www.cheshireandmerseyside.nhs.uk

NHS
Cheshire and Merseyside

Cheshire and Merseyside

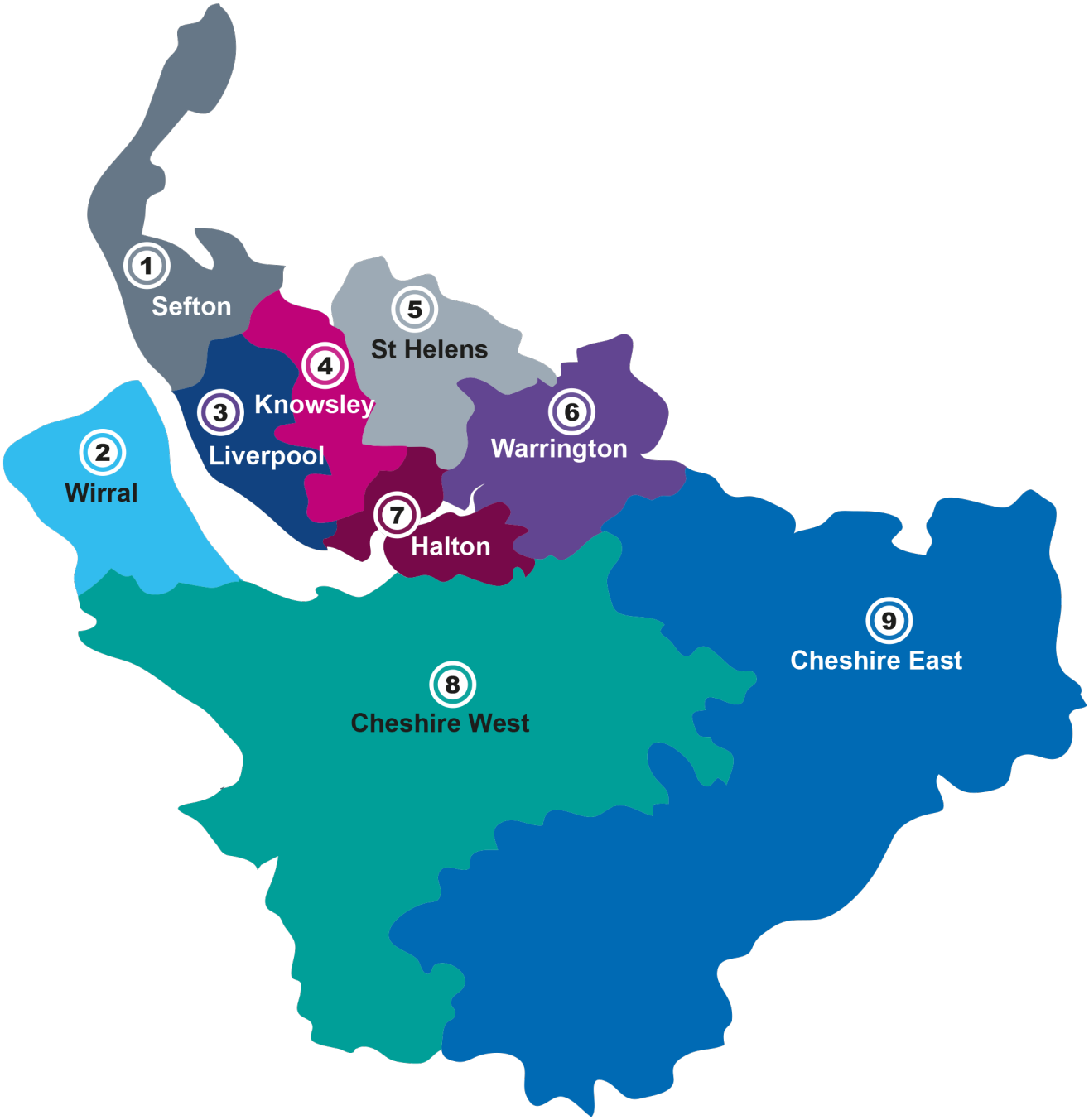
Joint Forward Plan: (Refresh) Our Place Partnership Plans

2024/25









1. Sefton
2. Wirral
3. Liverpool
4. Knowsley
5. St Helens
6. Warrington
7. Halton
8. Cheshire West
9. Cheshire East

1. Sefton

The Sefton Partnership plan sets out our objectives and how we will work together to deliver improved health outcomes for local people.

