#BecauseWeCare
Cheshire East Partnership

Cheshire East Partnership

Five Year Plan 2019 – 2024

Technical Appendix *V13 12092019*

Delivery of the NHS Long Term Plan in Cheshire East: Meeting the requirements of the NHS Implementation Framework

To enable the system to meet the requirements of the NHS Long Term Plan, this appendix describes a number of tangible actions that will be taken to meet the required standards and timescales, within the context of the comprehensive Cheshire East Partnership Five Year Plan. These have been set out to align with the core sections of the Plan. The Five Year Plan adopts an all age and inclusive approach to the health and care of our residents.

1) The human and community cost of preventable conditions

Everybody is responsible, whilst they have capacity, to manage their own health and wellbeing and to play a proactive part in their family and community's health and wellbeing. Empowering individuals and communities and building both their social capital and resilience are key. To improve the health and wellbeing of our communities and reduce the demand for social and health care, the focus on prevention needs to be embedded into all strategic plans, actions, services and programmes. We need to take a more proactive approach to building resilience and social capital through workplaces, schools, health and social care; and helping to communicate the personal responsibilities that come with being a member of a family, community and society.

Wanless's[1] fully engaged scenario was based on the insight that improving population health should be everybody's responsibility. It sought to carve out a middle way between approaches that emphasise the role of government and public agencies in health improvement and those that focus on what people should be supported to do to change the behaviours and lifestyles that give rise to ill health. Survey evidence shows that people understand that they have a responsibility to stay healthy even if their choices do not always reflect this. The middle way emphasises the assets of communities and focuses on the agency of people and communities in contributing to health improvement.

Solutions often arise out of the actions of third sector organisations and communities themselves that use innovative approaches to meeting people's needs. These charities have found new ways of delivering services that often seem beyond the reach of the NHS and its public sector partners, for example by making imaginative use of volunteers and experts by experience.

Individuals, families and communities can all play a part to improve wellbeing by adopting a healthy communities approach. We will use existing programmes such as 'Make Every Contact Count' and 'Every Mind Matters' in workplaces and communities and make training

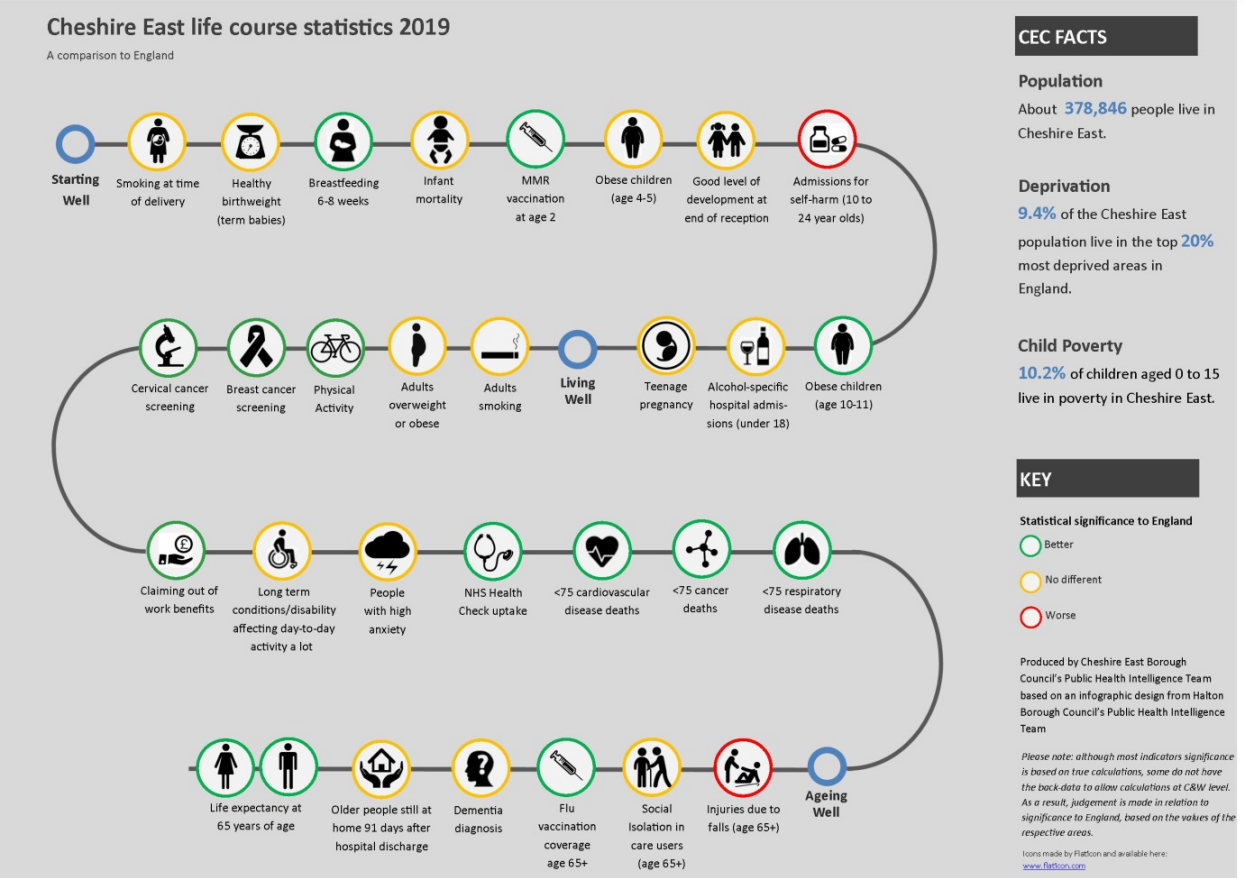
[1] Wanless D. Securing our future health: taking a long-term view. Final report. London: HM Treasury, 2002.

available on signposting people to services using local directories (such as the Live Well Cheshire East Website).

