#BecauseWeCare
Cheshire East Partnership

Date	**01 November 2023**
Time	**14:00 – 16:00**
Venue	Committee Suites, Cheshire East Council, Middlewich Road, Westfields, Sandbach, CW11 1HZ
Contact	jennyunderwood@nhs.net

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**			
	1	Welcome, introduction & Apologies	Chair	For noting	Verbal
	2	Declarations of Interest	Chair	For noting	Verbal
	3	Minutes of meeting on 6th September 2023 Action Log and matters arising	Chair	For approval / noting	Paper Page 2
14:05		**Plans and Priorities**			
14:05	4	Mid Cheshire Hospitals NHS FT Clinical Services Strategy & New Hospital Programme Update	Ian Moston Chief Executive Officer (MCHT)	For discussion	Paper Page 17
14:15	5	Delivery Plan for Health and Social Care in Cheshire East 2023-2028	Dr Matt Atkinson Consultant Public Health (CEC)	For noting	Presentation Page 49
14:25		**Any other Business**			
	6	Questions from the Public (standing item)	Chair	-	-
14.30		**CLOSE of Public CE H&CP Board Meeting**			
14:30		**Partnership Board Development Session (*Private*)**			
		World Café Workshop	Chair/ Mark Wilkinson (NHS C&M)/ Helen C-M (CEC)	For discussion	To follow
16:00	**Close of meeting**				
Next meeting		**Date: Wed 10th January 2023** **Time: 14:00 – 16:00** ***Format & Venue TBC***			

#BecauseWeCare
Cheshire East Partnership

Cheshire East Health and Care Partnership Board held in Public

Wednesday 6th September 2023
at 2.00pm – 5.00pm

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	✓
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	✓
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	✓
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	Apols
Mark Wilkinson	MW	Place Director	NHS C&M Cheshire East Place	✓
Dr Matt Tyrer	MT	Director of Public Health	Cheshire East Council	✓

Shelley Brough	SB	Acting Director of Commissioning and Integration/ Head of Integrated Commissioning	Cheshire East Council	✓
Anushta Sivananthan	AS	Consultant Psychiatrist/ Medical Director	Cheshire & Wirral Partnership NHS Foundation Trust	Apols
Dawn Murphy	DM	Associate Director Finance & Performance	NHS C&M Cheshire East Place	Apols
Aislinn O'Dwyer	AO'D	Chairperson	East Cheshire NHS Trust	Apols
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	✓
Debbie Burgess	DB	Deputy Associate Director Community Services	East Cheshire NHS Trust	
Richard Burgess	RB	Interim Associate Director of Transformation & Partnerships	NHS C&M Cheshire East Place	Apols
Amanda Best	ABE	Integrated Head of Community Led Care	NHS C&M Cheshire East Place	✓
Dr Patrick Kearns	PK	Associate Clinical Director	Place Partnership Group	✓
Hilary Southern	HS	Head of Corporate Business Support – Cheshire East & Cheshire West	NHS C&M Cheshire East & West Places	✓
Lesley Massey	LM	Deputy Chair *In place of Carolyn Wilkins, Chair*	Mid Cheshire Hospitals NHS Foundation Trust	✓
Mark Groves	MG	Service Lead *In place of Louise Barry, CEO*	Healthwatch Cheshire	✓
Tony Mayer	TM	Director	MHLDC Provider Collaborative	✓
Maddy Lowry	TW	Associate Director and Operational Lead *In place of Anushta Sivananthan Consultant Psychiatrist/ Medical Director, CWP*	Cheshire & Wirral Partnership NHS Foundation Trust	✓
Dr Phil Coney	PC	GP/ Clinical Lead	Knutsford Care Community	✓
Katrina Oliver	KO	Community Coach	East Cheshire NHS Trust	✓

Item	Discussion and Actions	Action Owner
	Meeting Management	

Item	Discussion and Actions	Action Owner
1.	**Welcome and Introduction**	
	Chair welcomed all to the meeting – introductions made.	
2.	**Apologies**	
	The Partnership Board: • **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 17 May 2023	
	The Partnership Board: • **NOTED and APPROVED the minutes of the Partnership Board meeting held on 17 May 2023**	
5.	**Action Log and matters arising**	
	• **Action 2022-007 – Declaration of Interests**: Have received DOIs from some members but not all, work is ongoing, waiting for formal guidance/ steer from ICB. As a general guide members asked to uphold good practice and provide an up-to-date DOI, as even where they may have declared one in their substantive employer/ role, often they are not attending in that role and could be representing a number of partners. Good practice to complete a separate DOI to support transparency and public perception as a public meeting. **The Partnership Board NOTED the Action Log.**	**JU/ HS**
6.	**Decision Log**	
	The Partnership Board NOTED the Decision Log.	
	Public and community focus	
7.	**Person's Story (standing item) (Mark Groves)** MG presented a Person's Story to the Partnership Board regarding an individual's (Person A) experience accessing community pharmacy provision. Person A sustained an eye injury, but mindful of avoiding putting pressure on A&E as they had had a similar incident previously, when they did attend A&E, and had been prescribed an antibiotic ointment, they decided to attend their local pharmacy in the first instance. The eye was panful, but eyesight was unaffected, so they believed it not to be serious. Person A attended their local Tesco pharmacy in Crewe. On speaking with the Pharmacist, they recommended 'every day' eye drops, not the ointment previously issued; Person A explained their previous injury and that the antibiotic ointment had worked, but the Pharmacist insisted the everyday drops would work. Person A used the everyday drops, but they caused more pain and did no relief. Therefore, they travelled to a different pharmacy in Crewe (Boots) to get a second opinion. They agreed the antibiotic ointment would be the best solution but were currently out of stock and recommending trying another Boots pharmacy (Sandbach) or an Asda pharmacy.	

Item	Discussion and Actions	Action Owner
	Person A rang the Boots (Sandbach) pharmacy to check if the antibiotic ointment was in stock before they travelled, and although the pharmacist was very patient and helpful, they did not have it in stock either. Frustrated and in pain they travelled out to a fourth pharmacy in Crewe, which looked to be closing (shutters half down and one family already waiting) and was told the Pharmacist had closed to have a break and would see him at 5pm. Unwilling to wait at this point Person A drove to a fifth pharmacy – Well Pharmacy in Shavington. Again, the pharmacist asked lots of questions and agreed the antibiotic ointment would be most suitable and had some in stock. Person A confirmed the ointment worked and pain was manageable. Summary – community pharmacies are helpful, and can avoid A&E attendances, but in this case, it took over 4 hours of driving around and unnecessary pain and frustration of the individual. Partnership Board discussed the issue of stock variances, noting if it hadn't been for the individual's determination to avoid A&E then they could have been another unnecessary presentation. Unreasonable to expect residents to have to endure such a feat just to access appropriate care, and unlikely they would in most cases, more likely would simply go to A&E. Board discussed the importance of the role of community pharmacies – the area of Crewe, for example, has a number of health inequalities – and that when national initiatives encourage residents to go to the pharmacy as opposed to a GP or A&E when it isn't an emergency, need to ensure the infrastructure is in place to manage the demand. NHS C&M ICB is responsible for the commissioning of community pharmacy provision and has a pharmacy representative on the board. Partnership Board to consider either scope to have a pharmacy representative (and, possibly, a dental representative) attend Partnership Board meetings. **ACTION:** AB to take back comments to Primary Care Practitioners Forum, which has links to key health partners across Cheshire East. Discuss if opportunities to improve communications and network links to enable better signposting where a pharmacy doesn't have stock. **The Partnership Board NOTED the presentation.**	**AB**
8.	**Care Communities' Spotlight (standing item)** **Knutsford Care Community (Dr Phil Coney & Katrina Oliver)** The Knutsford Care Community presentation was shared prior to the meeting, providing context about the population served and the purpose of the Care Community, including its three priority areas of wellbeing & social isolation, cardiovascular health and Home First. Programmes are evidence based, and PC shared the dashboard used to inform decisions about priority pieces of work. Three priority areas: 1. Wellbeing and Social Isolation	

Item	Discussion and Actions	Action Owner
	2. Cardiovascular Health 3. Home First Update provided on work undertaken and positive outcomes achieved so far, including: • **Parkletics** – evidence of wide partner working, providing access to free outdoor exercise/ gym space, and access to weekly wellbeing group sessions. Built strong evidence base of positive outcomes and patient stories and will report back into Partnership Board at future date. • **Knutsford Together** – charity that coordinates statutory, voluntary and community groups and services to connect people in need with the help and support they need. Provision of signposting support, online directory of services, phoneline and a weekly talking café. • **Monday Hub** – won team of the month at East Cheshire NHS Trust in October and can evidence impact on decrease in primary care presentations after an individual joins the club. • **Cardiovascular Health** – there is a high prevalence of hypertension in Knutsford and acknowledged a large percentage undiagnosed/ untreated. Outpatient waits can be up to a year; but the virtual cardiology clinics enable individuals to bypass GP/ hospital, the GP can access EMIS record online and provide advice, prescriptions etc directly. Again, building a strong evidence base of positive outcomes and patient stories, and will report back into Partnership Board at future date. • **Home First** – aims to reduce length of stay and prevent avoidable admissions. There is currently limited care available across Knutsford; the initiative brings together District Nurse Leaders, East Cheshire Hospice Palliative Care Team, EOL Partnership and local GPs to give patients access to a wide multi-disciplinary team within their own homes/ care homes. • **Dementia Pathway Project** – in response to higher than national average figures of people over 75/ 80 getting dementia; this scheme aims to enable quicker initial dementia diagnosis, provide local review clinic access and timely consultant access for more complex cases; bringing the care to the patient rather than them having to go into hospital. Evidence that waiting times have reduced significantly; and team won HSJ award for Partnership working in 2019. Asks of the Partnership: • Initial funding for several of the initiatives has now run out, and risk projects will cease unless can get system support. • A number of projects are not sustainable at small scale running at e.g., dementia pathway project and need partner buy-in • Support with estates issue – can evidence partnership working is key to many of the initiatives, but currently working out of ¾ buildings not really fit for purpose, want a shared space. The Partnership Board acknowledged the positive work being evidenced across the various schemes – in particular the work to improve social isolation and also identify where having a direct positive impact on reducing pressure in both primary and secondary care. Strong links with ongoing Public Health work/ priorities and interesting potential in some schemes just taking off e.g., smoking cessation. Suggestion that the	

Item	Discussion and Actions	Action Owner
	Care Community continues to build its evidence base, in particular evidencing the direct impact on hospital demand. Endorsement of the powerful impact the Care Communities models are having across Cheshire East and need to share best practice and outcomes wider. Challenge with discussing or agreeing financial support – need to understand what ability the Partnership Board has in committing funding or resources to valuable initiatives. Acknowledgement the purpose of the Partnership Board is around collaboration and inspiration (not scrutiny), but to that need ability to commit funding as partners. **ACTION:** MW/ IW to pick up with ICB around process for how and where place financial decisions can be made e.g., around 4 asks of the presentation (page 42 in pack). Response will be brought back to Partnership Board. **ACTION:** Next Care Communities update to come from Crewe Care community **The Partnership Board NOTED the update and ENDORSED exploring how could support additional work.** ***PC & KO left the meeting.***	**MW** **CA**
9.	**Mental Health Community and Learning Disability Collaborative** Tony Mayer, Director of the Mental Health Community and Learning Disability Provider Collaborative introduced the collaborative and update on work undertaken to date. TM drew the Board's attention to the two case studies at slides 6 and 7. Six priority areas agreed and have been presented to NHS C&M ICB, 12 months focus and then will review. Some of the initiatives are fully formed and already evidencing a positive impact, others are in their infancy. AW queried whether there was any direct quality representation on the collaborative, TM confirmed there wasn't currently but are reviewing the leadership, in particular quality inclusion, t the moment. Have been having discussions with Heads of Nursing and Clinical Leaders – CMAST collaborative does have a specific quality role so would be good to replicate, also due a multi-stakeholder discussion session around ASD, ADHD & SALT. TM also confirmed discussions are underway with Professor Ian Ashworth (NHS C&M ICB) re: population health work. **ACTION:** Provider Collaborative Update to be added to forward planner. **The Partnership Board NOTED the update.**	**CA**
	Plans and Priorities	
10.	**Sustainable Hospital Services Programme (Katherine Sheerin)** KS provided an update on the progress made under the Sustainable Hospital Services Programme.	

Item	Discussion and Actions	Action Owner
	Case of change approved last year, and the service models are now being developed – KS asked Board to note this is just one part of East Cheshire NHS Trust's strategy. ICB steer had been requested as it is a major change process, and September deadline provided to formally share plans/ costs etc and develop a pre-consultation business case – meeting held w/c 04/09, overall helpful and provided clarity to reach point of shared understanding. Ten services in scope – some are already addressed e.g., maternity; others still being developed. October Trust Board session in collaboration with Primary Care, designing the agenda together to ensure partnership working. The Partnership Board noted the update; clarity sought regarding feedback from over 600 responses to patient engagement, in particular Emergency Department provision, KS confirmed all concerns had been noted, and an emergency department at both Macclesfield and Stockport would be maintained, even though this was a particular challenge for Macclesfield due to its size and would be working closely with Stockport FT to ensure it could be maintained. Joint scrutiny panel to be implemented, and acknowledged there would be resource implications to the system – these will be addressed in the formal business case. **The Partnership Board NOTED the update.**	
11.	**Care Leavers Covenant (Amanda Williams)** AW provided an update on the progress made in implementing the Care Leavers Covenant within Cheshire & Merseyside. The report presented had been written on behalf of all C&M places - funding was made available for 10 'pathfinder areas', but unfortunately NHS C&M were not successful at the time but have decided to still progress with the work as the right thing to do. Report will be going to all Place Partnership Boards; then will be socialised amongst providers to get wider sign up. **The Partnership Board NOTED the update.**	
12.	**Dementia Implementation Plan (Shelley Brough)** SB updated the Board on the Cheshire East Dementia Implementation Plan to provide assurance to the Board on the delivery of actions agreed within Cheshire East's Dementia Strategy. The Partnership Board had previously fully endorsed the strategy and had asked for sight of the plan for assurance – detailed requests/ further information members advised to contact SB directly. Strategy/ Plan led by multi agency steering group – has taken the financial constraints of system into account - it builds on existing resources, developments, services, and funding already identified etc; bringing together and maximising what we already have/ are already doing. Monitoring of the plan will be through the Strategic Planning & Transformation group and an annual update will be provided to Partnership Board.	

Item	Discussion and Actions	Action Owner
	The Partnership Board discussed its role/ remit in supporting implementation of ideas/ initiatives where we know it will make a difference e.g., the Knutsford Care Communities work demonstrates a way of improving dementia targets. We need to support care communities more to make the system work better. Look at cascading Knutsford work as good practice. Discussion around how it could be taken forward; suggestion the dementia steering group needs to link to the care communities' group. and use the dementia work to test the process. Invest to save initiative, and right to do on all levels, but the Board noted the current financial position of the system and the risk that other work may have to stop to fund it. Will be a challenge, but there was confirmed appetite in testing it out. **ACTION:** MW, HCM & SB to take forward to all colleagues on partner groups and engage discussions how we could take it forward as partners. **The Partnership Board NOTED the update.**	**MW/ HCM/ SB**
	Planning and Performance	
13.	**Quality & Performance Group Report (Amanda Williams)** AW thanked partners for their commitment to the Cheshire East Quality & Performance group; so far two meetings held, and both have evidenced system engagement and partner working. AW provided the Board an update on the work of the group, covering the period June-August. During the June meeting there were presentations, discussions and actions agreed in relation to: • Section 136 provision • Section 117 mental health aftercare • Learning disability workforce and the impact on Greenways Assessment and Treatment Unit In August the areas covered were: • Child and Adolescent Mental Health • Children and young people assessed under the mental health act in an acute setting • Youth Justice System Health Needs Analysis The national police initiative 'Right Care Right Person' and the risks and issues around Autism and Attention Deficit Hyperactivity Disorder (ADHD) were discussed at both meetings. It was acknowledged that the Quality and Performance Group still has work to do around system data and the development of a system risk register (next meeting) and issues log. Number of children and young people who don't meet the criteria for CAMHS Tier 4 but end up in our acute services – there was a workshop earlier in the year and T&F group established to consider. Need to get better at comms with families to help navigate process and share info what's available and how work as a system to support families and children while they on the waiting list.	

Item	Discussion and Actions	Action Owner
	Also scoping the use of a Summary Hospital Index – ECT already have one in place, and it works well; bringing partners together to look at out of hospital pathways. DW, as Chair of SEND Partnership flagged place is due a SEND inspection imminently – we know under current pathways wait times for assessments (Neuro) are problematic and feedback from some of our peer e.g., Oldham were the inspection highlighted these issues. Widespread and systemic failings need to be addressed urgently, or risk we will have same findings. Acknowledgement made to all the work undertaken by AW and partners and the obvious appetite to tackle the issues; but needs more pace and must be able to evidence our improvements. **The Partnership Board NOTED the update.** ***Councillors Moran, Rhodes and Clowes left the meeting due to prior meeting commitment.***	
14.	**Strategic Planning & Transformation Group Report (Shelley Brough)** SB presented the report on behalf of Dr David Holden – report provides an update on the activities and highlights of the Cheshire East Strategic Planning and Transformation Group (SPT) Group to Sept 2023. 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), Operating Model and People Plan • Live Well for Longer Plan • Helpforce – Volunteer project, recognised nationally as innovative. • Place based VCFSE Model proposal inc. the Social Action Charter and the CE Place based VCFSE Grants • Cheshire East Estate Programme • The Cheshire East Blueprint developments x 3 workshops to conclude at the end of September. • The development of the Cheshire East Place Delivery Plan which includes the 8 Ps as the golden thread principles, with the Care Models embedded. The Partnership Board noted the work undertaken, in terms of the reporting format comparison made to the Dementia Plan update (previous agenda item) – felt further work could be done on improving the reporting – who leading on the items, where the resources were coming from etc. MW provided brief oversight/ context of Place governance structure and how SPT fits into the structure: Place Leadership Group (PLG) – oversight & Steer; Strategic Planning & Transformation Group (SPT) – designing and delivering tomorrow and the Operational Delivery Group (ODG) – ensuring the business-as-usual work is progressed.	

Item	Discussion and Actions	Action Owner
	The Partnership Board NOTED the update.	
15.	**Operational Delivery Group Report (Mark Wilkinson)** MW presented the report on behalf of Simon Goff – report provides an update on the activities and highlights of the Cheshire East Operational Delivery Group to Sept 2023. Well established group, membership comprising Chief Operating Officers of all of our providers and other roles with an operational or urgent & emergency care focus. Sixteen meetings held since its establishment, and a forward planner has been developed. The group has: • overseen, reviewed and endorsed the Better Care Fund Plan for 2023/24. • currently overseeing the development of the 2023/24 Winter Plan, ensuring • triangulated plan representative of all partner organisations • discussed key operational issues including secondary care mental health bed capacity, out of area placements; general nursing assistant (GNA) sustainability; over prescribing of care packages and links to social prescribing; demand and capacity reconfiguration and virtual wards. The Partnership Board noted the updates and a query raised regarding how we tackle Cheshire-wide issues e.g., what about partners that sit across both East and West, how do we work outside the existing boundaries and escalate, where necessary into the system. MW confirmed several work programmes are already working across both East and West including quality and finance – review on a case-by-case basis. **The Partnership Board NOTED the update.**	
16.	**Primary Care Advisory Forum Report (Amanda Best)** AB presented the update report to Partnership Board for assurance, and for the Board to identify what other areas/ information they would find useful being reported in. Just a copy of the minutes has been provided this month. Discussion regarding representatives on the forum – has Local Medical Committee (LMC) representation and would be a good place to bring in Local Pharmaceutical Committee and Local Dental Committee representation/ engagement. Primary Care covers all those areas, not just general practice. Partnership Board agreed a topical theme currently is access recovery, so suggestion the place-based Access Recovery Plan could be brought to a future meeting. Would like to involve Councillors in the discussion about what else would be useful to present, therefore add as an agenda item. **ACTION:** – Future agenda items: PC Advisory Group Feedback, and Access Recovery Plan to be added as future agenda items. **The Partnership Board NOTED the update.**	**CA/ AB**
17.	**Finance Report (Mark Wilkinson)**	

Item	Discussion and Actions	Action Owner
	MW presented the report on behalf of Dawn Murphy – report provides update on system finances April-July 2023. Report to provide a system-wide picture, but does not contain all partner's positions yet e.g., Local Authority data. **ACTION:** MW & HCM to consider mechanism for including LA financial data in the report – to present system position and enable understanding total resources available/ deployed. 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. There was an agreed planned deficit at the start of year, but now at significant risk of not achieving that plan – work is ongoing; but difficult as many of the savings that have been identified across the system are not recurrent. MW acknowledged that had been lacking dedicated financial capacity at Cheshire East Place until recently; however, Dawn Murphy (DM) is now in post as Associate Director Finance & Performance, Cheshire East; and DM is working on bringing all finance directors together on a Cheshire wide basis; to build a collective view and plan next steps as a Cheshire East (and where relevant, wider) system. New Finance & Resources Group established, covering both Cheshire East & Cheshire West as acknowledged interdependencies across both. The Partnership Board discussed the report, and a reminder the role of the Board wasn't to scrutinise an organisation's position, but to collectively own the challenges and identify opportunities/ ways of working that could mitigate some of the challenges. Should be a safe space to explore solutions and provide support. **The Partnership Board:** • **SUPPORTED the establishment of a Finance and Resource Group** • **AGREED support of the Financial Recovery Plan being managed via the Finance and Resource Group.**	**MW/ HCM**
18.	**Place Director Report (Mark Wilkinson)** MW provided an update on current highlights/ activity within NHS C&M Cheshire East Place. Following the recent Lucy Letby conviction, NHS Cheshire and Merseyside has scheduled discussions on some of the broader implications arising from the case, at the end of September. Will look to pull out learning, implications and issues around clinical governance, role of local quality committees, oversight & assurance etc. The issue affects staff across the whole system, even those not directly working at COCH. All providers are providing support to staff, Directors of Nursing are coming together to review learning, and work also being done at the child death overview panel will be reflected on. In meantime waiting to hear outcome from the statutory review.	

