Public Document Pack

# Cheshire East Health and Care Partnership Board

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|---|---|
| **Date:** | **MeetingDateLegal** |
| **Time:** | **MeetingTime** |
| **Venue:** | **MeetingLocation** |

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Agenda Item 1

#BecauseWeCare
Cheshire East Partnership

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| **Date** | **10 January 2024** |
| **Time** | **14:00 – 16:00** |
| **Venue** | Middlewich Community Church, 34-36 Brooks Ln, Middlewich CW10 0JG |
| **Contact** | hilary.southern@cheshireandmerseyside.nhs.uk |

# Cheshire East Health and Care Partnership Board

## AGENDA

**Chair: Isla Wilson**

| Time | Item No | Item | Owner (Incl. Partner Organisation) | Outcome Required | Format & Page No |
|---|---|---|---|---|---|
| **14:00** | | **Meeting management** | | | |
| 14:00 | 1 | Welcome, introduction & Apologies | Chair | Noting | Verbal |
| | 2 | Declarations of Interest | Chair | Noting | Verbal |
| 14:05 | 3 | Minutes of meeting on 1st November 2023<br>Action Log and matters arising | Chair | Approval | Paper Page 3 |
| **14:10** | | **Public and Community Focus** | | | |
| 14:10 | 4 | Person's Story (standing item) | Louise Barry, Healthwatch | Noting | Verbal |
| 14:20 | 5 | Care Communities Spotlight (standing item) –<br><br>Crewe Care Community (CCC) | Danielle Roberts, CCC Support Manager/<br>Clare Spargo, CCC Clinical Lead/<br>Emma Stuttard, CCC Service Manager | Discuss | Presentation -on day |
| **14:40** | | **Committee Development** | | | |
| 14:40 | 6 | Feedback from Development Session 01/11/12 | Isla Wilson/ Mark Wilkinson | Discuss | Paper Page 7 |
| **14:50** | | **Plans and Priorities** | | | |
| 14:50 | 7 | Clinical Services Strategy Update | Ian Moston | Noting | Paper Page 15 |
| 15:00 | 8 | Primary Care Access Recovery Plan Update | Amanda Best | Noting | Paper Page 38 |
| 15:10 | 9 | Care Community Operating Model | Anushta Sivananthan | Discussion/ Approval | Paper Page 67 |

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|---|---|---|---|---|---|
| **15:25** | | **Assurance & Performance** | | | |
| 15:25 | 10 | Place Director Report | Mark Wilkinson | Noting | Paper Page 91 |
| 15:30 | 11 | System Finance Report | Dawn Murphy | Noting | Paper Page 97 |
| 15:35 | 12 | Quality & Performance Group Report | Amanda Williams | Noting | Paper Page 106 |
| 15:40 | 13 | Strategic Planning and Transformation Group Report | Dr Dave Holden | Noting | Paper Page 116 |
| 15:45 | 14 | Operational Delivery Group Report | Simon Goff | Noting | Paper Page 123 |
| 15:50 | 15 | Primary Care Advisory Forum Report | Amanda Best | Noting | Paper Page 127 |
| **15:55** | | **Any other Business** | | | |
| - | 16 | Questions from the Public (standing item) | Chair | - | - |
| **FOR INFORMATION ONLY** | | | | | |
| | - | Crewe JSNA | | Info | Paper Page 132 |
| | - | Avoidable Mortality | | Info | Paper Page 200 |
| **16:00** | **Close of meeting** | | | | |
| **Next meeting** | | **Date: Wed 6th March 2024**<br>**Time: 14:00 – 16:00**<br>***Venue TBC*** | | | |

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# Cheshire East Health and Care Partnership Board held in Public

Wednesday 1st November 2023
at 2.00pm – 4.00pm

Committee Suites, Cheshire East Council
Westfields, Middlewich Road, Sandbach, Cheshire, CW1 1HZ

## Unconfirmed Minutes

Membership

| Name | Key | Title | Organisation | Present |
|---|---|---|---|---|
| Isla Wilson (chairperson) | IW | Chairperson | Cheshire & Wirral Partnership NHS Foundation Trust | ✓ |
| Amanda Williams | AW | Associate Director of Quality and Safety Improvement | NHS C&M Cheshire East Place | ✓ |
| Katherine Sheerin | KS | Director of Strategy and Partnerships | East Cheshire Trust | Apols |
| Cllr Arthur Moran | AMO | Formally Elected Member Representative (Councillor) | Cheshire East Council | ✓ |
| Cllr Janet Clowes | JC | Formally Elected Member Representative (Councillor) | Cheshire East Council | ✓ |
| Cllr Jill Rhodes | JR | Formally Elected Member Representative (Councillor) | Cheshire East Council | Apols |
| Dr David Holden | DH | GP/ Chairperson of Strategic Planning and Transformation Group | Place Partnership Group | - |
| Deborah Woodcock | DW | Executive Director of Children's Service | Cheshire East Council | Apols |
| Carolyn Watkins | CW | Chairperson | Mid Cheshire Hospitals NHS Foundation Trust | Apols |
| Ged Murphy | GM | Chief Executive | East Cheshire NHS Trust | Apols |
| Helen Charlesworth-May | HCM | Executive Director – Adults, Health and Integration | Cheshire East Council | ✓ |
| Ian Moston | IM | Chief Executive | Mid Cheshire Hospitals NHS Foundation Trust | ✓ |
| Lorraine O'Donnell | LO | Chief Executive | Cheshire East Council | - |
| Louise Barry | LB | Chief Executive Officer | Healthwatch Cheshire | ✓ |
| Mark Wilkinson | MW | Place Director | NHS C&M Cheshire East Place | ✓ |
| Dr Matt Tyrer | MT | Director of Public Health | Cheshire East Council | Apols |

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|---|---|---|---|---|
| Anushta Sivananthan | AS | Consultant Psychiatrist/ Medical Director | Cheshire & Wirral Partnership NHS Foundation Trust | ✓ |
| Dawn Murphy | DM | Associate Director Finance & Performance | NHS C&M Cheshire East Place | ✓ |
| Aislinn O'Dwyer | AO'D | Chairperson | East Cheshire NHS Trust | ✓ |
| Dr Daniel Harle | DHA | Medical Director | Cheshire Local Medical Committee Limited (LMC) | Apols |

Other in attendance

| Name | Key | Title | Organisation | Present |
|---|---|---|---|---|
| Guy Kilminster | GK | Corporate Manager Health Improvement | Cheshire East Council | ✓ |
| Dr Patrick Kearns | PK | Associate Clinical Director | Place Partnership Group | ✓ |
| Jenny Underwood | HS | Corporate Business Manager – Cheshire East & Cheshire West | NHS C&M Cheshire East & West Places | ✓ |

| Item | Discussion and Actions | Action Owner |
|---|---|---|
| | **Meeting Management** | |
| **1.** | **Welcome and Introduction** | |
| | Chair welcomed all to the meeting – introductions made. | |
| **2.** | **Apologies** | |
| | **The Partnership Board:**<br>• **NOTED the apologies received and any deputies in attendance.** | |
| **3.** | **Declarations of Interest** | |
| | No conflicts of interest pertinent to the items being discussed on the agenda declared. | |
| **4.** | **Minutes and Matters Arising** | |
| | **Minutes of previous meeting held on 6 September 2023** | |
| | **The Partnership Board:**<br>• **NOTED and APPROVED the minutes of the Partnership Board meeting held on 6 September 2023** | |
| **5.** | **Action Log and matters arising** | |
| | Open actions may be picked up in the development session<br><br>**The Partnership Board NOTED the Action Log.** | |

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|---|---|---|
| **6.** | **Decision Log** | |
| | **The Partnership Board NOTED the Decision Log.** | |
| **7.** | **Mid Cheshire Hospitals NHS FT Clinical Services Strategy & New Hospital Programme Update** | |
| | A presentation on the MCHFT strategy was given to the Board by Suzanne Crossley; outlining the strategy which was launched in 2022 alongside the digital strategy and noted how this now translates into the design of the new hospital.<br><br>The strategy outlines the 10 segments of the local population and the 4 care models developed. It was noted that there has been external stakeholder engagement and alignment with the Cheshire East blueprint work.<br><br>It was queried that a significant amount of the care described takes place out of hospital. IM acknowledged that no one part of the system can deliver 100% of care and the aim is for the joins to be invisible, and that this is about MCHFT recognizing the part they are playing within the system.<br><br>The strategy is an essential component of the development of the new hospital and the underlying principles are collaboration and bringing in lived experience of service users and ties in with the reducing inequalities agenda. It looks at whole week working and what a digitally mature organisation looks like and how this could be built into the new hospital.<br><br>Feedback included ensuring reference to children was more explicit within the document, and it would be helpful to see more how the public were involved in the development of the strategy.<br><br>Any further feedback/ comments be directed to IM.<br><br>**The Partnership Board NOTED the presentation.** | |
| **8.** | **Delivery Plan for Health and Social Care in Cheshire East 2023-2028** | |
| | The Board received a presentation on the delivery plan for Health and Social Care in Cheshire East.<br><br>It was noted that it is in effect the Health and Wellbeing Board strategy and Place plan brought into one, with separate delivery plans. It builds on and updates the previous plan and makes links with the Cheshire East blueprint work.<br><br>The delivery plan sets ambitious, but deliverable targets, being cognizant of financial pressures and not raising unrealistic expectations. The Board was given assurance that the aim is to put necessary grip in the system and look at how we spend the money we have differently, for example investing in a preventative offering.<br><br>It was noted that there are different starting points across Cheshire East, and we need to understand the differential need. It needs to be connected to other areas of the system to have maximum impact. | |

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|---|---|---|
| | It is important that the HWB strategy is not only a health plan, but that the entirety of the plan is focused on how it supports better wellbeing.<br><br>**The Partnership Board NOTED the update.** | |
| **14.** | **Any other Business** | |
| | N/A | |
| | **Close of meeting.** | |
| **Date and Time of next meeting:<br>10 January 2024 @ 2pm – 4pm<br>Venue:** | | |

**ITEM 6**

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# Cheshire East Health and Care Partnership Board

# Health and Care Partnership Development

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|---|---|
| **Date of meeting:** | 10 January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Health and Care Partnership Development |
| **Report Author & Contact Details:** | Mark Wilkinson, Cheshire East Place Director<br>mark.wilkinson@cheshireandmerseyside.nhs.uk |
| **Report approved by:** | Mark Wilkinson, Cheshire East Place Director |

| **Purpose and any action required** | **Decision/→ Approve** | **X** | **Discussion/→ Gain feedback** | | **Assurance→** | | **Information/→ To Note** | **x** |
|---|---|---|---|---|---|---|---|---|

| **Committee/Advisory Groups that have previously considered the paper** |
|---|
| Place Leadership Group – 4 January 24 |

| **Executive Summary and key points for discussion** |
|---|
| On 1 November last year, the Partnership Board met to identify what's going well for the Partnership, areas for development, and suggested priorities. From those discussions ten proposed pledges have been developed. They cover partnership behaviours, meeting formats and focus, agenda setting to enable partnership maturity, and a commitment to learn from elsewhere. |

| | |
|---|---|
| **Recommendation/ Action needed:** | The Partnership Board is asked to approve the nine pledges above. |

| **Which purpose(s) of the Cheshire East Place priorities does this report align with?** | |
|---|---|
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | X |
| 3. Create a sustainable workforce | X |
| 4. Significantly reduce health inequalities | X |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e. date, method, impact e.g. feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | X | |
| | Patient / Public Engagement | | | X | |
| | Clinical Engagement | | | X | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | X | |
| | Legal Advice needed? | | | X | |

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|---|---|---|---|---|---|
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | X | | |

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| **Next Steps:** | The ICB place team will take the lead on delivering the pledges. |

| | |
|---|---|
| **Responsible Officer to take forward actions:** | Mark Wilkinson, Cheshire East Place Director |

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| **Appendices:** | Appendix 1 - Notes from Partnership Board Development Session 1st November 2023 |

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# Health and Care Partnership Development

## 1. Executive Summary

On 1 November last year, the Partnership Board met to identify what's going well for the Partnership, areas for development, and suggested priorities.

From those discussions nine proposed pledges have been developed. They cover partnership behaviours, meeting formats and focus, agenda setting to enable partnership maturity, and a commitment to learn from elsewhere.

## 2. Introduction / Background

Following the establishment of the Integrated Care system across Cheshire and Merseyside and Cheshire East Place's partnership within it, the Place Partnership Board was refreshed and met for the first time in September 22.

Subject to partnership maturity there remains an expectation that the Board will receive formally delegated decision-making powers to allocate resources and be accountable for population health outcomes, although the timescales for this change remain unclear. At present, formal accountability rests with individual organisations and post holders within them.

The shift from organisational to place / population focus is a significant developmental challenge and will clearly take commitment over a sustained period.

It is good practice for organisations and partnerships to periodically review their efficiency and effectiveness and make changes in response.

## 3. Partnership Development

On 1 November last year, the Partnership Board met to identify what's going well for the Partnership, areas for development, suggested priorities and how – as a Partnership Board specifically – we are working to deliver on meeting the needs of the people of Cheshire East. The notes from that session are attached as Appendix 1.

From those discussions a number of proposed pledges have been developed and are set out below with a supporting rationale.

| Our pledges. We commit to: | Rationale |
|---|---|
| 1. Act as a full and equal partnership board members irrespective of our organisational roles. | Our membership derives from the organisational position we hold / are elected to. When serving on the board the partnership itself assumes some precedence. |
| 2. Act with openness and transparency including on the sharing of financial positions. | Collaborative behaviour. |

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| 3. Allow as much time as needed to assess organisational and system financial and other impacts before any decisions are made with partnership implications. | Collaborative behaviour requires the consideration of system impact alongside organisational impact. |
| 4. Develop the basis for mutual accountability in a way that adds value and avoids duplication. Likely to include setting some targets. | Systems and processes to reinforce mutual accountability between partners are key elements of successful collaboration. |
| 5. Focus on priority areas that the Board is best equipped to tackle. We will agree these at our next meeting. | There's a huge agenda across health and care. As place partners it's helpful to focus on those issues where collaboration is essential. |
| 6. Greater use of other groups to drive action and make the case for collaboration and integration. Crucially, this includes the continued development of our care communities. | The Board itself has necessarily limited capacity and therefore must make full use of its sub-groups. |
| 7. Partnership Board report recommendations to be about doing things differently. This includes differential resource allocation to address inequality. | In the balance of updates and action, we should 'tilt' towards action. |
| 8. Hold an equal split of wide-ranging meetings (place finance, quality, performance etc) and thematic sessions (for example Core 20 plus 5, new care models). Three each per year. | This proposal allows for more in depth discussion around selected themes and will thus help develop our partnership. |
| 9. Review partnership board papers from other place and consider a thematic board to board potentially with Cheshire West. | Respecting different local context there are significant similarities – and therefore learning opportunities - between Cheshire East and other places. |
| 10. Hold at least one development / partnership review session each year. | Moving to a place / population focus alongside our historic organisational focus is a change requiring development and commitment over a sustained period. |

## 4. Recommendations

The Partnership Board is asked to approve the ten pledges above.

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# APPENDIX 1 - NOTES FROM PARTNERSHIP BOARD DEVELOPMENT SESSION 1ST NOVEMBER 2023

**1. What are you proud of in our place partnership? What have we achieved so far? Where are we making progress?**

a. From all members / partners we have seen a consistent commitment to our local health and care partnership (including the board itself).
b. There are good networks between Board members – the Board is made up of people connected to other groups / committees – which leads to good general intelligence about what's going on.
c. In our first year we have seen an increased spirit of collaboration – built on good relationships.
d. Good to see greater visibility of care communities and their work – allowing people at all levels to build relationships (previously mainly commissioners had the risk appetite to invest in care communities)
e. Stronger commitment to work together – it's becoming part of the 'day job', although it probably always was.
f. Excellent joined up working – especially at operational level.
g. We haven't retreated into silo working (yet) despite the challenging context we are all working in.
h. There are developing governance arrangements in place – with clarification around accountability and right people able to say 'yes'
i. The new refreshed joint health and wellbeing strategy with a stronger focus on the broader determinants of health
j. We have approved the Cheshire East Place digital inclusion plan
k. Development of our 2030 Blueprint workshops, and the Five Year Delivery Plan.
l. Our Living well in Crewe plan reflecting our renewed focus on health inequalities.
m. System quality and performance group.
n. Establishment of the Joint Outcomes Framework / JSNA work / BI at Place perhaps most notably the Care Communities dashboard.
o. Our first collaborative priority of Home First and including winter planning.

**2. What is within our gift that we haven't yet tackled? Are there specific themes or projects we should be prioritising and moving forward?**

a. Less 'show and tell' – more action and leadership (but we still need to get to know what is happening).
b. Greater use of sub-groups to drive action and make the (business) case for collaboration and integration.
c. Challenging up to the central ICB – use with caution, and some partners more able to do this than others.
d. Make better use of the leadership in the room. It's us!
e. Standardise stuff that works – scale it, whether that's across care communities or across other places.
f. Prioritise and hold ourselves to account.
g. Hard wire integration through more formal structures and systems – make it less apparently voluntary when times are tough.
h. Talk about money.

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i. Be more open – consider levers, discuss risk and risk appetite, how willing are we really to collaborate?
j. Create business cases for our money (whoever's budget it sits in).
k. Expect us to be the solution – there's nobody else that can do it in Cheshire East!
l. Used the evidence base.
m. Thematic problem solving – more time, by theme, solution focused.
n. Quick wins.
o. Revisit vision.
p. Rocks, stones, pebbles – what needs to be done at Place level? Be more mindful of what needs to happen at what level - organisations, HCP, ICS so we focus our time on the right things.
q. Greater collaboration with Cheshire West and Warrington.
r. Set some targets to drive collaboration and integration activity.
s. Language – we've agreed some shared lexicon – we need to use it.
t. Core 20 plus five – discuss and monitor. They are really important.
u. Be brave – tackle the tough stuff (Long term conditions, respiratory illness).
v. Consider adopting programme budgeting.
w. Be transparent about what we choose not to do – if everything's a priority then nothing is.
x. Commit to model future population need and be proactive
y. Put the Cure project in across Cheshire East

**3. As place partnership board members, how would you assess our development as place partners? Behaviours / trust / support / challenge etc. How can we increase our effectiveness, impact and collaboration?**

a. Not too many egos – pretty collaborative with good behaviour however need more challenge. Despite this relatively strong position how do we hardwire action focused integration into the way we work.
b. Lacked focus on our own board development. Trust needs to be built for the hard stuff.
c. For the political appointees there is a need for greater role clarity, and specifically where / how do we report in politically? Also, how does each partner fit together?
d. Elected member interested is directly connected to resident interests and that isn't always clear / explained. The elected members can play a unique role.
e. Opportunity to challenge each other – can we do more?
f. Impact could be increased with greater communication out to residents and partners. Also upwards to make our case across Cheshire and Merseyside.
g. Under pressure there is a risk of reverting to organisationally oriented behaviours.
h. We should identify projects where we all have resource invested – agree a couple of key priorities. Dementia and neurodiversity were suggested. Agree leads to bolster individual accountability.
i. In challenging times we should have a relentless focus on incremental improvement. Act more deliberately. Need to be brave to make a difference.

**4. How would you assess our development as a place partnership board? Structure / systems / holding to account / delivery /agendas/ effective meetings etc.**

a. We still need to more work to refine the relationship between the Health & Wellbeing Board and our own Health & Care Partnership Board. In some quarters there is still an element of not quite sure how it all works.

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b. Need to develop stronger system wide performance assurance – the Joint Outcomes Framework can do this for the Health & Wellbeing Board – reporting to provide assurance supported by clarity on accountability.
c. There's a lack of visibility of places and programmes and all the work that is likely going on – as a results people can question: how are they supporting the people we serve?
d. What does good look like? How do we compare to other places?
e. We need to be addressing the question of what's our risk appetite?
f. Having it presented isn't seeing and owning!
g. Having good plans, do we have systems and processes that can translate these into a person level offer.
h. System wide communication needs to be developed alongside organisational.
i. The role of political appointees requires further discussion and working through and how we need to be able to 'leave our badges outside'.
j. The right people are at the table which is a real asset.
k. What's the ask of us as a Board? – clearly not just information sharing.
l. In terms of what gets reported to Board, if could be 'earlier' there would be more time to shape/challenge/push each other – perhaps a thematic agenda might help with this.
m. Communication across all these meeting that we all attend can always be improved - C&M meetings, elected members, partnerships and key meetings – need to share 'up and out'.
n. As a side note, as a Partnership Board are we using scrutiny appropriately?

**MDW**
**06.12.23**

ITEM 7

Mid Cheshire Hospitals
NHS Foundation Trust

Mid Cheshire Hospitals FT

# New Hospital Programme

**Update Jan 2024**



Because you Matter

# Introduction

Mid Cheshire Hospitals
NHS Foundation Trust

As we enter 2024 planning work on the redevelopment of the Leighton site, as part of the New Hospital Programme, is beginning to scale quickly with ambitious timelines attached to it. The attached slide deck is designed to provide a stocktake of some of the important steps that have brought us to this point and to serve as a reference for decisions that will need to be taken over the coming months and years.

It starts with an explanation of what Reinforced Autoclaved Aerated Concrete (RAAC) is and how it is currently impacting the Leighton site.

It then looks at how the Trust strategy, which is informing our thinking about how we deliver services in the future, has been built based on the needs, behaviours, underlying health and changing utilisation of services by our population over time. It describes the four models of care that emerge from this work and their connectivity to the Cheshire East Health and Well Being Strategy and subsequent service blueprinting work that has started.

The next part of the document talks about our clinical services strategy, which we approved in December 2023, following public and partner consultation. This strategy describes the ambitions and objectives we have for the services we currently deliver and our ambitions for how they evolve as we begin to deliver our contribution to the new models of care. This document is important as it will inform the new type of estate we need to design to deliver these services.

After this the slide deck provides some context for the New Hospital Programme and what it means for how this development progresses. Importantly it recognises that this is a collaborative process with many elements of the design being defined nationally.

The slide deck concludes with a look at where we are now. It recognises the early enabling works that we are developing, the timelines we are currently working to and an initial view of the master plan for the site we are considering.

# What is RAAC

- Reinforced Autoclaved Aerated Concrete (RAAC)
- RAAC is a lightweight form of concrete panel that is very different from traditional concrete. It has no coarse aggregate and is made in factories using fine aggregate, chemicals to create gas bubbles, and heat to cure the compound.
- As with traditional concrete, steel is embedded into the concrete mix to provide reinforcement. The reinforcement should not be visible under normal circumstances.
- This aerated mix gives RAAC a 'bubbly' appearance.
- The original lifespan of the RAAC planks was 30 years and Leighton Hospital is now 50 years old.



Mid Cheshire Hospitals NHS Foundation Trust

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# Plank Conditions

Mid Cheshire Hospitals
NHS Foundation Trust

Water damage, natural deterioration, works carried out causing trauma to the planks and water ingress, have weakened the plank structure over time. These works are being checked in the ongoing survey programme and are monitored by Estates.



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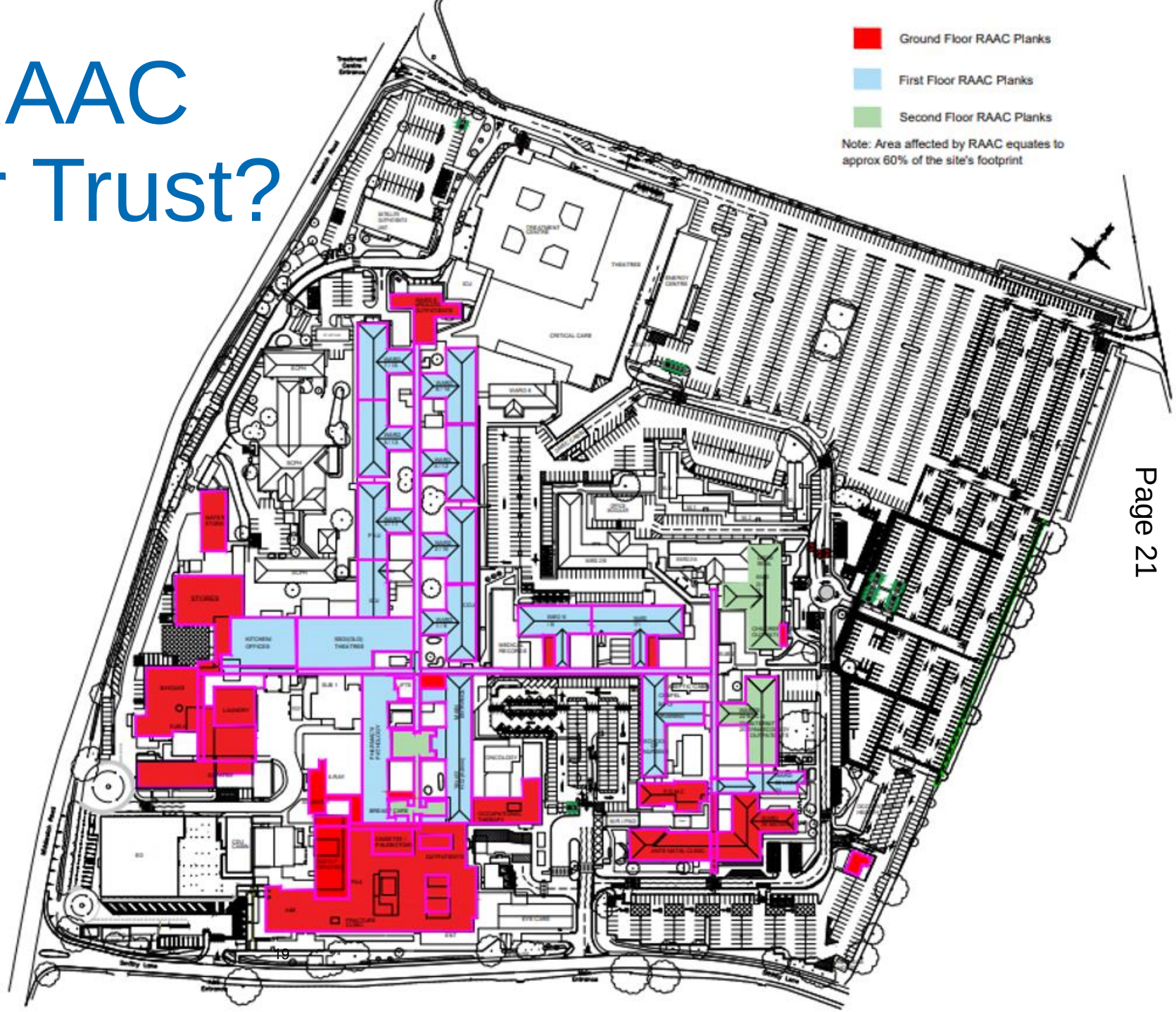
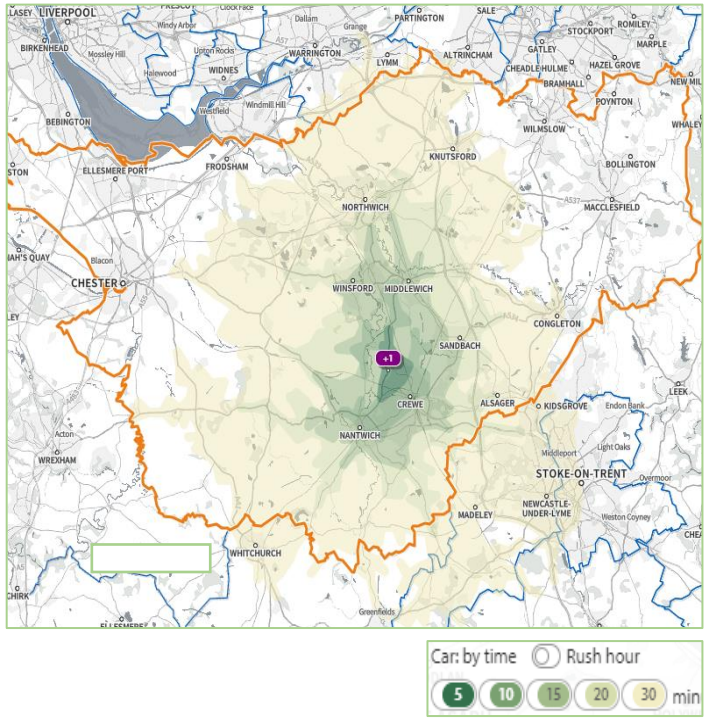
# Where is RAAC located in our Trust?

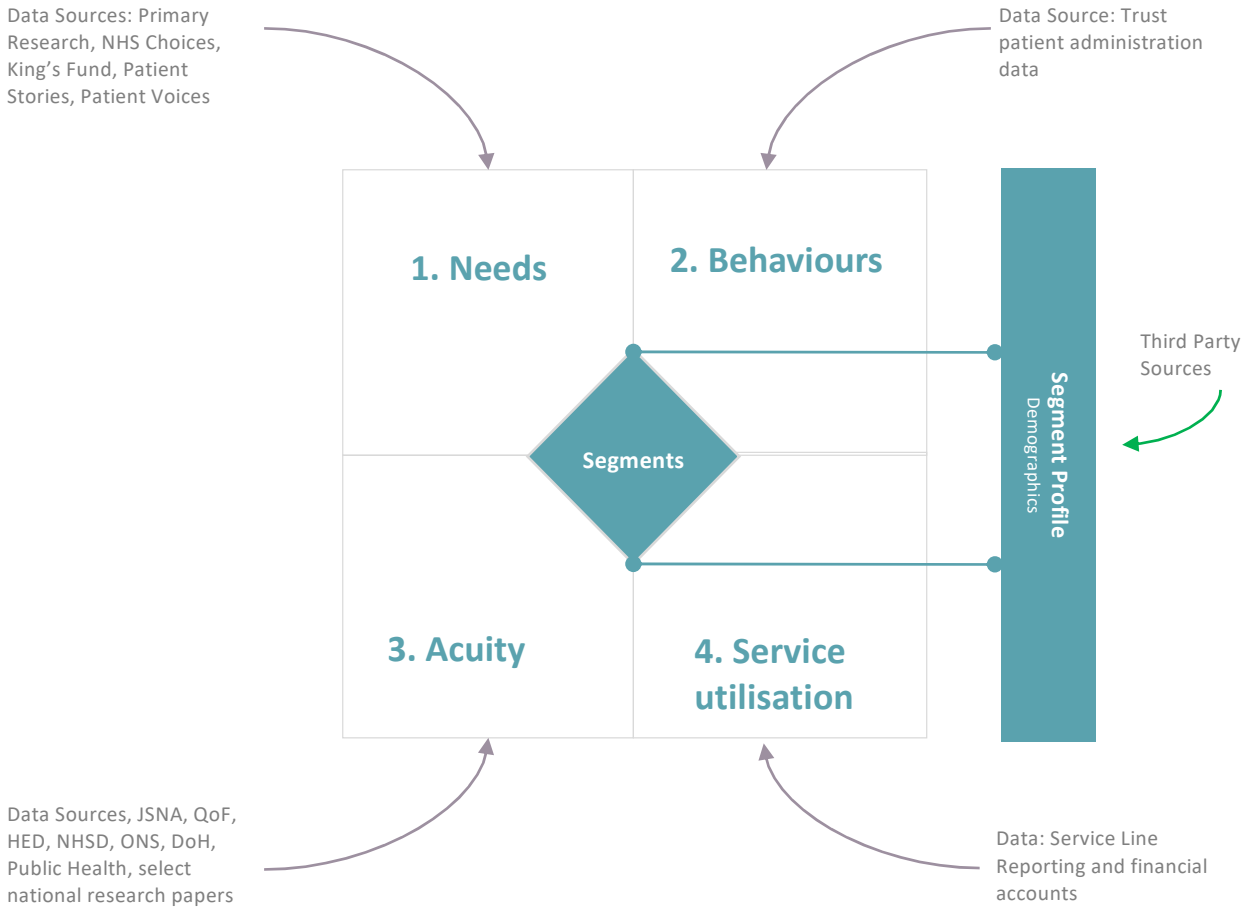
Main entrance
Outpatients
15 wards
PIU/SACU
Pathology
Hospital streets
Estates
Kitchens
Medical records



# Our Trust Strategy

Mid Cheshire Hospitals
NHS Foundation Trust



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# We identified 10 segments for our catchment population…

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

### 1. Carefree

Relatively healthy individuals supported in the community and have not had any acute episodes

| 1 in 2 | 0% |
|---|---|

### 2. Well Mother and Baby

Users of maternity services only, including both mothers and babies.

| 1 in 50 | 71% |
|---|---|

### 3. Consult and Follow-up

Users who only attend outpatient clinics usually for diagnosis and short-term treatment.

| 1 in 13 | 46% |
|---|---|

### 4. Urgent Need

Users requiring urgent attention, generally treated in A&E without the need for other follow up services.

| 1 in 12 | 67% |
|---|---|

### 5. Quick Fix

Users with one-off inpatient treatment which is usually short stay and elective

| 1 in 40 | 92% |
|---|---|

### 6. Unwell High Consumer

Users with no previous diagnosis or long-term conditions with high level of service usage

| 1 in 8 | 50% |
|---|---|

### 7. Living with it

Users with long term health conditions, managed through a combination of outpatients and the community.

| 1 in 36 | 50% |
|---|---|

### 8. Intense Need

Users with at least one long term health condition and have a high level of consumption across services.

| 1 in 17 | 41% |
|---|---|

### 9. Complex Elderly

Multiple long term health conditions causing multiple long stay inpatient spells.

| 1 in 300 | 67% |
|---|---|

### 10. End of life

Users with long term health conditions that die during an inpatient spell.

| 1 in 450 | 81% |
|---|---|

**Key**

| Proportion of catchment population | % of segment served by the Trust |
|---|---|



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Segment Portraits

# Segment 9: Complex Elderly

Our service users

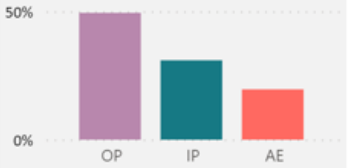
| Patients seen | Segment size |
|---|---|
| 1,532 | 2,278 |

Proportion of patients: 1 in 90

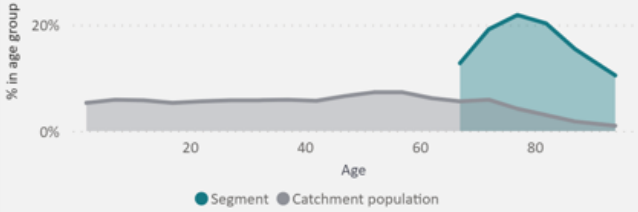
Gender: 47% 53%

% living in Crewe: 44.4%

Proportion of all activity type (%)




Age distribution across segment




"My health has deteriorated considerably since my wife passed away. I have diabetes, arthritis and high blood pressure. A few months back I was hospitalised for a week because of a heart failure. Time in hospital is stressful and I don't like being there.

I am usually confined to a wheelchair and I can't get dressed unaided. I get a visit from a carer twice a day and a district nurse helps me with my medication. I appreciate their help, but it does make me feel a bit useless. They often treat me like a child. It is also frustrating when they are new, because they don't know me, my likes and my dislikes.

I go to church every week. I like the people there, but I find it difficult to really open up to anyone. I don't really like to discuss my business with anyone other than my son.

I often feel depressed. I'm starting to forget more and I get confused easily. I'd like to know what to do to improve my memory.

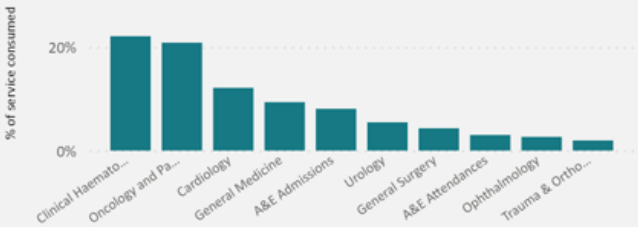
**Wants to:**
- feel more independent
- be listened to and have concerns acknowledged
- be engaged in the community
- have a purpose in life

**Frustrated by:**
- being dependant on others
- not being involved and helped to self care
- feeling bored and without purpose
- poor care and frequent changes in carers

**Attitude:**
- I want others to make decisions in my interest and with me
- I want to stay as well as I can as long as I can
- I worry about the unstable nature of my illness
- I worry about what will happen when I get worse

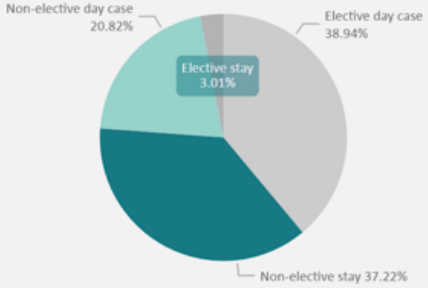
**Needs services that:**
- co-ordinate my care
- are local, caring and delivered by familiar people
- involve me and my family in decision making
- plan in the long-term and consider all my options

Services used by patient




| Total activity | Average length of stay | Income to cost | Percentage of total cost |
|---|---|---|---|
| 17,089 | 3.48 | 0.92 | 5.72% |

Type of inpatient spell





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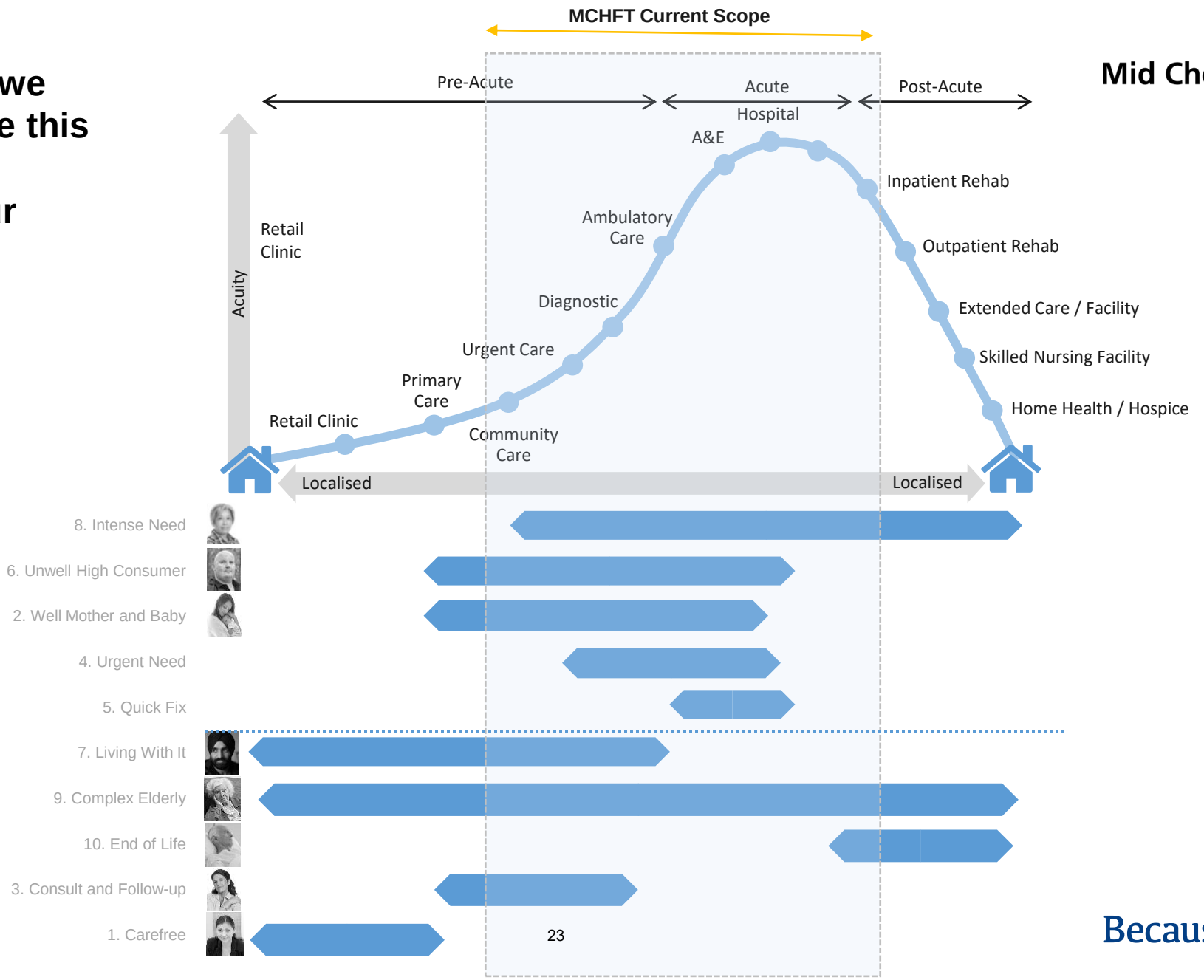
**We know that we cannot achieve this new way of working on our own …..**




Mid Cheshire Hospitals
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# Four distinct but inter-related delivery models to meet the needs of the population of Cheshire, sustainably

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### HELP ME WHEN THINGS GO WRONG

This model of care describes how we will provide medical and surgical services to treat patients, delivering optimal clinical outcomes and ensuring a good experience for all service users.

### HELP ME TO STAY WELL

This model of care encompasses primary prevention strategies to support how we will keep people well. It also describes how we will work with patients, carers and the local community to support people in managing their chronic conditions and how we will support our ageing population with their increasingly complex needs.

### HELP ME TO FIND OUT WHAT'S GOING ON

This model outlines how we will provide expertise, access and convenience to diagnose and develop treatment plans for our patients.

### HELP ME TO THE END OF LIFE

This model describes how we will provide highly personalised and holistic end of life care in the place that matters most to our patients and their families.

# Cheshire East Place Health and Wellbeing Strategy

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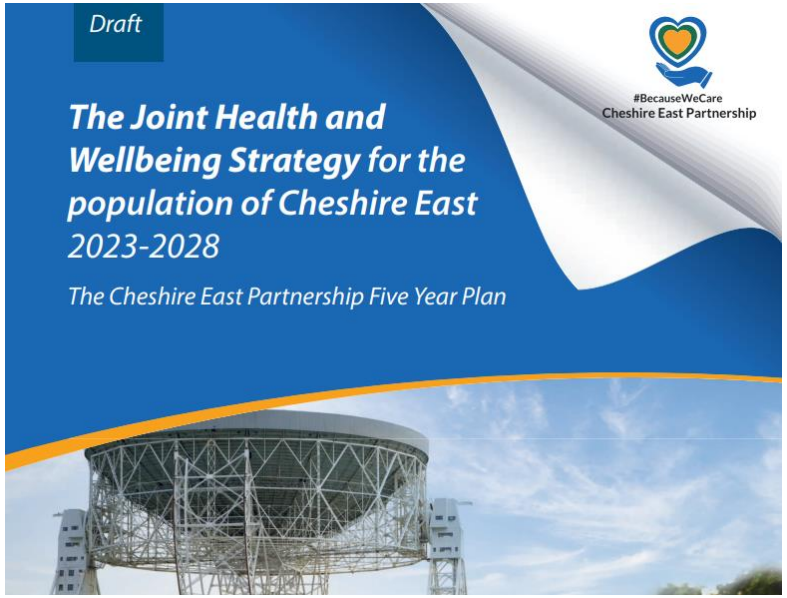


## CREATING A 2030 'BLUE PRINT' FOR HEALTH AND CARE SERVICES IN CHESHIRE EAST

*The recent Cheshire East Collaborative Leadership programme has stimulated some great discussions amongst colleagues across the Place. One of the discussions has been about whether we need a vision or blueprint for what services should look like in the medium / longer term future – say 2030.*

1 2 3 4 5 6 7

**Habit 1 – Be proactive**
We know that we already have a significant number of strategies and plans, but we think that we need something which sets out the agreed integrated model of service which we're all aiming for, so that we can test whether each project we're focusing on takes us towards this. So, using some of the techniques from the Leadership programme, and borrowing unashamedly from Steven Covey's 7 'The 7 Habits of Highly Effective People' in producing this briefing paper to describe what we mean.

**Habit 2 - Beginning with the end in mind**
We are proposing that we need to create a blueprint of what we're aiming for so that we have a better sense of the precious time, energy and resource we commit is taking us in the right direction. By blueprint we mean picture and narratives that set out what level and range of service every person in Cheshire East should expect from -
- Their GP
- Their PCN
- Their Care Community
- Their network of PCNs / Care Communities
- Their local hospital
- Social Services

**Habit 3 - Put First Things First**
Principles for the blueprint would be agreed, for example: -
- Be person-centred, outcomes focused, evidence based
- Ensure the best use of resources across settings
- Create the environment for a great place to work
- Take account of inequalities in access and outcomes
- Be developed inclusively across partners and people

**Habit 4 - Think win win**
The blueprint would:-
- Reflect a clear and valued contribution from all sectors
- Ensure that no one organisation is destabilised to the point of unviability
- Enable longer term planning for commissioners and providers (statutory and non-statutory)

**Habit 5 - First seek to understand**
Our starting point would be to review the outputs from the Caring Together (Eastern Cheshire CCG) and Connecting Care (South Cheshire and Vale Royal CCGs) transformation programmes, and to consider whether they still set out the destination we should be aiming for. There is a strongly held view that this was developed in an inclusive way to build a consensus approach at the time.
We would also review the more recent work including on the four care models to see how this can help to frame this picture and we would reflect on what has been achieved in the last few years, and the changes that have been made in service delivery which take us towards this.

**Habit 6 – Synergize**
We propose that all of this is brought together in a workshop (or series of workshops) during June / July with a diverse group from across Cheshire East to build our blueprint for 2030, with the aim to share for formal endorsement in October. We would also consider the need for separate implementation plans for the ECT and MCFT footprints, given different starting points and patterns of resources.

**Habit 7 - Sharpen the saw ('renewal')**
Whilst we want a very clear blueprint, at the same time we recognise that this will to an extent be iterative, effected by external events and the changing environment. So we will need an on-going check-in and review process with all stakeholders, to test currency and build in learning from implementation.

**Taking this forward**
We suggest that a small task and finish group drawn from the Strategy, Transformation and Planning Group is established to take this forward, reporting to Place CEOs. Our timescales would be to undertake the workshops over the summer, with a view to producing a draft blueprint for endorsement by all partners by October 2023.

Page 2 of 8

25

## A new model of care to meet changing needs

The make-up of our population continues to change and our plans for services need to reflect this. The economic regeneration of Crewe, arrival of HS2 and significant levels of housebuilding will bring in working age families to parts of the borough. Elsewhere we have fast growing cohorts of older people and our health and care services need to be ready to meet the needs of people with increasing frailty, multiple medical conditions and increasing levels of dementia.

New ways of working will be key to achieving better outcomes for our residents and meeting the changing and increasing demands. We also need to make the most of new technology, medicines and treatments that will improve health and wellbeing and make it easier to access health and care services when needed.

Our assumptions and planning will be tailored to promoting wellbeing and preventing illness, where possible and to supporting and empowering people to live with and manage frailty and several health conditions more effectively at home and in their communities. Local teams of health and social care professionals, working in partnership with families and carers, partners, will enable better co-ordinated care.