We have adopted a collaborative approach to developing our plan, working with all our partners to gain their unique knowledge, learning, and experience from working with local people. We have embraced the Partnership's collaboration agreement principles, which centre on working together so that we can:

- Achieve financial sustainability
- Deliver person-centred care
- Act ethically at all times – being open
- Act as one – focussing on outcomes
- Invest in innovation and creativity
- Act based on evidence and a structured framework

Our plan supports the delivery of the health and wellbeing strategy, Living Well in Sefton. We share a single vision, namely that Sefton will be:

"A confident and connected borough that offers the things we all need to start, live and age well, where everyone has a fair chance of a positive and healthier future".

Our plan sets out our objectives across the life course, starting from preconception and pregnancy and continuing right through to supporting those who are nearing the end of their life. The service areas included under each life-course stage have been identified based on their being (i) included within the national planning guidance, (ii) part of the JFP requirements or (iii) a local Sefton priority.

Start Well:	Live Well:	Age Well:	All Age:
1. Children & Young People 2. Early Years 3. Maternity	4. Cancer 5. Complex Lives 6. Diagnostics 7. Learning Disabilities & Autism 8. Long Term Conditions 9. Mental Health 10. Planned Care 11. Women's Health	12. Community Services 13. Dementia 14. Urgent & Emergency Care	15. Carers 16. Obesity 17. Palliative & End of Life Care 18. Primary Care

In order to realise our vision and deliver our objectives, we have identified three cross-cutting themes:

1. Reducing health inequalities: We recognise there are stark differences in the quality and length of life across Sefton and that we need to work together to prioritise those who stand to gain the most.

2. Service transformation: We know our provider partners are under increasing pressure and that we have to radically transform how we deliver services to local people.

3. Community first: We recognise our communities have a vital role in improving their health and wellbeing and we are committed to working with them and co-producing solutions together.

Delivery will, in turn, be supported by a series of enabler functions that include:

- Clinical and Care Leadership
- Communications and Engagement
- Digital
- Estates
- Medicines Optimisation
- Organisational Development
- Population Health Management

We have a shared commitment to adopting a “whole population, whole partnership” approach given that we know health and life chances are impacted by a wide range of factors. We therefore recognise that we will only achieve our objectives by strengthening how we work together as a Partnership.

2. Wirral

Planning for health and care services is not only driven by NHS Planning Guidance, but also influenced by local priorities as set out in Joint Strategic Needs Assessments and Health and Wellbeing Strategies.

