NHS
Cheshire and Merseyside

Population Health Improvement Plan 2026/2031

Contents – Population Health Improvement Plan

Our Population Health Improvement Plan

Glossary (Acronym buster)

There are many acronyms throughout the document - these are explained in the glossary this can be accessed through the link on each slide.

1. What is a Population Health Improvement Plan

A Population Health Improvement Plan (PHIP) is a strategic, data-driven approach to improving the overall health, wellbeing, and health equity of a defined group of people by addressing root causes of illness and promoting wellness across communities, not just within individual clinical visits, but across wider pathways, involving collaboration between healthcare, local government, and community partners.

Our PHIP is aimed at improving the health of the entire population. It is about improving the physical and mental health outcomes and wellbeing of people while reducing health inequalities.

It includes action to reduce the occurrence of ill health, deliver appropriate health and care services and action on the wider determinants of health. It requires working with communities and partner agencies.

Our vision is to embed a culture of improving population health and reducing inequalities through increasing system collaboration, capacity, capability and intelligence.

Our key goals:

- **Improve outcomes:** for all people by using data, intelligence and insight and embedding a population health approach across Cheshire and Merseyside.
- **Reduce inequalities:** in experience, outcome and access to care by increasing collaboration capacity and capability across the system.
- **Address wider determinants:** act on social, economic, and environmental factors influencing health (e.g., housing, education, employment and poverty) helping support broader social and economic development.
- **Enhance care:** Improve patient experience and make care more proactive and personalised.
- **Increase value:** Enhance productivity, efficiency and value for money while improving quality.

Living Healthy Lives

Starting Well

Growing Well

Living Well

Ageing Well

Dying Well

The PHIP is built around our key priorities and follows a life course approach. For each section of the plan we outline:

- The case for change
- Key outcomes
- The key impacts
- Our 26-27 commissioning intentions
- Our 27-28 commissioning intentions
- Our commissioning intentions years 3-5
- Our key metrics and measures
- Governance route and Exec Lead

2. How we have developed the priorities in this plan

In developing our PHIP priorities we have built from:

- Our Health and Care Partnership Strategy and Joint Forward Plan
- Priorities identified in our System Recovery Plans including efficiency, service sustainability and reconfiguration
- Our Integrated Needs Assessment (at C&M and Local Authority level)
- The Cheshire and Merseyside NHS Provider Blueprint

In addition to this our plan reflects additional priorities outlined in the NHS 10-Year Plan and Medium-term Planning Framework with a specific focus on delivery of the national shifts.

We have reflected the current context with a key focus on:

- Preventing and intervening early to prevent ill health; targeting priorities and populations identified through our population health needs assessment
- Commissioning for outcomes and value-based healthcare
- Providing more care in our neighbourhoods
- Reducing waiting times (Electives, Diagnostics and Cancer (EDC) as well as Mental Health, Neurodiversity and Primary, Community & Urgent Care)
- Delivering financial and operational efficiency and service sustainability through the opportunities highlighted in our Integrated Needs Assessment
- Safe, appropriate and cost-effective use of medicines cuts across our ambitions and is a key enabler of improved outcomes. The medicines management work plan is supporting several key system-wide areas where we are an outlier or have scope to improve, i.e., polypharmacy and frailty, antimicrobial stewardship, pain including opioids, safety and cost effectiveness.

We have recently refreshed our Integrated Needs Assessment:

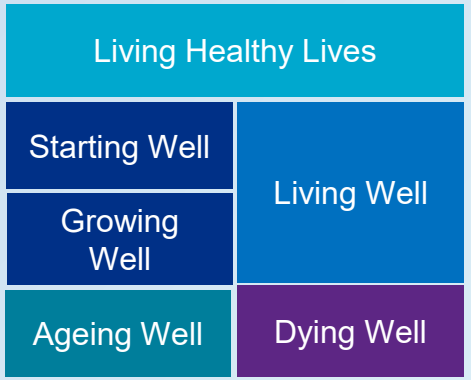
Current situation:

- The gap in life expectancy between those living in our richest and poorest areas continues to grow
- Cardiovascular Disease, Respiratory Disease and Cancer remain the leading causes of this gap
- Healthy life expectancy continues to reduce in all areas of C&M except Warrington.
- Increasing rates of chronic conditions, multiple chronic conditions and poor mental health are key contributing factors to declining healthy life expectancy.
- Growth in need and insufficient capacity to support neurodevelopmental conditions.