Through a detailed analysis of our population and local health and care needs, the new 'model of care' has been designed around the individual and will feature four elements:

**Figure 8: The new model of care**

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# Creating a viable model for the District General Hospital of the future …

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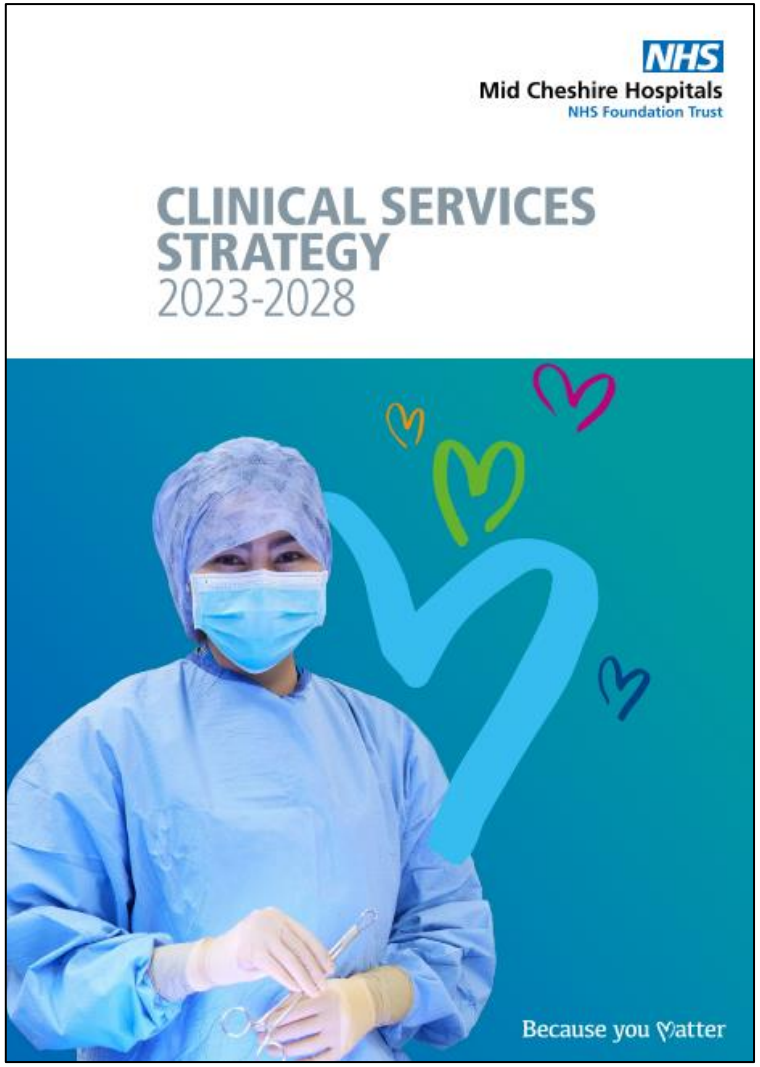


## Strategy Development

- Internal stakeholders
- Patient and service user feedback
- Primary Care clinicians
- Neighbouring NHS provider Trusts
- PLACE partners
- System partners
- GIRFT reviews and other national report findings

## Underlying principles

- Collaboration and partnership working
- Digital technology
- Service user voice and experience
- The NHS prevention pledge
- Whole week working

# Key objectives within our clinical service strategy

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| | |
|---|---|
| **Help me when things go wrong** | ➢ Increasing the proportion of acute care delivered in community and ambulatory settings across the whole of the week.<br>➢ Improving access and waiting times for access to elective care<br>➢ Development of centres of excellence for benign condition<br>➢ Expansion of locally delivered services where efficient and sustainable<br>➢ Working with system partners supporting regional programmes |
| **Help me to find out what's going on** | ➢ Expansion of diagnostic facilities across a range of community and hospital locations<br>➢ Streamlining of diagnostic pathways to ensure right person, right place, first time approach<br>➢ Greater use of digital technology (patient portals etc) to improve access and ownership of information |
| **Help me to stay well** | ➢ Maximising opportunities for health promotion and disease prevention through the development of co-located services in easily accessible locations.<br>➢ Development of screening services in community location<br>➢ Development of services to support our frail and elderly population within the community setting.<br>➢ Transition in delivery of care to predominantly community settings to support patients with chronic disease.<br>➢ Provision of rehabilitation facilities with dedicated optimal environment and specialist workforce. |
| **End of Life Care** | ➢ Contribute effectively to delivery of the C&M ICS Palliative and End of Life care plan<br>➢ Seven day specialist palliative care service which all patients can access<br>➢ Dedicated inpatient estate to support optimal environment |

# What is the New Hospital Programme?

Mid Cheshire Hospitals NHS Foundation Trust

**Key Government 2019 Election Manifesto included building 40 new Hospitals in England by 2030**

- Replacing outdated infrastructure with modern, innovative and environmentally sustainable buildings
- Deliver intelligent hospitals
- Develop national capability
- Build better, build faster and build a sustainable legacy
- Called Hospital 2.0

# What is Hospital 2.0?

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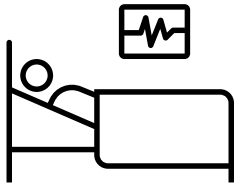
## • Standardised repeatable design



- Consistent Design Across all New Hospital Construction
- Some Be-spoking for Site Specific issues example ground conditions
- Kit of Parts e.g. bathroom components, doors (27k to 700)
- Uses Modern Methods of Construction

## Efficiencies

- Integrated whole systems approach enabling best-value procurement and construction
- Schedule and Time Savings as Design already Completed
- More cost certainty due to designs being re-used and less risk of design flaws.
- Allows more investment by private sector to innovate

## Improvements in patient care

- Enables consistent approach to transformation across the NHS
- Encourages standard and tested patient flows due to standardised patient pathways
- Greater Staff familiarity when working out of multiple hospitals
- Allows more input from Staff, Patients and patient representative groups



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# Hospital 2.0 is about a Collaborative approach

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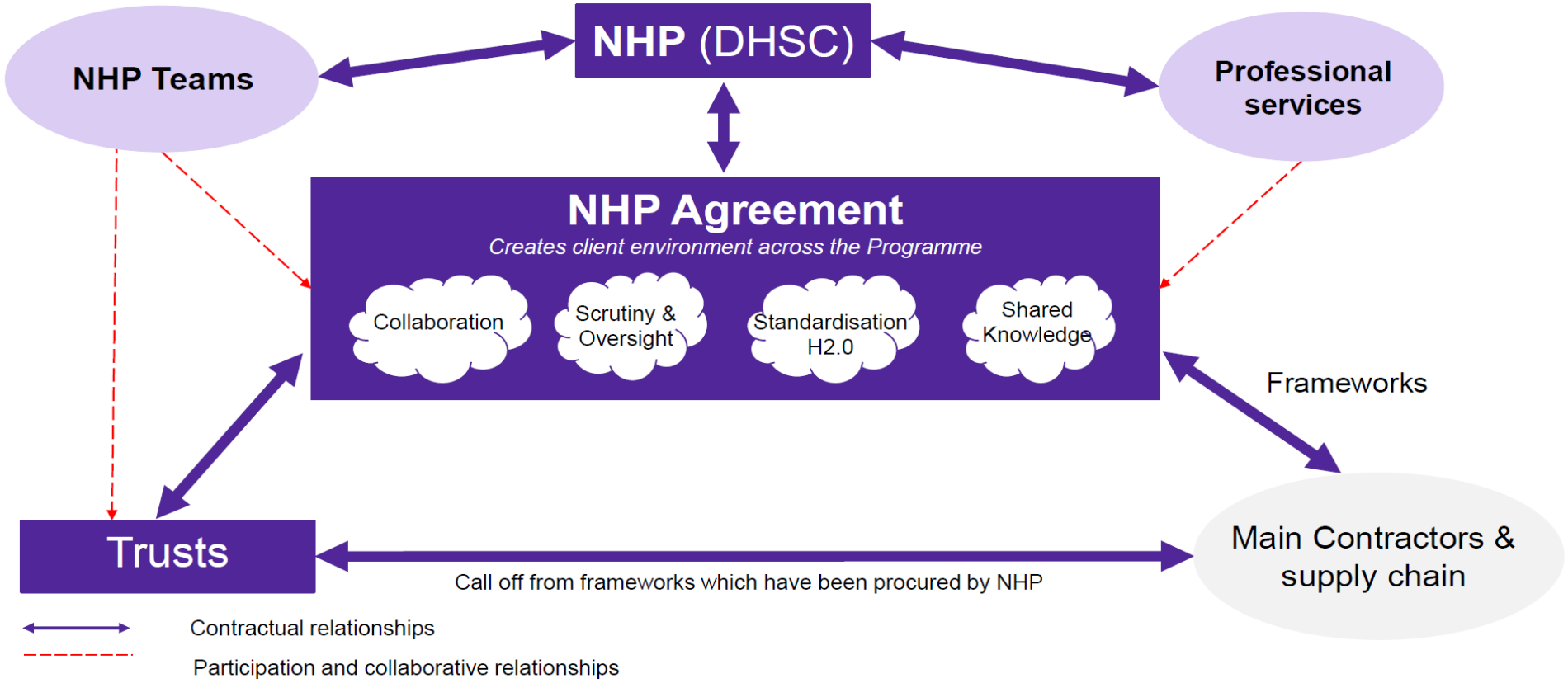
## NHP Environment for collaboration

The NHP environment is the collaborative environment that brings together NHP, Trusts and the Supply Chain to collectively realise the programme's objectives.



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# Build Standardisation Approach

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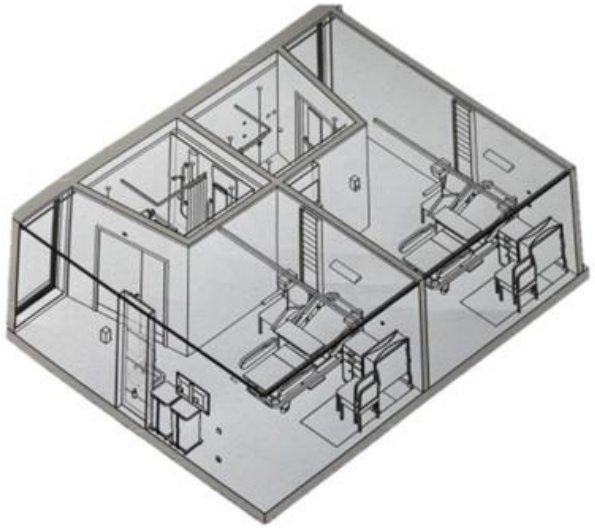
- Using Modern Methods of Construction (MMC) - off-site manufacture to reduce build time and help meet the NHS's net zero carbon ambitions

- Provisions for the procurement and mandating of common components

- Standard room design > the introduction of single rooms

- Digital technology and intelligence > Smart technology will reduce basic and repetitive tasks and free up time for patient care





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# 25th May 2023 Leighton announced as part of the New Hospital Programme

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**The new Leighton Hospital campus…**

**A unique opportunity to use RAAC to redesign the district health and care model for the future**





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# Reference site for hospital 2.0

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| Opportunity | Why Leighton Campus? | Our ask of you |
|---|---|---|
| To create a new clinical model for district health and care for the next 50 years | Large population, single acute integrated provider, long-standing relationships with evidence of improved care outcomes. | Engage and work with us to further develop a future service model that considers a population physical and mental health and care needs |
| To evolve the national workforce strategy to understand the question of where people want to work | We have already provided solutions to our recruitment challenges.<br>Our 'grow your own' ambition is strong | Meaningful engagement on service configuration and estate solutions that encourage long term retention from investment in talent |
| To demonstrate the safety and productivity gains a digitally mature organisation can achieve | Although digitally immature we have evidence of driving huge benefits to date | Funding to enable us to engage our people, systems and partners to deliver effectively embedded digital systems |
| To create a real world model hospital and develop a new financial framework | Our current financial position highlights the challenge facing DGHS and a financial recovery plan is under development | Encourage close and effective working with the national team to develop and test financial and budgeting solutions |
| To create a solution for an energy independent NHS | The Cheshire bowl is an ideal location for geothermal energy capture | Continue momentum and funding to explore an NHS powered by geothermal energy |

# Enabling works

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| Project | Brief Description |
|---|---|
| Electrical Capacity Upgrade | HV upgrade and resilience |
| Site Expansion | Adjacent land acquisition |
| Logistics Facilitation | Temp surface parking and laydown |
| Site Preparation & Infrastructure | New build site preparation |
| Sustainability | Geothermal and solar enablers |
| Overspill Logistics Area | Further laydown temp surface parking |

# Q1 2024 Key Milestones

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| Activity / Period | January | | | | | February | | | | March | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 01/01 | 08/01 | 15/01 | 22/01 | 29/01 | 05/02 | 12/02 | 19/02 | 26/02 | 04/03 | 11/03 | 18/03 | 25/03 |
| Fix schedule of accommodation | | | | | | | | | | | | | |
| Fix programme and phasing strategy | | | | | | | | | | | | | |
| Cost Preferred Way Forward & Short List | | | | | | | | | | | | | |
| Complete masterplan design and RIBA 1 Stage Design Report | | | | | | | | | | | | | |
| Financial & economic modelling | | | | | | | | | | | | | |
| Complete SOC | | | | | | | | | | | | | |
| Issue to ICB | | | | | | | | | | | | | |
| Receive letter of support from ICB | | | | | | | | | | | | | |
| Submit SOC to Trust Board | | | | | | | | | | | | | |
| Submit SOC to NHP & NHSE | | | | | | | | | | | | | |



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# Draft timetable

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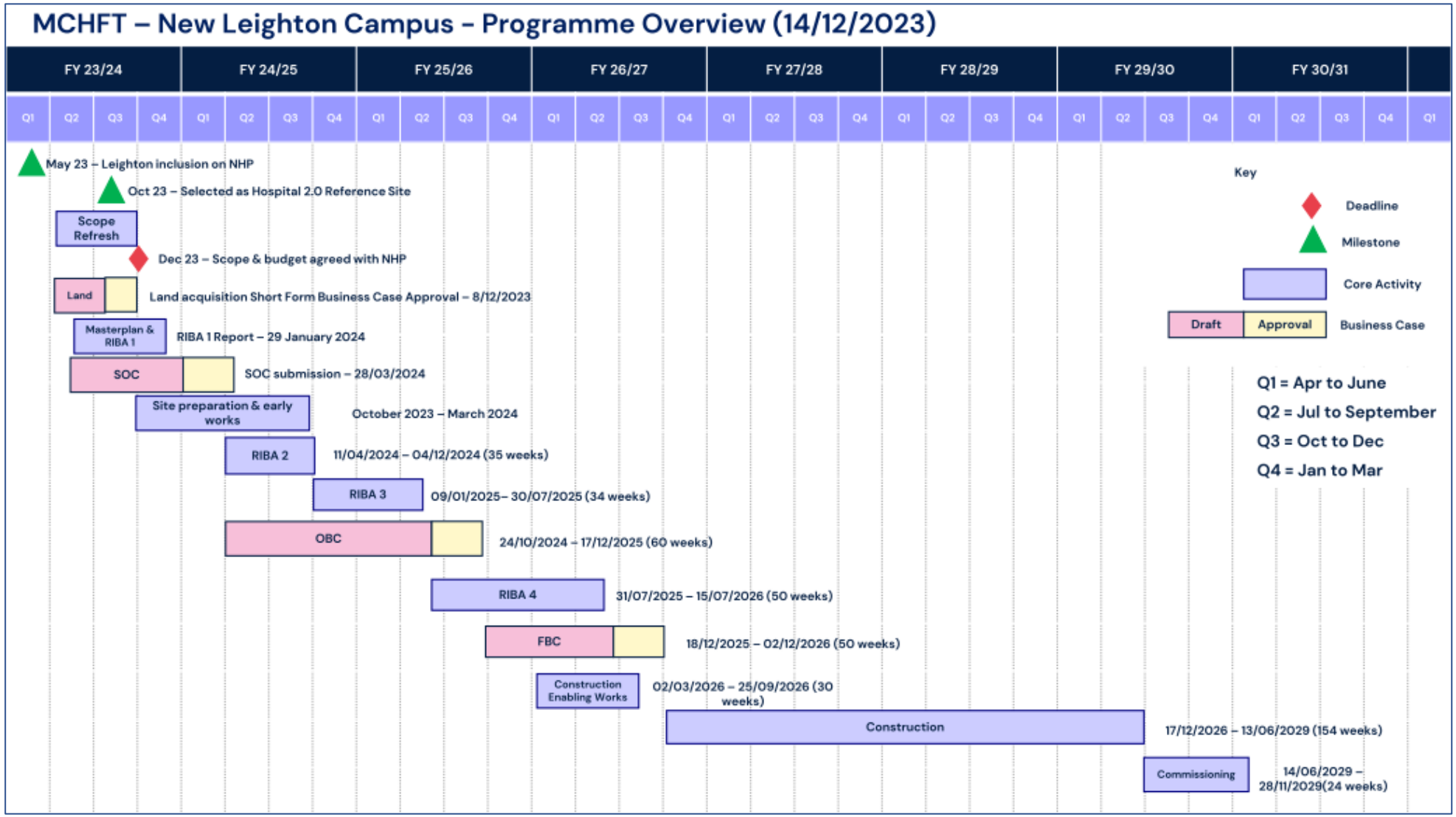




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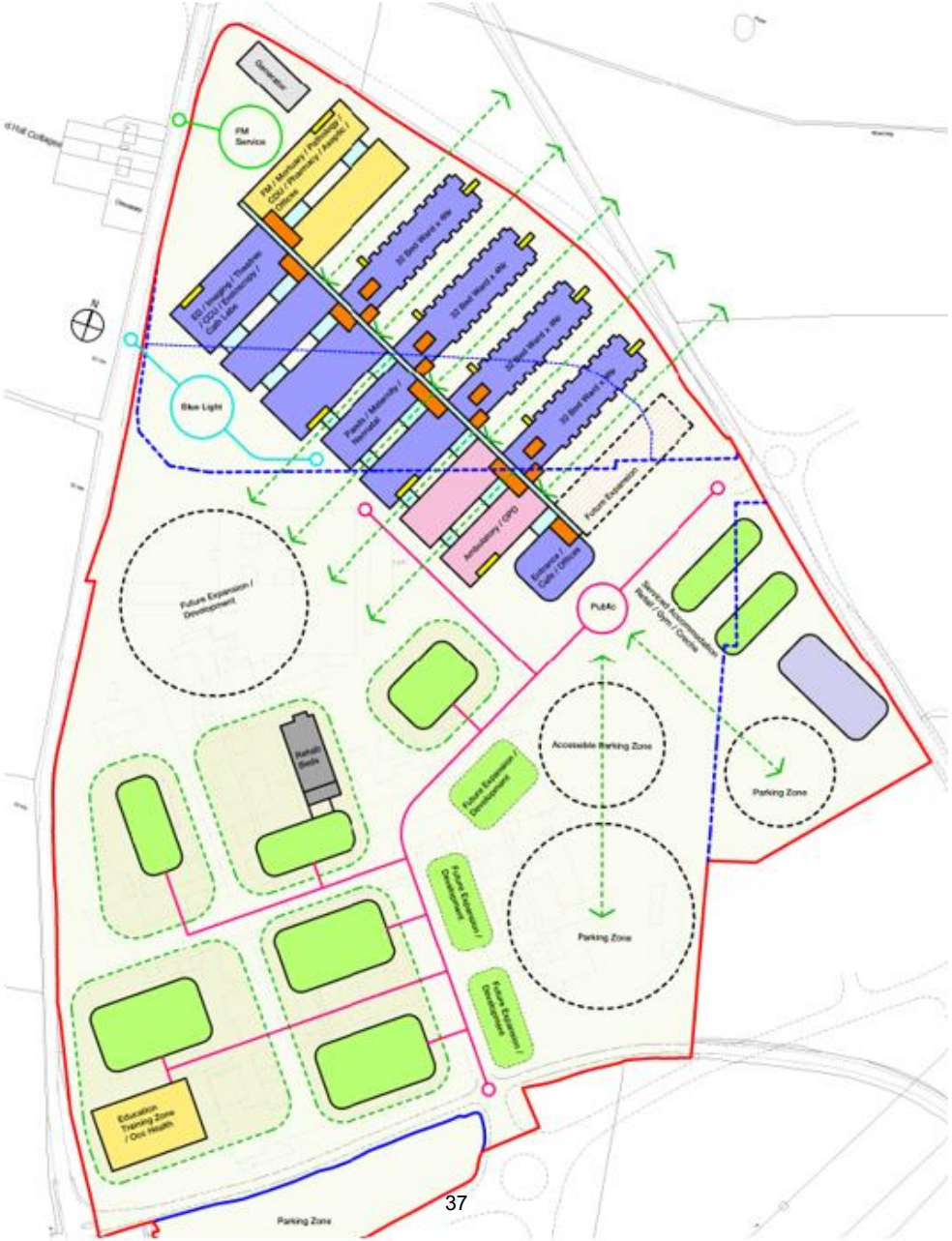
# Draft master planning



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#BecauseWeCare
Cheshire East Partnership

# Cheshire East Health and Care Partnership Board

# Cheshire East Access Recovery Programme – Summary of Progress

#BecauseWeCare
Cheshire East Partnership

| | |
|---|---|
| **Date of meeting:** | 10th January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Cheshire East Access Recovery Programme |
| **Report Author:** | Amanda Best |
| **Report approved by:** | Mark Wilkinson |

| **Purpose and any action required** | **Decision/→ Approve** | | **Discussion/→ Gain feedback** | | **Assurance→** | **X** | **Information/→ To Note** | **X** |
|---|---|---|---|---|---|---|---|---|

**Executive Summary and key points for discussion**

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Board is asked to:**<br>a) Note the content of the Report. |

**Consideration for publication**

Meetings of the Health and Care Partnership Board will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:

| | |
|---|---|
| The item involves sensitive HR issues | |
| The item contains commercially confidential issues | |
| Some other criteria. Please outline below: | |

**Which purpose(s) of the Cheshire East Place priorities does this report align with?**

Please insert **'x'** as appropriate:

| | |
|---|---|
| 1. Deliver a sustainable, integrated health and care system | |
| 2. Create a financially balanced system | |
| 3. Create a sustainable workforce | |
| 4. Significantly reduce health inequalities | |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e., date, method, impact e.g., feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | | |
| | Patient / Public Engagement | | | | |
| | Clinical Engagement | | | | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | | |
| | Legal Advice needed? | | | | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | | |

#BecauseWeCare
Cheshire East Partnership

# Cheshire East Access Recovery Programme – Summary of Progress

## 1. Introduction

1.1 The purpose of this report is to provide the Cheshire East Health and Care Partnership Board with an overview and understanding of the requirements within the Primary Care Access Recovery Programme and to appraise the Board of the progress that Cheshire East Place is making towards delivery the Access Improvement objectives.

## 2.0 National Policy – Recovering Access to Primary Care

### 2.1 National Aims & Ambitions

2.1.1 National guidance document can be found here https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

2.1.2 Aimed at General Practice but with some Community Pharmacy actions due out of ongoing national negotiations.

2.1.3 Aim to tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice.

2.1.4 Enabling patients to know how their needs will be met when they contact their practice.
A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022.*

2.1.5 Integrated Care Boards (ICBs) have to ensure their plans are submitted to Boards in October/November using the following document as guidancehttps://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/

2.1.6 The plan focuses on four areas to alleviate pressure and support general practice further;

2.1.6.1 **Empowering Patients**
*Improving Information and NHS App Functionality*
*Increasing self-directed care*
*Expanding Community Pharmacy*

2.1.6.2 **Implementing Modern General Practice Access**
*Better digital telephony*
*Simpler online requests*
*Faster navigation, assessment and response*

2.1.6.3 **Building Capacity**
*Larger multidisciplinary teams*
*Increase in new doctors*
*Retention and return of experienced GPs*
*Primary Care estates*

2.1.6.4 **Cutting bureaucracy**
*Improving the primary/secondary care interface*
*Building on the bureaucracy busting concordat*

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## 3.0 Public and Patient Feedback

3.1 Most of our residents' report having a good experience of accessing GP Services, the care they receive and have a high level of trust and confidence in their Healthcare Professions. We can evidence this through external validation via the GP National Survey results, detailed below.

**Place Summary Metrics**

| Group | Metric | National | ICS | Cheshire East | Cheshire West | Halton | Knowsley | Liverpool | Sefton | St Helens | Warrington | Wirral |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall Experience | Q32. Overall, how would you describe your experience of your GP practice? **% Good** *(Very Good + Fairly Good)* | 71% | 72% | 76% | 78% | 67% | 63% | 70% | 71% | 69% | 71% | 76% |
| Making an appointment | Q16. Were you satisfied with the appointment (or appointments) you were offered? **% Yes, took appt** *(Patients who selected 'I was not offered an appointment' have been excluded)* | 72% | 73% | 77% | 76% | 69% | 66% | 72% | 73% | 69% | 74% | 74% |
| | Q21. Overall, how would you describe your experience of making an appointment? **% Good** *(Very Good + Fairly Good)* | 54% | 54% | 62% | 59% | 42% | 41% | 51% | 51% | 50% | 53% | 58% |
| Local GP Services | Q1. Generally, how easy is it to get through to someone at your GP practice on the phone? **% Easy** *(Very Easy + Fairly Easy)* *(Patients who selected 'Haven't tried' have been excluded)* | 50% | 48% | 54% | 53% | 35% | 41% | 44% | 44% | 47% | 47% | 56% |
| | Q2. How helpful do you find the receptionists at your GP practice? **% Helpful** *(Very helpful + Fairly Helpful)* *(Patients who selected 'Don't know' have been excluded)* | 82% | 83% | 85% | 87% | 78% | 78% | 80% | 83% | 82% | 82% | 86% |
| | Q30. During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to? **% Yes** *(Yes, definitely + Yes, to some extent)* *(Patients who selected 'Don't know/doesn't apply' have been excluded)* | 93% | 93% | 94% | 96% | 91% | 88% | 93% | 93% | 93% | 93% | 94% |
| | Q47. Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP practice was closed? **% Good** *(Very Good + Fairly Good)* *(Patients who selected 'Don't know/can't say' have been excluded)* | 45% | 44% | 43% | 48% | 45% | 39% | 43% | 40% | 49% | 37% | 49% |
| Access to on-line services | Q4. How easy is it to use your GP practice's website to look for information or access services? **% Easy** *(Very Easy + Fairly Easy)* *(Patients who selected 'Haven't tried' have been excluded)* | 65% | 66% | 67% | 70% | 64% | 57% | 65% | 65% | 70% | 62% | 67% |

Place ragged against ICS Average: Green > than comparison, Amber = comparison, Red < than comparison

3.1.1 In addition, 100% of Cheshire East GP Practices are rated as being Good or Above by the Care Quality Commission (CQC). A testimony to the hard work and commitment staff make every day in ensuring that their services are safe, effective and well led.

3.1.2 That said, our residents have told Healthwatch about some of the challenges they face in accessing some GP services. As delegated commissioners of General Medical Services we have a duty to respond and put in place a series of improvement recommendations as detailed within the Access Recovery Programme.

3.1.3 The improvements we expect to be made as a result of the Access Improvement Plan aim to ensure that people:

- Feel valued and important/understood from their first point of contact with their GP surgery by encountering less hurdles and receiving friendly, clear information about how to access appointments and services - avoiding people feeling isolated and disenfranchised.
- Feel confident when calling their General Practice and that unpaid carers are listened to and included when appropriate.
- Can make or manage appointments by visiting the Surgery; by an uncomplicated telephone system that is answered in a timely manner; or by online systems where appropriate and accessible to people. Each of these methods should respect people's privacy.
- Understand what the process/system is for apps and technology for those that want to use it, with clear information of when it is available and what the alternative is, particularly for those that require reasonable adjustments for access.

- Have assurance that language & translation services are included effectively, which could reduce the *did not attends* (DNAs) and cancelled appointments.

- Have a choice of appointments available to them, recognising the merits of face-to-face and online methods.

- Get an appropriate appointment from first contact with a date, time and name of who they will be seeing, and they understand the different roles within practices. With so many different language/names/titles used it is important that people know why they are seeing someone other than a GP, and that they know what they can do, both possibilities and limitations.

- Be given a set time for online consultations, rather than long periods of time that require time off work to wait.

- Be able to make follow-up appointments at the time of original/next appointment.

- Know what the next step/action is, when that is likely to take place, and how they can keep track of any referral.

## 4.0 Access Improvement Ambitions

4.1 Our ambition is not only to improve access to general practice services for our population, but to achieve a **single more consistent offer of Primary Care (General Practice) access**. In 23/24 the system will have invested circa £90 million in access related support and developed a single set of performance measures to support and quantify 'improvement' across the system.

4.2 Cheshire East Place is an active contributor in delivering these ambitions.

Our key aims are;

- **Enabling better, easier access to more appointments:**

    - **Access to a routine appointment within two weeks**
      Using the IIF (Investment and Impact Fund) indicator measurement and data collection from booking to appointment, to achieve measurable increases in 23/24 and beyond.

    - **Same day appointments for patients who require them**, with all patients provided with an appropriate response following initial contact, that same day, in line with the recent national contract amendments.

    - **That patients can easily access the practice by all available means**, noting the specific feedback via the GP Practice Survey, Friends and Family Tests, our Healthwatch colleagues and that patients want to see the biggest improvement in **telephone access.**

    - **Delivering more appointments overall** by all available means, with an agreed target and trajectory for 24/25 and beyond.

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- **Ensure equality of access for all patients, communities, and vulnerable groups.**

- **Investing in our primary care workforce** including wellbeing offers, retaining GPs and responding to the asks in the National Long-Term Workforce Plan:
    - **A clear plan to retain GPs within the ICB** – patients tell us they value direct contact with their 'GP', and the ICB and specifically Cheshire East Place has a considerable percentage of GPs in their 50s who may be considering leaving the profession in the next few years. Not foregoing the need to develop and retain our Practice Nurses and management teams as well.
    - **Maximising ARRS (Additional roles)** to maximise spend and recruitment by March 2024.
    - **Increasing our headcount GPs** based on the national ambition.
    - **A clear delivery plan 1/4/2025 to respond to the NHS Long Term Workforce plan.**
    - **Prioritisation of Wellbeing offers,** recognising the huge pressures facing our primary care workforce, working with our Local Medical Councils (LMCs) and practice staff.

- **Support all our practices to have the key elements of the 'Modern General Practice Access Model'** in place by December 2024 **-** this model underpins all our access ambitions and as part of this we need to ensure best practice and progress is shared and celebrated.

- **'Measuring success'** not just by using our performance dashboard, but by working with all our key stakeholders to collect meaningful patient feedback, particularly in our most challenged areas and populations.

## 5.0 PCARP Finance

5.1 The overall aim of the funding outlined in the table below, is to deliver an improved experience of access for patients, better continuity of care where most needed, and improved job satisfaction for staff.

5.2 Each of the funding streams have been allocated at System level, with some funding allocated to Places based on a fair shares model. Centralised funding has been held back to support a whole system "at scale" approach to developing Access Improvement and Transformation projects.

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**Table 1 PCARP Finance**

| SDF and Primary Care Access Recovery Funding | Total C&M allocations | Cheshire East Place |
|---|---|---|
| GP Practice Fellowships | 1,667,000 | - |
| Supporting GP Mentors | 392,000 | - |
| GP IT and Resilience | 568,328 | 84,609 |
| C&M GP Retention | 320,869 | 40,166 |
| Top Slice for Digital Funding | 600,000 | - |
| Transformation Funding Pool | 3,054,216 | 460,348 |
| Leadership & Management | 2,004,835 | 280,342 |
| **Total SDF 23/24** | **8,607,248** | **865,465** |
| Capacity and Access Support Fund (CAP) | 8,116,762 | TBA |
| Capacity and Access and Improvement Payment (CAIP) | 3,478,612 | TBA |
| Transition Cover and Transition Support Funding | 2,050,000 | - |
| Cloud Based Telephony | 1,178,000 | - |
| ARRS Support | 65,782,087 | 9,439,440 |
| Pharmacy Offer (£TBC) | TBC | TBC |
| **Primary Care Access Recovery Support Funding** | **80,605,461** | |
| **Total Funding** | **89,212,709** | **10,304,905** |

5.3 It is worthy to note that given the challenged financial position of the ICB, less funding has been made available to Places / PCNs compared to other years and the funding streams have been consolidated from previous years. This is most notable in the Digital Transformation Funding areas.

Whilst there is one funding pot, the funding and support available covers the following.

1. **Transformation** which incorporates:
   - Local GP retention fund
   - Primary Care estates business cases
   - Training hubs
   - Primary Care flexible staff pools
   - Practice Nurse measures
   - Practice resilience
   - Transformational support (which included the previous Primary Care Network (PCN) development and digital-first primary care funding lines)
   - PCN leadership and development (£43 million)
2. **Workforce** programmes which cover:
   - The Additional Role Reimbursement Scheme
   - General Practice fellowships
   - Supporting mentors scheme
   - International GP recruitment

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3. **GPIT** which covers:
   - GPIT – infrastructure and resilience
4. **Capacity and Access Support Fund** (CAP and CAIP) paid in 2 parts.

5.4 The aim of the CAP funding is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led.

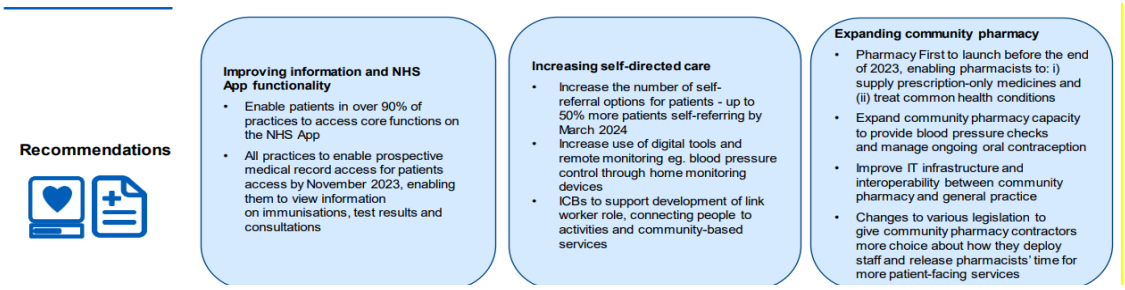
## 6.0 Key Reporting Periods

6.1 In line with the National guidance, Systems are required to provide detailed updates on progress at key reporting periods. These being November 2023 and March 2024. Interim updates will be submitted to the ICB each month to ensure progress.

Cheshire East Leadership Team receive the updated reports for sign off prior to submission.

## 7.0 Summary of Progress in Cheshire East

### 7.1 Empowering Patients




#### 7.1.1 Progress So Far

- All Practices are actively engaged at all levels and working with IT providers to support practices with enablement which has led to steady progress.
- Practices have applied system changes to update settings to allow prospective record access.
- > 50% of practices have confirmed that direct bookable appointments are available on line
- Secure NHS App messaging has been enabled where the software is in place to do so.
- All practices use messaging software to support better patient communications including self-monitoring either via AccuRx or Patches.
- Go live of Community Pharmacy First in Quarter 4
- Expansion of Pharmacy Contraception Service and relaunch of the Blood Pressure Check Service on 1 December 2023.

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Cheshire East are actively working with our Medicines Management leads and Local Pharmaceutical committee leads to understand the opportunities within the Community Pharmacy First Programme and promote to both General Practice and our residents.

All remaining practices will continue to work towards the requirements by the end of March 2024.

## 7.2 Implementing a Modern Model of General Practice

**Recommendations**

**Better digital telephony**

- All practices to transition to digital telephony by December 2025 to make full use of i) multiple call management; (ii) call-back functionality; (iii) call-routing and (iv) integration with clinical systems
- NHSE to support transition to digital telephony to those practices that commit by 1st July 2023
- 1000 practices to be utilising this technology by the end of 2023

**Simpler online requests**

- NHSE to provide general practices with high quality online-consultation, messaging and booking tools by July 2023
- ICBs, Primary Care Networks and GPs to agree most appropriate tools to support transition to new model

**Faster navigation, assessment and response**

- NHSE to invest in new National Care Navigation Training programme for up to 6500 staff starting in May 2023
- NHSE to fund higher-quality tools that enable the shift to online requests and enable all practice team to contribute to rapid assessment and response
- NHSE to support practices committing to transformation with extra capacity over the next two years - £13,500 per practice

### 7.2.1 Progress So Far

- All PCNs submitted Capacity & Access Improvement Plans in July that were approved by Cheshire East Leadership Team for the ICB.
- All practices are being supported via the Place team to move off their current digital telephony provider by the end of March 2024 and to migrate to a new Cloud based Telephony (CBT) system that is recongised on the National Procurement Framework and which provides the full functionality described in the PCARP guidance. This includes Patient call waiting and patient call back functionality.
- It has been confirmed in December that all practices in Cheshire are eligible for additional financial support which is being made National through the CBT Phase 2 offer. Details of which are to be confirmed.
- All practices have had their websites audited against the National toolkit earlier in the year and recommendations made. Changes and upgrades will be required before the end of March 2024
- All Practices in Cheshire East have successfully applied for Transition Funding to support them at the point of going live and implementing the new model of Modern General Practice. The total funding pot to support practices is circa £580,000.
- Approximately 120 additional staff have accessed Care Navigation Training, either via the regional or National Offer.
- All Practice have access to online consultation, messaging and booking tools.

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## 7.3 Building Capacity

**Recommendations**

**Larger multidisciplinary teams**
- 26,000 more professionals in general practice and 50 million more appointments by 31 March 2024
- Funding for up to £385m for Additional Roles Reimbursement Scheme (ARRS) in 2023/24
- All primary care staff to be able to access suite of health and wellbeing offers and the Practitioner Health Service

**Increase in new doctors**
- Up to £35 million of SDF funding available for GP fellowships in 2023/24
- Further expansion of GP specialty training – and make it easier for newly trained GPs who require a visa to remain in UK
- NHSE to work with partners to identify opportunities for other doctors, eg SAS doctors, to work in general practice multidisciplinary team

**Retention and return of experienced GPs**
- DHSC agreement to make retire and return easier and protect NHS staff from higher tax charges driven by inflation
- Encourage experienced GPs to stay through the pension reforms announced in the Budget
- NHSE to launch campaign to encourage GPs to return to general practice and invest in GP retention schemes

**Primary care estates**
- ICBs to work with local partners to better anticipate where housing developments are putting pressure on existing services
- Changes to local authority planning guidance this year to ensure due consideration of primary care capacity

### 7.3.1 Progress So Far

- Cheshire East Place works closely with the Cheshire LMC and Cheshire Training Hub to understand our General Practice workforce profile and to develop our local prospectus of support and development offers.

- Our support offers are not limited to GPs. We have commissioned a range of additional programmes to develop and retain Practice and Business Managers.

- We have recently surveyed GPs including GP Partners, Salaried GPs, Locums, newly qualified GPs and overseas doctors to understand their future career aspirations – receiving circa 100 responses. This feedback will be invaluable in informing our future priorities.

- Cheshire East Place is in the second year of funding the GP Educational Leads for the Additional Roles. Our evaluation in Quarter 3 return extremely positive feedback from both ARRs and GP Educators and we have committed to funding this via SDF Transformation monies next year (subject to the funding being made available)

- The next phase of the programme will be to repeat the process with our Nurses.

- The Cheshire East Place approach to GP recruitment and retention has been shared with the wider ICB Workforce Group as an example of best practice that may be adopted across the system.

- Recruitment of 216 WTE Additional Roles across the 9 PCNs.

- The table below details the breakdown of which roles have been recruited and are in post. Based on workforce plans, Cheshire East anticipates spending 90% of the ARRs budget.

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**Table 2. Additional Roles Summary**

| Role | Total |
|---|---|
| Advanced Practice Nurse | 2.80 |
| Care Coordinator | 43.89 |
| Clinical Pharmacist | 39.89 |
| Clinical Pharmacist Advanced Practitioner | 1.59 |
| Digital and Transformation Lead | 5.67 |
| General Practice Assistant | 13.63 |
| Health and Wellbeing Coach | 1.00 |
| Mental Health Practitioner | 13.00 |
| Nursing Associate | 6.07 |
| Paramedic | 8.45 |
| Pharmacy Technician | 18.87 |
| Physician Assoc | 8.33 |
| Physiotherapist | 18.49 |
| Social Prescribing Link Worker | 26.36 |
| Trainee Nursing Associate | 8.39 |
| **Total** | **216.42** |

- Working with System Partners to develop local PCN Estates strategies that can inform the future delivery model of Primary and Community Led Care. The Cheshire East Place PCN Plan is in the final stages of production.

### . 7.4 Busting Bureaucracy

**Recommendations**

**Improving the primary – secondary care interface**

- Secondary care to prioritise onward referrals to ensure referrals are not sent back to general practice and resulting in further delays
- NHS trusts to provide accurate and up to date fit notes and discharge letters, highlighting clear actions for general practice
- NHS trusts to establish their own call/recall systems for patient follow ups
- ICBs to ensure providers establish single routes for general practice and secondary teams to communicate rapidly
- ICBs to report progress on improving the interface with primary care

**Building on the Bureaucracy Busting Concordat**

- Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing with the Bureaucracy Busting Concordat
- Examples include, working with the aviation industry to encourage clear, proportionate and pragmatic processes, so passengers with medical conditions who need to fly with medication/medical equipment can do so easily

#### 7.4.1 Progress So Far

Cheshire East Place has established the Primary and Secondary Care Interface Forum.

- The group will be working on ‘operationalising’ the consensus document and thus delivering the asks within the Primary Care Access Recovery Plan.

- In particular, looking to ensure there are clear escalation routes and communication between Primary and Secondary Care.

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- Chaired by Dr Paul Bishop, Medical Director for Cheshire East Place, it has representation from both Primary Care clinicians including Local Medical Councils as well as Secondary Care colleagues,

- Linking up Primary and Secondary Care Access, Capacity and Demand data sets, to better inform and appraise System Partners on seasonal pressures to better inform decision making. A working group has been established to look to link UEC Metrics with the APEX reports and the OPEL System GP Practice reports.

Community Pharmacy first Programme and promote to both General Practice and our residents.

## 8.0 Next Steps and Key Milestones

1. **To End of March 2024** ICB Programme Board structures remain in place.

2. **Jan 2024 onwards** – The ICB will be developing a System Dashboard which will be updated monthly. Cheshire East Place level plans will be updated with local metrics as informed by PCNs and monitored via the Primary Care Advisory Forum, with collective discussions at fortnightly primary care leads meeting (inter place and system).

3. **Jan – March 2024** Patient feedback – how do we know our plans are working. Commission additional work pending the GP Patient Survey 2024, at place/system level to understand the impact of these measures – to be discussed further with stakeholders.

4. **Jan-March 2024 -** Gather in more case studies of 'success' / best practice in line with the Fuller Recommendation.

5. **March 2024** - Place plans updated for March Board, ongoing assurance at place level through place primary care Advisory Forum and CELT.

## 9.0 Summary and Conclusion.

9.1 The Primary Care Access Recovery Programme is a detailed programme of work that requires system support. Whilst it's largely focused on actions for General Practice Improvement there are a number of key areas that require system support and fully align to the principle of the Fuller Stocktake report and associated recommendations.

9.1.1 Cheshire East Place has made good progress in the delivery of key aspects of the programme and is on track to meet key milestones.

9.1.2 Cheshire East Place has taken a proactive and pragmatic approach to supporting Practices in accessing financial support.

9.1.3 We recognise that Transformation Programmes may not yield a linear approach to improvement, especially given external factors such as Winter Pressures, Industrial Action and other factors but there is a high degree of confidence that the actions being taken and

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the level of engagement with Practices and PCNs that we can maintain our strong Access performance.

## 10.0 Appendices

**Appendix 1** Cheshire East Place Access Recovery Plan.

Place%20summary%20PCARP%20Access%

**ITEM 8 - Appendix 1**

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# Cheshire East Place

# Access Improvement Plan FINAL v6

## Recovering Access to Primary Care & associated funding

## Part of System Access Improvement Plan

This template is to bring together elements that will form part of the System Access Improvement Plan, in line with the recently released Guidance.

NHS England » Primary care access improvement plans – briefing note for system-level plans

Primary Care Access Improvement Plan - Briefing note for system-level plans - Recovering Access to Primary Care - FutureNHS Collaboration Platform

https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/

| | |
|---|---|
| **Name of Place** | **Cheshire East** |
| **Report Author and Contact email** | **Amanda Best**<br>**Amanda.best@cheshireandmerseyside.nhs.uk** |
| **Version** | **1.2 _ Final** |
| **Date** | **18th October 2023** |

**Please forward to Chris Leese c.leese@nhs.net by 20th October for collation at System Level ready for November Board final overall version.**

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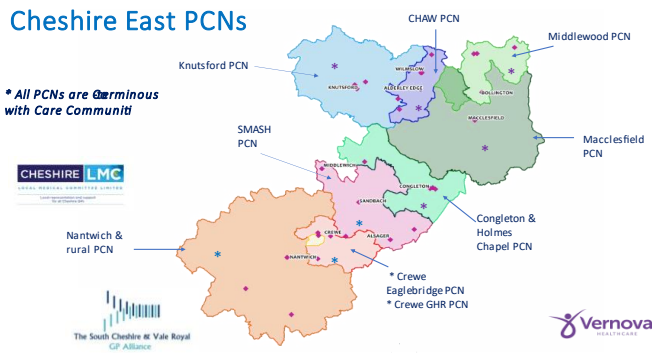
| Section Heading | Details and Links | Cross reference to NHS England » Primary care access improvement plans – briefing note for system-level plans noting you are responding as a **place** |
|---|---|---|
| **Section 1 Overview** | https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/<br><br>https://www.england.nhs.uk/wp-content/uploads/2023/05/PRN00475-ii-delivery-plan-for-recovering-access-primary-care-190523-v1.1.pdf | |
| | 1.1 Summary of place level challenges (Patient feedback, place concern, health inequalities, etc) | Cheshire East Place serves around 400,000 residents, with 34 GP Practices, 74 Community Pharmacies and 2 Acute hospitals and Community services providers.<br><br>Across the Borough, GP Practices are configured into 9 Primary Care Networks all of which are coterminous with our Care Communities except for Crewe which is configured into 2 PCNs given the size and demographics within these wards.<br><br>The map below details the location and spread of our General Practice Providers and General Practice Provider Collaborative partners across Cheshire East.<br><br>  <br><br><br>Cheshire East is unique in that it covers a large geographical area touching the boarders of Manchester, North Staffordshire and Shropshire as well as other Cheshire & Merseyside Places.<br><br>Within Cheshire East there are areas of affluence but also areas of high deprivation, rural poverty and an aging population. 22% of the population are aged 65 or over and a further 27% aged 45 – 64 years.<br><br>In the last 12 months, our net increase in population has been by 6,269 residents, with an average annual growth rate of 4%.<br><br>Unlike other areas, Cheshire East Place is highly dependent on General Practice for patients to access health services, The absence of minor injuries units or Primary Care Led Walk in Center (WiC) adds further access demands on core General Practice especially during Winter and seasonal illness. |

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Contractually, all Practices in Cheshire East Place meet GMS opening hours requirements, with no periods of closure during core hours (8am – 6.30pm) other than on the agreed Practice Learning Time afternoons, of which there are 9 per annum. These have been agreed as a standard approach across the Cheshire and Merseyside ICB.

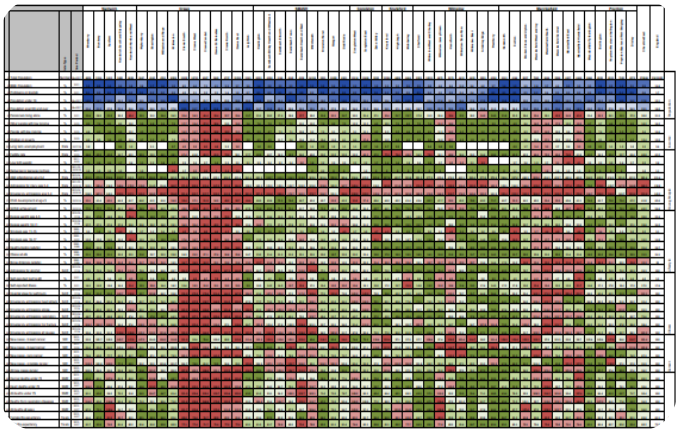
Cheshire East GP Practices provide their own Extended Access in accordance with the PCN DES requirements. Access provision is not subcontracted to a third party, thereby providing a greater level of patient care continuity.

Compared to the national or regional figures, the average practice list size is significantly greater in Cheshire East given the number of practices with registered list sizes greater than 20,000 patients. This is due to merged practices and high population growth areas.

| Average | List Size |
|---|---|
| Cheshire East Average | 12,756 |
| North West Average | 7,998 |
| England Average | 9,617 |

The Town of Crewe presents its own unique challenges.

Crewe is an area of high deprivation, high unemployment and greatest health inequalities as clearly highlighted in the Cheshire East Tartan rug and the dark red column on the left-hand side of the diagram below.



As an inclusive Place, Cheshire East welcome communities that require additional support. Recognizing that this adds additional access and public health pressures of which no or limited identified funding or resource. This includes our homeless population, East Timor and asylum and refugee communities as well as communities from ethnically diverse backgrounds.

Our disease burden can be described as follows;

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39% of the population have at least one long term condition (LTC) with 17% of the population recording more than one LTC.

The top 3 long term conditions are Hypertention, Depression and Asthma, closely followed by Diabetes, Cancer, CHD and CKD.

There is stark contrast in the average mortality age across the borough with residents in Crewe expected to die earlier than residents in other part of our Borough. The average mortality age for men is 78.1 years and 82.8 years for females.

Compared to our Cheshire and Merseyside peer Places, Cheshire East performs well in the GP National Survey. This is illustrated in the table below.

