Transforming our services - Contents

Section One

Our Core Transformation Programmes:

1. Children and Young People (CYP)
2. Palliative and End of Life Care (PEOLC)
3. Primary Care
4. Elective and Cancer Care
5. Outpatient Transformation
6. Cheshire and Merseyside Women's Health and Maternity
7. Mental Health Learning Disability and Autism / Transforming Care

Section Two

Additional Transformation Priorities:

1. All Age Continuing Health Care
2. Cardiovascular Disease (CVD)Prevention
3. Carers
4. Diabetes
5. Diagnostics
6. Neurosciences
7. Respiratory
8. Stroke
9. Sustainability and Partnerships

Section Three

Innovation and use of new Technology:

1. Research and Innovation
2. Promote Digital Maturity

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Section One
Our Transformation Programmes 2024-29

1. Children and Young People (CYP)
2. Palliative and End of Life Care (PEOLC)
3. Primary Care
4. Elective and Cancer Care
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Children and Young People

Children and Young People

Vision and Mission:

- **Give every child the best start in life.**
- **Enable all children, young people and adults to maximise their capabilities and have control over their lives.**

Working collaboratively to ssupport all our children to have a good start to life both in terms of their health and wellbeing and educational attainment to enable them to go on to live long and happy lives.

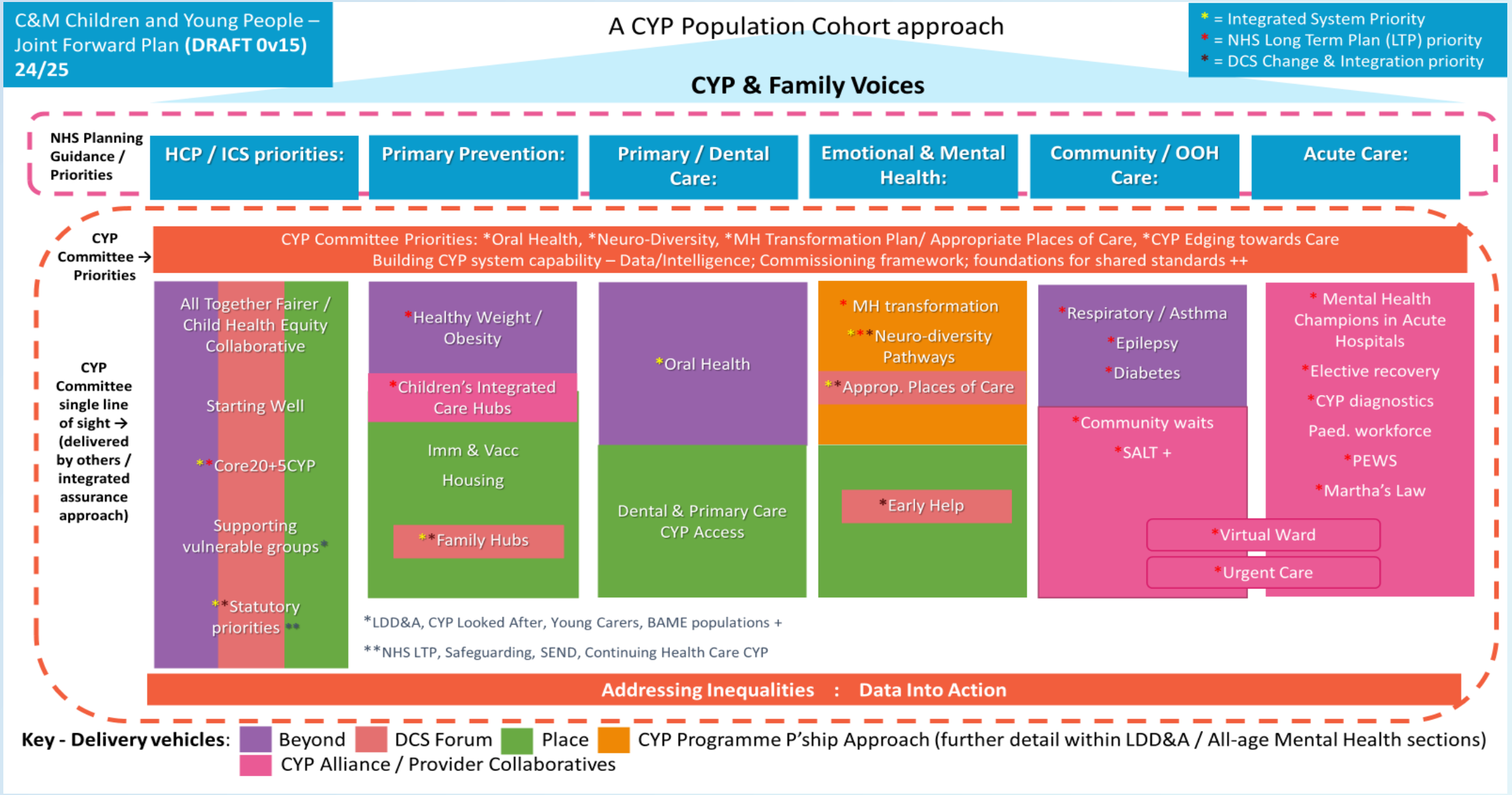
Case for Change: The population of the Cheshire and Merseyside System is around 2.7million, 25% of whom are Children and Young People (0-19 years).

- Delivering the Children and Young People commitments in the NHS Long Term Plan
- Cheshire and Merseyside Health and Care Partnership Priority Area – Marmot indicators
- BEYOND Cheshire and Merseyside Children's Transformation Programme
- Delivery of the Core20PLUS5 Children and Young People Priorities
- CYP mental Health Transformation Plan
- CYP Committee CYP priorities – CYP appropriate places of care/ Mental Health / Neurodiversity / Oral Health / on the Edge of Care
- Statutory requirements in relation to Special Educational Needs (SEND)
- Links to the Directors of Children's Service Forum / work programme
- Barnardo's and Institute of Health Equity on a Health Equity framework

Enablers:

Engagement:
The voices of children and young people and their families / carers are key to delivery
Linking agendas:
Cheshire and Merseyside Directors of Children's Service (DCS) – ensuring jjoined up approaches
System wide focus:
Working in partnership between Social Care, Health and the Third Sector, support preventative work, spreading examples of good practice.
Health Inequalities:
Delivery through a Population Health Lens focus on those most affected by poor outcomes
Workforce:
Improving system effectiveness and efficiency through creative and innovative development and use of the workforce
Digital and Data and use of new technology:
Use data, artificial intelligence and modelling to create a single line of sight for the needs of CYP

Children and Young People



Children and Young People

Some Children and Young People in Cheshire and Merseyside do not “Start Well”: Children are less likely to be breastfed at 6 – 8 weeks; In 6 of 9 Places, children have poorer communication skills at end of Reception than expected England levels; children are performing less well in school readiness / attainment particularly those eligible for free school meals; more school children are classified as overweight or obese at reception and Yr6; a greater proportion of children are within Local Authority care – some Places recording double the England average; significant increases in children being referred to CAMHS; over 35% of 5 years olds in Liverpool and Knowsley have obvious dental decay.

All Together Fairer highlights the needs of Children and Young People within its key recommendations:

- ***Give every child the best start in life***
- ***Enable all children, young people and adults to maximise their capabilities and have control over their lives***

This will be further strengthened by the Children’s Health Equity Collaborative (a partnership between NHS Cheshire and Merseyside, NHS South Yorkshire, NHS Birmingham and Solihull, the Institute for Health Equity and Barnardo’s) which identifies key indicators for children’s outcomes that will drive system understanding of areas to address the wider determinants of health inequities, and inform system led interventions.

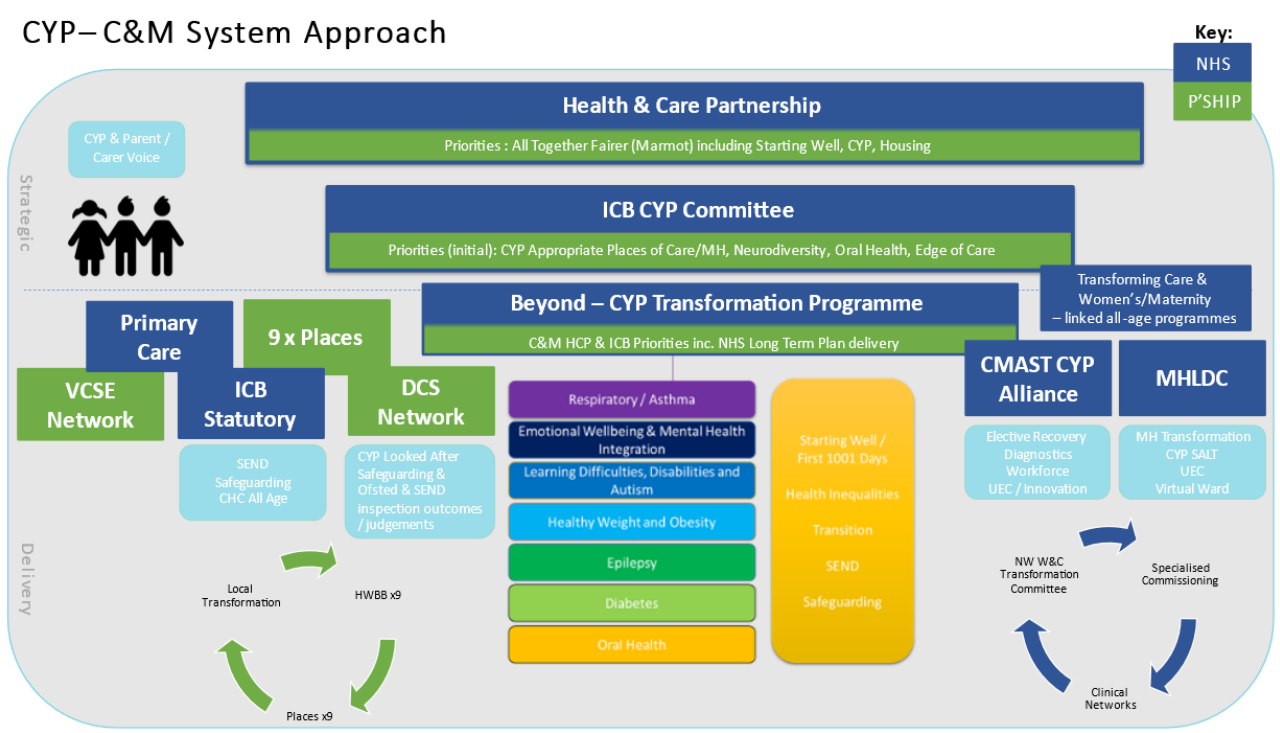
C&M has a strong focus on improving outcomes for babies, children and young people (0-25 years for children with SEN) and is taking a population cohort approach across the HCP to include Statutory Health Delivery, Public Health, Local Authority / Children’s Services and the VCFS Sector to challenge delivery and drive improvement. C&M is undertaking a whole system approach to improving child health outcomes:

- ***Supporting better coordination of care for the most complex needs (including SEND) and reducing health inequalities through the Core20Plus5 for CYP framework, for example, addressing poor oral health;***
- ***Recovery of CYP services including tackling the elective backlog and transforming community services to build capacity to address key issues inc. community waits / early developmental delay;***
- ***High quality care for major childhood conditions including mental health, neurodiversity, long term conditions and unhealthy weight;***
- ***Managing demand within urgent and emergency care with better self-care and access to paediatric advice in primary/community care.***

Children and Young People

The establishment of the Children's Committee embeds a commitment to "Starting Well" and will oversee development of a Children and Young Person's Strategy for C&M. The Committee has 4 key priority areas for system improvement over 24/25:

- ***Oral Health***
- ***Neurodiversity***
- ***MH Transformation Plan/ Appropriate Places of Care***
- ***CYP Edging towards Care***



We will :