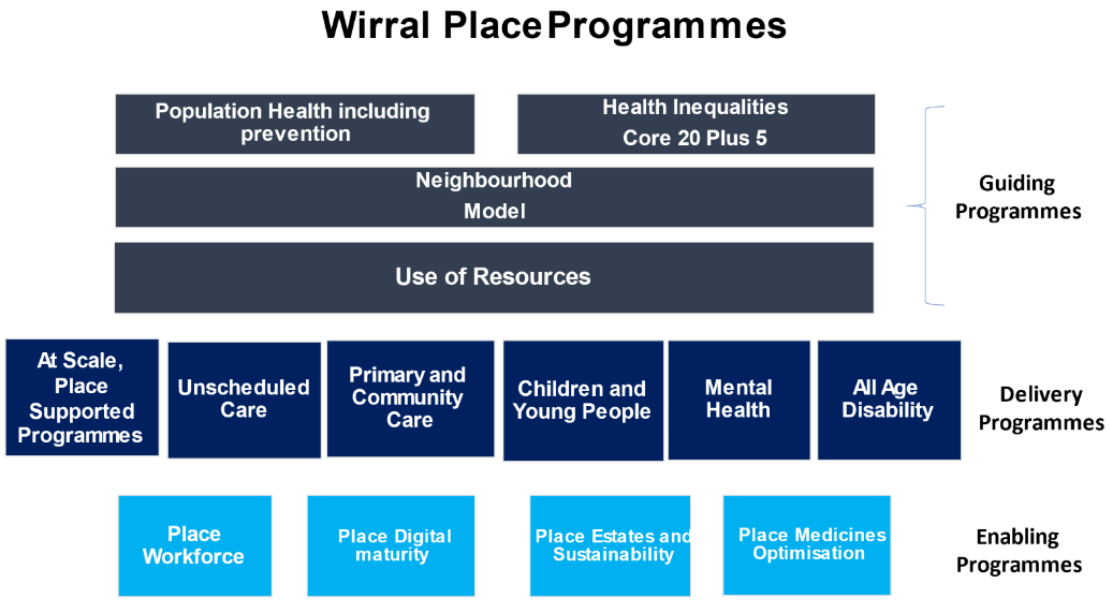
NHS Cheshire and Merseyside has recognised the importance of Place in how we have established our governance and working relationships in Wirral with system partners. Our planning for health and care services is influenced by and incorporates the Wirral Plan 2026 and the Wirral Health and Wellbeing Strategy 2022-2027 as well as NHS planning guidance.

This is demonstrated within the Wirral Health and Care Plan 2023-24, which was agreed by the Wirral Place-Based Partnership Board on 22nd June 2023.

The Wirral Health and Care Plan will not be rewritten for 2024-25 but will be refreshed and updated. The programmes of work agreed by the Wirral Place Based Partnership Board in June 2023 will continue and each Senior Responsible Officer will be asked to review and update these for the 2024-25 planning year. A series of Wirral system workshops have been put in place to support this.

The production of a refreshed Wirral Health and Care Plan is being overseen through the Strategy and Transformation Group, which reports to the Wirral Place-Based Partnership Board and will be supported by the Wirral Improvement Team. It is anticipated that the Wirral Health and Care Plan 2024-25 will be agreed at the June 2024 meeting of the Wirral Place-Based Partnership Board.

The Wirral Health and Care Plan 2024-25 programmes are set out below.



3. Liverpool

The One Liverpool business plan sets out the strategic intent, priorities, governance, and operational delivery plan of One Liverpool partners in 2024/25, to meet the ambitions in the One Liverpool Strategy.

The refreshed One Liverpool strategy has five core goals:

1. Targeted action to reduce inequalities
2. A system focus on prevention
3. Integrated services, shaped around the needs of our population
4. Health creating communities
5. A financially sustainable health and care system

Our priorities for 2024/25:

- System redesign of the whole urgent care pathway to improve flow, patient experience, and sustainability – right care, right place, right time:
  - Patients reach the best possible outcome in the shortest amount of time
  - A more effective service, enabled by improved ways of working and fewer barriers between teams
  - Better experiences for patients, staff and service users.
- Improve population health and reduce inequalities through prevention and anticipatory care, focused on 5 cohorts of our population:
  - Healthy Children and Families – Better Start, Good Respiratory Health, Emotional Health and Wellbeing
  - Disability - Learning Disabilities, Autism and Attention Deficit Hyperactivity Disorder
  - Complex Lives – Homeless Health, High Intensity Users of Services, Domestic Abuse
  - Long Term Conditions – Hypertension, Cardiology, Respiratory, Diabetes
  - Frailty - Integrated Frailty Pathway, Dementia, Virtual Wards, Care Homes

- Implement the opportunities identified in the Liverpool Clinical Services Review of acute and specialist services, intended to realise opportunities for greater collaboration to optimise clinical pathways in acute care in Liverpool. Priorities in 2024/25 include:
  - Addressing the short-, medium- and longer-term clinical sustainability challenges affecting women's health in Liverpool
  - Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites
- Strengthen integrated working arrangements between Liverpool Place partners and align capacity across Place Teams across Cheshire and Merseyside to deliver improvement where it makes sense to collaborate.
- Making best use of resources for financial sustainability, maximising use of the Liverpool pound and improving efficiency and effectiveness

The One Liverpool Strategy is being refreshed, supported by the One Liverpool Partnership Board, and informed by analysis of population need.