Item	Discussion and Actions	Action Owner
	Cheshire East has performed highly in the national annual survey of GP practices (Appendix A, page 123). Cheshire East, Cheshire West, and Wirral all top scoring and significantly ahead of national averages – thank you given to GPs and all colleagues who contributed to the scoring. There is always opportunity to do more, but it's a strong performance and should be acknowledged. Partnership Board acknowledged the success and credited the work down, however important to note the variation within Cheshire East as a place e.g., significant challenges and health inequalities in Crewe & parts of Macclesfield. Need to consider what could we do as place-based board to improve access to care in all settings. AB/ MW confirmed work underway within PC Teams; and a fuller discussion on access would be useful at the next meeting. See action in PC update above. GK confirmed he is taking a paper to Health & Wellbeing Board around the altogether fairer recommendations specifically in relation to Crewe; there has also been a specific Crewe JSNA – all helping to build a comprehensive evidence base. **The Partnership Board NOTED the update.**	
	Partnership Committee Effectiveness	
19.	**Forward Planner and Review (standing item)** Next meeting to include New Hospital Programme Update (Ian Moston)	**CA/ IM**
20.	**Evaluation of the meeting** The Partnership Board discussed the flow of the meeting and the following comments made: • Possibility of rotating standing agenda items - later items often time constrained and do not always get the discussion time they need • There was good challenge and input/ contribution from all partners. Could be useful to revisit terms of reference and purpose of the group, to ensure all members understand their capacity in which they attend and the role of the collective Board; need to ensure avoiding duplicating or replacing work/ discussions which occur in other meetings and/or subgroups. • Overall consensus the Care Communities and Dementia work really good, with strong evidence-based reports/ presentations that provided assurance and opportunities for next steps. **ACTION:** Development work to be undertaken to consider how best to shape agendas to meet the purpose of the Partnership Board.	**MW/ IW/ HS**
21.	**Questions from the Public (standing item)** N/A - No members of public in attendance, or questions submitted in advance.	
14.	**Any other Business**	
	N/A	

Item	Discussion and Actions	Action Owner
	Close of meeting.	
Date and Time of next meeting: 01 November 2023 @ 2pm – 4pm Venue: Westfields, Sandbach		

Updated: 6th SEPTEMBER 2023

	New
	Ongoing
	Completed
	Closed

Ref	Date raised	Description (please be as specific as possible in this cell)	P-B Owner	Action Delegated to (if relevant)	Deadline	Status	Comments / Update
2023-020	6-Sep-23	**Meeting Evaluation**: Development work to be undertaken to consider how best to shape agendas to meet the purpose of the Partnership Board.	Mark Wilkinson/ Hilary Southern/ Carol Allen	-	31-Mar-24	**Completed**	Development Session booked 01/11/23
2023-009	6-Sep-23	**Forward Planner**: New Hospital Programme Update to be added to November agenda; Ian Moston to update.	Carol Allen	-	1-Nov-23	**Completed**	Added to fwd planner
2023-016	6-Sep-23	**PC Advisory Forum**: Future agenda items: PC Advisory Group Feedback, and Access Recovery Plan to be added as future agenda items. Amanda Best to present.	Carol Allen	-	1-Nov-23	**Completed**	Added to fwd planner
2023-012	6-Sep-23	**Dementia Implementation Plan**: LINKS to 2023-008. MW, HCM & SB to take forward to all colleagues on partner groups and engage discussions how we could take it forward as partners.	Mark Wilkinson/ Helen C-M/ Shelley Brough	-	1-Nov-23	**NEW**	
2023-009	6-Sep-23	**MHLDC Provider Collaborative**: Provider Collaborative Update to be added to forward planner.	Tony Mayer/ Carol Allen	-	1-Nov-23	**Completed**	Added to fwd planner
2023-008	6-Sep-23	**Care Communities**: Next Care Communities update to come from Crewe Care community	Carol Allen	-	1-Nov-23	**Completed**	Added to fwd planner
2023-008	6-Sep-23	**Care Communities (Knutsford)**: MW/ IW to pick up with ICB around process for how and where place financial decisions can be made e.g., around 4 asks of the presentation (page 42 in pack). Response will be brought back to Partnership Board.	Mark Wilkinson/ Isla Wilson	-	1-Nov-23	**NEW**	
2023-007	6-Sep-23	**Person's Story**: AB to take back comments to Primary Care Practitioners Forum, which has links to key health partners across Cheshire East. Discuss if opportunities to improve communications and network links to enable better signposting where a pharmacy doesn't have stock.	Amanda Best	-	N/A	**Completed**	
2022-018	17-May-23	**Person's Story**: The Partnership Board could start conversations with the Learning Disability Partnership Group around their achievements and struggles with Health Care. Action: The Partnership Board agreed to have a conversation with the Council's Learning Disability Partnership Group.	Helen Charlesworth- May	-	6-Sep-23	**Completed**	Agenda has Patient Story as standing item - picked up under this schedule
2022-019	17-May-23	**Person's Story**: The Partnership Board agreed to discuss the Learning Disabilities findings following the Quality and Performance Group.	Amanda Williams	-	6-Sep-23	**Completed**	Agenda has Patient Story as standing item - picked up under this schedule

CE HCP Decision Log 2023-24

Updated: 06/09/2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Partnership Board Decision (e.g. Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
HCP-DE-23-09	6-Sep-23	**Care Communities (Knutsford)**	**N/A**	1) ENDORSED exploring how could support additional work.	
HCP-DE-22-32	17-May-23	**Joint Dementia Plan**	**N/A**	1) APPROVED the final version. 2) REQUESTED to review the Implementation Plan so that all the partners can be clear their contributions are appropriate.	
HCP-DE-22-33	17-May-23	**Family Hubs**	**N/A**	1) SUPPORTED the current Family Hubs developments that will enable a focus on joint resources for services making the most difference to families.	
HCP-DE-22-34	17-May-23	**Partnership representation on Health and Wellbeing Board**	**N/A**	1) AGREED and NOMINATED Isla Wilson to represent the Partnership Board at the Health and Wellbeing Board. 2) AGREED and NOMINATED Ian Moston as the Deputy at the Health and Wellbeing Board.	
HCP-DE-22-35	17-May-23	**Strategic Planning and Transformation Group Update**	**N/A**	1) SUPPORTED the development of the Strategic Planning and Transformation Group.	

NHS
Mid Cheshire Hospitals
NHS Foundation Trust

CLINICAL SERVICES STRATEGY 2023-2028

Because you Matter

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FOREWORD

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Chief Executive

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Chief Medical Officer

Introducing our Clinical Services Strategy

We are delighted to publish this clinical services strategy which sets out how our clinical services will transform over the next five years to deliver high quality and truly patient focused care.

It comes at a very exciting time for our Trust. In May 2023 the Secretary of State for Health and Social Care announced that the RAAC hospitals were to be prioritised in the national New Hospitals Programme and we are to have a new Leighton Hospital. It is hoped that, using the 'Hospital 2.0' blueprint, a new hospital could be operational at the turn of the decade. This gives us a unique opportunity to design and build the estate to deliver fully on our commitments made as part of this strategy.

At the same time, we are pressing on with digital transformation and our collaboration with East Cheshire NHS Trust last year saw innovative plans for a joint electronic patient record - the Digital Clinical System – approved and the Trust is now into the build and implementation phase, working with Meditech IT Inc as system provider.

We continue to play a proactive role in the development of integrated care plans across Cheshire & Merseyside and our local Cheshire East and Cheshire West Place-based systems. We believe, and it is the cornerstone of our five-year Trust Strategy, there is the opportunity to progress innovative, responsive and effective care in the best setting for the patient, be it in the hospital or out in the community.

We have developed this strategy with energy and passion, building on earlier work to better understand our population and their health needs. More than 100 staff attended the initial strategy events with many more contributing within their individual specialties. We have engaged with partner organisations and with our public through a series of events, listening and responding to the feedback given. We would like to thank everyone involved for their valuable input and support in developing this strategy. This is an exciting time for us and a great opportunity to deliver real benefits for our patients and our staff. We look forward to continuing to work with all of our stakeholders to deliver this.

ABOUT MID CHESHIRE NHS FOUNDATION TRUST

The Trust provides a full range of local hospital and community services, taking referrals from a wide geographical area including East Cheshire (population 399K) and West Cheshire and Chester boroughs (population 357K).

We provide high quality planned and unplanned/ emergency care, including critical care as well as child health, maternity services, and intermediate care across our sites at Leighton Hospital in Crewe, Victoria Infirmary in Northwich, and Elmhurst Intermediate Care Centre in Winsford.

The Trust has also delivered community services across 26 medical centres and schools since 1 October 2016 through the Central Cheshire Integrated Care Partnership, in collaboration with the South Cheshire and Vale Royal GP Alliance.

With the formation of Integrated Care Systems in July 2022, the Trust became a strategic partner in both Cheshire East and Cheshire West 'places' and in two provider collaboratives. The Trust is part of the Cheshire and Merseyside Integrated Care System caring for a population of over 2.7million.

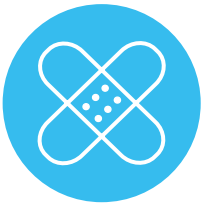
The Trust operates its acute clinical services through four clinical divisions: Medicine and Emergency Care; Surgery and Cancer; Women and Children's and Diagnostics and Clinical Support Services.

Its community services are managed through the Central Cheshire Integrated Care Partnership, with the Estates and Facilities and Corporate Services Divisions providing support to all areas. It provides the following services:

- Emergency and elective inpatient services
- Day case services
- Outpatient services
- Diagnostic and therapeutic services
- Maternity
- Children's health
- Community services including preventative work.

110,455
A&E attendances of which we admitted **36,168** emergency patients

430,595
patients referred for treatment, of which **58.4%** are waiting less than18 weeks



291,584
first and follow up outpatients of which **57,259** were by telephone

18,328
patients referred under the 2-week-wait cancer pathway of which **89.5%** were seen within two weeks

114,313
diagnostic tests were carried out

3,101
births were supported

What we want to achieve, how we will do this and what we believe in.

OUR MISSION IS:

To inspire hope and provide unparalleled care for the people and communities of Cheshire, helping them to enjoy life to the fullest.

OUR OBJECTIVES ARE:

1. **Improving Health Outcomes** to deliver the best care and experience centred on the patient's needs
2. **Working in Partnership** to collaborate across boundaries to enhance patient care
3. **Empowering and enabling our staff** to be the best that they can be
4. **Building a Better Tomorrow** to deliver a sustainable and innovative infrastructure

OUR VALUES ARE:

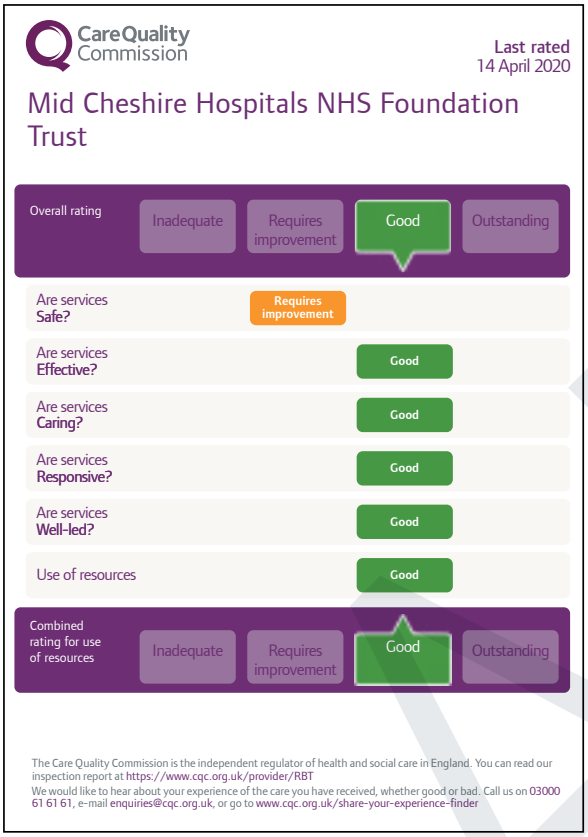
We put you first

We strive for more

We respect you

We work together

Because you Matter



CQC Inspection Ratings:
The Trust was last inspected in 2019 and rated overall as "Good".

Improvement Matters

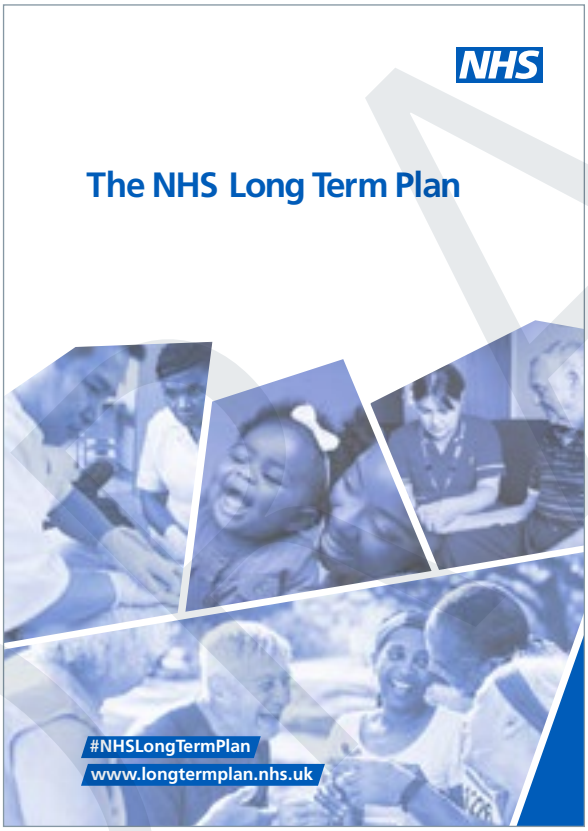
In 2022, the Trust launched its 'Improvement Matters' programme which is its approach to developing and embedding a culture of continuous improvement throughout the organisation. A single improvement methodology is championed which supports both continuous incremental improvement as well as the transformative approach required in developing our services to align to our four models of care set out in our new Trust strategy. The pyramid below shows our overarching Trust mission alongside our quality vision and our improvement aims of always providing care which is person centred, safe and effective. These are all underpinned by our Trust values and behaviours.

STRATEGIC CONTEXT

Our clinical services strategy sits in the context of a number of key national and local drivers:

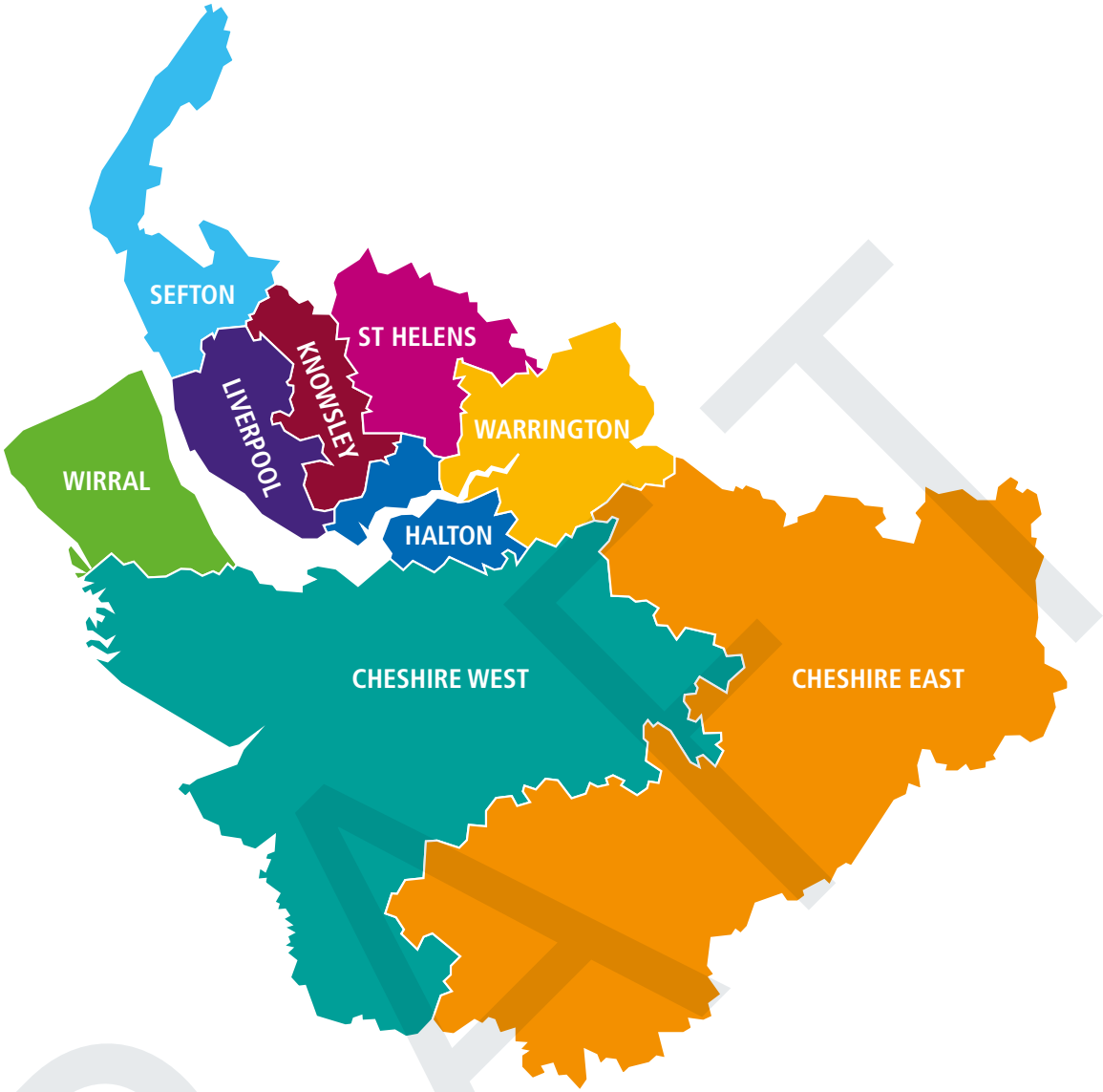
National: The NHS Long Term Plan

Published in 2019, the NHS Long Term Plan is a national strategy, providing overall direction for a new service model which focuses on the treatment of illnesses through the provision of joined up care between local health and care organisations and other agencies. The plan sets out priorities for improving cancer detection and treatment, diabetes, cardiovascular and respiratory health, dementia and children's health.



NHS Long Term Plan v1.2 August 2019

The Long Term Plan supports a shift towards services being delivered in community settings where this can be achieved. Specifically, it outlines a shift in emphasis within urgent and emergency care, supporting treatment models based on same day emergency care principles and reducing the need for emergency hospital admissions. The overall aim of the plan is a shift in focus from organisation to system and place working with a demonstrable improvement in population health outcomes. This is also recognised within the NHSE Delivery Plan for Recovering Urgent and Emergency Care Services published January 2023.



The Cheshire and Merseyside Integrated Care System (ICS)

The Trust resides within the Cheshire and Merseyside Integrated Care System, comprising of 18 NHS Trusts, 355 GP Practices, 9 Local Authorities, serving a population of 2.7 million people.

It also encompasses voluntary, community, faith and social enterprise organisations from across the local authority areas. The ICS has developed four core priorities for its work over the coming years:

- To improve population health, with a specific focus on reducing deaths from cardiovascular disease, suicide and domestic abuse, reducing levels of obesity and reducing harm caused by alcohol consumption.
- To tackle unequal outcomes and access to services, reducing the life expectancy gap in the most deprived communities, in children and those with mental health conditions. Early diagnosis, treatment and outcomes for cancer are also a focus alongside supporting those with chronic diseases to access services in the most deprived areas.
- Enhancing productivity and value for money by designing and delivering services at scale (where appropriate) to drive better quality and improved effectiveness and efficiency. Prioritisation of greater resources available to support prevention and wellbeing services.
- To support broader social and economic development, embedding a commitment to social value in all partner organisations.

It is clear that the challenges faced in health and social care cannot be managed by organisations alone. Effective collaboration across system partners is key to delivery of exceptional care to improve the health and wellbeing of our communities.

Cheshire East Place

The Trust sits within both Cheshire East and Cheshire West Places, two of nine local authorities within the Cheshire and Merseyside ICS. Cheshire East Place is located between the North and the Midlands and is the third largest unitary authority in the Northwest next to Manchester and Liverpool.

The Cheshire East Joint Local Health & Wellbeing strategy for the place sets out ambitions to reduce health inequalities, improve the physical and mental health and wellbeing of local residents and helping people to be healthy and happy and to enjoy a good quality of life. There is a particular focus on health and wellbeing in children & young people and on improving mental health.

Cheshire West Place

The Trust also sits within the Cheshire West Place that forms part of the Cheshire and Merseyside ICS. The population within this area is set to see an increase of 10% across all age groups 2035. Compared to England, quality of life is generally good for many people across the borough, however, there are pockets of significant disadvantage where residents experience poorer living conditions, educational attainment, economic prospects, and more years of poor health.

Cheshire West Place strategy is to reduce inequality, increase years of healthy life and promote improved mental and physical health and wellbeing for everyone in Cheshire West.

Inter-relationships with other partners

The Trust has a number of partnerships with other NHS provider organisations which support the delivery of effective and sustainable services across a number of clinical specialties. Although being part of the Cheshire & Merseyside ICS, many of the tertiary centre services are provided by or in collaboration with The University Hospital of North Midlands (UHNM), which is located 17 miles southeast of the Trust. For some services, the Trust is part of larger more formal networked services, in line with national ambitions. The North Midlands and Cheshire Pathology service is a good example of this.

For the delivery of cancer care, the Trust has a number of partnerships, spread out within Cheshire & Merseyside, Greater Manchester and with UHNM. These are largely based around historical relationships within individual clinical specialties.

Our Trust strategy 'Because you matter'

Our Mission – To inspire hope and provide unparalleled care for the people and communities of Cheshire, helping them to enjoy life to the fullest.

During 2021, the Trust undertook some pioneering population segmentation work to better understand the healthcare needs of our population. This enabled us to build a better picture of our service users and their distinct needs when accessing healthcare. Key population insights gained from this work were:

- A predicted population growth in the region of 5-8% in the next 5 years, with the biggest growth in the population 65 + years.
- 17% of children are living in low-income families
- 11% of areas within the Trust's catchment area are within the 10% most deprived areas in the UK

Analysis of our clinical service lines and the users of it allowed us to develop detailed insights into the health needs of our local population. We were able to see and describe how people used our services differently. Some segments of our population, for example, have their needs well catered for with our current service models.

Examples of these are those using maternity services, having an operation, or those who are injured or acutely unwell and need urgent treatment. For many of the segments of our population, however, the traditional District General Hospital (DGH) model of care no longer works well as hospitals have developed to deal with specific issues of specialism, and we do not always work effectively with people who have multiple health conditions and other care needs. Often, we are only able to offer a solution to one part of their problem and therefore their experience of our care is not as good as it could be. Many of our service users have found their experiences have been made worse following the Covid-19 pandemic.

The insights from our population segmentation work led us to build four models of care which are based around these differing needs. These care models will form the basis of all our strategic plans and this clinical service strategy. Our four models of care are described as:

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.

Importantly, these models of care are not aligned to either hospital or community services or to specific clinical divisions within the Trust. Each of the four care models offers an integrated model of care, encompassing both hospital and community services working collaboratively within each of them.

OUR CLINICAL SERVICES STRATEGY

Our four models of care will form the basis of all our programmes of work to redesign and develop our clinical services over the next five years. Importantly, transforming to deliver care aligned to these four models cannot be achieved by Mid Cheshire alone and will require close collaborative working with Place and System partners and neighbouring Trusts.

Our Clinical Strategy is looking to the future but is also seeking to identify what can be done now, in a transitional phase as we strive to support our local population to live well independently, and to provide high quality clinical services at our Trust.

Strategy development

A series of engagement events with internal stakeholders were held throughout 2023 which gave an opportunity to share more widely the four models of care developed as part of the overarching Trust strategy. Clinical divisions were asked to identify their key priorities which would support in the transformation of working towards the new care models. The development of these priorities was supported by use of patient and service user feedback, GIRFT reviews and other national report findings, workforce considerations and identified opportunities for collaboration and partnership working.

In addition, we have undertaken local engagement with a range of stakeholders:

- Service users
- Primary care clinicians
- Neighbouring NHS provider Trusts
- Place partners
- System partners

In addition, the strategy has been developed in line with the Clinical Care Constitution for Cheshire & Merseyside ICS, which sets out four pledges for the delivery of clinical services:

- To deliver high quality resilient services through an evidence based approach
- To work collaboratively with a relentless patient focus
- To improve health outcomes
- To transform clinical services to add value

Key Drivers

New Trust Strategy: Our new trust strategy and the four models of care as outlined above are our starting point for considering how our clinical services need to evolve to best meet the needs of our local population.

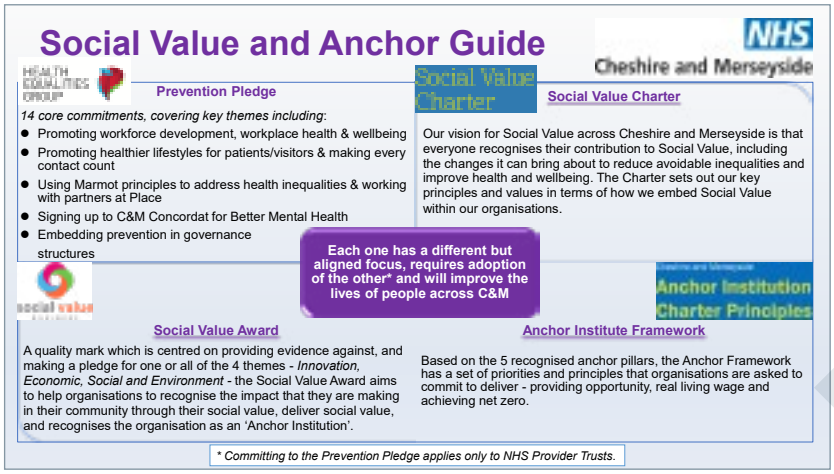
Creating a viable model for the District General Hospital (DGH) of the future: DGHs collectively deliver a large volume of core elective and emergency services. Increasingly, more of these services are delivered via partnership arrangements and/or via 'hub and spoke' models. This recognises the improved clinical outcomes which are often demonstrated by concentrating services in places where high volumes can be delivered and the challenges around sustainability of some clinical services. It is important that this direction of travel is balanced with consideration of what the future role of DGHs should be as current models of operation are challenged both in terms of financial and workforce sustainability.