Understanding the local system is key to the success of a health and care system. It is very important that the process in which a decision is made by local health services is clear, appropriate, timely and communicated well. It needs to be flexible enough to allow the person to have the right support/service at the right time.

Our residents need to influence and determine what local services are required. Services should be commissioned and delivered based on the local population's needs through a process of co-production. Local decisions can take into account local criteria that might determine or impact upon need: urban or rural communities, transport links, crime hot spots, deprivation, population demographics, age, ethnicity etc. Local decision making is also more accountable to the local population.

As a Cheshire East Partnership we will focus upon the prevention of ill-health, early intervention and health improvement. The Cheshire East life course statistics diagram (below) illustrates how we are performing against a number of indicators. This is based upon information within the Joint Strategic Needs Assessment[2] and helps to inform where we need to focus our attention:



Smoking

[2] The Cheshire east Joint Startegic Needs Assessment can be found via this link: https://www.cheshireeast.gov.uk/council_and_democracy/council_information/jsna/jsna.aspx

Smoking is the single most significant cause of health inequalities, with smoking rates higher among people with a mental health condition, prisoners, looked after children and LGBT people. Smoking prevalence in over 18s in Cheshire East varies in different areas with higher levels in Crewe. Smoking in pregnancy rates remain high.

Health and care commissioners in Cheshire East will review and revise the trajectory to continue to reduce the smoking rates across the population over the next 5 years. This will include the impact of:

- Working collectively to introduce the CURE programme by Q1 2020 - 2021, which has evidenced significant positive benefits in early adopters in greater Manchester
- Offering and encouraging the take up of NHS funded tobacco treatment services for all inpatients who smoke by 2023/24
- Introducing a new smoke-free pregnancy pathway for expectant mothers and their partners, sharing local best practice across Cheshire East to enable a reduction trajectory from current baseline performance
- Support for individuals to stop smoking within the community, as well as specialist support within hospitals and other settings for people with mental health conditions or pregnant women
- Providing a universal smoking cessation offer for people using specialist mental health services, as well as those accessing learning disability services
- Skilling up all staff in Making Every Contact Count (MECC) ensuring smoking cessation advice is included in assessment / treatment
- Skilling up staff to deliver Every Mind Matters

Obesity

Health and care commissioners in Cheshire East will review and revise the trajectory to reduce obesity rates across the population over the next 5 years. This will include the impact of:

- Access to weight management services in primary care for people with a diagnosis of type 2 diabetes or hypertension with a BMI of 30+
- Maximising the patient benefits from those people who are referred to the Tier 3 weight management services
- Expand the “Healthier You” programme including a digital offer
- Take forward a pilot that offers a very low calorie diet for obese people with type 2 diabetes
- Ensure all our NHS premises meet the strengthened requirements to offer healthy food for our staff and patients
- Ensure nutrition has a greater place in continuing professional health and care training
- Physical Activity – 12 week programme, involving one to one guidance by a coach providing guidance and support to access a range of suitable activities within the community such as guided walks and aerobics
- Weight Management – 12 week multi-component programme aiming to gradually build weight loss behaviours and to encourage cardiovascular activity

- Family Weight Management – 13 week programme consisting of 1 to 1 sessions for children and young people with families. This will involve identification of lifestyle change goals and a family action plan, with a focus on a non-diet appropriate and participation in age-appropriate physical activity.

Alcohol

Reducing alcohol harm is one of the key strategic prevention priorities under the Cheshire and Merseyside population health programme work streams. Alcohol has a significant impact on Accident and Emergency figures, with 70% of attendances at peak times being alcohol related. The cost of dealing with alcohol related harm is some £412 per resident, per annum. The cost of alcohol harm is however, more than just financial, as we have seen the devastating affects it can have on individuals, families and communities. 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. We will continue to work with colleagues across Cheshire and Merseyside to explore the opportunities available to reduce excessive consumption.

We will review and strengthen the specialist Alcohol Liaison/Alcohol Care Teams within our hospitals to increase their impact in our inpatient settings as well as how they integrate with existing services provided in the community. We will also offer brief advice on reducing alcohol harm specifically in relation to early identification and management of mental health conditions.

Substance Misuse

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 and include doctors, recovery coordinators, nurses, recovery champions, peer mentors and volunteers.

Antimicrobial resistance

Across Cheshire East we will continue to optimise use, reduce the need for and unintentional exposure to antibiotics, in line with the five-year action plan on Antimicrobial Resistance.

Reducing antimicrobial resistance is Public Health England's top priority, and is considered the greatest threat to global health in our lifetime, and as a system we will continue to work to support the ambitions of PHE in reducing antimicrobial resistance. We have ambitions to support deep dives into individual GP practices to look at any inappropriate prescribing; feedback on any practices with improvements or changes in prescribing with possible reasons, which can be shared across other practices to assist them in improving. Similarly, shared learning across the acute sector with regard to medicines management antibiotic formularies will be a part of the integrated pathology network programme (N8) with University Hospital North Midlands. Using the antimicrobial prescribing data available from providers, including GP out of hours, we will triangulate to identify the unwarranted variation using locally available business intelligence.