**Place Summary Metrics**

| Group | Metric | National | ICS | Cheshire East | Cheshire West | Halton | Knowsley | Liverpool | Sefton | St Helens | Warrington | Wirral |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Overall Experience | Q32. Overall, how would you describe your experience of your GP practice? **% Good** *(Very Good + Fairly Good)* | 71% | 72% | 76% | 78% | 67% | 63% | 70% | 71% | 69% | 71% | 76% |
| Making an appointment | Q16. Were you satisfied with the appointment (or appointments) you were offered? **% Yes, took appt** *(Patients who selected 'I was not offered an appointment' have been excluded)* | 72% | 73% | 77% | 76% | 69% | 66% | 72% | 73% | 69% | 74% | 74% |
| | Q21. Overall, how would you describe your experience of making an appointment? **% Good** *(Very Good + Fairly Good)* | 54% | 54% | 62% | 59% | 42% | 42% | 51% | 51% | 50% | 53% | 58% |
| Local GP Services | Q1. Generally, how easy is it to get through to someone at your GP practice on the phone? **% Easy** *(Very Easy + Fairly Easy) (Patients who selected 'Haven't tried' have been excluded)* | 50% | 48% | 54% | 53% | 35% | 42% | 44% | 44% | 47% | 47% | 56% |
| | Q2. How helpful do you find the receptionists at your GP practice? **% Helpful** *(Very helpful + Fairly helpful) (Patients who selected 'Don't know' have been excluded)* | 82% | 83% | 85% | 87% | 76% | 78% | 80% | 83% | 82% | 82% | 86% |
| | Q30. During your last general practice appointment, did you have confidence and trust in the healthcare professional you saw or spoke to? **% Yes** *(Yes, definitely + Yes, to some extent) (Patients who selected 'Don't know/doesn't apply' have been excluded)* | 93% | 93% | 94% | 96% | 91% | 88% | 93% | 93% | 93% | 93% | 94% |
| | Q47. Overall, how would you describe your last experience of NHS services when you wanted to see a GP but your GP practice was closed? **% Good** *(Very Good + Fairly Good) (Patients who selected 'Don't know/can't say' have been excluded)* | 45% | 44% | 43% | 48% | 45% | 39% | 43% | 40% | 43% | 37% | 49% |
| Access to on-line services | Q4. How easy is it to use your GP practice's website to look for information or access services? **% Easy** *(Very Easy + Fairly Easy) (Patients who selected 'Haven't tried' have been excluded)* | 63% | 66% | 67% | 70% | 64% | 57% | 63% | 65% | 70% | 62% | 67% |

Place rag-ed against ICS Average: Green > than comparison, Amber = comparison, Red < than comparison

Nationally, GP survey satisfaction results have fallen since pre covid years and a Place summary does not highlight the variation in results across practices.

Nevertheless, we commend our Practices for their work and ongoing efforts to deliver a high-quality service to our population and note that a number of practices in Cheshire East have some of the highest satisfaction scores in the country for their overall satisfaction rates.

Centre to our plans for delivering excellence in health and care are our Care Communities, of which General Practice is the cornerstone.

Care Communities have been in development for a number of years and though our System Blueprint work, expect these to grow and develop to support delivery of our Cheshire East Health and Wellbeing Plan, and Outcomes Framework.

Our strategies start from an evidence-based approach and as we look to the future delivery model of integrated health and care by 2030 and beyond, it's important that our Access Recovery Programme provides long term sustainable solutions to delivering community led care that is co-produced.

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| | | |
|---|---|---|
| | | Finally, with expanding GP Teams and a greater provision of Community led services the Estates and Digital strategies will need to reflect our changing delivery model for local General Practice and out of hospital care.<br><br>Generally speaking, the Estates provision in Cheshire East is good compared to other areas, but that does not forego the importance of future estates and capital requirements to accommodate expanding teams.<br><br>The lack of funding hampers the ability to expand into additional space, to co locate with Community services and provide the hard wiring to underpin a more efficient Community Led Care offer. |
| | 1.2 Summary of actions to address / links to other plans | Please see Appendices attached to more fully understand the actions and plans in place to support the access recovery programme.<br><br>Cheshire East Place are working with system partners to develop a system blueprint that broadly describes the architecture for a modern fit for the future health and social care system. This builds on our previous strategic plans, and links to the Cheshire East Health and wellbeing Strategy and Delivery Plan as well as the Cheshire East Outcomes Framework. |
| | 1.3 Overall place level ambition summarised (with metrics<br><br>Is there a clear vision that aligns with the ambitions of the Delivery Plan for Recovering Access to Primary Care?<br><br>Have interdependencies been considered to maximise system benefit e.g., UEC?<br><br>Do plans incorporate all ICB actions from the delivery plan checklist?<br><br>Do plans set out the ICB's delivery approach for all aspects of the delivery plan for recovering access to primary care i) empower | There is a clear vision in Cheshire East that aligns with the ambitions of the Delivery Plan for Recovering Access to Primary Care to improve the experience of patients and staff in accessing and delivering health care services. Metrics in the CAIP plans reflect this.<br><br>We do not yet have a Place based Strategy for Primary Care but will be reviewing the objectives from the Cheshire & Merseyside Primary Care Plan to develop our local recommendations and deliverables centered around access, capacity and demand.<br><br>Cheshire East has an emerging GP provider Collaborative that has a vision for where and how it can support General Practice with a clear mandate from local practices with accompanying delivery plan. This is a tripartite range, made up of representatives from both Cheshire East GP federations, the LMC, local Clinical Leadership. The purpose being.<br><br>• **Representation and Engagement:** To be able to speak on behalf of the General Practice Community in Cheshire East<br>• **Design and Delivery of New Models of Care**: influencing pathway redesign and provider services that fit between Primary and Secondary care.<br>• **Support and Quality Improvement**; Consistency in quality, access and supporting innovation in service improvement.<br><br>With regards to PCARP, PCNs and Practices submitted and had approved CAIP Plans in July that align to the national requirements. Metrics have been agreed, derived from both national measures and locally determined. |

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| | | |
|---|---|---|
| | patients; ii) implement modern general practice iii) build capacity; iv) cut bureaucracy?<br><br>Are there clear, quantified improvement trajectories?<br><br>Are there clear delivery milestones?<br><br>Does the plan set out how ICBs will monitor and track delivery against trajectories and milestones?<br><br>What are the mechanisms to collect, analyses and share data?<br><br>Is the ICB confident that the plans will make a difference and patients will know the plans are working?<br><br>Does the plan give the overview of progress to date? | **Appendix 1** summaries the PCN CAIP plan these and details the metrics that the ICB will monitor and the reporting period.<br><br>Qtr. 3 metrics are in the process of being collated. With associated quantified improvement trajectories that will be mapped.<br><br>All actions are assessed against the ICB plan and aligned Place based plans for improvement.<br><br>We have completed an assessment of delivery against the PCARP Checklist, and the current rag rating can be seen in **Appendix 2** which provides a high level of assurance that at this stage, Practices are well informed and engaged in the programme and on track for delivery.<br><br>All practices have access to a Practice and PCN APEX report as detailed in **Appendix 3** to better understand their Access, Capacity and Demand trends These are reviewed at Place level to provide further intelligence as to how the access improvements are being made.<br><br>September saw the launch of the Cheshire East OPEL reports linking through subjective as well as quantifiable data to feed into winter pressure planning via the Home First Governance stream and UEC teams.<br><br>We intend to build on the narrative to provide trends and themes to better predict and manage seasonal illness and strengthen our system preparedness in meeting Access, Capacity and Demand as a system.<br><br>Interdependencies have been considered to maximise system benefit as described above.<br><br>Our plans link through to Winter plans and UEC and Place Operational board as well as Community Led Care via Care Communities, and SPT.<br><br>Place teams will work with Practices and PCNs to oversee implementation. We will review access data, including those measures outlined in the Plans but we will also use a quality improvement methodology and encourage practices to try new ways of working that best fit their delivery model.<br><br>We recognise that all practices are on their access recovery journey. To support them on this journey we have actively encouraged practices to think about the enablers within the Programme that will assist.<br><br>The System Development Fund (SDF) funding will be used to enhanced PCN digital requirements, such as moving towards greater digital interoperability.<br><br>Practices have been encouraged to think about their future delivery model, whether this is a Total Triage model or a hybrid model, and to consider the Transition Support funding to get them where they want to be.<br><br>All Practices are in the process of migrating to a Cloud based telephone system that incorporates all the key functions identified in the recovery plan. |

**Commented [AM1]:** In PM stock take we said…….
**How will patients know the plan is working:**
- Their calls will be handled through a queuing system and then answered or a call back offered. Engaged tones will be a thing of the past.
- They will not be asked to call back another day for an appointment. Instead, they will know on the day how their request will be managed.
- Those that prefer on-line access will increasingly find their requests are handled promptly and effectively through this route.
- They will have access to more services in their local community pharmacy

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| | | This includes.<br>• Call waiting<br>• Call routing<br>• Call back.<br><br>We will use our established forums to share and discuss progress on a quarterly basis and feed into Place Governance for assurance reporting i.e., Primary Care Advisory forum and Place Operational Board.<br><br>We do not expect there to be a linear improvement trajectory as any change programme takes time to embed. But we are confident that the plans will make a difference and improve both Patient and staff satisfaction. |
| **Section 2 Access Recovery Improvement** | https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/<br><br>https://www.england.nhs.uk/publication/network-contract-des-capacity-and-access-improvement-payment-for-2023-24/ | |
| | 2.1 CAIP Plans Practice and PCN level agreed and progress to date.<br><br>Does the ICB plan include an overview of PCN/practice plans?<br><br>Assurance that all required actions have been included in plans.<br><br>Delivery confidence for all aspects of the recovery plan i) empower patients; ii) implement modern general practice iii) build capacity; iv) cut bureaucracy?<br><br>Are there clear, quantified improvement trajectories?<br><br>Are there clear delivery milestones? | Each PCN has an agreed CAIP Plan and associated Metrics. As above, a summary is provided in A**ppendix 1**<br><br>The ICB Plan includes an overview of the PCN / Practice Plans including short-, medium- and long-term objectives.<br><br>The Place plan also details key themes and trends, initial improvements made, goals and measures currently in place.<br><br>Practices are enabling patient to see their health records, book appointments and order repeat prescriptions using the NHS App.<br><br>All practices are in the process of transitioning to a new model of General Practice, including the switch to Cloud Based Telephony with call waiting / queuing, call routing and call back functionality. We have implemented a soft deadline of December and a hard deadline of March 2024 for completion.<br><br>All practices have online and video consultation software active and expanding their digital tools and care navigation offer.<br><br>In Cheshire East few practices are onboarding to the full Patches Online and Video consultation platform, opting instead to self-fund AccuRx. But all are fully compliant with the contractual requirements.<br><br>All practices have now had their websites audited using the national Website audit toolkit.<br><br>Feedback and recommendations have been made to practices by the Place Primary Care team so that they can make any necessary improvements by the end of March 2024. |

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| | Does the plan set out how ICBs will monitor and track delivery against trajectories and milestones?<br><br>What are the mechanisms to collect, analyses and share data?<br><br>Is the ICB confident that the plans will make a difference and patients will know the plans are working? | We will continue to work with our Cheshire & Merseyside ICB and NHS England colleagues, including digital to understand what the funding envelop will be for next year and what will be included in the Digital Access Procurement Framework and C&M SDF Digital bids that will enable Practices and PCNs to fully deliver their ambitions.<br><br>*n.b The National Access Digital Procurement Framework has been delayed, now expected to be December 2023.* |
| | 2.2 Place level improvement initiatives agreed and progress to date | You will see in the attached information that the Place Plans do detail improvement initiatives.<br><br>The Plans have been shared with the Cheshire East Place ICB Leadership Team and we will continue to monitor progress quarterly.<br><br>We welcome feedback from our Cheshire and Merseyside colleagues by way of sharing learning across Places, to maximise the development opportunities. |
| | 2.3 System / National ICB level improvement initiatives / place implementation of this<br><br>Take-up of support and training offers? How has place supported this<br><br>Has the Support Level Framework been used with practice and PCNs to identify support needs?<br><br>What local support is being provided/funded? How is the ICB leveraging and | Cheshire East Place has widely promoted the General Practice Improvement Programme (GPIP) and Support Level Framework (SLF) offer both to Practices and PCNs.<br><br>We have extended training offers to General Practice as well as inviting the SLF team to attend Practice Manager meetings during July and September to promote the offer and uptake.<br><br>The interest in the structured support offers has been relatively low compared to other Places. 1 practice has accepted the intensive support offer and is realizing great benefits with a further 2 practices and 1 PCN participating in the Intermediate offer.<br><br>All other practices are accessing the universal offer.<br><br>We will continue to promote the benefits of the SLF, although it may be that participation will come in the new year due to winter pressures.<br><br>In addition, Cheshire East Place has identified a further 8 practices for a support level conversation with the Place team, based on current access data. No dates have been set for the discussion, but the offer has been made to practices.<br><br>In total 35% of practices will have accessed some level of intervention conversation via the SLF and we will continue to promote the support available. |

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| | ensuring maximum uptake of national transformation support and training offers, including ensuring participation from PCN/practices that need support the most | The feedback from Practices on the PCN support offer has been mixed. But we are happy to work with the ICB teams and SLF team to understand why and what we can do differently to promote engagement.<br><br>All Practices have accessed the National Care Navigation Training offer. |
| | 2.4 Winter Resilience response https://www.england.nhs.uk/publication/delivering-operational-resilience-across-the-nhs-this-winter<br><br>Support the delivery of key actions from the Primary Care Recovery Plan that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:<br>• engaging and nominating their practices and PCNs to join the national general practice improvement programme<br>• supporting practices to move to cloud-based digital telephony and to access the right digital tools<br>• understanding general practice | As part of our system planning General Practice has been actively engaged in the development of the Winter Plans for 2023.<br><br>Accepting that there is likely not going to be additional funding this year for Acute Respiratory Hubs, plans have been drawn up within Care Communities and PCNs to boost capacity during winter if required.<br><br>All of the initiatives detailed below have been included in the Winter resilience plans for Primary Care<br><br>➢ Primary Care Network led Extended Hours for evening and Saturdays<br>➢ Primary Care Access Recovery Programme including transition to a new model of modern General Practice.<br>➢ Robust and resilient General Practice Out of Hours service including Acute Visiting Service.<br>➢ Care Communities Business cases to extend Primary Care Assessment –Respiratory, Frailty, High Intensity Users, Falls – (Subject to additional funding)<br>➢ The nationally commissioned Community pharmacy consultation service (CPCS) as this will have a potentially bigger and synergistic impact with the Pharmacy First minor ailments service on lower acuity conditions. CPCS takes referrals from general practice and NHS111, while Pharmacy First provision also takes walk ins.<br>➢ Primary Care resilience and activity data<br>➢ Exploring initiatives to enhance the falls prevention programme, including access to falls exercise classes and care homework (System)<br>➢ Health & Wellbeing services for Asylum seekers and Refugee communities<br>➢ Full implementation of the Primary / secondary care interface recommendations<br>➢ Roll out of the General Practice OPEL system to support system pressures reporting.<br><br>Most Care Communities have aligned priorities to Falls and high Intensity Users and building capacity.<br><br>These include.<br>• Staff capacity to support system changes if required. |

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| | transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to<br>• continue improvement:<br>○ to understand and better match demand and capacity.<br>○ Increasing capacity with larger multidisciplinary teams, including over the Christmas period<br>Places lift and drop answer to planning ask for winter into this section | • Seven-day service provision across the system<br>• Joint systems communication plan<br>• Boosting flu and Covid vaccinations in partnership with CWP<br>• Enhancing the Primary care workforce via Additional Roles.<br>• Primary care / Secondary Care interface objectives.<br>• Boosting same day / urgent appointments<br><br>As Described in section 2.3, there is ongoing active engage to encourage participation in the support programmes and to share the learning and early indications from Practice feedback is that the changes they have identified along with the implementation of a new telephone system is realising benefits to staff and patients.<br><br>The APEX reports will provide run time data over winter to accurately measure and record access, capacity and demand trends.<br><br>The Opel reporting system for General Practice went live in September and this will be used to feed into System winter pressures planning to understand and predict demand surge, and the rise of seasonal illness.<br><br>A key challenge in Cheshire East is the rising prevalence of Covid cases which is impacting on staff sickness.<br><br>A more detailed summary of the Winter Plans can be found in **Appendix 4** |
| **Section 3 Funding Stream outcomes to support retention, transformation and workforce** | https://www.england.nhs.uk/long-read/primary-care-service-development-funding-and-general-practice-it-funding-guidance-2023-24/<br><br>https://www.england.nhs.uk/long-read/transition-cover-and-transformation-support-funding-to-move-to-a-modern-general-practice-access-model/ | |
| | 3.1 Transition Funding Summary and outcomes/awards | Cheshire East has a plan for supporting Practices to access the Transition Funding. At the time of writing, the plan is being finalised with Place Leadership sign off by the end of October.<br><br>The guidance has been circulated and there have been local conversations with practices on how they can access the funding when they are ready to move forward with implementing their plans. 33 / 34 Practices have expressed an interest.<br><br>Key themes identified are increasing staffing capacity to review back log of work and clear appointments, implementing recommendations, provide |

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| | | additional capacity to help smooth the transition to a new model, finalising their understanding of their capacity and demand modelling.<br><br>The outcomes that will be achieved will be.<br>➢ Reducing in the backlog of tasks within the appointment systems<br>➢ Clear appointment systems to allow patients to be treated or signposted on the day they call.<br>➢ Improved patient satisfaction rates<br>➢ Improved staff satisfaction rates.<br>➢ Reduction in the numbers of calls abandoned.<br>➢ Reduction in the number of days patients are waiting to speak to or see a healthcare professional. |
| | 3.2 SDF Funding including outcomes of GP Retention Plans, Transformation and Development or Digital – Place priorities for spend<br><br>Is there a clear plan for how national funding will be used and maximised?<br><br>How will the ICB track and report on spend and ensure funding is spent in-year<br><br>Has the ICB considered how other funding could be aligned?<br><br>**How will the ICB ensure PCNs/practices are receiving funding and resource in a timely way to support delivery and transition?** | Cheshire East have developed a clear funding plan associated with the Place level Support Development funds that promote retention and workforce.<br><br>This has been shared with our Cheshire & Merseyside Finance colleagues as well as Place leadership.<br><br>Our plans have been coproduced with PCN Managers and Clinical Leads to ensure that they best meet the PCN Development requirements.<br><br>We have allowed some flexibility at this stage due to the lack of certainty around what will be funded nationally via the Digital Access Framework and also locally via the SDF Digital bids.<br><br>The SDF plan can be seen in **Appendix 5**<br><br>As previously mentioned, we work closely with our Cheshire and Merseyside Training hub partners and Cheshire LMC to develop a range of programmes that support and promote recruitment and retention.<br><br>**Appendix 6** – GP Retention Plan Cheshire East summarises how we are utilizing our resources locally.<br><br>In addition, we have committed to using the former PCN Development fund and latterly the SDF Transformation funding to continue our place programme of PCN Education Leads in each PCN to support the retention and development of the additional roles in Cheshire East and support them to feel embedded within the teams.<br><br>In the summer we surveyed the staff involved in the programme and the feedback was overwhelmingly positive with both Educational Leads and ARRs valuing the time and support they can provide to each other.<br><br>This can also be reviewed in **Appendix 6** |

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| | 3.3 Other investments to support Development, via local/transformation funding pots, place discretionary funding | Please see above, section 3.2 with regards to the wider range of initiatives that we have implemented.<br><br>It is also worth mentioning that as a Place we are working in partnership with the Cheshire LMC to supplement any wider recruitment or retention initiatives. |
| **Section 4 ARRS (Additional Roles)** | https://www.england.nhs.uk/publication/network-contract-directed-enhanced-service-additional-roles-reimbursement-scheme-guidance/ | |
| | 4.1 Place additional roles summary/spend and posts/outcomes<br><br>Has the ICB set out plans to support and build their workforce, **including supporting PCNs to use their full ARRS budget,** delivering GP retention schemes and promoting national health and wellbeing offers? | Active recruitment of the Additional roles continues in year 4 of the DES.<br><br>In Cheshire East we have recruited just over 220 whole time equivalent additional roles across the 9 PCNs.<br>Most of these roles are within care co-ordination and social prescribing, pharmacy technicians and physiotherapists.<br><br>The table below shows the breakdown of roles. |

| ARRs Job Role | Total |
|---|---|
| Pharmacy Technicians | 19.09 |
| Clinical Pharmacists | 39.9 |
| Clinical Pharmacists (Advanced) | 1.59 |
| First Contact Physiotherapists | 18.58 |
| Paramedic | 9.6 |
| Clinical Practitioner Nurses (Advanced) | 5.8 |
| Physician Associates | 10.3 |
| Care Co-ordinators | 42.01 |
| Social Prescribing Link Workers | 29.68 |
| Health & Wellbeing Coaches | 1 |
| Nurse Associates | 7.07 |
| Training Nurse Associates | 5.83 |
| GP Assistants | 13.48 |
| Digital & Transformation Lead | 5.01 |
| Adult MHP (Band 6) | 1 |
| Adult MHP (Band 7) | 7.6 |
| Adult MHP (Band 8a) | 1 |
| Children and Young Persons MHP (Band 5) | 3 |
| **Totals** | **221.54** |

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| | | PCNs have submitted workforce plans indicating their intention to spend their allocations.<br><br>We note the risks associated with these plans and the current drawn down position as detailed below.<br><br>• Lack of certainty on the budget allocations for 2024/25 and possible financial impact of Agenda for Change pay scale up lifts<br>• Available workforce to fill roles<br>• Embedding staff into existing practices – Pastoral Care / Mentorship and supervision<br>• Funding to support the oncosts for roles including provision of IT<br>• Estates Capacity – expanding teams within General practice requires additional room capacity which is limited / and or may require the removal of other community-based teams out of GP Surgeries.<br><br>Mitigations in place.<br><br>• Looking at short term contracts to supplement existing teams for 6 months.<br>• Pooled resources across a number of PCNs<br>• Joint PCN recruitment processes<br><br>As previously mentioned, one of the great success initiatives in Cheshire East has been the Clinical Educational Lead role in each PCN to support the mentoring and development of the ARRs staff, funded through the SDF Transformation monies and previously the PCN Development Fund which has seen retention benefits.<br><br>A number of PCNs, notably CHAW and CHOC have embraced a team approach especially with Mental Health Practitioner which is being regarded as best practice. |
| **Section 5 Health Inequalities** | | |
| | 5.1 How the place approach tackles HI / access<br><br>How does the plan support equality, diversity, and inclusion? How does it support practices in areas of deprivation and practices | Cheshire East has undertaken an analysis over the past 3 years against key indicators to understand where there may be access challenges or inequalities and it is clear that patients in areas of higher poverty and deprivation do record a lower level of satisfaction with accessing services.<br><br>And residents who live Crewe are more likely to access A&E rather than a GP practice.<br><br>Cheshire East Place recognizes this to be a fact and is engaged in conversation with Partners about how resources are distributed based on need, although this is at a very early stage. |

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| | disproportionally affected by health inequalities? **More prompts on this section to follow** | We have been able to utilize some funding last year to increase access to general practice though the Better Care Fund and winter pressures funding. An example of this being our Asylum Seeker and Refugee support programme to manage registrations and health checks of residents in hotels in Crewe and if funding is available there are plans drawn up to look at expanding access for high intensity users with a focus on children and young people.<br><br>We are also at the beginning of a conversation around dentistry provision in Crewe and in the process of mapping provision and services as in ability to access dental services impacts both primary and secondary care locally.<br><br>The Crewe Care Community Clinical Lead and Clinical Lead for Eaglebridge Health Centre sit on the improving equalities commission with Local Authority and Public Health, and we are actively involved in the JSNA work that focuses on our health inequalities and areas of need. |
| **Section 6 Patient Engagement and Communications** | | |
| | 6.1 Engagement and communications with patients, key stakeholders (LMCs etc) at a place level as part of place plans<br><br>Has the plan been co-produced with patients and local communities?<br><br>Has the ICB put in place a robust communications delivery plan that focuses on promoting key delivery plan and campaign messaging at place level and to local communities? Note current plan is for this to be centrally led as much as possible so place should just articulate anything extra/local it has done/is doing | Plans are in the early stage of public engagement and we wait the launch of the national campaigns led by NHS England colleagues.<br><br>Practices have discussed their CAIP plans and access challenges with their PPGs to inform the local actions.<br><br>Practices have consulted their PPGs to understand their access challenges and are taking the discussions forward via their patient groups. And we encourage practices and PCNs to engage with Health Watch to access the wealth of intelligence that will help inform their improvement plans.<br><br>As practices are transitioning on to new telephone systems, patients are being informed of any changes to phone numbers and benefits via their social media platforms and patient engagement forums.<br><br>As this place summary is collated will be shared with colleagues to help shape the narrative and plans moving forward.<br><br>This Place report has been received by PCNs, Place Executive Leadership team, the LMC and Healthwatch. |

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| **Section 7 Place risks and mitigations** | | |
| | 7.1 Place identified risks, mitigations and management | Key Risks associated with the plan can be summarised below.<br><br>**Risk**: Increased demand on services impacting on delivery of high-quality Primary Care Services and resilience of practices.<br><br>**Mitigation**: Implement recommendations within the PCARP<br>Implement recommendations within the Fuller Stocktake Report<br>**Risk**: Inability to attract and retain a General Practice workforce to adequately delivery safe and effective services.<br><br>**Mitigation**: Comprehensive menu of Workforce recruitment and retention offers for General Practice staff, including GPs, Nurses and Practice Managers in partnership with the Cheshire Training Hub and LMC.<br><br>Survey of GPs and practice staff to get a better understanding of what is important to our workforce and their future work ambitions.<br><br>**Risk**: Inability to expand practice teams to accommodate the increased appointments and range of services due to lack of facilities (Estates and Digital technology).<br><br>**Mitigation**: Engagement with Estates Mapping and strategy planning<br>Maximising available funding such as the SDF Funding and PCARP to support digital transformation.<br><br>**Risk**: Lack of effective public engagement in delivering the recommendations within the Access Recovery Plan leading to minimal impact on access satisfaction rates and improvements<br><br>**Mitigations**: PCNs and Place to work with Public, patient groups including Healthwatch to co-develop plans. Use social media and websites to promote changes and benefits to patients and support patients to navigate new systems and processes. |

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| **Im** | e.g Place CAIP Plan templates<br>Place Patient Survey outcomes<br>Place Funding allocated to place<br>Place BI figures, list sizes and outcomes<br><br>**Appendix 1** – summary of CAIP Plans and Metrics<br>**Appendix 2** – PCARP Check List for Cheshire East<br>**Appendix 3** – APEX report<br>**Appendix 4** – Winter Plan<br>**Appendix 5** – SDF and ARRs Plan<br>**Appendix 6** – GP Retention Plan -Cheshire East |

**For information – Plan Timelines – working backwards from NHS C&M Board**

- Board meeting 30th November
- Submission for papers 16th November TBC
- Sign off week 13th-16th November via Programme Board
- Final editorial Stage 2 - 6th-10th November via Programme Board
- Collation/editorial Stage 1 - 23rd October to 3rd November via Programme Board
- Place plan elements completed by 20th October and submitted to c.leese@nhs.net
- SRO elements completed 20th October and submitted to c.leese@nhs.net

#BecauseWeCare
Cheshire East Partnership

# Cheshire East Health and Care Partnership Board

# 10 January 2024

## Care Communities Operating Model

#BecauseWeCare
Cheshire East Partnership

| | |
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| **Date of meeting:** | 10/01/2024 |
| **Agenda Item No:** | |
| **Report title:** | Care Communities Operating Model |
| **Report Author & Contact Details:** | Anushta.sivananthan@nhs.net |
| **Report approved by:** | Strategic Planning and Transformation |

| **Purpose and any action required** | **Decision/ Approve** → | x | **Discussion/ Gain feedback** → | | **Assurance** → | | **Information/ To Note** → | |
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| **Committee/Advisory Groups that have previously considered the paper** |
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| Care Community development group<br>Strategic Planning and Transformation<br>Place Leadership Group |

| **Executive Summary and key points for discussion** |
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| This is a proposed model for improving population health and reducing health inequalities by strengthening the governance, functions and autonomy of our Care Communities (integrated neighbourhood teams). Using our population health data, the team (of existing teams) will "segment" the population and use a biospychosocial model to improve outcomes, ensuring a more targeted and coordinated approach for those with the most complex needs and highest inequalities. There will be a requirement for services to move to alignment to the Care Communities, with a view to offering improved consultation and advice via multidisciplinary team support. The teams are grounded in their neighbourhoods/communities and will ensure that the community and community assets are integral to any health, wellbeing and care offer. |

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| **Recommendation/ Action needed:** | 1. Partners to take the document back to their own organisations (including clinical leaders) to understand impact and changes that maybe required in how colleagues will work.<br>2. Undertake the further work that is required - especially financial modelling, use of population health data (CIPHA), wider engagement within organisations and the public.<br>3. Confirm details and phased piloting of the model from April 2024 |

| **Which purpose(s) of the Cheshire East Place priorities does this report align with?** | |
|---|---|
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | X |
| 3. Create a sustainable workforce | X |
| 4. Significantly reduce health inequalities | X |

| Document Development | Process Undertaken | Yes | No | N/A | Comments (i.e., date, method, impact e.g., feedback used) |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | X | | There is currently an ongoing piece of work by CFOs to understand the financial impact. |
| | Patient / Public Engagement | | X | | Further work via the Comms workstream is required to get improved patient and public engagement. |
| | Clinical Engagement | X | | | There is engagement with health provider partners, social care, Local Authority communities team, Public health, Place ICB, Healthwatch and VCSFE. Further work is required after approval in principle of the operating model, to engage wider. The Care community operating model is a key component to delivering the Cheshire East System Blueprint. The model is based on the Fuller stocktake, published last year. |
| | Equality Analysis (EA) - any adverse impacts identified? | | X | | Health equity and reducing health inequalities has been central to the development of the model. |
| | Legal Advice needed? | | X | | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | X | | | Internal place governance oversight and input. |

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| **Next Steps:** | All organisations will need to take the proposed operating model through their Boards and their clinical/professional structures to consider impact.<br>Understand the financial modelling/impact.<br>Undertake wider engagement.<br>Confirm details and phased piloting of the model. |

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| **Responsible Officer to take forward actions:** | Anushta Sivananthan, Joint Medical Director, Cheshire and Wirral Partnership NHS FT<br>Mark Wilkinson, Cheshire East Place Director |

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| **Appendices:** | Operating model |

# Operating model for Care Communities

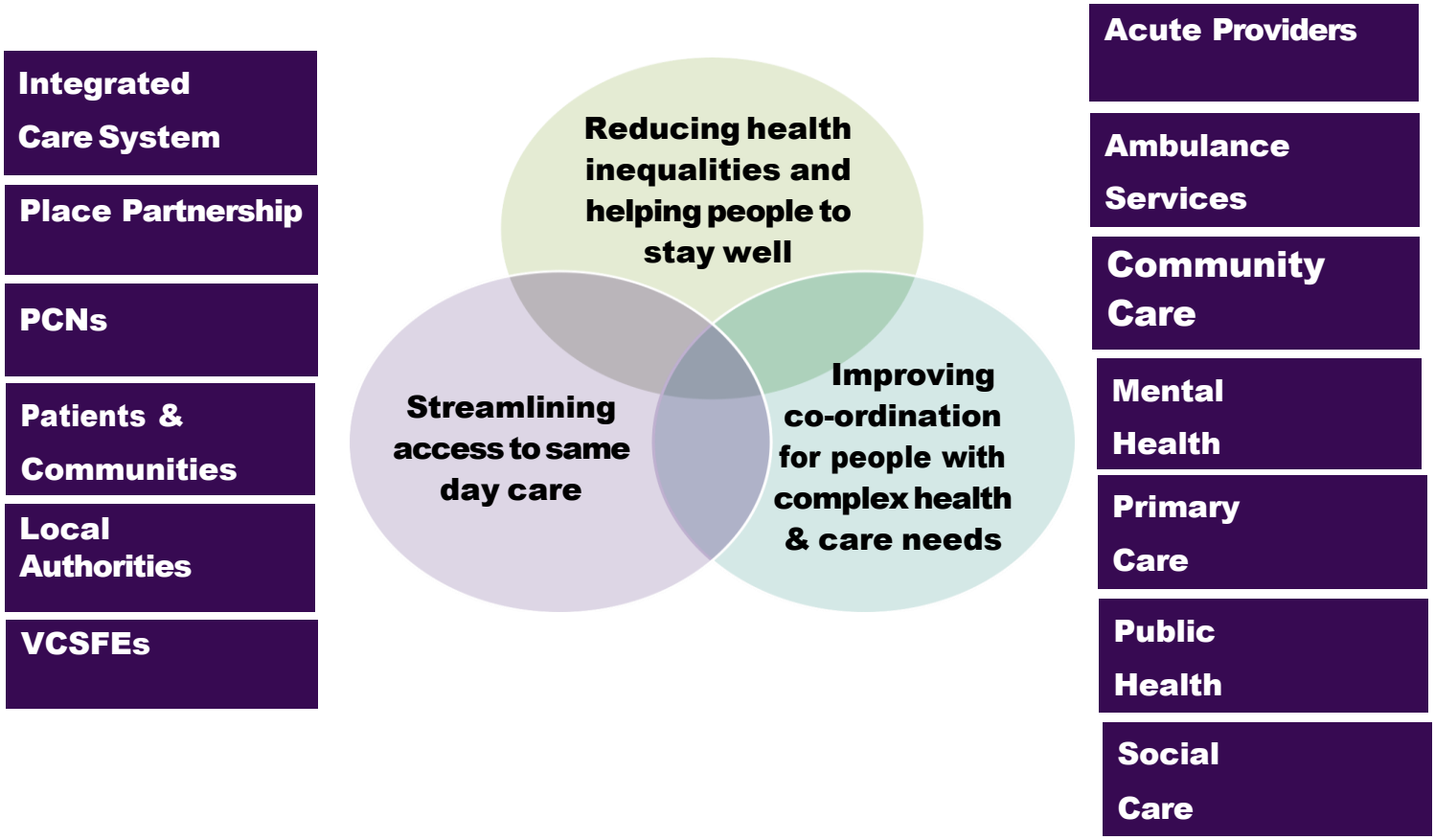
*"At the heart of the new vision for integrating primary care is bringing together previously siloed teams and professionals to do things differently to improve patient care for whole populations"*
Fuller Stocktake

## Introduction

Care communities are geographically aligned, local teams of individuals drawn from general practice, community health, mental health, acute trusts, social care, the VCSFE, local Healthwatch, optometry, dentistry, and community pharmacy to focus on the local population's health and well-being and their needs; helping people to stay in good health for longer (population health)

The concept of the Care Community is to support people to be in good health and when needed, to arrange care, interventions and provide innovative personalised solutions. These solutions will be co-delivered and co-produced in partnership with the local community, drawing on local assets and engaging with services wider than traditional health and care (eg housing, police, fire & rescue, schools).

Working in partnership is the fundamental principle to delivering not only a successful Care Community but a community that cares. The Care Community is a "team of teams" based on a registered population footprint.

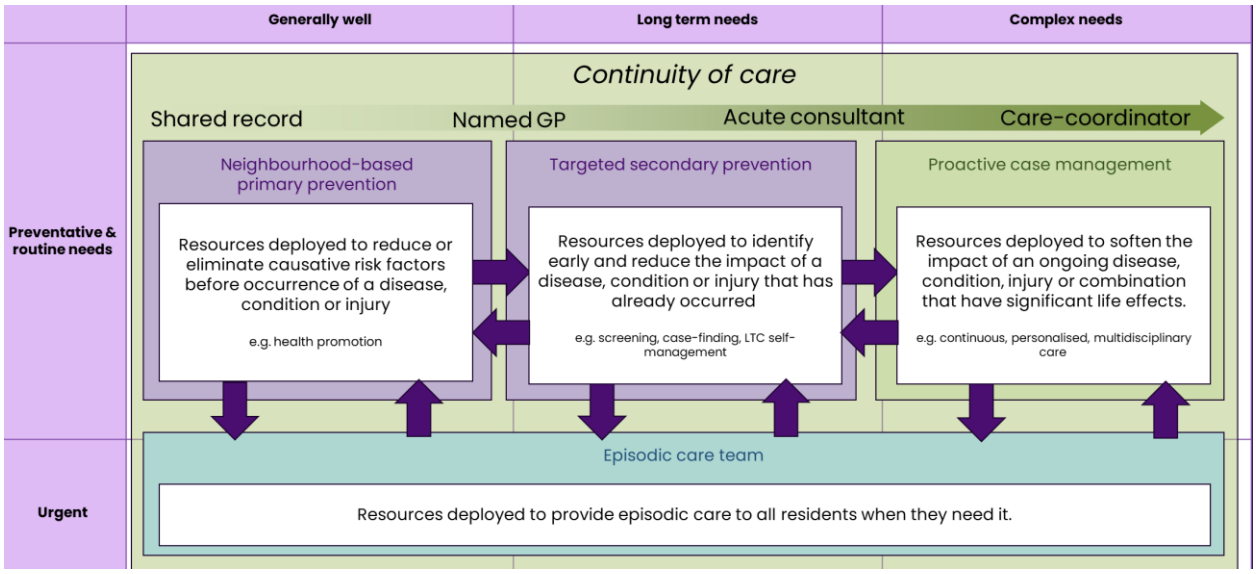


**Characteristics of a Care Community**

The Fuller Stocktake identified several key enablers - “conditions for success”.
These included:

- A more psychosocial model of care and a more holistic approach to the health and wellbeing of a community, with “teams of teams” rooted in a sense of shared ownership.
- Realignment of associated resources, for example, aligning community health services and secondary care specialists to neighbourhood teams.
- An improvement culture and a safe environment to learn and experiment, with support to PCNs to play their part in innovation and transformation of local services.
- A shared, system-wide approach to estates with a “one public estate” approach to development.
- Data and digital infrastructure that enables information about patient care to be appropriately shared.
- Locally-led investment and support with a firm understanding of current spending distribution across primary care, weighted by deprivation and other elements of the Core20PLUS5 approach.
- A high-quality and sustainable model of primary care delivery within the existing GP contract.

## Model of delivery of Care Communities




## Membership of Care Communities

Whilst local teams and local people are all key to delivering a successful Care Community, a core group of individuals made up of colleagues from each of the partner organisations will be central to decision making within their Care Community. The “core team” will be named individuals, from services within the Care Community, have a commensurate level of autonomy for decision making and play an active role in developing elements of the Care Community.

The Core Team will continually seek to build relationships within the Care Community, understand the skills and experience of colleagues within the local areas and deliver on building stronger integration to deliver improved population health.

The core team will operate within the principles of equal voice, equal value and equity in driving forward improvement actions determined by the group. The core team will meet regularly, with frequency determined by the team.

Each of the core team members will take on leadership roles for innovation and change within their respective area. The team members will focus on the population health status of the whole population, be collaborative, offer people using services access to information and be allowed to invest where they see improvements in population health.

**Local Innovation and Decision Making Core group:**

- Primary Care Network Clinical Director
- Care Community Clinical Lead
- Coach / Service Manager
- Social Care
- Public Health
- CWP Mental Health
- Healthwatch
- VCFSE

Wider members of the Care Community should include local councillors, other Local Authority links, operational support from health and care services, Police, Fire and Rescue and local housing providers. This list is not exhaustive and Care Communities will have other members of their communities with whom they would wish to engage. Care Communities will engage their populations and find ways to connect with their entire communities using the assets that are available locally.

Local secondary care providers should align clinical leaders within their organisations to each Care Community to ensure effective pathways of care between primary and secondary care, and move to supporting the Care Community multidisciplinary team.

**Management structure**

In addition, there will be an integrated leadership and management team drawn from the Core Group membership. The Leadership and management team will consist of a Care Community Clinical/Practitioner Lead, a PCN Clinical Director, a Community Manager/Coach, nursing or AHP lead and a Social Care Lead.

The leadership function will be responsible for the oversight of effectiveness, quality, and safety of integrated service delivery and for the stewardship of resources. The leadership element of the core team will also be the “key influencers” at “Place” with clear visibility, demonstrably contributing to Place plans and be able to articulate their local Care Community priorities.

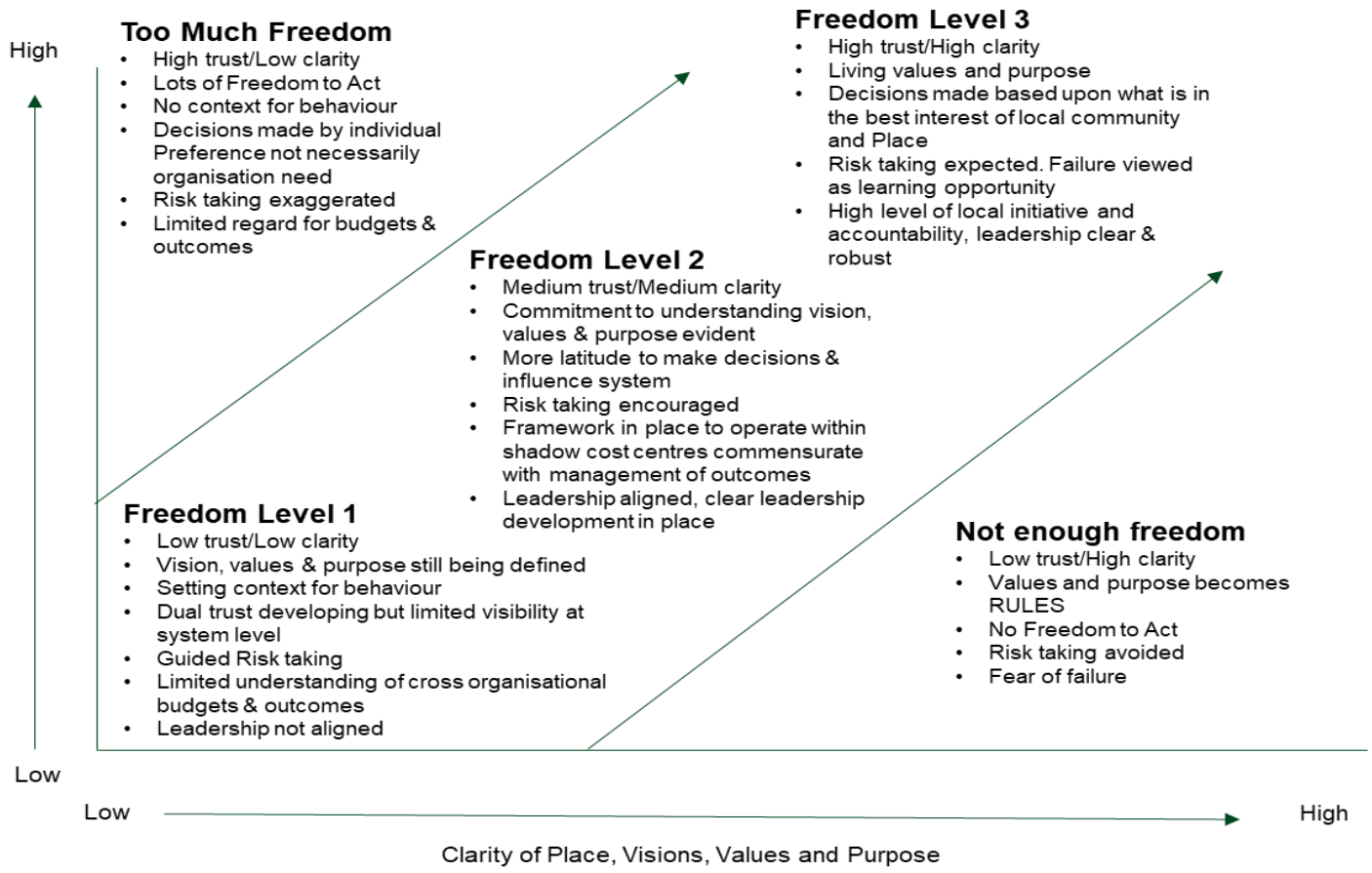
The leadership team will have:

- Responsibility to report priorities and performance into Place
- Influence Place plans through the use of local data
- Oversight of effectiveness, quality and safety
- Stewardship of resources, determining local spend within cost centres
- Support innovation and improvement
- Engage with their local populations using assets available.

## Freedom within a Framework

To operate successfully, the operating model will evolve over time within a framework initially determined by current status, with an aim to operate with greater freedom within a framework.

### Freedom within a Framework Diagram




To support these freedoms, the progress against the maturity matrix (already in use) will be assessed subjectively and objectively.

Out of Hospital maturity assessment

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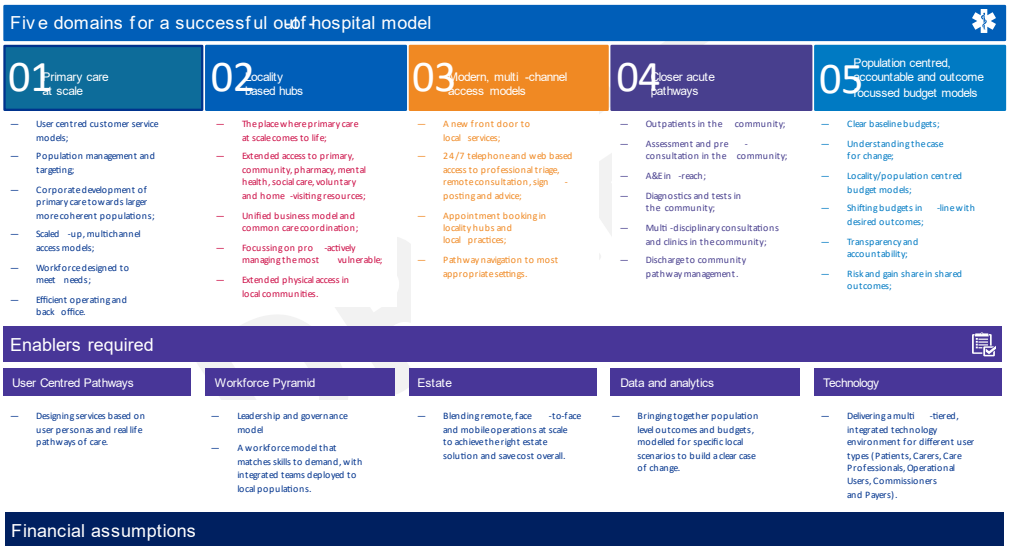


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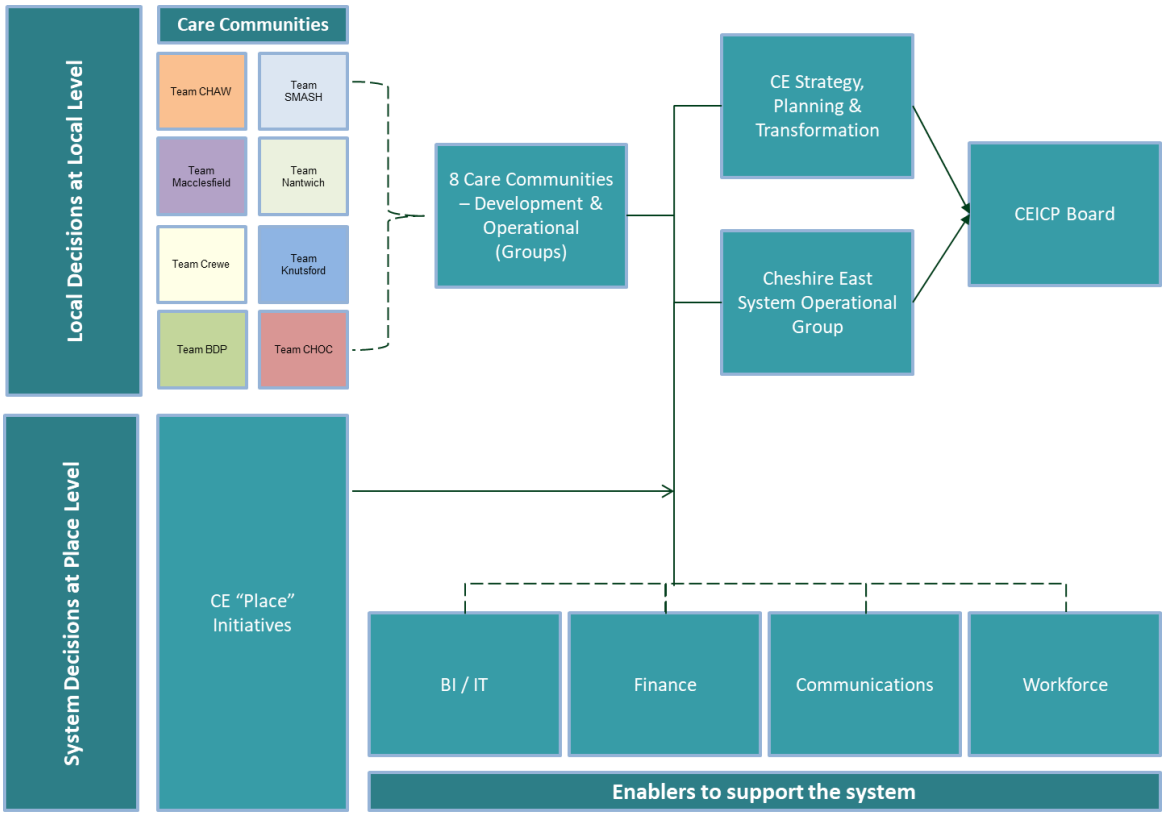
Please see Appendix 2 for further detail.