This strategy considers how the Trust can develop its future role as a DGH, ensuring that it can provide a balance between the clinical services that are best delivered through partnership arrangements and what can be safely and effectively delivered more locally by MCHFT. This will continue to ensure that we can attract and retain a skilled clinical workforce whilst delivering financially viable services within a system setting.

Estate opportunities and New Hospital Programme application

The Trust has a number of challenges with its estate but also significant opportunities with its incorporation into the **New Hospital Programme for a rebuild of the Leighton Hospital site**. This will provide a unique opportunity to design and build the required estate to ensure full delivery of the clinical services strategy.

Currently clinical services are provided at three sites, Leighton Hospital, Victoria Infirmary (Northwich) and Elmhurst (rehabilitation facility) plus a variety of community locations. This strategy touches on many of the estate considerations and decisions that will need to be made in the future around the best location of the services that we deliver. Two of the key estate themes that feature in this strategy are of the need to have dedicated and sometimes separate estate for elective, emergency and diagnostic patient flows and of the need to deliver more of our services in accessible locations throughout our local communities.



Prevention Pledge

As a Trust, we have committed to The NHS Prevention Pledge which aims to improve the health of our local population by embedding health promotion and health prevention within core service delivery and Trust environments. The pledge comprises 14 core commitments on cross cutting prevention themes including:

- Reduction of preventable risk factors (smokefree sites, healthier catering offer)
- Addressing health inequalities and strengthening diversity and inclusion
- Working with partners at place to build community capacity e.g., social prescribing

Underlying principles

Delivery of our four care models will be supported by several underlying principles which will be applied to all of the clinical services which we offer.

Collaboration and Partnership working

We know that we cannot deliver our clinical services ambitions alone and that to truly move to our four care model way of working requires us to work collaboratively and in partnership with a number of health and social care organisations. This includes partnering with larger NHS providers to provide sustainable and efficient services which deliver optimal outcomes for our patients and contributing to system programmes of work through ICS provider collaboratives. Transitioning to the four care models will also require close and integrated working with several partners at place level. These ambitions will be supported through developing the necessary collaborative working skills and development of new roles within our people plan which support this integrated approach to healthcare.

Digital technology

Digital technologies will contribute significantly to transformation of patient care, supporting us to work in an effective and efficient way in partnership with our service users. We want digital evolution to be a key supporter of how we transform our clinical services, whilst at the same time recognising the differing needs and digital skills and attitudes amongst users of our service.

Digital Clinical System

Service user voice and experience

We want every person and their families who use our services to have a positive experience. In order for this to happen consistently, we are committed to making sure the voice of our patients and service users is better heard and is listened too, being a key influence in shaping the design and delivery of our clinical services. This will mean:

- The development of a 'lived experience' panel where we look to recruit people with experience of our services and/or of managing various conditions to support us to improve the quality of services we deliver
- Services are co-designed with the patient, their carers and family, recognising and adapting to the varied needs that people have.
- Patients are at the forefront of their care, having clear input into the care they receive and how they receive it, resulting in more patient choice.
- Joining up the services for our complex patients, who have a range of issues and need support across a number of clinical specialties.
- Through the delivery of our quality strategy, improve the support that we give to patients who may require adaptations to their care such as patients with a learning difficulty, dementia or neurodivergent conditions
- Services for Children and Young People are family friendly, recognising inclusivity and the complexity of modern families and their needs. Young people are transitioned into adult services seamlessly.

Reducing health inequalities

Tackling health inequalities is a key national and system aim. Health inequalities relate to the differential abilities of population groups to be able access and positively experience health services. This can lead to a reduction in health outcomes amongst certain population groups.

We know that within our organisation and at place and system level, that we need to be more proactive in taking steps to reduce health inequalities. Whilst this work is much broader than this clinical services strategy, we give a commitment here that we will incorporate these principles into the design and transformation of our clinical services.

Whole week working

As a core principle, we will seek to adopt a 'whole week' working approach to all of our clinical services which require this, ensuring that patients have equitable access to these services across 7 days and that senior decision maker presence is consistent across the whole week. We recognise that this is about investing in additional staff and expanding roles, rather than stretching existing services across 7 days. We will look to deliver this ambition through our divisional 'people plans'.

Our care models and key objectives

This section details each of the four care models, setting out the key focus areas in each for the next 5 years. Each care model has a number of outcomes associated with it, by which the success of this clinical services strategy will be measured. Importantly these outcomes combine both specific programme outcomes with population health outcomes that our strategy ultimately seeks to influence.

HELP ME WHEN THINGS GO WRONG

"Providing medical and surgical services to treat patients, delivering optimal clinical outcomes and ensuring a good experience for all service users."

This care model reflects the delivery of our traditional core medical and surgical services for the population that we serve. It recognises the national and regional priorities around delivery of urgent and emergency care and recovery of elective services post pandemic, as well as key areas set out in the NHS Long term plan related to cancer outcomes and cardiovascular and respiratory health.

Our key objectives within this care model will be:

- Increasing the proportion of acute care delivered in community and ambulatory settings across the whole of the week.
- Improving access and reducing waiting times for people accessing elective care.
- Development of centres of excellence for benign medical and surgical conditions.
- Expansion of locally delivered inpatient and outpatient services where safe, efficient and sustainable to do so with specialist estate and workforce to support.
- Working with system partners to contribute effectively to Cheshire & Merseyside programmes of work related to clinical services.

CASE STUDY
HELP ME WHEN THINGS GO WRONG

David attends his GP with a lump in his groin. He is referred to the general surgical team where he requires a face to face assessment in order that a clinical examination can be performed. David chooses an appointment on a Tuesday evening at the Victoria Infirmary in Northwich, 10 minutes from where he lives. He has not needed to take any time away from his self employed work to do this. The diagnosis of a hernia is confirmed and David is keen for an operation to manage it. David's preoperative assessment and consultation is undertaken online. He is able to upload data from his smartwatch to support with assessment of his cardiovascular system, meaning that he does not need to attend any further appointments. Six weeks later, David attends for his operation at one of the Trusts elective care centres on a Saturday morning.

CASE STUDY
HELP ME WHEN THINGS GO WRONG

Salma is a lady in her 70's. She suffers from Chronic Obstructive Airways Disease (COAD) which is usually very well managed by her primary care team. One December she becomes more breathless than usual with a fever. Her General Practitioner diagnoses an infective exacerbation of her COAD and starts Salma on some antibiotics and steroids. The next day, Salma feels worse, she considers going to hospital for some further help but does not want to do this as her sister was admitted to hospital 3 years ago with a chest condition and died after spending 6 weeks there. Salma contacts the emergency triage system at her primary care centre. The advanced nurse practitioner refers her to the rapid response team in the community. She receives a review by this team within the next 2 hours in her own home, with some additional treatment prescribed for her. The team consider that Salma needs her oxygen levels and condition to be monitored for the next 72 hours and offer Salma an admission to the respiratory virtual ward. This means that she can stay in her own home and be monitored regularly with the help of technology. She receives regular review by the team over the telephone and with an in person home visit the day after admission.

Increasing the proportion of acute care delivered in community and ambulatory settings across the whole of the week.

Developments in medical care mean that many urgent medical and surgical conditions can now be managed without requiring admission to hospital. Avoiding unnecessary hospital admissions reduces the chance of patient deconditioning and other avoidable harms that can occur in the hospital setting. To support our aim of increasing the proportion of acute care delivered in community and ambulatory settings, we will deliver:

- An expansion of our existing Same Day Emergency Care (SDEC) services within Medicine, Surgery and Gynaecology, ensuring consistent access across the whole of the week.
- Development of specific estate with collocated emergency and acute assessment and short stay areas.
- Development and implementation of a Frailty Assessment Unit which increases the proportion of frail patients who are cared for on an ambulatory basis.
- An expansion of our virtual ward and community response offer to increase the number and breadth of patients that can be supported with acute conditions in their own home. Making Home First and discharge to assess models of care a default standard for all clinically appropriate patients, no matter the day of the week.
- Expansion of Home IV services to East Cheshire to support levelling up across C&M.
- Focus on proactively identifying those people within the community in need to allow earlier intervention and targeting high intensity service users to understand drivers and better meet the person's needs.
- Development of ambulatory cardiology services, preventing the need for admission with acute heart failure where clinically appropriate.
- Development of gastroenterology 'hot clinics' and joint clinics with GPs/Community Colleagues facilitating collaborative and holistic care in an accessible and dynamic way.
- Review and progress the opportunities for minor injuries care in line with the vision for Community Diagnostic Centres.

Improving access and reducing waiting times for people accessing elective care

We know post pandemic that many patients are waiting longer to receive outpatient review and undergo elective procedures. Reducing waiting times for people to access such care is a key national priority for us to deliver. We will achieve this by:

- Developing robust primary care advice and guidance systems and a community triage offer via single points of access for a service.
- The development of elective surgical hubs enabling separation of elective and emergency patient flows within the Trust. This means that elective work will be less impacted by urgent and emergency care pressures at certain times of the year.
- Separated facilities for elective orthopaedic work to ensure year round access for patients and the ability to achieve accreditation as a dedicated elective hub site for Cheshire.
- Development of dedicated '23 hour' day case facilities to increase the volume and breadth of surgery performed without requiring overnight admission to hospital.
- Expansion of diagnostic and treatment room facilities to allow more procedures to be performed outside of the theatre environment where clinically best to do so.

Development of centres of excellence for benign conditions

We want to build on the excellent outcomes and efficiencies that are demonstrated by several of our clinical services, to develop them into centres of excellence across Cheshire & Mersey which are used to support specialty training and to enhance Consultant recruitment. These plans will be supported by having dedicated estate, state of the art equipment and specialist workforce in these areas. Our key areas to develop into centres of excellence are:

- High volume, low complexity surgery e.g. hernia repair & laparoscopic cholecystectomy
- Benign urological conditions
- Ophthalmology
- Integrated perinatal pelvic health service

Expansion of locally delivered services where safe, efficient and sustainable to do so with specialist estate and workforce to support

Many of the specialist services provided for patients at MCHFT are delivered in partnership with other organisations which is an effective way of ensuring delivery of safe and sustainable clinical services. Such partnership working will always form a core part of service delivery at MCHFT, however, we recognise, that due to our semi-rural location it can be difficult for patients and service users on occasions to access some of the services which are more remote. In addition, some of our services such as cancer services are delivered by multiple partners across several systems. Consolidating some of these partnerships may enable some of these services to be delivered closer to home for our patients. Our key focus areas to explore with partners will be:

- Enhancing the volume and breadth of locally delivered cancer services.
- expanding the provision of on site diagnostic services within medical specialties.
- Development of a respiratory enhanced care unit, incorporating national guidance recommendations around a specialist workforce.
- Development of a sleep and ventilation service.
- Further development of the existing hyperacute stroke service in partnership with tertiary providers.

Working with system partners to contribute effectively to Cheshire & Merseyside programmes of work related to clinical services.

The C&M clinical pathways programme has the aim of improving clinical outcomes consistently across the region by looking to reduce unwarranted variation and improve consistency in the way in which clinical services are delivered across the region. MCHFT will continue to be a key contributor to these programmes of work, which currently are focused on Trauma & Orthopaedics, ENT and Dermatology. In addition, MCHFT will continue to support ongoing system wide work to improve equity of access to diagnostic services.

How will we demonstrate success?

Within this care model, our key performance indicators will be:

- A reduction in treatment waiting times
- A reduction in length of stay for elective procedures
- Improvements in measures related to theatre productivity and efficiency
- Improvement in Patient Reported Outcome Measures
- Improvement in outcomes for people with cancer
- A reduction in attendances at the Emergency Department
- Improvements in performance metrics within the Emergency Department

These will contribute to the key population health outcomes of:

- Improvements in outcomes from cancer
- Reduction in equalities relating to ability to access services.
- Stratification of local population health data to support early intervention

HELP ME TO FIND OUT WHAT'S GOING ON

"Providing expertise, access and convenience to diagnose and develop treatment plans for our patients"

This care model supports patients to have easy access to a range of dedicated diagnostic facilities, coupled with rapid review of results and formulation of a management plan based on the most up to date evidence. It reflects the regional and national priorities of enhancing diagnostic capacity to support with improving outcomes within cancer services and for cardiovascular and respiratory health in particular.

Our key objectives within this care model will be:

- Expansion of outpatient diagnostic capacity with dedicated estate and facilities to support
- Streamlining of diagnostic pathways to ensure a right person, right place first time approach.
- Use of digital technology to develop and implement patient portals, allowing greater access and ownership of information.

CASE STUDY

HELP ME TO FIND OUT WHAT'S GOING ON

Pavel had experienced two episodes of haematuria (blood in his urine). His GP had referred him to the Trust for a review and some further investigations as necessary. Pavel attended the haematuria clinic five days later where the results from his urine and blood samples were available. He underwent an initial health assessment by a Physician Associate using a clinical diagnostic pathway which indicated that further investigations were required. That morning, Pavel had a CT scan to further assess the cause of his haematuria. The scan was reported that same morning but did not show a cause for his haematuria. The results were discussed with Pavel and a further investigation (flexible diagnostic cystoscopy, insertion of small telescope into the bladder) was recommended. This was undertaken on the same day as part of the 'one stop haematuria clinic'. Following the procedure, Pavel met with the Consultant urologist who advised him of the results of the investigations and discussed with him the recommended management plan.

Expansion of outpatient diagnostic capacity with dedicated estate and facilities

We will look to increase the volume and range of diagnostic procedures carried out at our existing Community Diagnostic Centre at Victoria Infirmary, Northwich. This includes an expansion of endoscopy capacity and medical imaging in particular. Working with Place partners, we will look at how we can expand our network of diagnostic facilities, giving priority to placement of them in the areas with the poorest health outcomes. Our ambition is to create a network of stand alone diagnostic centres, which our patients can access when well, avoiding the need to visit acute areas of the main hospital.

In line with our commitment to delivering recognised centres of excellence, we will develop specialist investigation units within Urology, Gynaecology & Breast Surgery where patients can experience a 'one stop' approach to assessment and diagnostics. Within our cancer services, we will look to expand the range of cancer diagnostic procedures undertaken at MCHFT such as CT guided biopsy and endobronchial ultrasound. These actions will not only enable our patients to access diagnostics closer to home but will also support with recruitment and retention of the skilled clinical workforce needed to deliver our diagnostic services.

For our inpatient population, we will continue to provide a full range of diagnostic services on site with more specialised services provided in partnership with neighbouring organisations. A key commitment from this strategy is to expand the availability of onsite diagnostics and procedures which will support urgent and emergency care pathways to be delivered in full on the Leighton site. This includes expansion of interventional radiology and procedures which are performed onsite.

Streamlining of diagnostic pathways to ensure a right person, right place first time approach.

Access and provision of appropriate diagnostic services need to be considered in the context of the whole pathway that our patients will experience. As part of this strategy, we will review and develop existing diagnostic pathways, ensuring that triage of referrals and the provision of advice & guidance services are well embedded throughout all of our clinical specialties. An example of this is through collaboration with Primary Care, Community services, cardiology and diagnostics to develop a 'Breathlessness pathway'. Within community services, our focus will be on improving pathways for Autism Spectrum condition diagnosis by reducing waiting times for assessments to occur. Within diagnostic services in particular, we will look to expand the use of alternative medical workforce roles, ensuring that our staff are supported to undertake additional training opportunities.

We are committed to working as an effective partner within the Cheshire & Merseyside ICS and maximising the use of diagnostic resources across the system, ensuring that no patient across C&M waits longer than necessary for their diagnostic test.

Use of digital technology to develop and implement patient portals, allowing greater access and ownership of information.

We know that many patients would prefer to have better access and ownership of their clinical information, which would empower them to develop a better understanding of diagnosis and management of condition. Our key projects which would support with this during the lifespan of this strategy are:

- Development of an electronic patient record within maternity services
- Development and roll out of the use of patient portals, providing access to diagnostic examination results, advice and guidance on condition management and personalised management plans where appropriate.
- Explore digital solutions to improve timely and appropriate access to Speech and Language Therapy, and ensure that families are able to access information that they require at all times

How will we demonstrate success?

Within this care model, our key performance indicators will be:

- Reduction in waiting times for all diagnostic examinations and procedures (locally and system wide).
- Improvement in early cancer diagnostic rates.
- Ability to offer a same day service for rapid diagnostic investigations across the whole of the week.
- The majority of routine diagnostics delivered within the CDC setting
- Improvements in length of stay for emergency care pathways

These will contribute to the key population health outcomes of:

- Improvements in cardiovascular and respiratory health
- Improvements in outcomes from cancer
- Reduction in equalities relating to ability to access diagnostic services.

HELP ME TO STAY WELL

"Working with patients, carers and the local community to help people to remain well and best supported to manage their chronic conditions"

This care model considers how we might best support our patients and service users to remain well. This includes maximising opportunities for health promotion and disease prevention for those who are well but also crucially supporting people with a range of chronic medical conditions to best manage their condition and optimise quality of life. There is a specific focus on how we can support our ageing population to remain well and independent for as long as possible.

Our key objectives within this care model are:

- Maximising opportunities for health promotion and disease prevention through the development of co-located services in easily accessible locations.
- Supporting patients with chronic disease to better manage their conditions.
- Development of services to support our frail and elderly population within the community setting.
- Provision of dedicated rehabilitation facilities to enable people to remain independent for as long as possible.
- Development of maternity services in line with national recommendations.

CASE STUDY

HELP ME TO STAY WELL

Eve, 75 is a resident of Cheshire East, living alone in a rural part of the community. She was diagnosed many years ago with heart failure and diabetes mellitus which up until 12 months ago had been very well managed . In the last few months, Eve had been getting more breathless and less mobile due to her heart failure and had also been struggling to control her blood sugars. She was referred to a community Complex Care Practitioner who following a review and discussion with Eve made some medication changes and facilitated discussions between the specialists involved in her care. Eve remained under the care of the community heart failure service, which was able to undertake her appointments in her own home. With the encouragement of her Complex Care Practitioner, Eve made contact with a heart failure charity who were able to support her with advice and contact with a charity volunteer. As part of Eves ongoing contact with the community Complex Case Practitioner, she underwent a multifactorial falls assessment and was identified as being at a high risk of having a fall. Eve was offered the chance to participate in the Cheshire Falls Prevention programme which she found helpful to keep her physical strength up, alongside the opportunity to interact with other people on the programme.

Maximising opportunities for health promotion and disease prevention through the development of co-located services in easily accessible locations.

Every patient contact should be viewed as an opportunity to promote health and to signpost to the services on offer which support this ambition. Within this strategy, there will be a particular focus on:

- Expansion of our child health hubs within community settings. Our hubs provide an opportunity for parents and children to access a range of multiagency services. Since their launch in 2020, we have developed community clinics to support the management of unsettled infants and infants with prolonged jaundice and to support paediatric phlebotomy. Our focus for the future will be to work with local authority partners to further develop the family hub programme across place, in particular to support children and families with special educational needs and disability . This will continue to support integrated working across all partner agencies.
- Further embed and develop our tobacco dependency treatment services which support our patients, relatives and staff. Tobacco addiction is a significant factor which contributes to poorer health outcomes. Our CURE service has successfully supported many patients to stop smoking. The next key steps to deliver are an expansion of this programme within our maternity services and to contribute to an integrated smoking cessation service throughout Cheshire.
- Development of screening services in community locations. Screening for disease before it becomes symptomatic is an important component of improving outcomes at individual and population level. Breast screening services are currently located solely on the acute site at Leighton which can make access difficult for some groups of people, contributing to health inequalities. This strategy sets out a commitment to work with local partners to develop screening services at various community locations.

Supporting patients with chronic disease to better manage their conditions

We will work collaboratively with patients, their families and other agencies to ensure better joined up support for those living with chronic disease. Through our digital strategy, we will empower patients to have ownership over their health data and to ensure that where appropriate, information is shared more effectively between agencies. We will look to ensure greater ease of access to our services for patients with chronic disease, for example by the continued expansion of our community heart failure and respiratory services.
Key focus areas will be:

- Implementation of a new pump service for patients with diabetes, to ensure they receive care and support closer to home.
- Development of Diabetic Specialist Nurse antenatal community clinics.
- Development of a Rheumatology helpline available 7 days a week with access to hot clinics.
- Use of technology to monitor patients with long term conditions e.g. diabetic, cardiac patients with use of artificial intelligence technology where developed, to identify those needing intervention.
- Expansion of virtual wards and remote monitoring to prevent admissions and support earlier discharge for patients with long term conditions.
- Focus on empowerment and self-care where appropriate e.g. Wound Care
- Consider integrating fragile specialist services to improve sustainability and collaboration across hospital and home e.g. Diabetes, Tissue Viability Services.
- Explore opportunities to increase numbers of therapy staff and broadening of therapy roles across CCICP and inpatient areas to improve support in the assessment and management of chronic conditions.

Greater integration of services with other community providers to improve access and outcomes with ophthalmology and audiology services

We know that the care and treatment provided as part of our acute Trust is often only a small part of the wider management of a patient's condition and that for optimal outcomes, close collaboration with other health and social care professionals and services are needed. In some cases, with appropriate support, some of these services could be better provided by other allied health providers in community settings.

Development of services to support our frail and elderly population within the community setting.

We know that older patients make up a significant proportion of the population served by our Trust and that this will only increase with time. Hospital admission in this patient group can increase the risks of harm, especially related to deconditioning so our strategy has a focus on specific support for this segment of the population which will aim to reduce the need for acute hospital admissions. Our key focus will be on:

- Development of a community falls pathway which will provide a holistic service supporting with falls prevention and admissions avoidance, helping people to remain as independent as possible for the longest period of time

- Supporting care homes with the management of conditions in the community to enable people to avoid hospital admission where possible.

Provision of dedicated rehabilitation facilities

Rehabilitation services are an essential component of a patients journey in returning to good health. We want to review and develop how we deliver rehabilitation services to best meet the needs of our patients. Starting from our established principles of 'Home First', we will look to increase the provision of home and community rehabilitation pathways. For those patients requiring more specialist and/or longer term rehabilitation facilities, we have an ambition to develop dedicated inpatient facilities, physically separated from acute patient flows which provide an optimal environment for patients to rehabilitate. This strategy will seek to consolidate existing bed based rehabilitation services into a single location service which provides optimal rehabilitation facilities across Cheshire.

Development of maternity services in line with national recommendations.

We will continue to develop our maternity services in line with national recommendations, particularly around the delivery of a full continuity of carer model of maternity care by 2024. This will require a review and development of community estate to support this ambition. We will continue to achieve high standards in relation to accreditation as a breast feeding friendly organisation in order to support place ambitions of improving children's health.

How will we demonstrate success?

