tr>
<tr>
<td>2017/18</td>
<td>1656.00</td>
</tr>
<tr>
<td>2018/19</td>
<td>1553.50</td>
</tr>
</tbody>
</table>

We are the third best performing best performing CCG in our peer group and have set an 11% reduction over the 5 year planning timeframe.

**Figure 18:** Our ambition for improving the health-related quality of life for people with long-term conditions

<table>
<thead>
<tr>
<th>Year</th>
<th>Average EQ-5D score for people reporting having one or more long-term condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011/12</td>
<td>76.44</td>
</tr>
<tr>
<td>2012/13</td>
<td>77.46</td>
</tr>
<tr>
<td>Baseline</td>
<td>77.50</td>
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<tr>
<td>2014/15</td>
<td>78.10</td>
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<tr>
<td>2015/16</td>
<td>78.70</td>
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<tr>
<td>2016/17</td>
<td>79.50</td>
</tr>
<tr>
<td>2017/18</td>
<td>80.20</td>
</tr>
<tr>
<td>2018/19</td>
<td>81.00</td>
</tr>
</tbody>
</table>

The CCG is currently ranked highest (best) of our ten peer CCG’s. Our improvement ambition would stretch our performance but still leaves us “best in peer group”.

**Figure 19:** Our ambition for reducing emergency admissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Emergency admissions composite indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>1907.48</td>
</tr>
<tr>
<td>2010/11</td>
<td>2028.18</td>
</tr>
<tr>
<td>2011/12</td>
<td>1990.04</td>
</tr>
<tr>
<td>2012/13</td>
<td>2026.62</td>
</tr>
<tr>
<td>Baseline</td>
<td>2026.60</td>
</tr>
<tr>
<td>2014/15</td>
<td>2026.60</td>
</tr>
<tr>
<td>2015/16</td>
<td>1901.60</td>
</tr>
<tr>
<td>2016/17</td>
<td>1791.60</td>
</tr>
<tr>
<td>2017/18</td>
<td>1670.00</td>
</tr>
<tr>
<td>2018/19</td>
<td>1520.00</td>
</tr>
</tbody>
</table>

The CCG is currently 6th in our CCG peer group. We aspire to achieve a 25% reduction in our admissions which is the third largest reduction of this cohort of CCGs.
Figure 20: Our ambition for increasing the proportion of people having a positive experience of healthcare

<table>
<thead>
<tr>
<th>Year</th>
<th>The proportion of people reporting poor patient experience of inpatient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>139.78</td>
</tr>
<tr>
<td>Baseline</td>
<td>139.80</td>
</tr>
<tr>
<td>2014/15</td>
<td>138.00</td>
</tr>
<tr>
<td>2015/16</td>
<td>137.50</td>
</tr>
<tr>
<td>2016/17</td>
<td>137.00</td>
</tr>
<tr>
<td>2017/18</td>
<td>136.50</td>
</tr>
<tr>
<td>2018/19</td>
<td>136.00</td>
</tr>
</tbody>
</table>

For this indicator we have the second best baseline of our peer CCGs.

Figure 21: Our ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community

<table>
<thead>
<tr>
<th>Year</th>
<th>The proportion of people reporting poor patient experience of inpatient care</th>
</tr>
</thead>
<tbody>
<tr>
<td>2012</td>
<td>3.34</td>
</tr>
<tr>
<td>Baseline</td>
<td>3.30</td>
</tr>
<tr>
<td>2014/15</td>
<td>3.25</td>
</tr>
<tr>
<td>2015/16</td>
<td>3.18</td>
</tr>
<tr>
<td>2016/17</td>
<td>3.08</td>
</tr>
<tr>
<td>2017/18</td>
<td>2.96</td>
</tr>
<tr>
<td>2018/19</td>
<td>2.80</td>
</tr>
</tbody>
</table>

We are currently the best performing of our peer CCG’s. We have set a stretching 15% improvement to continue this performance (Figure 21).

Appendix C also indicates our activity projections for the five year period.

5.1.4 Change Initiatives
The CCG has defined a range of projects which will support delivery of the longer term strategic objectives which form our Caring Together Programme whilst also helping deliver our more immediate operational planning priorities. Within these plans the CCG has identified a range of outcome measures which will measure the impact of these changes on the health of our population.

5.2 Two Year Operational Plan
The CCGs Two Year Operational plan has been developed to address immediate operational and quality improvement initiatives and to capture the full range of innovative pilots and early adopter innovations that support delivery of the Caring Together Transformation Programme across the full five year time period covered in this document.

The operational plan covers the following five thematic areas;
- Proactive & Urgent Care
- Mental Health
- Learning Disabilities
- Improving Quality of Services & Care Pathways
- Children, Young People & Transition.
5.3 Proactive and Urgent Care Programme

There is a key national imperative to increasingly move the delivery of care from a hospital closer to the patient’s home. In Eastern Cheshire this is a core principle of the Caring Together Programme, and as part of an iterative development of services to meet this objective, a range of initiatives have been developed as part of our Operational Plan:

• commissioning of Urgent Primary Care Services – This programme includes the commissioning of a Primary Urgent Care service which allows rapid GP response to patients in need of urgent GP assessment to avoid a potential conveyance to an A&E department or admission to hospital. In addition the programme will focus on development of a revised NHS 111 offer and implementation of NHS Pathways
• as part of the Better Care Fund we will develop integrated health and social care services specifically including community based stroke rehabilitation as part of the wider development of stroke services which also comprises of completion of the implementation of the hyper-acute stroke model
• expand the care pathways available offering ambulatory care through development of community based treatment services, intermediate care and recovery
• development of an Integrated Model of Care built around a wider Primary Care service, integrated with community services, social care and the third sector with greater emphasis on supporting our population to manage their own health

• implementation and development of risk stratification and case management to identify and support Proactive Management of “high risk” patients. Improve information sharing through effective use of “patient passports” and “shared records”
• identify hidden carers (adult and children) ensuring those entitled to support receive it, signposting to other agencies, support services and information ensuring carers are offered regular health checks.

This work will support providing access to the highest quality urgent and Emergency care. Figure 22 illustrates the draft model of how we intend to deliver this for our population.

Figure 22: Eastern Cheshire draft urgent and unplanned care model to provide high quality urgent and emergency care

- One point of contact: call centre staffed by skilled assessors
- Self managed
- Routine community care appointment
- Telephone screening
- Locality based assessment centre: skilled generalist and specialist professionals diagnostics directory of services shared care record
- Health and social care assessment of need using assistive technology and domiciliary teams
- Specialist community elderly care teams
- Urgent care response
- Rapid home assessment care planning and monitoring of acute episode
- Integrated community teams
- On going care coordination and delivery
- Hospital services via 999 or self transport
- Local services via 999 or self transport
5.4 Mental Health Programme

Eastern Cheshire has seen historic underinvestment in mental health services which the CCG has inherited from its predecessor organisations. This creates a real challenge in delivering the national Parity of Esteem objective to rebalance investment in mental health compared to physical health services. The CCG is however committed to development of mental health services.

