Cheshire East Integrated Care Partnership
ICP Strategy
And
Transformation Delivery Plan
September 2020 – March 2022

Cheshire East Place Vision

"Our vision is to enable people to live well for longer;
to live independently and
to enjoy the place where they live. "

Contents

Executive Summary

Cheshire East Integrated Care Partnership (ICP) is within the Cheshire East Place. One of the key challenges is how to work differently and how to engage partners and colleagues differently and effectively across our local health and care system.

There are multiple drivers for change: The health inequalities in the population we serve are increasing; There is not enough capacity or finance to deliver the same model of health and social care with an ageing and expanding local population; there is national impetus for change for example with the NHS Long Term Plan; we are required to meet a challenging financial deficit to achieve system financial balance. There are instability and capacity issues in all of our services and particularly in primary and social care.

There are multiple ways of meeting this challenge and various health and care systems around the world can demonstrate where they have been successful in this regard.

We have set out on the journey to have 8 "Care Communities" as our hubs and focus for local care delivery and we are working towards putting structures in place to provide the partnership working, with a common purpose, commensurate autonomy and enablers for them to be effective.

There is a further challenge to ensure that as a system we have a consistency of offer to our population that allows for large scale improvement in health and outcomes to be delivered across the place and allowing innovation and rapid testing of good ideas that will enable our Care Communities to flourish.

The National Association of Primary Care (NAPC) Primary Care Home programme "is about delivering care for patients as locally as we can to them that is sensitive to their needs". This was how the Care Communities were initially intended to function and our transformation programme will support this aim. The Primary Care Home model moves away from a reactive model of care to a proactive, preventative approach to health using a biopsychosocial model.

By April 2021, The ICP Board will ensure that their role is to improve health and wellbeing, by using all of our assets to support the development of care closer to home, will have developed at a board level to take into account population health and look strategically at care needs and delivery for Cheshire East population. We will have dissolved some silos, developed the partnership and begun the process of reducing unwarranted variation and ensuring consistency of offer across primary, community, mental health and social care to an agreed minimum offer.

Care Communities will be more robust with an identified cost centre, indicative budget and with identified enablers. Their core team will be visible and baseline assessment of community assets and maturity will have been completed in order to understand the sum of their constituent resources and estates. Each will have access to a dashboard showing key metrics "at a glance" to allow rapid interpretation and responsive action.

Each Care Community will have developed a social prescribing offer and this will be available to the whole Cheshire East population. There will be a mental health first offer in development and assessment of wellbeing including formal assessment where necessary as routine in all long term condition reviews. Each Care Community will have completed or be undertaking a quality improvement project in cardiovascular and respiratory health. There will be two established Children's hubs in Crewe and Macclesfield with advice and guidance for parents on common childhood conditions. Childhood immunisation uptake will be improved.

Public Health colleagues will work with the ICP teams to being to tackle the wider determinants of health. Communities of practice will share learning from all of these projects and test and spread using a quality improvement approach.

By April 2022, Care Communities will be at the heart of care delivery for all of our major providers. Community care team capacity will increase to enhance the offer. We will be making use of technology to enhance monitoring of health and embedding point of care testing. People will be supported to stay safe well and independent in their communities. Hand in hand with the community and voluntary sector we will be working with local authority colleagues to further develop community groups and assets to support wellbeing and keep people as well as possible for as long as possible before needing our health and care services.

Innovation and improvement methodology will be embedded and further local projects encouraged. Community diagnostics and access to rapid specialist advice will become the norm. Care services will respond rapidly to escalation of need and provide an intervention from within the team
The ICP will be taking more responsibility for the local budget and working in partnership with a strategic commissioner to tackle the wider determinants of health and care needs, ensuring that we make inroads into these in order to keep our population well.

Public and service users will be vital partners in this journey and their voice will be heard throughout the ICP structure.

Cheshire East Integrated Care Partnership

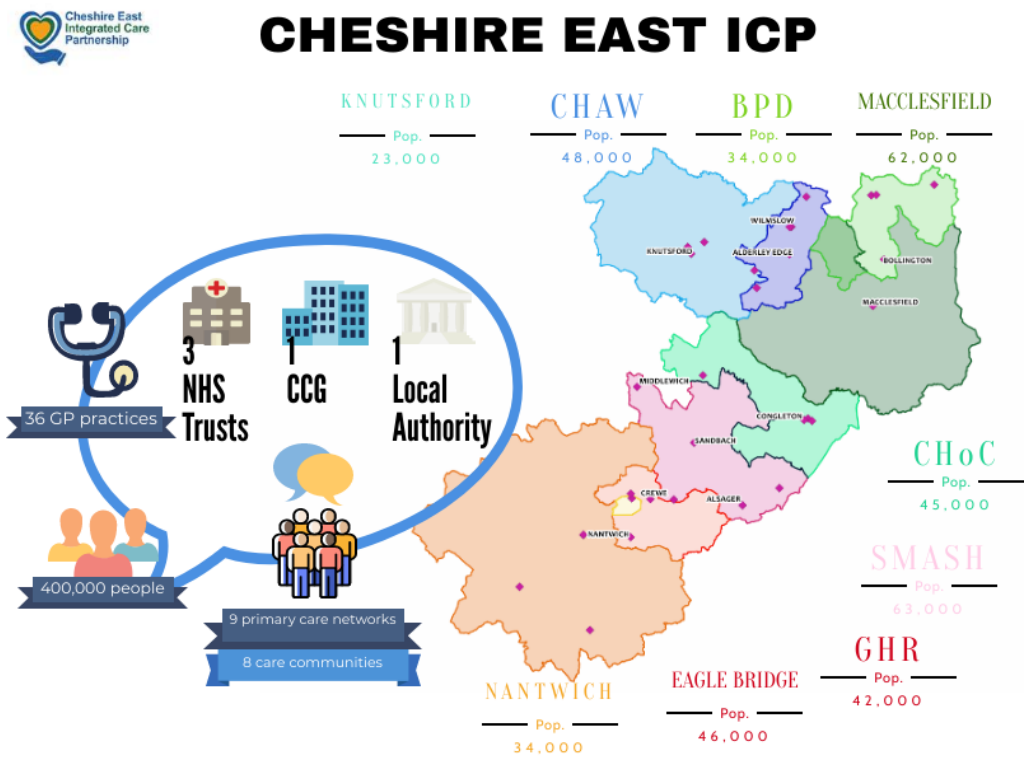


Fig1: Cheshire East ICP

The Cheshire East ICP serves a population of ~400,000 people. Figure 1 describes how it is divided into its constitutional geographies of 8 “Care Communities” and 9 Primary Care Networks (PCNs) within one

Cheshire East Council boundary. In the main the Care Communities and PCNs are coterminous with the exception being Crewe Care Community which contains two PCNs within it.