Future projections:

- Over the next three years in C&M we expect to see an increase of 84,783 people with long-term conditions costing an additional £187 million
- By 2040 - a 50% increase in diabetes, 31% increase in cancer and a 51% increase in atrial fibrillation.
- By 2040 - there will also be a 44% increase in people aged 75+.
- As an area with higher than average rates of frailty and falls this poses another significant challenge.

The PHIP is built around our key priorities and follows a life course approach.



- Living Healthy Lives – Prevention and Proactive Care
- Neighbourhood Health
- Maternity and Neonatal Care
- Children and Young People
- Mental Health
- Neurodiversity, ADHD, Learning Disability and Autism
- Frailty and Falls
- Palliative & End of Life Care

3. Our approach to Population Health Management

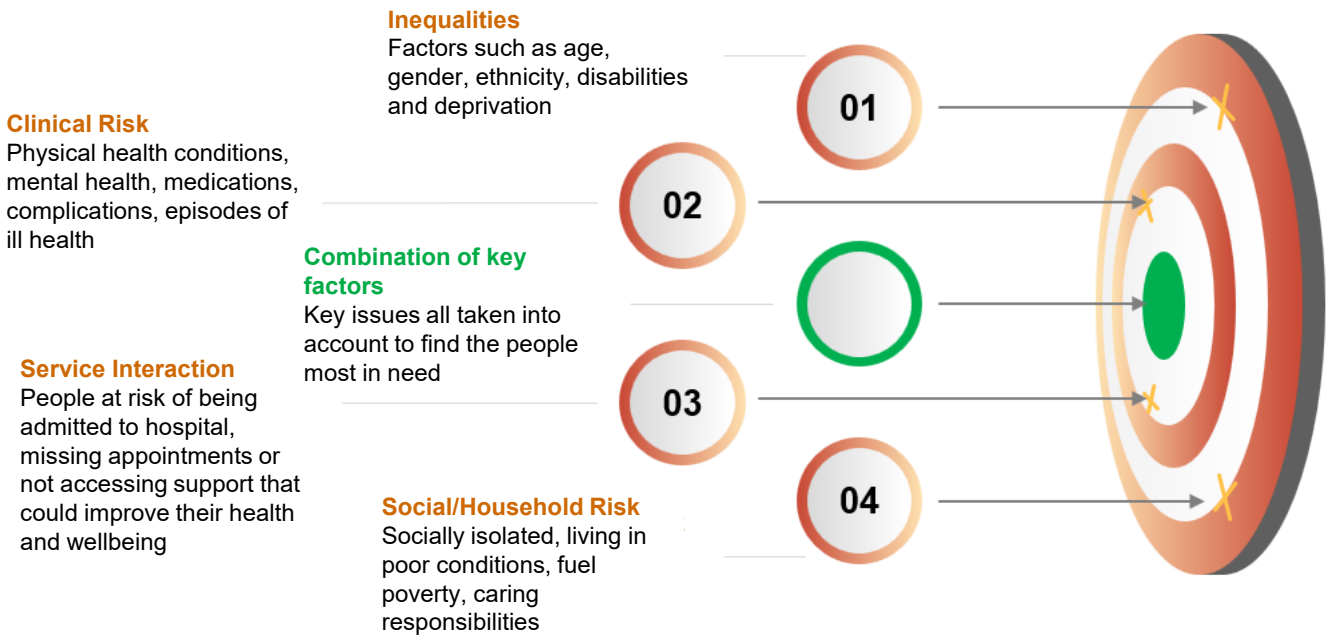
Improving outcomes: for all people by using data, intelligence and insight and embedding a population health management approach across Cheshire and Merseyside.

We will take a Population Health Management approach to turn Data into Action and identify and then deliver the priorities in our Population Health Improvement Plan by:

Using data and benchmarking tools, including the Federated Data Platform Strategic Commissioning Tool, to inform commissioning decisions and target investment for maximum impact.

Applying segmentation and risk-stratification across NHS providers so people with the greatest need – such as those with long-term conditions or long waits – receive proactive, coordinated support.

Linked Data: Broader Perspective



Enhanced case finding to predict population health needs, considering multiple conditions and severity to enable targeted interventions. Developing capability through our Population Health Academy so staff can use analytical tools to tackle health inequalities locally and lead commissioning and transformation at scale.

We are using insight from our Integrated Needs Assessment and the Johns Hopkins Model to identify population groups needing support. This shows:

- 25.4% of residents are “low-need adults” but account for only 4.4% of spend.
- The multimorbid, high-complexity group represents 4.7% of the population but 26% of spend.
- The multimorbid, medium-complexity group makes up 14.8% of the population and 22.4% of spend.