During the first half of 2014-15 the CCG is constructing a detailed mental health strategy and implementation plan which will achieve this objective over the next 5 years. This plan will be developed alongside our co-commissioners, providers, service users and the third sector to target investment at those services which will deliver the greatest clinical return on investment for our population. Whilst this longer term plan is being developed the CCG has already identified the following schemes which it will be implementing as part of our two year operational plan:

- **Children and Adolescent Mental Health Services 16-19 and Transition:** assess the capacity and demand of the service currently available; and as a result improve access and the pathway to adult services
- **Access to primary mental health:** commission additional community support and wellbeing options, re-design the current primary mental health model
- **Psychiatric Liaison:** extending operating hours and capacity of liaison psychiatry services and develop links with general health providers of urgent care services
- **Physical Health checks:** put new measures/procedures in place to ensure that all people with serious mental illness receive regular physical health checks
- **Dementia:** Implement case finding initiatives to identify those with dementia and introduce best practice dementia care including increasing and improving the post diagnostic support available, move towards more locally based services.

These schemes and intentions are summarised in Figure 23. The CCG will also continue to develop plans to implement the national requirements to implement choice of mental health provider and Payment by Results as a funding mechanism.

5.5 Learning Disabilities

Working with our Health and Wellbeing partners we will:

- deliver the Life Course Review for Learning Disabilities. This project will ensure a major whole system review of Learning Disability and Autism Spectrum Disorder support and provision. We will work with partners to take a whole life (birth to death) view of individual and carer needs, service requirements, and efficient use of the public funding that will secure new integrated pathways of care
- the CCG will continue to develop proactive health checks for those members of our population with learning disability in order to improve the health outcomes of this population
- develop CCG capability to meet new statutory responsibilities for children with Special Educational Needs and Disability.

5.6 Improving Quality of Services and Care Pathways

Whilst the CCG generally performs well, in comparison to its peers, in relation to many national quality metrics we have identified the following areas as those with greatest opportunity for improvement:

- continue to implement a whole health economy approach to patient safety and avoidance of patient harm. This work specifically focusses on pressure ulcers, healthcare acquired infections, falls in a hospital setting and ensuring 24-7 care standards
- ensuring systems support consistently safe prescribing practice
- development of the Eastern Cheshire prescribing formulary
- reduce inequalities in cancer mortality across our geography through early recognition & Staging of Cancer. This will include providing Macmillan Funded Training for Practice Nurses
- continuous improvement in bringing services closer to home, including development of more local chemotherapy services
- develop and implement a quality framework for care homes, re-commissioning care homes doctors enhanced service and expansion of the support available to include. multi-professional support through neighbourhood teams
- re-procure Community
### MENTAL HEALTH AND SUBSTANCE MISUSE PROGRAMME

**Inspiring Better Health and Wellbeing**  
**Valuing People, Working Together, Innovation, Quality, Investing Responsibly**

<table>
<thead>
<tr>
<th>Context</th>
<th>Health Need Priorities</th>
<th>Projects</th>
<th>Priority Areas</th>
</tr>
</thead>
</table>
| • Inadequate resources for Mental Health commissioning.  
• Current health & social care system is not sustainable.  
• Growing demographic demand.  
• Rapidly growing aging population.  
• Need to drive up best standards of care.  
• Maintain top quartile mortality rates.  
• Improve peoples experience of care.  
• Need to maximise social assets and create social accountability.  
• Better use of staff skills & time.  
• Financial deficit. | • To protect our citizens from avoidable harm.  
• To prevent people from dying prematurely.  
• To make care more integrated.  
• To ensure high quality, effective mental health services are available to all.  
• To address inequalities. | • 16-19 CAMHS/Transition.  
• Primary Mental Health Provision.  
• Parity of Esteem.  
• Psychiatric Liaison.  
• Dementia Care. | • Assess the capacity of and demand on the 16-19 service and commission accordingly.  
• Expand the scope and capacity of Primary Mental Health services.  
• Ensure that all people with a severe mental illness receive physical health checks.  
• Increase the capacity and move towards 7 day working in Psychiatric Liaison.  
• Introduce best practice Dementia Care. |

**National Measures**

• Secure additional years of life for people with treatable mental and physical health conditions (minimum 3.2%).  
• Increase the proportion of people entering Primary Mental Health services by 15%  
• Achieve the IAPT recovery rate of 50%  
• Increase dementia diagnosis rate to 67%  
• Increase the proportion of older people living independently at home following discharge from hospital.  
• Improve the experience of people using community mental health services.  
• 95% of adults with Mental Health on Care Programme Approach (CPA) who were followed up within 7 days of discharge from psychiatric inpatient care.  
• Identifying the prevalence of depression compared.

**Local Priority Measures**

• Increase the proportion of people feeling supported to manage their condition.  
• Increase the number of people with severe mental illness who have received physical checks.  
• Achievement against IAPT trajectory.

**Other Local Measures**

• Reduce the number of Emergency Admissions.  
• Reduce the number of Emergency Readmissions within 30 days.  
• Reduce by 15% the number of people waiting longer than 28 days to access mental health services.

---

**5.7 Children, Young People and Transition**

The CCG will be focusing on the following:

• ensuring appropriate transition between Children’s & Adults Services covering both Mental Health and Long Term Physical Health  
• commission Redesigned Neurodevelopmental Pathways

---

**Non-Obstetric Ultrasound Diagnostics as well as Wet Age Related Macular Degeneration (AMD) and related macular services**

• apply and disseminate best practice and innovation e.g. through NICE and through engagement with the Academic Health Science Network  
• roll out end of life planning tools across primary care and improve the capture of information regarding patients actively on the Gold Standards Framework  
• continued development of services for Military Veterans.
• empowered parents/children - Increasing the self help and advice offer available in alignment with the Caring Together Programme work-stream
• collaborate with Health and Wellbeing Partners on a joint early help strategy & early years strategy.

5.8 QIPP (Quality, Innovation, Prevention and Productivity)

In addition to the range of schemes described already the CCG has also developed a supplementary number of QIPP initiatives which are focused on improving the quality and efficiency of care delivery. These additional schemes include:

• reducing the variation of clinical practice in relation to secondary care outpatient referrals. This work focuses on those areas where Eastern Cheshire is benchmarked with peers as being an outlier in the way patients are currently being managed and will focus on ENT (Ear, Nose, Throat), Ophthalmology, GI (Gastro Intestinal)
• the CCG will also implement the outcomes of the Cheshire and Merseyside Commissioning Policy Review which has looked at best practice clinical evidence in relation to a range of clinical treatments
• variation in GP prescribing which has been identified through a review of Eastern Cheshire performance compared to peers, using the Better Care Better Value indicators
• re-procurement of the contract for provision of Enteral Feeds, and associated consumables
• a review of secondary care expenditure on “pass through” drugs and devices.