Within this care model, our key performance indicators will be:

- Improved uptake within breast and bowel screening programmes.
- A reduction in people requiring hospital admissions related to falls.
- Reduced hospital admissions for exacerbations of chronic diseases.
- Reduction in discharges to intermediate care beds rather than the patient's home.
- Reduction in level of long-term prescribed care in the community following discharge.
- Reduced hospital and community bed length of stay

These will contribute to the key population health outcomes of:

- Reductions in childhood obesity and dental decay
- Improvement in the number of older adults living well
- Improvements in cardiovascular and respiratory health outcomes

HELP ME TO THE END OF LIFE

"Providing the best possible end of life care in the place that matters most"

The Trust is part of an existing strategic collaborative for palliative and end of life care across Central Cheshire (figure 1). This is a multiagency partnership (Community services, acute palliative care service and St Luke's hospice) with the collective ambition to advocate, lobby and develop high quality personalised end of life care for the people of Cheshire. During 22/23 the Trust has seen the development of the Cheshire & Mersey Integrated Care System Palliative and End of Life Care programme which has 3 overarching ambitions of:

- Improving access to palliative and end of life care (early identification/prevention of unplanned admissions/ equitable access to specialist advice)
- Improving quality of palliative and end of life care (a confident workforce with appropriate knowledge and skills)
- Improving sustainability of palliative and end of life care (workforce plan & sustainable commissioning)

Within this clinical services strategy, palliative and end of life care is a key component of both hospital and community -based services and our ambitions relate to both aspects of this service. The key focus areas are:

- To continue to contribute effectively to delivery of the C&M ICS Palliative and End of Life care plan
- To develop a whole week integrated specialist palliative care service ensuring that patients and families can access services whenever is required.
- To increase senior decision maker presence within the service 7 days/week
- To develop specialist inpatient palliative and end of life care estate, providing an optimal environment for inpatients and their families receiving end of life care.
- To consolidate and expand the palliative care in partnership (PCIP) offer to deliver domiciliary end of life care where the person has a terminal diagnosis and this is their wish

Continued use of shared records including Electronic Palliative Care Co-ordination System (EPaCCS) via EMIS and the new Digital Clinical System.

For children and young people requiring palliative and end of life care, we will continue to work with our community and hospice partners and our paediatric home care team to deliver expert highly personalised care to this patient group and their families with an ambition that these services can be delivered over the whole of the working week.

How will we demonstrate success?

Within this care model, our key performance indicators will be:

- Improved communication with patients, their families and staff including proactive collaborative discharge planning where appropriate.
- Improved patient and family involvement in decision making and greater use of individualised patient care plans.
- Increased specialist palliative care input into patient care
- Improvements in reported measures of staff confidence and support in palliative and end of life care
- EPACCS record completed.

CASE STUDY

HELP ME TO THE END OF LIFE

72-year-old 'Brian' was diagnosed with prostate cancer which had spread to his liver and bone. He developed swollen kidneys and had a tube in place, a scan had demonstrated disease progression. He was admitted to hospital with confusion and lethargy under the care of the medical team, diagnosed with sepsis and was being treated with intravenous antibiotics to which he initially responded.

Brian was referred to the Specialist Palliative Care Team (SPCT) who met with he, his wife and daughter and as part of an advanced care planning conversation do-not-attempt-CPR was discussed. Both Brian and his family understood the rationale and there was open discussion about his prognosis which was likely to be a very few months at best, and Brian wanted to have his care at home. The SPCT liaised with his oncologist and the appropriate treatment plan.

Despite initially responding well to antibiotics Brian deteriorated over the coming days. He was reviewed daily by the SPCT, his family were updated and aware that his recovery was now uncertain and that sadly he was sick enough to die even during this admission. Symptom control medications were prescribed and open visiting for his family was arranged. Over the weekend St Luke's Hospice telephone advice line were alerted to his needs in case further advice was required.

On Monday Brian asked that active treatment for his infection be stopped and he be taken home as soon as possible. The SPCT discussed this with his family who supported his decision, and he was referred to the integrated placement team for fast-track application for funding of care. The SPCT explained to Brian and his family that he was going home for end-of-life care. The ward staff would refer to the district nurses for palliative care and the SPCT provided the community contact numbers for both day and night and explained what to do when Brian eventually passed away. The SPCT updated the community palliative care team on discharge to ensure continuity of care. His family took him home following delivery of a hospital bed and provided his care themselves until his package of care could start. Brian died peacefully a few days later with his family present.

Brian's wife wrote: "My husband was shown so much care by the palliative care team while he was in hospital, visiting him daily on the ward and explaining to us different treatments that they put into plan to help with his pain and making him as comfortable as possible. All he wanted was to go home – they pulled out all the stops to make that happen.'

ENABLING OUR CLINICAL SERVICES STRATEGY THROUGH OUR UNDERPINNING STRATEGIC PLANS

The delivery of our clinical services strategy will be enabled by and will impact on a range of supporting plans. A summary of these plans are provided below:

Workforce

Through our workforce plan, we have set out a clear vision and priorities to support delivery of the Trusts overall strategic vision and ambition. To fully deliver our four care models, may mean that new roles, skills and competencies need to be developed. An example of this may be the development of care co-ordination roles to keep people well. A further addition to our workforce plans is in how they can support our aim of delivering senior decision making presence across the whole of the working week throughout our clinical services. We recognise the huge impact that our workforce has on the experiences of our patients and service users and so a key strategic objective is for us to make MCHFT the best place to work which enables staff to deliver the highest levels of care. As part of this, we are committed to a principle of 'growing our own', supporting staff to develop their careers with us and maximising opportunities through apprenticeship pathways to do this. Our volunteer to career programme is a great example of how we can support local people into employment and deliver on our role as a community anchor organisation.

Leadership

Compassionate and inclusive, values-led and improvement-focused behaviours will be central to our approach in delivering the Trust strategy. Our leadership commitments around visibility , measuring success and harnessing the expertise of colleagues, patients and partners will ensure that our clinical services are developed effectively and are shaped for the future.

Partnerships

This plan recognises the centrality of partnerships to the delivery of our Trust strategy. It outlines how we will continue to develop these partnerships and how they might evolve and strengthen, supported by good governance principles, to drive forward our strategy and our new care models over the coming years.

Estates

This outlines our commitment to developing an efficient, well-utilised estate that offers an excellent and safe environment for patients, staff, carers, and visitors., whilst being sustainable in both environmental and financial terms. Our estates strategy will be a key enabler of our clinical services development as we seek to develop dedicated estate for separated urgent and elective patient services, dedicated rehabilitation space and a focus on delivery of clinical services in the community where this is feasible and desirable.

Digital

Our digital plan is key to the delivery of several of our care models. We will need to deliver and make progress with implementation of our Digital Clinical System (DCS) and of advancing the Joint Cheshire Care record to deliver a cohesive and integrated patient record across Cheshire which supports the delivery of seamless care between providers.. The use of patient led digital technologies which promote patient empowerment and support self-care will also be a focus.

CONCLUSION

This is a strategy for a wholesale change in the way in which we think about and deliver our clinical services. It outlines a shift from a service led delivery model to a population needs led approach, ensuring that as part of a place based system, we can contribute to shifting the dial on important population based measures of health.

The next five years will provide a real opportunity to transform our clinical services and importantly to build the estate required to do this and to recruit and retain the workforce that will be needed. This gives us a unique chance to improve the health and wellbeing of the communities in Cheshire that we serve and to contribute effectively to wider system initiatives.

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Because you Matter

Delivery Plan for Health and Social Care in Cheshire East 2023-2028

This plan sets out how the health and care system partners across Cheshire East will meet the aims set out in the revised Joint Local Health and Wellbeing Strategy (2023-28). We are working to contribute to four strategic outcomes:

1. Cheshire East is a place that supports good health and wellbeing for everyone
2. Our children and young people experience good physical and emotional health and wellbeing
3. The mental health and wellbeing of people living and working in Cheshire East is improved
4. That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place.

Delivering improvements will require committed and coordinated action across multiple partners and many of the key actions will sit outside the health and social care system. This delivery plan focuses on the actions of the health and social care system, but should be read alongside other key system documents, such as the Cheshire East Council Corporate Plan, which is currently being refreshed[1].

As a health and social care system we are constantly working to achieve the Triple Aim for population health:

- Improving the person's experience of care (including quality and satisfaction);
- Improving the health of populations; and
- Reducing the per capita cost of health and care[2].

This Triple Aim is echoed in the Health and Care Act of 2022, which places a duty on NHS commissioners and providers to consider the Triple Aim in all decisions and reduce inequalities across the three domains[3].

[1] Cheshire East Corporate Plan 2021-2025
[2] The IHI Triple Aim | IHI - Institute for Healthcare Improvement
[3] Health and Care Act 2022 (legislation.gov.uk)

We have agreed to improve the individual person's experience by considering care within four domains. Services provided can be considered to meet one or more of these care needs.

We will also focus on a person's (and a community's) strengths as well as their needs.

Figure 1 - Domains of care (from The Joint Local Health and Wellbeing Strategy for the population of Cheshire East 2023-2028)

However, to maximise the health and wellbeing of Cheshire East's residents, it is not sufficient to deliver good-quality health or care services. Our approach recognises that **we must improve the environment in which people live, learn and work** to address the wider determinants of health and wellbeing, that we must **improve preventative and proactive care** and that we must **reduce the inequalities** seen between areas and groups. Within services, we must tackle workforce challenges and improve the experience of delivering care for our staff.

Our health and care system is large and complex and can contribute to the strategic outcomes in many ways. Much of the work ongoing and upcoming is contained within the plans of individual services and organisations. Whilst some key elements are included here as appendices, we instead focus this delivery plan on describing a set of organising principles which will support us in decision making over the next 5 years. These are our 8 Ps.


PROGRESS
• Developing a Joint Outcomes Framework to measure our progress towards our strategic objectives
• Taking forward recommendations from All Together Fairer (Marmot) and Living Well in Crewe reports
• Implementing a Cheshire East approach to quality and safety improvement
• Developing a system Blueprint for 2030 and beyond
Place
• Improving the environment in which we live, learn, work, travel and socialise
• Making the healthy choice, the easy choice by making health promoting places
Prevention
• Addressing lifestyle and behavioural risk factors
• Reducing preventable illness and deaths
Proportionate universalism
• Tackling inequalities through coordinated efforts across the life course
• Developing an offer for everyone but with the greatest efforts focused on those with the greatest need
Partnership working and co-production
• Building seamless, integrated services around the person
• Delivering on the potential of our Care Communities
Proactive care
• Finding diseases and risks early
• Intervening quickly and proactively to improve outcomes
Person-centred approaches
• Looking at the whole person and prioritising what matters to them
• Supporting self care and making every contact count
Programmes of care
• Looking topic by topic and working with residents and staff to understand our data and experiences
• Allocating resources across the whole system to where they will help most

Figure 2 - 8 Ps

Contents

1. PROGRESS	How we will move forward and measure the changes we make, delivering improvements in quality and safety and the reduction of inequalities.

Where we are

Our residents in Cheshire East generally experience good health and wellbeing when compared to other areas in the north-west of England and beyond. However, for several indicators, our place is worse than England overall.

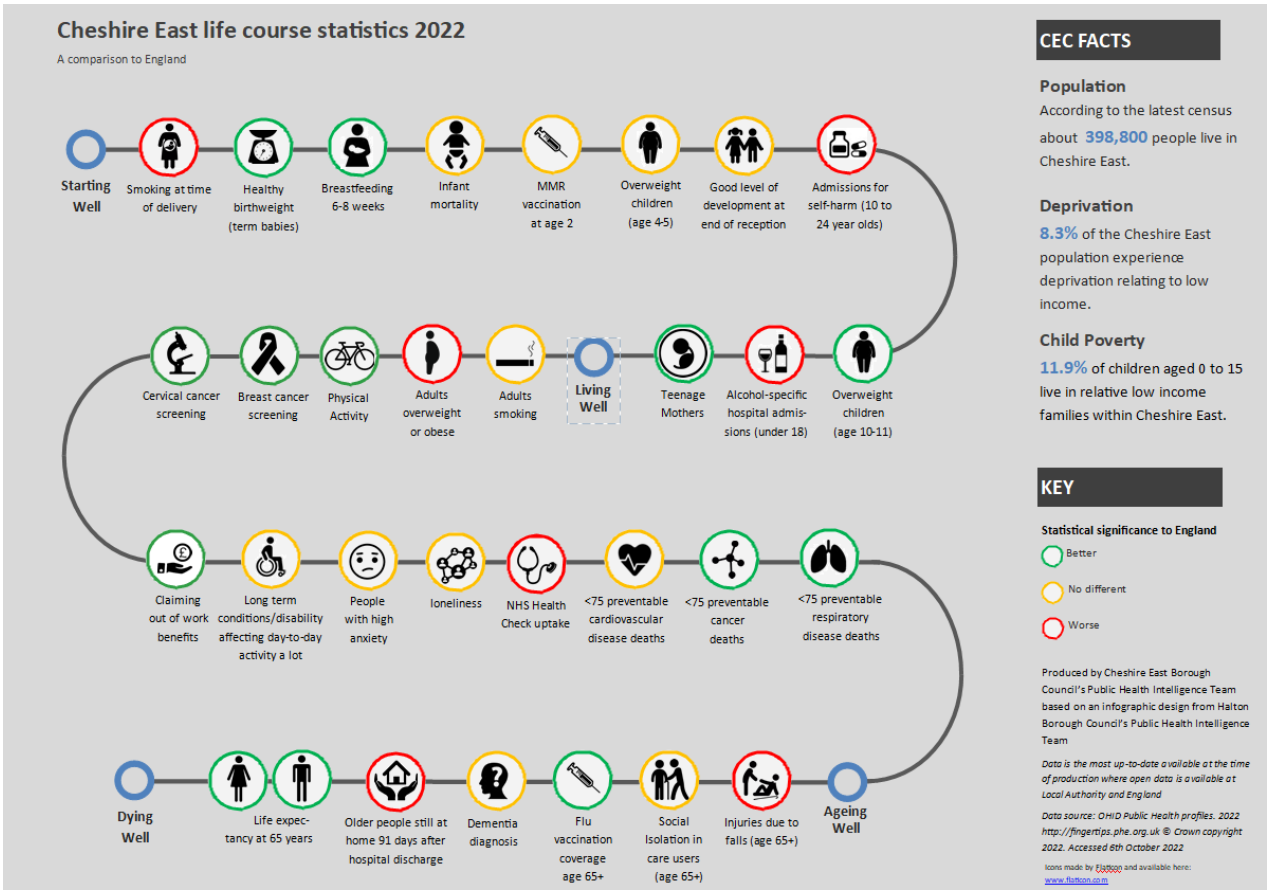


Figure 3 - Cheshire East health statistics across the life course (versus England)

Also, overall Cheshire East figures don't tell the whole story. We know we need to address the inequalities we see within the Borough. These can clearly be seen on the Cheshire East "Tartan Rug", which shows that central Crewe and parts of Macclesfield have worse outcomes than England across several indicators (**see Section 4 appendix – Proportionate** universalism).

Are we moving forward?

Our Cheshire East Joint Outcomes Framework aims to inform and monitor progress against our four strategic objectives. The framework will help us to ensure that as a Place, we are addressing inequalities and optimising our approaches to enabling wellbeing and preventing ill health. The Phase 1 indicators are below and Phase 2 indicators are currently being developed.

Joint Outcomes Framework metrics	
Priority area	**Indicator**
Overarching	Life expectancy Healthy life expectancy
1 - Create a place that supports good health and wellbeing for everyone living in Cheshire East	Unemployment rates Fuel poverty rates
2 - Ensure that our children and young people are happy and experience good physical and mental health and wellbeing	Smoking prevalence at time of delivery Good development at 2.5 years Overweight and obesity at year 6
3 - Improve the mental health and wellbeing of people living and working in Cheshire East	Isolation in our social care users/carers Emergency admissions for self harm
4 - Enable more people to live well for longer in Cheshire East	Physical activity Alcohol-related harm

How will we develop our system targets?

We have developed provisional targets and will agree more specific system targets and timescales by the end of 2023/24. This work will be informed by Phase II of the Cheshire East Joint Outcomes Framework.

Each will be expanded through consultation with system partners, reviews of trends and plans to include specific results (eg a percentage reduction) and timescales – by how much and by when.

Our provisional targets (all targets subject to confirmation) are:

Cheshire East is a place that supports good health and wellbeing for everyone	**Our children and young people experience good physical and emotional health and wellbeing**
• Increase social value weighting and impact in all new contracts, commissions and procurement • Reduce inequalities and overall rates of alcohol-attributable hospital admissions across Cheshire East	• Increase access to and reduce wait times for children and young people's therapies and to mental health services
The mental health and wellbeing of people living and working in Cheshire East is improved	**That more people live and age well, remaining independent; and that their lives end with peace and dignity in their chosen place**
• Increase proportion of people with severe mental illness or with a learning disability who receive an annual physical health check • Increase access to Talking Therapies and reduce demand for secondary care referrals for mental health issues	• Reduce inequalities and overall rates of avoidable deaths across Cheshire East • Reduce 4-hour waits in A&E and eliminate corridor care • Increase in proportion of people discharged to usual residence and reduction in permanent admissions to care homes • To identify all people who are likely to be approaching the end of life and ensure an advanced care plan is in place

How will we move forward?

Quality and safety improvement
Incremental steps will be made as we develop a Cheshire East approach to quality and safety improvement. This will build on the QI approaches already in place in several of our provider organisations. We will identify issues, test solutions and track changes over time as we aim to embed these approaches across our health and care system.

We will review and mitigate risks as we progress and learn from all serious incidents. We will be responsive and learn from our successes and failures. This includes addressing complaints or recommendations from inspections.

Enabling workstreams
Changes to service design and delivery will rely on available estates and finance, communications and engagement and on our skilled workforce.

We recognise the opportunities that digital ways of working offer and we present some of these throughout the report.

All Together Fairer

Overall progress must be accompanied by a reduction in inequalities. All places across Cheshire and Merseyside have committed to deliver on All Together Fairer and become a "Marmot Region" that addresses health inequalities across the life course [4]. Relevant key recommendations will be presented throughout this report but we are also taking forward these actions as we develop our Place-level governance.

Relevant recommendations from All Together Fairer
Marmot recommendation - Adopt Cheshire and Merseyside's Marmot indicators in their own organisations (e.g. NHS, local authorities, businesses, VCFSE sector)
Marmot recommendation - Integrate Place Plans in each Place Executive and create memoranda of understanding between Place Executives and Health and Wellbeing Boards to align Health and Wellbeing Strategies and Place Plans*

* In Cheshire East this means absolute clarity on respective responsibilities for delivery between the Health and Wellbeing Board and the Health and Care Partnership Board with demonstrable alignment across strategies and plans.

Living Well in Crewe

An example of a holistic approach to improving health and wellbeing, reducing inequalities and taking a place-based, whole-life course approach was set out in a **report by the Cheshire East Increasing Equalities Commission – Living Well in Crewe** [5]. This report made recommendations to all local partners and is used as a source document in both the Health and Wellbeing Strategy and this associated Delivery Plan.

Developing a System Blueprint

We are bringing together system leaders in a series of workshops to review recent local programmes such as Caring Together and Connecting Care. We are learning from the resident engagement and care models developed to develop a new System Blueprint. This will describe what our health and social care system will look and feel like for 2030 and beyond and will be produced in late 2023.

More detailed plans will require an in-depth review of need and provision. In 2024 we will work to understand future demands on the system by analysing trends in demographics and health states, using this to inform future service design.

[4] executive-summary.pdf (instituteofhealthequity.org)
[5] Living Well in Crewe AHC 1.0.pdf (cheshireeast.gov.uk)

2. Place	The **environment in which we live, learn, work and socialise** has the biggest impact on our health behaviours, life chances and health and wellbeing outcomes.
Improving our places will require the coordinated efforts of partners both within and beyond the health and social care system. Key to this will be the update of Cheshire East Council's Corporate Plan, currently in progress. As a health and care system, however, we do recognise our own role in improving the lives of our residents and staff.	

Joint Outcomes Framework metrics	
1 - Create a place that supports good health and wellbeing for everyone living in Cheshire East	Unemployment rates Fuel poverty rates
4 - Enable more people to live well for longer in Cheshire East	Physical activity
Relevant recommendations from All Together Fairer	
Marmot recommendation - Work with local residents and partners (e.g. businesses, NHS) to improve quality of existing green spaces in areas of higher deprivation	
Marmot recommendation - Develop Region-wide actions to create health promoting environments (e.g. unhealthy advertising, planning decisions)	
Marmot recommendation - Implement and enforce a 15 percent social value weighting mandatory in all NHS procurement	

Climate change and clean air

We must play our part in mitigating the impact of climate change[6] and will **calculate, monitor and reduce the health and care carbon footprint** from services and medication use and support active travel for staff and residents (see **Respiratory**). We will work through the Place Sustainability Network to achieve net zero targets[7].

NHS organisations will support the national ambition to improve air quality by cutting business mileages and fleet air pollutant emissions by 20% by 2023/24. We will continue to review our practices, sites and supply chain to help achieve a 'Net Zero' health and care service[8]. Cheshire East Council is committed to being carbon neutral by 2025[9].

[6] Climate and health: applying All Our Health - GOV.UK (www.gov.uk)
[7] ICB Cheshire East Programme Priorities 2023/2024
[8] B1728-delivering-a-net-zero-nhs-july-2022.pdf (england.nhs.uk)
[9] Carbon Neutral Council (cheshireeast.gov.uk)

We recognise our role in promoting active travel for our service users and staff.

Digital opportunities	• Shared booking systems to reduce the number of patient visits • Smart planning and scheduling to minimise community staff travel • Virtual appointments and telehealth including further development

Social value and anchor institutions

We aim to achieve public and social value, not just to save money[63]. We will use our power as providers, as commissioners of services and as purchasers to generate social value. We can do good in our local communities and help the environment by embedding social value across the commissioning cycle[10]. **We will support the inclusion of social value weighting in contracts, commissioning and procurement**[7].

The NHS itself has a powerful role as an employer. Half of NHS spending is on workforce and the NHS is the largest employer in England. The role of the NHS as an employer is especially important in more deprived areas. This has been recognised in our role as a local Anchor Institute[11].

Our health and care staff of today are also our current and future patients, carers and community support and so **health and care jobs must promote wellbeing**.

[10] Cheshire East Social Value Procurement Policy
[11] icb-meeting-agenda-papers-271022-public.pdf (cheshireandmerseyside.nhs.uk)

3. Prevention	Many of the gaps we see in health and wellbeing outcomes can be explained by differences in **lifestyle risk factors**, such as smoking, lack of exercise, poor diet and excess alcohol consumption. **Though often driven by a person's environment, effective interventions are available**.
Behavioural risk factors will be assessed as part of a holistic, person-centred approach to all health and care interactions (see **Person-centred approaches**). Broader life factors will be considered and addressed by social prescribers (see **Primary Care Networks**)	

Joint Outcomes Framework metrics	
4 - Enable more people to live well for longer in Cheshire East	Physical activity Alcohol
2 - Ensure that our children and young people are happy and experience good physical and mental health and wellbeing	Smoking prevalence at time of delivery Overweight and obesity at year 6
Relevant recommendations from All Together Fairer	
Marmot recommendation - Ensure any new walking and cycling infrastructure reaches areas with the lowest rates of physical activity	

Digital opportunities	• LiveWell – access to information and support around smoking cessation, weight management and alcohol or substance misuse • Targeted digital communications to promote vaccination in underserved groups • Risk stratification tools to identify those potentially prone to falls

Smoking

Smoking is the single most significant contributor to health inequalities, with smoking rates higher in our most deprived areas and among people with a mental health condition, looked after children and LGBT+ people. Smoking rates whilst pregnant remain high locally. Targeted action will include:

- Improvement of smoking cessation service for adults and young people (One You)
- Offering and encouraging the take up of NHS funded tobacco treatment services for all inpatients who smoke by 2023/24 with expansion of the CURE programme[12]
- Moving tobacco support services from the community smoking service to midwifery units in acute trusts to provide more accessible support for pregnant women with pilot of an incentives scheme[13].

[12] The CURE Project: improving NHS smoking cessation services - Ogden - 2020 - Prescriber - Wiley Online Library
[13] NHS England » Saving Babies' Lives Care Bundle

- Providing a new universal smoking cessation offer for people using specialist mental health services, as well as those accessing learning disability services.

Overweight and obesity

In England, **childhood obesity is rising** and the gap in prevalence is widening between the least and most deprived (The Health Foundation, 2022). Our six central Crewe electoral wards have higher rates of overweight and obesity than the Cheshire East average in children[14].

We welcome the launch of the Cheshire and Merseyside physical activity strategy, **All Together Active**, and will work with the regional team to develop our Place-level plans to boost exercise, activity and participation in sports[15].