Vaccination rates

For Cheshire East as a whole, MMR vaccination rates are above national, North West and the Cheshire and Merseyside averages, with first dose coverage close to, or above, the 95% target in recent years. In line with other areas, fewer children receive the second dose by the time they are five years old. Alongside the Screening and Immunisation team and our local CCGs, work continues to identify opportunities for improvement, and in particular reduce variation between practices.

Seasonal flu vaccination for those aged 65 years and over across Cheshire East is overall very good with less than a quarter of the practices in our area not reaching the 75% target. Locally the opportunities for greatest improvement in flu vaccination uptake are in those with additional risk factors under the age of 65, or 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.

We will support Public Health England's national vaccinations campaigns, which encourage increased vaccinations for our population. Such campaigns include the HPV campaign: from September 2019, with all 12 and 13 year olds in school year 8 being offered on the NHS the human papillomavirus vaccine.

2) New services for new needs as our population changes

A strong start for our children

We will ensure delivery of the aims of the Better Births strategy, working in partnership with the Cheshire & Merseyside and the Greater Manchester and East Cheshire Local Maternity Systems, including;

- 50% reduction in stillbirth, neonatal and maternal deaths and brain injury by 2025
- Reduced pre-term births
- Embedded UNICEF Baby Friendly Initiative across Cheshire East
- Perinatal mental health services are implemented with training delivered to GPs and midwives
- Sufficient capacity and service development for neonatal critical care services and to develop allied health professional (AHP) support
- Delivery of Postnatal physiotherapy and multidisciplinary pelvic health clinics
- Maternal Health – 12 week programme aiming to encourage greater physical activity amongst pregnant women and healthy diet before and after pregnancy

We will review and amend the trajectory for improved performance of childhood screening and immunisation programmes, focusing on reducing health inequality.

We will ensure care delivered to children and young people is age appropriate, integrated in relation to physical and mental health needs and between different care settings as well as ensuring effective transition to adult services, particularly for our most complex young people, in line with Safeguarding Children's Partnership arrangements. By the end of Q3 2019 – 2020 a plan will be in place for the implementation of the Imperial model of Child Health Hubs, with those Hubs being rolled out by the end of 2020. This will reduce unwarranted variation in attendances and admissions for children under 4 as well as ensure that the mental wellbeing of children and young people are linked in robustly (working alongside mental health in schools).

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. We will measure the success through hospital admission and readmission performance against current baselines, as well as patient-reported outcomes.

We will continue to develop mechanisms to support children and young people to be emotionally resilient and to know when to seek support for their mental health, including through online support as well as school and college based mental health support teams. The Emotionally Healthy Schools project has transformed the mental health support in schools and is currently delivering effectively. There is an extended hours crisis line for children and young people with mental health needs up and running and available to parents and children as well as professionals. This is particularly important given the high levels of admissions for self harm amongst 10 to 24 year olds in Cheshire East.

Personalised Care

Personalised care will become business as usual across the Cheshire East health and care system. This will include:

- Additional trained social prescribers in each Primary Care Network. A pilot is underway in Macclesfield (using HCP transformation funding) to pilot social prescribing and this will inform the roll out across the other PCNs/CCs
- Maintaining and sharing widely the repository of PCN/CC aligned community assets to be drawn upon by social prescribing link workers
- Approximately 1300 people will have a personal health budget so they can control their own care, improve health experience and achieve better value for money
- Approximately 5000 people will have a personalised care and support plan to help them manage their long term condition(s)
- Developing the skills and behaviours of clinicians and professionals through practical support and training to use personalised care approaches each day including motivational interviewing and trauma informed practice (training currently being rolled out in mental health and social care providers)
- As we re-evaluate guidance and ‘care pathways’ we will ensure that they support person centred care, by giving patients, carers and professionals the information and flexibility they need to support, what can be difficult, person centred decisions
- Supporting people with long term conditions, through appropriate services, guidance and advice to help with self-management and coordinated care

Frailty

The Frailty care (co-designed with support from the National Associate Clinical Director for NHS E) is focussed on identifying and intervening in people with rising frailty (including falls). Training funded through the HCP will support systematic training across all health and care partners (including wider public sector, for example the Police and the community - taxi drivers, hairdressers etc). The aim is to support people with rising need with appropriate interventions to prevent further frailty. By Q4 2019 - 2020 there will be frailty champions in all Care Communities and across community pharmacy. In addition to this, local authority

support has ensured that all CC staff will be trained in dementia awareness which will also assist as an intervention to reduce/prevent rising frailty.

Falls prevention

Cheshire East Place has recently published a falls prevention strategy, with a vision of working together to reduce falls and promote independence.

In Cheshire East, we have a large and fast growing older population, of which the frail and vulnerable form a significant proportion. A fall often results in a person needing to stay in hospital and can permanently reduce their physical and mental health and wellbeing.

The key outcomes for the falls prevention group are:

- Identifying those likely to have a fall
- Helping those likely to fall in order to prevent falls
- Working effectively with people who have fallen to help reduce the likelihood that they will fall again

Early help and prevention are central to implementation of this strategy. This means giving support to individuals at risk at an early stage, before they experience a significant fall.