5.9 A step change in the productivity of elective care

Analysis of the Commissioning for Value packs indicates opportunities in Circulatory and Musculoskeletal care and forms part of our operational QIPP plans. Our five year strategic plan for elective care is focused on the wider system reconfiguration that is necessary to support long term productivity gains and will address three key inter-related themes:

• the need to secure long term high quality, sustainable elective care services
• the creation of innovative community based elective care solutions
• maintaining our focus on efficient high quality referrals in-line with our current upper quality performance when compared to our peer group.

Through our involvement in the Healthier Together and the South Sector Challenged economy programmes the CCG will be working in partnership with NHS South Manchester CCG and NHS Stockport CCG to ensure access to sustainable high quality elective services commissioned collaboratively and supporting elective care providers to seek greater network solutions compliant with the Healthier Together standards.

The CCG has a successful track record on increasing access and productivity of elective care by increasing the range of market providers (Audiology, diagnostics, minor surgery etc.) and will continue to expand this commissioning approach in both its two year operational and five year strategic plans. Through the five year plan we expect to achieve a 7.3% reduction in first outpatient appointments and will continue our current trajectory of converting impatient activity to day case surgery.

5.9 Specialised services concentrated in centres of excellence

As part of the South Sector Challenged Health Economy work, which will align services and patient flows within the South Sector it is likely to be proposed that University Hospital South Manchester (UHSM) might be designated as the specialised services provider for relevant specialised services in the South Sector. If this is agreed then NHS Eastern Cheshire CCG patients will have access to UHSM and other specialised services providers.

5.10 Seven day services

We are committed to delivering 7 day access to health and social care services, and have already implemented 7-day working across a number of elements of the health and social care system. The “Caring Together” programme will improve urgent access to primary care in normal and extended hours. Adjustments to NHS 111 and Out of Hours contracts will further improve seven day access to primary care.

5.11 Our Two Year Operational Plan

Our Two Year Operational Plan is summarised in Figure 24.
### Figure 24: Two Year Operational Plan (1/2)

<table>
<thead>
<tr>
<th>Programme</th>
<th>How we will make a difference (Schemes)</th>
<th>Sub Projects</th>
<th>Drivers (Evidence to Support the Intention)</th>
<th>Primary Outcome Measure (%)</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NRS111</td>
<td></td>
<td>Community circle rehabilitation service</td>
<td></td>
<td>19%</td>
<td>21%</td>
<td>36%</td>
<td>37%</td>
<td>36%</td>
<td>35%</td>
</tr>
<tr>
<td></td>
<td>NRS Pathways development</td>
<td></td>
<td>Re-commissioning of hyper-acute services</td>
<td></td>
<td>23%</td>
<td>28%</td>
<td>33%</td>
<td>30%</td>
<td>22%</td>
<td>28%</td>
</tr>
<tr>
<td></td>
<td>AYS Pilot scheme</td>
<td></td>
<td></td>
<td></td>
<td>36%</td>
<td>66%</td>
<td>64%</td>
<td>65%</td>
<td>64%</td>
<td>65%</td>
</tr>
<tr>
<td></td>
<td>Urgent Care Working Group - Development Plans</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Development of integrated health and social care services (BCC) e.g. stroke rehabilitation</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Commission by project teams – including the development of the re-commissioning of hyper-acute services and a 1-week community circle rehabilitation service</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Expanded the Pathways for Ambulatory Care to develop Community-based Treatment Services, intermediate care and recovery</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>AOS pathway development</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
<tr>
<td></td>
<td>Intermediate Care &amp; Research</td>
<td></td>
<td></td>
<td></td>
<td>11%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
<td>12%</td>
<td>13%</td>
</tr>
</tbody>
</table>

**Programmatic Interventions**

- Development of an Integrated Model of Care built around a Primary Care service, integrated with community services, social care and the third sector will enable greater emphasis on supporting people to manage their own health.

- Implementation and development of risk stratification and case management to identify and support proactive management of “high risk” patients. Improving information sharing through effective use of “patient passports” and “shared records.”

- Expanding the concierge service to include multi-professional support through neighborhood teams.

**Learning Disabilities**

- Work in partnership with Health & Wellbeing Board partners to undertake the Life Course Review for Learning Disabilities.

- Develop ESG capability to meet statutory responsibilities for Children with Special Educational Needs (SEN).
### Figure 24: Two Year Operational Plan (2/2)

<table>
<thead>
<tr>
<th>Component</th>
<th>Activity</th>
<th>Goal</th>
<th>Indicator</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Implement a system to identify &amp; recall patients with serious mental illness to health checks</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Developing a community-based memory service for dementia patients</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Improve Access to Services, &amp; promote Dementia friendly Communities through Dementia Alliance</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Vexatives of our primary care mental health service strategy to improve access, develop outcomes while providing best value for money</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Improve Quality of Service &amp; Care Standards</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Continue to implement a whole health economy approach to patient safety, focusing on present access, healthcare acquired infections, falls in hospital setting and 24/7 care</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Continue development of services for military veterans</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Ensuring systems support consistent safe prescribing practice</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Development of the Patient Centric prescribing framework</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provide Maximal Funded Training for Practice Nurses in Early Recognition &amp; Staging of Cancer</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Develop and implement a quality framework for care services</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Re-commission carers homes, doctors service when required</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Re-Process Var. Age Related Necessar Organisation (VARO) and related service</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Apply and disseminate best practice and innovation e.g. through ANGIE and through engagement with the Academic-Service Science Network</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Roll out end of life planning tools across primary care and improve the capture of information regarding patient activity on the Gold Standards Framework</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td><strong>Ensure Access to Various Psychiatric</strong></td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Commitment to Redesign Adult Mental Health Pathways</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Improve access to CAMHS 16-25 years service</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Empower parents &amp; children; increasing the self help and advice offer available</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Support the mental &amp; young people with an NPI plan</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Collaboration on joint early help strategy &amp; early years strategy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

**Table Notes:**
- **Goal:** Indicates the primary outcome that the plan aims to achieve.
- **Indicator:** Represents the key metrics used to measure progress towards the goal.
- **Target:** Specifies the target values for each indicator.

**Additional Resources:**
- People feeling supported to manage their long term condition
- Waiting times for access to appropriate social services
- Achievement of IAPT trajectory
- People with severe Mental Illness who have received a list of physical checks
- Excelinle diagnosis of dementia
- Improving experiences of community mental health services

**Key Performance Indicators (KPIs):**
- Year One: Survival: Lower GI
- Year One: Survival: Lung
- Potential years of life lost (PYLL) from diseases considered amenable to healthcare (cancer, record of diagnosis)
- Year One: Survival: Brain
- Impaired reporting of patients’ safety incidents
- Pressure Sores Frequency (incidence)
- Incidence of C-BOI
- Incidence of MRA
- Falls Prevention (hospital admissions)
- Formulary compliance
- Patient Experience of Hospital Care (negative responses)
- Patient Experience of GP Care and Use of Primary Care (negative responses)
- Bereaved carers’ views on the quality of care in the last 9 months of life
Chapter 6: Extended Primary Care
Extended Primary Care

The CCG needs to expand the Primary Care offering in order to meet the changing needs of our population. In order to facilitate delivering this radical development the CCG is exploring opportunities to extend CCG co-commissioning of Primary Care with NHS England, how the existing Primary Care contract can be adapted to support this changed model as well as ongoing iterative development of aligned incentives to commence the journey of change. In 2014-15 this includes medicines optimisation and a proactive care scheme.