4. Knowsley

Our ‘Knowsley Plan’ sets out our vision, objectives and how we will work across the system to deliver health improvements for the people of Knowsley in the next two years.

We set out how the ‘health element’ of the vision will be delivered (Knowsley 2030) and how we will work with our partners to realise our key health-related ambitions. Knowsley Healthier Together, as a placed-based partnership, addresses the critical health challenges and embraces the opportunities to improve health services across the Borough.

Our vision for Knowsley brings us together as a local system and fully aligns with the Cheshire and Merseyside Health Care Partnership Strategy, Joint Forward Plan (in development) and the NHS Long-Term Plan.

The vision is based on the principles of Kindness, Honesty, and Trust:

Enabling people to live healthier, more independent lives through high-quality, seamless care.

Our vision is for everyone to have a great start in life and get the support they need to live healthy and longer. We will do this by working together as equal partners to support seamless person-centred care and tackle health inequalities by improving the lives of the poorest fastest.

We want Knowsley to be a place:

- with a thriving inclusive economy with opportunities for people and business
- with welcoming vibrant neighbourhoods and town centres
- where people are active and healthy and have access to the support they need
- where people of all ages are confident and reach their full potential
- where safe and strong communities can shape their future

We will take a life course approach to tackling inequalities and addressing our top health challenges:

- Life expectancy
- Obesity
- Depression
- Long term conditions
- Smoking
- Population Health

We will build on our achievements over the last 12 months including the learning from the pandemic. In delivering Knowsley 2030 and the Cheshire and Merseyside Health and Care Plan – 2023/25 we will focus on:

- Starting well, Mental Health and Learning disabilities
- Living Well and Planned Care
- Ageing well and Urgent Care
- Primary Care

Each area has a structured programme of work. The work will be underpinned by creating the right foundations supported by a number of enabler functions: Planning, Estates, Finance, Digital and Medicines Management.

Knowsley Healthier Together Board

The board Provides strategic leadership for and delivery of the overarching strategy and outcomes framework for the Place-based partnership and to achieve the objectives of NHS Cheshire & Merseyside ICB and the Knowsley Borough 2030 Strategy to improve the health and wellbeing of the Knowsley population. The board is supported by a number of local delivery groups.

We will focus on developing our maturity as this is important to improve our ability to improve services and achieve greater local financial and service autonomy.

5. St Helens

Our St Helens Place-Based Partnership Plan details our strategic approach to improving the health and wellbeing outcomes of residents of the borough, providing high-quality services that meet local needs.

Our Vision:

One Place, One System, One Ambition - Improving people's lives in St Helens together.

Our Mission:

Bringing people closer together, by tackling health inequalities in St Helens

We have a number of guiding principles:

- Ensure Children and Young People Have a Positive Start in Life
- Promote Good Health Independence and Care Across Our Communities
- Create Safe and Strong Communities and Neighbourhoods for All
- Support a Strong, Thriving, Inclusive and Well-Connected Local Economy
- Create Green and Vibrant Places That Reflect our Heritage and Culture

Our Values-based Principles:

- We will be compassionate and inclusive as we work to deliver quality Services.
- We will strive to make a difference continuously learning and improving what we do.
- We will be open and honest and work with integrity at all times.

Mental Wellbeing with a focus on:

- Prevention and reduction of self-harm and suicide
- Reducing loneliness and isolation
- Improve wellbeing of children and young people
- Expand VCS Capacity to support mental health and wellbeing.

Healthy Weight with a focus on:

- Support healthy eating choices in the Borough.
- Encourage residents to lead a more active lifestyle.
- Reduce diabetes.

Care Communities with a focus on:

- Deliver a multi-disciplinary team's care approach in neighbourhoods.
- Reduce unavoidable system pressures in primary and secondary care.
- Treat and support people to recover and stay well in their own homes 'self-care'.

Inequalities with a focus on:

- Tackling the wider determinates of health and improving our Marmot indicators
- Raise the aspirations of children and young people in St Helens
- Continue to influence partners to reduce inequalities.