This approach helps us work with our partners to target support by:

- Predicting who is at risk of deteriorating health.
- Identifying people not receiving optimal care, such as people who would benefit from a review of the medicines they are taking.
- Highlighting who would benefit from a managed care plan, including people living with frailty or nearing end of life.
- Focusing on residents in the most deprived areas who may be facing a range of challenges.
- Co-ordinating resources to have the most positive impact.

4.Outcome and value based contracting

In line with the principles outlined in our Five-Year Clinical and Strategic Commissioning Plan (see page 15), we have identified a set of commissioning and contracting approaches that will enable our transition toward a strategic commissioning approach centred on improving population health outcomes. These approaches are designed to support collaborative, long-term planning; incentivise outcome-focused delivery; and ensure that all commissioning activity remains compliant with national regulations, statutory responsibilities, and recognised best-practice guidance.

Neighbourhood Health is our key delivery vehicle to delivering the 10-year plan. As a commissioner we will develop a consistent framework from which neighbourhoods will be commissioned:

- An outcomes-based commissioning specification that will align with the Neighbourhood Health Framework expected to be published later this year.
- To coordinate proactive and preventative care and urgent and rehabilitative care locally in line with the population priorities identified through our Integrated Needs Assessment.
- Assess how, over time, we might delegate population-based budgets that would be underpinned by clear contractual documentation and expectations and use of financial levers to reflect delivery of key outcomes.

In line with the Provider Selection Regime (PSR), we will **work with partners to** support **market-development** activity that enables accountable care models and creates a more agile, stable care market.

Our priorities are:

- Maximising Alder Hey's role as an early Advanced Foundation Trust, improving outcomes for children and young people through an Integrated Health Organisation (IHO) and planning how we adopt the IHO contract model.
- Implementing lead-provider arrangements in mental health, with the lead subcontracting to capable partners.
- Strengthening provider collaboratives across NHS and VCFSE sectors and developing a Primary Care Collaborative to support neighbourhood delivery.
- We recognise this is a significant shift for commissioners and providers, requiring collective capability-building and realignment of system capacity.

Our plans for **service change** centre on developing neighbourhood health, with partners working to defined geographies and initially using the new Single/Multi Neighbourhood Provider contracts to support delivery at scale.

- NHS providers will realign services to neighbourhood footprints, ensuring consistent access to community care, diagnostics and specialist support.
- Commissioning will move to a single primary-care specification, based on integrated needs-assessment and neighbourhood population-health priorities.
- Provider collaboration will be strengthened through working to single service specifications, building on Modern Service Frameworks and agreed priorities with the ICB.
- We will only commission services able to meet national standards for access, quality, safety, outcomes and which are financially sustainable.

We will **shift resources from hospital to community** by commissioning neighbourhood health services based on allocative efficiency, in line with population need and to achieve equitable health outcomes.

- For 2026–27, we have identified a £29.6m transformation fund (with further growth in future years) to drive the "left shift" from hospital to community, analogue to digital, and sickness to prevention.
- This investment will support transitional periods where new models transform from existing services. It will be tied to demonstrable reductions in demand for elective and non-elective acute care and will require providers to deliver additional efficiencies so that core activity can be sustained within a reduced funding envelope.

5. Investing in the ‘left shift’ to provide neighbourhood health (1 of 2)

Our 5 Year Clinical and Strategic Commissioning Plan sets out priorities that will drive the 10-Year Plan shifts—from hospital to community, sickness to prevention, and analogue to digital—through a neighbourhood health model.

We have committed significant investment to support this, including a £29.6m transformation fund in 2026–27 (rising in future years) and additional to national Service Development Funding (SDF) and national funding allocations which support a number of areas already included in our plans, such as improved access to mental health services, capital developments, and the expansion of our digital capability.

Our approach focuses on integrating existing services and aligning current resources into new innovative models of care, building support around people, and will actively avoid creating parallel services that add complexity and cost to our system.

The investment areas opposite reflect our initial priorities—those identified through our integrated needs assessment as having the greatest potential to improve population health while reducing pressure and cost in the most challenged parts of the system.

In making these investments we will determine clearly the outcomes which will measure success and how we will ensure plans deliver their intended goals.