## Governance & reporting

To support development and delivery, the 8 Care Communities will report into the 8 Care Community Development and Operational Groups. The 8 Care Communities Leadership function will meet bi-monthly for development and reporting purposes. In addition, the Care Community Coaches/Service Managers will also meet bi-monthly with a focus on operational delivery. It is proposed the Care Community development group will report into the Strategy, Planning and Transformation Board by way of a report; and the Operational Delivery Group will report into the Cheshire East System Operational Group, by way of a nominated representative.

## Governance & Decision-Making Structure




## Quality and safety

Individual partner contracts will continue to be monitored through the relevant contractual arrangements. However, as part of the work to increase maturity (and thereby increased responsibility and accountability), all Care Communities will be asked to provide 2 quality goals in 23/24 based on their current intelligence (whether this be for example complaints, incidents, compliments etc). This will form a process by which the Care Community develops systems and processes for Quality Management (Joseph Juran). There are 3 main aspects of quality management which are Quality Planning /goal, Quality Improvement and Quality Control. The enabling support to develop this approach will come from all partners and be led by the Care Community Leadership team. The reporting of the achievement of these quality goals will be through the routine Care Community reports to the 8 Care Communities Development & Operational Group.As Care Communities mature, they will take on more responsibility and accountability for quality of care of integrated services.

*J.M. Juran's Trilogy Diagram*

### Budgetary responsibility and alignment of financial drivers

Each care community will have a cost centre which will comprise of the cost (including on costs) of all the personnel aligned to that care community. The care community will also have access to financial data on prescribing, admissions-, Right Care and long-term care placements to begin with. This will allow the care community to make changes to existing personnel structure (or use vacancy monies) to meet the goal to improve population health. There is a requirement for delegation of some resources from partner organisations to be able to enable this. Changes in existing investment/personnel must be reported to the 8 Care Communities Development & Operational Group and an impact assessment must be completed. A timeline to develop a level of delegated autonomy will be developed, in partnership with relevant stakeholders.

### Enabling support

To enable Care communities to deliver improved population health as well as system priorities, several enabling actions will need to be taken by partners. The care communities will have access to: -

- Business intelligence - population health as well as performance and impact (development of Care Community dashboards)
- Finance professionals - to support cost centres
- Integrated IT access
- Estates plans
- QI capability & capacity
- Leadership and management development

Care Communities need delegated authority from provider partners to change the way resource is used. The ICB may wish to trial a different contracting mechanism to support integration, focusing on population health outcomes.

### Population Health and the needs of the population.

Population health includes:

- *A shift in focus from Illness to Wellness* ie health promotion, disease prevention, health literacy
- *Holistic care needs* ie a personalised or MDT approach to care that focuses on the person affected and their supporters

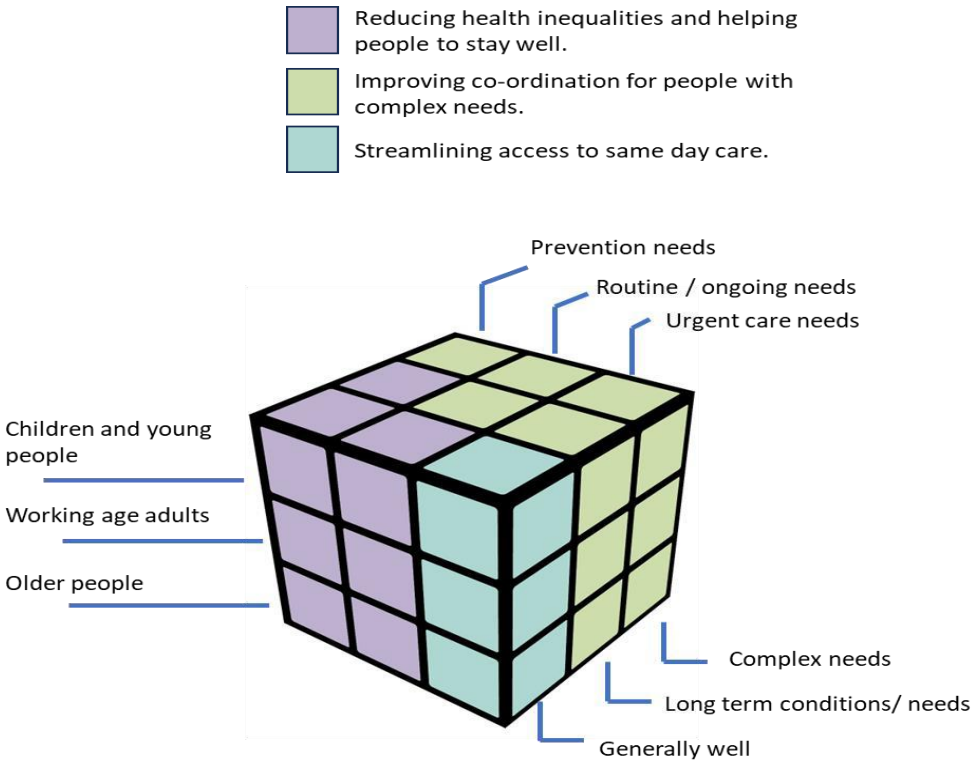
To improve population health each Care community needs to:

- KNOW the population health needs
- ENGAGE with the population
- MANAGE the entire population through segmentation

**NAPC's** Primary Care Home cube provides a simple, accessible model for looking at population health management in three dimensions:

**Stage of life:** children & young people, working age adults and older people.

**Holistic health and care needs:** currently well, people with long-term conditions (LTCs), and those with complex biopsychosocial health needs.




## Current capacity

The Place will help develop a collective view of the assets and resources available to respond to identified local needs. It will not just look at primary care or wider health services, but also the capacity within wider public services including adult & children's social services, public health, and the local VCFSE services**.**
Care Communities will be supported to map:

- Individuals engaged in primary and secondary prevention, including wider primary care, VCFSE services, and public health
- Individuals involved in the care of those with complex needs, including adult and children's services, primary, community and acute specialists, and existing multi-disciplinary teams
- Individuals involved in provision of same day care, including primary care and those supporting urgent & emergency care pathways

## Care Community People Plan

In recognition that our workforce is our greatest asset, the Care Communities will need to be fully conversant with the Care Community People Plan. The plan has been developed by our Care Communities over the last year and is now in first year mobilisation phase. The following 4 component parts make up the plan: -

- Growing our workforce
- New ways of working
- Creating a health leadership culture
- Caring for our people

Support for delivery will be by way of provider Workforce/OD colleagues. The role of Care Communities is to embrace the plan and support delivery by way of the Core Groups.

### Risk management and escalation

The Leadership team are required to review their business information, performance, and quality of care to put improvement actions in place. Care Communities can escalate risks or issues to the 8 Care Communities Development & Operational Groups.

### Performance reporting and management

Operational performance, quality of care including safety, effectiveness, and experience as well as use of resources will be reported once every 2 months to the Place Operational group. Each Care community will hold a risk register which will help Cheshire East Place to understand the risk to delivery and support to mitigate risk. By providing this information, Care Communities can provide assurance to providers and the ICB as to their progress against Place and Care Community objectives, as well as escalation for support.

### Transformation & Intelligence

Each Care Community will be supported to further develop their local dashboards, determined by their local intelligence and local needs and priorities. The intelligence will be drawn from several data sources to understand both positive and negative variation in experience, effectiveness and outcomes of health and care.

### Social Value

Care Communities will be supported to meet the requirements around social value of services commissioned and delivered, their progress towards Net Zero and to support delivery of the Cheshire and Mersey Prevention Pledge. The Pledge is integral to the delivery of population health.

### Fair Society, Healthy Lives

Using our population health data, including premature mortality, Care Communities will be supported to understand health inequalities within their population so they can work with partners to deliver innovative solutions to reduce health inequalities.

### Development and support

The 8 Care Communities Development & Operational Groups will continue to support development and maturity of the Care Communities, accepting that each Care Community is at differing levels of maturity and may require different levels of help and support. The progress to delegation of budgets, authority to use resources differently and risk and reward mechanisms will be iterative and developmental.

Appendix 1.

| Building Strong Care Communities - the next level (High level plan 2023/24) | | | | | |
|---|---|---|---|---|---|
| **Model features** | | | | | **Resulting in** |
| **Care Community Blueprint** | Care Community development group sessions - revisit model & functions of a Care Community, host development events with local stakeholders (Making the Care Communities real for residents) | | | Care Community Blueprint - gain system agreement | **A consistent approach to the model and functions of a Care Community** |
| **Integrated Teams** | Strengthen the Care Community Core Groups - Team building & further developing roles, values, behaviours & priorities. | | Develop the wrap around support functions, inlcuding Workforce, BI, project support, development of proposals. | | **Care Community Core Groups operating as unified providers of services** |
| **Leadership Structure** | Working with Care Community Core Groups, define & design the leadership structure, roles and levels of decisions making | | Design & test an accountability framework (freedoms within a framework) | | **Care Communities as decision making units, for local population & local delivery** |
| **Leadership Development** | Review current leadership offers across the Place & begin to define potential requirements | Accessible leadership programmes for Care Community Core Groups | Accessible leadership programmes for Care Community Core Groups | Accessible leadership programmes for Care Community Core Groups | **Local leaders with commensurate skills to lead local integrated teams** |
| **Assurance** | Develop the governance & consistent reporting framework for Care Communities | Initiate meetings with clear terms of reference & reporting requirements | Ongoing review of governance & reporting, dynamic amendments as required | Formal review of governance & reporting | **Care Communities which report into the system, are held to account for delivery & hold a position of "influencing" future service delivery** |
| **Quality Improvement (capability & capacity)** | Baseline review of current QI capability & capacity across all Care Communities | Develop & agree the framework for increasing QI capability & capacity (inc catalogue of offers) | QI programmes for all Care Community Core Group members | QI programmes for all Care Community Core Group members | **The beginning of a consistent approach to QI across the Place** |
| **Bi & Finance** | Business Intelligence support, developing local dashboards for each Care Community | | Bi & finance working group to develop an understanding of service demand, cost and outcomes. | | **Meaningful dashboards which support local decision making** |
| **Devolved Budget** | Working group to establish current costs in each Care Community | | Working group to develop a framework for devolved budgets | | **Framework prepared for testing devolved budgets, for each Care Community** |
| **IT** | Support required – re: activities | | | | |
| **Align Secondary Care** | Develop forums for linking Care Communities & Secondary Care colleagues, building relationships around a common purpose | | Hold workshops to develop end to end pathways (2 x clinical areas) | | **Closer working relationships, delivering on simplified service user pathways** |

## Appendix 2
KPMG maturity matrix

Out of Hospital maturity assessment

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# Overview

The out-of-hospital maturity assessment is based on six domains – five relating to the maturity of the model of service delivery itself, and one domain assessing the maturity of the key enablers.

## Five domains for a successful out-of-hospital model

### 01 Primary care at scale
- User centred customer service models;
- Population management and targeting;
- Corporate development of primary care towards larger more coherent populations;
- Scaled-up, multichannel access models;
- Workforce designed to meet needs;
- Efficient operating and back office.

### 02 Locality based hubs
- The place where primary care at scale comes to life;
- Extended access to primary, community, pharmacy, mental health, social care, voluntary and home-visiting resources;
- Unified business model and common care coordination;
- Focussing on pro-actively managing the most vulnerable;
- Extended physical access in local communities.

### 03 Modern, multi-channel access models
- A new front door to local services;
- 24/7 telephone and web based access to professional triage, remote consultation, sign-posting and advice;
- Appointment booking in locality hubs and local practices;
- Pathway navigation to most appropriate settings.

### 04 Closer acute pathways
- Outpatients in the community;
- Assessment and pre-consultation in the community;
- A&E in-reach;
- Diagnostics and tests in the community;
- Multi-disciplinary consultations and clinics in the community;
- Discharge to community pathway management.

### 05 Population centred, accountable and outcome focussed budget models
- Clear baseline budgets;
- Understanding the case for change;
- Locality/population centred budget models;
- Shifting budgets in-line with desired outcomes;
- Transparency and accountability;
- Risk and gain share in shared outcomes;

## Enablers required

### User Centred Pathways
- Designing services based on user personas and real life pathways of care.

### Workforce Pyramid
- Leadership and governance model
- A workforce model that matches skills to demand, with integrated teams deployed to local populations.

### Estate
- Blending remote, face-to-face and mobile operations at scale to achieve the right estate solution and save cost overall.

### Data and analytics
- Bringing together population level outcomes and budgets, modelled for specific local scenarios to build a clear case of change.

### Technology
- Delivering a multi-tiered, integrated technology environment for different user types (Patients, Carers, Care Professionals, Operational Users, Commissioners and Payers).

## Financial assumptions

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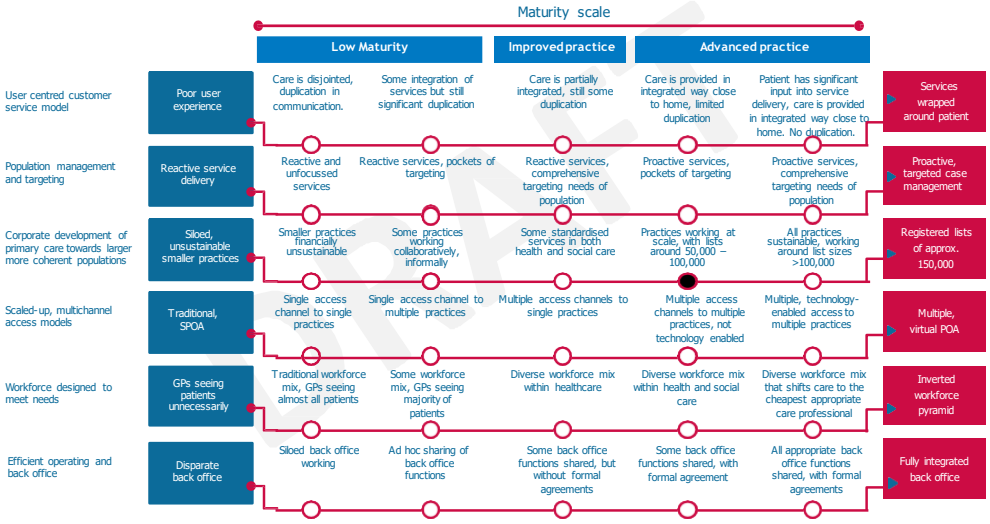
# Primary care at scale

**1** **Primary care at scale is critical for out of hospital models, as it is here that the population (via the registered list) can be closely managed. At-scale primary care provides a new front-door to reduce unnecessary A&E attendances, proactively manages the population's health, and supports patients to stay healthy.**

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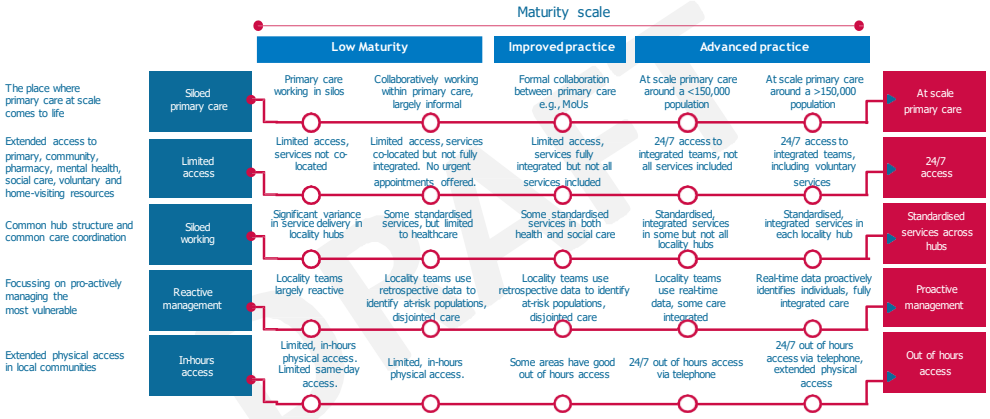
# Locality based hubs

**Out of hospital models are based around geographical, locality -based hubs that offer a GP-led model to manage demand and are the main delivery mechanisms of integrated health and social care in the community. Locality -based hubs need to be adapted to suit local structures, geography and population needs.**

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# Multi-channel access

**3** Locality -based hubs require clear, streamlined access points. Multi-channel access models allow patients to receive primary care services in a more timely manner. It allows professionals to see a larger volume of patients and allows patients to access care in a more convenient way through the use of technology.

Maturity scale

| | | Low Maturity | | Improved practice | Advanced practice | | |
|---|---|---|---|---|---|---|---|
| A new front door to local services | Multiple 'front doors' | Multiple entry points, unclear pathways, physical access only | Multiple entry points, unclear pathways, physical and virtual access | Single front door to locality hubs | Clearly signposted, physical single front door to locality hubs | Clearly signposted, virtual and physical single front door to locality hubs | Single 'front door' |
| Telephone and web based access to professional triage, remote consultation, sign-posting and advice | Limited access | No telephone and web based access | Telephone access, but limited services | Telephone and web based access, but limited services | Technology enabled access to triage and signposting. | Technology enabled access to triage, consultation, signposting and advice. | 24/7 access |
| Appointment booking in locality hubs and local practices | Siloed working | Appointment bookings done separately by organisation | Multiple channels for bookings, duplication and unclear processes | Some locality hubs able to book limited number of services | All locality hubs able to book limited number of services | All locality hubs able to book appointments for health and social care services | Fully integrated |
| Pathway navigation to most appropriate settings | Poor signposting | Disparate pathways, unclear signposting | Limited signposting, pathways not well documented or known by patients or all professionals | Standardised pathways | Clearly signposted, standardised pathways | Clearly signposted, streamlined pathways well-understood by professionals. | Streamlined and clearly signposted |

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# Closer acute pathways

**0** Locality -based hubs provide a new forum for services that are traditionally provided in an acute setting. Improving the interfaces between acute and community care, and moving some acute services into the locality hubs brings care closer to home, reduces costs, and generates capacity in the acute sector.

Maturity scale

| | | Low Maturity | | Improved practice | Advanced practice | | |
|---|---|---|---|---|---|---|---|
| Outpatients in the community | None in community | No outpatient services in community | Some outpatient services in community, but little pathway integration | Some outpatient services in community, with good pathway integration | Comprehensive outpatient services in community, but with little pathway integration | Comprehensive outpatient services in community, with good pathway integration | All appropriate specialties |
| Assessment and pre-consultation in the community | None in community | No assessment and pre-consultation in community | Disjointed and limited pre-assessment or pre-consultation in community | Some pre-assessment or pre-consultation in community | Number of pre-assessment or pre-consultation in community | Comprehensive assessment and pre-consultation in community | All appropriate |
| A&E in-reach | None in A&Es | No A&E in-reach | Informal in-reach services, not in all A&Es | Formal in-reach but disjointed between health and social care | Fully embedded health and social care community in-reach team | Fully embedded health and social care community in-reach team | All A&Es have service |
| Diagnostics and tests in the community | None in community | No diagnostics and tests in community. Access only via acute providers | Some diagnostic and testing in community, ad hoc | Some diagnostic and testing in community, processes system-wide | GP direct access to diagnostics and testing | GP direct access to diagnostics testing, completed in community | Access for all communities |
| Multi-disciplinary consultations and clinics in the community | None in community | Siloed working, consultations and clinics in acute settings | Multi-disciplinary consultations and clinics, in acute setting | Some fully integrated consultations and clinics in community | Fully integrated consultations in community | Fully integrated consultations in community, based in locality hubs | All localities have clinics |
| Discharge to community pathway management | Poor processes | No clear discharge pathway. Disjointed health and social care services. | Ad hoc discharge pathways. | Standardised discharge pathways. | Standardised pathways. Limited number of specialist, multi-disciplinary discharge teams | Specialist, multi-disciplinary discharge teams working with locality hubs. First assessment within 48 hours | Clear processes |
| Efficient operating and back office | Disparate back office | Siloed back office working | Ad hoc sharing of back office functions | Some back office functions shared, but without formal agreements | Some back office functions shared, with formal agreement | All appropriate back office functions shared, with formal agreements | Fully integrated back office |
| Urgent Treatment Centres | Significant duplication | Multiple entry points (WICs, MIUs, UCCs etc) | Some streamlining of existing services | GP-led, 12 hours a day every day. Without diagnostics on site. | GP-led, 12 hours a day every day. With diagnostics on site. | Same-day and routine appointments at same facility | 12/7/364 |

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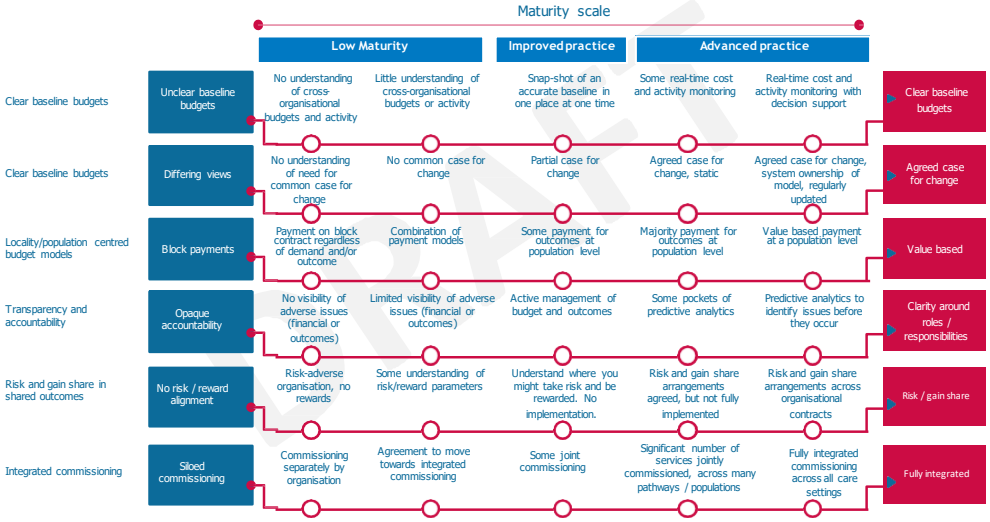
# New payment models

**05** **Moving activity into the community requires realignment of payment incentives to encourage and facilitate new ways of working. Therefore successful out of hospital models have population centred, accountable and outcome focussed budget models.**

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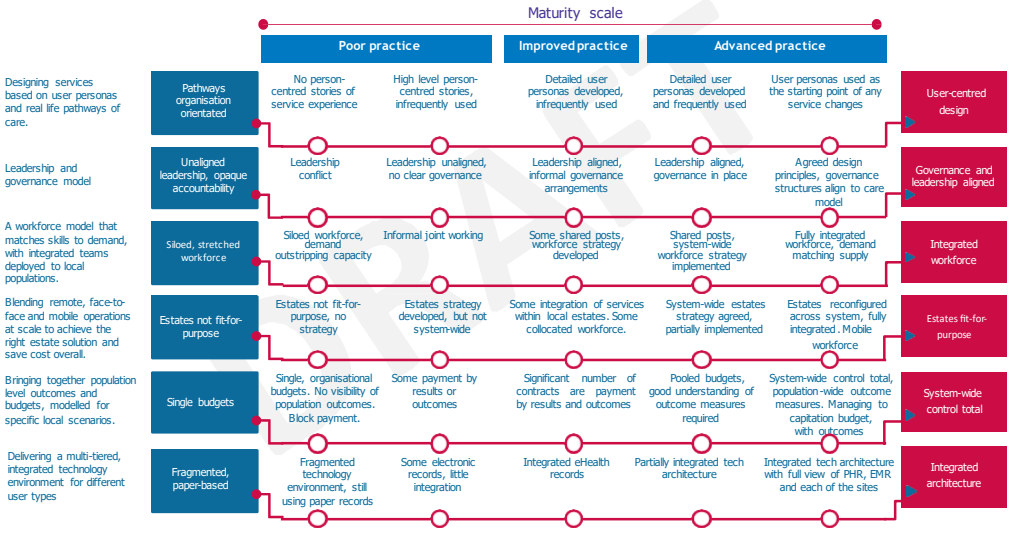
# Key enablers

**Implementing successful out of hospital models requires critical infrastructure and processes to be in place. In particular, an appropriate workforce, estates configuration, technology platforms, and data and analytics capabilities.**

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Acknowledgements :

National Association of Primary Care (NAPC) Primary Care Home model
NHSE/PPL/Nuffield Trust- Modelling Integrated Neighbourhood Working- draft
J Jurans Quality Management System -Trilogy -Diagram.

*Proposed definition of complexity:*

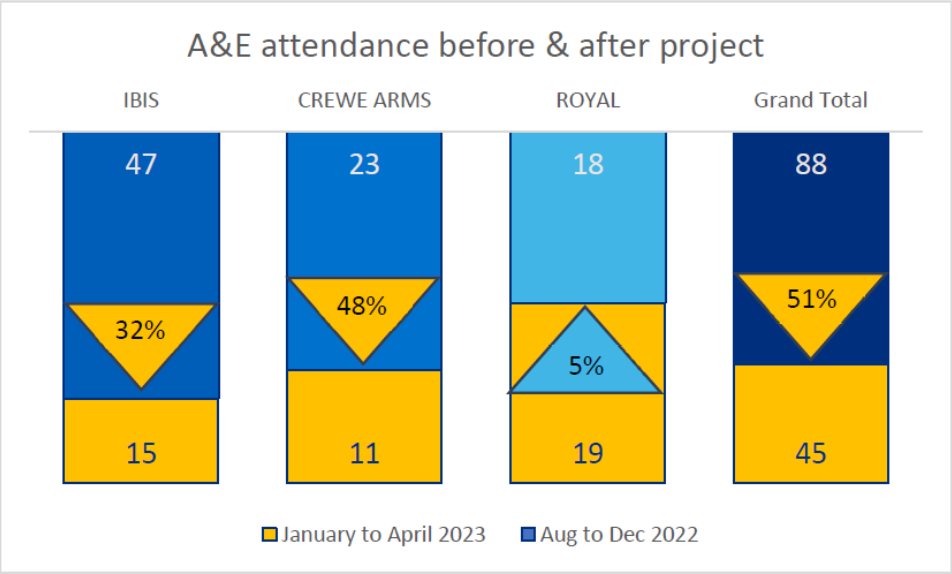
Residents living with two or more long term conditions
A person with a Learning Disability and or autism
Having Serious Mental Illness
Moderate to severe frailty *and* one of the following: Hypertension, Depression, Asthma, Diabetes, CHD, CKD, Hypothyroidism, Stroke or Transient Ischaemic Attacks, COPD, Cancer, Atrial Fibrillation, Heart Failure, Epilepsy, Dementia.

Case studies from Care Communities.

# Team Crewe

## The Asylum Outreach Project

Asylum seekers are placed temporarily into Crewe hotels either whilst awaiting status change or for onward relocation. For many this is a bewildering and frustrating time. The majority have experienced both physical and emotional trauma along their journey to the UK, and some within their countries of origin. These are vulnerable, socially excluded people who need support to adjust to UK systems and to interpret health information and services.
Patients presenting at A&E were often unable to express their needs or explain underlying issues linked to the symptoms they were presenting with. The drop-in clinics provided a safe space for patients to present their immediate health concerns. The clinics were popular and provided opportunities to interact and to educate on self-care



# Team Knutsford

## Cardiology Virtual Clinics

In April 2022, Knutsford Care Community began to trail cardiology virtual clinics with Dr Rob Egdell, Cardiologist Consultant at Macclesfield Hospital. The clinics took the form of a weekly virtual question & answer clinic and clinicians within Knutsford PCN could refer 3 cases per week, one from each GP surgery. The clinics have been a success however ongoing support is required for this to become business as usual.

**Aims**

• Discuss and seek advice virtually face to face for patients with complex heart failure within the community
• Formulate advance care planning for patients with advanced heart failure
• Improve learning opportunity for patients with advanced heart failure in Primary Care
• Improve communication between Primary and Secondary care • Improve the patient's experience • Reduce hospital attendance

**Heart Failure MDT's**

Dr Russell also holds a monthly Heart Failure MDT which offer the opportunity for clinicians to discuss or seek advice. The initiative started in Knutsford Care Community and has since been rolled out across the Care Communities in East.

**Cardiology Virtual Clinics – Outcomes**

Pilot period results (4 months)

- 7 clinics on a Wednesday lunchtime lasting 30 mins to 1 hour
- 21 patients in total discussed
- In 19 patients a referral to secondary care outpatients' was saved (90%)
- In 2 patients direct access to secondary care investigation was achieved and then follow up arranged

A total of 60 patients have been discussed in the virtual clinics from August 2022 – July 2023

Cost Saving: average cost of attendance at cardiology outpatient clinic in acute setting - £136 without tests or £242 including tests (ECG; Echo)

**Case Study**

A 67 year old anxious male was investigated for PAF. His ECHO was normal and a holter monitor was performed remotely which showed 4 beats of VT. The man was discussed during a virtual cardiology clinic. His heart was normal, his examination was normal and he had no worrying symptoms. The patient was reassured with safety netting. This saved 3 hospital attendances (2 x Holter monitor, 1 x cardiology OPD), lead to a faster diagnosis time and improved patient satisfaction. This was a shared learning experience.

# Team Macclesfield

## Hypertension Case finding- Outcomes / Impact

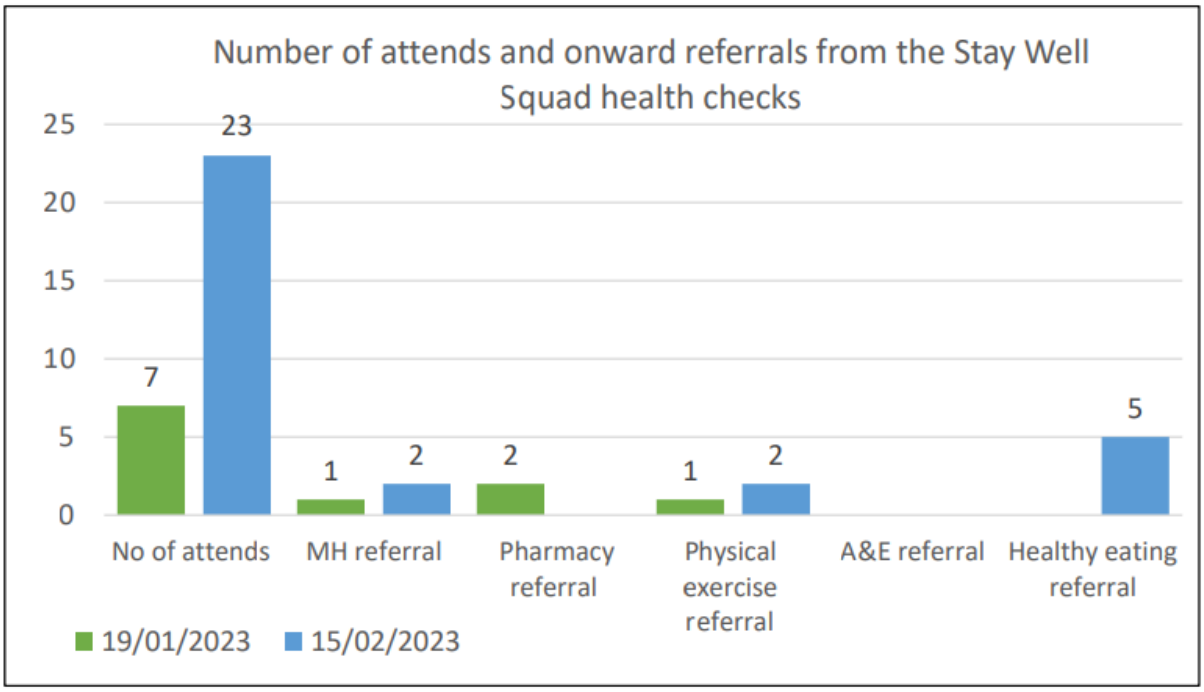
We have started to collect process measures around the number of health checks delivered and onward referrals made

**Ageing well roadshows**

| Event | Total BPs taken | How many elevated BPs but on Hypertensives | BPs over 180/80 escalated to next day clinic |
|---|---|---|---|
| Ageing well event 1 | 300 | 50 | 10 |
| Ageing well event 2 | 60 | 20 | 1 |
| Ageing well event 3 | 200 | 15 | 0 |

The Macclesfield Care Community worked collaboratively with Macclesfield PCN and wider partners to present an ageing well roadshow seasonally. The event is delivered with a tailored approach to mild, moderate and severe frailty. The roadshows present opportunities to identify residents with undiagnosed hypertension and nursing staff were able to signpost to other services and give advice accordingly regarding blood pressure readings and other lifestyle domains.

**Community health checks**




The total number of people who attended for a health check with the Stay Well Squad equated to 7.5 hours in saved primary care hours, based on seeing 4 patients per hour in a clinic. Unfortunately, the stay well squad was decommissioned in May 23. We are currently working with other partners to deliver health checks in the community.

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# Cheshire East Health and Care Partnership Board

# 10 January 2024

## Place Director Update

| | |
|---|---|
| **Date of meeting:** | 10 January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Place Director Update |
| **Report Author & Contact Details:** | Mark Wilkinson, Cheshire East Place Director |
| **Report approved by:** | Mark Wilkinson, Cheshire East Place Director |

| **Purpose and any action required** | **Decision/ Approve** → | | **Discussion/ Gain feedback** → | X | **Assurance** → | X | **Information/ To Note** → | X |
|---|---|---|---|---|---|---|---|---|

| **Committee/Advisory Groups that have previously considered the paper** |
|---|
| None |

| **Executive Summary and key points for discussion** |
|---|
| The paper provides briefings on several key topics: Joint Targeted Area Inspection on the criminal exploitation of children, Urgent and Emergency Care Recovery and Improvement Group, rationalisation of office accommodation in Cheshire East, ICB review of Continuing Healthcare Expenditure (CHC), mental health resource demand and capacity, dermatology services, developing the Cheshire and Merseyside performance report, and meetings and visits. |

| **Recommendation/ Action needed:** | To note the report |
|---|---|

| **Which purpose(s) of the Cheshire East Place priorities does this report align with?** | |
|---|---|
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | X |
| 3. Create a sustainable workforce | X |
| 4. Significantly reduce health inequalities | X |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e., date, method, impact e.g., feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | X | |
| | Patient / Public Engagement | | | X | |
| | Clinical Engagement | | | X | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | X | |
| | Legal Advice needed? | | | X | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | X | |

| **Next Steps:** | None |
|---|---|

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| | |
|---|---|
| **Responsible Officer to take forward actions:** | Mark Wilkinson, Cheshire East Place Director, NHS Cheshire and Merseyside |

| | |
|---|---|
| **Appendices:** | None |

# Place Director Report

## 1. Introduction

This report presents key activities and issues for the Partnership together with information on areas of personal focus since the last meeting.

## 2. Key issues

### Joint Targeted Area Inspection on the criminal exploitation of children

In July 22 Cheshire East's Safeguarding Childrens Partnership received a Joint Targeted Area Inspection on the criminal exploitation of children. A number of recommendations were made which have been implemented over the last year or so.

The relevant agencies have all agreed that individual agency and partnership actions are now completed. Ongoing improvements should therefore be managed and scrutinised via existing governance within each agency and across the Safeguarding Partnership. In essence, these ongoing improvements are business as usual.
This decision will be confirmed with the ratification of a final closure report at a special meeting on 22 January 24.

### Urgent and Emergency Care Recovery and Improvement Group

The NHS England delivery plan for recovering urgent and emergency care services (January 2023) sets out a number of ambitions including:

- Patients being seen more quickly in emergency departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024.
- Ambulances getting to patients quicker.

These ambitions represent one of the fastest and longest sustained improvements in emergency waiting times in the NHS's history. It is acknowledged that delivery will require prioritisation at a national level, but also local flexibility – there will not be a one size fits all solution, and local systems, working with social care and others, are currently developing local plans reflecting local needs.

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NHS Cheshire and Merseyside has established governance to deliver against this ambitious agenda in a co-ordinated and effective approach. The scope of this group – which reports to the Transformation Committee - includes the following workstreams:

- System Capacity & Demand
- In Hospital Patient Flow
- Discharge
- Community Patient Flow
- Oversight & Resilience

## Rationalisation of office accommodation in Cheshire East

Following a comprehensive staff consultation and engagement exercise the ICB in Cheshire East is preparing to leave the former CCG headquarters in Bevan House – this site will then be put up for sale.

Our new location from 1 February will be Infinity House on the Crewe Business Park – co-located with Mid Cheshire Hospitals NHS FT. Together with our earlier rationalisation of our space in New Alderley House in Macclesfield, we have embraced a hybrid working model and delivered significant revenue savings.

## ICB review of Continuing Healthcare Expenditure (CHC)

In response to significant financial and operational pressures on the CHC budget across Cheshire and Merseyside, an external company is being hired to review our processes and decision making. The contractor will work with Cheshire East and two other places in the first instance. It's important for us to participate given the financial pressures we face.

The agreed order of work will be as follows:

- Fast Track Reviews. (78 overdue across Cheshire East)
- 3-month CHC Reviews
- 12 Month CHC reviews

All cases with 1:1 input will be reviewed by our own in-house team. Reviews of these cases have been underway for the last few months and have delivered significant financial savings.

This work is expected to be mobilised by mid-January and appropriate project governance has been established.

## Mental health resource demand and capacity

Significant funding has already been targeted at the interface between Mental Health services, Social Care and out of area placement spend, however a bespoke, capacity, and resource review is now required to fully understand the associated expenditure and system opportunities within existing block funded financial commitment. A number of people are being supported within the

'wrong' type of placement, which is placing a significant financial pressure on the Cheshire East System and delivering sub optimal outcomes for people.

A Home First transformational priority programme has been initiated to support the decompression of the issues along with a strategic SUPER MADE oversight group that will focus on the medium to long term challenges, such as Housing, care provider capabilities and new models of care and support. This will bring about efficiencies and improve quality and safety along with focusing on moving people into services that provide the right type of support.

The desired outcomes from this work – which is due for completion by the end of January - are as follows:

- Understand and quantify the financial costs of the existing commissioned provisions, e.g., demonstrating the current investment in services.
- Fully understand the operational Governances and oversight for all commissioned provision including contract end dates and timelines for contract termination notices.
- Forecasting using the system's historical data and predictive analytics to anticipate future demand and expenditure.
- Produce a report that articulates the associated financial costs, system opportunities and make recommendations where funding can be released and repurposed to support service development.

## Dermatology Services

The Place Leadership Group (PLG) has received an update report on Dermatology services summarising some of the context and history to the current service and providing an update on planned next steps in reviewing the service and developing an integrated working model between Secondary and Primary Care. There is an opportunity to do something different across Cheshire East, South Cheshire & Vale Royal.

The group were enthusiastic about the potential to create a truly integrated service between Secondary and Primary care, as opposed to simply moving the service from one to the other; but also acknowledged the work currently being led by the CMAST Provider Collaborative and need to avoid duplication.

A working group is being established, to be chaired by Dr Paul Bishop and further update to be brought back to the PLG in due course.

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## Developing the Cheshire and Merseyside performance report

NHS Cheshire and Merseyside have developed a performance report which will be presented to future public board meetings. Although not all data is broken down by Place it is possible to discern relative areas of strength within the report and areas for greater focus.

In relation to the strengths, Cheshire East was performing well overall (e.g. in comparison to C&M), in particular across primary care. Limitations of the report include the fact that it only reports NHS health data, does not include any local authority or third sector data.

## Meetings and visits

Since the last meeting of the Board, I have undertaken the following key meetings and visits:

- Visited Priorslegh Medical Centre in Poynton.
- Led a third successful team building event for the Cheshire East place team prior to Christmas.
- Visited Cheshire and Wirral Partnership's Mulberry Ward with their Chair and CEO for a 'walkabout'.
- Supported the Blueprint Workshops aimed at a consensus view of what we want our health and care services to look like in 2030.

### 3. Recommendation

The Board is asked to note the report.

**ITEM 11**

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# Cheshire East Health and Care Partnership Board

# System Finance Report - Month 8

| | |
|---|---|
| **Date of meeting:** | |
| **Agenda Item No:** | |
| **Report title:** | System Finance Report – Month 8 |
| **Report Author:** | Katie Riley – Head of Finance |
| **Report approved by:** | Dawn Murphy – Associate Director of Finance and Performance |

| **Purpose and any action required** | **Decision/→ Approve** | | **Discussion/→ Gain feedback** | | **Assurance→** | | **Information/→ To Note** | X |
|---|---|---|---|---|---|---|---|---|

**Executive Summary and Key Points for Discussion**

The Cheshire East system planned for a deficit of £53.4m for 2023/24. This covers the following partner organisations:

- Cheshire and Merseyside Integrated Care Board (Cheshire East Place)
- East Cheshire NHS Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Cheshire and Wirral Partnership NHS Foundation Trust
- Cheshire East Council

Reporting from Cheshire East Council has been included. However, due to the different reporting timescales for Local Authorities, the second quarter review has been included with no further update to month 8.

The system is forecasting to achieve the planned deficit of £53.4m at month 8.

However, there is £83.3m of risk reported against this achievement currently mitigated by potential identification of further savings, implementation of financial recovery actions and collaborative working across the system. This brings the risk adjusted forecast to a deficit of £93.0m, an adverse variance to plan of £39.7m.

Efficiency savings of £58.4m are forecast to be achieved against a target of £56.8m, but £2.0m of the risk mentioned above is associated with delivery of these targets.

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Board is asked to:**<br><br>Note the content of the report. |

| **Consideration for publication** | |
|---|---|
| Meetings of the Health and Care Partnership Board will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate: | |
| The item involves sensitive HR issues | |
| The item contains commercially confidential issues | |
| Some other criteria. Please outline below: | |

| **Which purpose(s) of the Cheshire East Place priorities does this report align with?** | |
|---|---|
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | X |
| 3. Create a sustainable workforce | |
| 4. Significantly reduce health inequalities | |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e., date, method, impact e.g., feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | | |
| | Patient / Public Engagement | | | | |
| | Clinical Engagement | | | | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | | |
| | Legal Advice needed? | | | | |
| | Report History – has it been to other groups/ committee input/oversight (Internal/External) | | | | The financial position for each organisation will have been presented through internal governance structures. |

## System Finance Report – Month 8

### 1. Introduction

1.1 The purpose of this report is to update on the overall financial position of Cheshire East Place. Partners include Cheshire and Merseyside Integrated Care Board (ICB), Cheshire and Wirral Partnership NHS Foundation Trust (CWP), Cheshire East Council (CEC), East Cheshire NHS Trust (ECT) and Mid Cheshire Hospitals NHS Foundation Trust (MCHFT).

1.2 This report is based on the forecast produced at the end of Month 8, November 2023, for NHS organisations. Due to differences in reporting frequency and timescales, information from Cheshire East Council's second quarter review has been included.

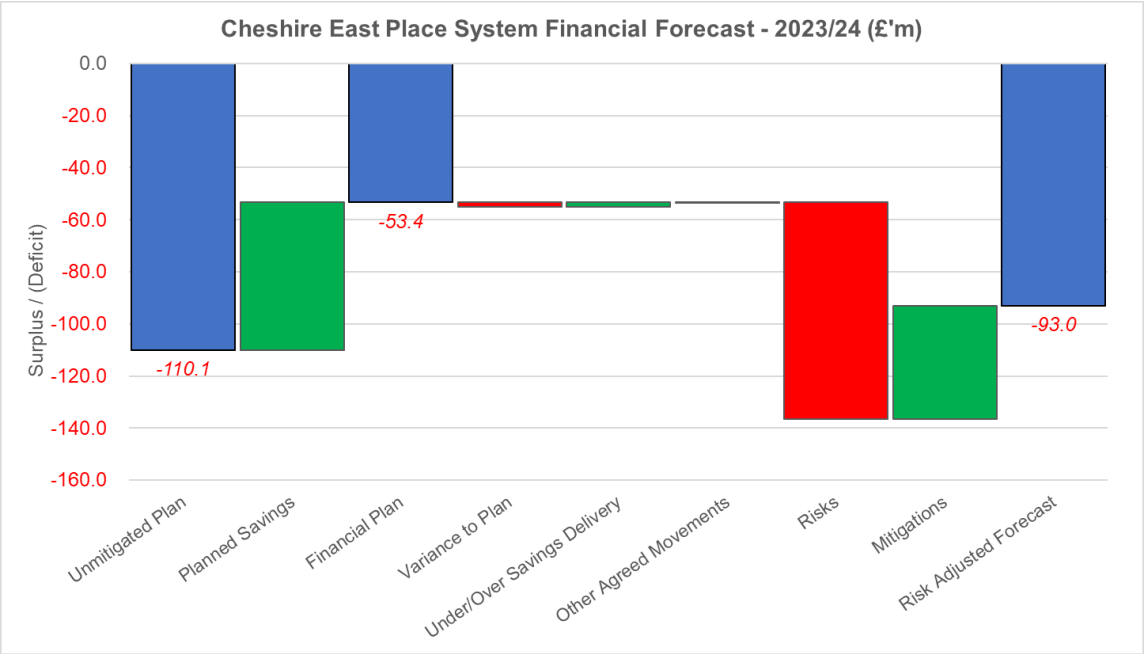
1.3 The key issue is the challenged financial position of all organisations within the partnership and the impact this has on all sectors and providers of health and social care.

1.4 Where organisations provide a significant level of service to more than one Place, their financial reporting has been apportioned out using an approximate percentage split but the total organisational position can be seen in Appendix 2.

### 2. System Financial Position

2.1 The financial position of Cheshire East Place is challenging, organisations are facing increasing demand and increased costs across all their activities which is causing significant financial pressure.

2.2 The planned deficit agreed following the planning round for 2023/24 was £53.4m. The current reported forecast deficit across the system is in line with plan at £53.4m, however considerable risk has been reported against this achievement as summarised in the graph below:




2.3 In total, £83.3m of risk has been identified at month 8 and this is discussed further in section 3 of the report. It is hoped that this amount can be partially mitigated by

identification of further savings, delivering financial recovery actions and working collaboratively across both the Cheshire East and the Cheshire and Merseyside systems.

2.4 There is currently a small favourable variance to plan reported against efficiency savings targets but more material risk has been noted against the delivery so this will need to be monitored closely over the next few months.

2.5 There is a more detailed breakdown of the summary financial position presented in Appendix 1 and Appendix 2 in tabular form.

## 3. Risks

3.1 Each organisation reports risks in a slightly different format but these have been grouped into categories for simplicity and to present a consistent position across the system.

3.2 The largest risk relates to costs associated care, particularly in continuing care and mental health / learning disabilities packages of care, a risk of £16.9m. This includes costs being incurred both by the ICB and also CWP for out of area placements. Demand, complexity and price growth are all factors driving those pressures.

3.3 The rising cost of staffing poses a significant risk to the system of £6.9m. This includes additional costs being incurred because of industrial action, as well as increased costs associated with the pay awards and healthcare assistants.

3.4 The risk of other inflationary pressures totals £9.0m and this covers inflation on energy prices, inflation on prescribing costs and increases in costs due to contract changes.

3.5 The NHS providers are also reporting risks relating to Elective Recovery Funding totaling £3.7m.

3.6 Finally, the other material risk is reported against delivery of efficiency targets. £2.0m of risk has been reported at month 8 and as mentioned above, as a system Cheshire East need to maximise delivery against those plans.

3.7 Risks for CEC have been categorised as Other, (£36.8m of the £42.4m); some of this value relates to health and social care services but the balance relates to other services provided by the Local Authority.

3.8 Last month, £89.5m of risk was identified, so the amount of risk reported has reduced by £6.2m.

## 4. Mitigations

4.1 Possible mitigations of £43.7m have been reported to partially offset the risks described above but the majority of these are reported quite generally in terms of finding additional savings in year, implementing financial recovery actions and working collaboratively across the system to minimise cost pressures.

4.2 Similarly to the risks, mitigations identified by CEC have been reported against the Other category because some will relate to Health and Social Care but others won't, the total £18.1m.

4.3 Further work is needed across the Cheshire East system to understand what is deliverable before year end.

## 5. Efficiency Schemes

5.1 Cheshire East Place included plans to achieve £56.8m of efficiency savings during 2023/24. A significant proportion of this target was planned for recurrently.

5.2 Currently, it is forecast that this target will be exceeded by £1.6m, with total delivery of £58.4m. However, there are variances being reported by individual scheme area. Detail by organisation and scheme is shown in Appendix 3.