Priority actions will include:

- Expanding the "Healthier You" programme including a digital offer
- Ensuring all our NHS premises meet the strengthened requirements to offer healthy food for our staff and patients and exploring taking this forward in all public sector settings
- Increasing uptake of three-month weight management programmes
- Implementing the Childhood Obesity Plan and continuing to support the school physical activity programme 'walk a mile'
- Continuing the National Child Measurement Programme and working with schools to support physical activity and healthier diet options
- Exploring the implementation of the digital Our Family Health offer aimed at families with children aged between 4-7 years and tackling obesity through Family Hubs

Alcohol

Reducing alcohol harm is one of the key strategic priorities under the Cheshire and Merseyside population health programme. While alcohol-related harm in Cheshire East is below the England average overall, **in some parts of Crewe you are more than twice as likely to be admitted to hospital with an alcohol-related condition as the England average**[16]. An ambition of the Cheshire East Place is to align our plan to the NHSE ambitions listed in the Long Term Plan, and to develop an evidence based standardised care pathway[17]. We will:

- Review and strengthen the specialist Alcohol Care Teams within our hospitals
- Understand and address the effects of debt, gambling and domestic abuse
- Address the impact of alcohol on pregnancy and on children and families
- We will coordinate actions within our Combating Drugs Partnership (see **Substance Misuse**).

[14] Crewe JSNA Deep Dive (in draft)
[15] All Together Active Strategy - All Together Active (champspublichealth.com)
[16] Crewe JSNA Deep Dive (In draft)
[17] NHS Long Term Plan » Alcohol

Substance Misuse

We are taking forward the recommendations in the Government's 10-year Drugs Plan by developing a Place-level **Combating Drugs Partnership**[18],[19]. The Partnership held their inaugural meeting in January 2023 and will be leading the development of a new strategy to tackle harms from drugs and alcohol over the course of this year with a new substance misuse JSNA chapter as its foundation.

We will continue to support people through our commissioned substance misuse services, delivered collaboratively with a range of providers. This all-age service has recovery teams that are based across Cheshire East.

Vaccinations

Although for Cheshire East as a whole, MMR vaccination rates are above national, North West and the Cheshire and Merseyside averages, with first dose coverage at 93%, there are inequalities in uptake and more can be done.

Cheshire East GP practices have achieved the second highest uptake of seasonal flu vaccination in the over 65s in the North West region - with 73% of patients vaccinated across the Borough in this cohort. Locally the opportunities for greatest improvement in flu vaccination uptake are in 2 and 3-year-olds and pregnant women. We will continue to work to ensure that our population is vaccinated, and wherever possible offer flexible locations across the borough, in addition to our GP surgeries.

This local approach helped us improve COVID-19 vaccination rates in areas with low uptake, such as central Crewe. Here, we worked with voluntary faith organisations and employers to boost participation amongst Eastern European groups and we offered accessible clinics (including a mobile offer) to support marginalised groups to benefit from the vaccine. These lessons can be applied across our immunisation programme.

Falls prevention

A fall often results in a person needing to stay in hospital and can permanently reduce their physical and mental health and wellbeing. Cheshire East is worse than the England average for rates of admission for falls in people aged 65 years and older[20].

Our **Falls Prevention Group** will improve identification of those at risk of falls and put preventative strategies in place across health services and in care homes. Promotion of the issue of falls will take place via a series of communications including a local falls awareness week.

A new falls service will be piloted which aims to reduce the risk of people falling via use of multifactorial risk assessments and home hazard checks. The One You Cheshire East Service will continue to deliver falls prevention classes.

[18] From harm to hope: A 10-year drugs plan to cut crime and save lives - GOV.UK (www.gov.uk)
[19] Cheshire East Combating Drugs Partnership ToR
[20] Public health profiles - OHID (phe.org.uk)

4. **Proportionate universalism**	Tackling inequalities through coordinated efforts across the life course with an offer for all but the **greatest efforts focused on those with the greatest need**

Joint Outcomes Framework metrics	
Overarching	Life expectancy Healthy life expectancy
Relevant recommendations from All Together Fairer	
Marmot recommendation - Work in partnership with local communities to assess digital exclusion priorities	
Marmot recommendation - Reduce inequalities in digital exclusion by delivering hardware and funding support for basic digital skills	
Marmot recommendation - Involve VCFSE sector organisations and networks tackling racism in businesses and the public sector	

Digital opportunities	• A digital first, system wide approach could free up resources to focus on marginalised groups and support digitally excluded residents • Continued integration with and analysis of population health data

Core20PLUS5 (adults)

We will implement the Core20PLUS5 national approach to the reduction of health inequalities. The approach targets improvements in health outcomes for key conditions within the most deprived local areas and for other groups[21].

Pending work on avoidable deaths will help confirm that these are priority work areas in Cheshire East (see **Avoidable deaths**).

Core20 refers to improving outcomes for the most deprived 20% of England's population. Whilst health and wellbeing outcomes in Cheshire East are often better than the England average, these overall figures mask significant inequalities within our Borough**. Those in our most deprived areas not only live shorter lives but spend more years in poor health.**

This is seen both nationally and in Cheshire East where the **inequality in life expectancy** at birth is 9.5 years and 7.2 years for males and females respectively (2018-20) but the **inequality in** healthy life expectancy at birth is wider at 13.5 years and 12.6 years for males and females respectively (2009-13)[22].

[21] Inclusion Health: applying All Our Health - GOV.UK (www.gov.uk)
[22] Public health profiles - OHID (phe.org.uk)

That residents in deprived areas experience more years in poor health is unfair but it also increases demands on our health and care services and reduces the local workforce. **Reducing the gap is a key step in creating sustainable services and a vibrant economy**.

Our Tartan Rug (see **Section 4 appendix – Proportionate** universalism) is a striking visual reminder of the area-level inequality across Cheshire East, with two clear vertical bands of red in central Crewe and Macclesfield showing poor outcomes across a large range of indicators. We have seen that 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[23] and that 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[24]. Three Crewe wards (Central, South and St Barnabas) were 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[23].

Avoidable deaths

We will examine avoidable deaths (mortality) across Cheshire East at ward level[25]. This means examining death data across the Place to determine rates of:

- **Preventable mortality:** Causes of death that can be mainly avoided through effective public health and primary prevention interventions (i.e. before the onset of diseases/injuries, to reduce incidence).
- **Treatable (or amenable) mortality:** Causes of death that can be mainly avoided through timely and effective health care interventions, including secondary prevention and treatment (i.e. after the onset of diseases, to reduce case-fatality).

This will allow us to **determine the underlying causes for the gaps in life expectancy** we see across our Place and give us targets for actions to reduce them, especially within our Core20 areas.

PLUS groups

PLUS groups are those within and beyond our Core20 areas that experience poorer access or benefit from services and poorer health and wellbeing outcomes. Some examples include:

Armed forces and veterans

We will continue to work together with partners to better understand the mental health needs of our Cheshire East veteran population and their families. There will be access to specialist mental health/psychological therapy services for military veterans, adhering to the 'Veterans in Mind' service across Cheshire and Mersey. CWP are a Veteran Aware NHS trust[26] and Cheshire East

[23] Partnership-Board-Agenda-Papers-Wednesday-28th-April-2021.pdf (cheshireandmerseysidepartnership.co.uk) – P.86
[24] 'Left behind' neighbourhoods - Local Trust
[25] Avoidable-mortality-2019-Joint-OECD-Eurostat-List-preventable-treatable-causes-of-death.pdf
[26] Support for our armed forces community :: Cheshire and Wirral Partnership NHS Foundation Trust (cwp.nhs.uk)

Council has received the Armed Forces Covenant Employer Recognition Scheme Silver Award[27].

Gypsies and Travellers
Gypsy and Traveller communities experience worse health, die earlier than the rest of the population and are less likely to receive effective continuous health care that meets their needs.

We are working in partnership with other organisations and lived experience communities to develop and implement a strategy to improve the health and wellbeing of this population group living and travelling in Cheshire East.

Refugees and asylum seekers
Partners are supporting several hundred single adults and families placed in hotels and houses across the Borough. We are supporting their wellbeing needs and addressing complex health concerns by ensuring access to local GP services and providing specialist health protection advice.

Homelessness
We will continue drop-in service provision for those experiencing homelessness and rough sleeping in Crewe. Improved mental health provision for those experiencing homelessness is an ICB priority, as is that for refugees and asylum seekers[28].

Other groups
We will review 2021 census data to understand where our residents who identify as ethnic minorities or LGBT+ are living to ensure services are present to meet their needs.

Our work must consider the poor health outcomes seen in some other groups discussed elsewhere, such as those with learning disabilities, and ensure equity of access to preventative, diagnostic and treatment services (see **Learning Disabilities and neurodiverse conditions**).

Women's health

Whilst women live longer lives than men, they often spend more years in poor health and the conditions that affect them can be under-researched and insufficiently provided for[29]. Amongst women in Cheshire East, there are significant disparities in uptake of cancer screening, which is most marked for cervical cancer screening, where low uptake is seen in central Crewe[30]. Women need fair access to education, advice, investigations and treatments across the life course (see **Section 4 appendix – Proportionate** universalism). Trans men and non-binary individuals assigned female at birth also require access to many of these services[31].

[27] 24/05/2022 - Council receives Armed Forces Covenant Silver Award ahead of Armed Forces Day weekend (cheshireeast.gov.uk)
[28] ICB Cheshire East Programme Priorities 2023/2024
[29] Women's Health Strategy for England August 2022 (publishing.service.gov.uk)
[30] Crewe (cheshireeast.gov.uk)
[31] bma-response-to-dhsc-women-health-strategy-call-for-evidence-june-2021.pdf

Digital exclusion

Service transformation will require digital innovation, but many people feel can feel excluded. We will take forward the recommendations in the Digital Inclusion Strategy[32] and design services that work for all. Digital transformation could free up capacity, some of which can be used to improve services for those who are digitally excluded (such as through in-person or telephone access).

[32] Cheshire East Digital Inclusion Strategy in draft

5. Partnership working	By working together at Place, we can build seamless, integrated services around the person. Health and care services will be coordinated across the public, commissioned and VCFSE sectors to ensure people receive the right care in the right place.

Joint Outcomes Framework metrics	
2 - Ensure that our children and young people are happy and experience good physical and mental health and wellbeing	Good development at 2.5 years Overweight and obesity at year 6
3 - Improve the mental health and wellbeing of people living and working in Cheshire East	Isolation in our social care users/carers
Relevant recommendations from All Together Fairer	
Marmot recommendation - Embed partnerships across local systems with healthcare, the VCFSE sector, local economic plans and strategies beyond leaders	
Marmot recommendation - Make the case to VCFSE sector and local authorities to shift from only emergency provision to act on the social determinants of health	
Marmot recommendation - Work in partnership to improve school readiness for all and reduce inequalities between children eligible and not eligible for Free School Meals. Ensure support is focussed to develop children's early learning, especially with regard to speech and language skills and the ACEs agenda.	

Co-produced services

Service transformation will be done with residents, not to them. True co-production is difficult, but we will build on successful programmes and take forward the co-design principles laid out in the **Living Well for Longer Plan 2022-2025**[33].

We will use the expertise of Healthwatch and local VCFSE partners to engage residents and ensure changes address their priorities and needs.

Our service models will be built around the individual person and their needs and strengths:

Figure 4 - Domains of care (from The Joint Local Health and Wellbeing Strategy for the population of Cheshire East 2023-2028)

[33] Layout 1 (cheshireeast.gov.uk)

A strong start for our children

We will implement our **Children and Young People's Plan 2022-26** to give our children the best possible start in life[34]. The approach was developed with the Cheshire East Youth Council and the Children and Young People's Trust (See **Section 5 appendix – Partnership** workingError! Reference source not found.

This comprehensive plan will address needs and strengths in physical and mental wellbeing and improve the life chances of our young people. It prioritises looked after children and those with special educational needs as well as considering broader factors such as school attendance and safeguarding.

In addition, we will:

- Offer patient initiated follow up in paediatric outpatient clinics
- Ensure delivery of the aims of the Better Births strategy[35] and learn the lessons of the Ockenden review[36]
- Continue the support for the returned maternity services at East Cheshire Trust
- Continue the expansion of the Cheshire and Mersey Specialist Perinatal Service for mental health.

Digital opportunities	• Understanding online abuse and harm towards children • Integrated service delivery and shared records in new community locations including family hubs

VCFSE as full partners

Our voluntary, community, faith and social enterprise (VCFSE) services provide vital lifelines, supporting some of our most vulnerable residents. They have increasingly proven to be dependable, cost-effective providers of more proactive and organised support. As a system we will value the contributions our VCFSE partners make. **Where we are piloting new approaches, we need to ensure that there are clear pathways to evaluation and wider roll-out with a plan to commission effective interventions**.

One such pilot is the Green Spaces for Wellbeing programme. This partnership programme supports users to access nature and undertake activities in local parks.

Elsewhere, CWP commission the Mental Health Wellbeing Alliance and VCFSE services are commissioned to support discharges from acute hospitals and a pilot of a new Transfer of Care service will help match patients and service users to the organisations that can keep them safe in the community.

[34] (Public Pack)Agenda Document for Cheshire East Health and Wellbeing Board, 29/11/2022 14:00 – p175
[35] NHS England » Implementing Better Births
[36] Final report of the Ockenden review - GOV.UK (www.gov.uk)

Digital opportunities	• Data and record sharing with VCFSE providers • User centred design of service directories to ensure people receive the right information and support including LiveWell

Health and care services

Partners will review the annual national NHS Operational Planning Guidance to commission and deliver services that meet the actions and objectives discussed[37]. The main targets are shown in **Section 5 appendix – Partnership** working.

Primary Care Networks

Primary care is central to the delivery of our new care models. GP practices across Cheshire East have grouped in clusters to form Primary Care Networks (PCNs), covering their local neighbourhood populations of between 20-50,000 people. We will support the ongoing development of all Primary Care Networks through their clinical directors.

General Practice will remain the bedrock of service delivery in Cheshire East, and we will support Practices to build capacity and implement the national Modern General Practice Access standards which will enable patients to have their needs met through their preferred care interface, either digitally, face to face or on the telephone.

Social prescribing has now been expanded and will continue to expand across our Care Communities and this will support primary care networks to refer people to social activities and community groups.

The ICB is working to maximise opportunities created through the DES (Directed Enhanced Services) contracts to which each PCN is signed up[38]. This will include accelerating recruitment to ARRS (Additional Roles Reimbursement Scheme) roles[39].

Digital opportunities	• To improve access to care, including offering online and video consultations • Chatbots or automated streaming and signposting • Clinical decision support

Care Communities

See - **Section 5 appendix – Partnership** working

Our 8 Care Communities have fully formed core groups made up of clinical leads and multi-agency partners, including Healthwatch and VCFSE leads. Each use population health data and local knowledge to develop their local priorities and improvement plans.

In addition, Cheshire East partners have aligned supporting functions to include business intelligence, quality improvement and a new role of Care Community Support Manager.

[37] PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf (england.nhs.uk)
[38] ICB Cheshire East Programme Priorities 2023/2024
[39] Integrating additional roles into primary care networks | The King's Fund (kingsfund.org.uk)

Care Communities will increasingly become the bedrock of delivering local services for local people, locally determined by local knowledge. With a shared purpose and shared commitment to continuous improvement, further opportunities will be defined, for example, increasing 7-day service delivery and development of clearer, more robust links with secondary care as part of a "one system" approach.

Digital opportunities	• Analytics and data-driven quality improvement • Integrated service delivery and shared records in new community locations

Acute hospital care

Cheshire East are continually working to review acute service delivery and linking to Cheshire and Merseyside programmes to ensure our local hospitals continue to deliver high quality, safe and patient-centred care.

East Cheshire NHS Trust is working with Stockport NHS Foundation Trust to create sustainable hospital services for the people of eastern Cheshire and Stockport. However, it is fully recognised that sustainable hospital services can only be realised through seamless services across primary, community and secondary care, and by working in partnership with patients, their families, local communities and VCFSE groups.

Digital opportunities	• Analytics and data-driven quality improvement • Development of MyCareView • Our electronic patient records, improving data collection • Clinical decision support • Record sharing and task management

Urgent care

We have been working collaboratively across Cheshire East health and social care system to offer urgent care at or close to home, reducing risk and ensuring that wherever a person accesses care, that support is delivered "Right Place, Right Service, Right Time".

We will develop clear and viable community alternatives to ensure that people can access the support they need and only visit emergency departments when it is essential to do so.

We will:

- Enhance 7-day access to community health and care services including therapies
- Continue transformation in mental health crisis care with crisis cafes and crisis beds
- Review ED capacity and resources to ensure it is fit for our future population

We will continue to implement our Home First (see **Section 5 appendix – Partnership** working) model to respond to crises and help people remain at home. This includes the development of our integrated workforce and expansion of a discharge to assess model.

Planned Care

Waiting lists for planned treatments and procedures grew during the COVID-19 Pandemic and nationally stand at more than 7 million people – the longest since records began in 2004[40]. These delays can contribute to pain, anxiety, worsened quality of life and deterioration in someone's health. Whilst limited hospital beds due to delayed discharges or the need for ringfenced surgical units may contribute, the majority of those on waiting lists are waiting for diagnostics, decisions, or outpatient or day case treatment[41].

As we continue the elective recovery programme, we must **analyse our waiting list data by relevant characteristics and ensure that we tackle inequalities amongst those waiting for treatment**[42]. We must prioritise treatment based on need and tackle long waits. Access to healthcare can be improved by offering more diagnostic and treatment capacity in the community (if appropriately resourced) and through improving patient pathways and community access to specialist advice.

Digital opportunities	• Population health analytics to understand waiting list inequalities • Integrated diagnostics to make best use of capacity • Remote monitoring to reduce the need for outpatient follow-up

Social care

Our care teams carry out a vital role in keeping people well in their own homes, promoting independence and dignity and often preventing the need for acute hospital or residential care. Pressures in the system can lead to a poor experience for those individuals who rely on support and an impact on our hospitals through increased admissions and delayed discharges. These **shared problems require shared solutions**.

We are working to self and peer assess our services via the ADASS (Association of Directors of Adult Social Services) Northern Collaborative. We will provide assurance to the ICS and the Care Quality Commission (CQC) that we are offering safe and effective care services at Place level[43].

We have a number of initiatives to improve standards of healthcare delivery in our care homes through the Enhanced Health in Care Homes Framework[44]. This will improve outcomes for some of our most vulnerable residents.

We must continue to value and support our family and informal carers by implementing the All-Age Carers Strategy 2021-2025 and by working through the All-Age Carers Hub to provide help, training, respite and support[45].

Digital opportunities	• Remote monitoring, assistive care technology and telehealth to keep people safe in their own homes

[40] Strategies to reduce waiting times 2022.pdf (kingsfund.org.uk)
[41] Waiting on the waiting list, but what for? | The King's Fund (kingsfund.org.uk)
[42] C1466-delivery-plan-for-tackling-the-covid-19-backlog-of-elective-care.pdf (england.nhs.uk)
[43] CQC webinar | Local Authority Assurance and Integrated care systems oversight - YouTube
[44] the-framework-for-enhanced-health-in-care-homes-v2-0.pdf (england.nhs.uk)
[45] Report Template v4.0 (cheshireeast.gov.uk)

6. Proactive care	Screening and case finding, rapid access to diagnostic tests, proactive treatment – finding diseases early and intervening quickly to give the best chance of a good outcome.
Over time, will use all available information to determine risk and create bespoke interventions based on needs – a population health management approach	

Joint Outcomes Framework metrics	
Overarching	Life expectancy Healthy life expectancy
4 - Enable more people to live well for longer in Cheshire East	Physical activity Alcohol

We are developing models of care that can rapidly react to a person's needs but are also proactive and anticipate need and avoid unnecessary illness, disruption and cost. We must ensure that clear pathways exist to promote rapid diagnosis and treatment of physical and mental health conditions.

Early identification can improve outcomes in many disease pathways. Key activities include national screening programmes for cancers or case-finding approaches to cardiovascular diseases and risk factors (such as the NHS Health Check or local testing for high blood pressure).

For all case-finding activity, we will ensure that activity is evidence-based and that there are clear pathways for rapid diagnosis of serious health problems.

Health checks

The NHS Health Check is commissioned across Cheshire East. We will continue to review the uptake across our primary care practices and work to narrow gaps and ensure that those who might benefit are able to do so. This means looking for **inequalities in uptake** and ensuring that people receive appropriate advice, treatment or referral when a risk factor is identified.

It is estimated that for people with serious mental illness (SMI), 2 out of 3 deaths are from physical illnesses that can be prevented[46]. Cheshire East is working in partnership with the PCNs and provider organisations to increase the uptake of annual health checks to 60% (from a recent baseline of 35%) by piloting a new programme in GP practices[47].

We will also review the quality and uptake of annual health checks for those with learning disabilities aged 14+.

Digital opportunities	• Digital health checks, at home or point of care blood testing • Risk stratification and targeting of health checks

[46] Premature mortality in adults with severe mental illness (SMI) - GOV.UK (www.gov.uk)
[47] Partnership approach to SMI physical health checks | Equally Well

Community pharmacies

Pharmacies are a key part of the health and care infrastructure and are often situated in our areas of greatest need. Following the 5-year community pharmacy contractual framework[48] is the development of Healthy Living Pharmacies[49]. Pharmacies are expanding their role as community hubs and becoming a health promoting environment. Many are offering mental health support or are becoming dementia friendly pharmacies.

Services include case-finding for high blood pressure, delivering vaccinations, initiating long-term medication and reviewing concordance or inhaler technique.

Digital opportunities	• Electronic prescriptions • Record sharing

Frailty

We will identify and support people with rising frailty (including falls) and implement systematic training across all health and care partners and other public facing roles. There will be frailty champions in all Care Communities and across community pharmacies. In addition to this, local authority support has ensured that all Care Community staff will be trained in dementia awareness. We will also:

- Continue development of a single community and hospital care frailty assessment and care plan
- Introduce virtual wards for those with frailty and improve access to community geriatricians
- Ensure people assessed as being frail are supported at home and up-to-date care plans are in place
- Utilise analysis being undertaken at an ICS level to better understand the needs of residents experiencing frailty across Cheshire East.

Digital opportunities	• Improved frailty identification from primary care records • Virtual wards with remote monitoring or telehealth • Population health analytics to identify those at risk of admission or other poor outcomes

Population health management (PHM)

Our residents are not all alike. Some are relatively healthy and use services infrequently. Others have multiple health complaints that put them at high risk of needing inpatient care or more intensive support. These groups need different things from our local health and care system[63].

[48] NHS England » Community Pharmacy Contractual Framework 2019-2024
[49] HLP - Introduction and background - PSNC Website

We will work with partners across Cheshire and Merseyside but will **develop a Place-based approach to population health management**. Rather than offering one-size-fits all services, we will use the individual-level data held within our partner organisations to develop segmentation models, risk-stratify our population and **deliver targeted, personalised care**. This will build on the linked data sets created as part of the CIPHA programme and the population health work undertaken by the System P team. Over time we will develop predictive analytic tools to enable us to proactively engage those at the highest risks of poor outcomes.

In all of this work we will be mindful of the need to balance targeted and population-level interventions.

Digital opportunities	• Improved data collection, aggregation, and analysis to understand our population using all available data • Risk stratification and targeted, personalised approaches to health and care

7. Person-centred approaches	Looking at the whole person and prioritising what matters to them through shared decision making
We will co-produce services and bring them closer to a person's home wherever practicable	

Joint Outcomes Framework metrics	
3 - Improve the mental health and wellbeing of people living and working in Cheshire East	Isolation in our social care users/carers
4 - Enable more people to live well for longer in Cheshire East	Physical activity Alcohol
Relevant recommendations from All Together Fairer	
Marmot recommendation - Identify methods to involve local residents in the development of health inequalities assessments and remedies at place level, e.g., through the creation of community engagement panels	

Promote and support self-care

Self-care is vital for individual wellbeing and many health complaints are managed with self-monitoring or simple over the counter remedies without any formal assessment by a clinician. We want to promote self-care and management, health promotion, education and individual responsibility, where appropriate[63]. Our local system will build on national infrastructure to ensure people have **rapid access to trusted information with a digital first offer** that enables those who can care for themselves to do so and identifies and signposts those who need additional support. This asset-based approach will focus on what people *can* do. We will make the best use of pharmacies and their wider health and wellbeing offers to facilitate people maximising their own agency and wellbeing.