Creating integrated pathways with Primary, Community and Secondary Care Clinicians working together in a “multidisciplinary teams” model to support people to be cared for in their own home or neighbourhood, through:

- **Diagnose to Refer model:** holistic symptom assessment with rapid access to diagnostics through community diagnostic centres/local testing, reducing unnecessary urgent care and outpatient referrals. Initial pathways will focus on respiratory, CVD risk management and frailty.
- **Single Urgent Care Clinical Assessment Service:** a Cheshire & Merseyside-wide model with community and secondary care clinicians supporting people to receive care at home.
- **Community-based intermediate tier services:** focusing on high-volume elective specialties moving care into community settings/models (initially Gynaecology, Dermatology and ENT).

Our Population Health Improvement Plan includes further areas of “left shift” where we aren’t immediately planning to make additional investment but will work with partners to maximise existing assets within new care models, including:

- *Implementing 24/7 mental health neighbourhood crisis centres and community rehabilitation.*
- *Developing an intermediate urgent-care tier, including virtual wards and community beds (including step-up beds), to use existing capacity more efficiently.*

5. Investing in the “left shift” to provide neighbourhood health (2 of 2)

Investing in a consistent universal community services offer for our residents:

- In 2026–27, as part of developing a whole-system frailty offer, we will introduce a Home Assessment service for people who fall, including home-based diagnostics (e.g., X-ray) to avoid unnecessary hospital conveyance.
- We will implement single service specifications and tackle long waits for community services, with priorities including:
    - **Children and Young People:** speech and language therapy, physiotherapy, occupational therapy, community paediatrics and neurodiversity.
    - **Adults:** neurodiversity
- A consistent care-home MDT model (including wider primary-care input such as oral health).
- We will also invest in achieving a consistent end-of-life care model across Cheshire and Merseyside.

Using Population Health Management intelligence to proactively support those with greatest need in neighbourhoods:

- We will commission Neighbourhood Teams to use population-health-management tools to deliver proactive support and personalised care plans. Until national neighbourhood contracts are available, this will be commissioned through General Practice providers using a Local Enhanced Service (LES) with clear, measurable outcomes. This approach will give partners flexibility to use local assets including VCFSE organisations and NHS provider resources to implement the model.
- Commission a consistent Shared Care neighbourhood based prescribing service to reduce unnecessary outpatient attendances.

Supporting this:

- We will also commission system wide digital solutions to enable this and other community-based MDT models.
- Neighbourhood priorities will be intelligence-led and focus on key population groups - people with multimorbidity, long-term conditions (including CVD risk management and respiratory), frailty, and children and young people - to prevent escalation in care needs and reduce reliance on secondary care.
- This approach will align with, not duplicate, existing commissioning arrangement, including the national GP Contract.

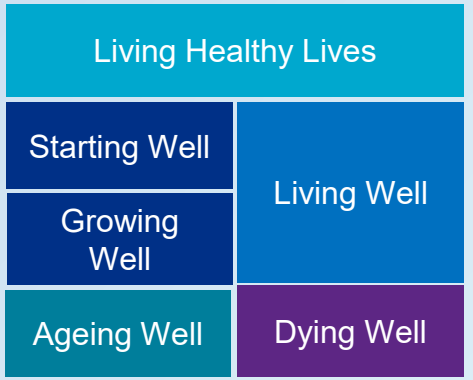
As referenced earlier it is recognised there are wide ranging opportunities for investment. Over the coming year, we will use the intelligence from our integrated needs assessment to work with partners to agree further priorities for future years as part of a longer-term investment strategy.

6. Assuring delivery and monitoring of our Plans

- As part of our new operating model, we will reflect revised and enhanced governance to oversee how we operate, and this will be reflected in our approach to delivery of the priorities in this plan.
  - Each Programme will have an Executive Senior Responsible Officer and Programme Lead who will be responsible for ensuring that plans will deliver against agreed objectives with clear measures of success and timescales.
  - As part of our revised operating model programmes will be assured through a consistent programme management approach, reporting delivery progress through either a new Strategic Commissioning Programme Board or, if appropriate, through another Board sub-committee and then as part of a single improvement plan to the ICB Board.
  - Monitoring of progress against delivery will use strategic trackers of our key priority milestones, metrics and measures (based on outcomes wherever possible) through Board Sub Committees and through a monthly Integrated Performance Report (IPR) to Board.

See Page 64 for a summary of programme governance and executive accountability for each work programme.

The PHIP is built around our key priorities and follows a life course approach.



- Living Healthy Lives – Prevention and Proactive Care
- Neighbourhood Health
- Maternity and Neonatal Care
- Children and Young People
- Mental Health
- Neurodiversity and Autism
- Frailty and Falls
- Palliative & End of Life Care

7. What are the key risks to our plan?

Our Five-Year Clinical and Strategic Commissioning Plan and Population Health Improvement Plan have been developed to directly support addressing key risks identified by our Board.