Since 2017 the Clinical Commissioning Groups (CCGs) had encouraged the local formation of Care Communities. These were collaborations of local provider teams with development support and basic funding provided to encourage them to develop shared aims and take a local view of health and care in their neighbourhood.

During this time they have been supported but have been limited in their overarching co-ordination and scope. This is in part due to not being able to access the funding and resources required to develop further.

Care services have come a long way since the inception of the NHS and evidence based medicine and care has done much to increase life expectancy, healthy years and quality of life. As a result of this we have entered a new era of people living longer with multiple conditions, with multiple medications and family units that are generally more spread across the country. This new challenge requires an additional focus on the individual and for local populations to provide expert generalism and support around people and the communities they live in. For this reason our health and care services need to evolve to maintain this excellence in quality but also provide the support needed in later years to keep people safe, well and independent.

Despite our best efforts inequalities have increased over the last 10 years and these need addressing within our approach. The wider determinants of health and wellbeing will be at the forefront of the ICP plan and in line with the NHS long term plan, the local 5 year plan and our CCG's commissioning intentions.

The advent of the NHS long term plan and the emergence of PCNs have further strengthened commitment to local, functional, robust teams and the resources allocated to these are significant. As an ICP we wish to build on this foundation and wrap the care we provide around this to create functional teams which anchor the ICP in communities directly and we invite specialists and advice in rather than refer out.

Health and care systems are complex, as are individual people and the systems their lives create. We will attempt to create an environment and care system which is flexible enough to meet these needs while still providing assurance on quality and equity of service, access and parity of esteem for all of our population groups.

Cheshire East Place Vision and Strategic Goals

Cheshire East Place Vision - Focus Areas:

- Tackling inequalities, the wider causes of ill-health and the need for social care support through an integrated approach to reducing poverty, isolation, housing problems and debt
- Prevention of ill health, early intervention, health improvement and creating environments that support and enable people to live healthily
- Ensuring our actions are centred on the individual, their goals, and the communities in which they live and supporting people to help themselves
- Having shared planning and decision making with our residents

Cheshire East Place Strategic Goals:

- To develop and deliver a sustainable, integrated health and care system
- To create a financially balanced system
- To create a sustainable workforce
- To significantly reduce the health inequalities

Principles

There are multiple examples of care systems around the world which have found ways of working that have shown benefit. Similar to the model in Jonkoping, Sweden we will use a fictional patient to map our system and look at where the pinch points are in the system for high cost patients, delayed transfers of care and overall public experience.

Realising the benefits of and achieving the Place vision will take some time. However, there are principles that we could all adhere to across the Cheshire East Place in order to demonstrate commitment and support this. Some of these have been set out previously in other documents – but broadly **we should be**:

- Improving the resident and patient experience and the quality of care provided
- Reducing unwarranted variation in care and outcomes ensuring equity of service for our population
- Using system resources effectively, driving value for money and having a single agreed information set to measure and monitor our programme of work
- Using evidence based approaches where possible
- Improving resource utilisation and reducing waste
- Demonstrating a willingness to allow innovation and to follow through with test, prove and implement at scale approach
- Look at high frequency attenders and how they interact with the system
- Improving interactions within teams and between and across providers

To do this we need:

- Access to good and current business intelligence (BI) – not just data but analysis that informs improvement and that we can standardise
- Resources and flexibility
- Strong and effective clinical and practitioner leadership
- A 'One Team Around A Population' ethic
- Shared outcomes
- Alignment of purpose from partner organisations to allow our current workforce to work flexibly and with a united purpose
- Increased improvement capability

Lastly there is a need to understand the competing financial drivers and desire for return on investment. Some interventions particularly population health measures may not deliver an in-year return and we need to understand how we facilitate this longer term approach in the current environment of financial restraint.

Scope and Duration of Plan

This document is intended to describe the transformation of the Cheshire East ICP from its inception to the end of the 2022 financial year. The intention is to set the direction of travel and roadmap for the next 18 months for the ICP and the outputs that are expected.

Transformation Themes

The selected transformation themes are key in the development of the ICP and its move towards a sustainable working arrangement. One of the challenges to overcome is that essentially the ICP covers two historically distinct healthcare systems divided by the M6 motorway. The population of the previous East Cheshire CCG footprint with patient flows into and out of Macclesfield Hospital (East Cheshire Trust) and East Cheshire Trust community services and the previous South Cheshire CCG with patient flows into and out of Leighton Hospital (Mid Cheshire Trust) and CCICP community services. Social Care services have also been delivered as a South and East in recognition of this situation

There are issues of sustainability of services to address and also sharing of learning across these historic footprints. One of the first orders of business for the ICP is to bring these two health and social care economies together and develop a shared purpose and team.