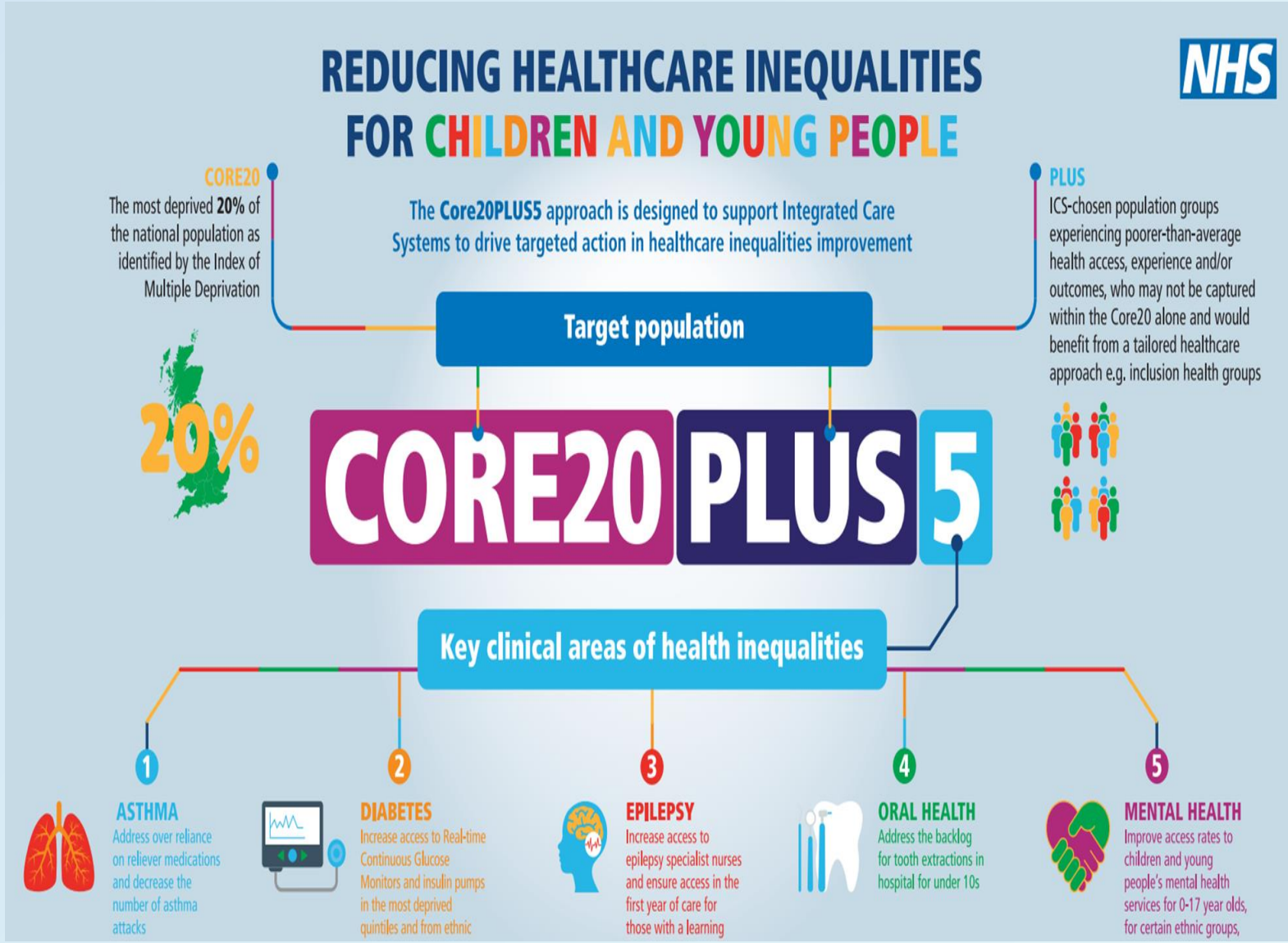
- Engage and involve young people as representatives on the various groups and committees - working with them to co-create solutions that work for them
- Embed a single line of sight of the outcomes for CYP, driving improvements in health and social care to address the impact of health inequalities
- Deliver programmes of work in line with Core20PLUS5 for CYP
- Work in partnership between Social Care, Health and the Third Sector. support preventative work, spreading examples of good practice
- Implement targeted interventions around alternatives to hospital care, reducing variation in diabetes and epilepsy care and early intervention around healthy weight and obesity
- Implement the recommendations of the Asthma and Epilepsy Bundles
- Deliver the ambition of the national Family Hubs and Start for Life programme (2022-2025), including strengthening the work of Children's Centres
- We will Implement the NHS Universal Family (Care Leaver Covenant) Programme so that care experienced young people have opportunities to be supported into roles within the NHS by October 2023
- Support integrated working via Place Based Gateway meetings.
- Develop a model of best practice for safe places for CYP who need alternatives to hospital care due to emotional well-being or social needs
- Implement a health and care workforce strategy and plan for Cheshire and Merseyside that supports integration and collaboration.
- Convene a system response to Neuro-diversity – supporting pathway redesign and quality improvement.

Children and Young People - Programme delivery

Beyond: Cheshire and Merseyside's Children's and Young People (CYP) Transformation Programme.

The Beyond Programme is our integrated health & care CYP programme, which includes shared integrated priorities from the C&M Directors of Children's Services and NHS, focused on bringing delivery/services together. Priorities are linked to the crosscutting Starting Well themes, CORE 20+5 for CYP and All Together Fairer to ensure a population health approach, routed in prevention/early intervention and tackling inequalities.

- ***Emotional wellbeing and mental health***
- ***Learning disabilities / autism***
- ***Diabetes***
- ***Epilepsy***
- ***Respiratory / asthma***
- ***Healthy weight and obesity***
- ***Oral health***



Children and Young People - Programme delivery

VCFSE Network

Established in May 2023 the Cheshire and Merseyside Voluntary, Community, Faith and Social Enterprise CYP Network, co-ordinated and supported by the VSNW CYP Network Manager, meets bimonthly, as well as occasional online meetings to discuss and review specific topics. In February this included feeding back on the consultation around the C&M CYP Mental Health Plan. The network currently has 28 members representing all of the 9 places in C&M, including VCSE infrastructure, delivery and specialist organisations.

VCSE organisations within the network and across C&M will continue to deliver a wide range of activities and services that meet most if not all of the priority workstreams outlined in this plan. However, following discussions within the Network, members have stated their intention and commitment to co-ordinate their focus on the four key priorities identified by the ICB CYP Committee:

- ***Mental Health***
- ***Neurodiversity***
- ***Edge of Care***
- ***Oral Health***

By sharing good practice and learning, undertaking collaborative and partnership working with each other and statutory partners the VCSE Network believe that they can improve outcomes, gather great evidence of the impact and outcomes being achieved across the priority areas, increase efficiency, increase funding coming into Cheshire and Merseyside and achieve better value for money for commissioners.

The Directors of Children's Services (DCS) Forum

There is an established Cheshire and Merseyside Directors of Children's Service (DCS) Forum that leads the CYP agenda undertaking the required statutory duties across the 9 Places footprint of the ICS. The DCS Forum plan aims:

- To provide focus on and deliver measurable improvements in the following five priority workstreams:
  - ***Early Help and Prevention***
  - ***Workforce and Sufficiency***
  - ***SEND***
  - ***Emotional Wellbeing and Mental Health***
  - ***Residential Commissioning & Sufficiency***

- To bring added value to the above workstreams via underpinning cross-cutting themes:
  - ***Contributing to Sector Improvement***
  - ***Improving Education and Skills***
  - ***Creating the Conditions for Change***

- To specifically complement and support the work of the NHS ICB Beyond Programme which aims to improve outcomes for children and families through the following health-related initiatives:
  - ***A Think Family Approach***
  - ***Continuing Health Care and Therapeutic support to children***

Children and Young People - Programme delivery continued

CMAST CYP Alliance

Cheshire & Merseyside's Acute and Specialist Trust (CMAST) Provider Collaborative Chief Executive Officers' agreed a proposal in Summer 2023 to take a proactive and planned approach to improving access to services for children, delivered through a new CMAST CYP Alliance.

The newly established Alliance brings together senior CYP leadership from CMAST member trusts. The Alliance will drive service improvements for all CYP in the region by collaboratively delivering against the agreed core priorities, alongside the existing C&M Paediatric Network. Priorities include**:**

- **Elective recovery**
- **CYP diagnostics**
- **Paediatric workforce**
- **Urgent care systems (shared innovation and best practice)**

The Alliance will:

- Ensure the quality of acute care is consistent so that all CYP in C&M have the same high standard of care whichever service they use.
- Proactively and collaboratively tackle underlying problems and/or identify opportunities to share best practice and innovate.
- Bring together a breadth of experience, expertise, and perspective from across the paediatric hospital system into one forum known as the CMAST CYP Alliance.

Key areas of Delivery for 24/25 include:

A focus on Primary Prevention

Healthy Weight / Obesity

- All 9 Place areas access "Why Weight to Talk" training to support proactive conversations about healthy lifestyles
- Healthy, Exercise, Nutrition for the Really Young (HENRY) groups to be delivered across C&M to support 2000 families to make healthier choices
- 5 schools supported by Everton in the Community to involve CYP in healthy choices
- Halton Place continue to roll out their Digital App to enable 80 children to better manage their healthy lifestyle choices
- Complication of Excess Weight Service: 100 referrals per year supported to manage the complication of severe obesity

Additional areas of development include:

- Children's Integrated Care Hubs
- Immunisations, Screening and & Vaccinations – links to Population Health programme
- Housing and Health – colder homes
- Development of Family Hubs

Primary / Dental Care

- Oral Health / Dental & Primary Care CYP Access
- Parent Champion approach to promoting dental care to be mobilised across Liverpool Place
    - 15,000 toothbrush and toothpaste packs provided to children in Liverpool
    - 5,000 families receiving advice/intervention around supervised toothbrushing
- Scoping of existing Oral Health offer across Place (April 24)
- Supervised toothbrushing programme to be mobilised across C&M focussed on CORE 20 population (Sept 24)

Children and Young People - Programme delivery continued

Emotional Wellbeing and Mental Health:

Access to Mental Health

- Digital point of access (As One) for EHWB support / CAMHS rolled out across all C&M Places increasing access to support
- MH Champions to be in place across all DGHs to support the needs of Children and Young People with EHWB needs
- Children in Crisis:
    - Multi-agency Gateway meetings will be embedded in BAU to prevent inappropriate inpatient admission and to ensure earlier intervention and access to cross-agency support (Sept 2025)
    - Appropriate Places of Care outline model developed for Place delivery

Neuro-diversity

- Whole System approach to Neuro-diversity
    - Develop a baseline position for CYP neurodiversity across C&M to understand variance and improve consistency of offer
    - Develop a CYP neurodiversity capacity and demand model to enable more effective service and workforce planning.
    - Develop longer term plans for workforce development that will enable the levels of need to be met.
    - Reduce health inequalities and improve clinical outcomes for Children and young people focusing on those with neurodiversity.
- Sensory friendly environments will be established in a local college and CWP A&E to support CYP with neuro diversity issues – increasing college attendance and attendance for tertiary care
- Sefton ND Learning Programme: 250 families to be supported whilst awaiting an ND assessment through group approaches.
- Third Sector (Koala Northwest) delivery of Sleep service in Wirral – 200 families to be supported
- Standardised Pathways to be developed to support CYP at risk of Foetal Alcohol Syndrome Disorder (FASD) and their families

Early Help

- Family Hubs: Live at Place level, with shared C&M learning and principles for infant mental health and family functioning (March 2026)

Children and Young People - Programme delivery continued

Community / Out of Hospital Care

Respiratory (by March 2025)

- Smoking Prevention: 90 schools to be trained to deliver INTENT (a smoking / vaping prevention programme) in CYP – to prevent exacerbation in children's respiratory disease
- Parent Champions: established across 5 Places to develop peer support to parents re bronchiolitis / RSV. 40 parent champions trained to support via Children's Centres / 3rd sector
- Pharmacy support – 100 pharmacies providing checks of inhaler techniques
- 4 respiratory hubs to be established to support accurate Asthma assessment and diagnosis
- 80% of staff within Asthma Friendly Schools will be trained in Asthma to enable appropriate support to be given to CYP
- 20 Primary Schools will have attained Asthma Friendly Schools Accreditation to better support CYP Asthma management