Our focus will be upon commissioning and the development of borough-wide, appropriate, evidence based services which are both individually and collectively successful in reducing the likelihood of at risk people falling and injuring themselves. This will include completing and reviewing formal risk assessments, the continuation of falls specific exercise classes and community equipment being available which can further reduce the risk of falls. The newly commissioned 'One You' Service will include falls prevention through a 26 week OTAGO programme including strength and balance exercises with a choice of group or one to one support.

We will continue to develop opportunities to work collaboratively, to ensure that all available data and evidence-based practice is used to inform future falls prevention commissioning across the whole of Cheshire East.

Palliative and End of Life care

The Cheshire and Merseyside Palliative and End of Life care programme aims to enable and deliver care which is planned, less reactive and personalised, for people with life limiting conditions to live well, before dying with peace and dignity in the place of their choice. We support the Cheshire and Merseyside programme, and have a resilient community sector which supports many Cheshire East residents in dying in a supported manner, which accommodates their choices where possible. The Cheshire End of Life Partnership, through its Collaborative Strategic Plan for Palliative and End of Life Care, is a key partner in this work and will play a leading role in taking it forward.

We want to support our residents, and also empower our communities to encourage resilience as the experience at the end of ones life can impact the mental health and wellbeing of those around the dying. We want to ensure that care is coordinated and

residents' wishes listened to; maximising comfort and wellbeing, with a workforce that is prepared to care.

We want every person within Cheshire East Place to get fair access to end of life care, regardless of who they are or the circumstances of their life. We would like to work with our partners to continue to improve our end of life care services, so that everybody in Cheshire East has the chance to live well before dying with dignity. By listening and responding to the wishes of our population, we aim to care in a manner that provides a positive experience, not merely for patients, but for their carers and families as well.

We will ensure that all organisations have an Advanced Care Planning policy in operation with a workforce education plan in place aligned to the core competencies identified within the Cheshire & Merseyside Advanced Care Planning Framework. We will develop and implement innovative models of proactive and timely care, via our care communities and if needed, introducing new partnerships across organisations.

The Cheshire East Integrated Care Partnership

The aim of the Cheshire East ICP is to bring together the main NHS providers and Local Authority into a virtual organisation creating a 'space' to work together to take a whole population perspective. The common purpose is to integrate care services to support improvement in population health. The eight care communities across Cheshire East (see below) are critical to the success of this new way of working and have already demonstrated progress, working locally to improve the health and well-being of the population. This is an essential prerequisite step in developing effective integration for Cheshire East. Considerable preparation has already taken place to prepare for the establishment of the ICP, with the ambition of establishing formal arrangements and beginning delivery of an agreed set of services by April 2020.

The purpose of the ICP is to improve the health and wellbeing of the population, the quality and safety of services, the patient outcomes and reduce the inequality gap, adhering to models of both clinical and financial sustainability.

The vision is that Cheshire East ICP will strive to improve the health and wellbeing of local communities enabling them to live longer and healthier lives. Partners have committed to do this by engaging with and empowering citizens to support early intervention and prevention, creating and delivering safe, integrated and sustainable services that meet people's needs and by the best use of assets and resources available. The Cheshire East ICP values are inclusion, empowerment, innovation and improvement, honesty and integrity, openness and transparency and partnership working.

The Cheshire East ICP will provide the structure, processes and governance arrangements to enable the system to work differently to support care communities to deliver a wider scope of integrated care and to enable resources to be deployed in a way that maximises health improvement and reduces inequalities.

Primary Care Networks

GP Practices across Cheshire East have grouped in clusters to form Primary Care Networks, 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, aligning expanded multi-disciplinary health and care community teams around each Network, to deliver fully integrated community-based care. The initial focus will be on developing excellent relationships between Primary Care Networks and wider community partners across their neighbourhood, including police and fire services, the voluntary and faith organisations and community leaders. The employment of Social Prescribing Link Workers through the PCNS provides a great opportunity to enhance relationships with the community, voluntary and faith sectors.

Additional investment will be available to support Primary Care Networks to develop innovative ways to increase capacity through a more diverse workforce offer, reduce avoidable A&E attendances, admissions and delayed discharges as well as standardising, patient pathways to reduce avoidable outpatient visits and over-medication.

Individual practices and their Primary Care Networks will be supported to maximise digital opportunities to improve access to care, including offering online and video consultations. This will build upon and align with the work already underway through the Care Communities.

Our Care Communities

Cheshire East Place has eight Care Communities (CC) which mirror the PCNs, except in Crewe where two PCNs sit within the Crewe Care Community geography. All CC have dedicated and funded clinical leadership time to develop integrated working within the CC. The CC have used the data available in the JSNA as well as some hospital data to develop improvement plans and areas of focus. Whilst there are a range of commonly agreed improvements, there is also local variation based on population need. This has resulted in wide spread small and large scale change and improvements to delivery of care in the community across, general practice, community services and mental health. There is a dashboard to monitor key metrics for CC. The CC have successfully bid for innovation monies (from HCP transformation funding) to test out areas of improvement for example, modern Doppler devices for management of leg ulcers and Atrial Fibrillation screening using mobile technology. The CC clinical leads are engaged with the CC strategic development group which is supporting the reduction in unwarranted variation in the delivery of care and ensuring there is a common narrative across place.

A key enabler has been the ability of all partners to support leadership (clinical and managerial) in the development of CC. Whilst the arrangements vary (dependant on resource), the structure of GP clinical lead, managerial support from community services and aligned social care and mental health senior clinicians/practitioners has developed and will continue to mature. The place has funded dedicated GP clinical leadership time to ensure not only PCN development but also CC development.