To support the overall delivery, we have identified a number of enabler programmes:

Digital Transformation: We have a robust digital transformation plan to build on our investments, innovations and the achievements that are continually made.

Population Health Management: We will build on and embed the use of real time population health data and analytics to drive the focus on population health and care strategies at place and in our localities.

Workforce: We will shape and support our workforce to meet the needs of the future. St Helens will be an attractive, innovative place to work, develop and contribute to the growth of the Borough.

Our local plan: This plan articulates our commitment to delivering integrated services to our communities whilst aligning to and learning from the All Together Fairer approach adopted by the Cheshire and Merseyside system.

6. Warrington

Our Vision:

Warrington is a place where we work together to create a borough with stronger neighbourhoods, healthier people, and greater equality across all our communities.

This vision is supported by three key outcomes in our Health and Wellbeing strategy (HWBS) which support the eight priorities aligned to the Marmot principles.

Warrington will be a place where:

1. Children are given the best start in life and can fulfil their potential.
2. Adults can work and live fulfilling lives, in a vibrant and healthy borough.
3. Older people enjoy a healthy, independent, and fulfilling old age, feeling safe and connected within their communities.

Delivery of the HWBS is owned by the Warrington Together Partnership Board (WTPB) which has representatives from all partners across Warrington, including Healthwatch and a representative from the Voluntary, Community, Faith, and Social Enterprise Sector. A life course approach has been adopted with robust delivery plans in place to enable transformational change:

Starting Well

Every child should have the best start in life. The best start in life is about good physical and mental health for every child, about children being safe and growing up in settled families, and about getting the best from school and education so they can lead successful adult lives. We want Warrington to be a place where children enjoy their childhoods and go on to achieve great outcomes.

Staying Well

Tackling the wellbeing factors and wider determinants that impact poor health including obesity and alcohol, focussing on improving outcomes for people experiencing poor mental health and those with learning disabilities and/or autism. Additionally, we will support those who are experiencing poverty.

Ageing Well

Supporting people to live at home for longer. This theme will focus on developing the Single Front Door to support the delivery of interconnected services by directing residents/patients to services who have the skills, expertise, and capacity to care for them. Embedding a proactive care approach, maximising virtual wards, enhancing care in care homes, ensuring

successful transfer of care when people move between care interfaces and supporting people to die with dignity.

WTPB is supported by a Finance, Investment and Resource Group which will seek to mobilise the pooling/alignment of budgets at Place (via the Better Care Fund) to achieve economies of scale and maximise outcomes as well as a Quality and Performance Group which provides oversight of system quality, particularly in relation to resident/patient experience.

The Warrington Together themes are supported by a number of enabler workstreams, including: Communication and Involvement, Digital, Estates, Workforce and Business Intelligence.

The enabler workstreams not only support the delivery of the plans for each theme, but they will also deliver against local priorities such as:

- A cross-sector Workforce strategy to mitigate the workforce recruitment and retention issues being experienced across the Borough.
- A Digital Strategy to enable shared care records to be easily accessed between partners (a key finding of our recent Special Educational Needs and Disability SEND inspection), improving the quality of care for our residents, also upskilling our residents to access digital solutions.
- Joining up emerging Estates strategies across Primary, Community and Secondary Care. Developing hubs to house additional primary care roles, making the ambition of a new hospital for Warrington a reality and streamlining existing sites that aren't fit for purpose into a purpose-built intermediate tier facility.
- This work will be underpinned by robust, meaningful data and our communications and engagement teams will ensure partners and residents alike are informed, engaged and involved in co-production where possible.

The outcomes are owned by the Health and Wellbeing Board and monitored via an outcomes dashboard – the strategy is underpinned by a robust delivery plan and associated metrics.

7. Halton

Our One Halton's Ambition:

To improve the health and wellbeing of the population of Halton by empowering and supporting local people from the start to the end of their lives by preventing ill health, promoting self-care and independence, arranging local, community-based support and ensuring high-quality services for those who need them.