Epilepsy

- All Provider trusts will complete Epilepsy in Children (EPIC) audit to support clear baselines and improvement trajectories (March 2024 – March 2028)
- Mental Health support improvement project: PAVES project to be implemented to support children with Epilepsy recruitment of MH support for areas where this is not in place (March 2024)
- Improved access to Specialist Nurse Support (March 2024)

Diabetes

- Roll out of access to CGM / HCL across C&M to support management of diabetes to ensure all young people have access where appropriate
- Training being provided to support transition of CYP into Adult diabetes care

Children and Young People - Programme delivery continued

Urgent Care

Aim:
- Improve access for CYP who need urgent care and reduce the number of unwarranted ED attendances
- Priorities:
- Map community nursing and virtual ward offers across the region and develop a common set of standards for care
- Co-design and implement a Virtual Ward offer for Cheshire and Merseyside
- C&M Paediatric 111 in place ahead of the Winter – underpinned by a multi-disciplinary shared workforce model
- Support adoption of ED advice and guidance tools
- Facilitate RSV vaccination response

CYP Diagnostics

Aim:
- To support the development of the C&M CYP Diagnostics strategy
- Priorities:
- Conclude the C&M CYP Diagnostics strategy chapter and implement Phase 1 deliverables once agreed (TBC)
- Support regional solution for routinely collecting and analysing paediatric diagnostic data
- Develop common set of standards and pathways for paediatric diagnostic activity and services

Additional areas of development

- Paediatric workforce improving system effectiveness and efficiency through creative and innovative development and use of the workforce
- Paediatric Early Warning System (PEWS) – roll out – standardised approach
- Martha's Law – first phase will be implemented in the NHS from April 2024
- Virtual Wards – continued development work to expand use

Children and Young People - Programme delivery continued

Acute Care

Elective Recovery
Aim:
- Reduce waiting times for elective recovery & deliver care in an appropriate setting.
- No CYP waiting longer than 52 weeks for treatment by end 24/25 (NB: requires further capacity and demand modelling)

Priorities:
- Community hubs (dental)
- Surgical hub for high volume / low complexity
    - Establish a surgical hub at Warrington
    - Develop a proposal for a larger offer at Halton, which would include theatres, outpatients, diagnostics and endoscopy
    - Rewrite safe pathways for expanded elective secondary care pathways
    - Expand the skilled paediatric workforce to support the hubs
    - Use that learning to evaluate the opportunity to expand further into the Clatterbridge hub

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Palliative and End of Life Care (PEOLC)

Palliative and End of Life Care

Mission:

The Aim of the Palliative and End of Life Care PEOLC Programme is to enable access to good quality end of life care equitably across Cheshire & Merseyside.

Links to our strategic objective: Tackle health inequalities in outcomes, experiences and access.

Case for Change –

There are approximately 25,000 deaths in C&M each year. The current projection is the number of deaths will increase by over 25% by 2040 and there will be an increase from 75% to 87% in people needing palliative care support as the population ages and people have more complex needs.

- Core element in our 23-28 Joint Forward Plan
- The palliative and end of life care delivery plan for Cheshire and Merseyside is founded on the National Ambitions Framework for Palliative and End of Life Care, the NHS Long Term Plan priorities and NICE guidance

Enablers:

Digital and Data: PEOLC data dashboard: to support primary care with early identification of those at end of life, and further development to enable a data dashboard for additional health and care settings.

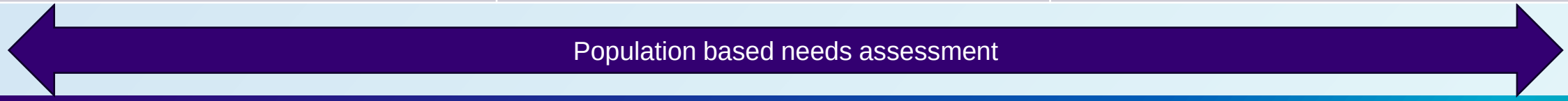
Workforce: Education and training modules to upskill the workforce to support high quality end of life care.

Hospice Support: Hospices providing palliative and end of life care services to support babies, children, young people and adults to live well and die well.

Engaging with People: Supporting the “voice” of people with lived experience to contribute to the design and delivery of palliative and end of life care services

Palliative and End of Life Care (PEOLC)

Key Priorities	Outcomes	Measures
Early Identification	Increased number of patients identified and included on a GP EOLC register with a personalised care support plan	0.6% of the GP population to be included on a GP EOLC register and by the time they have died 60% of patients to have a personalised care support plan
Workforce	Consistency in 24/7 SPC access across C&M	Place workforce planning
PEOLC leadership at Place	Each Place assessed as a thriving locality for strategic PEOLC planning and delivery	Six monthly assessment against the PEOLC Place Maturity Matrix
EPaCCS (Electronic Palliative Care Coordination Systems) *SNOMED is a numerical identifier for a clinical concept or term	Each Place will use SNOMED* codes as part of EPaCCS to enable live clinical decision making	Use of EPaCCS codes on the dashboard
Population Based Needs Assessment	By Place a PBNA completed to enable service planning	Completed PBNA report by Place
Carer Check-in	Staff at PLACE trained to develop a perosonalised plan for carers	Number of staff trained and Place audit
Personalised Care Support Planning (PCSP)	Increased number of staff completing training for PCSP	Place education and training records



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Primary Care and Dental Plans

Primary Care Access Recovery Plan

Dental Plan

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Elective Recovery and Cancer Programmes

Including Clinical Pathways Programme

Elective Recovery Programme Overview

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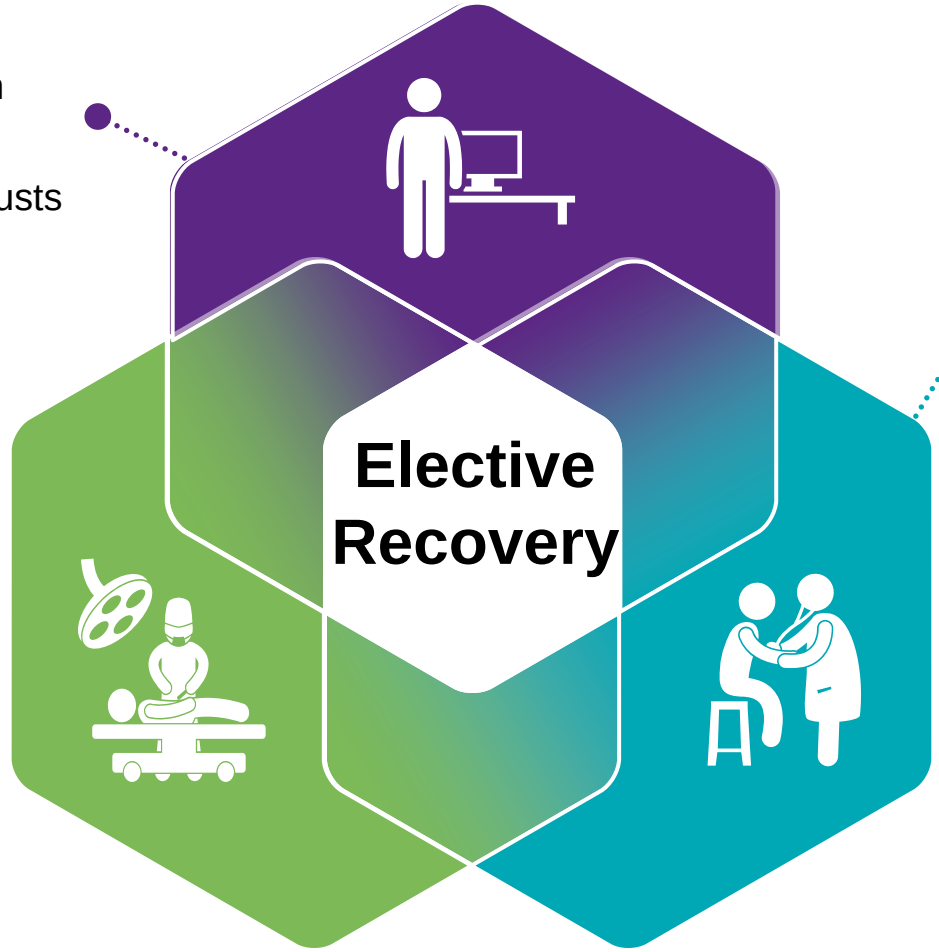
Waiting lists and PTL management

- Weekly PTL meetings with trusts
- Review of clearance rates to March
- Validation of waiting lists
- Hands-on support for challenged trusts



Reducing Variation

- Facilitating and co-ordinating mutual aid requests
- PIDMAS alternative choice
- Maximising IS capacity
- Prioritisation of long waits
- Levelling waiting times across C&M
- Shared facilities such as elective surgical hubs

Theatre productivity

- Theatre utilisation dashboard
- Opportunity packs for trusts
- Shared booking & scheduling tools
- Fallow theatres assessment
- Theatre Academy training programme

Elective Recovery Programme & Project Detail

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Risk stratification & cohorting

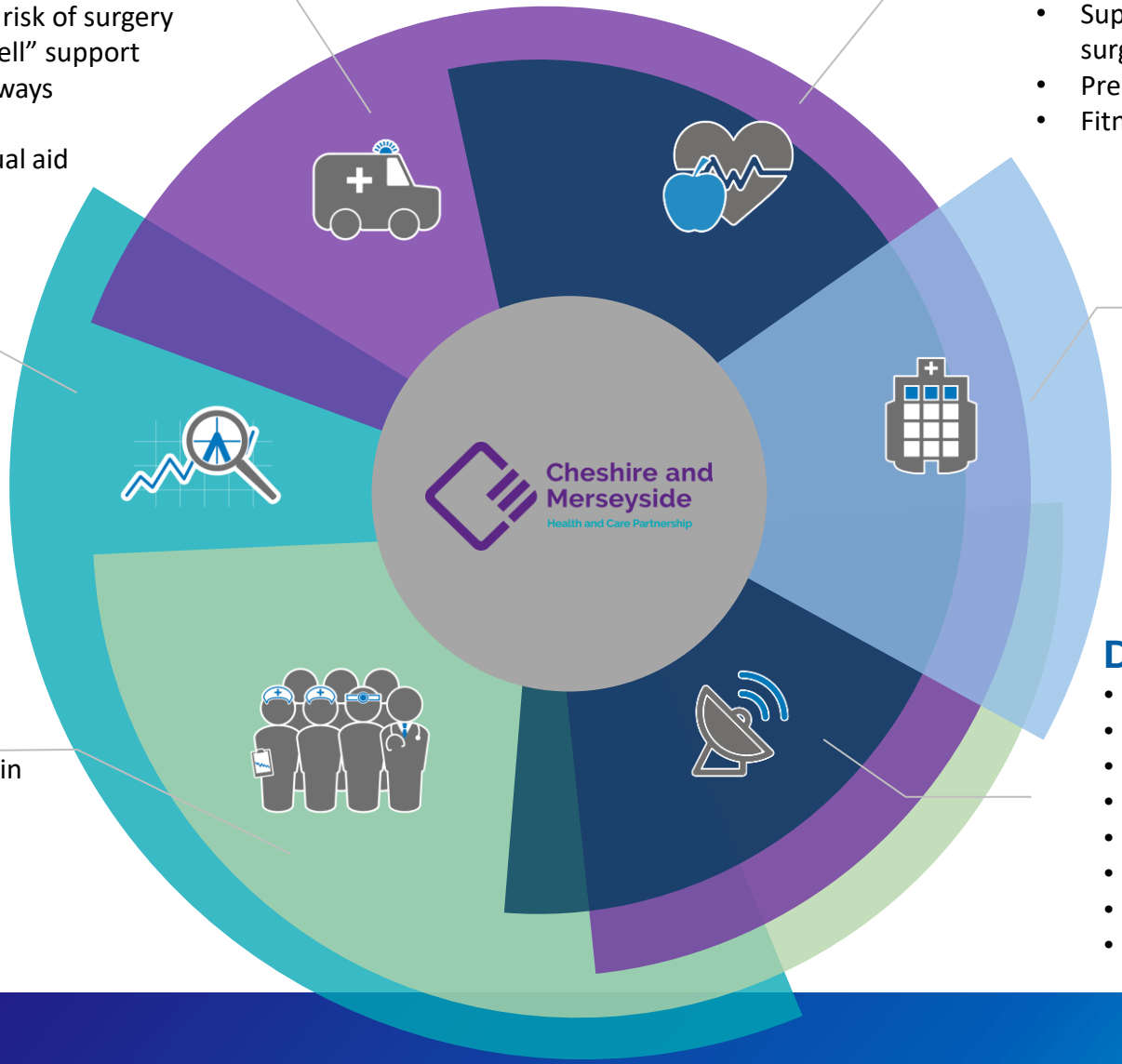
- Prioritisation and reducing clinical risk of surgery
- Identifying patients for “waiting well” support
- Identifying patients for HVLC pathways
- Linking primary care data (CIPHA)
- Cohorting patients for IS and mutual aid
- Defendable decision-making