Funding for innovation from HCP transformation monies is leading to the pilot of a “chatbot” for those with long term conditions (on an elective basis) which will be evaluated and learning shared across the Place by March 2020.

Care communities are using a variety of methods to engage with their communities to ensure more effective community alignment.

The Care Communities use the JSNA “tartan rug” and “tartan shawl” for identifying areas of improvement. The availability of hospital usage by postcode/street has enabled Care Communities to focus improvements to those who are high intensity service users.

The development of peer review of GP referrals into secondary care has helped reduce unwarranted variation in GP referral patterns.

The clinical engagement has ensured a biopsychosocial approach to care rather than a traditional clinical model, understanding wider determinants of health and working with LA partners to address these issues.

Further development work is being undertaken to ensure all staff are trained in “Making Every Contact Count” to ensure prevention and motivational interviewing is integral to care delivery across the place. The “three conversation” model / motivational interviewing is widely established within social care. NHS providers will learn from social care to ensure this model of an asset based approach is embedded.

3) Transforming Existing Services

Community Care

By PCNs practices working together with their aligned (and the ambition is integrated) community teams in the care Communities, there will be a shift towards greater emphasis on preventative and anticipatory care and rapid response, particularly for those patients identified as frail and/or having long term conditions. The approach will be supported by the use of digital technology and making use of the available intelligence including through use of predictive analytical tools to identify patients at rising risk. Risk stratification is undertaken using Aristotle across the Place.

The development of Care Communities will be supported by the development of a wider integrated workforce who have sufficient and appropriate IT equipment and shared information to maximise the mobile working hours available for increasing time to care. For example we will roll out by the end of 2019 the use of new dopplers bought by transformation monies which increase the capacity of the district nurses.

Service development opportunities will be utilised to increase capacity for 7 day working, enhancing the availability of timely packages of care and working across and with partner organisations to eliminate duplication, to avoid unnecessary admissions to hospital and reduce length of stay.

This will be underpinned by a shared commitment to continuous quality improvement, empowering clinical leaders and front line teams in the development and delivery of new standardised ways of working, using recognised quality improvement methodology to co-design, locally test and scale up at pace.

Cheshire East will develop a phased plan to meet the new primary medical and community health service funding guarantee over the next five years, across primary medical, community health and continuing health care services.

Acute Hospital Care

We are committed to working with our partners to enable clinically sustainable services that meet the needs of our patients both now and in the future, recognising that the way services are currently delivered may need to change. The Cheshire East Acute Sustainability programme forms part of the Cheshire and Merseyside overarching clinical sustainability programme, looking at how best we can ensure our local hospitals continue to deliver high quality care.

The local programme is looking at how three acute services in particular – urgent and emergency care, women's and children's services and elective care - are configured and how that might need to develop in future to ensure sustainable, high quality care. The work will take into account the work taking shape in the care communities.

Service change proposals will be developed through extensive stakeholder engagement and may require a full public consultation in line with NHSE guidance on service change.

Urgent care

We will improve the responsiveness of community health crisis response services to deliver services within two hours of referral and reablement care within two days of referral.

In addition, we will fully implement the Urgent Treatment Centre model by autumn 2020. Urgent Treatment Centres will work alongside other parts of the urgent care network including primary care and other community based services to provide a locally accessible and convenient alternative to Accident and Emergency for patients who do not need to attend hospital.

We will look to continue to integrate the urgent care response across Cheshire East, basing development on our care communities, to provide an integrated network of care that meets both the existing and developing clinical standards, enabling more people to be cared for closer to home without the need to attend A&E.

Crisis care for mental health will be implemented by the end of 2019 – 2020 delivering alternatives to A&E. This will include crisis beds in the community for those with mental health needs. There will be 6 commissioned crisis beds so there are alternatives to hospital admission, thereby reducing occupied bed days.

We will ensure our A&E services are fit for purpose both in terms of sufficient numbers and skills of our workforce, as well as estate capacity to meet the changing and growing demographics of our population.

There will be a continued focus on maintaining and improving current performance for urgent and emergency care. This will enable the more timely care and treatment of acutely unwell patients to optimise clinical outcomes.

Planned Care

We are commencing a programme of transformation across planned care that focuses on three key elements; empowered self care and shared decision making, reformed referrals and transformed outpatient services.. The emphasis is on implementing national best practice to reduce unwarranted clinical variation in outcomes. This will be underpinned by an increased use of digital technology providing options for virtual appointments and more effective tracking of a patient's journey as well as building on successful single points of

access which has reduced referrals to orthopaedics, rheumatology and pain in the southern part of the Cheshire East system.

As a result, waiting time targets will be achieved including no patient waiting more than 52 weeks from referral to treatment and 92% of patient pathways being completed within 18 weeks. This will also support achieving financial stability for the system overall.

Cancer Care

We will work to deliver the Long Term Plan commitments for the people of Cheshire East including:

- By 2028, 55,000 more people will survive cancer for five years or more each year
- Three in four cancers will be diagnosed at either stage 1 or 2
- Roll out of fecal immunochemical test (FIT) for symptomatic and non-symptomatic patients
- Integration of breast screening programmes across Cheshire East to improve sustainability and to meet national screening population sizes
- Increased radiology capacity for MR and CT at Leighton
- £23 million investment in a new Christie Cancer Centre will serve 1500 new patients in Cheshire East, providing radiotherapy, chemotherapy, outpatient care, holistic support and information services. The centre will be built at Macclesfield District General Hospital and is due to be competed in 2021.