The list of changes below have been developed alongside NHS England Cheshire Warrington and Wirral:

• **Extended Primary Care.** Extended primary care for patients to have access to a wider range of services either delivered directly by Practices or services wrapped around them.

• **Advanced Access and alternative access.** Extended access in primary care that reduces bottle-necks and promotes streamlined access to GP’s through wider availability and whilst differentiating between patients with complex and acute needs and enables proactive management for those with complex needs.

• **Care Coordination.** The care coordinator will coordinate and navigate care and advocate for the patients’ needs creating the team around the person, working with the named GP.

• **Care of Frail Older People and Continuity.** Care of frail older people with complex needs who are often unable to attend surgery and inevitable delays in care can result in an emergency admissions are a major focus for CCGs.

• **Neighbourhood Teams.** Who will be responsible for delivering care on the ground to defined populations. This approach is integral to the care coordination model.

• **Quality Improvement.** Unwarranted variation will be reduced and seek to achieve quality improvements.

• **Shared IT and new technology developments.** To facilitate the development of services an investment in supporting technology will be supported.

• **Systems for Wellness and self-care.** The GP registered list enables GP practices to contribute to promoting the health and well-being of the local community. This supports a change of emphasis by clinical staff to enable patients to develop the skills needed for self-care and self-management.

• **Systems to Improve Capacity.** It is also clear that Practice working patterns are changing with increasingly more non GP appointments being provided and the need to develop systems to change with these patterns.

• **Prescribing and Medicines Optimisation in Primary Care.** A prescribed medicine is the most common health care intervention in primary care, and Clinical Commissioning Groups are responsible for managing the medicines budget as well as seeking to improve outcomes through medicines optimisation. Medicines Optimisation aligns with CCG and Primary Care objectives by:
  • Improving patient experience
  • Reducing referrals and unplanned admissions
  • Reducing medicines waste
  • Improving the quality of care
  • Improving outcomes.

• **Non-Medical Primary Care Independent Contractors.** General practice is a major component of primary care, but the contribution of other independent contractors supports CCG commissioning arrangements. In some cases this will be independent contractors taking on work currently undertaken in secondary care (for example performing eye examinations currently done in ophthalmology clinics) or primary care (for example community pharmacists providing medicines for minor ailments). In other cases, the independent contractors may play an important role within the extended practice team (for example community pharmacists supporting patients with medicines optimisation).
Chapter 7: Five year financial plan and forecast
7.1 Financial Context

Health and social care spending on the citizens of Eastern Cheshire is around £346 million per year (Figure 24). Around a third of this is spent on hospital care, a thirteenth on GP practices (Primary Care), one sixth on community care, one seventh on social care, one twentieth on mental health and the rest on other services such as prescribing and specialist care.

![Figure 24: Healthcare spend in Eastern Cheshire](image)

Despite the comparative protection of Health budgets by the government when compared to other public services we know that the next 5 years is going to be financially challenging. We know that the future pressures and increasing demands on services arising from the increasing age and ill health of our population will compromise the ability of Eastern Cheshire to commission the provision of services whilst remaining within its financial allocations.

The consequence of doing nothing would be that the local health economy would be facing a projected financial shortfall in 2014/15 of £36.9m (11%), rising to £86.2m (26%) in 2018/19. We therefore need to design a new way of providing services that can be delivered within the funding available. As part of designing new services we also need to ensure that our buildings are fit for purpose and fully utilised. We believe this cannot be done by one organisation, but needs to be done across health and social care, with everyone working together.

7.2 Five Year Financial Plan

In its first year of operation (2013/14), NHS Eastern Cheshire CCG has successfully delivered a small but significant surplus of £204,000, despite working within an historical inherited deficit. This has required us to use our resources to cover our expenditure and not deliver the business rules, defined as good practice by NHS England for CCG’s, and included:

- need to have 2% of our resources available to spend on one off items
- deliver a surplus of 1%
- include a contingency of 0.5% of our resources.

During 2013/14, NHS England introduced a new method of allocating money to Clinical Commissioning Groups. The principle adopted in setting new allocations are based on
equity and fairness and take into account three main factors in healthcare needs:

- population growth
- deprivation
- the impact of an ageing population.

This approach starts to address the underlying, historical deficit which NHS Eastern Cheshire CCG inherited.

Figure 25 shows the CCG five year financial forecast and outlines two key elements:

- small but improving surplus on its underlying (ongoing) activities of £300k - £2,522k over the five years.
- Caring Together programme costs.

The delivery of the underlying surplus requires NHS Eastern Cheshire CCG to identify ways of reducing its expenditure to ensure it lives within its funding. The level of efficiency savings (QIPP) required over the five years is a minimum of £18m. The significant majority of these savings will arise from the Caring Together programme.

7.3 Transformation Programme

The Caring Together programme is aiming to transform health and social care for all the citizens of Eastern Cheshire by developing and implementing a new model of care. This challenging task needs to be done within the funding available to ensure the system is viable and sustainable for the future.

To deliver the new model of care requires a different workforce in terms of numbers and skill mix and culture of working. The different types of staff needed have been identified by care component and gaps in demand assessed, revised to reflect productivity improvements over the five years and also where there is an overlap of staff currently providing care which will be required within the new model. The costs of these staff, including training and organisational development have been included in the investment required (Figure 26).

---

**Figure 25: NHS Eastern Cheshire CCG Five year financial forecast**

<table>
<thead>
<tr>
<th></th>
<th>£’000</th>
<th>2014/15</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td></td>
<td>225,551</td>
<td>234,895</td>
<td>242,029</td>
<td>246,708</td>
<td>252,116</td>
</tr>
<tr>
<td>Programme Spend</td>
<td>(222,612)</td>
<td>(233,152)</td>
<td>(241,557)</td>
<td>(245,169)</td>
<td>(249,298)</td>
<td></td>
</tr>
<tr>
<td>QIPP Savings</td>
<td>2,200</td>
<td>3,057</td>
<td>4,514</td>
<td>4,064</td>
<td>4,063</td>
<td></td>
</tr>
<tr>
<td>Underlying Surplus</td>
<td>300</td>
<td>400</td>
<td>600</td>
<td>1,231</td>
<td>2,522</td>
<td></td>
</tr>
<tr>
<td>Caring Together Programme Costs</td>
<td>(2,300)</td>
<td>(200)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Underlying Surplus</td>
<td>(2,000)</td>
<td>200</td>
<td>600</td>
<td>1,231</td>
<td>2,522</td>
<td></td>
</tr>
</tbody>
</table>