5.3 Delivery of the schemes identified by CEC has been reported in full but due to slippage in some, more recently identified mitigations make up part of this value.

5.4 As mentioned in earlier sections of the report, £2.0m risk of under delivery has been reported and so this needs to be managed closely to make sure benefits are maximised where possible.

## 6. Conclusions and Next Steps

6.1 This report is produced monthly and presented within Cheshire East to ensure everyone is aware of the financial position and the challenges being faced.

6.2 Due to differences in reporting frequency and timescales, information from Cheshire East Council's second quarter review has been included. This will be updated in line with the Local Authorities reporting timetable, so won't be updated monthly.

**Appendix 1**

| Cheshire East System Financial Position - Month 8 2023/24 | | | |
|---|---|---|---|
| Narrative | Surplus / (Deficit) | | |
| | Plan (£'m) | Forecast (£'m) | Variance (£'m) |
| Planned Income / Allocation | 1,523.7 | | |
| Planned Expenditure | -1,633.8 | | |
| **2023/24 Unmitigated Surplus / (Deficit)** | **-110.1** | **-111.7** | **-1.6** |
| Efficiency Schemes | 56.8 | 58.4 | 1.6 |
| Agreed Movements from Plan | | 0.0 | 0.0 |
| **M8 Reported Forecast Surplus / (Deficit)** | **-53.4** | **-53.4** | **0.0** |
| Risks | | | |
| Staffing (incl. Industrial Action) | | -6.9 | -6.9 |
| Elective Recovery Fund | | -3.7 | -3.7 |
| Inflationary Pressure (incl. Medicines) | | -9.0 | -9.0 |
| Efficiency Savings | | -2.0 | -2.0 |
| Unplanned Care / Winter | | -1.3 | -1.3 |
| Care Costs (incl Social Care and Packages) | | -16.9 | -16.9 |
| Cash Support Costs | | -1.0 | -1.0 |
| Other | | -42.4 | -42.4 |
| Mitigations | | | |
| System Working and Further Savings | | 25.5 | 25.5 |
| Other | | 18.1 | 18.1 |
| **2023/24 Risk Adjusted Forecast Surplus / (Deficit)** | **-53.4** | **-93.0** | **-39.7** |

## Appendix 2

**Cheshire East System Financial Position - Month 8 2023/24**

| Narrative | Breakdown by Organisation (£'m) | | | | | Total (£'m) | *Total Org (£'m)* | |
|---|---|---|---|---|---|---|---|---|
| | ICB | ECT | MCHFT | CWP | CEC | | *MCHFT* | *CWP* |
| **M8 Reported Forecast Surplus / (Deficit)** | **-36.4** | **-4.4** | **-12.7** | **0.0** | **0.0** | **-53.4** | ***-18.9*** | ***0.0*** |
| Risks | | | | | | | | |
| Staffing (incl. Industrial Action) | 0.0 | -3.0 | -3.5 | -0.4 | 0.0 | -6.9 | *-5.2* | *-2.0* |
| Elective Recovery Fund | 0.0 | -3.7 | 0.0 | 0.0 | 0.0 | -3.7 | *0.0* | *0.0* |
| Inflationary Pressure (incl. Medicines) | -4.7 | -2.9 | -1.3 | -0.1 | 0.0 | -9.0 | *-2.0* | *-0.7* |
| Efficiency Savings | 0.0 | 0.0 | -2.0 | 0.0 | 0.0 | -2.0 | *-3.0* | *0.0* |
| Unplanned Care / Winter | 0.0 | 0.0 | -1.3 | 0.0 | 0.0 | -1.3 | *-2.0* | *0.0* |
| Continuing Care and Packages of Care (incl OOA) | -16.1 | 0.0 | 0.0 | -0.8 | 0.0 | -16.9 | *0.0* | *-4.3* |
| Cash Support Costs | 0.0 | 0.0 | -1.0 | 0.0 | 0.0 | -1.0 | *-1.5* | *0.0* |
| Other | -2.5 | -0.2 | -2.9 | 0.0 | -36.8 | -42.4 | *-4.3* | *0.0* |
| Mitigations | | | | | | | | |
| System Working and Further Savings | 3.3 | 8.8 | 12.1 | 1.4 | 0.0 | 25.5 | *18.0* | *7.0* |
| Other | 0.0 | 0.0 | 0.0 | 0.0 | 18.1 | 18.1 | *0.0* | *0.0* |
| **2023/24 Risk Adjusted Forecast Surplus / (Deficit)** | **-56.3** | **-5.4** | **-12.7** | **0.0** | **-18.7** | **-93.0** | ***-18.9*** | ***0.0*** |

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## Appendix 3

**Month 8 Cheshire East Summary of Delivery - Efficiency Schemes**

| Scheme Name | Recurrent / Non Recurrent | Over / (Under) Achievement | | |
|---|---|---|---|---|
| | | Plan (£'m) | Forecast (£'m) | Variance (£'m) |
| **ICB (100% Share)** | | | | |
| Continuing Care | Both | 3.264 | 3.165 | -0.099 |
| Home First | Recurrent | 3.000 | 3.000 | 0.000 |
| Medicines Management | Both | 2.186 | 2.272 | 0.086 |
| Other | Non Recurrent | 0.000 | 0.753 | 0.753 |
| Unidentified Amount | Non Recurrent | 0.487 | 1.165 | 0.678 |
| **ECT (100% Share)** | | | | |
| Pay Efficiencies | Both | 5.276 | 6.675 | 1.399 |
| Non Pay - Medicines Optimisation | Both | 1.200 | 0.197 | -1.003 |
| Non Pay - Procurement | Both | 0.650 | 2.121 | 1.471 |
| Non Pay - Estates and Premises | Both | 0.000 | 0.011 | 0.011 |
| Non Pay - Pathology and Imaging | Both | 0.294 | 0.000 | -0.294 |
| Non Pay - Service Redesign | Both | 0.180 | 0.000 | -0.180 |
| Non Pay - Other | Both | 0.291 | 0.732 | 0.441 |
| Income | Both | 0.000 | 0.758 | 0.758 |
| Unidentified | Both | 2.412 | 0.000 | -2.412 |
| **MCHFT (67% Share)** | | | | |
| Pay Efficiencies | Both | 10.240 | 8.809 | -1.430 |
| Non Pay - Procurement | Both | 0.111 | 0.438 | 0.327 |
| Non Pay - Estates and Premises | Both | 0.823 | 0.466 | -0.358 |
| Non Pay - Service Redesign | Both | 1.315 | 1.977 | 0.662 |
| Non Pay - Digital Transformation | Both | 0.000 | 0.108 | 0.108 |
| Non Pay - Other | Both | 0.000 | 0.530 | 0.530 |
| Income | Both | 0.206 | 1.877 | 1.671 |
| Unidentified | Both | 1.510 | 0.000 | -1.510 |
| **CWP (19.8% Share)** | | | | |
| Pay Efficiencies | Both | 1.466 | 1.563 | 0.097 |
| Non Pay - Procurement | Both | 0.000 | 0.006 | 0.006 |
| Non Pay - Estates and Premises | Both | 0.065 | 0.078 | 0.013 |
| Non Pay - Corporate Services Transformation | Both | 0.069 | 0.251 | 0.182 |
| Non Pay - Service Redesign | Both | 0.098 | 0.033 | -0.064 |
| Non Pay - Other | Both | 0.024 | 0.000 | -0.024 |
| Income | Both | 0.317 | 0.393 | 0.076 |
| Unidentified | Both | 0.488 | 0.202 | -0.286 |
| **CEC (100% Share)** | | | | |
| Home First | Both | 5.000 | 20.784 | 0.000 |
| Pensions | Both | 4.146 | | |
| Grants | Both | 1.829 | | |
| LD Service Review | Both | 1.750 | | |
| Other | Both | 8.059 | | |
| **Total** | | **56.754** | **58.363** | **1.609** |

# Cheshire East Health and Care Partnership Board

# Cheshire East Quality & Performance Report

# January 2024

| | |
|---|---|
| **Date of meeting:** | 10th January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Cheshire East Quality & Performance Report |
| **Report Author:** | Amanda Williams - Associate Director of Quality & Safety Improvement Cheshire East |
| **Report approved by:** | Mark Wilkinson- Place Director |

| **Purpose and any action required** | **Decision/→ Approve** | | **Discussion/→ Gain feedback** | | **Assurance→** | X | **Information/→ To Note** | X |
|---|---|---|---|---|---|---|---|---|

**Executive Summary and key points for discussion**

In this reporting period there have been two meetings of the bimonthly Quality and Performance meeting (October and December 2023). October's focus was person-centred stress testing of the Cheshire East winter plan. The December meeting was slightly shorter and started to explore the data and intelligence available to the Cheshire East system that can be used to inform quality issues.

In October the person-centred stress test of the winter plan (which has been developed by partners) was shared and scrutinised.

The December meeting had a presentation from Healthwatch around the intelligence and feedback they receive from local people using health and care services. The group received a report outlining the themes from serious incidents and patient safety incidents reported to the Integrated Care Board between October 2022 and November 2023. There was also a presentation from public health around the Joint Outcomes Framework development.

Updates were received on work since the last Quality and Performance meeting regarding the national police initiative 'Right Care Right Person' and the risks and issues around Autism and Attention Deficit Hyperactivity Disorder (ADHD).

Actions and next steps from the meetings are:

1. Care Communities to review the person-centred stress test and provide support to implementation and development of mechanisms to monitor the quality measures.
2. To agree with Healthwatch more detailed feedback to come back to a future quality and performance group.
3. To scope what data and intelligence is available from Adult and Childrens social care that would be helpful to review from a system quality perspective.
4. To have a focus on alcohol and substance misuse at a future meeting.
5. It was agreed to have a Crewe focus at the February Quality and Performance meeting, building on the focused discussions planned with the health and care partnership board.

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Board is asked to:**<br><br>a) NOTE the contents of the report.<br>b) Gain ASSURANCE that system leaders and staff across the partnership are coming together to explore system risks and issues and begin to work together to improve quality and performance and to improve the experience and outcomes for local people in Cheshire East. |

| | |
|---|---|
| **Consideration for publication** | |
| Meetings of the Health and Care Partnership Board will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate: | |
| The item involves sensitive HR issues | N |
| The item contains commercially confidential issues | N |
| Some other criteria. Please outline below: | N/A |
| **Which purpose(s) of the Cheshire East Place priorities does this report align with?** | |
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | |
| 3. Create a sustainable workforce | |
| 4. Significantly reduce health inequalities | |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e., date, method, impact e.g., feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | X | |
| | Patient / Public Engagement | | | X | |
| | Clinical Engagement | | | X | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | X | |
| | Legal Advice needed? | | | X | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | X | |

# Quality & Performance Report September 2023

## 1. Introduction

This report is an overview of the information discussed and assurance gained at the Cheshire East Quality and Performance Groups held on 25th October 2023 and 15th December 2023.

The purpose of the bimonthly Quality and Performance group is to discuss and gain assurance around system quality and performance issues and risks. Membership includes senior leaders and executive directors from partners working across Cheshire East.

Each meeting includes a focus area. October's focus was to scrutinise the person-centred stress test of the Cheshire East Winter Plan. The December meeting explored some of the data and intelligence available to the system that can be used to inform future quality concerns.

The terms of reference were agreed at the first meeting in June 2023. Care communities were represented at the October meeting. This was particularly important when looking at the winter plans. The scheduling of the meetings will be reviewed to facilitate general practice involvement in the meetings going forward.

## 2. Updates from the last Quality and Performance Group

**Right Care Right Person**
Right Care Right Person (RCRP) is a model for Police and partners to ensure that calls for service are responded to by those with the right skills, training, and expertise to provide the best possible service to the public. This is a national programme which will be implemented by Police across England and Wales.

Cheshire Constabulary is introducing RCRP in phases. It will affect how the Police respond to calls in relation to concern for welfare; patients who have walked out from healthcare facilities; Police involvement in Section 136 and 135 of the Mental Health Act and the conveyance of patients.

Phase 1 is due to go live on 8th January and relates to concern for welfare.

Under RCRP, Police will only attend a concern for welfare call if it is deemed:

- an immediate threat to life or of at least serious harm to the public or partners
- a crime is reported (may not require an immediate deployment)
- Police action is required to prevent a child from suffering significant harm.
- based on the information and intelligence, responding staff from other agencies will face a risk of violence

Unless these thresholds are reached, the Police have no duty to act.

Engagement began in June 2023 and workshops have been held since then at strategic, tactical, and practitioner levels. Representatives from all partners that are impacted by RCRP have attended.

Cheshire East Safeguarding Adults Board and Cheshire Police have both approached partners for assurance that they are preparing for the launch of phase one. This is currently being collated.

There is a memorandum of understanding between North West Ambulance Service (NWAS) and Cheshire Fire and Rescue service regarding gaining access to properties where there are welfare concerns that don't meet the threshold for police response.

Further communications are needed for primary medical services (general practice). This has been raised with Cheshire police as a gap. It is important that we, as a system, monitor the impact of the changes.

**Autism and Attention Deficit Hyperactivity Disorder (ADHD)**
The task and finish group set up following the Quality and Performance Group meeting in August 2023 has met twice. 400 children/ families on the Autism/ ADHD waiting lists in eastern Cheshire have received a letter offering support while waiting. The support offered includes: a visit, an appointment at one of the family hubs, drop in service information and self help information.

The partners in Cheshire East are piloting a single triage system to ensure that the right children are on the waiting list and that for other children appropriate advice and support is offered in a timely way. The partnership working, at speed, to make improvements has been positive and reflects the commitment to make changes for the benefit of children, young people and families in Cheshire East.

## 3. Person-centred stress testing of the Cheshire East winter plans- October 2023

On 27th September 2023 the NHS Cheshire and Merseyside System Quality Group had a focus on quality aspect of the winter plans. It was agreed that each Place would look at identifying a number of quality measures as part of their plans. Cheshire East decided to take a person-centred approach to looking at the quality of the winter plans.

Various operational scenarios had been looked at to develop the stress testing. Mitigations proposed through the winter plan were then mapped to each of the scenarios to see if there were any gaps that required further input. Colleagues from various partners worked together. In each scenario consideration was given to what support an individual would need and to consider what 'good' would look like.

The stress test was broken down into the following areas:

- Support me to stay independent.
- Support me to find out what is wrong with me.
- Support me when things go wrong.
- Support me to return to the place I call home.
- Support me at the end of my life.

It was agreed that the work was a good starting point. It was noted that the plans were proposed against a backdrop of providers struggling to recruit staff or with other workforce pressures such as sickness/ absence. The following is a summary of the discussion and suggestions to strengthen the plans:

- Consider incorporating the voluntary sector within the plans to mitigate some of this pressure.
- To do more structured communications over the winter period to help people get to the right place at the right time for support if needed. Also, to ensure the messages are consistent and reaching both local people and staff within all partner organisations.

- Need to consider how we measure some of the quality measures proposed e.g. How do we know if someone is being supported to remain as independent as possible?
- It would be beneficial, when ready to share this work, to send out to care communities to feedback how it would look for their residents. It was agreed that this would be key to developing the work and looking at how care communities can assess outcomes for people.

The care communities representatives at the meeting welcomed the person-centered stress test and agreed to take the work forward with regards to refining the quality metrics.

***Appendix 1- Person-centred stress test with quality metrics***

## 4. Cheshire East system data and intelligence- December 2023

**Healthwatch intelligence and feedback**

The group heard an overview of how Healthwatch gains feedback from local people and staff working in Cheshire East. This includes:

- Healthwatch staff engaging with local people and communities in public places e.g. markets, community centres/ groups, refugee hotels, 'Pride' and other major events.
- Attendance at each of the Care Communities meetings.
- Feedback centre, call and emails to the team.
- Citizen focus panel. Feedback also through snapshot questionnaires and surveys.
- A&E watch and enter and view to any publicly funded health and care setting. This information is shared back with the provider to check before publication.
- Carrying out focused reviews such as access to wound care clinics, dental services and reablement
- There have been over 1000 comments to the feedback centre. Every comment is read and fed back to the provider.
- Healthwatch also provide the health independent complaints advocacy service.
- CQC contact Healthwatch for any intelligence around a provider to support their inspections.

There is a challenge for Healthwatch to look at themes from the feedback due to capacity constraints, but it is possible to provide more detailed information at a future meeting. There is variability in how providers use the feedback provided through Healthwatch. The Trusts have a process for the enter and view/ A&E watch information but not necessarily for other feedback sent from the feedback centre.

**Themes from Serious Incidents (SIs) and patient safety incident reported to NHS Cheshire and Merseyside.**

Most reported incidents from providers have been around diagnostics followed by maternity.

| Categories of Serious Incidents reported by Cheshire Wirral Partnership, East Cheshire Trust & Mid Cheshire Hospitals Foundation Trust: | Total (1/11/22 to 31/10/23) |
|---|---|
| **Diagnostic Incident including delay meeting SI criteria (including failure to act on test results)** | 9 |

| | |
|---|---|
| **Maternity/Obstetric Incident meeting SI criteria: Baby Only (this includes foetus, neonate, and infant)** | 7 |
| **Slips/Trips/Falls meeting SI criteria** | 7 |
| **Apparent/Actual/ Suspected Self-inflicted Harm meeting SI criteria** | 7 |
| **Medication Incident meeting SI criteria** | 6 |
| **Treatment Delay meeting SI criteria** | 5 |
| **Surgical/invasive procedure incident meeting SI criteria** | 4 |
| **Pending Review (a category must be selected before incident is closed)** | 4 |
| **Pressure Ulcer Meeting SI Criteria** | 4 |
| **Maternity/Obstetric Incident meeting SI criteria: Mother and Baby (this includes foetus, neonate, and infant)** | 4 |
| **Major incident/emergency preparedness, resilience, and response/suspension of services** | 3 |
| **Abuse/Alleged Abuse of Adult Patient by Third Party** | <3 |
| **HCAI/Infection Control Incident meeting SI Criteria** | <3 |
| **Sub-Optimal Care of the Deteriorating Patient** | <3 |
| **Maternity/Obstetric Incident meeting SI criteria: Mother Only** | <3 |
| **VTE meeting SI criteria** | <3 |
| **Confidential information leak/information governance breach meeting SI criteria** | <3 |

Patient safety incidents are predominantly reported from general practice but also from Trusts and care homes. These are reported onto Datix by NHS Cheshire and Merseyside. Some of the incidents reported are self reflective but others are regarding partners. Most are low or no harm.

| **Top 15 categories of Datix reports:** | **Total (1/11/22 to 31/10/23)** |
|---|---|
| **NHS 111** | 108 |
| **Communication Issue** | 60 |
| **Failure in referral process** | 45 |
| **Other** | 43 |
| **Medication -Wrong drug/medicine** | 43 |
| **Referral -Delay/failure/other issue** | 42 |
| **Medication Omitted medicine/ingredient** | 38 |
| **Access / admission –delay / failure in access to hospital / care** | 36 |
| **Assessment –lack of clinical or risk assessment** | 31 |
| **Discharge correspondence -error / inaccuracy / delay** | 27 |
| **Unsafe / inappropriate clinical environment (including clinical waste)** | 27 |
| **Safeguarding** | 27 |
| **Results -Delay/missing/other issue** | 26 |
| **Communication failure –outside of immediate team** | 24 |
| **Treatment / procedure –delay / failure** | 24 |

All NHS 111 incidents are reported so this shows disproportionately high. There are also a high number of communication issues reported between partners. There is a theme around community pharmacy medication errors. These are currently going to NHS England to be investigated; however, this is being transferred to NHS Cheshire and Merseyside and processes for oversight moving forward are being agreed.

The group received an update on the national move from the serious incident framework to patient safety incident response framework (PSIRF). This shifts the focus from every incident being reported to the commissioner and being individually investigated to a more thematic approach to incidents and emphasis on learning and quality improvement. In-depth investigations will still be required for:

• Death thought more likely than not to be, due to problems in care.
• Death of a person with learning disabilities or autism
• Incidents meeting the Never Events criteria
• Child deaths
• Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria
• Mental Health related homicides
• Death of patient detained under the Mental Health (1983) or where the Mental Capacity Act (2005) applies, where there is a reason to think that the death may be linked to problems in care (incidents meeting the learning from death criteria)
• Deaths in custody (where health provision is delivered by the NHS)
• Safeguarding incidents in which:
  - Babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence.
  - Adults (over 18 years old) are in receipt of care and support needs from their local authority.
  - The incident relates to Female Genital Mutilation (FGM), Prevent (radicalisation to terrorism), modern slavery and human trafficking or domestic abuse/ violence.

Although the group received an overview of the types of incidents reported and themes it would be beneficial at a future meeting to have a report of any learning and improvements made as a result of the reporting and review of incidents.

**Joint Outcomes Framework overview**
Cheshire East Joint Outcomes Framework is being developed to inform and monitor health and care transformation towards closer integration and to summarise progress in relation to the joint health and wellbeing strategy/ Place plan and Place-level Delivery Plan.

The Cheshire East Health and wellbeing strategy 2018-2021 has recently been refreshed. This strategy will also act as the Place plan and will run from 2023-2028. A Place level delivery plan is also being developed in parallel. This will run from 2023-2028 and focus on implementation of the strategy and health and care transformation.

The joint outcomes framework is being developed alongside these two documents and through two initial phases, led by the Business Intelligence enabling workstream group.

Phase one has a small number of high level key outcome indicators that positively impact on system pressures. Phase one focuses on indicators within the office for health improvement and disparities public health fingertips tool- so utilising a single data source. The outcomes framework has been informed by the Joint Strategic Needs Assessment (JSNA), tartan rug, public health outcomes framework and multi partner conversations.

There are four outcome areas:
Healthy Places, looking at long term unemployment and modelled estimates of the proportion of households in fuel poverty.
Healthy, happy children focusing on smoking status at time of delivery (which is an issue for Cheshire East), Child development outcomes at 2-2 ½ yr, prevalence of overweight Children (age 10-11yrs).
Mental wellbeing has a focus on social isolation and hospital admissions from self-harm (Cheshire East is significantly worse than national average)
Living well for longer and dying in a place of choice has an upstream outcome around physically active adults but also admissions for alcohol specific conditions.

Healthwatch have inputted into the JSNA and outcomes framework. Care Communities dashboards to be aligned with the joint outcomes framework. Next steps include:

- Developing a power BI dashboard- it is important to have data at ward level in order to support the work to address health inequalities across Cheshire East.
- Raising awareness of phase one indicators with care communities and wider stakeholders
- Agreeing a second set of indicators (more downstream) to monitor against the Place Level Delivery Plan that will sit alongside the Joint health and wellbeing strategy/ Place Plan, aiming for more timely and regularly updated metrics than in phase one.
- Need a joint action plan to make the outcomes framework and wider JSNA relevant and real for all.

There are challenges including:
- Capacity across all partners and changes to the workforce associated with integrated care system evolution and system pressures.
- Current and anticipated financial positions of partners.
- Need to translate the indicators into plain English to enable ownership and usability across local communities. Further community engagement is important.
- The framework needs to be responsive to any new regional and national programmes and guidance and also any potential future change in political landscapes.
- Need to develop lines of responsibility for monitoring and actioning the intelligence presented.
- Need to consider information governance as the metrics become more specific in phase two.

On 19th October 2023 the Shared Outcomes toolkit for Integrated Care Systems was released and Cheshire East is progressing well against the toolkit.

The group discussed about the increase in alcohol misuse and impact this is having on emergency departments and short hospital stays. A focus on this as a system was seen as a priority area.

## 5. Actions and next steps

1. Care Communities to review the person-centred stress test and provide support to implementation and development of mechanisms to monitor the quality measures.
2. To agree with Healthwatch more detailed feedback to come back to a future quality and performance group.
3. To scope what data and intelligence is available from Adult and Childrens social care that would be helpful to review from a system quality perspective.
4. At a future meeting to review the learning and improvements made across the system as a result of serious incident and patient safety incident reporting.
5. To have a focus on alcohol and substance misuse at a future meeting.
6. It was agreed to have a Crewe focus at the February Quality and Performance meeting, building on the focused discussions planned with the health and care partnership board.

## 6. Recommendations

c) NOTE the contents of the report.
d) Gain ASSURANCE that system leaders and staff across the partnership are coming together to explore system risks and issues and begin to work together to improve quality and performance and to improve the experience and outcomes for local people in Cheshire East.

ITEM 13

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# Cheshire East Strategic Planning and Transformation (SPT) Group

# Chairs Report January 2024


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| | |
|---|---|
| **Date of meeting:** | Cheshire East Partnership Board - 10.1.2024 |
| **Agenda Item No:** | |
| **Report title:** | Strategic Planning and Transformation Group Chairs Report Jan 2024 |
| **Report Author & Contact Details:** | Dr David Holden |
| **Report approved by:** | Dr David Holden |

| **Purpose and any action required** | **Decision/ Approve** → | | **Discussion/ Gain feedback** → | X | **Assurance** → | X | **Information/ To Note** → | X |
|---|---|---|---|---|---|---|---|---|

| **Committee/Advisory Group previously presented** |
|---|
| N/A |

| **Executive Summary and key points for discussion** |
|---|
| This report details the activities and highlights of the Cheshire East Strategic Planning and Transformation Group (SPT) Group to January 2024. The SPT group aims to support the achievement of the Cheshire East Integrated Transformation Programme Plan, including reporting and tracking progress, identifying, and mitigating risk and developing solutions to system/Place based challenges, across the current priority areas and enabler workstreams. |

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Health and Care Partnership Board is asked to:**<br>**1) Note the report**<br>**2) Note the risks and escalations** |

| **Which purpose(s) of an Cheshire East priorities does this report align with?** | |
|---|---|
| Please insert **'x'** as appropriate: | |
| 1. Deliver a sustainable, integrated health and care system | x |
| 2. Create financially balanced system | x |
| 3. Create a sustainable workforce | x |
| 4. Significantly reduce health inequalities | x |

| **Document Development** | **Process Undertaken** | **Yes** | **No** | **N/A** | **Comments (i.e. date, method, impact e.g. feedback used)** |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | x | |
| | Patient / Public Engagement | | | x | |
| | Clinical Engagement | | | x | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | x | |
| | Legal Advice needed? | | | x | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | x | |

| | |
|---|---|
| **Next Steps:** | None |


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| | |
|---|---|
| **Responsible Officer to take forward actions:** | Dr David Holden - Chair of Cheshire East Strategic Planning and Transformation Group |

| | |
|---|---|
| **Appendices:** | None |

# Cheshire East Strategic Planning and Transformation Group Chair's Report – January 24

## 1. Introduction

This report details the activities and highlights of the Cheshire East Strategic Planning and Transformation Group (SPT). The SPT group aims to support the achievement of the Cheshire East Integrated Transformation Programme Plan, including reporting and tracking progress, identifying, and mitigating risk and developing solutions to system/Place based challenges, across the current priority areas and enabler workstreams.

The planning for this period has been challenging due to industrial action and significant workforce and system operational challenges.

## 2. Key Highlights

### 2.1 Completion of 4th System Blueprint Workshop

Series of four workshops completed to refresh and design the 'System Blueprint'. Four sessions held over several months, led by a design group, with representation from all major stakeholder groups. We looked at previous strategies (Caring Together, Connecting Care, 4 Care Themes), the System through the voice/needs of the people we serve, where services should/could be placed and finally the agreement of the design principles and 'postcards from the future'. The final output is heavily influenced by the Place Delivery Plan and Health and Wellbeing Strategy.

Next steps:

1.) *The working group completing the output in the form of design principles for the system and a workplan*
2.) *Communications team to prepare material for integrated workforce, boards and public*
3.) *Final Blueprint output to be shared with Partnership Board for endorsement*

### 2.2 Development of Primary Care Confederation

Development of the Primary Care Confederation continues – focused on General Practice at present. Standardised data is being produced utilising the 'APEX' platform. Data is being fed through to both ICB Place teams and the Place Operational Group regularly now to improve the Capacity and Demand picture for Place. MOU developed and agreed. Work underway to improve General Practice Capacity and Access. Gives Place partners a forum to engage with General Practice. Large programme of development and workforce support

and planning underway with the Training Hub including support and integration of ARRS staff.
Key Challenges:
*1.) Estates pressures arising from increase in ARRS staff*
*2.) Limited resource available*
*3.) Low morale and from workforce surveys and planning there is pressure on GP workforce including reduction in GP Partners and retention challenges including those in mid-career*

### 2.3 Primary/Secondary Care Interface Work Programme Initiated

As one part of the measures to mitigate the issues above, work has commenced on Primary/Secondary Care interface. This is in line with the C&M interface programmes occurring (or due to) in all Places and also nationally. Initial meetings led by Dr Paul Bishop held between the Medical Directors across large acute trusts and Primary Care.

Next Steps:
*A programme of work is being developed focussed around improving flow, reducing bureaucracy and relationship building which was felt to be of critical importance to how we work in an integrated setting.*

### 2.4 Workforce (People) Plan

The Care Community People plan needs a sponsor and a workforce lead. It was developed following engagement with all stakeholders in our Care Communities. The plan needs the support of partners and system to implement in a meaningful way. The lack of a workforce lead is indicative of the system pressures and workforce pressures that are currently being faced.
*This item is here for escalation of risk in delivery*

### 2.5 Care Communities

Steady progress is being made with the development of our Care Communities. The Care Community Operational Framework is being finalised. Work is also underway regarding risk/gain share arrangements, finance and refreshment of their core strategies. Regular development meetings are taking place, with the Care Community managers and the “8 Care Communities Together” steering group coordinating overall.

Dashboards and maturity matrices are in Place for all Care Communities and the core leadership teams are established. Work is underway to support the VCFSE sector also in terms of engagement and co-ordination following the cessation of the Social Action Partnership contract.

Key risks include resourcing and limitation of aspiration as a result. However, much has been achieved through relationship building, pooling resource and working in an integrated fashion in tandem with local people and groups (evidenced via the Care Community presentations at the board meetings).

Key Issues:
1.) *Formalising the operational arrangements*
2.) *Maintaining progress and supporting development*
3.) *Moving from pilot to BAU and spreading across given limited resource*

*Note: Professor Clare Fuller, National Medical Director for Primary Care will be attending Cheshire East Place on 7th March 2024 to discuss development of 'Integrated NeighbourhoodTeams' (our Care Communities) and progress towards the intended aims in the "Fuller Stocktake".*

## 2.6 Estates Planning and Major Infrastructure Developments

The workplans for all the enablers including the Digital, Workforce, BI and Communications programmes are all being refreshed but estates has risen to the top of the agenda due to the major infrastructure developments (New Hospital Programme and Sustainable Hospital Services programme) and also the pressure being put on Community estate with more people cared for at home alongside rapid discharge, virtual wards and the increased workforce in General Practice via the PCN ARRS scheme. This has been evidenced by the displacement of Community Services staff in a number of settings.

An ICB wide clinical and estates strategy piece supported by an external consultancy has been undertaken with all PCNs but unfortunately has struggled with accuracy and the output is therefore delayed. A Place estates overview was prepared by the estates workstream but is waiting on the output from the Primary Care element to complete.

*Enablers are a major risk to our overarching strategy as they will determine the ability for Place to achieve its ambitions of integrated working*

*Next Steps:*
1.) *Refresh Enabler Workplans*
2.) *Review currently available estates data and identify risks/opportunities*
3.) *NHP and SHS programmes to provide monthly report to SPT board*
4.) *Provide an updated risk register to Partnership Board*

## 2.7 Dermatology Integrated Service/Pathway Development

An opportunity has arisen to develop an integrated Dermatology pathway. It is an area of significant pressure for our Place also. This work is being led by ICB clinical leads overseen by Dr Paul Bishop. The work developing this pathway including the financial, risk/gain share and whole pathway development will form the foundation for other areas and therefore is a test case for our integrated system and achieving the 'Triple Aim'.

*A monthly report will be supplied to SPT board for this with progress and timelines.*

## 2.8 C&M Transformation and Provider Collaboratives

As the maturity of our System develops there is increasing interdependency between Place and System programmes. These relationships will be critical to delivering our Place ambitions. For Cheshire East this also means working closely with colleagues in Cheshire

West and Greater Manchester to ensure that the population and work flows seamlessly across borders and organisations where this is relevant.

*Next Steps:*

*1.) Regular update on provider collaborative workstreams provided to Place leadership and Operational Group*

*2.) C&M Transformation Programmes and Priorities mapped*

*3.) Place representation to be identified at appropriate fora*

## 3. Activity

### 3.1 Planning

The SPT Group forward plan is focused on:

- Designing the future operating model of Cheshire East Place
- Setting the agenda for transformation priorities
- Receiving proposals for innovative change programmes across Cheshire East Place
- Receiving updates on work that is progressing within Place that will have a transformative effect on multiple partners across the Place system
- And understanding the initial impact of this programme of transformation to enable the transition to implementation, and final hand-over to the Strategic Operational Group

In order to fulfil these aims, the SPT have agreed to develop the following:

- High level Strategic Planning
- Population outcomes priorities
- Current system level finance

### 3.2 Papers Endorsed

Since being established the SPT group have endorsed the following:

- Place Development Framework update and reporting mechanism
- Health and Wellbeing Strategy and Place Plan
- Cheshire East Outcomes Framework – Phase 1
- Care Communities Priorities (inc winter proposal)
- Care Communities People Plan
- Live Well for Longer Plan (a Place based Framework for coproduction)
- Helpforce – Volunteer project
- Place based VCFSE Model proposal inc the Social Action Charter and the CE Place based VCFSE Grants, which has been included within the S75.
- Care Communities Operating Model
- Cheshire East Estate Programme
- Health and Wellbeing Strategy (and Place Plan)
- The Cheshire East Blueprint developments x 4 workshops concluded Dec 23
- The development of the Cheshire East Place Delivery Plan which includes the 8 Ps as the golden thread principles, with the Care Models embedded
- A revised VCFSE model for 2024 onwards.
- Care Communities Chairs reports

### 3.3 Risks/Escalations

Risks / Issues:

- System wide and organisational financial pressures
- Capacity to deliver transformation while managing business as usual and system pressures
- Limited project management capacity
- Interdependencies with cross C&M ICB plans and cross border planning with VR footprint for MCHT and GM footprint for ECT
- Significant Estates pressures in the Community created by various factors but not least by increase in ARRS staff available to PCNs creating a pressure on General Practice estate.
- No current workforce lead identified

### 3.4 Future Plans

Forward Plan for SPT includes:

- Finalising the Cheshire East Place Blueprint
- Outcomes Framework – Phase 2
- Cheshire East Place Delivery Plan
- Dementia Developments and progress against the delivery plan
- Acute Sustainability and New Hospital developments
- Primary Care Development
- Dermatology Services
- Cheshire & Merseyside Transformation
- Joint Market Position Statement (MPS) and Commissioning Intentions

## 4. Recommendation

Cheshire East Place Partnership Board are asked to note the report and continue to support the development of the SPT group and delivery of its aims.



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**ITEM 14**

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# Cheshire East Health and Care Partnership Board

# Cheshire East Operational Delivery Group - update

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Cheshire East Partnership

| | |
|---|---|
| **Date of meeting:** | 10th January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Cheshire East Operational Delivery Group - update |
| **Report Author:** | Simon Goff – East Cheshire Trust Chief Operating Officer |
| **Report approved by:** | |

| **Purpose and any action required** | **Decision/→ Approve** | | **Discussion/→ Gain feedback** | | **Assurance→** | | **Information/→ To Note** | X |
|---|---|---|---|---|---|---|---|---|

**Executive Summary and key points for discussion**

The Operational Delivery Group meets on a monthly basis with representation from the key partners and stakeholder organisations in Cheshire East Place. The group has dealt with the following issues:

- Coordinating the Cheshire East Place Winter Plan including stress and scenario testing.
- Oversight of Urgent and Emergency Care Performance
- Oversight of the implementation of Urgent Mental Health services and the development of a strategic outline case for a Response Centre.
- Oversight of the Winter phase Vaccination programme for Covid and Flu.
- Oversight of the GP Access recovery plan.

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Board is asked to:**<br>a) Note the contents of this report for information. |

**Consideration for publication**

Meetings of the Health and Care Partnership Board will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:

| | |
|---|---|
| The item involves sensitive HR issues | |
| The item contains commercially confidential issues | |
| Some other criteria. Please outline below: | |

**Which purpose(s) of the Cheshire East Place priorities does this report align with?**

Please insert **'x'** as appropriate:

| | |
|---|---|
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | X |
| 3. Create a sustainable workforce | X |
| 4. Significantly reduce health inequalities | X |

| Document | Process Undertaken | Yes | No | N/A | Comments (i.e., date, method, impact e.g., feedback used) |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | X | |

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| | | | | | |
|---|---|---|---|---|---|
| | Patient / Public Engagement | | | X | |
| | Clinical Engagement | | | X | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | X | |
| | Legal Advice needed? | | | X | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | X | |

## Cheshire East Place Operational Delivery Group - Update

### 1. Introduction

The purpose of this report is to provide a brief update on the workplan of the Cheshire East Operational Delivery Group. The Operations Group seeks to maximise the effectiveness of 'business as usual' place resources and is the integrated Place forum responsible for operational planning, performance, and delivery.

### 2. Key Issues

The following key issues have been led on the Operational Delivery Group in the past 3 months:

#### Coordinating the Cheshire East Place Winter Plan including stress and scenario testing.

Winter planning is a statutory annual requirement to ensure that the local system has sufficient plans in place to manage the increased activity during the Winter period and plans have been developed in partnership with Cheshire East system partners across the place. The overall purpose of the Winter plan is to ensure that the system can effectively manage the capacity and demand pressures anticipated during the Winter period October 2023 to 31 March 2024. Our system plans ensure that local systems can manage demand surge effectively and ensure people remain safe and well during the Winter months. The planning process considers the impact and learning from last Winter, as well as learning from the system response to Flu and Covid 19 to date. Plans have been developed based on robust demand and capacity modelling and system mitigations to address system risk.

#### Oversight of Urgent and Emergency Care Performance

To ensure the Group maintains oversight of developments, risks and issues in Urgent and Emergency Care, a dashboard plots the impact of planned interventions and improvement activities on the following key performance indicators on both Acute hospital providers in Cheshire East:

- Average Daily Type 1 ED Attendances
- Average Daily non-elective admissions
- Average Daily Discharges
- Average daily number of patients not meeting the Criteria To Reside (excluding discharges)
- Average daily number of patients with 21+ day LoS

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In addition, the following Mental Health-specific metrics are tracked:

- Average daily number of Cheshire East mental health patients placed out-of-area
- Average daily number of Cheshire East mental health delayed transfers of care

**Oversight of the implementation of Urgent Mental Health services and the development of a strategic outline case for a Response Centre.**

To ensure there is a robust approach to the provision of Urgent Mental Health services, a Rapid Response Service has been commissioned to support the transport, support, and observation to patients across the Cheshire and Wirral NHS Foundation Trust footprint. The service sits within the Urgent Care First Response portfolio and is delivered in collaboration with ISL.

The service undertakes the following functions:

1. Section 135/ Section 136 observation in acute hospital place of safety (POS)
2. Patient conveyance
3. Supporting Patients in A and E departments who have been assessed as requiring a mental health inpatient bed.
4. Support to inpatient mental health wards
5. Support to Home Treatment Teams
6. Support to the Crisis Line

**Oversight of the Winter phase Vaccination programme for Covid and Flu.**

The Winter Vaccination campaign is one of the key elements of the preparedness programme as set out by NHS England. Progress with the roll out and uptake of the programme has been reported through the Operational Delivery Group with any issues or delays highlighted to partner members of the group for resolution.

## 3. Recommendations

The Board is asked to note the contents of this report for information and work undertaken and led on by the Cheshire East Place Operational Delivery Group in the past 3 months.

**ITEM 15**

#BecauseWeCare
Cheshire East Partnership

# Cheshire East Health and Care Partnership Board

# Primary Care Advisory Forum Report – December 2023

#BecauseWeCare
Cheshire East Partnership

| | |
|---|---|
| **Date of meeting:** | 10th January 2024 |
| **Agenda Item No:** | |
| **Report title:** | Primary Care Advisory Forum Report – December 2023 |
| **Report Author:** | Amanda Best |
| **Report approved by:** | Mark Wilkinson |

| **Purpose and any action required** | **Decision/→ Approve** | | **Discussion/→ Gain feedback** | | **Assurance→** | | **Information/→ To Note** | **X** |
|---|---|---|---|---|---|---|---|---|

**Executive Summary and key points for discussion**

This report details the activities and highlights of the Cheshire East Primary Care Advisory Forum since the last reporting period.

The Primary Care Advisory Forum is established to support the Cheshire and Merseyside Integrated Care Board (ICB) Primary care Committee in the management of Place-based Primary Care policy and decisions and to discharge functions in line with the Policy & Guidance Manual and Decision making matrix, as agreed by the ICB.

Key Points to note:

- PCAF meet bi-monthly.
- The forum is held Jointly with Cheshire West with separate sections to debate and inform local Transformation, Development ad contractual aspects of the Primary Care Programme. However, from 2024 Cheshire East Place will be moving to a purely place based forum.
- Key points of focus have been centred on the Primary Care Access Recovery Programme. Please note the separate paper contained within the agenda pack.

| | |
|---|---|
| **Recommendation/ Action needed:** | **The Board is asked to:**<br>a) Note the content of the Report. |

**Consideration for publication**

Meetings of the Health and Care Partnership Board will be held in public, and the associated papers will be published unless there are specific reasons as to why that should not be the case. This paper will therefore be deemed public unless any of the following criteria apply (please insert **'x'** as appropriate:

| | |
|---|---|
| The item involves sensitive HR issues | |
| The item contains commercially confidential issues | |
| Some other criteria. Please outline below: | |

**Which purpose(s) of the Cheshire East Place priorities does this report align with?**

Please insert **'x'** as appropriate:

| | |
|---|---|
| 1. Deliver a sustainable, integrated health and care system | X |
| 2. Create a financially balanced system | |
| 3. Create a sustainable workforce | |
| 4. Significantly reduce health inequalities | |

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| Document Development | Process Undertaken | Yes | No | N/A | Comments (i.e., date, method, impact e.g., feedback used) |
|---|---|---|---|---|---|
| | Financial Assessment/ Evaluation | | | X | |
| | Patient / Public Engagement | | | X | |
| | Clinical Engagement | | | X | |
| | Equality Analysis (EA) - any adverse impacts identified? | | | X | |
| | Legal Advice needed? | | | X | |
| | Report History – has it been to 0ther groups/ committee input/ oversight (Internal/External) | | | X | |

## Cheshire East Primary Care Advisory Forum Report – December 2023

### 1. Introduction

1.1 The purpose of this report is to provide the Cheshire East Health and Care Partnership Board with an overview of the Primary Care Development Programme and to appraise the Board of key items discussed and agreed via the Primary Care Advisory Forum (PCAF).

1.2 Supplementary information relating to Primary Care is included which may not be reflected in the PCAF minutes.

1.3 The purpose of PCAF is to to manage Place-level decisions relating to Primary Care within Cheshire East Place, as agreed with the Cheshire and Merseyside ICB (CMICB) Primary Care Committee and documented in the CMICB Primary Care Decision Making Matrix' (Decision Making Matrix).

1.4 PCAF is established within the Governance structures of Cheshire East Place and reports into the Cheshire East Leadership Team (CELT) and Operational Board.

### 2. Key Business

2.1 **Establishment.**

2.2 **Primary Care Access Recovery Programme (PCARP)**

2.2.1 A Key National and local priority for Primary Care is delivering the Primary Care Access Programme. A separate report is contained within the agenda pack, but key points are summarised herein.

- PCARP is aimed at General Practice, with elements that are aligned to Community Pharmacy and System actions. The National aims and ambitions are summarised below.
    - Aim to tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice.

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- Enabling patients to know how their needs will be met when they contact their practice.

- A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022.*

- Integrated Care Boards (ICBs) have to ensure their plans are submitted to Boards in October/November using the following document as guidancehttps://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/

- The plan focuses on four areas to alleviate pressure and support general practice further.

**Empowering Patients**
*Improving Information and NHS App Functionality*
*Increasing self-directed care*
*Expanding Community Pharmacy*

**Implementing Modern General Practice Access**
*Better digital telephony*
*Simpler online requests*
*Faster navigation, assessment and response*

**Building Capacity**
*Larger multidisciplinary teams*
*Increase in new doctors*
*Retention and return of experienced GPs*
*Primary Care estates.*

**Cutting bureaucracy**
*Improving the primary/secondary care interface*
*Building on the bureaucracy busting concordat*

2.2.2 Much progress has been made so far in achieving the key objectives of the programme. Cheshire East has provided a high level of assurance to the Central ICB team meeting key deadlines and is on track to achieve milestones and deliverables this year.

2.2.3 All practices are meeting their contractual requirements in respect of Core and Extended opening Hours.

2.2.4 33/34 Practices are now reporting Access, Capacity and Demand activity through the APEX reports. One practice is currently unable to report via APEX due to the configuration of their appointment system.

2.2.5 This is in additional to the project work to link up Primary and Secondary Care Access, Capacity and Demand data sets, to better inform and appraise System Partners on seasonal pressures and to inform decision making when capacity exceeds demand. A working group has been established to look to link UEC Metrics with the APEX reports and the OPEL System GP Practice reports.

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2.2.6 Key risk remain, if Practices are unable to migrate off their current telephony systems, however, mitigations are in place through Cheshire East Place and the Central Digital Transformation Teams. Confidence intervals remain high.

2.2.7 Given the work to migrate Practices to a new telephone system with enhanced functionality, it is difficult to predict the initial response. However, early indications for those practices that have migrated is promising.

2.3.1 There are no Quality or Contractual concerns to note for this reporting period. Cheshire East Place is developing a Quality Dashboard to look at key performance metrics for General Practice. We hope to conclude this before the new financial year and have in place a systematic tool to report the quality of Primary Care and will supplement the ICB Access Dashboard.

2.3.2 We are also pleased to advise that effective of November 2023 Hungerford Road Surgery received a CQC rating of good bring all Practices in Cheshire East to a minimum rating status of good.

### 2.4 Primary Care Estates

2.4.1 Primary Care Estates remain one of the biggest risks to Cheshire East Place. With the push to increase out of hospital provision and enhanced Community Led Care and the expansion of the Additional Roles, there are risks associated with the capacity to house services and people. These risks have been highlighted to both Strategy, Transformation and Partnership Board, Operational Board and OSC.

2.4.2 Cheshire and Merseyside ICB has commissioned GB Partnerships, an external consultancy to conduct a PCN level Primary Care Estates review and subsequent PCN / Place plan. Work to finalise the plans is in its latter stages and will be shared with Place Partners once agreed. This will identify Place priorities for Estates investment needs.

### 2.5 Development of the General Practice Provider Collaborative

2.5.1 Cheshire East Place has a long-standing ambition to strengthen the voice and role of General Practice as an effective and resilient Place Partner.

2.5.2 The “Confederation” has been operation in some form since April 2022 with a remit from local General Practice to represent them at Place and system level.

2.5.3 The confederation is a membership organisation, facilitated by a Memorandum of Understand and a leadership team comprising both the GP federations – South Cheshire GP Alliance, Vernova Healthcare CIC) and the Cheshire Local Medical committee.

2.5.4 The confederation has an outline work plan that is in the process of being refreshed to reflect Place Priorities. Amongst which is implementing community-based Dermatology hubs to support elective recovery.