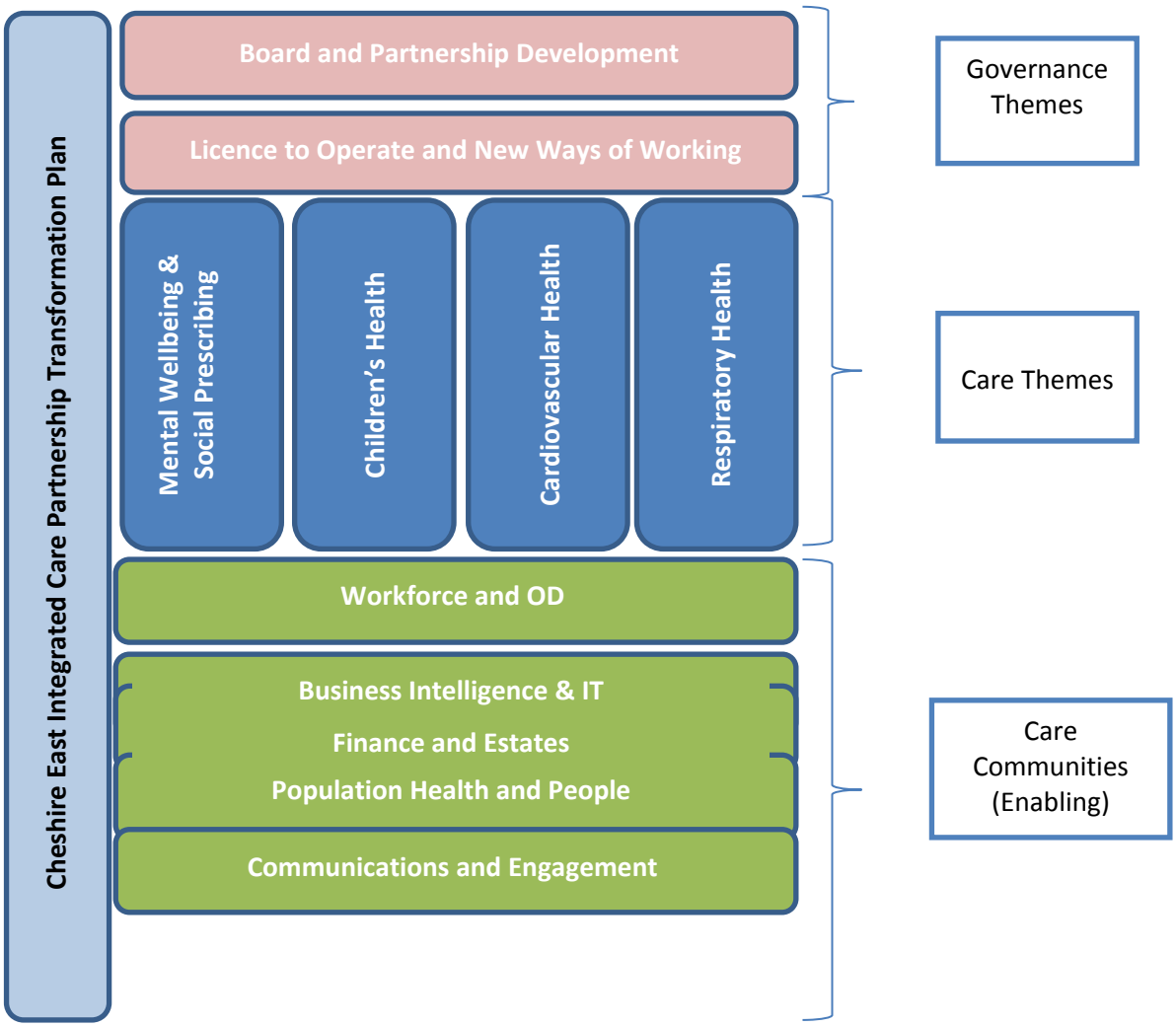
Given the historic differences in services offered, the ICP will spend time until April 2021 understanding and reducing inequity of community services across the new ICP footprint and ensuring that the stage is set to develop these further moving into 2021/22 financial year.

The care themes allow an opportunity to test new ways of working and develop new services.

In December 2019 a development workshop was held at South Cheshire College. Work was done in small groups with representatives from multiple stakeholders to be able to give feedback about how they believed the ICP should develop and what was needed to make this attempt at developing a local integrated care model successful.

The feedback has been collated and supports this transformation document. In summary, the ask was to ensure that Care Communities were supported to develop with recurrent resource and that the population data was readily available to the teams working in those areas. There was also an expressed need to develop infrastructure and governance arrangements to enable devolution of resources and accountability. Lastly there was the issue of trust and how we develop this both in governance sense to share resource risk, clinical risk and accountability, which will only occur through communication and engagement.

For this reason Care Community development is considered separately to the overall ICP development in this plan.



Corporate/Governance Theme

Within this theme is board development and ensuring that the partnership works. Developing trust is essential to working together especially when it comes to sharing risk and reward. To April 21 there will be time and resource dedicated to this and ensuring the governance arrangements facilitate the working we need to see across teams in Care Communities.

Within this theme there will also be a need to look at contracting arrangements, regulation, relationship with the new strategic CCG and how resource is transferred.

A communications plan that is regular and robust also sits within this theme and is currently in development.

Teams need time to coalesce around the Care Community footprints and in the main are aligned. Time will be given to considering how to allow team members to operate at the top of their licence in the interests of the populations they serve.
As part of developing understanding to April 21, a mapping exercise will be undertaken to establish the assets and offers available across both previous CCG footprints and commence the process of ensuring equity of services up in line with this.

A summary of activities is listed in the table below.

Care Themes

Our evidence, which is a combination of public health data, Marmot reviews, Rightcare data, JSNA and local system intelligence shows that key starting areas to develop some of the principles of the ICP with are:

- Cardiovascular Health
- Respiratory Health
- Mental Wellbeing and Social Prescribing
- and Children's Health (in the form of setting up Children's Hubs)

These areas were selected as there was a perceived need, evidence that we are outliers in this area in our Place and an opportunity to demonstrate the kind of working and thinking that will help our ICP flourish.

There are some specific asks within the clinical areas and an explanation of why these were selected is outlined below.

There are many other areas that would have been suitable all with valid claims, for instance care of older adults and frailty (which we will add as a theme in 2022). However, there are already programmes of work underway in these areas and so to make a start on how we want to work we considered the below.
Care communities may have other local priorities to work on and this will continue to be supported with the 80:20 principle, with 80% consistent offer for the population across the Place and 20% local variation and innovation responsive to local need.

All initiatives and improvement plans will be required to demonstrate the impact they are expected to have in the short, medium and long term. Project support for each care community will be available through the ICP and will assist in the setting of outcomes and the monitoring and reporting of progress.

The four areas of activity are not exclusive nor are they a comprehensive plan for the delivery of our ICP in time. They are intended to test and prove some of the ideas discussed in this document.

Children's Health

The potential scope here in children's health and wellbeing is broad. We have for the time being elected to keep safeguarding and child safety out of scope.