**Figure 26: NHS Eastern Cheshire CCG Estimated Caring Together Investment / Savings**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>QIPP Gap (as per 5 year plan)</td>
<td>(2.2)</td>
<td>(5.3)</td>
<td>(9.8)</td>
<td>(13.9)</td>
<td>(18.0)</td>
</tr>
<tr>
<td>Caring Together Investment</td>
<td>0.0</td>
<td>(3.9)</td>
<td>(7.9)</td>
<td>(12.2)</td>
<td>(16.3)</td>
</tr>
<tr>
<td>subtotal - Financial Gap</td>
<td>(2.2)</td>
<td>(9.2)</td>
<td>(17.7)</td>
<td>(26.1)</td>
<td>(34.3)</td>
</tr>
<tr>
<td>QIPP (Non Caring Together)</td>
<td>2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caring Together Savings</td>
<td>2.0</td>
<td>8.2</td>
<td>22.9</td>
<td>44.2</td>
<td></td>
</tr>
<tr>
<td>Total (Deficit)/Surplus</td>
<td>0.0</td>
<td>(7.2)</td>
<td>(9.5)</td>
<td>(3.2)</td>
<td>9.9</td>
</tr>
</tbody>
</table>
The initial Caring Together programme estimates savings on top of our existing QIPP target of between £3.1m - £9.9m by 2018/19, with cumulative savings over the five years of between £31 - £44m.

Figure 27 shows assumptions and financial savings relating only to NHS Eastern Cheshire CCG findings from the transformation programme so far. The wider Health and Social Care economies position is subject to further validation.

These savings are based on the low levels of additional investment required in staffing, IT, Estates, less the predicted reduction in existing acute activity. The reductions that have been used to underpin the financial assumptions are:

- emergency (non elective) admissions by 25 – 30%
- planned (elective) admissions by 7 – 12%,
- outpatient appointments by 5-15%
- accident & emergency (A&E) attendances by 7-17%

The focus of these reductions will concentrate initially on the top 20% of the population who are most at risk of experiencing poor health and currently use 70% of overall health and care resources. The savings are based on benchmarking of GP practices, the CCGs against similar CCGs, evidence from international and UK examples of impact of changing the way care is delivered and interviews with care professionals.

A key risk in implementing this strategy relates to the interim years (2015-2018) where circa £24m of cumulative investment is required, in order to realise the estimated cumulative savings of £44m. The financial modelling provides assurance that the savings are achievable, although further validation and refinement is required. The savings opportunities are significant in value and will lead to a long term financially sustainable future.

The identification of the £24m investment will need to be agreed prior to the transformation programme beginning. Any failure to secure the funding will result in a combination of:-

- Caring Together not implemented in full
- full financial saving opportunities not realised
- longer timeframe to implement
- potential prioritisation of existing services in order to meet the financial gap.

Delivery of a strategic transformational programmes, such as Caring Together, is not without risk which in part is reflected in the range of savings identified and the status of development as a strategy. As part of the financial modelling, sensitivity analysis has been undertaken and an assessment of the degree by which these are subject to change undertaken. This will be refined through the implementation planning.

In order to deliver a strategic transformation change programme of this size, a programme management cost of £2.3m in 2014/15 and £200k in 2015/16 is required in order to achieve the level of savings over the five years. As such the CCG has an approved deficit plan of £2m for 2014/15.

The Caring Together programme is supported both locally and nationally as a way of delivering a sustainable Health and Social Care system for the future. In addition, Eastern Cheshire is part of nationally recognised challenged health economy, encompassing Stockport, South Manchester, Tameside and Eastern Cheshire and is tasked with identifying a financially sustainable solution for the provision of secondary care services. The impact of Caring together is part of that work.

7.4 Better Care Fund

In recognition of the national challenge to improve integrated care, the Government has introduced the Better Care Fund, with initial investment in 2014/15 but implementation of the fund in 2015/16 of £11.6m. For Eastern Cheshire, the Caring Together programme unites a shared vision of NHS Eastern Cheshire CCG and Cheshire East Council for improving outcomes for residents through improving how health and social care services work together.

The Better Care Fund is a supportive enabler to the Caring Together 5 year plan to commission a transformed model of integrated care, which will ensure that residents experience quality care and support that is appropriate to their needs, and supports them to live as independent and fulfilling lives as possible.

The Better Care Fund is a supportive enabler to the Caring Together 5 year plan to commission a transformed model of integrated care, which will ensure that residents experience quality care and support that is appropriate to their needs, and supports them to live as independent and fulfilling lives as possible.

The Caring Together programme will identify those services that are appropriate to be included within the Better Care Fund in order to deliver the expected outcomes.
Figure 27: NHS Eastern Cheshire CCG Estimated Caring Together Savings (based on 20% of population)

Key
- Does not deliver financial balance
- In financial balance up to 1% surplus
- Achieves 1% surplus or more

Forecast net position in 2018/2019

<table>
<thead>
<tr>
<th>Low savings scenario</th>
<th>Medium savings scenario</th>
<th>High savings scenario</th>
</tr>
</thead>
<tbody>
<tr>
<td>High investment</td>
<td>Low investment</td>
<td>Low investment</td>
</tr>
<tr>
<td>Low productivity</td>
<td>High productivity</td>
<td>Low productivity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>High productivity</td>
</tr>
<tr>
<td>-£5.9m</td>
<td>-£1.4m</td>
<td>-£2.7</td>
</tr>
<tr>
<td></td>
<td>£1.8m</td>
<td>£0.5m</td>
</tr>
<tr>
<td></td>
<td></td>
<td>£5.0m</td>
</tr>
</tbody>
</table>

Savings assumptions

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>Medium</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Totals £m</td>
<td>14.9</td>
<td>18.1</td>
<td>21.3</td>
</tr>
<tr>
<td>A&amp;E</td>
<td>7%</td>
<td>12%</td>
<td>17%</td>
</tr>
<tr>
<td>OP</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>EL</td>
<td>7%</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>NEL</td>
<td>25%</td>
<td>28%</td>
<td>30%</td>
</tr>
</tbody>
</table>

Note: The above table relates to NHS Eastern Cheshire CCG estimated savings as a commissioner. Further work is required to validate the wider Eastern Cheshire Health & Social Care economy impact.
Chapter 8: Enablers
In delivering the CCGs five year strategic plan, we recognise there are number of very important enablers that underpin our ambitions, new quality standards and the new care system.

NHS Eastern Cheshire CCG has identified seven key enablers required to deliver the new care system. Figure 28 summarises the seven key enablers whilst Figure 29 to Figure 31 provides more detail about each enabler.