Provider focus

- Top decile provider performance
- Theatres improvement
- GIRFT pathways & HVLC lists
- Strengthening non-elective & critical care capacity
- Separation of green and hot site activity
- Mutual aid and partnerships
- OP improvement

Workforce innovation

- Shared and ringfenced workforce in elective hubs
- “ Theatre Right ” staffing
- Innovation in role redesign
- Workforce strategies



Waiting well and prehabilitation

- Reducing risk of decompensation while waiting
- Supporting lifestyle changes to reduce clinical risk of surgery
- Prehabilitation advice and support (Sapien Health)
- Fitness for surgery

Increased capacity

- 4 elective hubs being mobilised,
- Mutual aid hub
- Shared approach to PTL to reduce variation in WL
- Focus on 104+ weeks and P2
- Rapid upscale of IS usage
- Cohorting the right patients for different sites
- GIRFT pathways and top decile
- Strengthened IS offer

Digital innovation & system working

- System level command centre
- Shared PTL concepts and mutual aid
- End to end pathway redesign
- Expansion of virtual wards and remote monitoring
- NHS App, and Patient Empowerment Portals
- Shared elective hub facilities & pathways
- Advice and guidance pathways
- Digital appointments

Elective Recovery Programme Metrics

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Goal	Target	Metric Detail
Enhance waiting list management	• Maintain zero 104 week position • Maintain zero 78 week position • Eliminate 65 week waits • Validation – meet national target	Eliminate 65 week waits by September 2024 and maintain
Enhance elective productivity	• Achieve 85% theatre utilisation for all trusts capped • Reduction in fallow theatres • Increase utilisation in elective hub theatre utilisation • Advice and guidance • Outpatient follow-up reduction	Achieve 85% capped theatre utilisation by September 2024
Focus on opportunities to improve outpatient performance using the Further Faster toolkit	• Focus on pre-appointment and PIFU checklist to help eliminate 52 week waits	• **Pre-appointment -** pre-referral specialist advice utilisation rate. Target = >21/100 - pre-referral specialist advice diversion rate. Target = >55% - post-referral specialist advice utilisation rate. Target = >21/100 - post-referral specialist advice diversion rate. Target = >55% • **PIFU -** PIFU utilisation rate. Target = >5%

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Clinical Pathways Programme

Clinical Pathways Programme Overarching Principles

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Patient Centered

Improving patient experience and outcomes, and reducing inequalities in care

Sustainable

Developing service models that are resilient and fit for the future

Innovative

Harnessing new technologies and innovations to improve care and productivity

Clinical Pathways Programme Prioritisation

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The Clinical Pathways Programme (CPP) brings a structured and methodical process to review specialties and develop improvement plans at a whole pathway level.

In order to determine the phasing of subsequent specialities into the CPP, a range of factors were considered, along with conversations with medical directors, executive teams and clinical leads. This broad criteria was agreed by the leadership team, and factored in to decisions as to prioritisation of specialties for CPP focus.

1. Clinical

- Quality factors
- Cancer conversions
- Urgent pathway conversions
- Link with non-elective

2. Operational

- Overall specialty volume
- Long waits volume (+78 and 65 weeks)
- Workforce pressures
- Fragile services
- Local service closures
- Critical mass

3. Strategic

- Fit with GIRFT agenda
- Highlighted through benchmarking / best practice data
- Financial implications or link to securing ERF

4. Deliverability

- Anticipated time to review
- Complexity of review
- Anticipated impact of winter / covid
- Senior executive and clinical support

It was agreed that Orthopaedics should be the first CPP specialty, and that was initiated in 2022/23. ENT and Dermatology were added in the latter part of 2022/23, followed by Gynae, Cardiology and Ophthalmology which were initiated in 23/24. Orthopaedics is now into “business as usual” phase, which is still supported by the CPP team. ENT, Dermatology, Gynae, Cardiology and Ophthalmology remain in focus as CPP priorities.

Clinical Pathways Programme Overview

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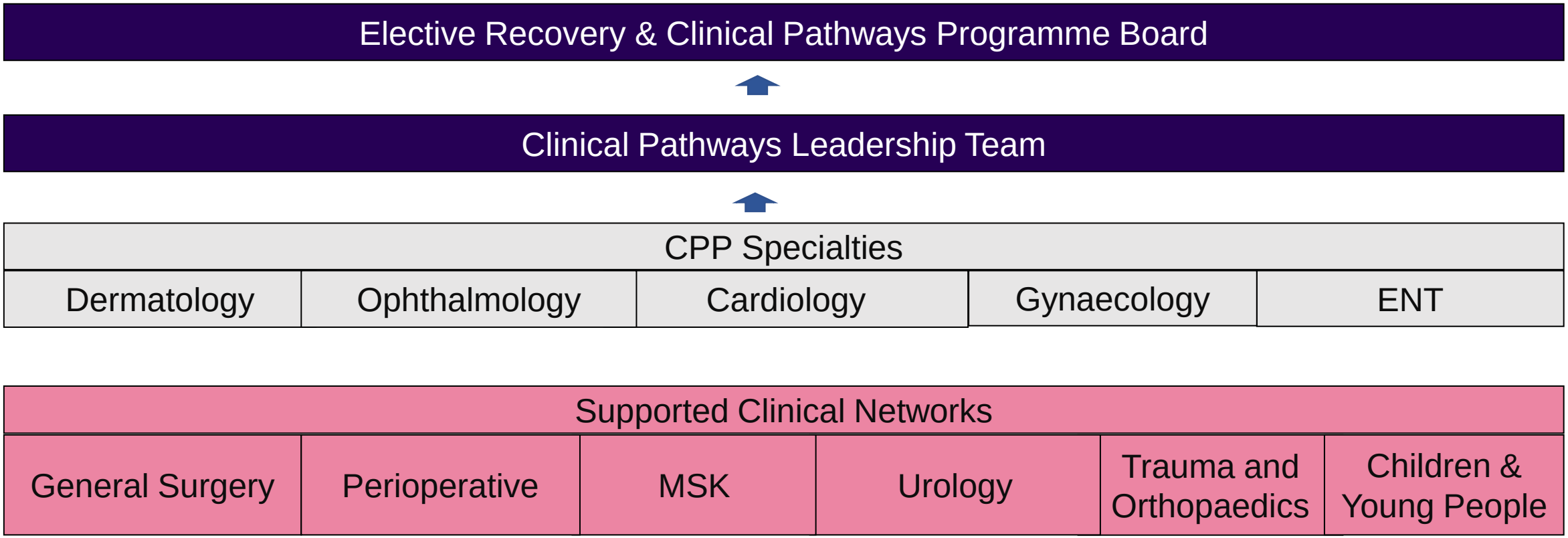
It was agreed that Trauma and Orthopaedics should be the first CPP specialty, and that was initiated in 2022/23.

ENT and Dermatology were added in the latter part of 2022/23, followed by Gynae, Cardiology and Ophthalmology which came on board in 23/24. Orthopaedics is now into “business as usual” phase, which is still supported by the CPP team along with other clinical network programmes.

ENT, Dermatology, Gynae, Cardiology and Ophthalmology remain in focus as CPP priorities.



Cancer

Successes in 2023-24:

- Phase three of the roll-out of the Targeted Lung Health Check (TLHC) programme has been completed and mobilisation plans for phase four are in place with go-live scheduled for Q1 2024/5. Over 100,000 invitations have been sent to date, and over 350 cancers have been found, with over 80% being diagnosed at an early stage.
- The success of the TLHC programme has contributed to an improvement in the rate of early diagnosis of cancer. The faster rate of improvement in Cheshire and Merseyside has closed the historic gap between our ICS and England.
- C&M continues to participate in the multi-cancer blood test clinical trial, with participant retention rates exceeding 90%.
- The Alliance-led community partnerships programme is utilising the skills and knowledge of the councils of voluntary services and grass-roots community organisations to increase awareness of cancer symptoms, increase participation in cancer screening programmes, and redress health inequity.
- Other Alliance-led activities to support cancer early diagnosis and Core20PLUS5 objectives include targeted public awareness campaigns, numerous projects focusing on tobacco control, obesity, supporting primary care, and improving the efficiency of diagnostic pathways.

As partners we will:-

- Work collaboratively across Cheshire and Merseyside to build on best practice and implement new initiatives to prevent cancer and reduce inequalities
- Support Primary Care with the implementation of the early cancer diagnosis agenda, including initiatives to increase cancer screening
- Reduce waiting times for diagnosis and treatment
- Work with healthcare professionals to provide improved, personalised, and faster treatments and care
- Invest in the skills and education of cancer professionals and support workers
- Reduce unwarranted variation in care, access, experience, and outcomes
- Reduce health inequalities for vulnerable communities, who have been affected by cancer

The **Cheshire and Merseyside Cancer Alliance** is accountable to NHS England and leads on our Integrated Care System Cancer Programme.

It is an NHS organisation that brings together healthcare professionals, providers, commissioners, patients, cancer research institutions and VCFSE (Voluntary, Community, Faith and Social Enterprise) sector partners to improve cancer outcomes.

2024 -25 and beyond - The Cheshire and Merseyside Cancer Alliance supports innovation and strategic commissioning. It has eight core workstreams (for more information click the links):

- **Prevention and early detection**
- **Screening**
- **Faster diagnosis**
- **Personalised care**
- **Workforce**
- **Public Engagement**
- **Genomics**
- **Health inequalities and patient experience.**

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Outpatient Transformation

Content currently being developed

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Women's Health and Maternity

Women's Health and Maternity Programme (WHaM)

Purpose:

- Provide system leadership and oversight for the safety, delivery and assurance of the Local Maternity and Neonatal System (LMNS) and Women's Health Services and conditions.
- Maximise opportunities for transformation and the improvement of clinical services and care for women's health conditions while reducing health inequalities. The programme of work raises the profile of women's health across the life course, brings providers, communities, and workforce together to prioritises the wellbeing, life chances and outcomes for all women and babies across Cheshire and Merseyside.

Enablers:

- **Accessing National, Regional and Local investment**
- **Effective cross sector Partnerships –** building on existing networks
- **Focused research and Innovation –** using an evidenced based approach
- **Effective Communication and Engagement** – with both public and professionals
- **Digital Transformation –** enhancing Digital and data and use of new technologies

Case for Change:

Maternity and Neonatal Three Year Delivery Plan:
The Three Year Delivery Plan outlines the actions being taken by the ICB/LMNS to make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families on a system wide basis and supports delivery of the national ambitions. Whilst most women have a positive experience of NHS maternity and neonatal services, and outcomes have improved, it is acknowledged that there are times when the care provided is not as good as it should be. We also know that families from some groups, especially ethnic minorities, have had particularly poor experiences.