**End Report.**

ITEM FOR INFO ONLY

# Crewe JSNA

Executive Summary

August 2023

Please see the full report for more details and references:

https://www.cheshireeast.gov.uk/pdf/jsna/healthier-places/crewe-jsna-full-report-.pdf

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Whilst this report focuses in on some of the challenges in Crewe, we want our readers to read this with the understanding that Crewe also has lots of strengths such as[1]:

- Residents with great pride in their town
- A place that is a hub for social interaction and activity
- Attractive spaces like Queen's Park
- Unique heritage and some beautiful buildings
- Skilled workers and important businesses
- Dedicated frontline services

Crewe's values reflect its strengths and its potential[2]:

- We are people powered
- We get things done together
- We build connections

Source:
(1) Towns Fund Consultation Report, Crewe Town Board, January 2021
(2) A Place Brand for Crewe, Crewe Town Board, April 2021







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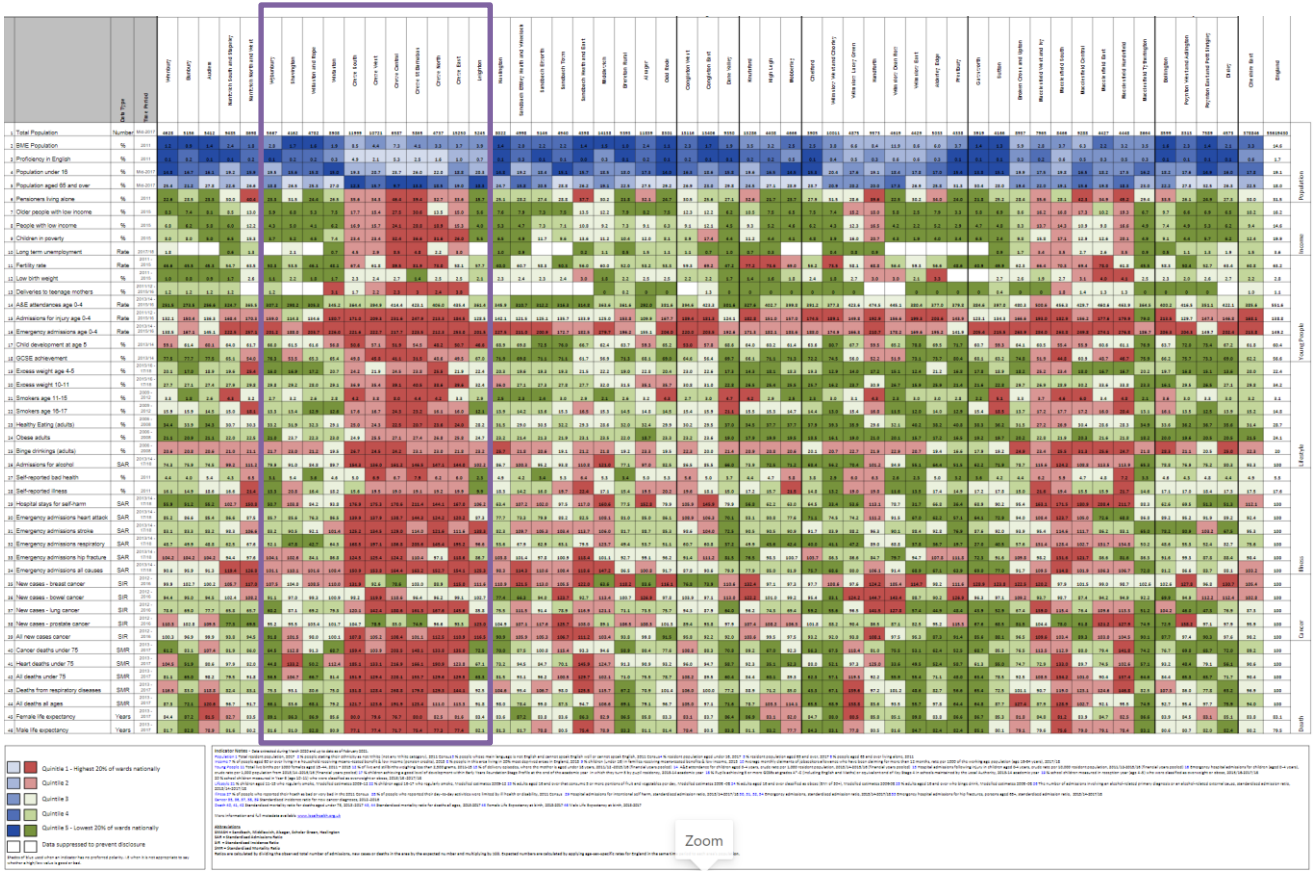
# Crewe

- When people think of Crewe, they might think of different areas. For the purpose of this JSNA we are considering the Crewe Care Community.

- The town sits within the larger Crewe Care Community. In this report we frequently separate out the ‘Crewe 6’ electoral wards – those in central Crewe which experience higher levels of deprivation and poorer health outcomes than the rest of the Crewe Care Community.

- The town and civil parish of Crewe is best known for its large railway junction and history of rail and locomotive manufacturing. It continues to be important for rail and for manufacturing, including through the Bentley car factory.

Image taken from: Summer Events Queens Park - Crewe (cheshireeast.gov.uk) (accessed 05/04/23)



- Crewe is different to the rest of Cheshire East
- The ‘Crewe 6’ wards also contrast with the other Crewe wards, such as Leighton and Shavington, many of which are green and better than average
- We need to be aware, therefore, that there are inequalities within the Crewe Care Community as well as between Crewe and other areas in Cheshire East.

[Tartan Rug (cheshireeast.gov.uk)]

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# WHAT WERE THE RECOMMENDATIONS FOLLOWING THIS REVIEW?





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# Summary of gaps in support

When considering the need seen across Crewe in relation to the support that is available the following gaps have been identified:

1. There needs to be more joined up green corridors, play spaces for children and sporting facilities.
2. More support is needed to link up people of different ages and ethnic backgrounds.
3. More activities are needed for young people or those with disabilities to do in the evenings.
4. We need a joined up local and national strategy to tackle childhood obesity.
5. We need excellent education for all Crewe pupils with necessary support for those in the most deprived groups.
6. More support is needed for those in the most disadvantaged groups to access good quality jobs.
7. There is a need for more sufficient primary care provision to meet the increased needs in Crewe and facilitate proactive and preventative care.







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# Local Authority, NHS and Voluntary, Community, Faith and Social Enterprise organisations, need to:

1. Follow the plans set out within the **Live Well in Crewe** document, which can be found here: Living Well in Crewe AHC 1.0.pdf (cheshireeast.gov.uk)
2. Continue with the development of green spaces to ensure they are attractive and accessible to those in our most deprived areas.
3. Review health, care and other local services to ensure they meet the changing needs of Crewe's residents and that our offers reflect the increasing ethnic diversity of Crewe.
4. Continue to support first time young mums in Crewe.
5. Target engagement activities and use Family Hubs to improve uptake of 2 year old free childcare places, especially in and around Crewe East.
6. Continue to work with schools, parents and Family Hubs to improve diet and increase exercise to reduce childhood overweight and obesity in central Crewe.
7. Examine childhood development data at small area level to understand inequalities in early years provision and outcomes and continue coordinated efforts to improve educational attainment for those educated in Crewe secondary schools, especially in Maths and English.
8. Understand uptake in adult learning across Cheshire East and ensure that it is targeted towards the most deprived groups.
9. Examine causes of avoidable mortality and address biggest contributors and continue work to reduce smoking rates and alcohol-related harm in central Crewe and explore inequalities in screening uptake to develop targeted action plans for Crewe.
10. Ensure GP practices in our most deprived areas are appropriately resourced to meet the needs of local people. Facilitate networking with GPs in other deprived areas to share best practice.
11. Link the findings of this JSNA to other current and future JSNAs, the Tartan Rug and the Joint Outcomes Framework.

# It is important to note

- At time of writing this JSNA, in most cases where we were able to look at national and Cheshire East data for Crewe and its wards, it was not then possible to further compare it by protected characteristics such as gender reassignment, sexual orientation, ethnicity or religion.
- Further work is therefore needed to understand how these groups are differentially affected by issues in Crewe.
- Many of the issues faced by people of Crewe are related to poverty and require national and local approaches to address them. Please see the Poverty JSNA for further information Poverty (cheshireeast.gov.uk).





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# WHAT WERE THE FINDINGS THAT LED TO THESE RECOMMENDATIONS?



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# Overarching key messages

- When examining the Tartan Rug, **overall health and wellbeing in the Crewe locality has declined** compared to other areas between 2017 and 2021[1].
- **13 of our 18 most deprived small areas (LSOAs) in Cheshire East are within the Crewe Care Community[2].**
- For both males and females, **life expectancy in the 'Crewe 6' wards is lower than England[3].**
- **Crewe has a younger population** compared to Cheshire East, with fewer people in older age groups than Cheshire East overall[4].

Source:
(1) Tartan Rug (cheshireeast.gov.uk)
(2) Data Source: Ministry of Housing and Local Government, 2019 Index of Multiple Deprivation. Produced by Cheshire East Business Intelligence. Crewe Deprivation 2019 to 2010 Swipe Map (arcgis.com)
(3) 2016-2020 Male Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright 2023 & 2016-2020 Female Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright 2023
(4) Office for National Statistics, Mid-2020 Ward based Population Estimates. To be updated with census 2021 data following release





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# Crewe engagement findings

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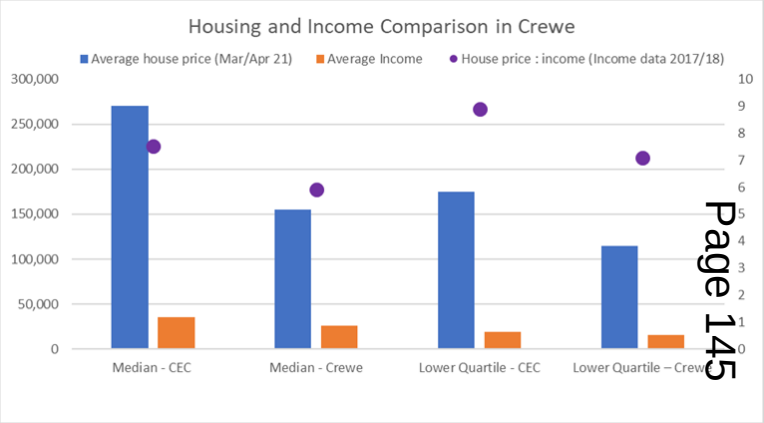
# What is Crewe like to live in as a place?

- The highest levels of **low-income households in Cheshire East are in Crewe Central, Crewe St. Barnabas and Crewe North,** although there are also other areas across Cheshire East with high levels of low-income households[1].
- Crewe has some of the **highest rates of private rented housing stock** in Cheshire East – in Crewe Central and Crewe South[1].
- **Crewe is one of the more affordable areas to buy housing** but still presents a challenge, particularly for households on the lowest incomes[2].
- Based on modelled estimates, there is a **higher proportion of households in the 'Crewe 6' wards that are in fuel poverty** compared to the England and Cheshire East averages[3].
- The Cheshire East wards with the highest levels of **fall hazards** and general **housing disrepair** are in the more urban locations of Crewe South and Crewe Central (as well as Macclesfield Central)[1].






(1) Email correspondence- (Housing Standards & Adaptations Manager, 20.10.22 – BRE Client Report, 2019)
(2) Email Correspondence (Research Support Officer, 14.10.22)
(3) *Source: Department for Business, Energy and Industrial strategy*
'Office for Health Improvement & Disparities. Public Health Profiles. [10/11/22] https://fingertips.phe.org.uk © Crown copyright [2022]'



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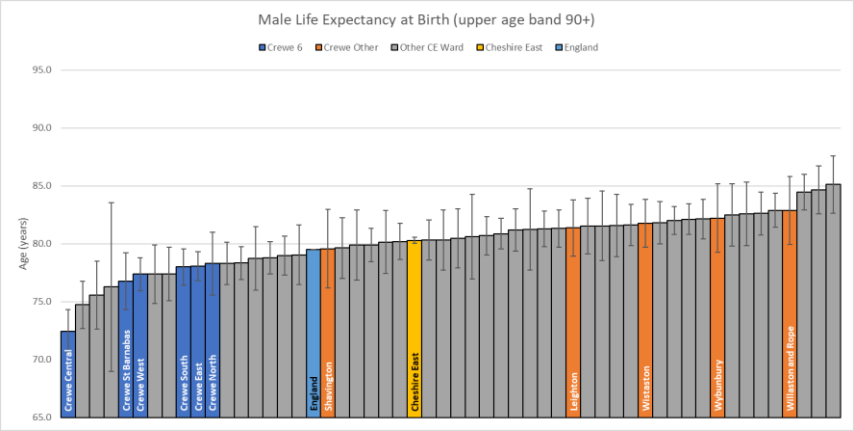
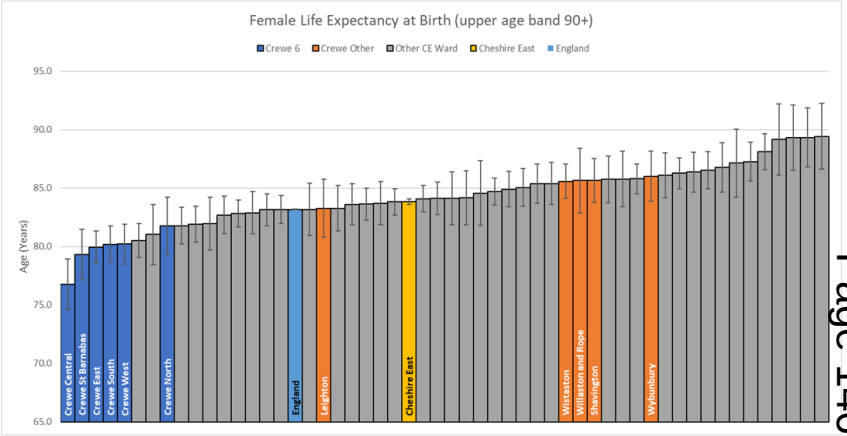
# Life expectancy




4 of the 11 Crewe wards have significantly worse life expectancy for males compared to England[1].

For females, the five lowest wards in Cheshire East are all in the 'Crewe 6' area[2].

Data Source:
(1) 2016-2020 Male Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright 2023
(2) Data Source: 2016-2020 Female Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles. Available from: https://fingertips.phe.org.uk © Crown copyright 2023



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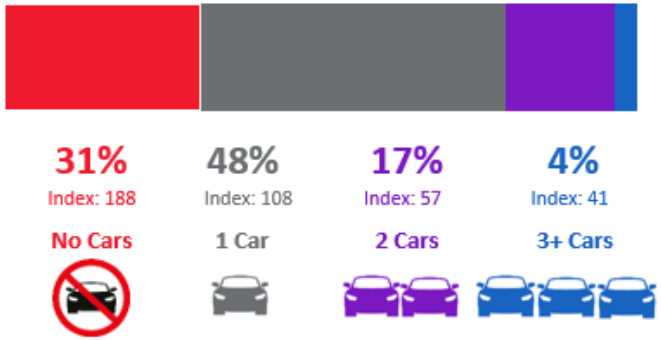
# How easy is it to cycle, walk and eat healthily in Crewe?

- **More people in Crewe cycle to work** than other parts of Cheshire East and England (2011 Census)[1].
- The Cheshire East Excess Weight JSNA (2019) noted a **higher concentration of fast-food outlets in our most deprived wards, especially in Crewe[2].**
- According to the 2012 Open Spaces Assessment, Crewe has green corridors, allotments, adult sport provision and children's play areas but there are **shortages of children's play spaces and adult sport facilities** in some areas[3].

- Households in the 'Crewe 6' wards are 88% more likely not to have a car than those households in the rest of Cheshire East[4].




(1) cheshire-east-council-cycling-strategy-march-2017.pdf (cheshireeast.gov.uk) (accessed 14.04.23)
(2) PowerPoint Presentation (cheshireeast.gov.uk) (accessed 14.04.23)
(3) Open spaces assessment (cheshireeast.gov.uk) [accessed 27 February 2023]
(4) Acorn Data analysed for Cheshire East Council (Email from CEC BI manager September 2021)



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# What is Crewe like as a community?

- The 2021 Census shows **Crewe as the most ethnically diverse area in Cheshire East** with 18.4% of residents with ethnicities other than white British[1].
- The proportion identifying as ‘Other white’ (white ethnicities outside of white British, white Irish, Gypsy or Irish Traveller or Roma) almost doubled from 2011 to 2021 to over 9% of Crewe’s residents[1].
- Indian and Other Asian groups also significantly increased as a proportion of residents[1].
- One Crewe resident expressed that Crewe would benefit from support in integration of nationalities.

- Other residents commented that
  - **Poverty had got worse**
  - There **wasn't enough on offer for children and young people or people with learning disabilities** in the evenings.



Data Source:
(1) Office for National Statistics [ONS], Census 2011 (KS201EW) ward-based data, and 2021 (TS021) ward-based data.





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# Starting well in Crewe: what is it like growing up in Crewe?

- In terms of child poverty (based on IDACI*), the **'Crewe 6' LSOAs** are consistently the most deprived areas in Cheshire East[1].** accounting for all in the most deprived decile and around half in the second most.
- **Referrals to our Family Nurse Partnership to support young first time mothers (under the age of 18 years) are increasing**, especially in the south of the Borough (including Crewe)[2].

*IDACI-Incomed Deprivation Affecting Children Index
**LSOA- Lower Super Output Area

- During spring 2022 across Cheshire East, the average uptake of the early education entitlement for 2-year-olds was 84% which was higher than the national average of 71.9%. Uptake across the borough varies with Monks Coppenhall Children's Centre footprint (Crewe East) being the lowest at 72%[3].
- Crewe has some of the **highest demand for the Holiday Activities and Food programmes[4].**
- **Around 27% of reception children living in a 'Crewe 6' ward have excess weight**. This gap widens further by year 6 and 42% of children living in 'Crewe 6' have excess weight compared to less than one-third in Cheshire East overall[5].

Data Source:
(1) Ministry of Housing, Communities & Local Government, 2019 Index of Multiple Deprivation. Produced by Research and Consultation
(2) Email correspondence from CEC Integrated Commissioning Manager October 2022
(3) Email correspondence from CEC Childcare Development Manager September 2022 & August 2023
(4) Holiday Activities and Food Programme (Holiday Activity Fund Easter Impact Report, 2021)
(5) August 2022 Local Health, Office For Health Improvement & Disparities ] https://fingertips.phe.org.uk © Crown copyright [2022]. Data for Cheshire East only shows 2017/18 and 2018/19 data due to the Covid-19 Pandemic lockdown in March 2020 causing the 2019/20 collection to be cancelled. Based on the Child's LSOA area of residence.

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# What is it like learning in Crewe in early years and primary school?

- Children living in the **'Crewe 6' wards have lower rates of good level of development at the end of reception** at 50% compared to Cheshire East at 66%. Crewe wards outside of the 'Crewe 6' have similar rates to the Cheshire East average[1].

- **87% of 'Crewe 6' and 83% of 'Crewe Other' primary pupils in Crewe attend a school which is rated good or outstanding**. This compares to 94% in Cheshire East and 89% in England[2].

- Progress between KS2 and KS4 is lower in Crewe Care Community schools than the Cheshire East and national averages in both disadvantaged and non-disadvantaged groups. However, the gap between the disadvantaged and non-disadvantaged cohorts is lower than the Cheshire East and national gaps[3].

- The **% of students achieving expected levels of phonics in year 1 reduced** between 2019 – 2022 by 8% in the Crewe LAP (Local Area Partnership)[4].

- The **% of students achieving expected level of writing, reading and maths at the end of key stage one reduced** between 2019 and 2022 by 10-12% in the Crewe LAP[4].

- The % **of students achieving expected levels of writing at the end of key stage two increased** between 2019-2022 by 1%, **the level of reading and maths reduced** by 7-9% in the Crewe LAP[5].

Data Source: (1) 2021-22 Academic Year, Early Years Foundation Stage Profile Return for Cheshire East Primary Schools
(2) Published Ofsted school inspection reports and pupil numbers are taken from the 2022 summer term school census returns.
(3) 2022 results are provisional released by the DfE in October 2022. Please see indicator notes for definitions of disadvantaged and non-disadvantaged.
(4) 2022 DfE statistics published 6 October Key stage 1 and phonics screening check attainment, Academic Year 2021/22 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk) 2019 and 2022 LAP results calculated in house by Cheshire East Received via email correspondence (Business Intelligence Officer, 30/11/22)
(5) Cheshire East and National pupil characteristic groups from DfE statistics published 22 December 2022 '- Table "ks2_regional_local_authority_and_pupil_characteristics_2019_and_2022_revised"'- National figures based on state funded schools and academies Key stage 2 attainment, Academic Year 2021/22 – Explore education statistics – GOV.UK (explore-education-statistics.service.gov.uk)2019 and 2022 Local Area Partnership (LAP) results calculated in house by Cheshire East based on the location of the school Received via email correspondence (Business Intelligence Officer, 01/02/23





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# What is it like learning in Crewe in secondary school and beyond?

- Only **69% of pupils attend a secondary school in the Crewe 6 area that is rated good** or outstanding. This compares to 100% of children attending a Crewe Other school. In Cheshire East, the overall figure is 94% and England it is 82%[1].
- **Crewe Care Community schools are below the Cheshire East and national average Attainment 8 scores. However, the gap between the disadvantaged and non-disadvantaged cohorts is lower than the Cheshire East and national gap**[2].

Data Source:
(1) Published Ofsted school inspection reports and pupil numbers are taken from the 2022 summer term school census returns.
(2) 2022 results are provisional released by the DfE in October 2022. Please see indicator notes for definitions of disadvantaged and non-disadvantaged
(3) Cheshire East Business Intelligence, National Client Caseload Information System (NCCIS) August 2022 Submission

- Although the proportion of children achieving grade 4 or 5 and above is lower than the Cheshire East and national average, the gap between disadvantaged and non disadvantaged students' achievements is less than the Cheshire East and national average[2].
- **A third (34%) of all those who are not in employment, education or training (NEET) in Cheshire East live in Crewe –** higher than the overall percentage of 16 to 17-year-olds that live in Crewe (25%)[3].
- **'Crewe 6' (58) has the highest overall number of 16 and 17-year-olds NEETs in Cheshire East while 'Crewe Other' (9) has the lowest**[3]**.**





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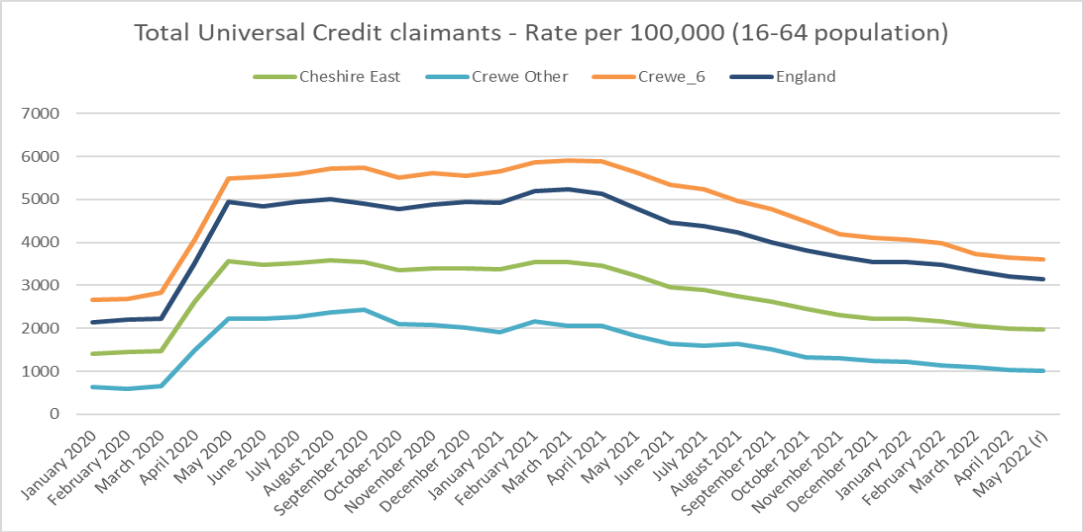
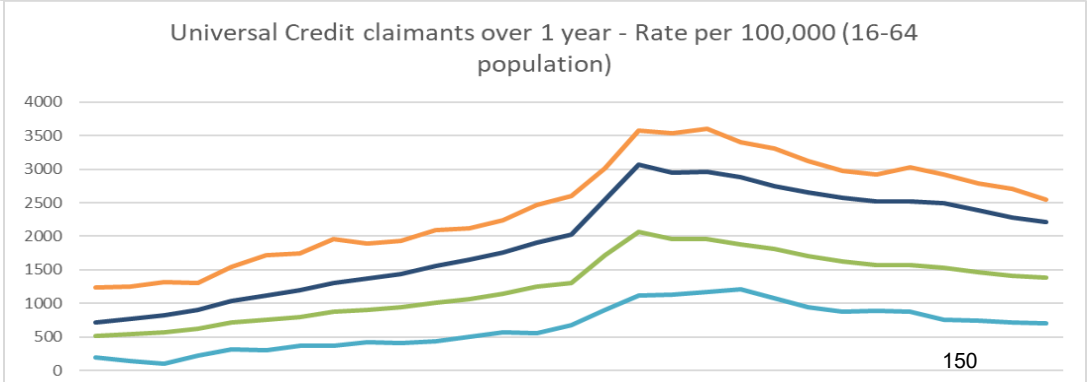
# Working in Crewe




The COVID-19 pandemic has had a significant impact on the number of people claiming Universal Credit (UC) who are searching for work. Overall rates increased sharply during the initial lockdown period in 2020 before stabilising and are now gradually reducing.

People claiming UC for over a year gradually increased between April 2020 and March 2021 as people who were out of work pre-pandemic struggled to get back into employment. March 2021 to May 2021 mirrored the significant increase seen a year before. Rates have since reduced although are much higher than was seen pre-pandemic.

The 'Crewe 6' area has consistently had a higher rate of individuals claiming Universal Credit compared to England and Cheshire East. As of May 2022, 'Crewe 6' claimants are almost twice as likely to claim Universal Credit compared to Cheshire East.

Data Source: DWP Universal Credit – searching for work, May 2022 figures provisional. ONS Mid-2020 Population Estimates used, 16-64 population used as denominator. To be superseded by latest Census 2021.16-64





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# Avoidable mortality, 2018-20

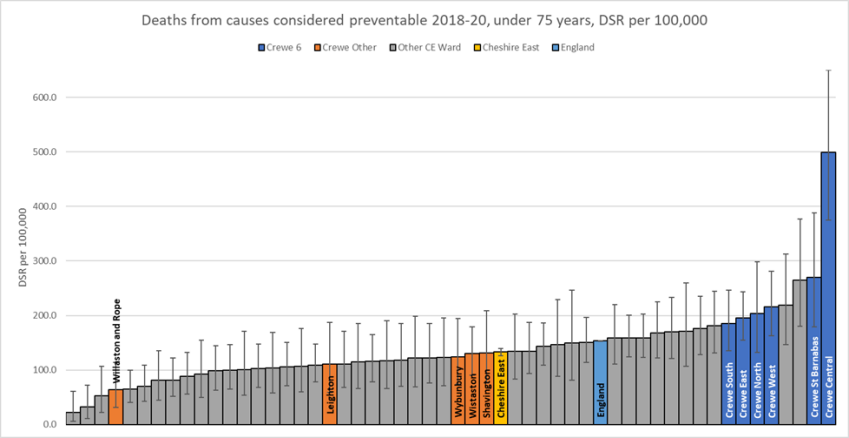
Of **premature** deaths in 'Crewe 6' wards (those occurring before age 75), **3/4 are considered avoidable**[4]**.**

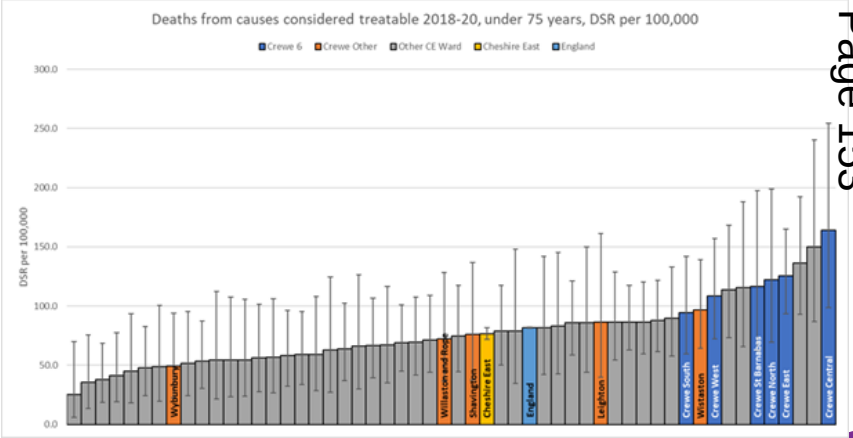
**Preventable mortality** (2/3 of avoidable deaths) shows the number of deaths that could be avoided by public health and primary prevention interventions

- The 'Crewe 6' wards have some of the highest rates of preventable mortality in Cheshire East. All of the Crewe 6 wards fall within the worst 10 wards in Cheshire East. **Crewe Central is an outlier**, with a rate almost double the next highest.

**Treatable mortality** (1/3 of avoidable deaths) shows the number of deaths that could be avoided through effective and timely healthcare interventions, including secondary prevention and treatment

- The 'Crewe 6' wards have some of the highest rates of treatable mortality in Cheshire East. 5 out of the Crewe 6 wards fall within the worst 10 wards in Cheshire East, with Crewe South at number 11.




Data source: Produced by Cheshire East Public Health Intelligence from Office for National Statistics: Annual Mortality Extracts 2018-2020 using ONS 2020 definition Office for National Statistics (ONS) Avoidable mortality by local authorities in England and unitary authorities in Wales, 07 March 22 release contains the latest definition (2020) and data.
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/avoidablemortalitybylocalauthorityinenglandandwales



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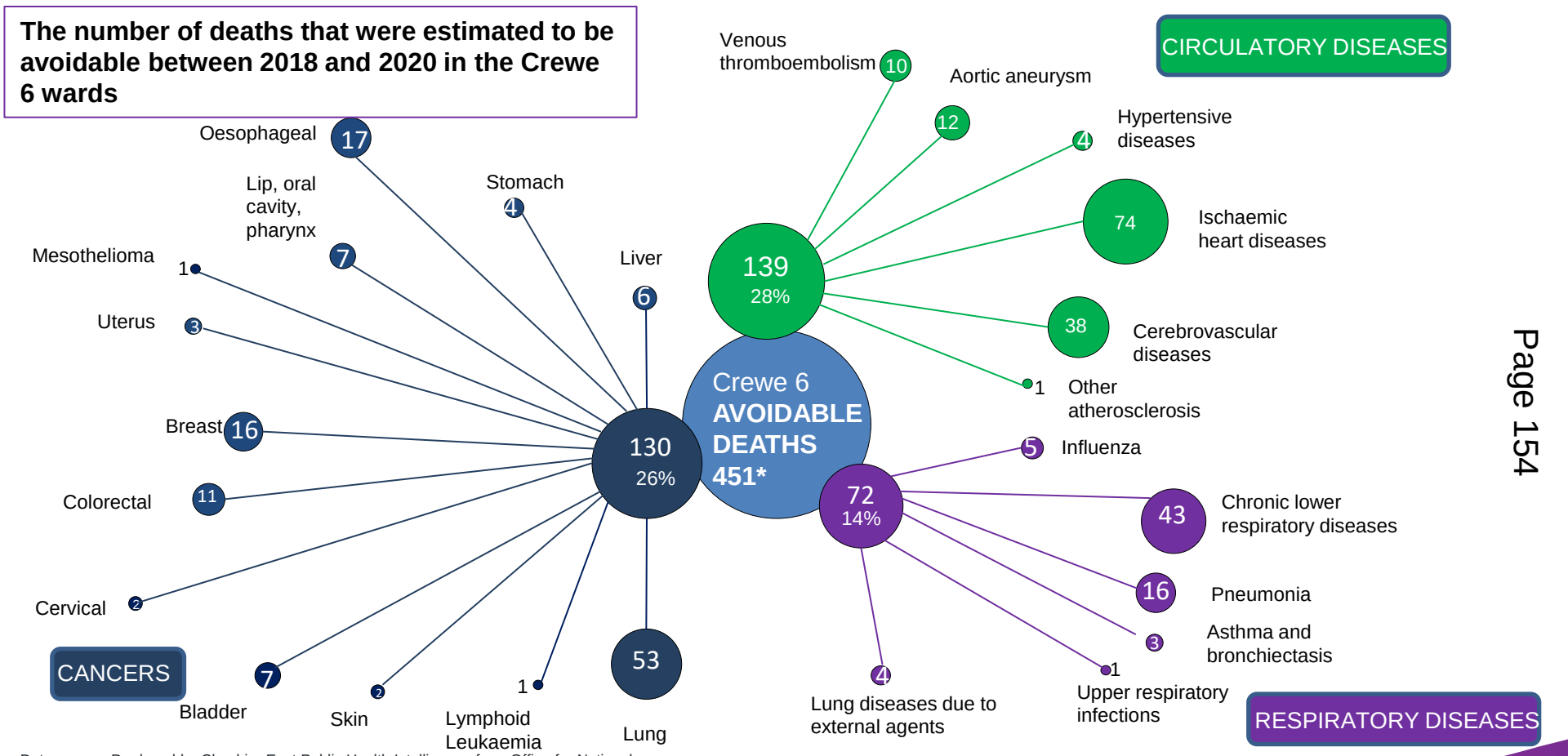
# The number of deaths that were estimated to be avoidable between 2018 and 2020 in the Crewe 6 wards




Data source: Produced by Cheshire East Public Health Intelligence from Office for National Statistics: Annual Mortality Extracts 2018-2020 using ONS 2020 definition Office for National Statistics (ONS) Avoidable mortality by local authorities in England and unitary authorities in Wales, 07 March 22 release contains the latest definition (2020) and data.
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/avoidablemortalitybylocalauthorityinenglandandwales

* Circulatory diseases, cancers and respiratory diseases contributed to nearly 70% of avoidable deaths

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# Reducing preventable illness and deaths

- **Adults in the 'Crewe 6' area are less likely to be physically active**. In some areas over 4 in 10 adults are inactive. Some parts of Wistaston also have high levels of inactivity[1].
- **Some areas of Crewe have the lowest COVID-19 vaccination rates** across Cheshire East, with one of the lowest uptakes being in our Eastern European migrant communities[2].
- The **incidence of all cancers is worse than the England average in the Crewe North and Crewe East wards[3].**
- The **incidence rates of lung cancer in Crewe St Barnabas, Crewe Central, Crewe North and Crewe West wards are worse than the England average[3].**
- There are significantly **higher rates of alcohol-related admissions in residents (both adults and under 18s) of the 'Crewe 6'** compared to the England average[4].



Data Source:
(1) Active Lives Survey Nov 2018/19, Small level estimates.
(2) Taken from the Living Well In Crewe Report Living Well in Crewe AHC 1.0.pdf (cheshireeast.gov.uk)
(3) 'Office for Health Improvement & Disparities. Public Health Profiles. [25/11/22] https://fingertips.phe.org.uk © Crown copyright [2022]'
(4) Local Health, Office for Health Improvement and Disparities (OHID), Local Health - Small Area Public Health Data - Data - OHID (phe.org.uk) [accessed 10 February 2023]



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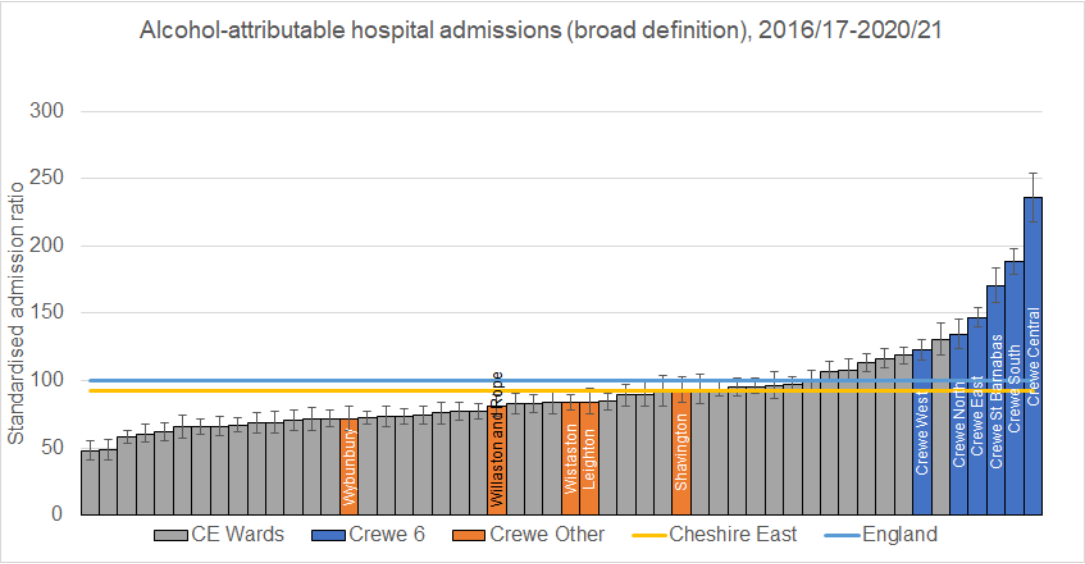
# Alcohol in Crewe




- The rate of alcohol-attributable hospital admissions in Cheshire East is significantly better than the England average.
- This masks differences across the authority, however, with all of the Crewe 6 wards being significantly worse than the England average. The other Crewe wards are similar to England.

Page 156

Data source: Local Health, Office for Health Improvement and Disparities (OHID), Local Health - Small Area Public Health Data - Data - OHID (phe.org.uk) [accessed 10 February 2023]

Notes: alcohol-attributable hospital admissions are split into broad and narrow definitions. The narrow definition includes only those cases where the primary diagnosis is an alcohol attributable condition (has an alcohol-attributable fraction rate greater than zero). The broad definition includes cases where the primary or any of the secondary diagnoses is an alcohol-attributable condition. The broad definition is more sensitive to changes in coding practice, whereas the narrow definition may under estimate the role of alcohol.



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# Reducing treatable illness and deaths

- In 2020, Crewe Central, Crewe South and Crewe St Barnabas were highlighted by the Cheshire and Merseyside Health and Care Partnership as priority wards for having **higher rates of hospital admissions and emergency presentations** than other wards with similar levels of deprivation[1].
- **Emergency department attendances in Crewe in children 0-4 years-old are higher** than the Cheshire East average[2].
- There is a **lower level of community pharmacy provision in the Crewe Care Community area,** particularly in the north of the town, although the number of pharmacies per 100,000 population is still comparable with England overall[3].
- **Two of the top ten practices in Cheshire East for number of patients per GP are within some of our most deprived areas in central Crewe[4].**
- There are significantly **lower rates of bowel and cervical cancer screening** in some of the practices covering 'Crewe 6' residents[5].

(1) Health inequalities and Covid-19, report by John Brittain and Professor Chris Bentley Partnership-Board-Agenda-Papers-Wednesday-28th-April-2021.pdf (cheshireandmerseysidepartnership.co.uk)
(2) Office for Health Improvement & Disparities. Public Health Profiles. [12 January 2023] https://fingertips.phe.org.uk © Crown copyright [2023]'
(3) The 2022 Pharmaceutical Needs Assessment (PNA) If a person (a pharmacist, a dispenser of appliances, or in some circumstances and normally in rural areas, a general practitioner) wants to provide NHS pharmaceutical services, they must apply to be included on a pharmaceutical list by proving they are (cheshireeast.gov.uk)
(4) NHS Digital, Patients registered at a GP practice, January 2021. Patients Registered at a GP Practice January 2021 - NDRS (digital.nhs.uk)
(5) GP Practice Profiles, Office for Health Improvement and Disparities (OHID), National General Practice Profiles - Data - OHID (phe.org.uk) accessed 10 February 2023]



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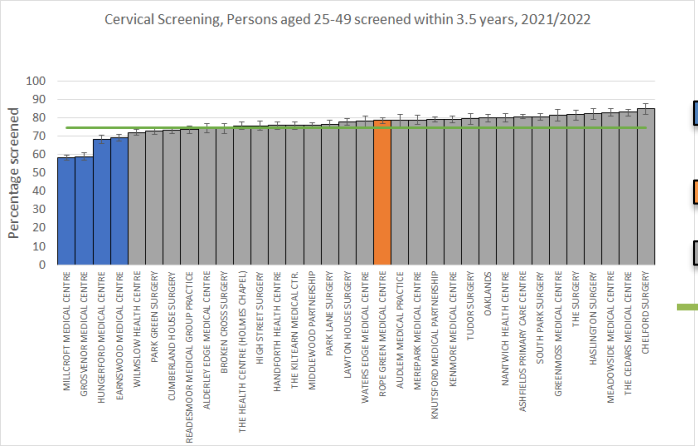
# Cancer screening – cervical and bowel

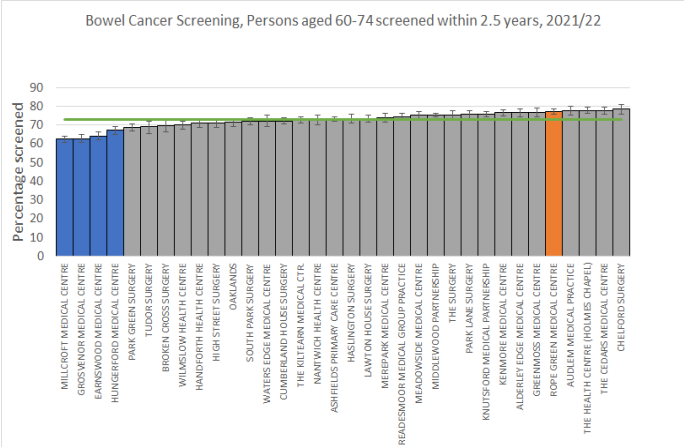



Crewe 6 GP Practices

Crewe Other GP Practices

Cheshire East GP Practices

Cheshire East Average




Cervical and bowel cancer screening rates in the Crewe 6 GP practices were the worst in Cheshire East. Low screening rates could lead to fewer cases of cancer being detected at the earliest stage and to higher rates of morbidity and mortality.

Data source: GP Practice Profiles, Office for Health Improvement and Disparities (OHID), [National General Practice Profiles - Data - OHID (phe.org.uk)] accessed 10 February 2023]

Notes: Uptake of cancer screening services in 2020/21 and, to a lesser extent, 2021/22, was affected by the Covid-19 pandemic. Significance has been calculated with reference to 95% confidence intervals.





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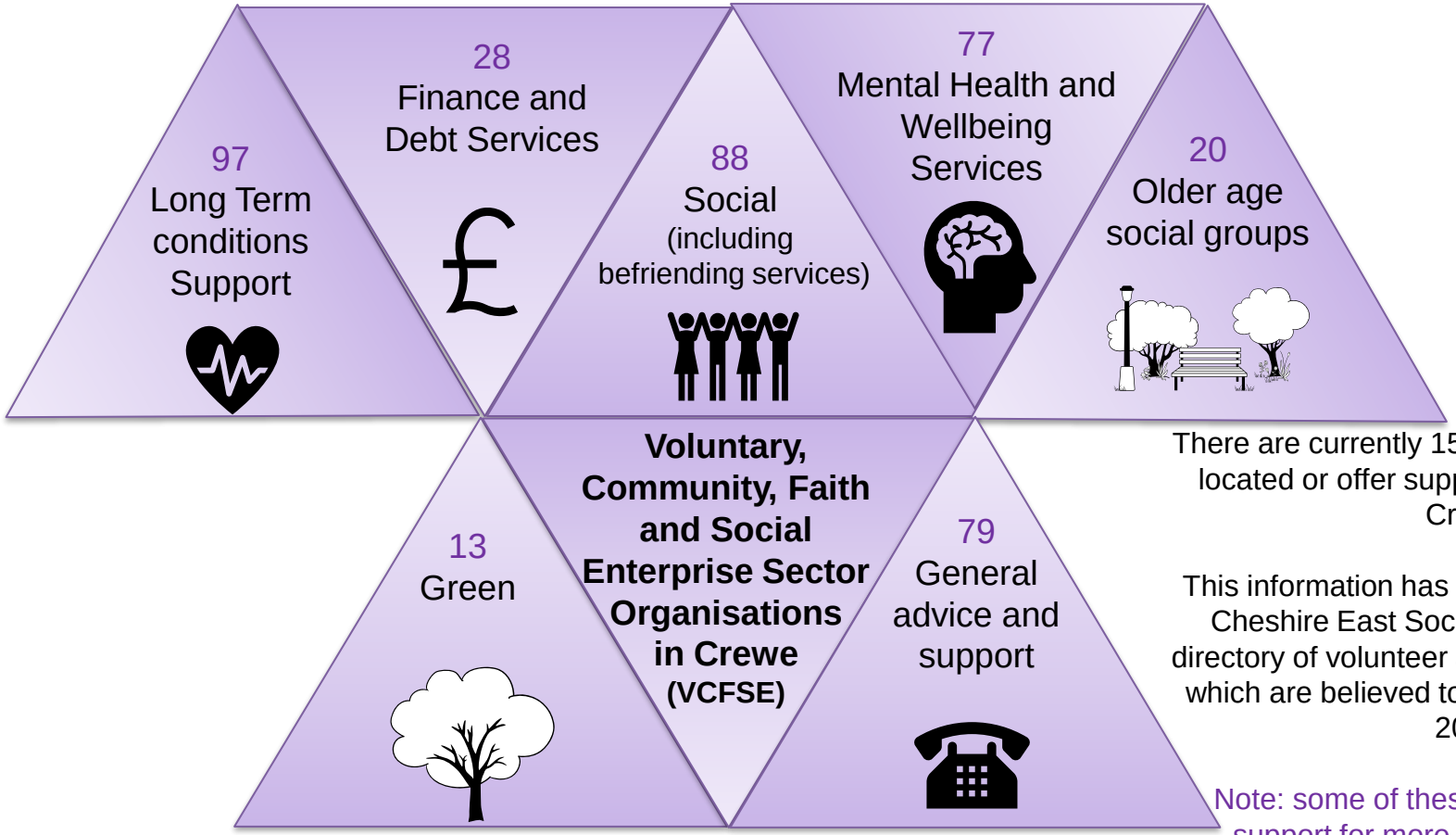


There are currently 150 organisations that are located or offer support to the residents of Crewe.

This information has been obtained from the Cheshire East Social Action Partnership directory of volunteer and community services which are believed to be accurate as at July 2022.

Note: some of these organisations offer support for more than one category

# VCFSE assets

Source: email correspondence from Partnerships and Transformation Manager CESAP (05/07/22)



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# How we went about this review

- This review is one of our Joint Strategic Needs Assessment (JSNA) deep dive reviews.
- The work was completed through a working group including Public Health and Business Intelligence, Research and Consultation, the Communities Team and the ICB.
- The working group used their experiences to agree
  1. The scope of this JSNA.
  2. The information that should be gathered.
  3. And the key messages and recommendations that should be formed from having looked at the information gathered.





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# What questions did this review aim to answer?

1. What is the extent and distribution of poverty and deprivation across Crewe?
2. What are the key challenges contributing to health and wellbeing inequalities across Crewe?
3. What assets do we have to address these challenges?
   - People, groups, physical geography, communities, services
4. What are the gaps in provision?
5. How can we address these gaps?
   - Sustainable/ongoing solutions/interventions
   - One-off interventions





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# What did this review cover?

To answer the review questions the working group agreed to review overarching measures for Crewe and issues across the life course:

1. Making Crewe a health creating environment
2. Supporting strong communities in Crewe
3. Giving every child in Crewe the best start in life
4. Boosting education and skills development in Crewe
5. Improving working lives in Crewe
6. Preventing ill health in Crewe





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# Living well in Crewe

## Executive summary

### Why Crewe

This is a report of the Cheshire East Increasing Equalities Commission, a multi-partner group who have considered what would help improve the health outcomes and life chances of the people of Crewe and who should consider taking action.

In this report, we see how lives are being cut short in Crewe because the building blocks for a healthy community are weak or missing. Life expectancy in every central Crewe ward is lower than Cheshire East overall with people dying over ten years earlier on average in parts of Crewe compared to the Cheshire East wards with the longest life expectancies.

We look across the life course at how things currently stand and how they could be improved with coordinated and evidence-based action. Crewe will thrive when its residents have good homes, places to exercise, access to good food and are helped to get the skills they need to access secure jobs. A thriving Crewe will benefit the whole of Cheshire East through the provision of quality services and amenities accessible to all and by attracting further investment into the Borough.

We recognise that health and wealth are inextricably linked. Deprivation contributes to poor health outcomes and, conversely, better health and wellbeing leads to increased productivity and economic success.

### Why now

There are tremendous opportunities to act in Crewe, leveraging the change we are already seeing through regeneration and capital investment, and the integration of health and social care services at place level. NHS services have new commitments around reducing inequalities and Cheshire East Council has committed to being an organisation that empowers and cares about people and to reducing health inequalities across the borough. The Council's Corporate Plan echoes the themes in this report, from developing a "thriving and sustainable place" and working with "residents and partners to support people and communities to be strong and resilient", to supporting "all children to have the best start in life".

### This report

We collaborated through multi-organisation workshops (one for each of the six themes below) to bring together current programmes and projects in the public and the voluntary, community, faith and social enterprise (VCFSE) sectors that are already benefitting Crewe's residents. We explored the gaps in provision to inform our recommendations. We then undertook a programme of community engagement, speaking to over 100 residents as well as reviewing relevant engagement exercises from other recent programmes of work for health services and for children.

### Recommendations of the Increasing Equalities Commission to public sector organisations and partners

Important ideas emerged across several workshops and discussions and can have a positive impact across multiple themes.