We will recognise and address people's broader needs and continue to develop social prescribing approaches and we will promote mental health through the Five Ways to Wellbeing.[50]

We will support more children and young people with long term conditions to understand and self-manage their condition(s), with the support of their carers/families, including the use of online resources and personalised care plans. An example in use is the CATCH app, which provides personalised health advice as children grow[51].

Digital opportunities	• Access to trusted sources of information • Wearables or home monitoring to facilitate self care

[50] Five ways to wellbeing - Mind
[51] CATCH - Common Approach To Children's Health (catchapp.co.uk)

Person-centred care

Where possible, care will be delivered close to home, within our eight Care Communities. For some, this will mean a digital or remote offer. Social prescribers in our Care Communities will link closely with VCFSE sector and community providers will support harder to reach groups and those who are digitally excluded (see **Digital exclusion**).

We will support shared decision making in all clinical and professional contacts by giving patients, carers and professionals the information and flexibility they need.

Digital opportunities	• Giving patients and service users access to and control over the information in their health and care records • Shared records with a single version of the truth so people don't need to repeat their story • MyCareView patient held record enhancements and further development

Making Every Contact Count (MECC)

This will move beyond behavioural risk factors and a checklist of activities. We aim to deliver holistic care, considering the whole person and supporting what matters to them. This requires a shift in culture from episodic and task-based care, to empowering staff to undertake more comprehensive assessments and address a broad range of issues that might lie outside of their professional role. To Make Every Contact Count, frontline staff will need training, support from leaders, and systems and processes to support assessment, advice and appropriate referrals[52].

Digital opportunities	• Improved electronic forms and prompting to facilitate conversations covering behavioural risk factors and wider determinants of physical and mental health • Decision support tools, service directories, seamless referrals to services from within the professional's native system

Palliative and End of Life care

Public Health Palliative Care International states that "it is absolutely crucial that communities are involved in their own health and wellbeing", and this must include their varied experiences of death and dying. A public health approach to death and dying would enhance the quality of life for the widest number of people in sickness and in health, in dying and in loss[53].

Discussing and sharing preferences about care at the end of life improves how people plan for and feel about their own mortality. We want to **normalise discussions** about this universal experience.

[52] Making Every Contact Count, Cheshire and Merseyside - Insight work with senior healthcare leaders (publishing.service.gov.uk)
[53] The PHPC Approach — PHPCI

A person's experiences at the end of life can affect wellbeing of those around them. To increase resilience, we will empower "Compassionate Communities" across Cheshire East, giving them the skills to support people who are dying or affected by loss and bereavement.

We want every person within Cheshire East Place to get fair access to palliative and end of life care and support. We want **everyone with life limiting conditions to live well, before dying with peace and dignity in the place where they would like to die**, supported by those important to them.

Our End of Life Partnership, hospices, NHS and social care providers are part of the Cheshire and Merseyside Palliative and End of Life care programme[54], which is committed to:

- **Improving** the **identification** of people who are likely to be in their last year of life. Once identified, people can be offered support to develop a **personalised care plan** and their care can be co-ordinated.
- Training and educating health and care staff:
    - To recognise when people are approaching the end of life
    - How best to work together to provide high quality care to the dying person and the people who are important to them.
    - Sharing information electronically across all care settings so that palliative and end of life care is timely and responsive

We are working across Cheshire and Merseyside to audit palliative and end-of-life care for children against national standards and are piloting specialist community nurse provision for children and young people.

Digital opportunities	• Work to identify those likely in the last year of life • Shared records and advanced care plans with important decisions recorded and shared

[54] CM-PEoLCN-Delivery-Oversight-ToR-July18.pdf (england.nhs.uk)

8. Programmes of care	Looking topic by topic, working with residents and staff to understand our data and experiences and **allocating resources** across the whole system to where they will help most

Joint Outcomes Framework metrics	
Overarching	Life expectancy Healthy life expectancy
3 - Improve the mental health and wellbeing of people living and working in Cheshire East	Emergency admissions for self harm

We will **look across the whole system for each topic area**, not just at individual settings or services. We will understand where activity is happening, **where we are focusing our resources** and whether there would be benefits to **investing in particular parts of the pathways to improve outcomes** and make services more efficient. This is a programme budgeting and marginal analysis (PBMA) approach, which is already being trialled in paediatrics.

Digital opportunities	• Matching and analysing financial and clinical information to understand need and spend across complex pathways

Mental Health

Mental Wellbeing is a focus for all Care Communities. We need to consider how we prevent mental illness and will sign up to the Prevention Concordat for Better Mental Health. We are developing a new All Age Mental Health Strategy for Cheshire East Place, which will describe how we will:

- Address the underlying reasons behind poor mental health
- Help to create the conditions for people to thrive
- Challenge the stigma around mental ill health
- Provide specialist help and support for mental illness

We will reduce complex barriers to education, training, employment and financial independence through our IntoWork programmes, which support mental wellbeing.

We will evaluate and expand mental health practitioner roles in PCNs (funded through the Additional Roles Reimbursement Scheme (ARRS)).

We will work with young people and schools to improve mental health support (see

A strong start for our children).

Our Primary Care Networks are supporting wellbeing through social prescribing models (see **Primary Care Networks**)

We will support our local providers to join NHS-provider collaboratives to take on responsibility for more specialised mental health, learning disability and autism services, facilitating more people to be cared for within or closer to their home.

Related to this is the need to reduce our reliance on and use of out-of-are mental health inpatient beds. These negatively impact on the care experience for individuals and families as well as the overall costs of care.

We will test and roll out adult community mental health access standards. The redesign of mental health services has resulted in increased resources in the community (from inpatient beds). The mental health provider is coordinating community mental health services around the PCNs and Care Communities.

In relation to older people's mental health, memory clinics are being integrated into PCNs and Care Communities. Pathways will be streamlined to reduce handoffs and, significantly, there will be improved psychosocial support to ensure that the care models for physical health are mirrored for those affected by severe and enduring mental health problems.

We will deliver a comprehensive crisis offer that enables more people to be supported to stay at home or within their community, working closely with all partners. This will include delivery of 24/7 adult crisis resolution and home treatment teams across Cheshire East and 24/7 crisis provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions by 2023. Crisis support for those with dementia is in development.

We will ensure that staff across the system are offered leading mental health support to maintain a healthy workforce.

Learning Disabilities and neurodiverse conditions

(see also

A strong start for our children)

We will improve the care for people with learning disabilities and/or neurodiverse conditions, ensuring integration with plans for mental health, special educational needs and disability (SEND), children and young people's services and health and justice as appropriate. There is a service for children with a learning disability up to the age of 18 to ensure effective transition to adult services. All settings can use the Cheshire East SEND toolkit to support children and young people[55]. Our mental health provider has developed a dynamic risk support tool to assist with admission avoidance for those with a learning disability.

We will:

- Learn from lived experiences as well as from Learning Disability Mortality Reviews (LeDeR). These reviews will always be undertaken within six months of the notification of death.
- support PCNs to deliver the SToMP (stopping over medication of people with a learning disability, autism or both) agenda.

[55] CE Toolkit for SEND - FINAL v2.0 (cheshireeast.gov.uk)

- Ensure children and young people with the most complex needs and their carers/families continue to have access to a keyworker.
- Ensure the sharing of local best practice across providers in relation to hospital friendly autism pathways.

Suicide and self-harm

The nine Local Authorities across Cheshire and Merseyside closely collaborate on suicide prevention. We believe that suicides are not inevitable and aspire to be a region where all suicides are prevented. Our third suicide prevention strategy was published in 2022 and sets out actions across four themes[56]:

- Men
- Children and young people
- People who have experienced self-harm
- People experiencing health and social inequalities

18 priority groups are identified, all of whom are at higher risk of suicide.

NHS commissioners are signed up to the Mental Health Crisis Care concordat. To accelerate action against suicide we will continue to focus upon leadership, prevention, safer care and intelligence.

We have access to a suicide prevention training package, which is offered in Cheshire East free of charge. In addition, we have trained over 500 front line staff in Cheshire East including Youth Offending teams, benefits and housing colleagues, as well as developing specific guidelines for schools[57].

Cheshire East Council has worked consistently to raise awareness on wellbeing and the importance of good mental health, including participation in campaigns such as Time to Change. Where a suicide has taken place, we have also developed and commissioned a suicide postvention service, Amparo, to support bereaved families, recognising the significant impact suicide can have[58].

Digital opportunities	• Rapid sharing of risks and concerns across the system so warning signs aren't missed • App or chat based mental health support for those who prefer it • Integration of System One CWP data with CIPHA Shared Care Records

Cardiovascular Health

Cardiovascular care is a focus for all eight Care Communities. Service redesign is prioritised at Place level and includes:

[56] Suicide-Prevention-Strategy-2022-2027-compressed.pdf (champspublichealth.com)
[57] CEC – Suicide Prevention in Schools Doc
[58] Get help now. Free and confidential,for as long as you need it. (amparo.org.uk)

- Increasing the numbers of people at risk of heart attack and stroke who are treated for the cardiovascular high-risk conditions; atrial fibrillation, high BP and high cholesterol – part of an ABC approach
- Promoting physical activity for cardiovascular health with the One You Move More service[59].
- Testing the use of technology to increase referral and uptake of cardiac rehabilitation as well as increasing rehabilitation capacity to meet expected demand
- An aspiration to increase access to echocardiography within Care Community settings and improve the investigation of those with breathlessness
- If appropriately resourced, the introduction of 'virtual hospital' working for secondary care cardiology has the potential to shorten time to resolution
- New community-based cardiology services, integrated with primary and secondary care, to improve the quality of care and reduce the pressure on secondary care services
- Exploring the use of a programme budgeting approach as part of heart failure pathway design
- Collaborating to overcome and ameliorate the significant challenges with cardiovascular care in East Cheshire with regards to recruitment of specialists.

Digital opportunities	• Virtual hospital working • Device based blood pressure or arrhythmia testing (if evidence based) • Remote cardiac rehabilitation

Respiratory

Our Place has developed a Respiratory Programme Group who are working to:

- Develop an innovative respiratory dashboard to understand need and care quality
- Link PCNs to a respiratory multidisciplinary team
- Improve access to spirometry and community diagnostics as part of an integrated breathlessness pathway
- Increase quality and capacity in pulmonary rehab through an expanded digital offer and improved community and hospital offers.
- Standardise the smoking cessation offer in secondary care
- Support the Green Spaces for Wellbeing Programme (see **VCFSE as full partners**)
- Lower the carbon footprint of inhaler prescribing
- Improve inhaler technique through apps and community pharmacies (work ongoing across Cheshire and Merseyside for younger people's asthma)
- Developing a model of remote monitoring as part of a virtual ward pilot

Digital opportunities	• Decision support tools to improve prescribing • Integration of community diagnostics and services

[59] How to Start Exercising | Free Exercise Classes to Get Fit : One You (oneyoucheshireeast.org)

	• Digital pulmonary rehabilitation

Diabetes

The NHS national diabetes prevention programme (NDPP) supports people who are at risk of developing type 2 Diabetes. We are committed to supporting this programme and we aim to widen choice for people as well as reducing health deterioration.

We will deliver the Long Term Plan commitments for people with type 1 and 2 diabetes, as well as supporting those at risk of developing diabetes.

Digital opportunities	• Digital monitoring of blood glucose (e.g. CGM or FGM)

Cancer Care

We will continue to work together locally, regionally and nationally to ensure our cancer care is world class, delivering the ambitions of the Long Term Plan in a way that improves the quality of life outcomes, improves patient experience, reduces variation and reduces inequalities. We will work to improve **early diagnosis** of cancer and ensure that 75% of cases are diagnosed at stage 1 or 2 by 2028 (see **Core20PLUS5 (adults)**).

We will examine **variation in cancer screening uptake** and tackle inequalities across Cheshire East, with a focus on central Crewe, where residents are missing out on bowel and cervical cancer screening opportunities.

We will continue to develop The Christie at Macclesfield to improve cancer treatment in our area.

Ongoing Place priorities include:

- Early diagnosis, linking closely with the Cheshire and Merseyside pathology Network to introduce integrated pathology testing
- By 23/24 PCNs will be working with the Cancer Alliances to help improve early diagnosis of patients in their own neighbourhoods
- We will work with the Cancer Alliance and the ICS to establish radiotherapy networks that include training and workforce options
- We will also work jointly across the Primary Care Networks and ICS to support a new service specification for children and young people's cancer services
- All breast cancer patients will move to personalised, stratified follow-up pathways once their treatments ends, expanding to include all colorectal and prostate patients.
- All patients diagnosed with cancer will have access to personalised care including assessments, care plans and advice and guidance

Oral health

The Cheshire and Merseyside ICB will become responsible for commissioning dentistry services from April 2023. Plans for improving access to dentistry are in development.

Locally, NHS England grant funding means that Cheshire East Council are working with the End-of-Life Partnership's care home support programme and upskilling staff working in care homes around mouth care, through in-person training to become Mouth Care Matters champions. We hope to provide training to domiciliary care workers in the coming years.

Supporting pillars

Digital

(See **Digital appendix**)

Digital refers to services that are provided and consumed through digital means, typically over the internet. These services can be in the form of software applications, online platforms, cloud-based services, or other digital offerings. Examples of digital services include online support, social media, online information, cloud storage, online consultations, and many others. The main characteristic of digital services is that they can be delivered and consumed instantly and from anywhere with an internet connection. They can offer convenience, accessibility, and often, lower costs compared to traditional, non-digital services.

Every significant change we make to our services requires digital infrastructure to support it. This ranges from signposting and advice to support self-care (eg using the Live Well directory[60]), to integrating providers' clinical records to enable population health analytics and integrated care, and providing devices and connectivity to offer remote monitoring or consultation and facilitate joint working in community locations.

Digitising health and care provides an incredible opportunity to create seamless and efficient services but the up-front challenges (and costs) should not be underestimated and **digital planning must be undertaken in parallel with service design**.

Workforce

(See **Workforce appendix**)

There is a national crisis in recruitment, training and retention of staff across health and social care, with thousands of posts unfilled. Efficient service design and the use of technology can ameliorate some of this impact, as can developing new roles and working in partnership with the VCFSE (voluntary, community, faith and social enterprise) sector.

However, it is clear that we must work together to develop **coordinated plans to recruit and retain staff** to deliver the high-quality services that our residents deserve and ensure that staffing issues do not exacerbate inequalities across services and places. The NHS People Promise would be applicable to all our teams across health and care partners – to work together to improve the experience of working in the NHS for everyone[61].

[60] Live Well Cheshire East
[61] NHS England » Our NHS People Promise

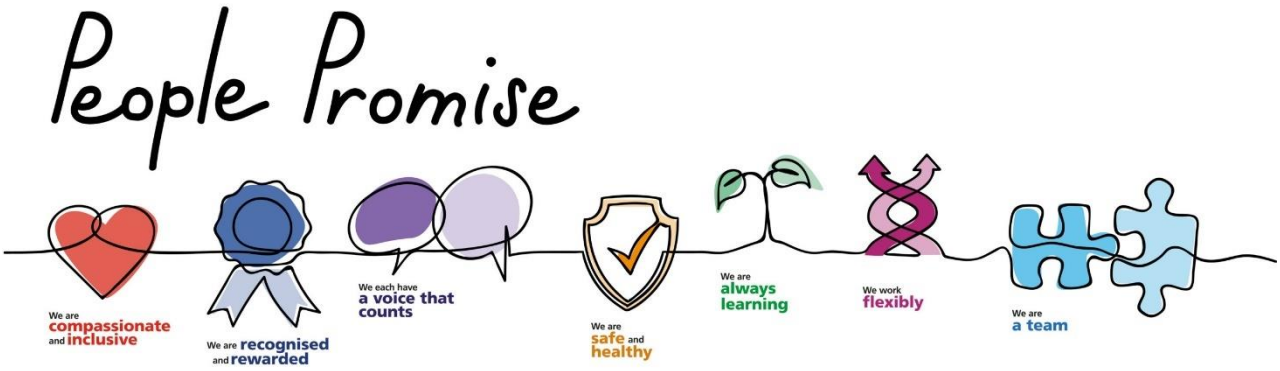


Figure 5 – The NHS People Promise[61]

Similarly, Cheshire East Council aspires to make Cheshire East the best place to live and the best place to work by supporting and developing our workforce to be confident, motivated, innovative, resilient and empowered[62].

Our Care Communities have already developed a three-year People Plan, which describes what they will do under the headings of:

Figure 6 - Care Communities People Plan

Each organisation will need to review its own workforce plans and these need to be reviewed as part of an overall Cheshire East Place approach.

Our partners are committed to improving outcomes for care leavers and make the best use of the talents within the care experienced community by offering fulfilling careers in health and care. Cheshire East Council will continue to develop apprenticeship and work experience offers, in addition to its role as a corporate parent. Our health services will implement the NHS Universal Family (Care Leaver Covenant) Programme and advertise the NHS C&M 'offer' to care experienced young people via the Care Leaver Covenant webpages.

Finance and estates

(See **Finance and estates appendix**)

[62] Corporate Plan (cheshireeast.gov.uk)

Innovative service delivery will require **innovative funding models**. Increasing need, limited budgets and inflationary pressure mean that we need to do more with less. We cannot afford to do nothing[63].

We will explore the **pooling of resources** to deliver **shared outcomes and share risk**. We will consider innovative **outcome-based commissioning** to appropriately **incentivise** the **prevention** of disease and the improvement of population-level health outcomes.

Business intelligence

The Business Intelligence enabler workstream will explore and align business intelligence capabilities across the local and sub-regional system. It will integrate intelligence from the JSNA work programme and local and sub-regional population health programmes. The group is leading the development of the Cheshire East Joint Outcomes Framework.

[63] Caring Together - Eastern Cheshire 5 Year Strategic Plan (2014)

Background and appendices

This plan has set out how the many partners who make up the health and care system in Cheshire East can contribute to delivering on our Joint Local Health and Wellbeing Strategy and support our strategic vision:

"To enable people to live a healthier, longer life; to live independently and to enjoy the place where they live."

Whilst delivering on this strategy is a broad challenge, encompassing tackling and improving the wider determinants of our residents' health, we recognise the unique contributions we can make to improving health and improving lives.

Within health and care, we must continue to radically reshape the care we deliver, to **empower our residents** and **place them at the centre** of a seamless, integrated system of support. We will **co-produce** these changes with our residents and frontline staff to ensure they work for all.

The health and care landscape has changed dramatically over the past three years since our previous plan was developed for 2019-2024. The COVID-19 Pandemic disrupted every facet of our lives and meant that aspects of our plans were postponed while we managed an unprecedented crisis. **The Pandemic exacerbated the inequalities across Cheshire East** and those who were most vulnerable bore the greatest burden. Our critical care services risked becoming overwhelmed as they treated people with underlying risk factors and chronic health conditions that meant they were less able to cope with COVID-19. This acute pressure was the tip of the iceberg, and the Pandemic highlighted the **need to make sure our population is as resilient as it can be** to ensure that all our services are able to deliver care during future crises.

In 2022, our Integrated Care System was formalised, with the functions of the Clinical Commissioning Groups (CCGs) transferring to the Cheshire and Merseyside Integrated Care Board. NHS providers, local authorities and partners have come together as the Cheshire and Merseyside Integrated Care Partnership. We are developing our partnership approach at Place level in Cheshire East, taking a bottom-up approach through our eight Care Communities and within those, GP practices working together in Primary Care Networks[64,65]. (See **Primary Care Networks**)

[64] ICP Transformation Plan.pdf (cheshireeast.gov.uk)

[65] Cheshire East is divided into geographies of 8 "Care Communities" and 9 Primary Care Networks (PCNs). In the main the Care Communities and PCNs are coterminous with the exception being Crewe Care Community which contains two PCNs.

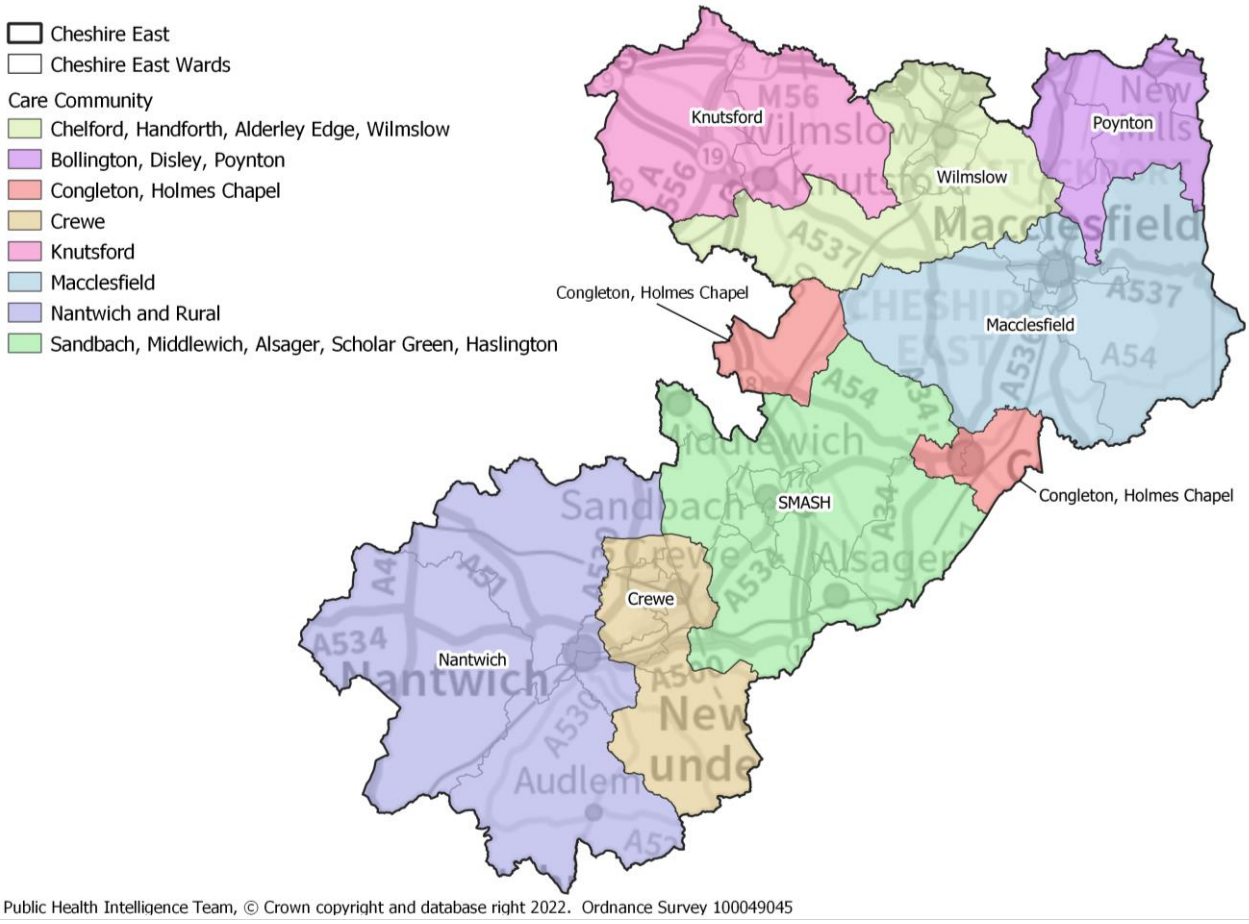


Figure 7 - Cheshire East Care Communities

COVID-19 led to disruption in service delivery and led to lost opportunities for prevention and proactive care. **Fair recovery of our elective services** remains a key priority for our partnership. Health services are working to recover services and catch-up on appointments and procedures delayed during the Pandemic, while managing incredible demand throughout the system. Social care services are stretched and facing extreme pressure. Our residents are dealing with a cost-of-living crisis, which is impacting on their health and wellbeing. Voluntary, community, faith and social enterprise (VCFSE) sector partners are working tirelessly to support them. However, though the Pandemic has presented us with new challenges, it has often accelerated our partnership working and we are well placed to build on these strengthened relationships to deliver seamless, person-centred services.