Halton has a Joint Health and Wellbeing Strategy which comprises four strategic priorities and associated goals across the life course approach and, during 2024-2025, we will continue as One Halton Partnership to take forward specific deliverables within each priority area:

- ### Wider Determinants of Health:

Improve the employment opportunities for the people of Halton in particular where it affects children and families.

Goal: A more financially active and enabled community who are employed in good jobs that provide greater financial stability, improves quality of life and provide better health outcomes

- ### Starting Well:

Enabling Children and Families to live Healthy Independent Lives.

Goal: More financially stable, informed and supported families with children who have better health outcomes.

- ### Living Well:

Provide a supportive environment where systems work efficiently and support everyone to live their best life.

Goal: A more supported and enabled community who are able to understand where to go to get the support and care they need in time.

- ### Ageing Well:

Enabling Older Adults to live Full Independent Healthy Lives.

Goal: A more active and independent older population who are able to live at home or are supported to get the care they need.

Integrated Neighbourhood Working:

One Halton partners have agreed that the evelopment of an integrated neighbourhood way of working as fundamental to our success.

Leadership, Oversight and Delivery Arrangements:

Achievement of our ambition and delivery of our strategic priorities is led and overseen by the One Halton Place Based Partnership Board and is supported by thematic priority delivery groups.

Senior Responsible Owners (SROs) are identified for each of the thematic priorities. Leading the group's work on behalf of the Board and ensuring appropriate representation from One Halton partners and other stakeholders (including Healthwatch Halton as the champion of service users) in their work, the SRO is accountable to the Board for setting out the key deliverables for agreement by the Board, putting in place the delivery architecture, plans, and resources, and providing updates on progress, impact, issues and risks.

There are a number of enablers that support delivery of this work such as clinical and care leadership, finance, estates, workforce, digital solutions, and communications and engagement.

Over the next 12 months, we will build on local achievements and continue to progress our early priority projects for delivery in each thematic area, ensuring we thread the need to address health inequalities, focusing on the recommendations in the Marmot Report "All Together Fairer", into our forward delivery plans.

Integrated Neighbourhood Model:

One Halton has identified integration as key to improving the experience and outcomes of local people within a sustainable health and care system.

Our vision for neighbourhood working is greater than just health and social care and moves beyond treating symptoms to addressing the underlying causes of poor health and wellbeing and supporting people to have a good life.

One Halton Partnership Board has agreed the purpose, features and principles of the Integrated Neighbourhood Model and this is being used to inform integrated neighbourhood working across the Borough and all thematic priorities. Over the next 12 months, we will embed the principles of this model further with partners by building on and applying learning from existing integration projects as well as seeking more early adopter test beds and pursuing opportunities for better integration.

8. Cheshire West

Cheshire West Place is unique in that its Joint Health and Care Strategy is also the Place Plan. This Place Plan runs until March 2026 and sets the key priorities for our local population. The Place Plan is available on the Local Authority website, along with a report summarising the key achievements from all partner signatories towards the commitments we have made to improve the health and wellbeing of the population of Cheshire West.

The Place Plan is ultimately the responsibility of the Health and Wellbeing Board. However, Cheshire West has also implemented both an Integrated Transformation Steering Group and an Integrated Operational Steering Group to ensure that the transformational and operational commitments are being delivered.

Cheshire West has an established Senior Leadership Team that works towards the priorities identified within the Place Plan. For our Integration Work Programmes, there are four key subgroups that support the Senior Leadership Team in delivering transformational change and operational resilience to achieve our objectives:

- Urgent Care Board
- Integrated Operational Delivery Group
- Integrated Transformation Steering Group
- West Cheshire Children's Trust Executive

We have outlined a number of strategic intentions:

- Demand Management and System Resilience
- Home First
- Supporting Local Communities.

In order to deliver these, we are focusing on:

- Increasing Self-Care and Peer Support – supporting Communities to flourish and managing people in their own homes.
- Building Community Care - development of Integrated Multi-Disciplinary Teams and supporting people in crisis to remain at home, enabling safe discharge.
- Reducing reliance on the Acute sector / bed-based care – improving flow including health led interventions to reduce admissions.