NHS Cheshire and Merseyside has formally accepted 'enforcement undertakings' with NHS England. In response we have committed to delivering rapid improvement work to provide additional assurance in a number of key areas – including financial planning, quality (with particular regard to mental health), leadership and governance.

The service and delivery requirements included in the national planning guidance, alongside local commissioning priorities, may be challenging to achieve given the current financial, performance and capacity context and as such need to be prioritised.

Delivery of the requested reduction in the running cost allocation may have a significant impact on the ICB's ability to deliver against our commissioning intentions. This will become clearer as we begin to understand the details of the revised operating models.

In embedding the new NHS operating model we will ensure that the ICB has the resources, skills, and abilities to deliver our role as strategic commissioner. It is recognised that the programme management resources we have to deliver our plan are limited, so we will target resources at the priorities in this plan. Progress will be closely monitored by our Executive Team and Board.

The intentions outlined in both plans will help mitigate these risks.

Board Assurance Framework:

- **Quality and Safety Failures in Commissioned Services:**
  Risk that services may not consistently deliver high-quality, safe, and equitable care, especially during the shift from hospital to community-based models.
- **Digital and Cyber Resilience Gaps:**
  Inadequate digital infrastructure, data sharing, and cybersecurity could disrupt care and hinder the transition to a digitally enabled NHS.
- **Failure to Reduce Health Inequalities and Improve Population Health:**
  Risk of not achieving measurable improvements for deprived and vulnerable groups if resources and actions are not sufficiently targeted.
- **Financial Sustainability and Productivity Challenges:**
  Inability to meet mandated savings and productivity targets could limit investment in prevention and digital transformation, and breach statutory financial duties.
- **Failure to Recover Access and Performance Standards:**
  Risk of not meeting national standards for access and performance, undermining public confidence and exacerbating inequalities.
- **System Fragmentation and Provider Sustainability:**
  Potential service loss or fragmentation if provider landscape is not proactively managed during commissioning of integrated, digital-first services.
- **Failure to Deliver Shift to Neighbourhood and Community-Based Care:**
  Risk of insufficient investment, workforce capability, or collaboration to achieve the transition from hospital-centric models.
- **Workforce Capacity, Capability, and Morale:**
  Organisational redesign and headcount reductions may destabilise morale and impede delivery of transformation priorities.

NHS
Cheshire and Merseyside

8. Living Healthy Lives

- Cancer
- Cardiovascular disease / renal metabolic
- Diabetes
- Respiratory
- Health protection
- Neighbourhood Health
- Neighbourhood health / Community Services
- Routine Immunisations
- Oral Health
- Serious Violence duty
- Smoking cessation
- Weight Management

Cancer – prevention and early intervention (Inc. Lung Health Checks)

Case for Change: Cancer is a leading cause of mortality in Cheshire and Merseyside, with around 7,000 deaths per year. Whilst early diagnosis and cancer survival rates have improved in recent years, cancer incidence and mortality rates remain higher than the national average.

Health Inequalities: Each percentage point improvement in early diagnosis rates delivers 731 years additional life expectancy and 454 healthy life years/Quality-Adjusted Life Years (QuALYs) per year. Individuals from deprived communities are disproportionately impacted by cancer. Consistent achievement of the constitutional waiting times for cancer will ensure all patients have equity of access to timely diagnosis and treatment which improves outcomes, especially in fast-progressing cancers. In addition to this, the HPV vaccination programme aims to reduce the incidence of cervical cancer. The NHS aims to eliminate cervical cancer by 2040, emphasising the vaccine's role in preventing HPV-related cancers in both sexes.

Financial: Improved prevention, early diagnosis and successful treatment of cancer has a direct positive impact on the health economy. Each percentage point improvement in early diagnosis rates delivers over £2.3m saving to the NHS in Cheshire and Merseyside and £5.6m benefit to the local economy.

Other Services: Early-stage cancers require less complex, less intensive diagnostics, treatments and aftercare. However, to detect more cancers early requires an increase in routine diagnostic tests and surveillance programmes. Sufficient diagnostic and treatment capacity will be required to achieve and maintain cancer waiting times.