Need: Cheshire East Council 'Tartan Rug' – high rates of admissions to hospital across the place for under the age of 4.

Proposed Intervention:

1) Child Health Hubs based on the Imperial Model
2) Potential to expand these to include Women's and Families Health also

Evidence:
https://www.cc4c.imperial.nhs.uk/child-health-gp-hubs
https://www.kingsfund.org.uk/sites/default/files/media/imperial-child-health-general-practice-hubs-kingsfund-oct14.pdf
https://www.england.nhs.uk/integratedcare/case-studies/child-health-hubs-see-patients-closer-to-home-and-reduce-unnecessary-hospital-trips/

In one hub 39% of hospital appointments were avoided altogether, further 42% were seen by a GP, 19% decrease in sub-speciality referrals, 17% reduction in admissions and 22% decrease in A&E attendance.

Resources Identified:
Funding received from the Cheshire and Merseyside Health and Care Partnership for this programme for Year 1. We undertook a successful bidding process and have commenced development of two child health hubs initially.

Plan:
Initially work has commenced with the aim of implementing child health hubs in Crewe Care Community and Macclesfield Care Community first.

There is a lead Paediatrician attached to this piece of work. Initially work will look at 0-4yrs and urgent care including frequent attenders (mainly respiratory issues, gastrointestinal issues and infant feeding).

Medicines management will be looking at data and prescribing behaviour in this cohort to help us understand the need.

Data will also drive where there are gaps in social/community support (eg housing, parenting support, health visitor services).

The hub will aim to be initially staffed by APNPs using current resource with aims to improve upon this over time.

A second strand will look at the use and roll out of the CATCH App – which will help parent signposting.

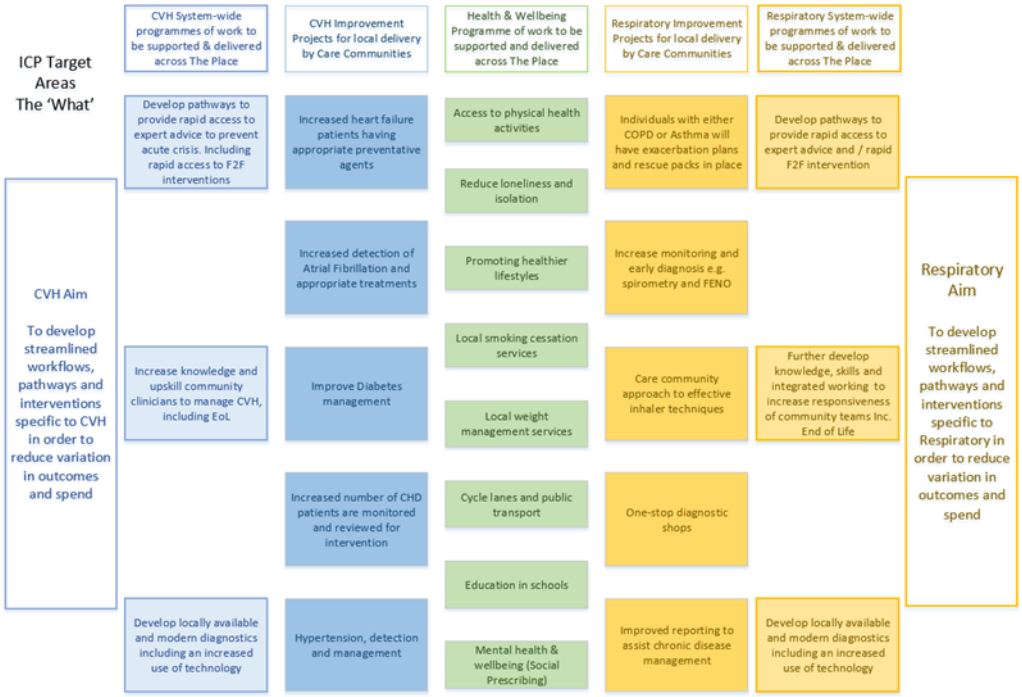
Following this, there will be a move to look at long term illnesses. The work will be based on local data and prescribing information alongside audit of admissions and pathways followed.

The hub approach involves specialists moving into the community to provide rapid access to expert advice and to improve the skills and confidence for clinicians (and families) to manage these conditions without the need for hospital interventions. The development will also identify how to signpost families to non-health support to address the wider determinants impacting on the children and their families. This will

demonstrate this way of working and hopefully provide a platform to be able to do the same for other clinical areas.

Cardiovascular Health

There is some overlap between the Cardiovascular and Respiratory Health Themes in terms of preventative measures. The diagram below illustrates how they overlap in the ICP plan.



Need:

In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality in the under 75s from CVD in comparison with our 10 most similar CCGs. This is a high cost area for the CCG and ICP. Cardiology services are struggling with sustainability issues. There are multiple population interventions that are possible which will allow us to embed a biopsychosocial approach rather than traditional model of care.

In terms of circulatory health alone Rightcare have identified potential opportunities of ~£2.2million for elective conditions and ~£4.1million for non-elective spend compared with the best of our 10 most similar peers. Circulatory conditions are an underlying cause of death in 25.1% of deaths nationally and Cheshire East is broadly similar to this.

The Rightcare data also shows that increased amounts of elective spend seems to correlate to a reduction in non-elective activity. There are also opportunities to streamline workflows, pathways and interventions to be more efficient in how we use our existing resources.

Proposed Interventions:

Several proposed methods of improvement to reduce variation in spend and outcomes have been discussed. Project Charters are being created and items for improvement will be discussed and approved at ICP transformation board. The intention for this area is that a 'menu of options' approach will allow Care Community teams to scrutinise their own data and implement methodology and plans that will address their local needs whilst remaining in line with the ICP plan.

Examples of interventions:

Public Health Intervention and Wider Determinants:-

1) Easy access to physical health activities/exercise
2) Reducing loneliness and isolation
3) Promoting healthier lifestyles
4) Effective and local smoking cessation services
5) Effective and local weight management services
6) Council encouragement to live healthily – provide cycle lanes, good public transport
7) Education in schools
8) "Know your numbers" and "Every Contact Counts" campaign – Hypertension and Atrial Fibrillation screening in all healthcare settings eg Pharmacy, Dentist, Optometrist when appropriate.