**Figure 28: Seven key enablers required to deliver new care models**

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Workforce</td>
<td>Scaled and empowered workforce to deliver both new and existing care models&lt;br&gt;Workforce is provided with training and up skilling to increase productivity and ensure better care is provided to the local population</td>
</tr>
<tr>
<td>2 Estates</td>
<td>Locality based model to allow community based workforce to co-locate and share knowledge and best practices</td>
</tr>
<tr>
<td>3 Leadership and cultural transformation</td>
<td>Senior clinical, professional, managerial and political leaders articulate a clear vision and empower teams to collaborate&lt;br&gt;Role modeling from most respected individuals in each professional group and within each locality of new ways of working</td>
</tr>
<tr>
<td>4 Organisational structure and governance</td>
<td>Board-level sponsorship and transparent decision-making&lt;br&gt;Form follows function in order to deliver integrated team working in each locality with high levels of productivity, flow of information, ability to manage risk</td>
</tr>
<tr>
<td>5 Patient/user engagement</td>
<td>Partnership with citizens in the co-development and ownership of care plans, and supporting them in managing their own care&lt;br&gt;Increasing the accountability and responsibility of citizens</td>
</tr>
<tr>
<td>6 Information</td>
<td>Flow of information across settings to support clinical decision making combined with transparency in performance, drives compliance with clinical and professional protocols and performance improvement</td>
</tr>
<tr>
<td>7 Contracting and commissioning</td>
<td>Incentives aligned across all providers, with funding mechanisms tied to coordinated and shared delivery of outcomes for a defined population</td>
</tr>
</tbody>
</table>
**Enablers** | **Description**
--- | ---
1 Workforce | • The Caring Together components have implications on the workforce requirements. The different components of the care model require additional workforce resources and the definition of new roles. To deliver these additional resources, we have first looked at making the current workforce more efficient, by improving productivity, reducing variability in performance across roles and centres, implementing mobile technologies to increase efficiency, reduce the number of unnecessary visits and reduce travel time. These efficiency levers will free up between 12 and 41% of current capacity depending on the roles, decreasing by that amount the number of additional workforce required by the new care model.

• Under the current assumptions, the additional workforce demand of 245 will be reduced to 196 WTEs due to overlap of functions and will be further reduced to between 46 and 120 WTEs after freeing up a capacity of between 148 and 330 WTEs from the existing workforce of 2,237 WTEs. This demand will mainly be concentrated on nurses with an incremental demand of between 25 and 61 WTEs and GPs with 16 to 22 WTEs.

2 Estates | • Caring Together has also an impact on Estates. After looking at the current estates across Eastern Cheshire, we have identified efficiency opportunities in the use of space by decreasing variability of surface per thousand patients across practices, which could free up between 480 and 1700m2. Also, we have presented the benefits of moving into a locality-model, to reduce fixed costs and duplication of workforce.

• We have considered 3 and 5 locality models for which we have run a travel time analysis. This analysis shows that in a 3-locality model, 100% of the patients are less than 30 minutes away from a locality when travelling by car (20 mins for 5-locality model) and that 90% of patients are less than 60 minutes away from a locality when using public transport (40 minutes for 3-locality model).
One of the biggest determinants of the success of change programmes is the engagement of staff and care professionals in the process of design and their ultimate enthusiasm for the success of the programme.

The design phase has focused on collaboration between care professionals through the Care Programme Board and the Care Model Design Groups.

In the next phase, more intensive collaboration will happen across all GPs and care professionals within Eastern Cheshire to ensure that there is staff ownership and buy-in, which will be critical. Individual visits with the GPs across Eastern Cheshire are already underway within the CCG.

In order to achieve transformational change, an appropriate organisational and governance structure is being established.

A full time programme management team will be put in place for the implementation phase.

Engagement with patients and carers across the system in the design of the new care models is vital to the success of the programme.

Patients have been actively involved throughout the design phase in the Empowered Persons CMDG, and have made significant contributions to the emerging design of the care model.

A more intensive period of patient and carer engagement will happen over the course of the next few months as we finalise the plans for implementation and operational design.
Figure 31: Information, contracting and commissioning enablers

<table>
<thead>
<tr>
<th>Enablers</th>
<th>Description</th>
</tr>
</thead>
</table>
| 6 Information and technology      | • IT systems are a key enabler of integrated care. It has been estimated by the ICT group that the investments in IT will amount to ~£2.3m recurrently each year in IT investment and running costs, with a cumulative necessary investment of £6.9 million over the period of 5 years until 2018/19.  
• This includes risk stratification tools, single patient care records, access to care records for staff and patients, EMIS contracts, data sharing agreements, data warehousing, WIFI for sites that are currently without internet connections, care planning and coordination software, and telemedicine. These costs have been developed with the ICT group and reflect the needs indicated in the design of the care model. |
| 7 Contracting and commissioning   | Four key questions will be addressed by commissioners to make a decision on appropriate contracting and commissioning models for Eastern Cheshire  
• How will integrated commissioning work?  
• What is the financial model between commissioners and providers?  
• What is the provisioning structure?  
• How will providers work together  
There are three broad types of reimbursement models that could be used to fund activity  
• Fee for service model which can either be fee for service or pay for performance.  
• Episode based model which may include bundled payments for acute episodes and bundled payments for chronic conditions.  
• Population based capitation model with per head fees given to providers to pay for whole population care needs. |

The Caring Together Five Year Strategic document will provide further details on all aspects of the Caring Together Programme and is due to be available July 2014.
## Appendices

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Summary of the Eastern Cheshire Health Economy</td>
</tr>
<tr>
<td>B</td>
<td>Outcome Trajectories</td>
</tr>
<tr>
<td>C</td>
<td>Activity Projections</td>
</tr>
</tbody>
</table>
Appendix A: Summary of the Eastern Cheshire health economy

**Total area population:** 204,000

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Total Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total CCG health spend</td>
<td>£225m</td>
</tr>
<tr>
<td>Total NHSE GMS spend</td>
<td>£26m</td>
</tr>
<tr>
<td>Total social care spend</td>
<td>£50m</td>
</tr>
<tr>
<td>Total NHSE specialist commissioning spend</td>
<td>£27m</td>
</tr>
</tbody>
</table>

**Providers**
- **Acute and Community services:** East Cheshire NHS Trust
- **Mental Health:** Cheshire and Wirral Partnership NHS Foundation Trust
- **Social Care:** Cheshire East Council
- **Primary Care:** 22 GP practices
- **Other providers:**
  - 38 pharmacies
  - 42 dentists
  - 48 opticians
  - 24 voluntary groups
  - Housing associations
  - One Community Interest Company2 (Vernova)

**Population**
- **Growing population:** Population forecast to increase by 28,000 (14%) by 2035
- **Ageing population:**
  - 20% of population over 65 compared to national average of 16%
  - Fastest growing over 65s and over 85s in North West
- **Growing burden of disease:**
  - Nationally, over half of people over the age of 75 have 1 or more Long Term Condition

1. Net of income for services including contributions from clients of approximately £13m
2. Vernova Healthcare CIC community interest company formed in October 2013
**Appendix B: National Outcome Trajectories for 2014-15 to 2018-19**