Women's Health:
Women are underrepresented in our large and diverse Cheshire and Merseyside health system and communities with additional challenges in ensuring equity and inclusion for women. While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. In response to the Women's Health Strategy for England and acknowledging the above inequalities, a local Cheshire and Merseyside Women's Health Strategy has been developed, describing priority areas of focus and actions to improve the health and wellbeing of women across the region.

Women's Health and Maternity Programme (WHaM)

Key Priorities	Outcomes	Measures
Continue to implement the themes from the 3 Year Delivery Plan for Maternity and Neonatal Services	Listening to and working with women and families with compassion	• 'Reduction in stillbirths, neonatal brain injuries, neonatal deaths, maternal deaths, and preterm births • All women have personalised and safe care through every woman receiving a personalised care plan and being supported to make informed choices • Improved choice of place of birth and continuity of care, focus on understanding disparities and outcomes for specific ethnic groups and those from areas of high deprivation - reduction in inequalities in access and outcomes for the groups that experience the greatest inequalities • Reduction in variation across services, providers and Places • Implementation of the essential actions from the Ockenden Report
	Growing, retaining, and supporting our workforce	
	Developing and sustaining a culture of safety, learning, and support	
	Standards and structures that underpin safer, more personalised, and more equitable care	
Improve women's health outcomes and healthcare services whilst addressing the health and social inequalities for all women and those in need of women's health services	Ensuring women's voices are heard	• Reduction of inequalities in experience and outcomes for women • Improved access to services and reduced delays in diagnosis • Increase in the number of Women's Health Hubs, with 1 hub in every Place by December 2025, with a focus on providing Long-acting Reversible Contraception (LARC) for all indications • Improved access to timely, accurate, high-quality evidence-based information
	Improving access to services	
	Improving information and education	
	Address disparities in health outcomes between women	
	Improve health in the workplace	
Liverpool Neonatal Partnership (LNP) Neonatal Surgery Unit (Alder Hey)	Investing in support for additional neonatal care, to meet service specifications and improve patient safety and clinical outcomes for babies requiring Neonatal Surgery	• Reduction of transfers. • Enhancement of specialist surgical offer for Neonates. • Progress towards British Association of Perinatal Medicine standards.

Health Inequalities – delivery through a population Health Lens focus on those most affected by poor outcomes

Care Pathways – supporting proof of concept - developing care pathways that are more effective and efficient

Workforce – improving system effectiveness and efficiency through creative and innovative development and use of the workforce

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Mental Health Learning Disability and Autism / Transforming Care

Including Dementia and Suicide Prevention

Mental Health Learning Disability and Autism

Vision and Mission:

Positive Mental Health for All free from stigma and discrimination.

- **Working collaboratively, we will adopt a proactive and preventative approach to reduce the long term impact for people experiencing mental health problems and for their families.**
- **We will continue to invest in mental health services at a faster rate than their overall increase in NHS funding allocation. We will also continue to ensure patients' legal rights to choice in mental health are respected as part of the drive to achieve parity with physical health.**
- **We will ensure that people living with dementia have access to effective mental health care and treatment with a view to maintaining mental health and wellbeing and reducing crises.**
- **We will continue to ensure that our system's suicide prevention, suicide bereavement and mental wellbeing work programmes are aligned to the key priorities within the Suicide Prevention Strategy.**

Case for Change:

Nationally by the end of February 2024 -1.92 million people were in contact with mental health services, at the end of February - the majority of these (1.23 million) were in contact with adult mental health services - 476,872 people were in contact with children and young people's mental health services - 275,737 people were in contact with learning disabilities and autism services - 434,594 new referrals were received, and 2.02 million care contacts were attended - 22,532 people were subject to the Mental Health Act, including 16,873 people detained in hospital.

- **Key aspect of the Long Term Plan / Five Year Forward View for Mental Health**
- **Priority area in the Cheshire and Merseyside Health and Care Partnership Interim Strategy**
- **Core element in delivering against Core20PLUS5 for both adults and children and young people.**
- **Supports the development of the Mental Health in Schools Team programme**
- **Core element in the 2023-28 Joint Forward Plan and the 24-29 refresh**
- **Delivering the Transforming Care Programme**
- **Supporting delivery of the Suicide Prevention Strategy**
- **Development of a Cheshire and Mersyside wide strategy for dementia**

Enablers:

Digital and Data:
- **Improving the Quality of Mental Health data**
- **Utilising new technology**

Workforce:
- **Implementation of the new Long Term Workforce Plan**

Mental Health / Learning Disability and Autism

Children and Young People	Outcomes	Measures
Parent Infant and Early Years	• Model to support relationships and mental health from conception to age 5 / alignment with family hubs	
Early Intervention & Prevention	• Ensure emotional health and wellbeing	
CYP MH in School Team Expansion	• Implement wave 11 of MHSTs utilising national SDF & provide additional trauma informed training	
CYP MH access & waiting times (including digital access)	• Implement recovery plan to achieve 2023/24 national ambitions as a minimum (1 of 6 key metrics to be delivered in 2023/24 but C&M ICB remains below national access rates)	• CYP accessing mental health services as % of LTP trajectory (planned number)
CYP MH Transition / 18-25 year	• Services currently cross adult CMHT, Talking Therapies, CYP	
CYP Crisis Care	• Aim to reduce numbers of CYP attending A&E and non-elective admission in crisis care	
CYP Eating Disorders	• Improve emergency care pathways for CYP with an eating disorder via implementation of MEED (Medical Emergencies in Eating Disorders), Guidance on Recognition and Management Report	• 95% in 4 weeks (routine) & 1 week (urgent)
CYP Neurodiversity Pathways	• Development of a Neurodevelopmental pathway for CYP to address long waiting times	
CYP MH Transformation Plan	• Refresh and develop a CYP Mental Health Transformation Plan to meet national requirements	
CYP Gender Identity Development Services (GIDs)	• Workforce training and education and development of referral pathways for new Merseyside based service	
CYP MH Inpatient Model	• Complete self-assessment to inform gaps against new national model of care	

Mental Health / Learning Disability and Autism

Adult Community - Key Priorities	Outcomes	Measures
Community MH access & waiting times	• Ensure delivery of 2023/24 national access ambitions as a minimum and implement recovery plan to achieve all national 'roadmap' deliverables	Access rate to community mental health services for adults with Severe mental illness (ICB board dashboard) 100% local trajectory LTP Ambition 20,600 (Mar24)
Complex Needs Service Model (PD)	• National Focus Area within Community MH roadmap	
Adult Eating Disorders	• National Focus Area within Community MH roadmap	
MH Rehabilitation	• National Focus Area within Community MH roadmap	
Adult MH Early Intervention & prevention	• Increase in visibility and identification of adults requiring early intervention and prevention	Referrals on the Early Intervention in Psychosis (EIP) pathway seen in 2 weeks local trajectory 60%
Physical Health in SMI checks	• Implement recovery plan to achieve 2023/24 national ambitions as a minimum (C&M ICB remains below national access rates)	LTP Ambition 19,359 (Dec23)19,921 (Mar24)
Individual Placement Support Services (IPS)	• Increase access to IPS in line with national ambition (Autumn Statement priority)	LTP Ambition 2,063 (Dec23)2,751 (Mar24)
Problem Gambling	• Establish satellite clinic in Liverpool as part of targeted national expansion & scope local provision via National Gambling Support Network (eg. Beacon Counselling Trust)	
Talking Therapies	• Implement recovery plan to achieve 2023/24 national ambitions as a minimum (1 of 6 key metrics to be delivered in 2023/24 but C&M ICB remains below national access rates)	Access rate for Talking Therapies services 100% local trajectory LTP Ambition 66,213 (Dec23)72,724 (Mar24)
Adult ADHD Service Redesign	• Improve access, experience and reduce waiting times	

Mental Health / Learning Disability and Autism

Inpatient Care - Key Priorities	Outcomes	Measures
MH Acute Care flow	• Eradicating adult acute Out of Area Placements (NHSE single biggest priority for mental health 2024/25)	Zero Out of Area Placements (OAPs)
Specialist Housing Solutions / Housing Strategy	• Reduce delays in discharge, readmissions of HIUs, improve experience & reduce OOA spend	
MH Inpatient Quality Transformation Programme	• Draft 3-Year Plans to localise and realign MH inpatient care	

Crisis Care - Key Priorities	Outcomes	Measures
MH Response Vehicles	• 3 new MH response vehicles to be mobilised as part of MH First Response Crisis Model	
NHS 111 Option MH	• National implementation of NHS 111 Option MH from April 2024	
MH Crisis Alternatives	• Develop alternative crisis services to reduce A&E attendance	
Section 136 Action Plan to meet Right Care Right Person aims	• Address actions to reduce delays in S136 processes and ensure that police Right Care Right Person timescales in relation to S136 can be delivered	

Mental Health / Learning Disability and Autism

Suicide Prevention - Key Priorities	Outcomes	Measures
Domestic Abuse and links to suicide training package"	• Pilot in a small number of local places with the view to roll out across C&M. Funding identified to procure	
CYP Self-harm & Safety Planning	• Collect self-harm data from schools and identify the support resources needed, and to consider a training package that includes awareness around self-harm, safety planning and self-harm kits	

Dementia - Key Priorities	Outcomes	Measures
Dementia Diagnosis Rates	• Recover diagnosis rate of 66.7% of prevalence (1 of 6 metrics to be delivered in 2023/24 but C&M remains below national ambition)	Dementia Diagnosis rate 66.7%
Dementia Strategy	• Develop and agree a Cheshire & Merseyside dementia strategy that enables the development of integrated models of care, as committed in the Joint Forward View	

Mental Health / Learning Disability and Autism Transforming Care

Transforming Care	Outcomes	Timescale	Measures
Personalised Care Short Breaks	• Agreement on standards • A service specification will be developed which incorporates these standards to support the commissioning of short beaks. • An action plan includes recruitment strategy • Small grants bid application has been distributed to commissioners and partners for projects which support young people in crisis. This is non-recurrent funding.	Will be resumed as we have recruited to the CYP Programme Lead post	
PBS service – Cheshire and Merseyside	• Updated service specification • Recruitment plan and options. • Workshop/meetings with place-based commissioners to raise awareness of the service • Cheshire and Merseyside model outlined. • Funding in place for 2023/24.	Sept 2024	
Key worker	• All areas have now recruited to their Key Worker posts. Plans are in place to convene a workshop to review practice and service delivery. • All areas to deliver services to 18-25years	All areas have a key worker service commissioned but working to deliver services to 18-25 year olds	
Development of CYP Intensive Support Function (ISF) across Cheshire and Merseyside	• Support Mid Mersey areas to fully implement CYP ISF/S. • Support the development of consistent pathways across Cheshire and Merseyside and peer support. • Learn from the ISF evaluation North West Neonatal Operational Development Network and develop an action plan to progress key areas across C&M.	2023/24 Q4	

Mental Health / Learning Disability and Autism Transforming Care

Transforming Care	Outcomes	Timescale	Measures
Capital bids – short breaks/respite / residential	• Work regarding the capital bids and adult provision continues.	2023/24 and 24/25	
Work with CYP Programme leads to develop an Eating Disorder service	• Develop ARFID service (Avoidant Restrictive food intake disorder) (Autistic Spectrum Disorders (ASC) population & others) • Support funding requests to develop ED service • Have access to ED services across C&M	24/25	
Annual Health Checks and Vaccinations	• ASC Health Facilitator Pilot • LD AHC/GP Pilot – roll out across subject to evaluation • Bowel Cancer screening • Stomp & STAMP • Covid Vaccination/Flu • Epilepsy Baseline Audit	2023/24/ 2024/25 ongoing	Number of Annual Health Checks (AHC's) carried out for persons aged 14 years or older or over QOF Learning Disability Register
ASC in Schools	• Evaluation Outcome • Expand to other areas	Pending	
Sensory Assessments	• C&M Service • Cost effective • Evidence based Practice • Knowsley Pilot (CYP)	23/24 – 24/25	