Our Health and Wellbeing Board must adapt to effectively tackle place-based issues beyond health and care services. In March 2023, the Board accepted the findings of a Local Government Association review and agreed to broaden its membership to include additional members of Cheshire East Council's Place Directorate as well as representation from housing providers and local businesses[66].

For our health and care services, the **Health and Care Bill (2022)** brings new commitments to population health improvement with a new Triple Aim:

[66] Minutes Template (cheshireeast.gov.uk)

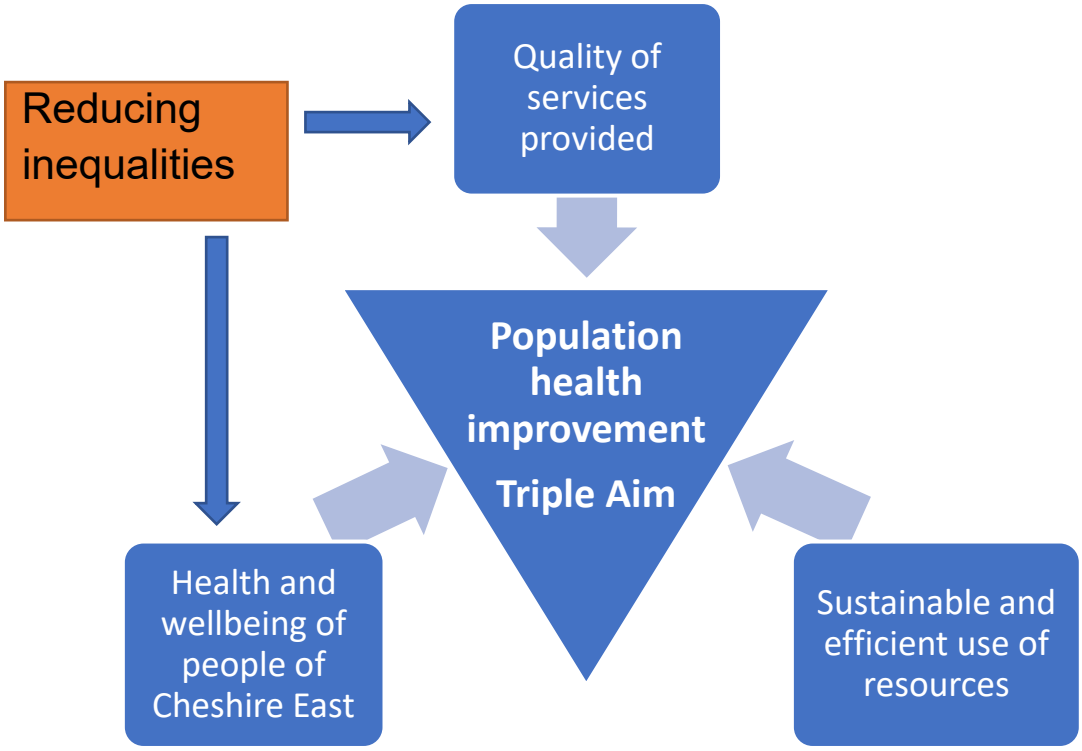


Figure 8 - NHS triple aim[67]

As a Place we are developing integrated governance and decision making but as a system we face significant financial pressures and difficulties in recruiting and retaining frontline staff. Delivering increased efficiency and quality to improve outcomes will need **close cooperation, pooling of resources** and the **bravery** to tackle the big challenges together. These include **digital transformation** alongside changing care models.

[67] Health and Care Bill: integration measures - GOV.UK (www.gov.uk)

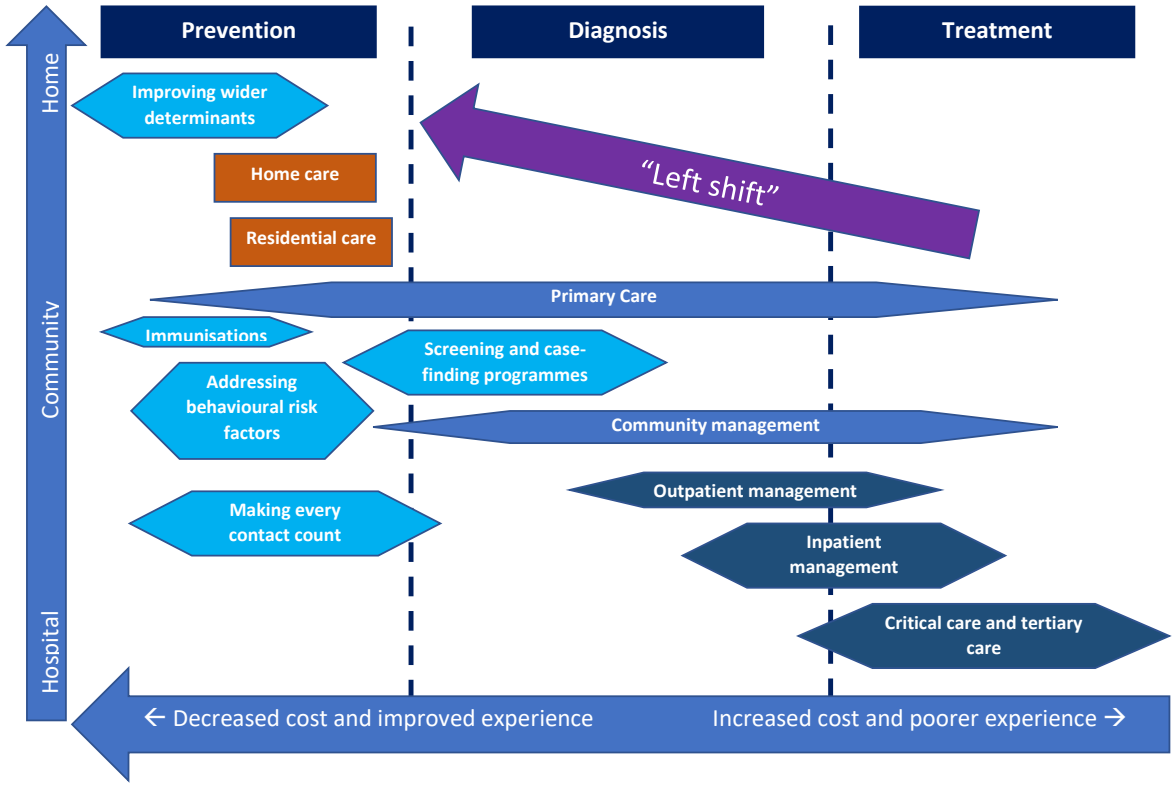


Figure 9 - A left shift to prevention and care closer to the person

Delivering quality, value and improved population health requires a **"left-shift"** at every level, **from treatment to prevention, from acute hospital care to community services** when clinically appropriate, making the best use of all of our resources and the lived-experience of our residents to redesign and transform the health and care system. We want to connect and empower individuals and communities to make the most of their own strengths and natural assets. However, to achieve this **community services must be appropriately resourced and funded**.

Section 4 appendix – Proportionate universalism

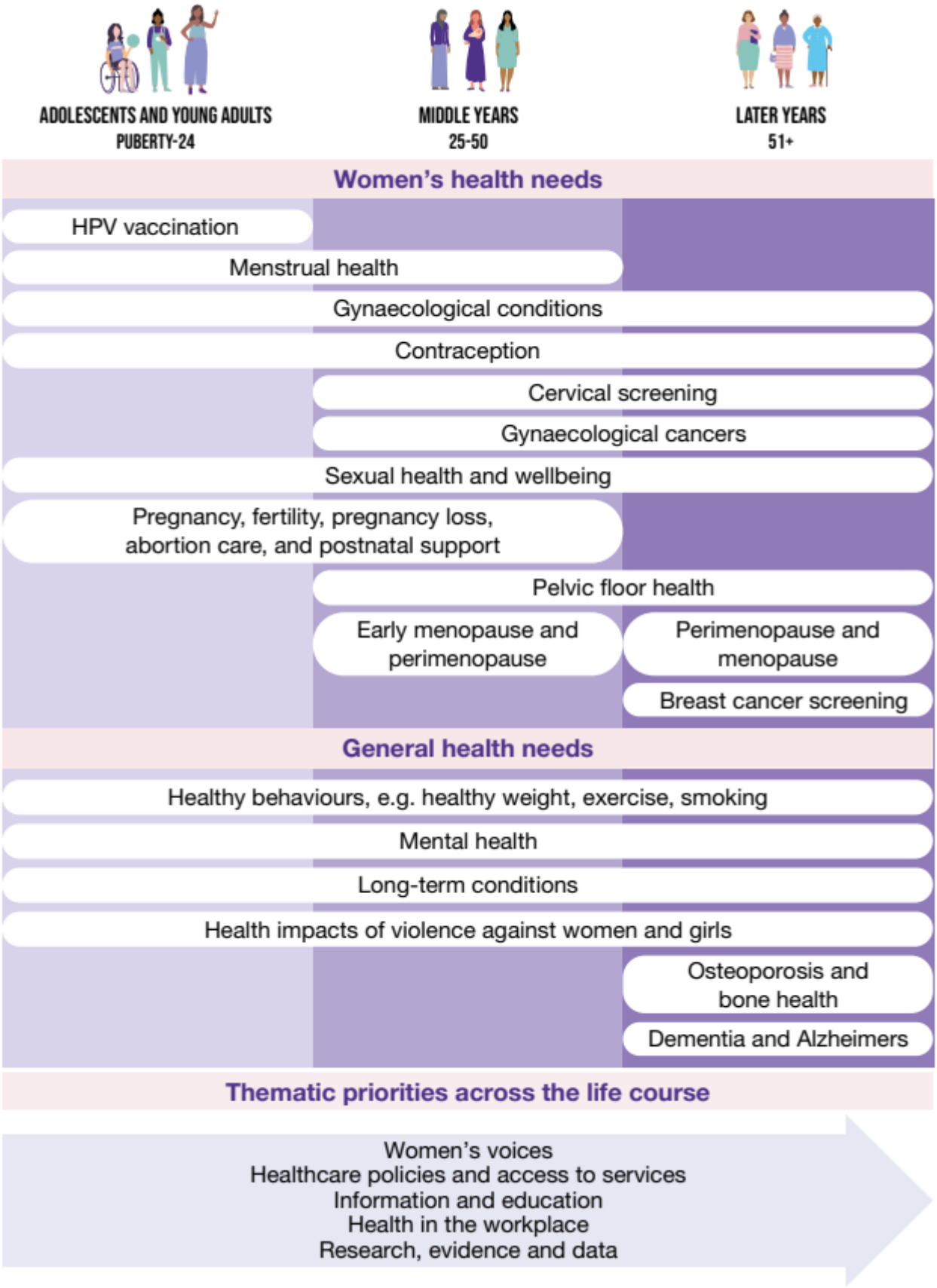


Figure 10 - Women's health strategy for England

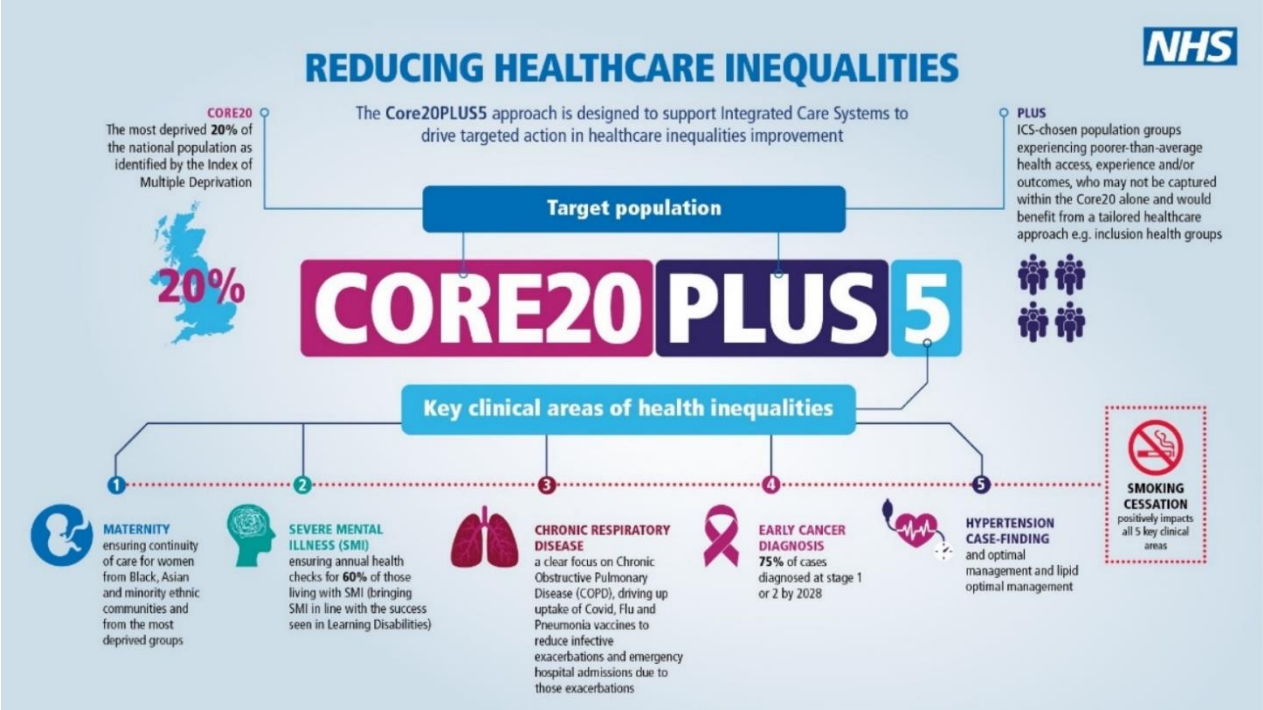


Figure 11 - Core20PLUS5 for adults

All Together Fairer

The 9 Places in Cheshire and Merseyside have committed to become a "Marmot Region" and take forward recommendations from the All Together Fairer report. Relevant recommendations are presented throughout this report, as below. The following are general recommendations that would be relevant throughout our work.

Relevant recommendations from All Together Fairer
Marmot recommendation - Adopt Cheshire and Merseyside's Marmot indicators in their own organisations (e.g. NHS, Local authorities, businesses, VCF sector).
Marmot recommendation - Integrate Place Plans in each Place Executive and create MoU between Place Executives and Health and Wellbeing Boards to align Health and Wellbeing Strategies and Place Plans.*

* In Cheshire East this means absolute clarity on respective responsibilities for delivery between the Health and Wellbeing Board and the Health and Care Partnership Board with demonstrable alignment across strategies and plans.

The principle of proportionate universalism originated in the Marmot work (see section 3 - Error! R eference source not found.) - reducing inequalities by providing an offer for all with the greatest efforts focused on those with the greatest needs.

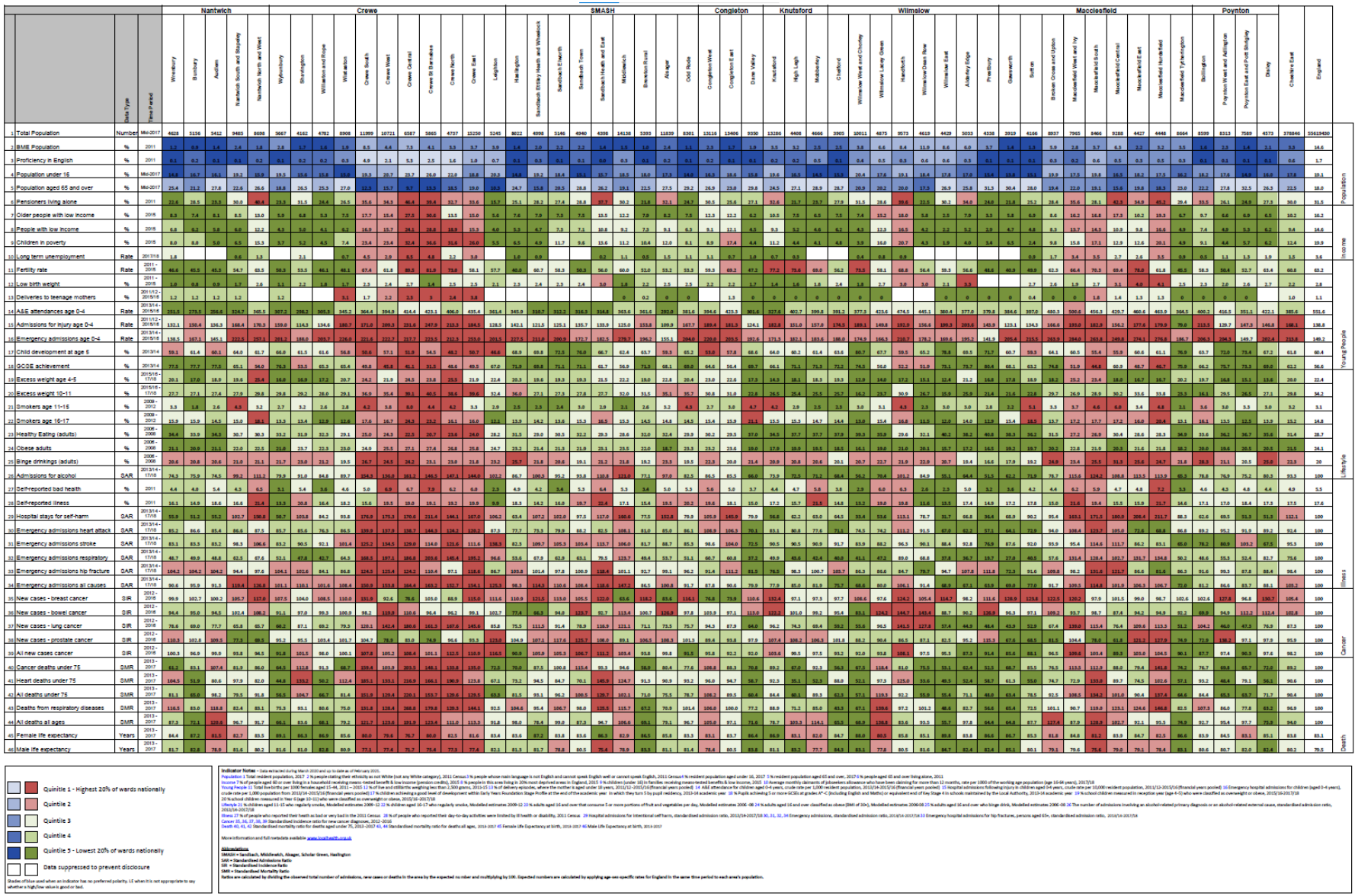


Figure 12 - The Cheshire East "Tartan Rug" - ward-level data compared to England averages

Section 5 appendix – Partnership working

Outcome 1 – Children and young people we care for are happy and able to achieve their full potential.

- Care for our cared for children and care leavers as any good parent would.
- Improve education, employment, and training outcomes.
- Work to give all children and young people a forever home and to keep them safe.
- Improve health and wellbeing outcomes.
- Prepare young people for adulthood.
- Work TOGETHER with children and young people.

Outcome 2 – Children and young people feel and are safe.

- Work as a partnership to protect children and young people from contextual safeguarding.
- Support the emotional health and wellbeing of our vulnerable children.
- Develop a pan-Cheshire 'All Age Exploitation Policy'.
- Develop the connectivity between community mental health services and early help provision.
- Continue to implement our plan to achieve consistently good quality social work practice.
- Embed our Neglect Strategy.
- Continue to embed our SHOUT campaign to raise awareness of sexual harassment and support schools and colleges to address these issues.

Outcome 3 – Children and young people are happy and experience good mental health and wellbeing.

- Deliver Cheshire East's All Age Mental Health Strategy 2019-2022 and review for 2023.
- Revisit the Taboo conference model.
- Improve maternal mental health in pregnancy and during parenthood.
- Needs assessment to better understand the emotional and mental wellbeing needs of children and young people and their parents.

Outcome 4 – Children and young people are healthy and make positive choices.

- Deliver our Cheshire East Partnership Five-Year Plan for 2019-2024 to tackle inequalities.
- Undertake a deep dive needs assessment around the impact of poverty, focusing on the Crewe area.
- Review how we can improve spending across childrens services.
- Support the promotion of inclusivity of LGBTQIA.
- Develop our child health hubs with a focus on maternity wellbeing, respiratory, obesity, SEND and children and young people's mental health.

Outcome 5 - Children and young people leave school with the best skills and qualifications they can achieve and the life skills they need to thrive in adulthood.

- Develop and deliver the next stage in our school organisation plan.
- Embed Education Well-being recovery.
- Respond to the emerging agenda as outlined in the recent white paper and green paper for SEND.
- Develop a collaborative support framework for attendance and behaviour in settings.
- Review our early years support through better use of national practice.
- Support children and young people to access further education, training, or employment through our Journey First programme.

Outcome 6 – Children and young people with additional needs have the support they need to achieve and be happy.

- Implement our SEND Strategy 2021-2024 with a focus on the following 5 priorities:
- Improve communication and coproduction with families who have children with SEND.
- Ensure children and young people with SEND have access to the provision and support they need.
- Improve the timeliness and quality of the annual reviews of EHC Plans.
- Ensure we have an effective and supported workforce.
- Recovery from the COVID-19 pandemic.

Outcome 7 – Children and young people have earlier access to support when they need it.

- Respect and build on the relationships and trust families have in us.
- Ensure our workforce across the partnership has the support, skills and training they need to deliver good quality support to families.
- Strengthen the Early Help Board.
- Develop an early help offer.
- Strengthen our Integrated early years offer.
- Embed the principles of Family Hubs.
- Develop a parenting strategy.