Managing Chronic Disease as effectively as possible:

1) Ensuring that all Heart Failure patients have appropriate preventative agents started and titrated to max tolerated dose (equating to 40% reduction in relative risk of long term mortality and hospital admission)
2) Ensuring that all patients with Atrial Fibrillation are encouraged to consider Anticoagulation where appropriate and then appropriately monitored
3) Improve Diabetes management - including local access to current effective treatments such as Libre testing kits and insulin pumps to improve compliance and ease of management
4) Ensuring that CHD (Coronary Heart Disease) patients are appropriately monitored and reviewed for intervention
5) Integrating Mental Health, Social Care and End of Life teams into clinical pathways.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for Heart Failure patients including sick day rules
2) Provide rapid access to expert advice in case of deterioration to prevent acute crisis
3) Explore community rapid access for those in need of rapid face to face intervention

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics and urgent specialist review
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) More locally available diagnostic services with reporting and advice that will allow community clinicians to continue to manage them in their own area
2) QI expertise and methodology to be applied to current workflow with a view to significantly reducing waste in terms of patient footfall, spend and activity both elective and non-elective

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:

All the above interventions have evidence of reduction in morbidity and mortality from various trials and pilots elsewhere. Based on local data it may be that the largest benefit will be from smoking cessation in one area and chronic disease management in another. Care Communities will prioritise interventions with

the greatest impacts. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

This Care Theme gives us an opportunity to show how our Place can work in different ways, streamline clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Respiratory Health

Need:
In the Rightcare Packs for both Eastern and South Cheshire CCGs we are outliers for non-elective spend and mortality. This is a high cost area for the CCG and ICP and the Respiratory services are struggling with sustainability. There are multiple population interventions that are also possible here.

Rightcare have identified opportunities for savings of ~£554K in elective conditions and ~£2.4million for non-elective conditions. Activity for Respiratory conditions is increasing across the Place over the last 5years.

Smoking levels have reduced across the Place over the last few years but still remain high in pockets.

Performance across the place for diagnosis confirmed/monitored with Spirometry for COPD is below our peers and also admissions for COPD in particular are on the rise.

Proposed Intervention:
There are several interventions to improve outcomes/spend and reduce unwarranted variation.
Project Charters are being created and items for improvement to be discussed and approved at ICP transformation board.

Public Health Intervention and Wider Determinants:

1) Reducing loneliness and isolation
2) Promoting healthier lifestyles
3) Effective and local smoking cessation services
4) Effective and local weight management services
5) Council encouragement to live healthily – provide cycle lanes, good public transport
6) Education in schools
7) Actions to improve air quality.

Managing Chronic Disease as effectively as possible:

1) Ensuring patients with COPD and Asthma have medications appropriate to their condition and a care plan
2) Ensuring people with COPD/Asthma have effective inhaler technique
3) Monitoring and diagnosis are supported for example with Spirometry and FENO testing and appropriate step up and step down management implemented
4) Increasing provision of and access to pulmonary rehabilitation
5) Access to secondary care advice where there is diagnostic uncertainty

6) Ensuring the IAPT and LTC offer is embedded into Care communities
7) Ensure effective end of life care planning for those with end stage disease.

Plan for acute deterioration/Exacerbation:

1) Exacerbation plans for those with COPD and Asthma.
2) Rescue packs in place where appropriate
3) Responsive community teams to be able to deal with deterioration – eg Integrated Respiratory Team, Advanced Community Practitioners and Paramedics.

Providing Rapid Access to Expert Advice:

1) Provision of Community Clinics
2) Education and MDT working
3) Consultants working in and with the community to educate upskill and contribute to MDTs
4) Using technology to bridge the Primary/Secondary care divide.

Providing Rapid Access to Community Diagnostics and reducing waste:

1) Locally available diagnostics including advice on distinguishing between conditions and when to step up to specialist care
2) One-stop diagnostic shops for symptoms where conditions may overlap (for example breathlessness)
3) Improved reporting to assist chronic disease management for all community team members.

Review of Acute and Secondary Care services to ensure best use of local resource across providers.

Evidence:
The above interventions have evidence of reducing morbidity and mortality from various trials and pilots elsewhere. Using local data it may be that the largest benefit/impact will be from smoking cessation in one area and chronic disease management in another. The list is not exhaustive and the Charters and Working Group will establish more formal plans.

Resources Identified:
Some of the activity will be in streamlining usual care. Resources for transformation are to be identified as part of the work plan.

The CURE project in place at MCHfT could also be supported out into the community in terms of smoking cessation and lung cancer care. There is also potential for spread across secondary care providers.

The Clinical Areas give us an opportunity to show how our Place can work in different ways, streamlines clinical pathways, reduce waste and unwarranted variation and our commitment to doing this across Care Pathways

Mental Wellbeing and Social Prescribing

Need:
There is a national recognised method of improving community resilience and increasing capacity in the voluntary sector. Evidence from Frome has also demonstrated impact on reduced need for GP appointments and ED attendances. A service is needed to cater for all aspects of mental wellbeing but in particular needs to address lower level mental wellbeing and social isolation as these impacts negatively on other aspects of health and social interaction.

The transfer of appropriate work into Primary Care cannot occur without a further transfer of work from Primary Care which is better supported by the community and via self-care.

Interventions:

1) Introduction of social prescribers via PCNs – curation and activation of the local community and voluntary sectors
2) Linking with the mental health forward view and providing first contact mental health practitioners with a particular focus on wellbeing at key (and early) points in all pathways providing an obvious first contact and support
3) Council connected communities project to link with ICP programmes and help provide infrastructure for voluntary sector (in conjunction with CVS)
4) The expansion of IAPT in line with the Mental Health Forward view.

Evidence:
Multiple national examples of where this has been successful in reducing workload across the whole system including A&E admissions and Primary Care activity. Strategic Development Group looked in particular at the Frome Model and how this model could be implemented locally.

Resources Identified:

1) PCNs have been funded for social prescribers at 100% to allow their introduction into primary care.
2) Council Connected Communities project is helping curate the local community
3) Need to develop a directory of services – examples of this are available locally
4) Improve links to 3rd Sector and
5) Mental Health forward view and Mental Health first pilots.