Mental Health / Learning Disability and Autism-Transforming Care

Transforming Care	Outcomes	Timescale	Measures
Inpatient Activity	• Clinically ready for Discharge • Dynamic Support Data base work • Care and Treatment Reviews (CTR/CETR) • Specialist Commissioning • Participate in the Quality Transformation programme for inpatients- 3yr plan	Ongoing work	Adult Inpatients with a learning disability and/or autism (rounded to the nearest 5)
Autistic Spectrum Condition (ASC) in Adults &CYP	• Midwifery services • Deliver on ASC framework recommendations • (Place Recovery Plans where needed) • Referral process • Develop assessment and criteria process • Develop Post Diagnostic Standards for CYP and Adults • Update ICB Web pages • CYP Neurodevelopmental Pathway	2024/25	
Performance	• Quality reporting needs ongoing development	In place	
Autistic Spectrum Condition (ASC) in Adults &CYP	• Midwifery services • Deliver on ASC framework recommendations • (Place Recovery Plans where needed) • Referral process • Develop assessment and criteria process • Develop Post Diagnostic Standards for CYP and Adults • Update ICB Web pages • CYP Neurodevelopmental Pathway	2024/25	

Mental Health / Learning Disability and Autism-Transforming Care

Transforming Care	Outcomes	Timescale	Measures
LeDeR Strategy	• Review actions • Define priorities • Promote learning • Effective communication • Performance monitoring • Annual Report • Resource review/ skill mix	2023/24- 24/25 In place – its now imbedding the learning from reviews – evaluating the model of service and sustaining the service financially	
Care and Treatment Review (CTR) Hub	• Effective coordination of reviews • Improve discharge planning • Dedicated resource • Avoid CTR's being delayed • Interim arrangement currently being discussed	Job Description for band 7's now approved Awaiting recruitment approval	
Community Adult Forensic Service	• Support discharges of spec comm patients • C&M service • Recurrent Funding identified • Funding for training C&M staff approved	2023/24 (April 2024) Recruitment has commenced following funding approval	
Co Production	• Confirm and Challenge (CC) to continue • NHS Contract in place for C&M • CETR/NWTD out to Tender Jan 2024 • Pathways Associates subgroups x4 feeding back to the Operational Board • Actions from C&C conference to be delivered	2023/24 NHS Contract in place and Contract Review meeting held A more collaborative approach to C&C agenda	

Mental Health / Learning Disability and Autism –Transforming Care

Transforming Care	Outcomes	Timescale	Measures
Performance	• Transforming Care (TC) Dashboard under development • Governance arrangements • TC LA Peer Reviews	Ongoing	
Preparing for Adulthood	• Establishing preparing for adulthood protocols and procedures. • Identifying resources/ roles and responsibilities • Transgender • Discussions at Desktop Review	2023/24 AquA being commissioned to lead on this commencing Q4 23/24 – Q1 2024/25	
Digital Inclusion	• Pilot until March 2024 • DST – PH Tool Pilot	March 2023/24 Q4 2023/24 onwards	
Oliver McGowan Mandatory Training	• Continue to support the programme to ensure staff receive the required training	Ongoing	
Adult Integrated Support Team (IST)	• Following a review, the skill mix of this service needs to be increased to support people in the community who are in crisis and avoid hospital admission.	Q1 2024/25	
CYP Dynamic Support Register (DSR)	• In accordance with the revised CETR/ DSR policy, there is a requirement to develop a CYP DSR.	Q4 2023/24	

NHS
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Section Two Additional Transformation Priorities:

1. All Age Continuing Health Care
2. Cardiovascular Disease (CVD)Prevention
3. Carers
4. Diabetes
5. Diagnostics
6. Neurosciences
7. Respiratory
8. Stroke
9. Sustainability and Partnerships

All Age Continuing Health Care (AACC)

Enablers:

Digital and Data:
- Development of a C&M performance dashboard drawing information at Place level
- Assessment and recommendation of an ICB wide AACC information system

Finance:
- Mobilisation of new operating model to drive efficiencies, effectiveness and value for money

Estate:
- Re-configuration of staff bases around Place areas

Workforce:
- Management of change to reflect change in accountability and equitable distribution
- Recruitment and retention strategy and plan to ensure delivery of standards, targets and sustainability
- Strengthened senior leadership through Associate Director of Nursing and Care- focusing on overseeing personalised commissioning

Mission:
Working together in a consistent way across C&M to deliver continuing care to all-age individuals within C&M 'Places'.

Links to our strategic objective:
Tackle health inequalities in outcomes, experiences and access and enhance quality, productivity, and value for money

Case for Change:
- The ICB is accountable for the fair and equitable distribution of All Age Continuing Health Care (AACC) funding against the assessed needs of our residents. This had previously been discharged by 9 accountable CCG's.
- The ICB is also accountable for the quality, safety and financial assurance of the continuing care provided.
- This area of provision has significant, and growing costs with significant overspend forecast, mainly due to increases in the cost of care rather than an increase in referrals.
- AACC review concluded that with poor performance against statutory targets and financial challenge in growth of activity and price, that a more cost effective and compliant operating model was required.
- The decision to in-house all AACC services previously outsourced to deliver greater parity of resource allocation between the Places was necessary to optimise scarce resources and provide the required assurance to the ICB as the legal entity responsible for commissioning decisions.

All Age Continuing Health Care (AACC)

Key Priorities	Outcomes	Measures
Embedding transfer of AACC service from third parties	Optimisation of the new AACC workforce model to include more effective ways of working, which should result in better performance, staff satisfaction, retention and value for money Completion of management of change process and reduced agency usage	Reduction in transition risks /improvement in CHC statutory targets to be compliant by end of 24/25
AACC Management of change to mobilise new workforce into operating model		Reduction in legal challenges/expenditure - less Independent Review Panel's and complaints.
Embed the new ways of working as part of the operating model. Alignment of standard policies and procedures.		Improved performance across a range of AACC performance measures.
Recruitment and retention strategy and plan		Reduction in agency expenditure, reduction in the number of vacancies, staff turnover and agency costs
Requirement assessment and business case for single information solution in preparation for 2025	Business case developed recommending single information solution and cost benefit analysis.	Business Case approval and move to implementation
Market management through consolidated frameworks and contracts - standardisation of policy and assessment processes	Consolidation of commissioning frameworks and opportunities to reduce costs of packages of care through market management	Slowing growth in costs of care by x% and value for money achieved through consistency and standardisation with greater ability to manage market pressures

Delivery of consistent high-quality commissioning of continuing care to meet the assessed needs of the population

Greatest value for money to achieve the care needs of the population

Cardiovascular Disease (CVD)Prevention

Vision and Mission:
Cheshire and Merseyside communities will have the best possible cardiovascular health

To achieve and where possible advance on the National Ambitions for atrial fibrillation (AF), high blood pressure (BP) and cholesterol detection and management by 2029 (with year-on-year progress being made towards that goal).

Links to our strategic objectives:
- Improve outcomes in population health and healthcare
- Tackle unequal CVD outcomes and access to prevention opportunities, and deliver against Core20PLUS5 priorities
- Enhance productivity and value for money
- Support broader social and economic development through a focus on improving cardiovascular health of the working age population

Enablers

- Improved resources and funding
- Effective cross-sector partnerships
- Focused research and innovation
- Effective communications and engagement
- Digital transformation to improve efficiency and effectiveness.

Case for Change:

Cardiovascular Disease (CVD) is the biggest contributor to the gap in life expectancy in the Northwest of England and a leading cause of premature death and health inequalities in Cheshire and Merseyside. It is associated with deeply embedded inequalities, particularly in relation to deprivation, certain ethnic minority groups, other demographics (e.g., working age males) and underserved or vulnerable communities (e.g., those with severe mental illness). CVD is largely preventable through a healthy lifestyle and the early detection and control of key risk conditions; atrial fibrillation (AF), high blood pressure (hypertension, BP) and high cholesterol (the 'ABC' of CVD prevention). In C&M it is estimated that improved blood pressure control alone could prevent around 1,500 additional heart attacks and strokes in C&M over the next 3 years.

Health Inequalities:
Ensuring delivery through a population health lens with focus given to the populations and communities most affected by poor cardiovascular outcomes.

Care Pathways:
Supporting proof of concept work to build cross sector care pathways that are more effective and more efficient than current ones

Technology:
Supporting proof of concept work to improve system effectiveness and efficiency through the use of digital technology (data and devices)

Workforce:
Improving system effectiveness and efficiency through the more appropriate use of the workforce

Cardiovascular Disease (CVD)Prevention

Key Priorities	Outcomes	Measures
• Monitor and target unwarranted variation in outcomes	• Routine & bespoke data is used to monitor and target unwarranted variation. Data is used to risk stratify patients and to target populations with unwarranted variation and inequalities	• AF diagnosis rates, and treatment to target levels • High BP diagnosis rates, and treatment to target levels • High cholesterol diagnosis rates, and treatment to target levels • Diagnosis rates of Familial Hypercholesterolemia • The numbers of strokes within the adult population each year • The numbers of heart attacks within the adult population each year
• Enable system leadership to improve cardiovascular disease outcomes	• C&M will have an affective CVD prevention groups to deliver improvement across the ICS with named and accountable delivery leads who use a networked approach to coordinate and improve care pathways and CVD prevention and facilitate collaboration & alignment with other ICS programmes e.g. Population health, Digital and Primary Care programmes.	
• Support a system wide response to improvement	• Primary care will be supported to reach patients in innovative ways (e.g. BP@home) and to work with cross-sector partners in a range of settings (e.g. community pharmacy checks, the voluntary sector and community outreach programmes).	
• Increase public awareness of cardiovascular disease	• The programme will use national and local communications campaigns and tools (e.g. Know Your Numbers week and the Happy Hearts website) to signpost patients to services and build public & professional awareness of CVD prevention.	
• Monitor and target unwarranted variation in outcomes	• Routine & bespoke data is used to monitor and target unwarranted variation. Data is used to risk stratify patients and to target populations with unwarranted variation and inequalities	

Carers

Our vision: is for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve.

Our mission: to work in partnership with carers and support organisations to develop and implement a Carers Strategic Framework for Cheshire and Merseyside.

NHS Long Term Plan Commitments:

- Identifying and supporting carers, particularly those from vulnerable communities
- Introduction of Quality Markers in Secondary Care, including Carer Passports
- Ability to share caring status with healthcare professionals wherever they present via electronic health record
- Carers understand the out-of-hours options that are available to them and have appropriate back-up support in place for when they need it
- Young Carer “top tips” for general practice to include preventative health approaches, social prescribing and timely referral to local support service
- Introducing best practice quality markers for primary care

Case for Change –

Supporting Carers is an essential contribution to narrowing health inequalities in access, outcomes & experiences. Furthermore, there is evidence for ethnic and socio-economic inequalities for carers. Support and inclusion of young carers will lead to better chances in life for children and young people.

Carers UK research estimates that 1 in 5 people are carers and their State of Caring Report 2023 states that:-

- Over half (57%) of people who had stopped working or reduced their hours at work to care said they had done this because of the stress of juggling work and care.
- Nearly half (49%) of carers who had given up work or reduced their working hours had seen their income reduce by over £1,000 per month.
- More than a quarter (27%) of unpaid carers have bad or very bad mental health, rising to 31% of those caring for more than 50 hours a week, or for over 10 years.