We will continue to review pathways to become more streamlined and ensure more opportunity for early detection through the use of innovative mechanisms such as rapid diagnostic centres.

We want our cancer care to be 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.

Cardiovascular Disease (CVD)

Cardiovascular disease is responsible for one in four premature deaths and accounts for the largest gap in health life expectancy. The Long Term Plan includes a major ambition to prevent 150,000 strokes, heart attacks and vascular dementia cases.

Cardiovascular care is a focus for all eight CC. This includes focus on smoking cessation, screening and intervention for hypertension, atrial fibrillation and heart failure. CCGs have made RightCare date available in accessible form for all CC to enable them to focus on areas of greatest variance. Building on the community work will be the need for timely specialist support and advice with a new model of outpatient care, ensuring there is a reduction in unnecessary outpatient visits. Cheshire East will improve the prevention, early detection and treatment of cardiovascular disease over the next five years, including;

- Prioritising cardiovascular service redesign as a major theme in the development of the Cheshire East ICP

- Rolling out screening for Atrial Fibrillation using mobile technology (currently in use in two Care Communities)
- Increasing the numbers of people at risk of heart attack and stroke who are treated for the cardiovascular high risk conditions; Atrial Fibrillation, high blood pressure and high cholesterol
- Testing the use of technology to increase referral and uptake of cardiac rehabilitation from 2021/22 as well as increasing rehabilitation capacity to meet expected demand
- Increase access to echocardiography and improve the investigation of those with breathlessness and the early detection of heart failure and valve disease, introducing one stop joint clinics between cardiology and respiratory services
- Work within Integrated Stroke Delivery Networks (ISDNs) improving and configuring stroke services, to ensure that all patients who need it, receive mechanical thrombectomy and thrombolysis in a timely manner
- The introduction of 'virtual hospital' working for secondary care cardiology will dramatically shorten time to solution for patients with cardiology problems
- New community based cardiology services, integrated with secondary care and primary care, will improve the quality of care and reduce the pressure on secondary care cardiology services
- Adhering to a programme of prevention, detection, treatment initiation and improved management, known as the ABC approach – Atrial fibrillation, blood pressure and cholesterol. A Place Plan will be developed by the end of 2019 with implementation beginning in 2020 focussing on AF, hypertension screening and intervention, community diagnostics for palpitations and community cardiology (including outpatient follow up).

We will also continue to work with our partners in tertiary centres to strengthen interventional clinical pathways. Cheshire Fire and Rescue Service are supporting an effective and seamless referral pathway for patients identified as potential atrial fibrillation cases through their Safe and Well checks

Diabetes

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

- Support for more people living with diabetes to achieve the three recommended treatment targets
- targeting variation in the achievement of diabetes management, treatment and care processes
- Ensure ongoing monitoring and support post pregnancy to ensure women continue to be monitored after giving birth

- Addressing health inequalities through the commissioning and provision of targeted services
- Expanded provision of access to digital and face-to-face structured education and self-management support tools for people with Type 1 and Type 2 diabetes
- Providing access for those living with Type 2 diabetes to the national HeLP Diabetes online self-management platform, which will commence phased roll out in 2019/20
- Strengthen the current offer to inpatients with diabetes, working in partnership with other providers to improve resilience
- Universal coverage of multidisciplinary footcare teams (MDFTs) and diabetes inpatient specialist nurses (DISN) teams, for those who require support in secondary care

Respiratory

We will increase the effective identification of people with respiratory disease to ensure more rapid access to appropriate treatment and care. We will support people to effectively manage their respiratory condition including use of their medications and having rapid access to appropriate community and primary care services at times of deterioration in their condition. We will continue to develop access to pulmonary rehabilitation, particularly for the most socio-economically deprived and hard to reach groups.

NHS organisations will support the ambition to improve air quality by cutting business mileages and fleet air pollutant emissions by 20% by 2023/24. At least 90% of the NHS fleet will use low-emissions engines (including 25% Ultra Low Emissions) by 2028 and primary heating from coal and oil fuel in NHS sites will be fully phased out. Cheshire East Council is committed to being carbon neutral by 2025.

Mental Health, Learning Disabilities and Autism

Mental Wellbeing is a focus for all Care Communities. We need to consider how we prevent mental illness and will sign up to the Public Health England (PHE) Prevention Concordat for Better Mental Health that aims to facilitate local and national action around preventing mental health problems and promoting good mental health. We will help to reduce complex barriers to education, training, employment and financial independence through our IntoWork support programmes which support mental wellbeing. In addition we will work with partners, for example to develop supplementary planning guidance in relation to wellbeing improvements through access to green spaces and active transport. In addition there is a need to improve access to services starting with a pilot of direct access mental health in general practice which, if it improves access and reduces need for secondary care will be rolled out across all care communities.

All CC are working with PCN and the local authority to develop social prescribing, aligning the various initiatives to build a community asset base as well as ensuring support to those who are socially isolated and those who have long term conditions.

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. The mental health provider is part of a collaborative for secure services, Tier 4 CAMHs and adult eating disorders, with clear development and delivery plans for 2019 – 2020 and 2020 – 2021. This will be supported by effective use of the shared care record to ensure clinicians have access to the most appropriate information to support each individual.