Ambitions for Improving Outcomes

### Outcome Ambition 1

**E.A.1 What is your ambition for securing additional years of life from conditions considered amenable to healthcare?**

<table>
<thead>
<tr>
<th>Year</th>
<th>PYLL (Rate per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>1743.2</td>
</tr>
<tr>
<td>2014/15</td>
<td>1730.1</td>
</tr>
<tr>
<td>2015/16</td>
<td>1717.1</td>
</tr>
<tr>
<td>2016/17</td>
<td>1697.9</td>
</tr>
<tr>
<td>2017/18</td>
<td>1656</td>
</tr>
<tr>
<td>2018/19</td>
<td>1553.5</td>
</tr>
</tbody>
</table>

*Note: PYLL forms part of the 2014/15 Quality Premium.*

### Outcome Ambition 2

**E.A.2 What is your ambition for improving the health-related quality of life for people with long-term conditions?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Average EQ-5D score for people reporting having one or more long-term condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>77.5</td>
</tr>
<tr>
<td>2014/15</td>
<td>78.1</td>
</tr>
<tr>
<td>2015/16</td>
<td>78.7</td>
</tr>
<tr>
<td>2016/17</td>
<td>79.5</td>
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<tr>
<td>2017/18</td>
<td>80.2</td>
</tr>
<tr>
<td>2018/19</td>
<td>81</td>
</tr>
</tbody>
</table>

### Outcome Ambition 3

**E.A.4 What is your ambition for reducing emergency admissions?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Emergency admissions composite indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>2026.6</td>
</tr>
<tr>
<td>2014/15</td>
<td>1976.6</td>
</tr>
<tr>
<td>2015/16</td>
<td>1901.6</td>
</tr>
<tr>
<td>2016/17</td>
<td>1791.6</td>
</tr>
<tr>
<td>2017/18</td>
<td>1670</td>
</tr>
<tr>
<td>2018/19</td>
<td>1520</td>
</tr>
</tbody>
</table>

*Note: the composite avoidable emergency admissions indicator forms part of the 2014/15 Quality Premium and is a measure in the Better Care Fund.*
## Outcome Ambition 5

**E.A.5 What is your ambition for increasing the proportion of people having a positive experience of hospital care?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
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<tr>
<td>2014/15</td>
<td>138</td>
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<tr>
<td>2015/16</td>
<td>137.5</td>
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<td>2016/17</td>
<td>137</td>
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<tr>
<td>2017/18</td>
<td>136.5</td>
</tr>
<tr>
<td>2018/19</td>
<td>136</td>
</tr>
</tbody>
</table>

## Outcome Ambition 6

**E.A.7 What is your ambition for increasing the proportion of people having a positive experience of care outside hospital, in general practice and the community?**

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td>3.3</td>
</tr>
<tr>
<td>2014/15</td>
<td>3.25</td>
</tr>
<tr>
<td>2015/16</td>
<td>3.18</td>
</tr>
<tr>
<td>2016/17</td>
<td>3.08</td>
</tr>
<tr>
<td>2017/18</td>
<td>2.96</td>
</tr>
<tr>
<td>2018/19</td>
<td>2.8</td>
</tr>
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</table>

### Indicator Definition (please specify the local measures chosen) max 4000 characters

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<th>Indicator</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Measure</th>
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</thead>
<tbody>
<tr>
<td>C3.2 Emergency readmissions within 30 days of discharge from hospital</td>
<td>222.1</td>
<td>2338</td>
<td>0.9500</td>
</tr>
</tbody>
</table>
### E.A.S.5 i) Number of C.Difficile infections in 2014/15

<table>
<thead>
<tr>
<th></th>
<th>2014</th>
<th>2015</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April</td>
<td>May</td>
<td>June</td>
</tr>
<tr>
<td>Number of C. Difficile infections</td>
<td>4</td>
<td>4</td>
<td>4</td>
</tr>
</tbody>
</table>

### E.A.S.1

**ii) What dementia diagnosis rate are you aiming for in 2014/15 and 2015/16:**

<table>
<thead>
<tr>
<th>E.A.S.1</th>
<th>Number of people diagnosed</th>
<th>Prevalence of dementia</th>
<th>% diagnosis rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>1744</td>
<td>3426</td>
<td>50.90%</td>
</tr>
<tr>
<td>2015/16</td>
<td>1806</td>
<td>3497</td>
<td>51.64%</td>
</tr>
</tbody>
</table>

### E.A.S.2

**iii) What level of IAPT recovery are you aiming for in 2014/15 and 2015/16?**

<table>
<thead>
<tr>
<th>E.A.S.2</th>
<th>The number of people who have completed treatment having attended at least two treatment contacts and are moving to recovery (those who at initial assessment achieved “caseness” and at final session did not)</th>
<th>(The number of people who have completed treatment within the reporting quarter, having attended at least two treatment contacts) minus (The number of people who have completed treatment not at clinical caseness at initial assessment)</th>
<th>% recovery rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>850</td>
<td>1667</td>
<td>50.99%</td>
</tr>
<tr>
<td>2015/16</td>
<td>910</td>
<td>1750</td>
<td>52.00%</td>
</tr>
</tbody>
</table>
E.A.1
i) Potential years life lost (PYLL) from amenable causes in 2014/15.

<table>
<thead>
<tr>
<th>E.A.1</th>
<th>PYLL (Rate per 100,000 population)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td>1730.1</td>
</tr>
</tbody>
</table>

E.A.2
ii) What trajectory are you aiming for in the composite avoidable emergency admissions indicator in 2014/15.

<table>
<thead>
<tr>
<th>E.A.4</th>
<th>Emergency admissions composite indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2014/15</td>
<td>474.384</td>
</tr>
<tr>
<td>Q2 2014/15</td>
<td>494.15</td>
</tr>
<tr>
<td>Q3 2014/15</td>
<td>513.916</td>
</tr>
<tr>
<td>Q4 2014/15</td>
<td>494.15</td>
</tr>
</tbody>
</table>

E.A.3
iii) For IAPT, what population of people that enter treatment against the level of need in the general population are planned in 2014/15 and 2015/16.

<table>
<thead>
<tr>
<th>E.A.3</th>
<th>The number of people who receive psychological therapies</th>
<th>The number of people who have depression and/or anxiety disorders (local estimate based on National Adult Psychiatric Morbidity Survey 2000)</th>
<th>Proportion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2014/15</td>
<td>620</td>
<td>20469</td>
<td>3.03%</td>
</tr>
<tr>
<td>Q2 2014/15</td>
<td>680</td>
<td>20469</td>
<td>3.32%</td>
</tr>
<tr>
<td>Q3 2014/15</td>
<td>770</td>
<td>20469</td>
<td>3.76%</td>
</tr>
<tr>
<td>Q4 2014/15</td>
<td>780</td>
<td>20469</td>
<td>3.81%</td>
</tr>
<tr>
<td>2015/16</td>
<td>3100</td>
<td>20469</td>
<td>15.14%</td>
</tr>
</tbody>
</table>

E.A.4
iv) Which Friends and Family patient improvement indicator have you selected for an improved average score to be achieved between 2013/14 and 2014/15.