	CARERS - Key Priorities	Outcomes	Measures
Strategic Development	Establish the Strategic Carers Partnership Group	Have the appropriate infrastructure and governance in place to progress the carers agenda across the ICS	Completed Sept 2023
	Develop Governance and reporting structures within the ICS - Agree key priorities and develop system action plan		Governance established and reporting of the Strategic Carers Partnership Group agreed - Priorities established and action plan for 2024-2025 with the Strategic Carers Partnership Group using a co-production approach
	Develop and Implement ICS Carers Charter		Carers Charter completed - increase sign up by 10% by 2025
	Translate best practice into business cases		Secure and optimise funding ringfenced for the carers' agenda.
Data & Intelligence	Develop Baseline for numbers of carers in C&M	Develop a performance management framework to monitor progress and allow stakeholders to hold the ICS to account	Presented to Strategic Carers Partnership in September 2023. Completed
	Conduct a mapping exercise on gaps in carers data		
	Develop a carers dashboard for C&M		Dashboard in place - Increase the number of carers identified year on year by 5% for the period of our Joint Forward Plan until 2028
Identify and Support Carers	Improve support to carers at hospital discharge	Provide adequate support to carers for the benefit of carers, the cared for and the health and social care system	100% of Carers receiving support at hospital discharge by 2026
	Improve identification and support to carers in primary care		Share data for numbers of carers registered with GP with primary care place leads and monitor the increase
	Improve experience of working carers		Establish baseline and assess improved experience via an annual survey
	Improve identification of carers in local areas through a new shared digital platform		Completed tender exercise for shared digital platform
	Support carers with breaks tailored to their needs		Establish baseline and increase access to carer breaks
	Improve identification and support for young carers		Memorandum of Understanding in place with the "No Wrong Doors" template between the ICB and Adult and Children Social Care

Workforce - Training and for professionals to:- increase carer awareness / enhance early identification of carers

Diabetes

Vision and Mission:

We aim to slow down the year-on-year increased prevalence of type 2 diabetes as well as increasing the uptake of patients onto prevention programmes and improving the care and outcomes for people with diabetes

We will ensure that:

- People at risk of diabetes are supported to prevent them developing the condition
- People living with diabetes have access to the best possible care and support they need to live well with diabetes
- People living with diabetes can monitor and self-manage their condition effectively
- Identify variation in experience, service provision and treatment outcomes for people in Cheshire and Merseyside
- Delivery of the NHS National Diabetes Prevention Programme (NDPP)
- Assuring implementation of Hybrid Closed Loop pathways

Case for Change:

- Diabetes is a major public health problem with diabetes diagnosis in the UK having risen from 1.4 million to 3.8 million since 1996. One in ten people aged over 40 now has type 2 diabetes.
- Core element in Children and Young People Core20PLUS5 - Improved access to gold standard care in deprived areas and ethnic minority communities, and more CYP with Type 2 diabetes receiving annual health checks.
- Delivery of national priority work programmes

Enablers:

- Ensuring alignment with other programmes, including Specialist Weight Management Services and Cardiovascular Disease, CYP and Core 20+5
- Streamlining of monitoring and planning

Health Inequalities – delivery through a Population Health Lens focus on those most affected by poor outcomes

Care Pathways – supporting proof of concept - developing care pathways that are more effective and efficient

Workforce – improving system effectiveness and efficiency through creative and innovative development and use of the workforce

Diabetes

Key Priorities	Actions/Outcomes	Measures
Care Processes delivery and Treatment Target improvement	• Improve care processes delivery and Treatment Target attainment	• 8 Care Processes delivered • Attainment of Treatment Targets
Prevention Programme	• Increase referrals to the Diabetes Prevention Programme (NDPP)	• Referrals • Starts
Structured Education Programme	• All Place populations to have consistent access to structured education (SE) provision	• Structured Education Place Offered • SE Attended
Multidisciplinary Footcare Teams	• Support all Place populations with sustainable access to a multidisciplinary footcare team	• MDFT service coverage by Place/Trust • Ulceration and amputation rates
Diabetes Inpatient Specialist Nurse DISN	• Support all Places with NICE compliant sustainable DISN services	• DISN service coverage by Trust • DKA, Hypoglycaemia and surgical care
Type 2 Young Onset Diabetes (T2DAY)	• Support introduction and implementation across C&M	• Number of patients seen • Young onset diagnoses rate
Type 2 Diet Replacement (T2DR/LCD)	• C&M implementation of the scheme	• Referrals • Starts against profile
Type 1 Disordered Eating (T1DE)	• C&M Disordered Eating project	• Referrals & Discharges
Supporting Diabetes Technology access and provision	• Improving Access and Provision, including **Hybrid Closed Loop** roll out	• HCL uptake • Technology uptake
Support for medicines optimisation	• Biosimiliar insulins and devices / Blood glucose monitoring strips and devices	TBA
Linked to Specialist commissioning - Renal Transformation Programme – Pathway, Variation & Equity	• To support and design interventions to commission and deliver services consistent with the Long-Term Plan - with a focus on improvement. To enable earlier detection and intervention for CKD and improve quality, safety and access to specialised renal services i.e. dialysis and kidney transplant.	• Improved detection, coding, treatment. • Delayed progression to dialysis • Improved outcomes of those on dialysis.

Diagnostic Programme

Successes in 2023-24:

- Increased the % of patients having their diagnostic test within 6 weeks to 90%
- Eliminated long waits with no patients waiting over 52 weeks and good progress being made to reduce that further
- Secured £8.1 million in capital funding to support an ambitious Endoscopy Transformation Programme to increase capacity and reduce waiting for patients across Cheshire and Merseyside
- Worked across provider Trusts to agree an approach to a Cheshire and Merseyside Pathology Laboratory Information System and commenced procurement for the system
- Expanded the Community Diagnostic Centres across Cheshire and Merseyside with 10 open and operating providing services closer to patients homes
- Mapped provision of diagnostic tests across the Cheshire and Merseyside geography, utilising data provided by primary and secondary care and the independent sector.

As partners we will:-

- Work collaboratively across Cheshire and Merseyside to build on best practice and maintain short waiting times across the system utilising robust mutual aid processes
- Maximise the use of additional capacity, increasing the tests carried out at the 10 Community Diagnostic Centres across Cheshire and Merseyside
- Reduce waiting times for diagnostic procedures, supporting earlier cancer diagnosis and faster progress to treatment
- Utilise the test mapping, working with colleagues in primary and secondary care to ensure that there is equity of access to patients for diagnostic tests
- Invest in the skills and education of diagnostic professionals utilising training academies
- Reduce unwarranted variation in care, access and experience, seeking and acting on patient and carer feedback
- Continue to maximise the use of digitisation to support efficiency and productivity across diagnostics

Cheshire and Merseyside Diagnostic Programme is one of the Cheshire and Merseyside Acute and Specialist Trust Collaborative (CMAST) transformation programmes, leading on diagnostics across the Integrated Care System Footprint.

The programme brings together healthcare professionals, providers, commissioners, patients and other partners to ensure that the population has access to safe, equitable, clinically effective, efficient, innovative, timely and sustainable diagnostic services which represent best value for money.

2024 -25 and beyond

The Programme will:

- Maximise additional diagnostic capacity, increasing test provision at Community Diagnostic Centres and reducing waiting times for patients
- Implement digital technology across modalities to provide efficiency gains across diagnostics
- Implement the first phase of the Endoscopy Transformation Programme, evaluating and planning for the next phase
- Continue to secure further national funding wherever possible to ensure services are future proofed
- Continue to provide opportunities to support and develop the diagnostic workforce across Cheshire and Merseyside

Neurosciences

Case for Change:
We recognise that we have variation in access and outcomes for neuroscience services and as such have identified a range of priorities.

Vision:
Improved outcomes for the population of Cheshire and Merseyside with neurological conditions.
Mission:
To achieve this through improving equity of access, at scale best practice pathways via clinically led work streams that will enhance quality, reduce variation and drive efficiencies.

Achievements:
- Best practice pathways have been developed, including a brain tumour pathway which is now well established with providers throughout Cheshire and Merseyside.

- Other collaborative pathways to optimise patient care and reduce unwarranted variation include, Parkinson's disease, Multiple Sclerosis, and Idiopathic Intracranial Hypertension.

Neurosciences

Our Priorities	Core Activities	Outcomes
Establish a strategic Vision and Plan for networked neuroscience care develop	Improve access to acute neurological care for patients to be assessed in a timely manner by an appropriate expert, to guide appropriate investigations. Through access to ambulatory care clinics and the Rapid Access Neurological Assessment (RANA) service.	Reduction in inappropriate admissions, unnecessary investigations and average length of stay for patients with acute neurological presentations.
Ensure effective collaboration mechanisms are in place to oversee the delivery of the networked neuroscience services across the whole pathway.		
Adopt a Population Health Approach, to assess the current performance - identifying key issues for the local Place based populations.	Pathway development and reviews of progress against GIRFT reports. Collaboration with regional spinal Musculoskeletal (MSK) services via a virtual MDT model allowing spinal practitioners in primary care access to specialist advice and education	Roll out best practice pathways to other providers in Cheshire and Merseyside.
Act as a specialist subject matter expert reference group, advising on the role and strategic direction of the neuroscience network programme.	A range of programmes to support patients with long term conditions are reviewed in collaboration with the Third Sector, including access to exercise and well-being programmes and engagement with Everton in the Community.	Improved patient experience
Review and development of appropriate performance measures, associated analysis, reporting and escalation frameworks.	Progress with the Cheshire and Merseyside pathway for thrombectomy – ongoing review including the aim to increase numbers of patients treated year on year and to maximise efficiency in the pathway.	Increase in the number of patients treated year on year and to maximise efficiency in the pathway.
Neurorehabilitation – Integrated Case Management & Care Models (Linked to Specialised Commissioning priorities)	Develop and agree a model of care with each ICB area that utilises integrated case management as a core feature to ensure that patient needs are met appropriately and adequate patient flow across the pathway	Reduction in: Out of Area placements, length of stay and delayed transfers of care, inappropriate and/or failed independent sector placements.

Neurosciences

Our Priorities	Core Activities	Outcomes
To identify opportunities and make recommendations to the Cheshire and Merseyside ICB	Spinal and Pain service: Progress against the spinal GIRFT report is reviewed, including impact on service configuration. The North West spinal network will review services for patients with back pain and design optimal pathways providing more equitable access.	Optimised patient pathway, improved patient experience and equity of access
Oversee the working of the groups to account for all aspects of the neuroscience network programme.	The Walton Centre hosted Cheshire and Merseyside Rehabilitation Network supporting patients who require complex rehabilitation. Further work is being undertaken to look at the future commissioning arrangement and the model of care including for patients with Prolonged Disorders of Consciousness (PDOC).	
Create an environment where all organisations can facilitate delivery of the objectives		

Respiratory

Narrow the gap in healthy life expectancy by improving lung health.
Eradicate tobacco dependency – half of the gap in life expectancy between rich and poor is due to smoking.
Improve air quality to reduce premature death.
Diagnose and treat of lung problems early to improve outcomes.

Core Aims:
Improve the early and accurate diagnosis of respiratory conditions.

Provide evidence based, cost effective treatment for people diagnosed and living with chronic respiratory disease alongside patient, family and carer education about how to effectively self-manage their health.

Ensure that services are designed to meet the need of the most vulnerable in our population, are easy to access and high quality. Transform the way that we deliver care to move to an integrated approach, tiered according to need.

Increase the knowledge and skills of healthcare professionals working across the system, enabling them to practice at their highest level by developing their skills and knowledge.

Promote the use of technology where appropriate to improve efficiency.

Work to prevent development of lung disease through partnership with smoking cessation and local efforts to target air pollution, warm/dry/mould free homes and encourage activity and exercise.