Plan:
To discuss as a Care Community how to best utilise this resource locally.

Work already underway in Care Communities:
Nantwich and Rural Care Community have already made significant strides curating a local directory of services and volunteer recruitment. Other projects are underway in Macclesfield and SMASH also.

The aim is to support this work and help develop the approach across all 8 Care Communities. Residents of Cheshire East should have access to a social prescribing service of some kind by April 2021. These will be mapped across the Place and enhanced in line with the intentions set out above and in keeping with need.

Mental Wellbeing:
Within this theme is also mental wellbeing and we will be looking to implement a mental health first model. We will aim to encourage wellbeing practitioners in Care Communities to enable rapid access and turnaround to support wellbeing in line with the mental health five year forward view.

We will look to embed assessment of mood and/or depression screening in all long term condition pathways and address inequalities and parity of esteem for all mental health conditions.

Local Innovation

There is also a method for allowing rapid testing, innovation and pursuing projects that address local need.

In doing this we need to ensure that we:

1) Use proven risk stratification tools/BI
2) Adopt an experiential learning approach
3) Adopt a QI approach
4) Improve Capability
5) Identify the aim of each project – some may be releasing capacity, others return on investment, others innovation

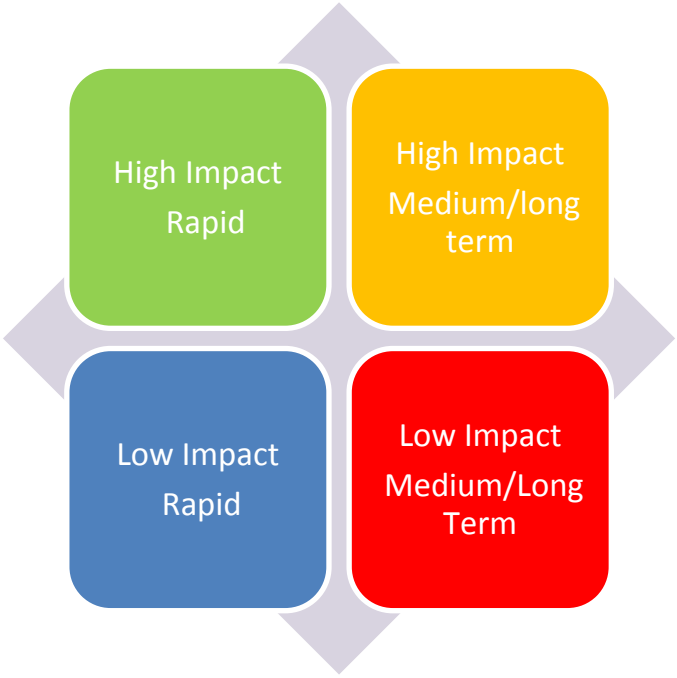
Each project should be commenced with a project initiation document which has been developed and then assessed against an agreed framework to allow development.

Each Care Community should be encouraged to bring their plans for peer critique. If approval for implementation is granted, there will be assistance from the ICP to plan for how this is possible to implement rapidly in other areas if it is relevant.

As a system we should favour plans which address:

1) Increasing GP access
2) Improving long term condition management/planned care
3) Escalating need in the community
4) Early Intervention of those with known needs, using risk stratification
5) Prevention
6) Wider determinants of health.

We will map activities across the Kaizen chart (below) in order to select the most relevant but ultimately this will be down to local determination within the allocated budget constraints.