We will test and roll out adult community mental health access standards. The recent 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 Primary care networks/Care Communities and will be bidding for Wave 2 national monies to facilitate this. In relation to older people's mental health, memory clinics are being integrated into primary care and Care Communities. The integration of mental health services with care communities will improve access to community services. 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 including the voluntary sector. This will include delivery of 24/7 adult crisis resolution and home treatment teams across Cheshire East by 2021 and 24/7 crisis provision for children and young people which combines crisis assessment, brief response and intensive home treatment functions by 2023. National monies are funding the delivery of extended hours for the children and young people crisis line.

In striving to support more people to manage their condition at home or in the community, we will look to ensure we make the best use of inpatient beds.

Specific objectives will include:

- Increasing access to children and young people's community mental health treatments (at least 34% receive treatment)
- Ensuring children and young people with an eating disorder receive treatment within four weeks (routine) and one week (urgent)
- Screening of school children and provision of parenting programmes where a need is indicated
- Develop school based mental health curriculum (social and emotional learning)
- Increasing access to psychological therapies (from 19% to 22%, predominantly in primary and community care
- At least 75% of people referred to IAPT begin treatment within 6 weeks
- At least 95% of people referred to IAPT begin treatment within 18 weeks
- At least 50% of people who complete IAPT treatment should recover
- Early intervention in Psychosis (EIP) – increase access to 56% of people receiving NICE-recommended packages of care within two weeks of referral
- Deliver all-age mental health liaison teams in acute hospitals
- At least 60% of people with a severe mental illness should receive a full annual physical health check
- Ensure that staff are consistently offered leading mental health support to maintain a healthy workforce

- Two thirds of people with dementia (over 65 years) should receive a formal diagnosis

We will improve the care for people with learning disabilities and/or autism ensuring integration with their 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. The mental health provider has developed a dynamic risk support tool to assist with admission avoidance into A&E beds for those with a learning disability.

A primary ambition for the Learning Disabilities and Autism work-stream is to involve people who use services, and their families, in the design, delivery and monitoring of all services. We want to ensure that our residents are involved in their care planning, making reasonable adjustments for people with learning disabilities and/or autism.

We will continue to improve care for those with Learning Disabilities by learning from lived experience as well as from Learning Disability Mortality Reviews (LeDeR). These reviews will always be undertaken within six months of the notification of death and all reviews will be analysed to address the themes identified with recommendations being reported through a local LeDeR report.

We will support all Primary Care Networks to continue to review medications for people with Learning Disability to prevent and stop all over medication for all ages. The provider and PCNs have started to deliver on the SToMP agenda.

We will ensure children and young people with the most complex needs and their carers/families continue to have access to a keyworker who can ensure a holistic approach to each individual's care.

We will 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 have been collaborating on the suicide prevention agenda – 'A Zero Suicide Strategy for Cheshire and Merseyside'. The vision is for Cheshire and Merseyside to become a region where suicides are eliminated, with people no longer seeing suicide as a solution to the problems they face. Self harm is similarly a primary focus, as 38% of those who died by suicide in Cheshire and Merseyside in 2014 and 2015 had previously self-harmed or attempted suicide.

In relation to the broader objectives for Cheshire and Merseyside, their focus will begin with overcoming inequalities, which aligns with the Cheshire East Partnership strategy; negative life events, experiences and poor health conditions are unequally distributed across the population, and all contribute to the underlying risk of suicide. We will also focus on children and young people, as if we are to eliminate suicides and reach zero we must start by preventing self harm and suicidal behaviour in our children, and subsequently, in their adult lives.

Both NHS Eastern Cheshire and NHS South Cheshire CCG are signed up to the Mental Health Crisis Care concordat and will be signing up to the PHE Prevention Concordat.

Further, in order to accelerate action against suicide we will continue to focus upon leadership, prevention, safer care, support after suicide 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. This is to support teachers when a child or young person discloses or shows signs of suicide.

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.

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 including minimising the need to utilise A&E at times of crisis. 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 to which both NHS Eastern Cheshire and South Cheshire CCG are associates.

We will ensure improved recovery will be defined and achieved in 50% of patients accessing Transition, Intervention and Liaison Service (TILs) and Complex Treatment Service (CTS).

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. They are largely invisible to health service commissioners. There is little robust data available to assist in effective commissioning and monitoring of services to meet existing health needs and improve health outcomes. We will ensure that their needs are considered as part of the Five year Plan.

4) Going digital

We will develop a comprehensive health and care digital strategy and investment plan describing how digital technology will underpin our system transformation, including

- all secondary care providers to be fully digitised by 2024 and integrated with the health and care system
- clear milestones for each NHS provider's increasing digital maturity
- plans to adopt Global Digital Exemplar (GDE) Blueprints and an approach based on IT system convergence to reduce unnecessary duplication and costs
- plans to adhere to controls and use approved commercial vehicles such as the Health System Support Framework to ensure technology vendors and platforms comply with national standards for the capture, storage and sharing of data

- 100% compliance with cyber security standards
- by 2020, every patient with a long-term condition will have access to their care plan via the NHS App, enabled by the Summary Care Record (SCR)
- all women have their own digital maternity record by 2023/24
- by 2021 all parents will have a choice of a paper or digital Redbook for their new babies

We will recommission the Cheshire Integrated Care Record in 2020, facilitating the sharing of patient information across the system. We will also continue the development of our patient held electronic record which is currently being piloted.