C4.2 Patient experience of hospital care

76

<table>
<thead>
<tr>
<th>CCG Activity</th>
<th>Elective Admissions - Ordinary Admissions</th>
<th>Total Elective Admissions - Day Case (FFCES)</th>
<th>GP Written Referrals (GABA)</th>
<th>Other referrals (GABA)</th>
<th>Total Referrals</th>
<th>Non-elective FFCES</th>
<th>All First Outpatient Attendances - following GP Referral</th>
<th>First Outpatient Attendances - All specialties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>April</td>
<td>330</td>
<td>1505</td>
<td>1835</td>
<td>3026</td>
<td>1758</td>
<td>4784</td>
<td>1658</td>
<td>4415</td>
</tr>
<tr>
<td>May</td>
<td>401</td>
<td>1968</td>
<td>1899</td>
<td>3177</td>
<td>1804</td>
<td>4981</td>
<td>1955</td>
<td>4524</td>
</tr>
<tr>
<td>June</td>
<td>355</td>
<td>1480</td>
<td>1835</td>
<td>2997</td>
<td>1779</td>
<td>4776</td>
<td>1533</td>
<td>4433</td>
</tr>
<tr>
<td>July</td>
<td>392</td>
<td>1640</td>
<td>2032</td>
<td>3260</td>
<td>1889</td>
<td>5158</td>
<td>1638</td>
<td>4831</td>
</tr>
<tr>
<td>August</td>
<td>336</td>
<td>1471</td>
<td>1807</td>
<td>3003</td>
<td>1685</td>
<td>4668</td>
<td>1602</td>
<td>4163</td>
</tr>
<tr>
<td>September</td>
<td>360</td>
<td>1839</td>
<td>1869</td>
<td>3324</td>
<td>1917</td>
<td>5241</td>
<td>1617</td>
<td>4838</td>
</tr>
<tr>
<td>October</td>
<td>346</td>
<td>1714</td>
<td>2060</td>
<td>3600</td>
<td>1981</td>
<td>5581</td>
<td>1585</td>
<td>5050</td>
</tr>
<tr>
<td>November</td>
<td>362</td>
<td>1653</td>
<td>2915</td>
<td>3352</td>
<td>1979</td>
<td>5331</td>
<td>1698</td>
<td>4851</td>
</tr>
<tr>
<td>December</td>
<td>300</td>
<td>1315</td>
<td>1615</td>
<td>2853</td>
<td>1646</td>
<td>4499</td>
<td>1704</td>
<td>4131</td>
</tr>
<tr>
<td>January</td>
<td>265</td>
<td>1239</td>
<td>1564</td>
<td>3142</td>
<td>1787</td>
<td>4929</td>
<td>1579</td>
<td>4562</td>
</tr>
<tr>
<td>February</td>
<td>222</td>
<td>1408</td>
<td>1730</td>
<td>3031</td>
<td>1746</td>
<td>4777</td>
<td>1576</td>
<td>4376</td>
</tr>
<tr>
<td>March</td>
<td>390</td>
<td>1608</td>
<td>1998</td>
<td>3331</td>
<td>1911</td>
<td>5242</td>
<td>1683</td>
<td>4911</td>
</tr>
<tr>
<td>Quarter 1</td>
<td>20593</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 2</td>
<td>29733</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 3</td>
<td>29117</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quarter 4</td>
<td>29425</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 2014/15 Total
- Elective Admissions: 4159
- Total Elective Admissions - Day Case: 18200
- GP Written Referrals: 38105
- Other referrals: 21802
- Total Referrals: 59967
- Non-elective FFCES: 19478
- All First Outpatient Attendances: 54985
- First Outpatient Attendances: 34063
- All Subsequent Outpatient Attendances: 117668

### 2013/14 Forecast Outturn
- Elective Admissions: 4226
- Total Elective Admissions - Day Case: 17769
- GP Written Referrals: 38098
- Other referrals: 21856
- Total Referrals: 59954
- Non-elective FFCES: 19789
- All First Outpatient Attendances: 54977
- First Outpatient Attendances: 34053
- All Subsequent Outpatient Attendances: 117847

### Forecast growth in 2014/15

<table>
<thead>
<tr>
<th>CCG Activity</th>
<th>2015/16</th>
<th>2016/17</th>
<th>2017/18</th>
<th>2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>2.4%</td>
<td>0.6%</td>
<td>-0.6%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>May</td>
<td>2.4%</td>
<td>1.8%</td>
<td>0.0%</td>
<td>-0.8%</td>
</tr>
<tr>
<td>June</td>
<td>1.4%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>July</td>
<td>0.0%</td>
<td>4.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>August</td>
<td>-0.6%</td>
<td>-0.8%</td>
<td>-0.8%</td>
<td>-1.0%</td>
</tr>
<tr>
<td>September</td>
<td>-0.8%</td>
<td>-1.8%</td>
<td>-1.8%</td>
<td>-1.8%</td>
</tr>
<tr>
<td>October</td>
<td>1.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>November</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>December</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>January</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>February</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>March</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
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<td>Quarter 1</td>
<td>0.0%</td>
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<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarter 2</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarter 3</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Quarter 4</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### 2015/16 Total
- Elective Admissions: 4091
- Total Elective Admissions - Day Case: 18484
- GP Written Referrals: 22486
- Other referrals: 37410
- Total Referrals: 58872
- Non-elective FFCES: 18871
- All First Outpatient Attendances: 54001
- First Outpatient Attendances: 33440
- All Subsequent Outpatient Attendances: 115704

### 2016/17 Total
- Elective Admissions: 3857
- Total Elective Admissions - Day Case: 18793
- GP Written Referrals: 22568
- Other referrals: 36609
- Total Referrals: 57663
- Non-elective FFCES: 18829
- All First Outpatient Attendances: 52899
- First Outpatient Attendances: 32718
- All Subsequent Outpatient Attendances: 113187

### 2017/18 Total
- Elective Admissions: 3728
- Total Elective Admissions - Day Case: 18837
- GP Written Referrals: 22505
- Other referrals: 35934
- Total Referrals: 56001
- Non-elective FFCES: 17170
- All First Outpatient Attendances: 51930
- First Outpatient Attendances: 32112
- All Subsequent Outpatient Attendances: 111112

### 2018/19 Total
- Elective Admissions: 3614
- Total Elective Admissions - Day Case: 18867
- GP Written Referrals: 22481
- Other referrals: 35277
- Total Referrals: 55559
- Non-elective FFCES: 19936
- All First Outpatient Attendances: 50983
- First Outpatient Attendances: 31021
- All Subsequent Outpatient Attendances: 109079

### Forecast growth in 2018/19
- Elective Admissions: -3.1%
- Total Elective Admissions - Day Case: -0.2%
- GP Written Referrals: -0.4%
- Other referrals: -0.2%
- Total Referrals: -0.6%
- Non-elective FFCES: -0.8%
- All First Outpatient Attendances: -1.8%
- First Outpatient Attendances: -1.8%
- All Subsequent Outpatient Attendances: -1.8%