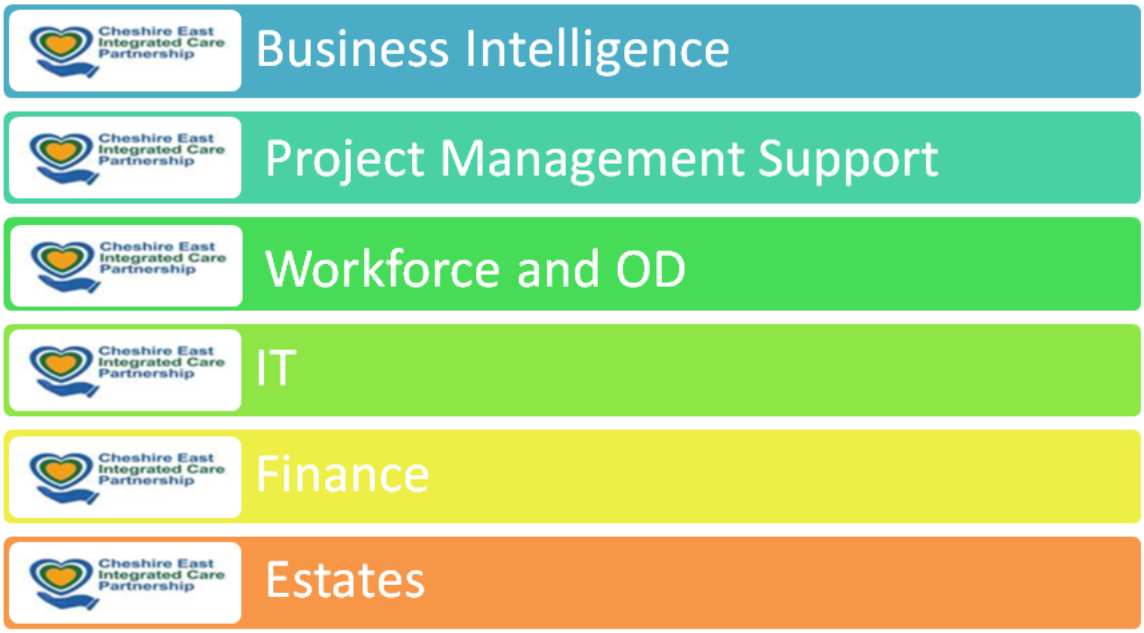


Care Communities Theme

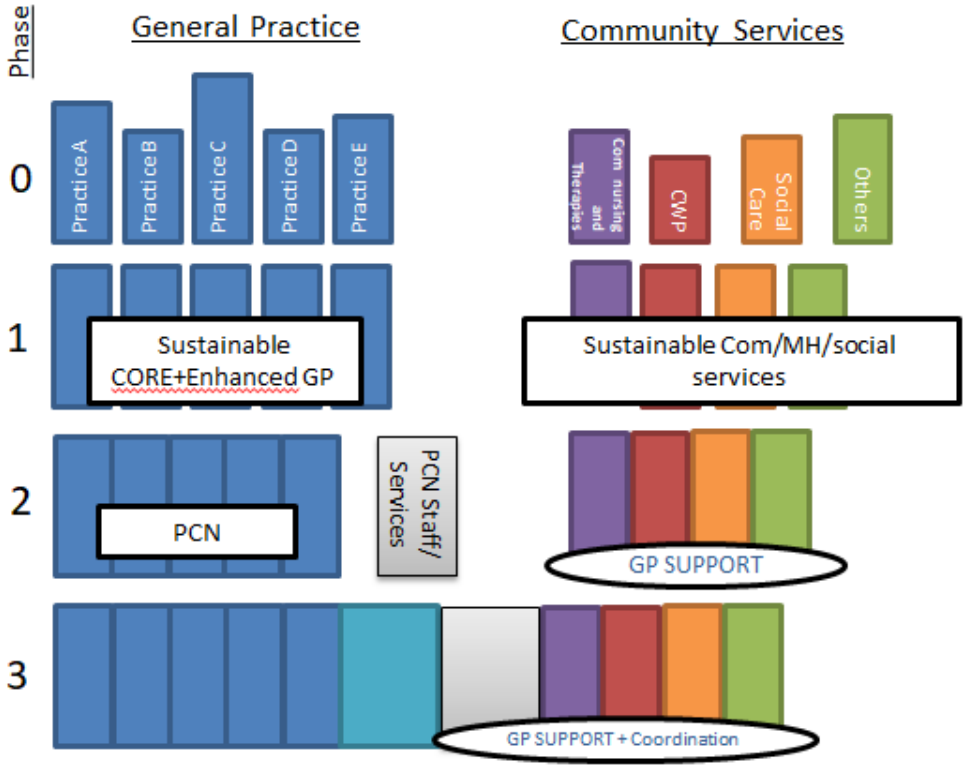
The development of the Care Community itself is of paramount importance in developing the ICP's way of working. All Care Communities are at varying stages of development and maturity.

We have developed an agreed maturity matrix to measure progress along this journey and allow support and enablers to be introduced that will support this process.

By April 2021 every Care Community should be able to identify a named individual responsible for their Care Community for several enabling themes listed below as a minimum:



In terms of functional development, the diagram below illustrates the different stages of development. There needs to be a gradual move from the considerable variation of offer across different areas to a consistent approach. Formation of PCNs will aid this process. In line with this and the work set out above we will level up the other partners' services. The ICP will aim to have all Care Communities working towards phase 3 by April 2022.



Primary Care Stability and Sustainability:
The current building blocks of Care Communities are General Practice and wider Primary Health, Social and Community care. All of these are under unprecedented pressure locally and the capacity of the few individuals that are currently working within each Care Community Team is not large enough to take on the kind of large scale transformational programme that is required. At present there has been temporary resource for clinical leadership but beyond that there is little incentive for practices to engage fully in the ICP mechanism as there is limited capacity.

Capacity:
Within Care Communities there has been provision for leadership but otherwise there is precious little resource (especially resource to be able to effect the changes that are needed, building in improvement and transformation capability). The idea that teams can free capacity to deliver large scale projects from within their current budget and human resource is not feasible and will likely lead to disengagement if not addressed.

Motivation and Engagement:
There needs to be an agreement from executives of Partner organisations to allow teams to flourish and self-determine but also to action change in a way that is meaningful for the populations the teams serve. There needs to be a framework of delegation from partner organisations to support teams and Care Communities to implement change that is required locally.

Teams need to feel they are doing the right thing, based on evidence, have adequate time and resource and have a degree of autonomy in order to be able to flourish in this new model – this is a challenge within the current regulatory frameworks with competing drivers, outcomes, targets and quality measures both local and national.

Estates:
Community estates and sourcing of sites for hubs and teams to work is a priority. We need to give due consideration also about how to bring specialist care into the community without breaking up

communities of practice that exist in secondary care and maintain excellent acute and specialist services for when they are called upon.

Suggestion:
There needs to be an immediate focus for the ICP on the stability and sustainability of Primary Care and in particular General Practice.

It will need to be based on a reciprocal arrangement and acknowledgement that providing services and systems that help General Practice will help the Care Communities and in turn the ICP. This will also create the capacity for them to take on more appropriate work in the revised pathways of care.

Dialogue needs to occur with local populations and third sector organisations to support communities to care for themselves when appropriate both in terms of self-care and communities supporting one another which will free capacity in primary and community care to serve those most in need.

Care Community Teams need access to good business intelligence and potentially be able to rapidly implement and test ideas to foster the idea of team working.

An indicative budget would also go towards making Care Communities more real, with a level of autonomy.

Further ideas for development

CCICP have demonstrated the benefits of working in different ways. They have organised co-located teams around a single point of access with teams that look after a local population rather than a condition group.

There is a shared IT system which is in common with GP practices. Reduced waste by looking at visiting load, reducing the need for duplicate visits and introducing innovative technology like Malinko which is making a real difference in terms of productivity and mapping demand.

The teams are interacting with General Practice to reduce home visiting workload and thinking about reducing waste in professional prescribing areas for example in Stoma Care has both improved care quality and reduced spend.

There have been projects across East Cheshire Trust which have also supported Care Community and team working successfully for example Frailty teams, Buurtzorg working, joint working between practice nurses and community nurses and developments in home visiting for those in crisis

However we need to go further and:

1) Expand the community offer
2) Bring specialist experience into the community providing rapid if not instant advice
3) Break down barriers between teams and reduce silo working, the Jonkoping approach
4) Understand the pressure points across the system and work collaboratively to resolve them
5) Reduce unwarranted variation across providers and ensure equity of services to all our population
6) Provide rapid access to diagnostics, guidance and advice
7) Invest in a population health approach
8) Invest in education and health promotion

9) Population education about how best to use services and when and how to access appropriate care
10) Utilise MDTs, the 3rd sector and assets in the community where possible
11) Look at high frequency attenders and high risk groups with an eye on equity of access, equality and parity of esteem for vulnerable groups
12) Reduce waste from multiple contacts for the same problem
13) Develop and invest in Primary Care and General Practice
14) Integrate Mental Health, Community and Social Care colleagues more effectively
15) Identify areas that improve experience for all care professionals in the system
16) We need to look at high cost pathways across the system and see where we can improve efficiency or transform work patterns.