5) Building the right health and care workforce

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 demand an expanded workforce which in Cheshire East will be inclusive and supportive, ensuring we enable all staff to maintain their own good health and wellbeing including through flexible working arrangements.

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.

The multi-disciplinary health and care community teams will be supported through the development of a primary care and community training hub that will deliver a set of core functions to educate, train and support the current and future workforce working as part of multidisciplinary teams in the community.

We want to make the NHS 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 during 2020/21. This will assist us in developing an overarching workforce and OD strategy.

We will work to improve leadership culture within Cheshire East Place, developing a coach approach to help develop effective and inclusive system leaders who role model our values and behaviours.

6) Financial Impact

A detailed remodelling of the Cheshire East Partnership system finances is currently underway, together with work to develop a financial recovery plan for Cheshire as a whole. There is currently a deficit and the work described above will, when fully implemented, help to manage demand and potentially reduce costs. Some examples of impacts are set out below:

The development of improved cardiovascular health for the population will reduce unnecessary outpatient attendances for those with chronic cardiac disease. Focus on prevention eg cardiovascular disease as well as smoking cessation will support reduced spend and improve outcomes.

The implementation of the child health hub model will reduce A&E attendances and admissions for those under 4.

The integration of memory clinics within CC will ensure reduced outpatient follow up as well as increase access to specialist memory services.

Integrating mental wellbeing and social prescribing will address currently unmet psychosocial needs of those with long term conditions (which impacts on hospital and GP usage), thereby reducing A&E attendances and admissions.

Embedding the “CURE” model of smoking cessation in Acute hospital providers will ensure reduction in admissions/readmissions, thereby reducing occupied bed days.

7) Outcomes Framework

Care Communities Outcome Framework – work in progress

Ambition	Outcome	Care Communities Strategic Outcomes	Sub Outcomes	Measure
Empowered Person People are empowered to take responsibility for their own health and well being	People are empowered to take responsibility for their own health and wellbeing and manage their own support as they wish, so that they are in control of what, how and when support is delivered to match their needs.	People have greater understanding of what they can do to live/maintain a healthy lifestyle People have a greater understanding of how they can manage their long term conditions	Increase in uptake in NHS Health checks Increase of people involved in the development of their care plan	Health Checks People with a LTC supported to manage their condition Making Every Contact Count?
Easy Access Access that is designed to deliver high quality, responsive services	Improved access to high quality, responsive services, support and appropriate information that provides everyone with the opportunity to have the best health and wellbeing throughout their life.	Consistent access to care services in the community during core hours 7 days a week – 24 hours a day		Access to services, including GP, mental Health, social care
Appropriate time in hospital Appropriate time in hospital with prompt & planned discharge into well organised community care	Reducing inappropriate time spent in hospital by increasing planned discharge into co-ordinated community care	Increased proportion of people supported at home	Reduction in people experiencing a health crises that results in hospitalisation or admission to a care home Increased number of people are supported to live well at home in times of crises Reduced number of placements to care homes Reduced length of stay in hospital Reduced emergency admissions Reduced readmissions	Referrals from A&E back into the community Intermediate Care referral and discharge information Proportion of people returning to their usual place of residence following a hospital stay Care home placements Length of hospital stays The proportion of people aged 65+ who are at home/ in extra care housing three months after the date of their discharge from hospital Readmissions
Rapid Response A prompt response to urgent needs so that fewer people need to access urgent and emergency care	Increasing the responsiveness of services to meet the urgent needs of the people they serve	Reduced unplanned care and crises	Reduced A&E Attendances Reduced Emergency Admissions Reduced number of emergency placements to care homes	A&E attendances Emergency admissions not referred by community teams Avoidable Admissions Emergency care home placements
High quality care The highest quality care delivered by the right person regardless of the time of day or day of the week	Increasing the quality of care provided in Eastern Cheshire regardless of the time of day or the day of the week	Maintain /Improve the quality of care provided in community settings regardless of the time of day or day of the week	Maintain/improve the quality of care provided by the community teams	Safety thermometer for community services Family and Friends Test for GP, community and mental health
Support for carers Carers are valued and supported	Carers feel valued and supported and are able to maintain or improve their desired quality of life.	Carers can balance their caring roles and maintain a desired quality of life	Increase in carers in receipt of a carers assessment Improvement in carers wellbeing	Proportion of carers in receipt of a carers assessment Carers wellbeing
Planned Pathways Simplified planned care pathways delivered as locally as possible	Improving outcomes from planned care via simplified pathways delivered as locally as possible	Improved communication and continuity of care between the community hub teams and secondary care	Reduced length of delayed transfers of care Increased proportion of people receiving care co-ordination, including a care plan Increased identification of frailty Increased use of end of life pathways and advanced planning .	Length of DTOC for acute and community beds Proportion of people with a care plan Proportion of people returning to their usual place of residence following a hospital stay The proportion of people aged 65+ who are at home/ in extra care housing three months after the date of their discharge from hospital Number of frailty cases Proportion of people dying in their preferred place of death
Integrated Care Staff working together with the person at the centre to proactively manage long term physical and mental health conditions	Improving peoples experience and outcomes of integrated care	Enhanced patient experience Increase in appropriate case finding and proactive management Increase in staff satisfaction	Improved co-ordination and alignment of interventions offered by different organisations including the 3rd sector Reduced barriers between organisations and professions Team members have greater satisfaction from working with people in a flexible way to deliver care matched to their individual needs	Case studies Integration survey/tool Staff survey

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