Case for Change: Respiratory disease affects one in five people and is the third biggest cause of death in England (after cancer and cardiovascular disease) causing 20% of all deaths. Those living in the poorest neighbourhoods are twice as likely to develop a lung condition, and seven times as likely to die from one than those in the richest areas

- Respiratory disease is a clinical priority in the NHS Long Term Plan
- It's a key Health and Care Partnership priority and core focus in the 2023-28 Joint Forward Plan
- Focus area in responding to the impact of the COVID-19 pandemic
- Core element of Core20PLUS5 - A focus on chronic obstructive pulmonary disease and increased uptake of COVID, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions and asthma is one of the 5 areas in the children and young people Core20PLUS5 programme.
- Links to Tackling Tobacco Dependency and our ambition to move to a Smokefree C&M
- Work around asthma and optimising 'Green' inhalers supports work to reduce our carbon footprint and Net Zero targets

Supporting links:
Tackling Tobacco Dependency Programme – expand and maintain current programmes and reduce smoking rates.
Fuel poverty – support work to reduce the impact of cold and damp homes on respiratory illness
Uptake of vaccinations – support link to population health to support vaccination uptake COVID, Flu and Pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions
Air Quality – support working around improving air quality to prevent exacerbation of respiratory disease

Respiratory

Key Priorities	Outcomes	Measures
Provide Adequate Spirometry capacity	• To increase spirometry capacity to provide adequate diagnostic services • To ensure NICE diagnostic recommendations are met to diagnose COPD & Asthma • To ensure universal C&M standards are adopted at place • To ensure compliance with ARTP standards of staff delivering spirometry	• Increased number of diagnostic spirometry tests performed across C&M annually by quality assured staff • Reduced waiting times for diagnostic spirometry – target 6 weeks maximum wait • Proportion of patients with a diagnosis of Asthma or COPD that have quality assured spirometry recorded (via Dashboard)
Clear the Backlog of spirometry caused by COVID-19 pandemic	• To work towards diagnosing people with COPD who do not have a Spirometry diagnosis • To ensure universal access to spirometry following C&M standards • To ensure NICE diagnostic recommendations are met to diagnose COPD & Asthma as mandated by NHSE • To support identifying the missing cohort and put plans in place to ensure testing is offered/provided	• Adequate diagnostic spirometry capacity available (using above metric) in all places • Reduction in the 'Missing Millions' patients with undiagnosed COPD (Rightcare data)
Implement & embed a diagnostic and treatment pathway for breathlessness	• To identify current pathways and services available to patients and highlight gaps • To Deliver the developed and approved breathlessness pathway • To streamline the current excessive times to achieve diagnosis for someone who is breathless as mandated by NHSE • Improve timely access to treatment for people with Idiopathic Pulmonary Fibrosis (IPF)	• Bundle of breathlessness tests completed within 6 weeks of request • Reduce RTT for patients with Respiratory disease referred to secondary care • Increase the number of patients receiving anti-fibrotic treatment for IPF
Develop and implement a diagnostic and treatment pathway for asthma	• To deliver Asthma pathway covering mild to severe asthma and provide adequate diagnostics for delivery of NICE guidance • Incorporate specialist commissioning Objectives for severe asthma into ICB (devolved from April 2024) • Optimise green inhaler prescribing to meet NHSE net carbon targets • Rationalise inhaler use to reduce costs	• Reduction in the number of patients with Asthma issued with >6 SABA inhalers in 12 months • Increase in the proportion of patients prescribed DPI vs MDI inhalers • Increase in the number of patients receiving biologic therapy for Asthma

Respiratory

Key Priorities	Outcomes	Measures
Transform Pulmonary Rehabilitation (PR) services	• Continue to deliver an optimal PR programme – a single integrated Service Specification implemented Nov 2023 • Facilitate the delivery of post exacerbation PR to reduce rehospitalisation • Continue to support services to develop and implement Health Inequality plans to ensure hard to reach groups are included in PR activity • Continue to support teams with the ongoing development of services in line with Meeting PRSAS Accreditation	• Increase in the number of patients completing PR • Reduction in the waiting time for PR • Increased number of patient accessing timely post exacerbation PR • All teams accomplish National accreditation for PR
'Greener prescribing' of inhalers	• Optimise dry powder inhaler use and reduce pMDI use to achieve NHS green targets	• Reduction in the number of patients with Asthma issued with >6 SABA inhalers in 12 months • Increase in the proportion of patients prescribed DPI vs MDI inhalers
Champion and promote 'Early detection of respiratory illness'	• Targeting high risk individuals to support early detection of lung cancer and COPD • Link diagnostic Spirometry to targeted Lung Health Check Programme to maximise health benefits and reduce healthcare inequality	• All patients with Respiratory symptoms attending TLHC programme offered quality assured diagnostic spirometry if this has not previously been performed • Increase in the number of patients diagnosed with COPD in the 20% most deprived communities as measure by IMD

Stroke

Vision and Mission:

We believe everyone deserves to live the best life they can after a stroke.

It is imperative that as a wider stroke community we come together to improve the quality of stroke services in Cheshire and Mersey for our patients, their carers and families, and our colleagues.

We will:

- Ensure rapid diagnosis of stroke and access to time-dependent treatment
- Develop integrated higher intensity care models for stroke rehabilitation to improve patient outcomes
- Link with the Cardiovascular and Respiratory (CVDR) networks to work collaboratively on both primary and secondary prevention
- Work towards reducing health inequalities across the Stroke entire pathway from prevention to life after Stroke

Case for Change:

Stroke is the fourth single leading cause of death in the UK and the single largest cause of complex disability. Approximately 100,000 people in England have a stroke every year, and 50% of stroke survivors will be left with disability (physical, communication, cognitive, psychological, visual, fatigue).

- Core element in the NHS Long Term Plan
- National Stroke Service Model delivery
- Responding to GIRFT – Getting it Right First Time
- Nationally, all stroke teams must submit patient level data to the Sentinel Stroke National Audit Programme (SSNAP) highlighting variation in care

Enablers:

- Effective data architecture and audit
- Clinical leadership
- Public awareness campaign and materials
- Adopting a person-centred approach via Patient Reported Experienced Measures (PREMS)
- Economic modelling to demonstrate benefits of an evidence-based stroke care pathway
- Collaboration with North West Ambulance Service (NWAS)

Stroke

Key priorities	Outcomes/Activity	Measures
Ensure rapid diagnosis of stroke and access to time-dependent treatment	• Greater efficiencies in door in door out (DIDO) process • Adherence to National Optimal Stroke Imaging Pathway NOSIP using AI (Brainomix procurement) to full potential, with improved data integration • 24/7 provision for thrombectomy in place • ABC care bundle – anticoagulant reversal, blood pressure lowering, care pathway • Growing and upskilling workforce through credentialling and training programme	• Increase thrombolysis and thrombectomy rates to 20% and 15% respectively, in line with National targets • By the end of 2024/25 ascertain the number of MRI slots available to stroke patients in line with NOSIP guidelines with the ultimate goal of securing MRI slots specifically for suspected stroke patients within one hour of arrival at hospital. • By 2024, all routinely admitting stroke services to achieve SSNAP score of “B” or above. • Increase in % of services that are stroke/neuro specialist combined Early supported Discharge/ Cognitive Rehabilitation Therapy (ESD-CRT) services through national Sentinel Stroke National Audit Programme (SSNAP) dashboard
Out of hospital and more integrated higher intensity care models for stroke rehabilitation to improve patient outcomes	• Pathway transformation for sustained needs-based, tailored community rehabilitation • Equipping patients to be able to effectively self-manage • Timely / equitable access to high quality rehabilitation as close to home as possible • Broadening access to telerehabilitation, psychological and vocational rehabilitation • Supporting people to manage in crisis reducing winter pressures	
Linked to Specialist Commissioning -	Optimising Stroke Pathways – From 999 to Thrombectomy • Ensuring timely access to intra-arterial thrombectomy through pathway development.	• 24/7 access across the region to mechanical thrombectomy • Positive impact upon key efficacy outcomes for patients • Reduction in stroke related deaths, disability and length of stay through implementation of NOSIP pathway.

Sustainability and Partnerships

Vision:
Improving health outcomes, addressing inequalities, achieving best value and developing social value sustainability

Mission:
To achieve net zero, increase social value, develop the anchor framework and support in reducing health inequalities

Estates:
We will work towards a sustainable estate that provides community activities and support VCFSE organisations

Case for Change:

To provide a framework to enable the ICB to achieve 10% focus on prevention, help to reduce health inequalities and achieve net zero to reduce pressure on, and ensure longevity of, our public services

Key Priorities	Outcomes	Measures
Develop a system Anchor plan setting out the principles of being a C&M anchor organisation and growing reach of the programme	Consistent approach aligning Social Value and Anchor work to support reducing health inequalities and ensuring alignment across programmes	Strategy developed and aligned with C&M Themes Outcomes and Measures (TOMs) and Anchor Assembly process
Strengthen partnership work to embed Social Value, Anchor and sustainability requirements across the ICS	Joined up approach to delivering on targets, maximising capacity and capabilities	Increased take up to C&M TOMs, Anchor Framework and delivery of Green Plan targets
Refresh our Green Plan to lead direction to achieving net zero	The refreshed Green Plan will set revised targets to deliver net zero	Series of priorities measured across 10 themes, reported to Sustainability Board, HCP and regionally

Health Inequalities - Our work supports reducing health inequalities and the anchor framework provides a mechanism for delivery

Air Quality - Improvements crosses numerous programmes for internal and external air quality

NHS
Cheshire and Merseyside

Section Three Innovation and use of new Technology

1. Research and Innovation
2. Promote Digital Maturity

Research and Innovation

The embedding of Research and Innovation into routine clinical care is essential if quality and safety is to be optimised and improved.

In line with NHS England's guidance on Maximising the Benefits of Research as well as our statutory responsibility to deliver research and innovation under the Health and Social Care act 2022 the NHS Cheshire and Merseyside Board has approved the establishment an Integrated Research and Innovation System (IRIS) that aligns with both local and national research and innovation priorities.

IRIS adds value to our Cheshire and Merseyside health and care environment by attracting research investment, strongly supporting innovation and enabling the ICS to evolve into a world class system of research and innovation excellence which supports delivery of the ICS and NHS Cheshire and Merseyside strategic objectives and priorities.

Successes in 2023-24:

- C&M has secured funding for Research Engagement Network (REN) programmes
- Won an NIHR Capital Investment Award for Mobile Research Units and Primary Care Research Hubs
- Supported the development of award-winning collaborations such as the Wirral Research collaborative

Mission:

As a key enabler within the NHS Cheshire and Merseyside Clinical and Care Constitution we will promote and engage with world-class Research and Innovation with our stakeholders

IRIS will:

- Convene Stakeholders
- Research and Innovation Planning
- Identify and Address Research and Innovation Priorities
- Influence the National Guidance and International Research and Innovation Agenda
- Expand Research and Innovation
- Promote Evidence-Based Practice
- Harmonise and Co-ordinate Research and Innovation Activities
- Cultivate a Learning Environment
- Leverage Commercial Contract Research and Innovation
- Develop the Research and Innovation Workforce and Infrastructure
- Sustainability
- Improve Healthcare Quality and Outcomes

Next Steps:

- Confirm and draw up the C&M ICB R&I Strategy, including:
  - Strategic Alignment with ICS priorities
  - Link into our nine Places
- Discuss and confirm how we will measure inward investment
- Confirm what capacity is in the system

Our Digital and Data Strategy aims to:
- Improve the health and well-being of our region by weaving our digital and data infrastructure, systems and services throughout the pathways of care we provide.
- Turn ‘intelligence into action’. to bring focused, and therefore meaningful, interventions to those who most need it.

It aims to:
- **Improve outcomes for individuals and the population**
- **Support Health and Care delivery, planning and transformation**

Through:
- A digitally empowered population
- A digital and data confident and competent workforce
- A secure and reliable intelligence provision

Goal 1
Strong digital and data foundations

Goal 2
‘At scale’ digital and data platforms

Goal 3
System wide digital and data tools and services

Key Priorities:
- Cyber security
- Electronic Patient Record (EPR) maturity
- Shared Care Records
- Digital Primary Care Transformation
- Data into Action
- Laboratory Information Management System (LIMS)
- Robotic Process Automation (RPA) and Generative Artificial intelligence (AI)
- Patient empowerment (NHS app, patient portals, digital inclusion)
- Staff digital skills development

Mechanisms for Change:
- Transformation Programmes
- Robust governance, leadership and management
- Partnerships
- Future proofing and innovation

Strategic Principles:
- Outcome Focused
- Care profession led
- Inspired by a rich diversity of people

Critical Success Factors:
- Increasing Digital Inclusion
- Developing and retaining a highly skilled workforce
- Ensuring sustainable financial investment
- Working Towards Net Zero targets

Mission:

We will be the most digitally advanced and data driven ICS in England by 2025