Work needs to be done on engagement with General Practice. GPs are a large part of the senior clinical presence in primary care. As a system we would benefit from them supporting other community based clinicians and dealing with complex care and cases.

To allow this we need to explore ways of removing work from them that could be performed by other team members. GPs will need in return to reduce their unwarranted variation and agree to be part of the system working in line with agreed local pathways and guidance to provide seamless patient journeys and transitions between teams.

We need to avoid unintentional consequences of actions and understand the impact of plans – for example bringing resource into the community and unintentionally destabilising secondary care provision.

Impact for Secondary Care Clinicians

Working in this ICP will require Consultant colleagues and other specialists in secondary care to support community teams in a different way. We will need to blur the boundaries between Primary and Secondary Care to provide seamless transfers of care and advice for our local population.

We will need to use their expertise to see the most complex individuals who really need their expert care and we will rely on them to provide subject leadership and insight into which evidence based interventions would benefit our population most.

We need them to provide advice and guidance to community teams and work with them to help upskill the entire workforce through experience and over time reduce the reliance on attending hospital for interventions that could be provided in the community. This will mean that “routine care” is provided in the Community with the hospital being reserved for only those most at need.

This will mean working in a different way. The ICP recognises that secondary care have Communities of Practice and the benefit that working in clusters with other specialists brings. Integrating specialist care in the community would need to be done without deconstructing functions that work well and we need to be mindful of this as a system. We need to protect them and use their time wisely.

Impact for Community Teams

Community Teams can expect to expand in numbers, scope and skill. There are members of the Community who traditionally in our local area have not been part of mainstream care. There will be increased integration with Dentists, Optometrists, Pharmacies, Paramedics as well as Social Care and Mental Health colleagues.

There will need to be an increased skill mix with teams having more members (for example respiratory/heart failure nurses) and working with more support and advice from colleagues.

Access to rapid expert advice and point of care testing will mean an increased ability to manage conditions locally without the need to transfer to other care environments.

We will aim to improve satisfaction and team morale by making it easy for staff to do the right thing for the local population and see the benefit of their new way of working.

Impact for the Population & Individual

There will be increased stability of local health and care services. There will be an understanding of "the local offer" and more care away from hospital settings and in the local community.

We will have responsive local health and care teams that are working to help people stay safe, well and independent in their communities and providing care close to them when their health or wellbeing deteriorates. There will be an overall increased level of confidence in living with long term conditions and support provided from early years until the end of life.

Individuals will experience care delivery which is much more streamlined, easier to access and focussed on the individual's health and wellbeing. The Jonkoping approach to improving care coordination and the experiences of particularly elderly individuals will be central to developments in the Community.

Impact for General Practice

GPs provide the senior clinical resource in the community. The ICP will work with local practices and PCNs to form the foundation for the Care Communities and ensure that in line with secondary care clinicians we respect and protect that vital infrastructure.

We hope to encourage them to contribute to the development and leadership of the Care Communities. Over time as the workforce expands and the new care models develop they will be able to provide support and guidance to community teams and support multi-disciplinary working in mutual benefit for our local population.

Resources and Allocation

It is recognised that the investment required to deliver significant transformation through a new models of care programme will be substantial. This aligns with current and historical understandings of local need

to fully develop proposals for service change that meets the future health and care requirements of our population. It is acknowledged that some funds will be released from changing the way services are currently provided but others need to be prioritised from new investment through robust business cases and commissioning support.

The ICP does have a limited amount of non-recurrent funding available for this year to support the initiation of our transformation plan. This will encourage the high trust system that we aspire to. Each Care Community will receive some small amount of funding directly as an indicative budget with an intent for the ICP to find a way to continue to invest in this if teams generate/demonstrate a value return (not merely in cash terms). The remainder of the non-recurrent funding for this year will be allocated to support ICP wide projects as set out in this plan and to deliver the business cases for the service redesign proposals.

The aim is to be ambitious and innovative. We will continue to apply to be part of national and HCP schemes which will enable us to achieve delivery of our theme areas and that will attract investment and benefit for our local population.

Summary

The purpose of the ICP is to improve population health and individual person centred outcomes, to reduce variation in those outcomes across the Place and to maximise our productivity. That is, do as much as we can with the money we have, and at the same time develop a programme of investment which is clear and agreed across our whole system.

There is not enough capacity in Primary Care or Care Communities to do whole system change alongside current service delivery. We need to increase capacity and sustainability in Primary Care and Care Communities which will improve the clinical capacity and ability to do other things.

The four Care Themes present an opportunity to demonstrate:

- Reduction in waste and clinical variation
    - via the Cardiovascular and Respiratory themes
- Reducing the need for specialist hospital services by introducing new ways of working (leading to improved primary care capacity)
    - via the Social Prescribing and Mental Wellbeing theme
- Providing access to specialist advice and bringing the specialist into the community for support and education
    - via the Children's Health Hubs

The learning from these target areas will allow us to develop our approach as an ICP and move towards defining our operating model going forward.

Future Plans and Evolution

As the ICP evolves in maturity we will expand the remit of Care Communities and the resources that are made available to them. The system will develop a shared accountability for the care of the population, no matter which parent organisation they originate from.

In terms of the care themes, we will add an “Older People’s Health” theme in 2021/22 to ensure that the care of older adults remains in focus for our ICP. This will allow us to build on the work completed at that time and fold in the work going on across multiple sectors on frailty and ageing well.

As we improve our coding, business intelligence and system working, the intelligence picture we gather will lead our plans into 2023 and beyond and we will keep the populations needs at the heart of this. Population health and tackling the wider determinants of problems will ensure that we make our system sustainable into the future and we continue to measure the impact of our plans.