*Medium Term Planning Framework (metric/measure or narrative)

We will: Reduce lives lost from cancer - Increasing the proportion of cancers diagnosed at an early stage and Improve five-year cancer survival rates - Reduce lives lost to cancer by improving the early detection of cancer and reduce cancer-related mortality pertaining to Breast, Bowel and Cervical

Our ambitions are:

- Increase the proportion of cancers diagnosed at an early stage by 3% points each year in line with CMCA ambitions
- Reduce the gap in rates of early diagnosis between the most and least deprived neighbourhoods
- Eliminate Cervical Cancer by 2040

2026-27 – Priorities

- Improve HPV vaccination rates (26-28)
- Introduce lung cancer screening to Cheshire, completing 100% coverage.
- Raise awareness of the lifestyle risk factors for cancer and the symptoms of cancer and improve uptake of cancer screening programmes through targeted campaigns and engagement in partnership with VCSFE organisations. focussing on those communities in IMD 1 and 2.
- Implement changes to the bowel cancer screening programme (FIT@80).
- Undertake a strategic review of robotic-assisted surgery.
- Optimise treatment outcomes through prehabilitation and rehabilitation.
- Develop and implement guidance for frailty assessment and management for patients with suspected and diagnosed cancer from initial presentation through to end of life.
- Improve urgent cancer care in line with CMCA's five-year urgent care strategy.
- Reduce the gap in rates of early diagnosis between the most and least deprived areas
- Continue to work with NHSE and partner ICBs on development of NW OPIC ahead of Section 7a commissioning transfer in 2027*
- Support changes to Cervical screening Programme, i.e. self-sampling

2027-28 – Priorities

- Work with system partners to reduce environmental risk factors for cancer.
- Transition lung cancer screening programme into two-year rolling programme for eligible population 2027-31
- Introduce a targeted triage tool to identify early-stage cancers in individuals who have never smoked.
- Implement changes to the cervical cancer screening programme.
- Improve identification of individuals at higher risk of cancer and optimise surveillance programmes 2026-28
- Reduce the proportion of cancers diagnosed in emergency settings, focusing on rarer cancers that cannot be staged.
- Implement the outputs of the review of robotic-assisted surgery.
- Using national and local clinical audits, identify and reduce variations in treatment outcomes.
- Improve urgent cancer care in line with CMCA's five-year strategy.
- Introduce patient-reported outcome measures (PROMs).
- Commission more flexible models of screening delivery

2028-31 – Priorities

- Maintain progress in line with the national cancer plan.
- Support patients living with and beyond cancer in the most appropriate setting (at neighbourhood level where possible).
- Strengthen screening workforce and provider resilience and scalability where it makes sense to do so

Key Metrics and Measures

- Reduce the incidence of preventable cancers by 3% by 2031*.
- Increase the proportion of cancers diagnosed at an early stage by 3% points each year*.
- Reduce the number of late-stage diagnoses (age-standardised rate per 100,000 to reduce from approximately 210 to 200, equivalent to 5%, by 2030)*.
- Improve treatment outcomes (improve five-year cancer survival by at least 1% point per year)*.
- Reduce health inequalities*.
- Improved HPV vaccination rates
- Improved screening uptake in all programmes by deprivation quintile

2026-27 – Priorities

- Introduce Single Queue Diagnostics for specialist investigations to create equity of access, choice and to achieve shorter average waiting times.
- Fully optimise MDT to improve timeliness of treatment.
- Deliver system pathway approach for skin, lung and gynae pathways, sharing resource where possible, building resilience and adopting best practice.
- Utilise AI and RPA to reduce administrative burden, improve efficiency and reduce errors.
- Expand care pathways which are straight to test (STT) to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers*.
- Optimise workforce to ensure roles are continually developed, staff are able to work at the 'top of their licence' to exploit capacity with shared and mobile workforce models to allow scarce workforce resource to operate across organisations.
- Improve visibility and access to data and intelligence to drive improvement through an intelligence strategy.
- Maintain a clear focus on cancer waiting times via a dedicated cancer performance forum and managed collaborative improvement plans and trajectories.
- Develop use of CDCs to increase diagnostic capacity and to support the spread of one-stop service models.
- Develop an SOP for inter-provider transfers to support timely management from diagnostic to tertiary sites, including the development of service contract agreements to facilitate joint care models.

2027-28 – Priorities

- Expand Single Queue Diagnostics for specialist cancer investigations and high-impact non-specialist diagnostics to create greater equity of access, choice and to achieve shorter average waiting times.
- Continue to optimise and embed MDT to improve timeliness of treatment.
- Deliver a whole-system pathway approach for breast, LGI and urology pathways, sharing resource wherever possible, building resilience for seasonal impacts and adopting best practice from across England.
- Further development of AI and RPA for example in referral optimisation, diagnostic reporting and information transfer.
- Continue to expand care pathways for cancer which are STT models to expedite access to diagnostics and target the non-cancer component of FDS, leading to increased focus on high-risk and diagnosed cancers.
- Continue to Optimise the cancer workforce and the development of shared and mobile workforce models to allow scarce workforce resource to operate across organisations.