Underpinning this we have identified a number of key joint transformation programmes continuing from 23/24 into 24/25, all of which are focused on early intervention / prevention and increasing community capacity:

- Intermediate Care / Integrated Discharge / Integrated Brokerage
- Community Care including Admissions Avoidance
- Community Partnerships (formerly Care Communities) Strategic Programme
- All Age Mental Health
- Accommodation and Care Models for those with Learning Disability and Autism.

The above are supported by a set of enabling workstreams including: People, Finance / Resources, Communications and Engagement (including the implementation of the Local Voices Framework), Estates, Business Intelligence and Digital.

Our Cheshire West Place key objectives are listed below:

- To reduce Avoidable Admissions through use of Step-Up Services and outreach from the Acute
- Maximise effective working of Community Care Teams with partners including Social Care, Primary Care and the VCFSE to keep more people from deteriorating into crisis
- Integrated Discharge that minimises delays and enables patient flow
- Develop Community Partnerships across the footprint that have a clear health / care support offer
- Enhance early intervention and emotional wellbeing
- Integrated offer for those with Neurodiversity, particularly pre and post diagnosis
- Improved accommodation offer for those with Autism or Learning Disabilities
- Reduce inappropriate out of area placements
- Develop and maintain a Healthy Work Action Plan
- Create a Social Isolation and Loneliness Action Plan
- Develop an Age Friendly Work Action Plan in line with our population needs.

Each objective has been broken down into a series of core workstreams which have a number of deliverables and a dedicated sponsor and business lead. Achievement is tracked against our Place Integrated Outcomes Framework.

9. Cheshire East

Vision: To enable people to live a healthier, longer life; with good mental and physical wellbeing; living independently and enjoying the place where they live

In Chesire East, we have defined four core outcomes that we are committed to delivering:

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

To maximise the health and wellbeing of Cheshire East's residents, we have identified a number of core principles underpinning the Joint Local Health and Wellbeing Strategy (2023-28). These principles focus around providing value for money, improving population health and decreasing unwarranted variation, alongside delivering the best individual and Carer experience. The plan recognises that staff must also be supported ensuring that they also have a positive experience.

In Cheshire East, we have adopted a number of 'Golden Threads' that support these principles:

- Place – improving the environment and making the healthy choice the easy choice.
- Prevention – tackling the risk factors that lead to poor health.
- Proportionate universalism – tackling inequalities with an offer for all but the greatest efforts focussed on those with the greatest need.
- Partnership working – public and VCFSE services working together closer to where people live.
- Proactive care – early diagnosis and intervention.
- Person-centred approaches – looking at the whole person and prioritising what matters to them through shared decision making.
- Production through engagement – reviewing programmes and allocating resources across the whole system to where they will help most.

We have threaded tackling health inequalities throughout place plans and there will be a focus on the recommendations in the Marmot report 'All Together Fairer'. This will be supported by additional work around Core20PLUS5 and Population Health Management with targeted interventions to support vulnerable groups. We will continue to radically

reshape the care delivered, to empower residents and place them at the centre of a seamless, integrated system of support. In doing this, we will co-design and co-produce these changes with residents and frontline staff to ensure they work for all.

There are several enabling workstreams which will help Cheshire East Place realise the delivery of this vision, these include: People & Leadership, Communications & Engagement, Digital Transformation, Estates Transformation, Finance, Major Service Redesign, and Care Community Development.

In Place we have identified a number of priority core themes for example: Home First; Primary Care Development; Mental Health & Neurodiversity; Healthy Weight; Dementia; and Cancer Care. Work across these areas will include a focus on:

- Further development of our Care Communities
- Improving access to community services and diagnostics
- Maintaining acute sustainability and the development of a new Hospital in Leighton
- Ensuring recovery of waiting times to pre-pandemic levels
- Financial sustainability.

Cheshire East Place will measure its success against our four core outcomes through a 'Joint Outcomes Framework'. Phase one of this framework is now live and seeks to measure our performance against 14 indicators of population health and wellbeing.