Figure 13 - Summary of Cheshire East Children's Plan

	Area	Objective
Recovering our core services and improving productivity	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

Figure 14 - NHS planning guidance 2023-24

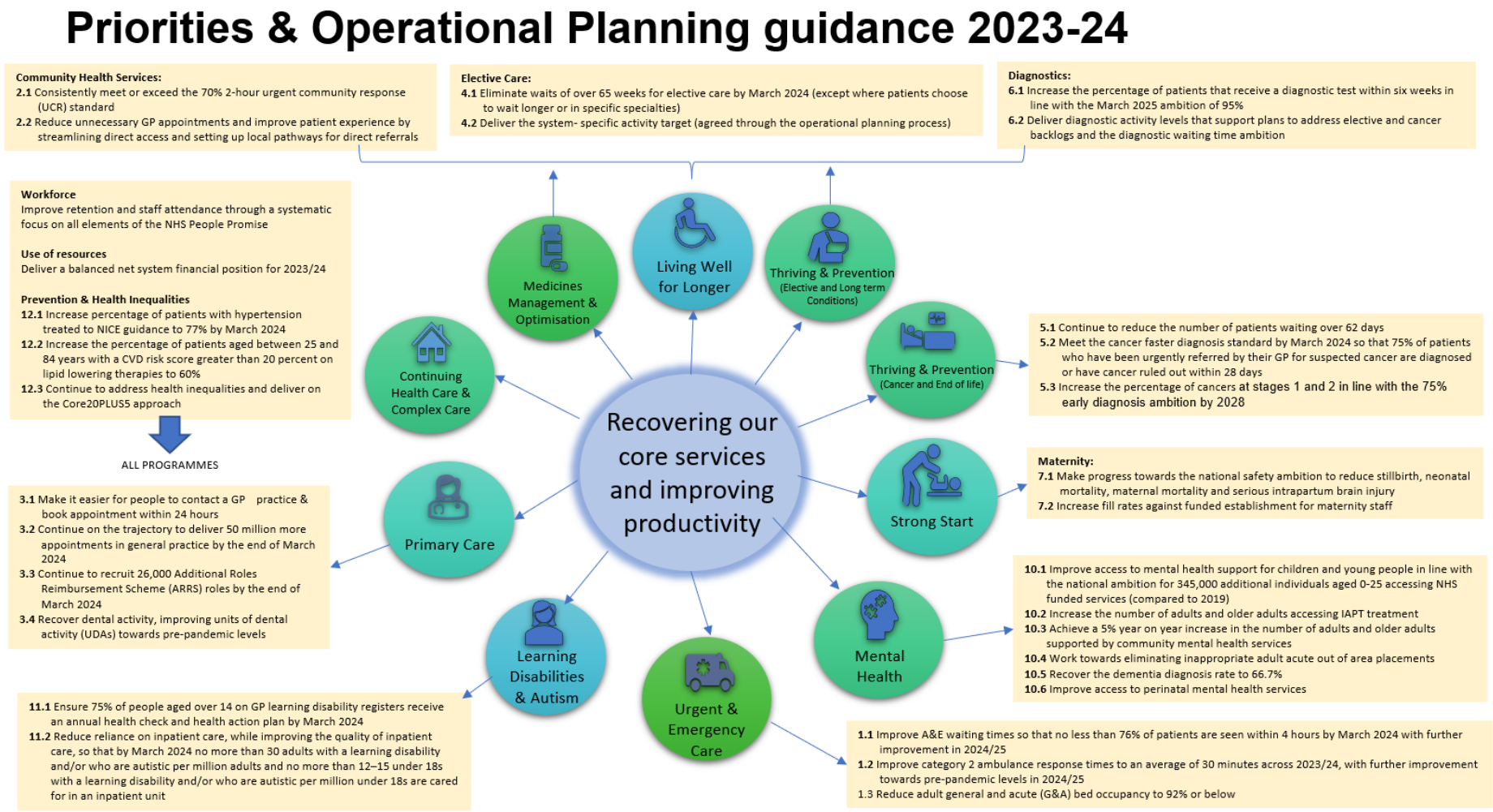


Figure 15 - NHS Planning Guidance 2023-24

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

Our Aims

1. We will provide an equitable and fully integrated urgent and emergency care service for patients with physical, mental health or social care needs, via our Care Communities in conjunction with secondary care services
2. We will harness digital solutions, collaborative working and information sharing so that the population of Cheshire East will be able to access the right advice, care or support in the right place, first time.
3. We will reduce attendances to Emergency Departments and reduce the length of stay for those admitted to an acute hospital bed by enabling patients to self-care and recover through our
4. Care Communities, underpinned by a philosophy of 'home first' wherever safe and appropriate. We will develop and deliver on system wide approaches to "growing" our workforce, developing skills and innovative/creative solutions as system providers, underpinned by the philosophy that working closely together will lead to sustainable future services

Programmes	Projects
Admissions Avoidance/ Prevention	• Development & promotion of alternatives to A&E via NHS111 and develop Cheshire Clinical Assessment services • Accurate Directory of Services (DOS) • Hospital at Home and Community 2-hour Crisis Response • Mental health Crisis Response • Seasonal plan for Covid & Flu • Supporting High intensity Users • AVS, GPOOH • Virtual Wards, Home Oximetry • Step Up Beds
Reducing LoS / Criteria to reside	• Implementing Same Day Emergency Care (SDEC) pathway • Continue to monitor capacity & demand • Improvement in 14 and 21 day Length of Stay • Embed discharge 0-3 pathway model across the system & improve flow monitoring • Integrated Frailty care pathway including Acute Frailty Service • Emergency Mental Health Improvement Plan MH • Non Emergency Patient Transport • Timely LoS patient reviews
Managing individuals at the hospital front door	• Frailty • Falls prevention strategy • Carers Strategy • Explore Discharge Support Grant / Virtual Wallet • Care Homes • Enhanced Health in Care Homes Framework • 7 Day discharges • Community Equipment, Telehealth • Community and Voluntary sector – Information and advice
Streamlined discharge & recovery – New model of Care	• Discharge to assess – New models of care • Home First OT Community Rehab Therapy Model • Maximise third sector support for safe discharges • Integrate Transfer of Care Hubs across Cheshire • Develop 7-day working • Effective SOP's to support seamless discharge
System Winter Plan	• High Intensity Users service • Community falls / Assistive technology • Carers pilot • Access to care home 7 Days • Ageing Well Prevention and Care • Help Force

Outcomes

1. Reduction in delays in hospital discharges
2. Reduction in delayed transfers of care
3. Improved partnership working
4. A care and support model that responds at the point of crisis
5. Offer more care at home and have the right amount of capacity and the right type to provide timely access to advice, treatment and support to prevent a hospital admission and support people to remain at home
6. Increases number of people being supported at home
7. An integrated workforce
8. A sustainable model for step up and step down beds

Measures

Number of people discharged via Pathway 1

Number of Short Term placements commissioned due to unavailable care at home

Care at Home Waiting list

Increase – Decrease in level of support and post review at day 91

Service User outcomes (reduced support, no ongoing support, increased support etc)

Reablement average length of stay

Permanent admission into a Care Home

Hospital re admission rates and reason for re admission

Number & proportion of patient with LoS of 7 days or more

Number & proportion of super stranded patients with LoS 21 days or more

Proportion of Criteria to reside patients

Figure 16 - Home First plan on a page

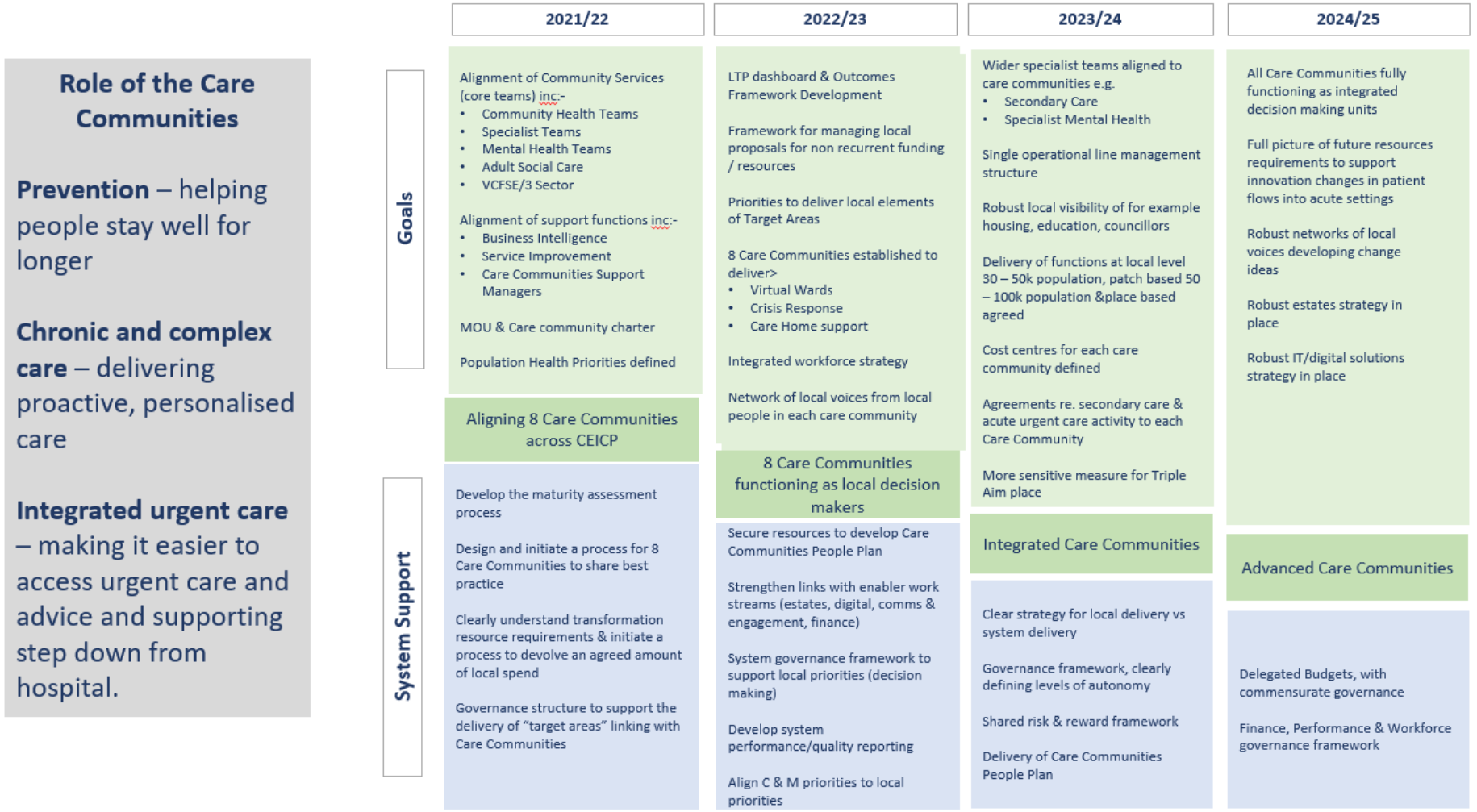
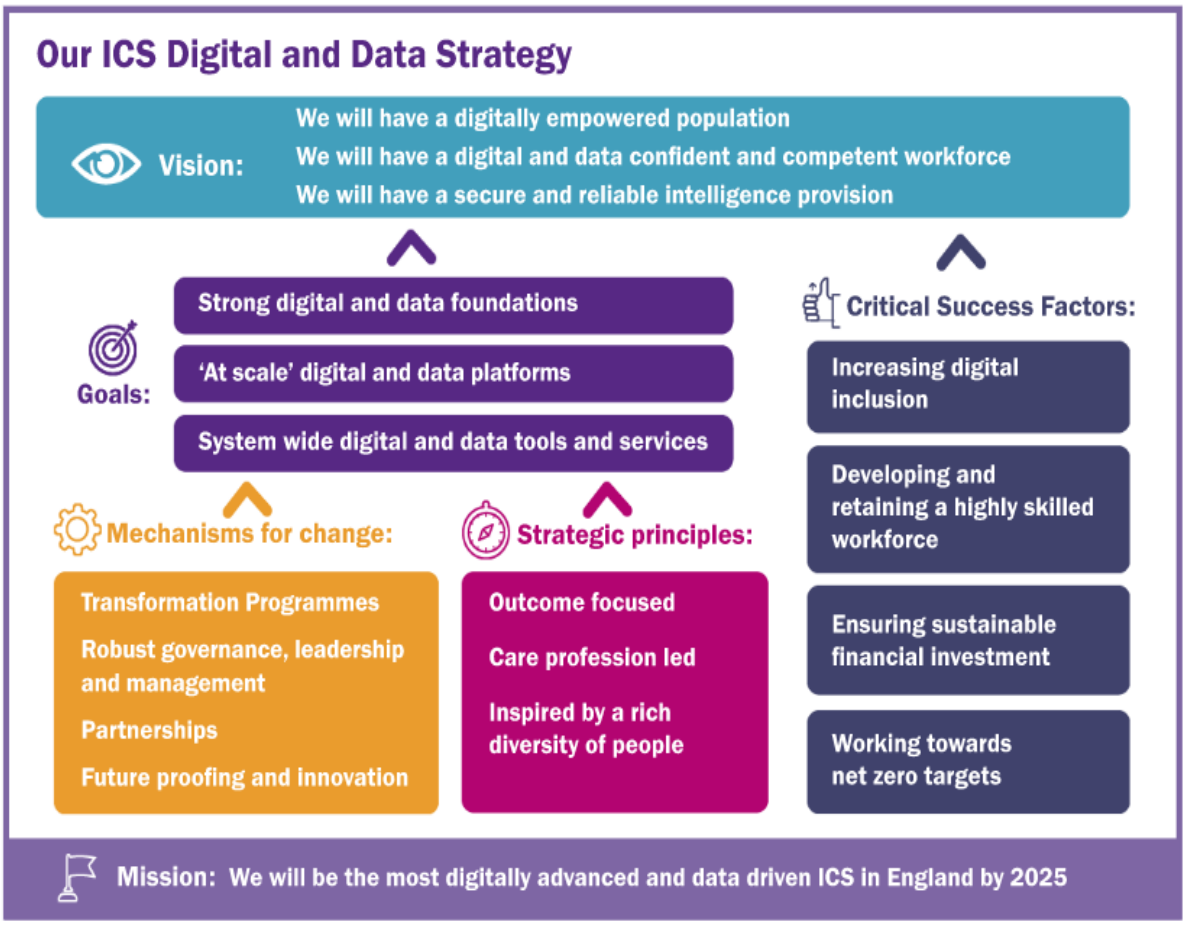


Figure 17 - Care Communities plan on a page

Digital appendix

The Pandemic caused a huge disruption to people's lives and the delivery of services they relied on and catalysed a rapid shift to online and remote working. We will ensure we take advantage of any positive changes and broaden roll-out to ensure people receive care in the best way possible. Cheshire and Merseyside ICS have set a challenging and compelling ambition for digital and data. We are committing to the levelling up of infrastructure to ensure all our population can derive the same benefit from technology. We are committing to turning 'intelligence into action' to focus on purposeful and evidence-based interventions. Through targeted resourcing and delivery, we will 'turn the dials' on improvement in health and care outcomes.

We will develop a comprehensive health and care digital strategy and investment plan describing how digital technology will underpin our system transformation and continue to work with colleagues to deliver the 'Digital and Data Strategy 2022–2025' and achieve the 3 goals: strong digital and data foundations, at scale digital and data platforms and, system wide digital and data tools and services.



Goal 1: Building Strong Digital and Data Foundations. Digital Maturity Assessments clearly show that there is a need to invest in core technologies and services to ensure that there is increased equity of provision across the whole of the system to improve the effectiveness and safety of care for all the population. This 'levelling up' of the basic digital and data infrastructure and systems supports safe practice and ensures we build strong foundations on which to deliver our ambition.

1. To level up digital infrastructure we will ensure:

Every member of health and care staff in CE P NHS and Local Authority Adult Social Care providers that needs access to digital equipment to undertake their role will have access to reliable and fit for purpose access devices by March 2025

1) Health and care staff in NHS and Local Authority Adult Social Care providers will have access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire East Place, by March 2025. This will be facilitated by working in partnership with other public services and network providers to access initiatives such as Gov Roam and the rollout of 5G through initiatives such as LCR Connect
2) An EPR across ECT and MCFT - our NHS trusts will have a minimum standard Electronic Patient Record (EPR) by December 2023, completed by March 2025.
3) For Adult Social Care, 80% of CQC registered adult social care providers (residential and non-residential) will have adopted a Digital Social Care Record (DSCR) by March 2024. This is in line with the 'Plan for Digital Health and Social Care' requirements.

2. To level up data and intelligence infrastructure we will ensure:
    a. Access to ICS wide person level health and care linked datasets by March 2023 as a corner stone for population health analytics
    b. The broadening of linked datasets available for analytics to include those outside of health and care such as education and housing by March 2024, through working with the ICS, Local Authority, and national partners
    c. The transfer of core health and care information between providers, within relevant Information Governance agreements and for the purposes of direct care, population health management, care planning and research, will be undertaken through a single health and care data architecture by March 2025. To support this, we will:
        i. Expand the information governance framework to include implementation of Data Sharing Agreements for use of data for research and innovation by March 2023
        ii. Implement electronic management of data sharing agreements via the Information Sharing Gateway by March 2023.
3. To level up 'safe practice' we will ensure:
    a. Provision of cyber security services including cyber security operations, incident response and assurance that complements and works alongside local health and care provider cyber security functions
    b. Access to ICS clinical safety subject matter expertise to ensure that the digital and data solutions in use across Cheshire and Merseyside are DCB0129 compliant (i.e., have appropriate safeguards associated with clinical and care hazards) and have been implemented in line with 'best practice' clinical safety standards (as outlined in DCB0160)
    c. Access to ICS Information Governance subject matter expertise to enable health and care providers to operate safely with regards to information sharing legislation and protocols – supporting the improvement of dataflows and streamlining necessary data sharing
    d. Access to ICS technical and data architecture expertise to ensure that system wide solutions align with Place and Provider systems to allow connectivity and ease of data flow across Cheshire and Merseyside, and also to ensure that national architecture standards and principles are maintained (e.g., 'cloud first', interoperability standards such as FHIR and the use of OpenAPIs)
    e. Digital environmental sustainability support to ensure that any system and CE Place based digital and data initiatives support the ICS' 'net zero' ambitions as outlined in the ICS' 'green plan'
    f. Data quality to establish a common approach for improvement in data quality across the ICS and CE P so that our decisions are based on sound data
    g. Data safety so that the public can be reassured that their data is used lawfully, with respect, held securely and that the right safeguards will be in place (through supporting adoption of the 'Five Safes' model).

Goal 2: Engage with 'At scale' digital and data platforms. CE P will engage with the ICS to continue to develop and expand its strategic digital and data platforms for use within all health and care providers and in all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population.

1. We will ensure that CE P engages with the Share2Care platform and that it is available in all NHS and Local Authority Adult Social Care providers, enabling sharing of a core set of health and care data across the whole health and care system by March 2024
2. We will engage with the ICS to ensure that all NHS and Local Authority Adult Social Care provider organisations are connected to integrated life-long health and social care records by March 2024, enabled by core national capabilities, local health records and shared care records, giving individuals, their approved caregivers and their care team the ability to view and contribute to the record.
3. We will continue the development and rollout of our patient held electronic record (PHR), MyCareView. We will ensure that we have implemented a Patient Empowerment Platform (PEP) that integrates with NHS App (as the 'front door' to health and care service for an individual or their carers) by March 2025.
4. We will continue to work with the ICS to build on the existing Remote Care platform (Docobo) delivering virtual ward and Long-Term Condition (LTC) monitoring services and expand this offering to deliver additional virtual ward beds (40 to 50 virtual ward 'beds' per 100,000 of the population by March 2024. We will also continue LTC monitoring for other specialties, as well as support for the wider NHS@Home programme which will drive the focus of the platform going forward. This will include:
    a. Supporting the availability of digital monitoring of vital signs for people in care homes and at home, contributing towards the national aim of a further 500,000 people being supported by this technology by March 2023
    b. Develop a tech-enabled annual physical check for people with severe mental illness by March 2023.
    c. We will also agree the care pathways where this platform can be used for supporting 'Care@Home' applications such as environmental monitoring and medicines management of those living at home (or in supported accommodation) to ensure they remain safe as part of the discussions regarding alignment with Technology Enabled Care (TEC) developments in Adult Social Care. Agreed pathways where people are supported in this manner will be in place by March 2024 and prevention and detection technologies will be used to protect the 20% of care home residents who are identified as at high risk of falls by 2024.
    d. Following the transfer of the Cheshire Care Record to the cloud hosted CIPHA platform, we will continue the work with the ICS on the development of the platform to include further Population Health Management reporting that enables the identification, segmentation, and evaluation of cohorts for the targeting of interventions. The work here will align with the overall Population Health approach as being developed by the System P programme, which will focus on identification of populations most vulnerable and at risk of adverse outcomes and developing services for those population segments most in need of improved health and care outcomes. It is intended to embed CIPHA reporting in action via System P and Population Health Board Programme/Networks by March 2023.
    e. We will embed Public View across Providers and Service Planners to include access, quality, activity, outcomes and workforce, containing national and local flows and underpinned by granular detail on Aristotle by March 2023.

Goal 3: Engage with System wide Digital and Data Tools and Services. CE P will continue to work with the ICS to further leverage the 'at scale' platforms through the development of ICS level applications, tools and services that support delivery of the ICS health and care objectives.

We will:

1. Implementing CE P and engage with the ICS wide Capacity and Demand reporting (based on an Operational Intelligence Hub) in the areas of urgent care (inclusive of community and mental health) and elective care by March 2023 (with further development 2023/24) to enable an ICS wide view to inform both planning and operations
2. Engage with the Trusted Research Environment (TRE) on the CIPHA platform by March 2025 so that data can be mobilised for research and innovation for our partner organisations, particularly for Stage 3 clinical trials and translational research
3. Engage with the ICS implementation of a single, mature performance information system (activity, finance, quality and outcomes) that all partners can access by March 2024
4. Work with providers to create analytical networks and assist in streamlining of data flows, processes and quality across CE P and the ICS
5. Work with Local Authority and Public health analytical networks and strengthen joint work programmes in delivery of local CE P and the ICS objectives.

It should be noted that CE P will need to engage with ICS as it supports the delivery of digital system wide tools and services that are used by all relevant stakeholders in Cheshire and Merseyside to ensure equity of provision and leverage economies of scale. These include:

1. Implementation of Robotic Process Automation (RPA) to perform and automate high-volume repetitive tasks (using process flows), to free up time for their clinical and/or non-clinical workforces, through a rollout plan in line with a clear evidence base of productivity benefits by March 2024. This builds on the work done by Trusts such as Alder Hey, who are establishing an RPA Centre of Excellence
2. Delivery of Office 365 optimisation and Training services to frontline health and care staff to support the use of these business-critical tools by March 2023
3. Supporting the on-going development of primary care through the establishment of a common online and video consultation platform, implementation of high-quality clinical decision support tools and the rollout of accredited apps for people to support management of their own physical and mental health and wellbeing by March 2023
4. To safely refer patients directly from community optometry services to hospital specialists and to share diagnostic imaging between primary and secondary care to support diagnosis without the need for additional scans or photos by March 2023
5. Support the rollout of electronic care records into care homes and other providers of social care including domiciliary care by March 2024.

Workforce appendix

We will deliver the commitments within the NHS People Plan and support the health and care workforce across Cheshire East to deliver integrated personalised care, in line with the place strategy.

As described, the growing demands faced by health and care services will require an expanded workforce. In Cheshire East we aim to be inclusive, flexible and supportive employers, ensuring we enable all staff to maintain their own good health and wellbeing.

We will build on the success of existing recruitment and retention plans, developing workforce capacity and capability and developing new roles to support a skill mix fit for the future. This includes new roles for Advanced Clinical Practitioners, Physician Associates and Nurse Associates.

We will develop detailed workforce growth plans to increase capacity and capabilities across Cheshire East including appropriate use of international recruitment, apprenticeship levy and schemes to improve retention by at least 2%. In delivering a holistic approach to workforce transformation, we aim to improve both our GP recruitment and retention performance as well as increasing our nursing and non-medical workforce through increased student placement capacity and close working with local education providers. By working together, we aim to breakdown the boundaries between health and care careers and showcase Cheshire East as a brilliant place to work through joint recruitment and retention initiatives.

We want to make Cheshire East the best place to work and as such are developing an Organisational Development (OD) and leadership diagnostic, aiming to inform the development of a clear plan and implementation programme that will assist us to deliver system transformation. This will assist us in developing an overarching workforce and OD strategy.

Our Care Communities People Plan commits us to a range of actions across four key themes:

1. Growing our workforce
    - Baseline current workforce
    - Identify core skills
    - Develop workforce strategy and tactical plans to address attraction, recruitment and retention
    - Create an integrated talent management plan for leadership roles
2. New ways of working
    - MECC training across CCs and partner organisations
    - Develop apprentice roles
    - Collaborate across organisational boundaries
    - Implement a quality improvement approach
3. Creating a healthy leadership culture
    - Widen engagement in projects and programmes
    - Promote learning, education and development frameworks
    - Develop coaches
    - Incorporate civility and social responsibility as core leadership attributes
4. Caring for our workforce
    - Develop a bespoke wellbeing offer for CC staff and partners
    - Increase learning, development and coaching offer to CC staff and partners.

Finance and estates appendix

Finance

One of the key priorities is to deliver services and the ambition of the Cheshire East Partnership Five Year plan within the funding available.

All partners are working across East Cheshire Place to develop and update System Wide Financial Recovery Plans identifying how we:

- Validate the predicted financial outturn for partners and system
- Recovery trajectories for the system, place and individual organisations
- Actions to achieve cash releasing savings
- Reducing unwarranted variation

These will require the specific financial allocations from the Cheshire and Merseyside ICB to our Place and will incorporate specific pooled budgeting between Cheshire East Council and Cheshire East Place to deliver shared outcomes.

Aligned to the FRP is the development of a system long term financial model which summarises the estimated costs in delivering the Cheshire East Partnership ambitions plus national guidance around the rate of inflation for various services i.e. drugs, growth demand, capital investments.

Estates

To develop and deliver a sustainable and integrated health and care system, partners are mapping the location, condition and development potential of our buildings. Discussions are ongoing around specific sites, including Knutsford Community Hospital, Congleton War Memorial Hospital and the Ashfields hydrotherapy pool.

Central Cheshire Integrated Care Partnership (CCICP) produced a five-year Community Estate Plan in 2022, which describes the baseline for locations and uses and sets out the vision of aligning estates with the future clinical model. The Cheshire and Merseyside Health and Care Partnership have proposed a similar Place-level review. The ICB are working with partners to align Primary Care Estates Plans to an overall Cheshire East strategy.