2028-31 – Priorities

- Maintain progress in line with the national cancer plan (due to be published in 2026).

Key Metrics and Measures

- Maintain performance against the 28-day cancer Faster Diagnosis Standard at the new threshold of 80%*.
- Achieve 80% performance against the 62-day cancer waiting times standard by March 2027, and 85% by March 2029*.
- Maintain performance against the 31-day cancer waiting times standard at 94% or above, rising to 96% by March 2029*.

*Medium Term Planning Framework (metric/measure or narrative).

CVD-RM secondary prevention

The Case for Change: CVD is the leading cause of morbidity, disability, mortality, and health inequalities in England with inequalities across the pathway from prevention to treatment. It causes around a quarter of all deaths in the UK.

Risk factors for CVD are more prevalent in Cheshire and Merseyside with high blood pressure the leading risk factor. Improving both the identification, treatment and management of atrial fibrillation, high blood pressure and cholesterol (ABC) would have a positive impact on economic productivity, prevent premature mortality and improve the quality of life for individuals and families.

Impact on Health Inequalities: CVD is among the largest contributors to health inequalities in life expectancy, accounting for one-fifth of the life expectancy gap between the most and least deprived communities. People living in our most deprived communities are four times more likely to die prematurely.

Financial and impact on services: If Cheshire and Merseyside met the 80% blood pressure treatment target ambition, we could prevent 337 heart attacks, saving £3.7m; prevent 502 strokes, saving £8.9m; and prevent 269 deaths in the next 3 years.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Improve the cardiovascular health of the population by optimising the identification and treatment of those with Atrial Fibrillation, high Blood Pressure (hypertension) and high Cholesterol (ABC)

Our ambitions are:

- Target of a 25% reduction in CVD related premature mortality over the next 10 years
- Systematically scale up CVD prevention in primary care focussing initially on those practices furthest away from target

2026-27 – Priorities

- Continue to develop evidence-based support for primary care enabling them to proactively identify, monitor and treat high-risk individuals with ABC risk factors at scale, initially targeting practices that are both lowest performers and experience greatest health inequalities.
- Develop a robust response to the CVD Modern Service framework.
- As a CVD Prevention Accelerator site we will work with our partners to test new community-led delivery models for secondary prevention.
- Develop an implementation plan in response to the lipid management mapping exercise including considerations re: lp(a) testing?
- A whole system approach to prevention, strengthening efforts to reduce smoking prevalence and obesity; working with partners in local government and VCSFE to ensure that referrals into pathways reference the impact on CVD.
- Work with North West Kidney Network to support identification of Chronic Kidney Disease (CKD) and optimisation of treatment.

2027-28 – Priorities

- Rollout of tools to support primary care and systematically work through practice/ PCNs targeting those with greatest need with the ambition of having a named CVD lead in every practice/ PCN.
- Ensure reference to CVD Prevention in any C&M wide Locally Enhanced Service specification for primary care and consider enhanced payments for results with communities at highest risk of CVD.
- Continued expansion of Prevention Accelerator work completed to establish appropriate outcomes/ metrics.

2028-31 – Priorities

- Continued rollout of 2027/28 priorities.
- Supporting the target of a 25% reduction in CVD-related premature mortality over the next 10 years, including testing the NHS Health Check online service*.

Key Metrics and Measures

26-27

- Increase in identification and treatment of ABC

26-28

- Prevention Accelerator outcomes and measures
- Yearly improvement and increase in identification and treatment of ABC

28-31

- Reduction in referrals to secondary care lipid services due to optimisation in primary care

CVD-RM - Diabetes

Case for Change: Diabetes is a major public health problem with diagnoses in the UK having risen from 1.4 million to 3.9 million since 1996. One in ten people over 40 now has type 2 diabetes. Core to Children and Young People (CYP) 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 /Diabetes Prevention Programme (NDPP).

Inequalities: Managing patients' health will likely reduce emergency admissions, reducing morbidity and mortality and delays in CVD events and extends life expectancy and support groups who are more at risk of disproportionately adverse outcomes. People with higher risks should be proactively identified and offered screening in accordance with NICE guidance, including people from high-risk groups.