- Put improving health and wellbeing and the reduction of inequalities at the heart of decision making – a Health in All Policies approach. Use power as employers, as providers, as commissioners of services and as purchasers to generate social value. Embrace proportionate universalism by creating an offer for all but with the greatest investment given to the areas with the greatest need.
- Continue to listen to residents and service users to co-produce solutions.
- Make the best of what we have, through improved information sharing and co-ordination of services.
- Select a small number of key metrics to tell us whether we are making meaningful change to residents' life chances.

### 1. *Make Crewe a health-creating environment*

Our health is shaped by the environment in which we live, learn and work. Well-designed places promote and support good health by making the healthy choice the easy choice.

- Consider health and wellbeing throughout the Local Plan. Create and make use of local powers to support active travel, provide green spaces and improve the food and drink environment.

### 2. *Support strong communities in Crewe*

People are proud of Crewe, whilst also recognising that it could be a better place to live. Our VCFSE sector gives us strong foundations to build on and we can leverage the corporate responsibility agendas of local businesses and organisations to benefit local people.

- Use regeneration opportunities to develop community spaces. Facilitate intergenerational and intercultural engagement.
- Coordinate action to address poverty and the cost-of-living crisis.

### 3. *Give every child in Crewe the best start in life*

The inequalities in life chances begin at an early age and often widen throughout a person's life. Parents and children in our most deprived areas, such as those in Crewe, are often those most in need of the help of high-quality ante-natal services, parenting support and early years services.

- Develop a clear and ambitious plan for supporting the vital First 1000 days of life. Use our localities approach to ensure expenditure on early years development is focused proportionately across the social gradient.

### 4. *Boost education and skills development in Crewe*

For regeneration and investment to benefit Crewe's residents, we need to support our young people to get the skills they need to take advantage of any new opportunities. On average, students in more deprived areas achieve poorer exam results than their peers and are more likely to experience school exclusion but schools in Crewe are already coming together to make strategic improvements to benefit their young people.

- Use The Pledge and the Institute of Technology programme to boost skills and employability.
- Continue to develop targeted support for those with special educational needs and those at risk of exclusion or involvement in crime.

### 5. *Improve working lives in Crewe*

Crewe remains a centre for high-quality manufacturing but also has many important entry-level jobs. Regeneration will bring new opportunities, including in the cultural sector. We should ensure that pay and conditions are adequate to support wellbeing and that Crewe's residents are able to progress and access higher quality jobs.

- Introduce a Fair Employment Charter to improve pay and conditions and ensure that jobs promote health and mental wellbeing.
- Take a multi-agency approach to tackling long-term unemployment.
- Ensure new job opportunities are promoted locally and support local residents to access them.

### 6. *Prevent ill health in Crewe*

All themes of the report contribute to a person's health and wellbeing and, consequently, their life expectancy and need for health and social care services. However, preventative and treatment services can also pay a key role in narrowing the gaps we see. Further analysis is needed to understand the causes of the avoidable deaths we see and allow us to target our response.

- Establish governance for place-based prevention and the reduction of inequalities and implement evidence-based programmes of ill-health preventive interventions that are effective across the social gradient.
- Ensure primary care services in our most deprived areas are adequately resourced and are able to support prevention and proactive care.

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# Introduction

In 2020, Cheshire East Health and Wellbeing Board established the Increasing Equalities Commission to lead and co-ordinate work across Cheshire East that focuses upon reducing the inequalities experienced by residents of the borough. The Commission quickly recognised that Crewe should be its initial focus.

In this report, we see how lives are being cut short in Crewe because the building blocks for a healthy community are weak or missing. We look across the life course at how things currently stand and how they could be improved with coordinated and evidence-based action. Crewe will thrive when its residents have good homes, places to exercise, access to good food and are helped to get the skills they need to access secure jobs, and a thriving Crewe will help the whole of Cheshire East as an attractive service town which brings investment into the borough.

We present the voices of the people of Crewe and call for co-production of plans to address their concerns and reduce the stark inequalities evident within the town.

Through this report, the Commission asks all public sector partners to use every lever available to improve health and wellbeing outcomes and to consider the reduction of inequalities in all decision making. This report outlines what the Commission believes will work to reduce inequalities in Crewe and across Cheshire East and builds on work already being undertaken. This will be an important source document for the refreshed Health and Wellbeing Strategy and an important next step will be for all partners to work together to identify priority areas for action, focusing on those interventions that will have the greatest impact.

As a system, we must act reduce the inequalities we see, as those in our most deprived areas who are living shorter lives will also spend more years in poor health, relying on our services. The planned update of the Joint Health and Wellbeing Strategy is an excellent opportunity for the local system to implement changes that will benefit the residents of Crewe and all in Cheshire East.

## Background

The planned **economic regeneration** of Crewe, the arrival of HS2 and the levels of capital funding allocated to invest in the town, all provide an opportunity to take a much more strategic approach, connecting the residents of Crewe with the opportunities that this investment offers over the coming decade and beyond. Through enhanced economic wellbeing we can create the conditions that allow for better health outcomes as well. Conversely, a healthier Crewe will boost productivity and generate economic success.

**The UK Government** has published its aspirations for Levelling Up the United Kingdom[1]. It recognises that, "While talent is spread equally across our country, opportunity is not." The paper sets out "12 missions" to rebalance the regions and increase the "6 capitals". See *Appendix 4 – Levelling Up the United Kingdom – 12 Missions and 6 Capitals*.

> "It is equally critical that we improve productivity, boost economic growth, encourage innovation, create good jobs, enhance educational attainment and renovate the social and cultural fabric of those parts of the UK that have stalled and not – so far – shared equally in our nation's success[1]."

We have referenced these missions and capitals throughout the report and linked them to our priority areas.

**The Cheshire and Merseyside Health and Care Partnership** have placed the reduction of health inequalities as a key aim for our local system. It gave a commitment for the sub-region to become a "Marmot Community" – one in which the entire system is committed to tackling health inequalities throughout people's lives, through a determined and joint effort across a number of sectors to achieve common goals.

[1] Levelling Up the United Kingdom - GOV.UK (www.gov.uk)

Our **Primary Care Networks** have new responsibilities around reducing health inequalities and NHS bodies must consider the effects of their decisions on inequalities[2].

**Cheshire East Council** has established fairness as one of the three core aims of its Corporate Plan (2021–2025)[3].

> "We aim to reduce inequalities, promote fairness and opportunity for all and support our most vulnerable residents[3]."

The Council has committed to being an organisation that empowers and cares about people and one that will reduce health inequalities across the borough. The Corporate Plan echoes the themes in this report, from developing a "thriving and sustainable place" and working with "residents and partners to support people and communities to be strong and resilient", to supporting "all children to have the best start in life".

## Why Crewe?

"Poverty in Crewe has got worse over the last ten years"

Though Crewe remains a centre for advanced engineering and manufacturing, it has joined other towns in the north of England, where long-term economic decline has been associated with poor health and wellbeing among its residents. But Crewe is changing, with a programme to transform the built environment already well underway. This is a once in a generation opportunity to level-up Crewe and improve the life chances of all its people.

"Areas are obviously deprived"

Whilst Cheshire East is a relatively affluent borough overall, Crewe contains some of the most deprived areas in England. People in these areas are not only living shorter lives but are spending more years in poor health. Health and wealth are inextricably linked, with those in so-called 'Left Behind Neighbourhoods' in England being nearly 50% more likely to die from COVID-19 and the poor health faced in these communities costing billions of pounds in health and social care costs and lost productivity[4]. These problems start early, and child poverty is a major contributing factor. There has been little improvement in recent decades.

Crewe's residents are on average younger than those in Cheshire East as a whole and households are more likely to be made up of single adults or lone parents than Cheshire East overall[5].

Based on the latest available data (2015-2019), the average life expectancy at birth in Cheshire East was 80.3 for males and 83.9 for females. For both sexes, life expectancy in every central Crewe ward is lower than the Cheshire East average. It is lowest for both in Crewe Central, at 72.7 for males and 76.8 for females. On average, males and females in Crewe Central are dying 11.6 and 12.1 years earlier, respectively, than their neighbours in Wilmslow East[6].

Crewe Central is in the top two worst wards across the whole of Cheshire and Merseyside for all-cause mortality under 75 and deaths from causes considered preventable[7].

Crewe has the only ward in Cheshire East designated as a 'Left Behind Neighbourhood' by Local Trust – one in which the community suffers from the highest levels of combined social, cultural and economic deprivation[8]. This is associated not just with poorer health and shorter life expectancy, but more challenging working lives and a lack of

---

[2] NHS England » Network Contract DES
[3] Corporate Plan (cheshireeast.gov.uk)
[4] New report shows almost £30bn health cost of England's most deprived communities - The NHSA
[5] Analysis of Acorn data for Cheshire East Council 2021
[6] Note that there is a level of uncertainty when calculating life expectancy using a relatively small number of deaths at ward level.
[7] Partnership-Board-Agenda-Papers-Wednesday-28th-April-2021.pdf (cheshireandmerseysidepartnership.co.uk) – P.86
[8] 'Left behind' neighbourhoods - Local Trust

social infrastructure (the connections, organisations and spaces to meet that enable communities to make positive changes for themselves)[9].

The **quotations in orange boxes** were taken from a programme of resident engagement described in *Appendix 3 – Engagement with Crewe residents 2022.*

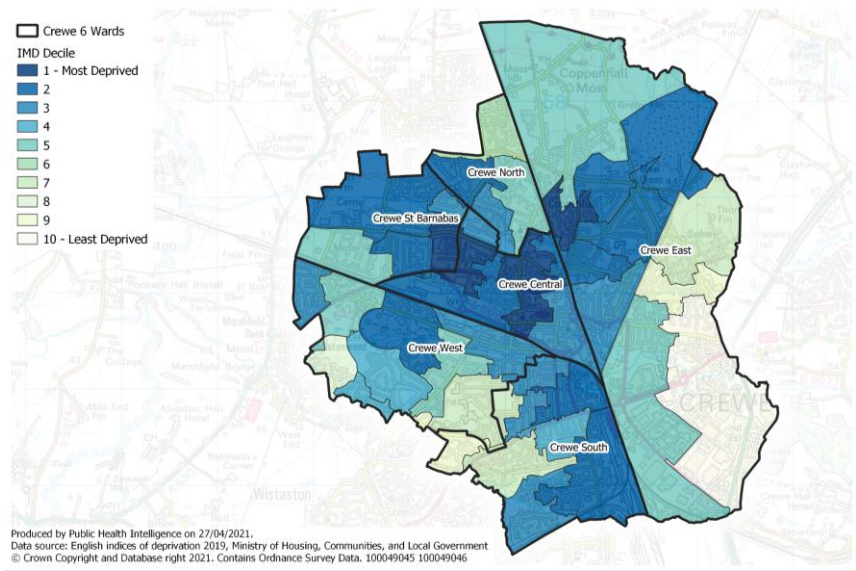


*Figure 1 - Lower super output area (LSOA) deprivation for six central Crewe wards (IMD 2019)*

Based on the Index of Multiple Deprivation (IMD), all the wards in central Crewe are amongst the most deprived in Cheshire East with three (Central, South and St Barnabas) being designated "priority wards" by the Cheshire and Merseyside Health and Care Partnership as health outcomes are even worse than might be expected for their level of deprivation[7].

However, the arrival of HS2 by 2033 will be a catalyst for growth and we have already secured a multimillion-pound plan for regeneration of the town centre, incorporating investment via the Future High Street Fund and the Towns Fund[10].

"It's a doughnut town – lots around the outside and nothing in the middle"

The true wealth of an area is the wellbeing of its people. We must use this moment to ensure that the changes benefit local residents by improving their environment and allowing them to reach their full potential and take advantage of the exciting opportunities incoming. A comprehensive and holistic approach is required that addresses the place and people's individual circumstances.

[9] Overcoming health inequalities in 'left behind' neighbourhoods - APPG for Left Behind Neighbourhoods
[10] Phase 2a: West Midlands to Crewe - High Speed 2 (hs2.org.uk)

# Cross-cutting themes and recommendations

## Work together to reduce the gap between Crewe and the rest of Cheshire East

| |
|---|
| Halve the gap in **life expectancy** between the six central Crewe wards and the wards with the highest life expectancy in Cheshire East within ten years. |
| Halve the gap in **healthy life expectancy** between the six central Crewe wards and the wards with the highest life expectancy in Cheshire East within ten years. |

## Prioritising health and wellbeing

Public sector organisations should **put improving health and wellbeing and the reduction of inequalities at the heart of decision making**. We should **agree wellbeing and inequality indicators** against which progress can be measured. The entire local system shares responsibility for improving these outcomes and we should all work towards **becoming a Marmot Community.**

Public sector partners have tremendous power as employers, as providers, as commissioners of services and as purchasers. To **generate social value**[11], we must recognise that spending money locally can generate long-term benefits, and these are more important than short-term savings. Local companies may need support to bid for local work.

To contribute to reducing inequalities, everyone from central government to frontline services should **embrace proportionate universalism** – creating an offer for all but with the greatest investment given to the areas with the greatest need.

## Listen to our residents

This strategy highlights issues and makes recommendations to partner organisations for how inequalities can be reduced, but partner organisations should **co-produce solutions to these issues with residents**.

Information and services must be **culturally appropriate and accessible to all, including those who don't have English as a first language.**

## Focus on Crewe

Crewe suffers from a mix of historic deprivation and poor health outcomes, but also has a tremendous opportunity for improvement through regeneration and health and care reorganisation. Place-based approaches should be supported, which means that **teams should be created with Crewe as their primary focus.** The Crewe Care Community and two Primary Care Networks provide strong foundations to build upon.

## Make the best of what we already have

Many great services already exist in Crewe and beyond. It is vital that information is in the hands of those that need it and that people access or are referred to both commissioned and non-commissioned services that will benefit them.

To do this, we should **review sources of information and referral pathways**, such as the LiveWell site, from the users' perspective and ensure they work for frontline practitioners and residents alike. This links to digital inclusion work to make sure services are accessible to all.

[11] Social-Value-Charter.pdf (cheshireandmerseysidepartnership.co.uk)

## Measure and track a small number of key metrics

Deprivation is deeply entrenched in the centre of Crewe. While its residents have experienced poorer health outcomes than other local areas for many years, these have fluctuated in response to national policies and economic conditions, local actions, and external factors. We are used to seeing data that shows these inequalities but now must **select a small number of priority measures that will tell us whether we are making meaningful changes to residents' life chances**.

A more detailed breakdown of health indicators for all wards in Cheshire East can be seen in Appendix 5 – with a high-resolution version available online[12].

These metrics must be supplemented by ongoing engagement as, ultimately, the people of Crewe will tell us whether we have done a good job.

[12] Tartan Rug (cheshireeast.gov.uk)

Increase the proportion of people in central Crewe who are regularly cycling or walking for travel by 50% in ten years.

## Priority 1 – Making Crewe a health-creating environment

Mission 3

Mission 9

Mission 10

Physical capital

**Key aims**

- Increase active travel across social gradient
- Improve open and green spaces
- Improve the food and drink environment
- Improve the availability of good quality, energy efficient homes

**We will measure**

- Utilisation of outdoor space for exercise / health reasons
- Fast food outlets per 100,000 population

### Background

Our health is shaped by the environment in which we live, learn and work (see *Appendix 6 – The determinants of health and wellbeing in our neighbourhoods*). Well-designed places promote and support good health by making the healthy choice the easy choice. While services are vital for supporting those in need, their effect on the overall health and wellbeing of a population is limited.

"Too many new houses, not enough infrastructure

"Pavements are unsuitable for wheelchair users… one young lady has been tipped out three times"

The planning of buildings, homes, and infrastructure to provide attractive and safe

### Current projects and services

| | |
|---|---|
| **Active travel** | |
| Travel | Strategic developments planned to encourage active travel through improved cycle and footpaths. Development of Crewe Railway Station, HS2 and the addition of a bus interchange. |
| Regeneration | Improvements to corridor between train station and town centre. Developing Valley Brook Corridor crossing town as a route for active travel with improved outdoor recreation facilities. |
| **Open and green spaces** | |
| Cleaner Crewe | Reclaiming and cleaning the alleyways in and around Crewe. |
| Green infrastructure | Pocket parks programme to improve current play spaces for children and young people and add to the area with more plants and trees. |
| Leisure & sport | Re-development of parks and green space to make them more attractive to use. |

neighbourhoods with access to green space and opportunities to exercise can dramatically influence the wellbeing of Crewe's people.

"Nature is a sanctuary. If you feel like you can't relax and your kids are unsafe, it's not a sanctuary"

Nearly a third of households in central Crewe do not have access to a car and so services and amenities should be convenient and accessible with provision made to support and encourage active travel.

Consideration should be given to interventions that can improve both health and the environment. For example, shifts from private car use to active travel modes can increase exercise, improve air quality and reduce carbon dioxide emissions.

We invited the **Town and Country Planning Association** to lead a multi-agency workshop around creating compact and complete neighbourhoods that support health. Much of the work of our planning teams and the forthcoming regeneration work in Crewe use similar concepts and ideas and we are using development opportunities to connect and enhance key areas of central Crewe to improve walkability and promote wellbeing. A future challenge is to ensure all of Crewe's residents can access everything they need within a manageable walk or cycle from their homes.

| | |
|---|---|
| Retail/commercial development | Use of empty retail space and improvements to the area's accessibility so that more people want to come and shop in Crewe and businesses want to set up in the town. |
| **Food and drink environment** | |
| Market Hall redevelopment | A social space for local business and residents redeveloped to give it a more welcoming and open feel. |
| Licensing | Broad programme of inspection and enforcement of food establishments and licensed premises. |
| **Quality homes** | |
| New homes | New housing developments within Crewe to encourage residents to stay in the area and for more people/families to choose Crewe as their home. Housing companies contribute to the New Homes Scheme, which benefits local projects and communities. |
| Guinness Partnership | Good quality social housing available. |
| Retrofitting | Planned energy efficiency improvements to existing homes |
| Planning | Article 4 directions introduced to require planning permission to convert properties to small houses of multiple occupancy (HMOs) in an area surrounding three streets in central Crewe. |

## Crewe regeneration plans[13]

| | |
|---|---|
| • A diversified town-centre offer for residents and visitors, with retail, commercial and leisure developments supporting 24-hour town-centre use and linked with thoughtful public realm improvements<br>• An enhanced cultural offer around Lyceum Theatre, a History Centre, a youth zone, redevelopment of Flag Lane Baths into a Community Hub<br>• Improvements to existing and new green infrastructure including tree-lined boulevards, children's play areas – Valley Brook Corridor connecting Queens Park to the Town Centre.<br>• Rationalised and improved car parking, new bus interchange, improved walking and cycling links, improvements in and around Crewe railway station with significant improvements along the Southern Gateway (Mill Street between station and town centre).<br>• Potential leisure and sporting developments<br>• Technology and Digital Innovation Campus<br>• New homes, warm and healthy existing homes | "Rejuvenated completely, no cheap crap shops like pound bakeries"<br><br>"Lack of toilets limits the time we can spend in parks"<br><br>"Children need equipment for all ages and abilities"<br><br>"We want more safe cycling for commuting and leisure"<br><br>"One time I [a child] fell off my bike and cut my lip on the broken glass" |

[13] Crewe Town Centre Regeneration Programme (cheshireeast.gov.uk)

## Recommendations

| No. | Detail |
|---|---|
| 1 | Consider health and wellbeing throughout the Local Plan. Create and make use of local powers to ensure new developments support active travel and provide green environments. |
| 2 | Maximise wellbeing gains to local residents in our capital projects and regeneration programmes. Capture Crewe's unique heritage and use signage, plaques or statues to link residents and visitors to places of interest. |
| 3 | Improve energy efficiency of housing across the social gradient[14] (this is to be part of the housing strategy). |
| 4 | Engage residents to ensure regeneration plans meet their needs. Involve them in decisions and ensure plans and current progress are communicated through multiple channels with dedicated communications resources for Crewe. |
| 5 | Support community-level schemes to introduce low traffic neighbourhoods or play streets. |
| 6 | Use all available powers to improve the food and drink environment to make the healthy choice the easy choice. This includes licensing of premises and limits on outdoor advertising of unhealthy products and services[15]. |
| 7 | Consider developing a selective licensing scheme and support increased housing and landlord enforcement to improve private rental housing standards. Monitor the impacts of Article 4 directions. |
| 8 | Map services and infrastructure to determine how compact and complete Crewe's neighbourhoods are. |
| 9 | Allocate revenue funding to properly maintain current active travel routes and public spaces. Design out crime with appropriate lighting, street furniture and use of CCTV. |

[14] SOCIAL GRADIENT – Rather than there being two opposing groups (the 'haves' and 'have-nots'), there is a social gradient in health that runs from top to bottom of the socioeconomic spectrum. Inequalities are experienced by most people and the lower someone's socioeconomic status, the poorer their health is likely to be. PROPORTIONATE UNIVERSALISM – interventions should help those across the social gradient, with most resources invested towards those with greatest need.

[15] Taking down junk food ads | Sustain (sustainweb.org)

Halve the proportion of Crewe's residents who regularly experience loneliness within ten years.

## Priority 2 – Supporting strong communities in Crewe

Mission 8

Mission 9

Mission 11

Social capital

**Key aims**

- Connect people and groups, empowering them to make positive local changes
- Reduce the impact of poverty, food insecurity, debt and limited social support
- Create inclusive local economies, inclusive growth and social value

**We will measure**

- Fuel poverty
  - See also Poverty deep-dive JSNA
- Social e.g. volunteering rates
- Economic e.g. local employment
- Environmental

### Background

People are proud of Crewe, whilst also recognising that it could be a better place to live. Crewe is increasingly diverse, with the highest proportion of people identifying as non-White British in Cheshire East[16].

Our Crewe community has strong foundations, many of which are led by our VCFSE sector[17]. This includes charities that provide a dedicated service, community groups that provide a safe haven for many, and individuals that look out for their fellow Crewe residents.

"I want more group activities or speakers for people my age [20s] as there's only pubs & football"

### Current projects and services

| | |
|---|---|
| Hope Church Asylum Cafe | Hope Church provide a safe space for those who have sought asylum in the UK to interact, learn English, learn how to ride a bike and help to access relevant services such as primary care. |
| The Haven on North Street Café | A community café offering placements and volunteering options for those with additional needs, as well as providing a wide variety of activities, such as Tai Chi sessions, newbie Tuesdays and games events. |
| St Paul's Centre | Like many VCFSE organisations, St Paul's offers a broad range of support. They help adults with learning disabilities by providing personalised work opportunities, alongside repairing second-hand bikes, operating a food bank, offering skills workshops, provision of free shoes and selling household furniture at affordable prices. |
| Senior Forum | The forum based at St Michael's Church Hall provides essential social and community support opportunities for older Crewe residents. This has recently become even more crucial as the local pensioners' group, which provided trips out and |

[16] Ethnicity Cheshire East Summary | Insight Cheshire East (arcgis.com)

[17] VCFSE – Third sector organisations comprising voluntary, community, faith and social enterprises

| | | |
|---|---|---|
| With this strength comes a real opportunity to develop the conditions that help the community to flourish and promote the health and wellbeing of those living and working in Crewe.<br><br>When we spoke to our residents, they wanted greater opportunities to connect with others like themselves and those from other nationalities and backgrounds. They wanted to retain the sense of history of Crewe and have more reasons to visit the town centre, which is currently missing its community spirit. Above all, they wanted to remove the barriers that stand in the way to community engagement and increase the number of positive activities that help them feel connected to their community. | | speaker events, folded in May 2022 due to lack of resource. |
| | YMCA Crewe | As a Connected Community Centre, the YMCA provides vital accommodation and support to those experiencing homelessness. They offer an academy which offers dedicated sessions to help those wanting to develop their independent living, relationship, gardening and sports skills, to name a few examples. |
| | Lighthouse Centre | Services and support for people experiencing homelessness, substance misuse, mental health disorders and social isolation. |
| | Chance. Changing Lives | Community Pantry and Saturday Kitchen to help those struggling to buy healthy food. |

If we are to truly support our Crewe community, this support must be 'done with' and not 'done to' our residents. Co-production opens up the opportunity to find sustainable solutions that truly meet the needs of our residents.

"There's no integration of different nationalities & religions… if organisations existed that could introduce people, that would be good"

"The lack of buses later on is like a curfew if you don't have other transport options"

"It needs to be local – for some it can be a choice between heat or spending time in the community"

"The heart's gone from the town all together, we need to get it back"

## Recommendations

| No. | Detail |
|---|---|
| 10 | Use regeneration opportunities to involve residents alongside promoting community and resident wellbeing. |
| 11 | Empower local people by engaging them in decision making at every level, from co-producing strategies to the design and delivery of interventions. |
| 12 | Facilitate and encourage intergenerational and intercultural engagement to rebuild the sense of community spirit that is inclusive to all. |
| 13 | Understand where we can begin to address poverty and the cost-of-living crises, for example through the poverty JSNA, the provision of fuel vouchers and housing improvements. |
| 14 | Ensure schools and public places lead through healthy food and beverage offers, and support community food infrastructure such as through urban agriculture. |

| | |
|---|---|
| 15 | Use all planning and enforcement levers to remove barriers and ensure that we are doing everything we can, in line with behavioural insights, to make the healthy choice the easy choice. |
| 16 | Use the purchasing and commissioning power of the Council and its public sector partners to invest in the local economy and prioritise social value. |
| 17 | Call on government to repair our social safety net by reforming Universal Credit and lifting statutory sick pay. |
| 18 | Support community use of spaces – e.g., open booking of Lyceum Square, schools and playing fields. |
| 19 | Engage local businesses to leverage corporate responsibility agendas to benefit local residents |
| 20 | Harness Crewe's heritage - organise events and activities to bring communities together, promote physical activity and aim to attract prestigious sporting events |

Halve the gap in the percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception) between Crewe and Cheshire East's best performing wards within ten years.

## Priority 3 - Giving every child in Crewe the best start in life

Mission 5 Levelling up

| | | | |
|---|---|---|---|
| Key aims | Maximise the health of mothers, babies and young children | Ensure the provision of high quality antenatal and maternity services, parenting programmes, childcare and early years education | Improve school readiness and reduce the inequalities in the early development of physical and emotional health, and cognitive, linguistic and social skills |
| We will measure | Smoking status at time of delivery<br>Reception: Prevalence of obesity | Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development) | School readiness:<br>Percentage of children achieving a good level of development at the end of Reception. |

### Background

Giving every child the best start in life starts with improving women's health and providing excellent ante-natal and maternity care. Support should be given around nutrition and breastfeeding. Parents should be given the backing they need through paid leave and parenting skills training. High-quality, affordable children's centres, childcare and nursery provision with a skilled and valued workforce can support a child's development, backed up by opportunities to learn and play in parks, libraries and homes.

**National situation**
Millions of British children live in poverty and fewer than half of those reach expected levels for English and maths by the end of primary school. In England and Wales, the public sector spends billions of pounds each year dealing with problems that start in childhood[18]. Looked-after children continue to

### Current projects and services

| | |
|---|---|
| **Health of mothers and children** | |
| Child Health Hub project | Delivery via children's centre – an approach which is closer to home and accessible for parents. |
| CATCH App | Common Approach to Children's Health - Free NHS health app for parents and carers of children from pregnancy to age five. |
| Crewe Autism Inclusive | Support for those with autism (diagnosed or suspected) and other neurodiversity, and families. |
| Better Health website – Start for Life | Website offering trusted advice for pregnancy, babies and toddlers. |
| Maternity Voices Group | A group formed of women and their families who work alongside commissioners and providers to develop and improve maternity services. |
| **Development and school readiness** | |
| Lifestyle Centre | Sensory room, Parent & baby swim sessions, toddler swimming sessions, play and stay sessions, dance for younger children. |

[18] The cost of late intervention: EIF analysis 2016 | Early Intervention Foundation

experience poor outcomes that persist throughout their lives.

As child poverty has increased, the funding for Sure Start and Children's Centres and other children's services has been cut, particularly in more deprived areas. Low rates of pay and qualifications in the childcare workforce are ongoing issues.

**Children in Crewe**
The six central Crewe wards have rates of child poverty, hospital admissions for injury (age 0-4), emergency hospital admissions (0-4) and child development at age 5 that are all worse than the England average (See *Appendix 7 – "Tartan Rug" – Health profiles for electoral wards 2021*). A new Children and Young People's Plan is in development, co-produced with Cheshire East Youth Council and the Children and Young People's Trust.

"As a mum of two young children I want parks to be a community space - it can be isolating to be a stay-at-home parent"

| | |
|---|---|
| Parenting Journey and 12 Stops Sessions | Delivered at Children's Centres. Starts from pregnancy up until your child begins school. Learn about your child's development all along the journey. |
| Library | Story Times, Baby Bounce, Rhyme Times, school visits. |
| Early Years speech and language therapy | Support of children and young people who struggle with feeding, swallowing, speech & communication, social interaction issues and stammering. |
| **Family support** | |
| South Cheshire CLASP | Support for single parent families. |
| Wishing Well Project | Children & Families service including parenting programme. |
| Motherwell Cheshire | Counselling services and mental health support, uniform hub, wellbeing walks. |

## Recommendations

| No. | Detail |
|---|---|
| 21 | Develop a clear and ambitious plan for supporting the vital First 1000 days of life, from conception to age two[19]. |
| 22 | Improve outcomes for children we care for utilising the priorities identified within the new Children and Young People's plan. *This recommendation T.B.C.* |
| 23 | Undertake a Joint Strategic Needs Assessment deep-dive review into Emotional and Mental Wellbeing in Children and Young People and take forward its findings. Ensuring there is clarity with other initiatives on this theme is essential. |
| 24 | Continue to develop and actively promote integrated family hubs in communities with the greatest need. |
| 25 | Advocate for increased national spending to reduce child poverty and support early years education and ensure allocation of funding is proportionately higher for more deprived areas. Advocate for increased pay and qualification requirements for the childcare workforce. |
| 26 | Target evidence-based support to help pregnant women become smoke free including incentivising quitting. |

[19] First 1000 days of life (parliament.uk)

| | |
|---|---|
| 27 | Ensure early years staff are trained in special educational needs and early recognition of neurodevelopmental conditions. |
| 28 | Ensure support for infant nutrition and breastfeeding is accessible and sufficient. |
| 29 | Review services to prevent and support where there are Adverse Childhood Experiences. Ensure workforce are appropriately trained. |
| 30 | Support and expand parenting programmes. |
| 31 | Invest in training for early years workforce – ensure private providers have sufficient resources to attend training sessions provided. |
| 32 | Utilise our localities approach to ensure expenditure on early years development is focused proportionately across the social gradient. |

"My son had problems with chronic stomach pains and started being anxious about going to the loo. We were quickly referred to Eagle Bridge Health Wellbeing Centre's Children's Bowel and continence clinic[33]."

"[The hospital] does not have a good reputation with post-natal care[33]."

"Have a toddler and it's been hard in lockdown not being able to do the usual activities and meet up with other mums and children. Not sure what activities are taking place now and what is going on in the local area for families. Enjoy the swimming lessons for pre-schoolers at Everybody Leisure[33]."

| |
|---|
| Halve the gap in exclusions and attendance between Crewe and the best performing areas in Cheshire East within ten years |
| Halve the gap in the proportion of pupils who achieve a level 2 and level 3 qualification between Crewe and the best performing areas in Cheshire East within ten years |

## Priority 4 – Boosting education and skills development in Crewe

Mission 5

Mission 11

Intangible capital

Human capital

| Key aims | Reduce gaps in educational attainment | Improve support and achievement for those with special educational needs | Increase aspirations and improve engagement at post-16 | Reduce exclusions, offending and drug and alcohol abuse in young people |
|---|---|---|---|---|
| We will measure | Attainment and progress in core subjects | Uptake of SEND training | 16–17-year-olds not in education, employment or training (NEET) or whose activity is not known | School exclusions<br>Alcohol specific conditions – Under 18s |

"We want more for young children to do, free or cheap so that all have a chance to go and keep the kids entertained"

"There is very little offered for teen and school-aged groups"

### Background

Nationally, there are persistent gaps at GCSE level between disadvantaged pupils and their peers, with a North-South divide evident. This gap is also experienced among pupils from ethnic minority groups, especially those who speak English as an additional language[20]. At age 16-18, those eligible for free-school meals are more likely to attend a further education college, rather than a sixth form school or college (where students are more likely to be studying for A levels)[21]. Regardless of institution type and prior attainment, those

### Current projects and services

| **Reduce gaps in educational attainment** | |
|---|---|
| Libraries | Provision of support for children and young people: homework help, Summer Reading Challenge, access to IT equipment, advice and support |
| Cubs, Brownies, Cadets, Duke of Edinburgh Award, Prince's Trust | Groups such as these give children and young people the chance to build friendships, confidence and skills. The Duke of Edinburgh scheme is internationally recognised allowing challengers to develop themselves through a range of experiences. |

[20] Covid-19 and Disadvantage gaps in England 2020 - Education Policy Institute (epi.org.uk)
[21] Going Further - Sutton Trust

from more deprived backgrounds in further education are likely to have a lower income at age 28 than their counterparts.

School exclusions have been rising since 2010 and a child from a disadvantaged background is three times as likely to be excluded from school[21]. Youth services have been cut and violent youth crime has been rising. The COVID-19 pandemic disrupted education and home-schooling exacerbated inequalities. One in eight young people in Cheshire and Warrington don't have access to a PC or laptop and 1 in 20 don't have access to suitable Wi-Fi. Many would not have had a quiet place to work or additional support from parents or carers[22]. Young people have lost vital social interaction with a mental health impact likely.

Several areas of Crewe have high levels of income deprivation affecting children[22].

Our primary schools perform well and achieve relatively good Ofsted results. Though some secondary schools perform well, Crewe has a lower proportion of secondary school places at good or outstanding schools as rated by Ofsted than Cheshire East overall. The Crewe and Nantwich constituency has Attainment 8 and Progress 8 scores that are lower than the England average, but this could be due to local deprivation as well as school quality. Over half (55%) of primary pupils in Crewe move to another area for secondary education, though schools and the College are working together to address this. Three Crewe secondary schools are now part of 'The Learning Alliance' (TLA) academy trust and are making strategic improvements to practice. Other primary focused academy trusts are also integrating their work to improve outcomes for younger pupils.

| | |
|---|---|
| Making a Difference for Disadvantaged Pupils | 11 Crewe primary and secondary schools joined the 2020/21 cohort to improve on high-quality teaching, targeted academic support and school-wide approaches and to develop and implement a Pupil Premium strategy fit for their setting. |
| Before and after schools' clubs | Local schools promote a range of initiatives including national tutoring programmes to secure better outcomes. Work needs to take place to evaluate the effectiveness of such initiatives and share best practice |
| **Support for health and those with special educational needs** | |
| SEND training | SEND Toolkit and evidence of impact of SEN training Offer. |
| SEND reviews | Several Crewe settings have already completed reviews of whole school practice to target improved outcomes for SEN learners |
| New SEN provisions | Planned new resource provision at Monks Coppenhall, Wistaston and Shavington High School. Enhanced mainstream provisions also available in local Crewe schools – e.g. Mablins Lane |
| Better Health – School Zone | Guidance on physical and mental health |
| **Increase aspirations and improve engagement at post-16** | |
| Post-16 education | Broad offer of apprenticeships, vocational qualification and A-levels can be tailored to student's abilities and aspirations e/g Cheshire College South and West; Crewe UTC |
| Inspiring the Future | Education and employers working together to build the skills needed for work. |
| **Reducing exclusions, offending and harm from substance misuse** | |
| Crewe Youth Zone | Zone to provide sports facilities, arts activities, café and social area for young people in and around Crewe. |
| CGL | Drug and alcohol services for young people |

We are building on Crewe's past to boost civic pride through education. Crewe Town Council's heritage officer has provided local history packs to support the curriculum in primary and secondary schools.

[22] Young People, Learning and Skills in Cheshire and Warrington – Presentation to Cheshire and Warrington LEP

Crewe has a popular and varied post-16 offer, though Crewe has rates of progression to higher education that are amongst the worst 20% in England[22]. This progression to higher education is negatively associated with deprivation nationally[21]. It is important that education and skills training help prepare people for success in their careers, and we can use the successful Cheshire and Warrington Institute of Technology bid to catalyse this[23].

"I used to let my kids go to the park quite happily. Wouldn't dream of letting my grandkids go now"

"Want youth clubs with more safeguarding against bullying and intimidation"

## Recommendations

| No. | Detail |
|---|---|
| 33 | To further implement a skills and employability initiative in Crewe coordinated through 'The Pledge' to help schools and colleges achieve the Gatsby Benchmarks |
| 34 | Review SEND toolkit and increase awareness in schools to support SEN children and develop a local response to the national SEND green paper[24]. Review uptake in training and compare to needs assessment requests to ensure schools with greatest need are benefitting from a bespoke training offer. |
| 35 | Review and clarify pathways for schools and colleges to access wellbeing and mental health support for pupils, students and staff through the DfE's Wellbeing in Education programme and associated initiatives. |
| 36 | Continue support for improving school attendance, specialist support for excluded or at risk of exclusion or being victims or perpetrators of crime including the development of a targeted Youth Support offer. |
| 37 | Develop training offer to ensure our young people can benefit from new employment opportunities in Crewe. Use Institute of Technology programme to catalyse change and ensure curriculum offer meets need and maximises the opportunity for young people to access employment. |
| 38 | Advocate for equitable funding for primary, secondary and post-16 education, at least in line with 2010 levels, and quality life-long learning opportunities across the social gradient. |
| 39 | Develop and promote role models via an alumni programme. |

[23] Cheshire and Warrington are winners in the £120m Institute of Technology Competition – Cheshire College – South & West (ccsw.ac.uk)

[24] Summary of the SEND review: right support, right place, right time - GOV.UK (www.gov.uk) SEND: special educational needs and disabilities

Halve the proportion of employees earning below the real living wage across Crewe within five years.

## Priority 5 – Improving working lives in Crewe

Mission 1

Mission 2

Intangible capital

Human capital

| Key aims | Improve access to good jobs and reduce in-work poverty | Reduce long-term unemployment | Ensure Crewe's residents benefit from new employment opportunities | Make it easier for people who are disadvantaged in the labour market to obtain and keep work |
|---|---|---|---|---|
| We will measure | Proportion of employed in permanent and non-permanent employment | Long-term unemployment rates | | Employment rate those with LD vs general<br>Those in contact with secondary MH services vs general |

### Background

Crewe remains an important centre for high-quality manufacturing and engineering, with Bentley, Whitby Morrison and Bombardier Transportation in the area.

While there are high level jobs in Crewe with many skilled workers, many live elsewhere and choose to commute to their workplace. There are important entry-level jobs but these do not always offer the opportunity to progress. Some lower-paid roles, like care work, are vital for society and we should improve pay and conditions to attract and retain staff.

"Opportunities [for asylum seekers] around learning and jobs are targeted at non-educated or low skilled, but we need opportunities relevant to our skills and experience"

### Current projects and services

| | |
|---|---|
| **Good jobs** | |
| Regeneration | The development and progression of Crewe into an accessible and thriving space for business and life. |
| Technology & Digital Innovation Campus | Campus within the centre of Crewe – attract new talent and keep young people within the Town. |
| Rail projects | HS2 will cement Crewe's place as a vital transport hub. Its rich railway history and excellent location makes it the right place for the headquarters of Great British Rail. |
| **Reduce unemployment** | |
| ESF Programmes | European Social Fund. To create employment opportunities and support local growth. E.g., Journey First – 12 months of support for those long-term unemployed to support education, training and work. |
| LEP (Local Enterprise Partnership) | Examining jobs, long-term unemployment, school engagement, strategic careers and enterprise. |

Workshop participants described many barriers to entering work and local services are not seen as sufficient to overcome them.

There is a perceived lack of English as a second language classes and frontline services report poor adult literacy amongst those in poverty and undiagnosed learning difficulties may be an issue for some.

"The bus isn't running when I finish some of my shifts"

| **Ensure Crewe's residents benefit** | |
|---|---|
| Apprenticeships | Numerous businesses/services offer apprenticeships to young people as a way to get them started in employment. |
| **Access for disadvantaged people** | |
| IPS (Individual Placement and Support)<br><br>CWP Access to Work scheme | Supporting people with severe mental ill health into work. |
| Supported Employment Services | Offering people with learning disabilities support to find and retain employment. |

COVID-19 has exacerbated inequalities. Those who were out of work are now further removed from world of work. Some benefitted from homeworking, but this was not an option in public facing roles or in routine and manual occupations, who have been more exposed to COVID-19[25]. Overall, those in more insecure employment (often women and those from minority ethnic groups) experienced the greatest fall in earnings over the course of the pandemic[26].

Many local businesses are small and medium-sized enterprises and have struggled during the pandemic and so are not taking on staff.

"Wage doesn't correlate with cost rises"

Whilst employment rates have risen over the previous decade, there has been an increase in poor quality or insecure work. Automation is leading to job losses, particularly for low-paid, part-time workers and the north of England will be particularly affected[27]. Though unemployment has fallen, pay has not kept pace with rising living costs[28].

"Minimum wage is too low, especially with bills, kids and the house to pay for"

Support to individuals and businesses during the COVID-19 pandemic is discussed in Appendix 2 - COVID-19 and Crewe.

Acorn analysis for Cheshire East Council (Figure 2), where income, social grade of work and employment for those resident in the six central Crewe wards was compared for the other wards in Cheshire East, shows that Crewe residents are more likely to be on a low income and much less likely to be on a high income, that they are more likely to be in routine and manual occupations and also more likely to be unemployed (Index of 100 is equal, 50 is half as likely, 200 is twice as likely).

[25] COVID-19 risk by occupation and workplace (publishing.service.gov.uk)
[26] Unequal impact? Coronavirus and the gendered economic impact - Women and Equalities Committee - House of Commons (parliament.uk)
[27] The rise of the robots could compound Britain's North/South divide – with 1 in 4 jobs at risk in cities outside the South | Centre for Cities
[28] UK Labour Market Statistics - House of Commons Library (parliament.uk)

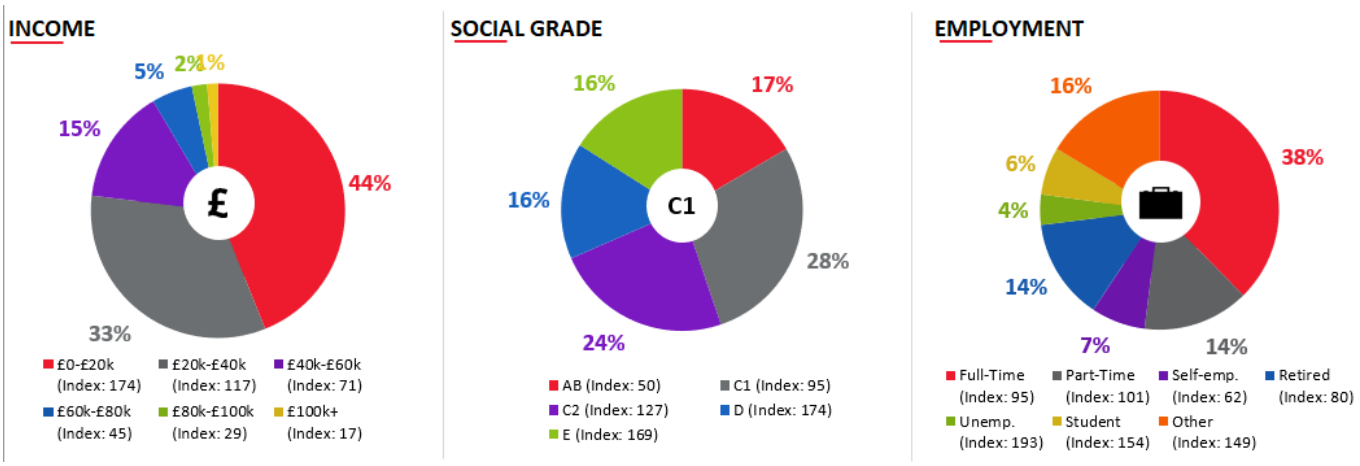


*Figure 2 - Six central Crewe wards compared to all other wards in Cheshire East*

Existing regeneration developments completed or in progress will deliver a small number of new jobs. More opportunities will be available in construction of major projects and the new infrastructure, and a more attractive, thriving and prosperous town will encourage more employers to invest in the area. Local partners collaborated on an excellent bid for Crewe to host the headquarters of Great British Rail in 2022.

## Recommendations

| No. | Detail |
|---|---|
| 40 | Focus on improving employees' mental health and adapt jobs to make them suitable for those facing barriers to employment. |
| 41 | Procure and commission locally so that spending and investment benefits Crewe. |
| 42 | Work with partner organisations across Cheshire and Warrington to support good quality employment in the subregion |
| 43 | Upskill local people to take advantage of regeneration and HS2 and work with incoming investors to ensure that job opportunities are promoted locally. |
| 44 | Work with LEP and local partners to tackle the long-term unemployment which has been exacerbated by COVID.<br><br>Examine replacement models such as ESF Journey First working alongside the Job Centre to match young people to appropriate jobs. |
| 45 | Work with partners such as Citizens Advice to ensure adequate legal advice and support for those with issues around work. Advocate for reduced conditionalities and sanctions in benefit entitlement, particularly for those with children. |
| 46 | Support Lyceum powerhouse development to provide career connections. Develop skills, co-create local activities and events (mentoring and skills development). Amplify opportunities for local residents to take up jobs in culture. |
| 47 | Create an innovation centre - TADIC (Technology and Digital Innovation Centre) to support (incubate) start-ups and small businesses. |

| |
|---|
| Increase the proportion of physically active adults in Crewe by 50% within ten years. |
| Halve the gap in avoidable mortality rates between Crewe and Cheshire East's best performing wards within ten years. |

## Priority 6 – Preventing ill health in Crewe

| | | | | |
|---|---|---|---|---|
| Key aims | Increase participation in sport and physical activity | Assess and tackle causes of avoidable mortality | Reduce inequalities in care access | Prioritise prevention and early intervention in healthcare |
| We will measure | Percentage of physically active and inactive adults | Avoidable mortality (preventable or amenable to healthcare) by ward | | Uptake of influenza and pneumococcal vaccinations<br>Cancer screening rates<br>NHS Health Checks |

We come to prevention and treatment services at the end of the report intentionally. "The NHS we all value and rely on was never meant to go it alone. It was supposed to be part of a wider system supporting people from cradle to grave; with decent jobs, pay, homes and education. To make sure the NHS can keep helping us in the way it was intended to, we need a broader system of support that can help all of us to thrive."[29]

However, many causes of illness and poor wellbeing can be modified through public health programmes or by proactive and preventative care in health services. We know that the environment shapes people's choices and behaviours but there is an awareness amongst Crewe's residents of the role lifestyle plays in health.

"Good health is a lifestyle choice"[33]

Mission 8 of the Levelling Up paper references improved wellbeing. Moving beyond physical health to a more holistic concept of health and wellbeing, we should consider the Five Ways to Wellbeing in our work[30]:

1. Activity – physical and mental improvement due to increased exercise
2. Connectivity – a sense of belonging and purpose
3. Mindfulness – sensory experiences, reduced stress, better mental health
4. Education and learning – health literacy, awareness and increased ownership, new skills
5. Giving back to the community – increased participation and enjoyment

[29] How to talk about the building blocks of health - The Health Foundation
[30] 5 steps to mental wellbeing - NHS (www.nhs.uk)

GPs in the centre of Crewe are seeing patients with multiple health issues, complex social issues, communication difficulties and people who may not have English as their first language. Nationally, practices in more deprived areas have less funding per patient once the increased need is adjusted for[31].

"I would like to say that my GP practice has been amazing. I've had long term problems with a shoulder injury and have been very well looked after, being referred for physiotherapy and the musculoskeletal service and eventually surgery[33]."

COVID-19 led to delayed access to non-urgent healthcare, with those who were poorer or had existing health conditions most affected[32]. According to Healthwatch research in Cheshire East, many in Crewe struggled to access face-to-face GP appointments. Telephone and virtual appointments were accessible and convenient for some, but there is a definite perception that in-person appointments are missing and would be valued. However, others praised the work of GP surgeries, pharmacies, hospitals and care homes during the incredibly difficult and disruptive period[33].

"We want GPs to be seeing people[33]"

Further information on the effects of, and response to, COVID-19 can be found in Appendix 2 - COVID-19 and Crewe.

## Current projects and services

| **Health improvement and community services** | |
|---|---|
| One You Cheshire East | Supports residents to eat well, move more and be smoke free. They also have family wellbeing programmes and falls prevention classes for older residents. |
| Community Pantry | Free fruit and vegetables available – encourage healthier lifestyle. Members can also receive support on a variety of issues including mental wellbeing. |
| Reading Well | Book collections within libraries to support a variety of physical and mental health conditions. |
| Bikeability | Courses ran within schools teaching children bike safety. There are also more inclusive courses for those with mobility issues. All run by Everybody Leisure. Further courses will be available to encourage active travel with improved town infrastructure too – making it safer and more accessible to bike and walk. |
| Saturday Kitchen | Support for the Homeless Community within Crewe. Food and essentials are available as well as access to services. Further developments to include a dental service. |
| Water Fluoridation | Fluoride added to the water to improve dental health. |
| Social Prescribing | Accessible from most GP surgeries the social prescriber deals with the wider determinants of health and will support patients who are struggling with debt, loneliness and social isolation as well as those looking to improve health through weight loss and exercise. |
| Crewe Lifestyle Centre | A hub within the centre of Crewe to encourage good physical and mental wellbeing through various activities and areas including a gym and pool. A library and café/social space is also located here. |

[31] Level or not? - The Health Foundation
[32] COVID-19 and disruptions to the health and social care of older people in England - Institute For Fiscal Studies - IFS
[33] Crewe-Healthwatch-Across-Cheshire-Report-Sep-Nov-2021.pdf (healthwatchcheshireeast.org.uk)

| | |
|---|---|
| Walking for Health | Walks delivered in the local area. Organised by the Canals & Rivers Trust and Everybody Leisure and Wishing Well. |
| Mental Health Support/Suicide Prevention | Crisis cafés, IAPT service and tailored Mental Health support for Men within Crewe (Twelfth Man Project). Suicide Prevention training offered via Cheshire East Council Health Improvement Team for any frontline service including more recently schools.<br><br>CHAMPs suicide prevention board and specific services like 24/7 SHOUT and AMPARO |
| **Prevention in health and care services** | |
| Crewe Care Community | A closer look at ill-health prevention through the encouragement of patient self-care. Raising awareness of key conditions such as high blood pressure. Re-development of Patient Participation Groups within Crewe. |
| CURE Project (Leighton Hospital) | Smoking Cessation therapy offered to inpatients who smoke – prescribing the correct Pharmacotherapy and encouraging abstinence whilst in hospital and upon discharge. |
| NHS Transformation | A new integrated, place-based system for care. |
| NHS Health Checks | Offered to residents who are 40 to 74 with no known heart disease. A physical health assessment delivered by the GP surgery with a view to detecting health issues – such as high cholesterol – early. |
| MECC (Making Every Contact Count) | Training of front-line staff to encourage lifestyle change and refer residents to appropriate services. |

## Recommendations

| No. | Detail |
|---|---|
| 48 | Implement evidence-based programmes of ill-health preventive interventions that are effective across the social gradient, e.g., focussing on alcohol reduction and obesity programmes across the social gradient, and taking forward the recommendations in the Khan Review to make smoking obsolete[34]. |
| 49 | Establish governance for place-based prevention; build on the localities model and localities JSNA. Ensure primary prevention (tackling risk factors before a disease occurs) is a priority for the Crewe Care Partnership. |
| 50 | Primary Care Services to be reviewed and made more easily accessible within the most deprived areas of Crewe. |
| 51 | Undertake "deep-dive" on Crewe as part of the JSNA process, this will identify key priority areas for ill health prevention. |

[34] Making smoking obsolete: summary - GOV.UK (www.gov.uk)

| | |
|---|---|
| 52 | Provide MECC training[35] for all frontline services and ensure that culture, leadership and systems are in place to make the interactions meaningful and effective. |
| 53 | Support GP practices to become Active Practices using the Active Practice Charter. |
| 54 | Focus core efforts of public health departments, and wider commissioned programmes, on interventions to improve the determinants of health. |
| 55 | Advocate for increased healthcare funding to deprived areas, especially in primary care. |
| 56 | Create neighbourhood hubs to keep care accessible and local. |

[35] Training in MECC (makingeverycontactcount.co.uk)

# Appendix 1 – About this report

This report was developed by a subgroup of the Cheshire East Increasing Equalities Commission. It was led by Dr Matthew Atkinson (Specialty Registrar in Public Health at Cheshire East Council) with project support provided by Rebecca Jackson.

The report sections were originally taken from the "Marmot Report", but these were later adapted to a Crewe context with a greater emphasis on the environment and communities. These changes reflect the importance of place for health and the opportunities we have through the regeneration of Crewe Town Centre.

Workshops were held for each of the six main sections of the report. For each section, one or more co-authors were identified. Their contributions were invaluable in providing key reports and references, sense-checking recommendations and ensuring alignment with other workstreams.

In the report we use data and narrative to create a sense of urgency, engage subject matter experts and the IEC to build a coalition and create and communicate a vision for a Health in All Policies approach.

## Workshops method

Across the 6 workshops we have had 67 individual delegates, many of whom attended multiple workshops.

Attendees were invited based on the following criteria:

- Membership of the Increasing Equalities Commission
- All members of Cheshire East Public Health Team
- Third sector Organisations who operate within the Crewe area
- Individual's job role and its purpose in relation to each workshop
- Membership of Crewe Town Council
- Membership of South Cheshire Chamber of Commerce

(*See appendix for details of organisations and Cheshire East Council Teams)*

These individuals were identified via the following methods:

- Cheshire East phonebook
- Research into Crewe and active community groups within the area
- Requests to other invitees to pass invitations on to any relevant colleagues

Individuals were invited via email and provided with an overview of the IEC and the themes of the workshop in question.

Workshops were started with an introduction and presentation from Matthew Atkinson (Public Health Senior Trainee), around the current situation within Crewe and included an overview of the work of the Marmot Community.

Following on from the initial presentation the group was split into 2 breakout rooms. This was completed manually to ensure a good mix of individuals, organisations, and job roles.

Within the first breakout room, the group were asked to consider the following:

- What is happening now?
- What's planned?
- What are the opportunities?
- What are the threats?

After approximately 15 minutes, the group reconvened in the main room and fed back results from discussion.

A short presentation followed, after which the theme for the second breakout room was given prior to going back into the same group as previously.

The group were asked to now consider:

- Are we meeting the needs?
- What are the gaps
- Who needs to be involved?
- What do we wish to be different at a national level?
- What do we wish we could do locally?

Again, the breakout rooms were used for approximately 15 mins, before reconvening and feeding back findings to the wider group.

The chat from both rooms, and Facilitator notes, were captured and saved.

## External organisations represented at workshops

Central Cheshire Integrated Care Partnership
Central Cheshire Integrated Care Partnership: Cheshire and Wirral Partnership NHS Foundation Trust (cwp.nhs.uk)

Healthwatch
Cheshire East
Home - Healthwatch Cheshire East

Chance Changing Lives
11-13 Coronation Crescent
Crewe
CW1 4EJ
Chance Changing Lives | Homeless Charity | Social Supermarket Crewe

MotherWell Cheshire CIC
156 Nantwich Road
Crewe
CW6 6BG
Motherwell CIC

Cheshire Halton & Warrington Race & Equality Centre
17 Cuppin Street
Chester
CH1 2BN
Cheshire Halton & Warrington Race & Equality Centre (chawrec.org.uk)

South Cheshire Chamber of Commerce
Couzens Building, Manchester Metropolitan University, Crewe Green Road, Crewe CW1 5DU
South Cheshire Chamber of Commerce | SCCCI Community

Child Health Hub
Oak Tree Children's Centre
Newcastle Street
Crewe
CW1 3LF
Oak Tree Children's Centre (cheshireeast.gov.uk)

Standguide Ltd
Cecil House
Samuel Street
Hightown
Crewe
Cheshire
CW1 3BZ
Homepage - Standguide Group

Crewe Town Board
Meet the board - We Are All Crewe

Crewe Town Council
1 Chantry Court
Forge Street
Crewe
CW1 2DL
Crewe Town Council

CVS Crewe
1A Gatefield Street
Crewe
CW1 2JP
CVS Cheshire East | Supporting Voluntary, Community and Faith Organisations across Cheshire East (cvsce.org.uk)

Everybody Sport & Leisure
Moss Square
Crewe
CW1 2BB
Crewe Lifestyle Centre - Everybody Sport & Recreation

Wishing Well Project
156 Nantwich Road
Crewe
CW2 6BG
Home - Wishing Well Project

# Appendix 2 - COVID-19 and Crewe

> "People living in more socio-economically disadvantaged neighbourhoods and minority ethnic groups have higher rates of almost all of the known underlying clinical risk factors that increase the severity and mortality of COVID-19, including hypertension, diabetes, asthma, chronic obstructive pulmonary disease (COPD), heart disease, liver disease, renal disease, cancer, cardiovascular disease, obesity and smoking[36]."

COVID-19 revealed and exacerbated inequalities. Our multi-agency approach sought to mitigate the harms to the most vulnerable groups and support businesses, and we have learned many lessons which will be useful in future situations.

Cheshire East recorded a high number of cases, with 1,825 daily cases being recorded at the most recent peak in January 2022[37]. The pandemic has had widespread impacts on Crewe's residents beyond the direct effects of the disease. Mental health has deteriorated, with increased loneliness and social isolation. Financial hardship has led to worry about the ability to support a family and the Council has worked hard to minimise the economic hit experienced. More than a quarter of our COVID-19 main and discretionary support payments since September 2020 have been to Crewe's residents.

> "COVID is being used as an excuse, when things around Crewe were bad beforehand"

## Supporting vaccination uptake:

Some areas of Crewe have the lowest vaccination rates across Cheshire East, with one of the lowest uptakes being in our Eastern European migrant communities. These communities were testing and getting vaccinated at a much lower rate compared to the rest of the Cheshire East population. This therefore puts these communities at a greater risk of contracting and transmitting COVID-19.

Local partners recognised the need for fixed clinics at GP practices, pharmacies, and mass vaccination centres. However, we quickly learnt that we needed a hyperlocal approach in our more hard-to-reach communities.

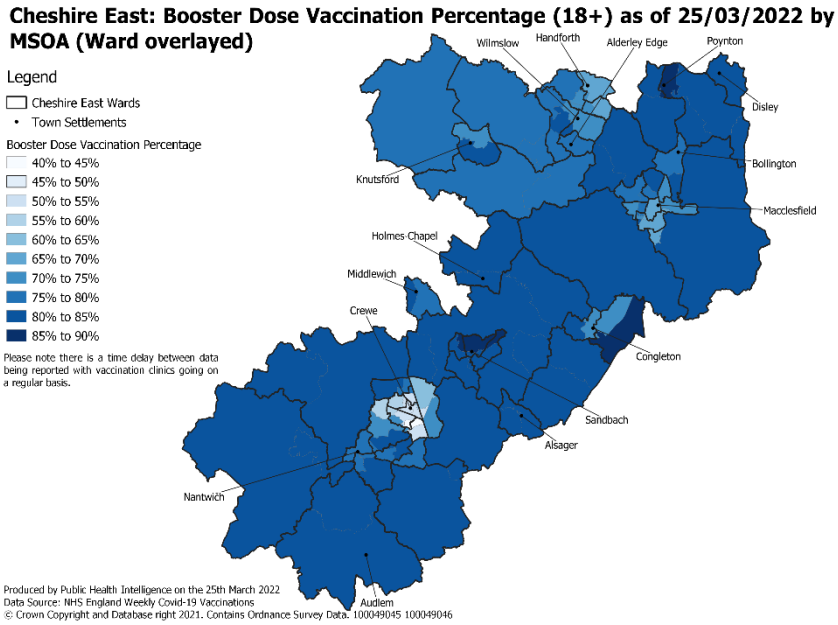


*Figure 3 - COVID-19 booster vaccination coverage for Cheshire East (lighter areas in Crewe show poorer uptake of vaccination)*

This approach included:

- Engaging with Voluntary Faith Sector Organisations and key local messengers to help encourage uptake.
- Local clinics in accessible locations and a vaccination bus as well as clinics in hotels housing refugees.
- We have worked closely with employers who have Eastern European employees to encourage uptake.
- Plans in development for other communities such as the Gypsy, Roma and Traveller, and boating communities.

[36] Health inequalities: Deprivation and poverty and COVID-19 | Local Government Association
[37] Cases in Cheshire East | Coronavirus in the UK (data.gov.uk)

## COVID-19 and Schools

Crewe childcare and education settings have reported over 3000 cases of COVID-19, more than 1 in 7 of the cases reported across the whole of Cheshire East. The COVID team gave expert advice when outbreaks and situations occurred and proactively engaged settings with higher numbers of reported cases.

## COVID-19 and Businesses:

COVID-19 restrictions had huge impacts on the business community. Requirements were often complex and, in some cases made opening unviable. Crewe's businesses adapted where they could, with hospitality businesses increasing takeaway offers and others moving to online business models.

Cheshire East gave plainly written translations of legislative changes, and businesses were contacted directly, when necessary, backed up by online information and a single point of contact for queries. Working with the Public Health team made it possible to offer onsite testing opportunities and links to vaccination to a number of businesses and these relationships have been maintained beyond the lifting of restrictions.

The pandemic has been particularly tough for small and medium-sized employers who might not have wider organisational support or the financial resilience to cope with huge disruptions to their operations. Over the past two years Cheshire East Council co-ordinated support to many local businesses by distributing 36,924 payments totalling over £166.5m through a number of different grant schemes. More than a quarter of this total went to businesses in Crewe, and this has helped businesses survive through the pandemic, to reopen safely and support growth.

## Lessons learnt:

- Understand local people and stakeholders to find key partners and credible messengers
- Generic communications will largely only be effective for the 'engaged majority', and while this is a large and important group, targeted engagement will be more effective for engaging minority groups.
- The Communities' team play an essential role in developing a hyperlocal approach that engages all groups.
- Go where the people are to make services convenient and accessible. Take opportunities to address wider health and wellbeing issues.
- Maintain and strengthen new relationships between Council teams, businesses, services and other settings. We can leverage these to address a wide range of health and wellbeing issues in the future.
- We must consider different ethnicities and languages, as well as considering the cultures in other countries. For example, Eastern European Migrants were more heavily informed and engaged by the media from their own countries than that in the UK.
- The Council is not always the most appropriate messenger, particularly in relation to young people. Work closely with young people and let them influence each other and others such as families and older persons.
- While the Youth Support Service offered online and phone support, detached teams were out weekly to ensure young people who were on the streets were informed and supported. Joint work was undertaken with the police to support the dispersal of groups of young people. This visible presence is vital.
- We must build resilience in Crewe to effectively respond to disruptive events.
- We must be solution focused and not problem focused. A slight shift in mentality makes a huge difference practically

"The pandemic has revealed stark differences in the health of the working age population – those younger than 65 in the poorest 10% of areas in England were almost four times more likely to die from COVID-19 than those in the wealthiest. Recovery needs to prioritise creating opportunities for good health – a vital asset needed to 'level up' and rebuild the UK economy[38]."

[38] Unequal pandemic, fairer recovery - The Health Foundation

# Appendix 3 – Engagement with Crewe residents 2022

Cheshire East Council's Communities Team led a programme of engagement in Spring 2022. Many thanks to the Swab Squad who were out meeting more than 100 people in Crewe to gather the experiences of residents. The team also reviewed relevant consultation and engagement exercises for other projects. Of those engaged specifically for this strategy:

## Gender

45% were female

55% were male

## Age

Approximately 60 children were engaged with as part of the Crewe Pocket Parks project which feeds into the green spaces section

26% were aged 20-39

38% were aged 40-59

36% were aged 60+

## Ethnicity

19% were from ethnic minority groups

81% were white

Healthcare related quotations may reference a separate piece of community engagement undertaken by Healthwatch Cheshire East – these are indicated by numbered footnotes[39].

[39] Our Reports - Healthwatch Cheshire East

## Appendix 4 – Levelling Up the United Kingdom – 12 Missions and 6 Capitals[40]

| **12 Missions** | |
|---|---|
| Mission 1 | By 2030, pay, employment and productivity will have risen in every area of the UK, with each containing a globally competitive city, with the gap between the top performing and other areas closing. |
| Mission 2 | By 2030, domestic public investment in R&D outside the Greater South East will increase by at least 40%, and over the Spending Review period by at least one third. This additional government funding will seek to leverage at least twice as much private sector investment over the long term to stimulate innovation and productivity growth. |
| Mission 3 | By 2030, local public transport connectivity across the country will be significantly closer to the standards of London, with improved services, simpler fares and integrated ticketing. |
| Mission 4 | By 2030, the UK will have nationwide gigabit-capable broadband and 4G coverage, with 5G coverage for the majority of the population. |
| Mission 5 | By 2030, the number of primary school children achieving the expected standard in reading, writing and maths will have significantly increased. In England, this will mean 90% of children will achieve the expected standard, and the percentage of children meeting the expected standard in the worst performing areas will have increased by over a third. |
| Mission 6 | By 2030, the number of people successfully completing high-quality skills training will have significantly increased in every area of the UK. In England, this will lead to 200,000 more people successfully completing high-quality skills training annually, driven by 80,000 more people completing courses in the lowest-skilled areas. |
| Mission 7 | By 2030, the gap in Healthy Life Expectancy (HLE) between local areas where it is highest and lowest will have narrowed, and by 2035 HLE will rise by five years. |
| Mission 8 | By 2030, well-being will have improved in every area of the UK, with the gap between top performing and other areas closing. |
| Mission 9 | By 2030, pride in place, such as people's satisfaction with their town centre and engagement in local culture and community, will have risen in every area of the UK, with the gap between top performing and other areas closing. |
| Mission 10 | By 2030, renters will have a secure path to ownership with the number of first-time buyers increasing in all areas; and the government's ambition is for the number of non-decent rented homes to have fallen by 50%, with the biggest improvements in the lowest-performing areas. |
| Mission 11 | By 2030, homicide, serious violence and neighbourhood crime will have fallen, focused on the worst-affected areas. |
| Mission 12 | By 2030, every part of England that wants one will have a devolution deal with powers at or approaching the highest level of devolution and a simplified, long-term funding settlement. |
| **6 Capitals** | |
| Physical | Buildings (including housing), machinery, equipment |
| Intangible | Software, databases, R&D, branding, art, training |

[40] Levelling Up the United Kingdom: missions and metrics Technical Annex (publishing.service.gov.uk)

| | |
|---|---|
| Human | Knowledge, skills, competencies |
| Financial | Loans and financial mechanisms needed to fund activity |
| Social | Personal relationships, social network support, civic engagement, trust and co-operative norms |
| Institutional | Leadership and local governance, autonomy, relationships between organisations |

# Appendix 5 – Proposed indicators in Cheshire and Merseyside Marmot Community

| Life expectancy | | Frequency | Level | Disagg. | Source |
|---|---|---|---|---|---|
| 1 | Life expectancy, female, male | Yearly | LSOA | IMD | ONS |
| 2 | Healthy life expectancy, female, male | Yearly | LA | IMD | ONS |
| **Give every child the best start in life** | | | | | |
| 3 | Percentage of children achieving a good level of development at 2-2.5 years (in all five areas of development)* | Yearly | LA | NA | DfE |
| 4 | Percentage of children achieving a good level of development at the end of Early Years Foundation Stage (Reception) | Yearly | LA | FSM status | DfE |
| **Enable all children, young people and adults to maximise their capabilities and have control over their lives** | | | | | |
| 5 | Average Progress 8 score** | Yearly | LA | FSM status | DfE |
| 6 | Average Attainment 8 score** | Yearly | LA | FSM status | DfE |
| 7 | Hospital admissions as a result of self-harm (15-19 years) | Yearly | LA | NA | Fingertips, OHID |
| 8 | NEETS (18 to 24 years) | Yearly | LA | NA | ONS |
| 9 | Pupils who go on to achieve a level 2 qualification at 19 | Yearly | LA | FSM status | DfE |
| **Create fair employment and good work for all** | | | | | |
| 10 | Percentage unemployed (aged 16-64 years) | Yearly | LSOA | NA | LFS |
| 11 | Proportion of employed in permanent and non-permanent employment | Yearly | LA | NA | LFS |
| 12 | Percentage of employees who are local (FTE) employed on contract for one year or the whole duration of the contract, whichever is shorter*** | - | - | - | NHS, local government |
| 13 | Percentage of employees earning below real living wage | Yearly | LA | NA | ONS |
| **Ensure a healthy standard of living for all** | | | | | |
| 14 | Proportion of children in workless households | Yearly | LA | NA | ONS |
| 15 | Percentage of individuals in absolute poverty, after housing costs | Yearly | LA | NA | DWP |
| 16 | Percentage of households in fuel poverty | Yearly | LA | NA | Fingertips OHID |
| **Create and develop healthy and sustainable places and communities** | | | | | |
| 17 | Households in temporary accommodation**** | Yearly | LA | NA | MHCLG / DLUHC |
| **Strengthen the role and impact of ill health prevention** | | | | | |
| 18 | Activity levels | Yearly | LA | IMD | Active lives survey |
| 19 | Percentage of loneliness | Yearly | LA | IMD | Active lives survey |
| **Tackle racism, discrimination and their outcomes** | | | | | |
| 20 | Percentage of employees who are from ethnic minority background and band/level*** | - | - | - | NHS, local government |
| **Pursue environmental sustainability and health equity together** | | | | | |
| 21 | Percentage (£) spent in local supply chain through contracts*** | - | - | - | NHS, local government |
| 22 | Cycling or walking for travel (3 to 5 times per week)- | Yearly | LA | IMD | Active lives survey |

[41]

[41] https://www.instituteofhealthequity.org/resources-reports/all-together-fairer-health-equity-and-the-social-determinants-of-health-in-cheshire-and-merseyside

## Appendix 6 – The determinants of health and wellbeing in our neighbourhoods

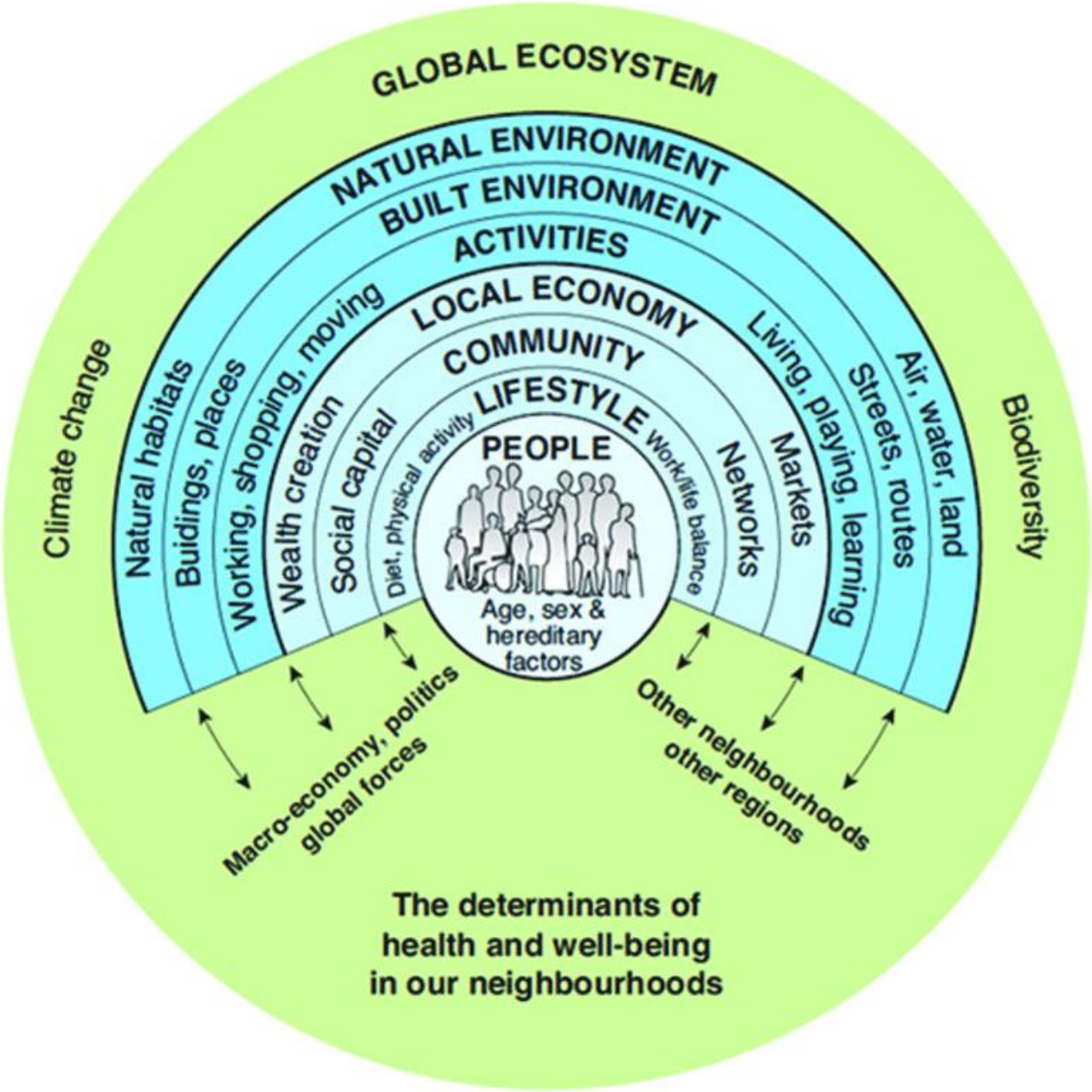


*Figure 4 - Neighbourhood determinants of health and well-being*[42]

## Appendix 7 – "Tartan Rug" – Health profiles for electoral wards 2021[43]

See final page

[42] Spatial Planning for Health: an evidence resource for planning and designing healthier places (publishing.service.gov.uk)
[43] https://www.cheshireeast.gov.uk/pdf/jsna/ward-profile-tartan-rug/tartan-rug-cec.pdf

# Health Profiles for Electoral Wards plus Primary Health and Social Care Areas February 2021

The chart below shows how the health of people in Cheshire East compares with the rest of England.

| | | | | Nantwich | | | | | Crewe | | | | | | | | | | | SMASH | | | | | | | | | Congleton | | | Knutsford | | | Wilmslow | | | | | | | | Macclesfield | | | | | | | | | Poynton | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Data Type | Time Period | Wrenbury | Bunbury | Audlem | Nantwich South and Stapeley | Nantwich North and West | Wybunbury | Shavington | Willaston and Rope | Wistaston | Crewe South | Crewe West | Crewe Central | Crewe St Barnabas | Crewe North | Crewe East | Leighton | Haslington | Sandbach Ettiley Heath and Wheelock | Sandbach Elworth | Sandbach Town | Sandbach Heath and East | Middlewich | Brereton Rural | Alsager | Odd Rode | Congleton West | Congleton East | Dane Valley | Knutsford | High Legh | Mobberley | Chelford | Wilmslow West and Chorley | Wilmslow Lacey Green | Handforth | Wilmslow Dean Row | Wilmslow East | Alderley Edge | Prestbury | Gawsworth | Sutton | Broken Cross and Upton | Macclesfield West and Ivy | Macclesfield South | Macclesfield Central | Macclesfield East | Macclesfield Hurdsfield | Macclesfield Tytherington | Bollington | Poynton West and Adlington | Poynton East and Pott Shrigley | Disley | Cheshire East | England | |
| 1 | Total Population | Number | Mid 2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 2 | BME Population | % | 2011 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Population |
| 3 | Proficiency in English | % | 2011 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 4 | Population under 16 | % | Mid 2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 5 | Population aged 65 and over | % | Mid 2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 6 | Pensioners living alone | % | 2011 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 7 | Older people with low income | % | 2015 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Income |
| 8 | People with low income | % | 2015 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 9 | Children in poverty | % | 2015 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 10 | Long term unemployment | Rate | 2017/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 11 | Fertility rate | Rate | 2011-2015 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 12 | Low birth weight | % | 2011-2015 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Young People |
| 13 | Deliveries to teenage mothers | % | 2011/12-2015/16 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 14 | A&E attendances age 0-4 | Rate | 2013/14-2015/16 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 15 | Admissions for injury age 0-4 | Rate | 2011/12-2015/16 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 16 | Emergency admissions age 0-4 | Rate | 2013/14-2015/16 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 17 | Child development at age 5 | % | 2013/14 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 18 | GCSE achievement | % | 2013/14 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 19 | Excess weight age 4-5 | % | 2015/16-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 20 | Excess weight 10-11 | % | 2015/16-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 21 | Smokers age 11-15 | % | 2009-2012 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 22 | Smokers age 16-17 | % | 2009-2012 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Lifestyle |
| 23 | Healthy Eating (adults) | % | 2006-2008 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 24 | Obese adults | % | 2006-2008 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 25 | Binge drinkings (adults) | % | 2006-2008 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 26 | Admissions for alcohol | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 27 | Self-reported bad health | % | 2011 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 28 | Self-reported illness | % | 2011 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 29 | Hospital stays for self-harm | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 30 | Emergency admissions heart attack | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 31 | Emergency admissions stroke | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Illness |
| 32 | Emergency admissions respiratory | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 33 | Emergency admissions hip fracture | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 34 | Emergency admissions all causes | SAR | 2013/14-17/18 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 35 | New cases - breast cancer | SIR | 2012-2016 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 36 | New cases - bowel cancer | SIR | 2012-2016 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 37 | New cases - lung cancer | SIR | 2012-2016 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Cancer |
| 38 | New cases - prostate cancer | SIR | 2012-2016 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 39 | All new cases cancer | SIR | 2012-2016 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 40 | Cancer deaths under 75 | SMR | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 41 | Heart deaths under 75 | SMR | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 42 | All deaths under 75 | SMR | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 43 | Deaths from respiratory diseases | SMR | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 44 | All deaths all ages | SMR | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |
| 45 | Female life expectancy | Years | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | Death |
| 46 | Male life expectancy | Years | 2013-2017 | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | [illegible] | |

Quintile 1 - Highest 20% of wards nationally

Quintile 2

Quintile 3

Quintile 4

Quintile 5 - Lowest 20% of wards nationally

Data suppressed to prevent disclosure

Shades of blue used when an indicator has no preferred polarity, i.e. when it is not appropriate to say whether a high/low value is good or bad.

**Indicator Notes:** Data extracted during March 2020 and up to date as of February 2021.

[illegible]

More information and full metadata available [illegible]

**Abbreviations**

SMASH = Sandbach, Middlewich, Alsager, Scholar Green, Haslington

SAR = Standardised Admissions Ratio

SIR = Standardised Incidence Ratio

SMR = Standardised Mortality Ratio

Ratios are calculated by dividing the observed total number of admissions, new cases or deaths in the area by the expected number and multiplying by 100. Expected numbers are calculated by applying age-sex specific rates for England in the same time period to each area's population.

Prepared by Cheshire East Public Health Intelligence, [illegible] February 2021

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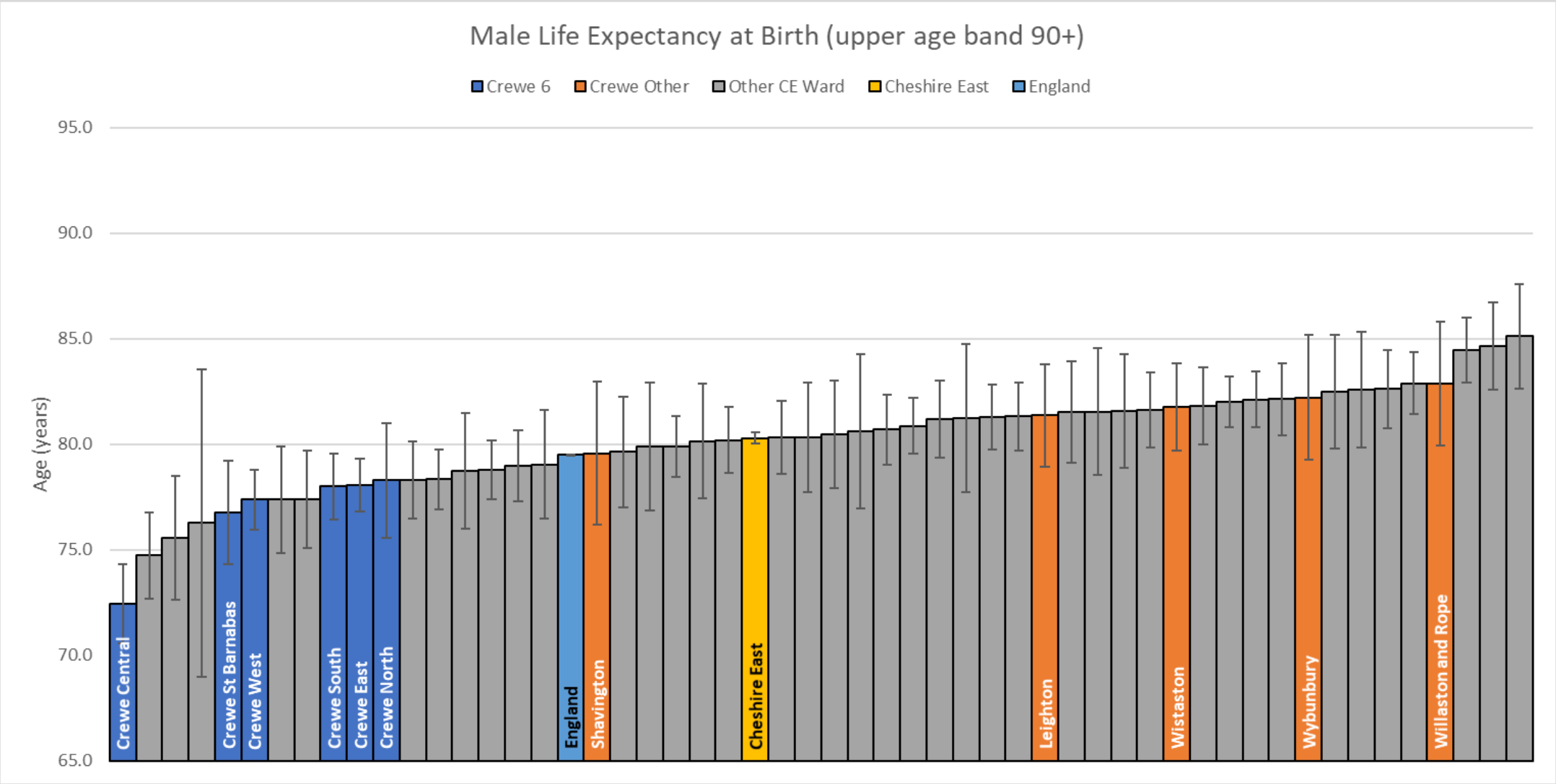
Cheshire East Partnership

# Avoidable deaths




See Life expectancy commentary in subsequent slides

Data source: 2016-2020 Male Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles.

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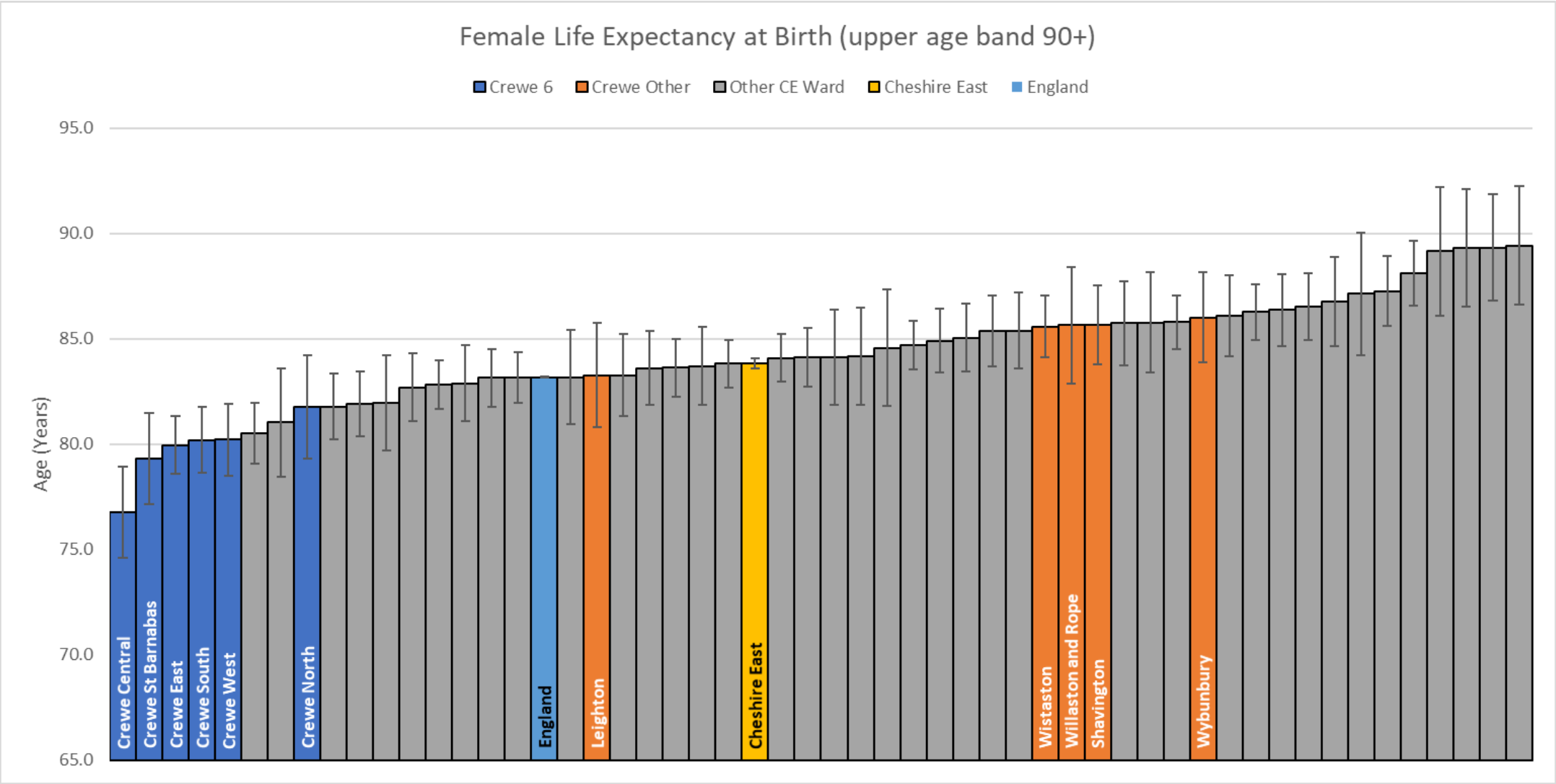


See Life expectancy commentary in subsequent slides

Data source: 2016-2020 Female Life Expectancy at Birth (90+) Office for Health Improvement & Disparities. Public Health Profiles.

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# Avoidable deaths and illnesses

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This project will examine cause of death data for **premature deaths (under 75)** to see which are coded as **avoidable**.

These avoidable deaths are categorised as:

- **Preventable** – could be avoided through effective public health and prevention OR
- **Treatable** (previously known as amenable) – could be avoided through timely and effective healthcare interventions

# Avoidable deaths example, Crewe CC

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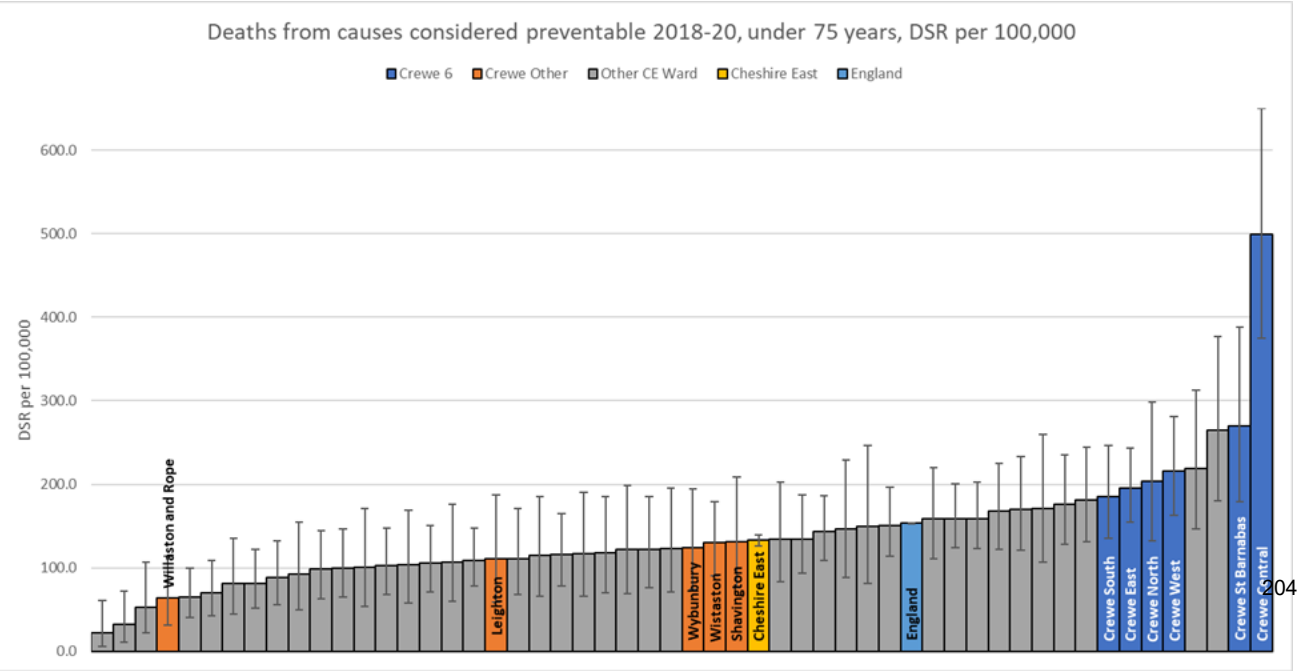
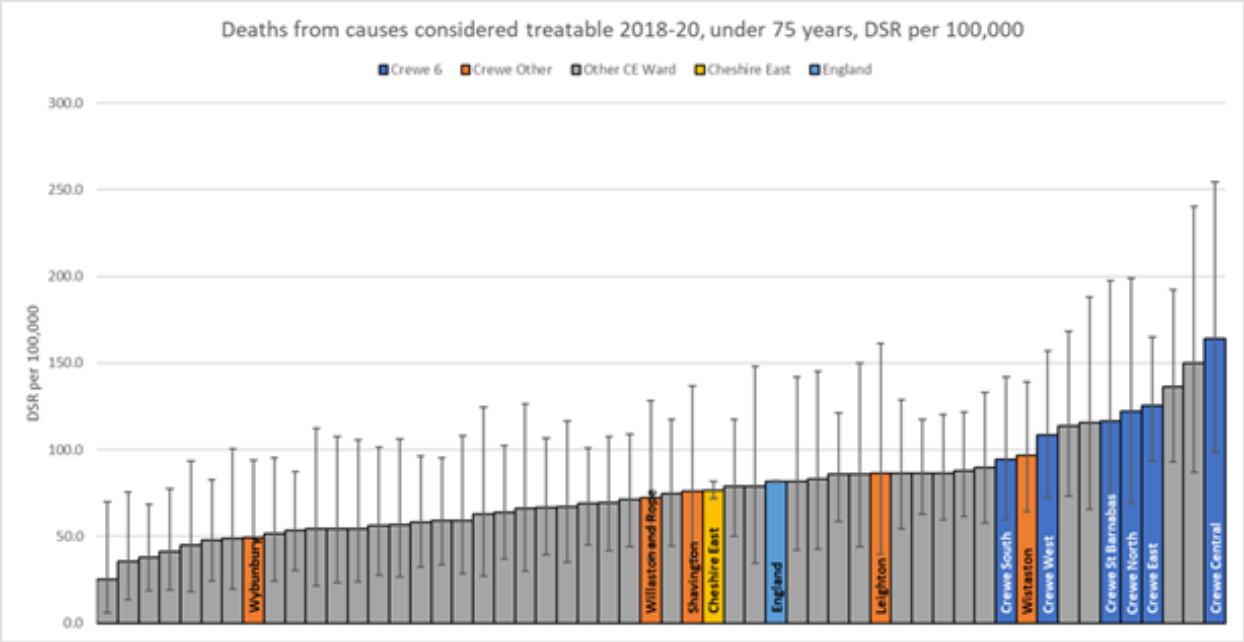
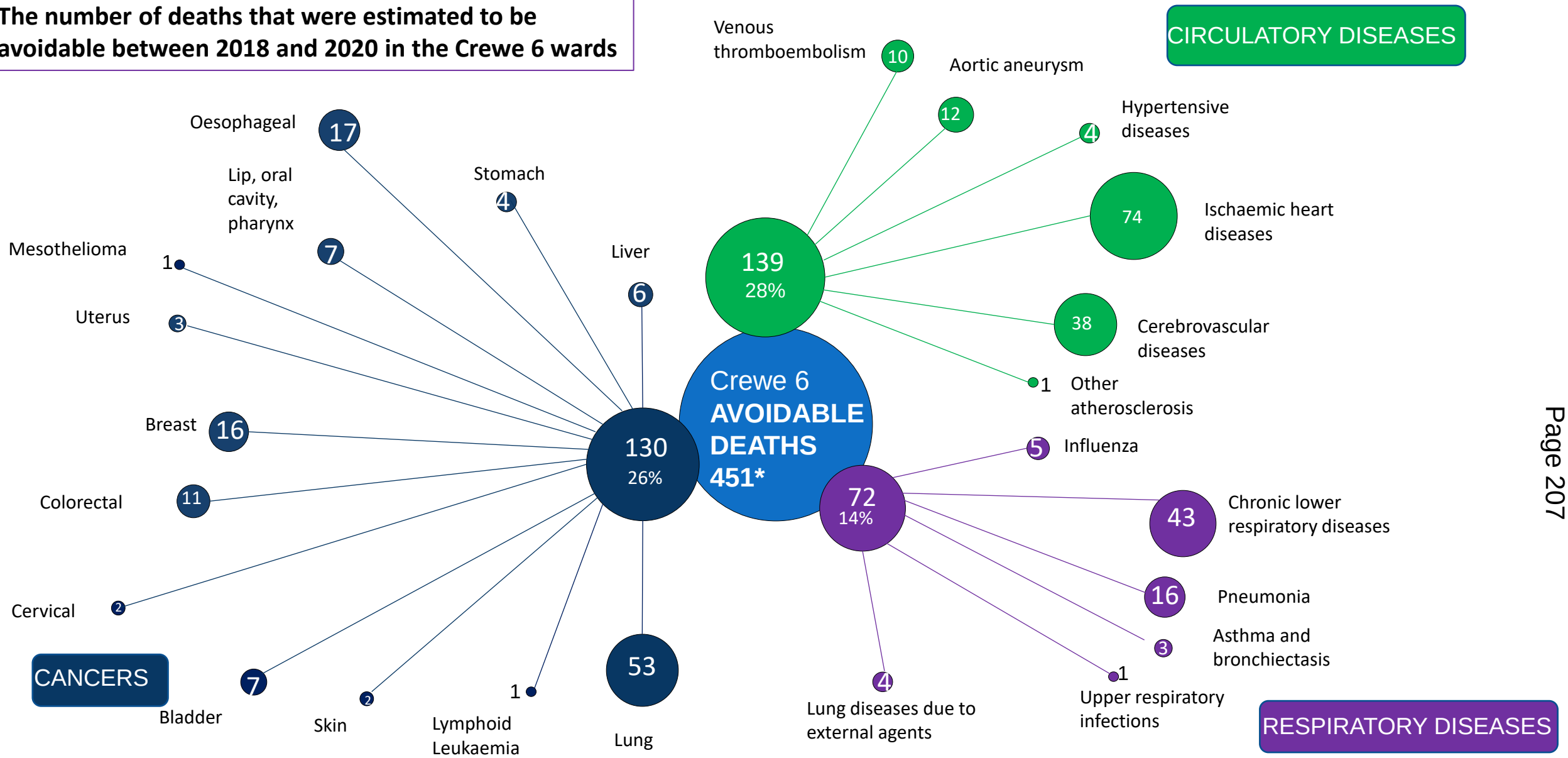
- Over three years (2018-20) there were **451 avoidable deaths** (3/4 of premature deaths) in the Crewe 6 (most deprived wards)
- **2/3** of these were **preventable**

- Most common causes were ischaemic heart disease (74), lung cancer (53) and chronic lower respiratory disease - COPD (43) – note smoking contributes to all
- **1/3** of these were **treatable**



# The number of deaths that were estimated to be avoidable between 2018 and 2020 in the Crewe 6 wards




Data source: Produced by Cheshire East Public Health Intelligence from Office for National Statistics: Annual Mortality Extracts 2018-2020 using ONS 2020 definition Office for National Statistics (ONS) Avoidable mortality by local authorities in England and unitary authorities in Wales, 07 March 22 release contains the latest definition (2020) and data.
https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/causesofdeath/datasets/avoidablemortalitybylocalauthorityinenglandandwales

* Circulatory diseases, cancers and respiratory diseases contributed to nearly 70% of avoidable deaths

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