Financial: The NDPP is a nationally funded programme. Reduction in diabetes will reduce treatment and social care costs. Maintaining control of diabetes will reduce the burden of disease reducing emergency hospital episodes. Medicines optimisation will reduce overall costs with an initial increase in prescribing costs i.e., use of best value SGLT2i treatments and appropriate and best value CGM and other treatments to offset costs.

Other Services: preventing and treating diabetes will reduce demand on primary and secondary care. The demand on social care and treatment costs in the longer term will reduce. People are more likely to remain without diabetes complications for longer, which will prevent the development of cardiovascular, stoke and myocardial infarction disease conditions.

*Medium Term Planning Framework (metric/measure or narrative)

We Will: Slow down the year-on-year incidence 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.

Our ambitions are:

- Targeted case finding to identify people at high risk of developing type 2 diabetes (National Diabetes Prevention Programme NDPP)
- Optimising proactive management, targeting those at risk

2026-27 – Priorities

- Increase the proportion of people with NDH who had a glycaemic test in the previous 12 months.
- Increase the proportion of people with NDH who have been referred to the NDPP. Including gestational diabetes.
- Increasing the proportion of patients whose last HbA1c record is 42 - 47mmol/mol (at high risk of NDH), without a GP record of non-diabetic hyperglycaemia or diabetes mellitus.
- Improving care and outcomes for Children and Young adults with type 2 Diabetes and variation through GIRFT action plans.
- Improving care for those transitioning from Paediatrics to adult care and addressing poorer outcomes through GIRFT action plans.

2027-28 – Priorities

- Increase the proportion of adults with diabetes receiving all 8 care processes in the preceding 12 months, ensuring increased proportion in the most deprived groups.
- Increase the proportion of people with diabetes meeting all NICE 3 treatment targets.
- Utilise available commissioned places for eligible patients for the NHS T2D Path to Remission Programme.
- Increasing the proportion of people with type 2 diabetes prescribed an SGLT2i except those patients with frailty/other more susceptible groups*.
- Increase the proportion of people with diabetes who are eligible for CGM or Hybrid Closed Loop who are prescribed this technology. Targeting susceptible ethnic groups and more deprived groups, including pregnancy.
- Increase the rate of referral and attendance of structured education programmes for T1 and T2 diabetes.

2028-31 – Priorities

- Tackling diabetes related foot disease and retinal health could be brought into plans.

Key Metrics and Measures 27-28 and beyond

- Maintain a year-on-year increase in the number of patients identified for being eligible for NDPP and an increase in the number of eligible patients referred into the NDPP programme.
- Year-on-year increase in the identification, utilisation or referral, with a focus on hard-to-reach groups.
- Year-to-year increase in the identification, utilisation or referral.
- number of people receiving diabetes care processes.
- Major foot amputation rates / surveillance of foot disease.
- Surveillance of retinal screening / retinal screening rate (this is the ninth diabetes Care Process.

Respiratory Disease

Case for Change: Respiratory disease is a leading cause of death and emergency hospital admissions in Cheshire and Merseyside.

Impact:

Inequalities: Prevalence of respiratory diseases, such as COPD and Asthma, is higher among those living in our most deprived communities and inclusion health groups, such as substance misusers.

Financial: Emergency hospital admissions for Asthma, COPD and LRTI cost £33.7 million in Cheshire and Merseyside in 2024/25.

Other Services: Respiratory disease impacts on economic productivity through lost productivity, missed workdays and early retirement. Children with Asthma often miss school frequently, leading to educational setbacks and the need for additional support.

We Will: - Improve outcomes for all patients living with respiratory disease:

- Reduce the rate of emergency hospital admissions for respiratory disease
- Increase the proportion and quality of respiratory disease reviews
- Reduce the prevalence of smoking among those with a respiratory disease diagnosis

2026-27 – Priorities

- Every patient with Asthma or COPD to have a high-quality face-to-face annual review in primary care delivered by an adequately trained practitioner.
- GP practices should review patients based upon agreed risk stratification tools- patients with the greatest need are reviewed at the earliest opportunity.
- All Asthma and COPD patients should have a confirmatory diagnostic test recorded in their primary care record.
- Systems established to maximise people receiving annual flu vaccinations.
- Ongoing smoking should be addressed at every clinical interaction, and Ottawa model tobacco dependency treatments provided at every hospital.
- People with COPD who would benefit from pulmonary rehabilitation should receive this within national timelines.

Key Metrics and Measures

- Inc. the % of face-to-face COPD and Asthma annual reviews in primary care.
- Increase the % of patients with Asthma with a FeNO recorded.
- Increase the % of patients with COPD with spirometry recorded.
- Increase the %of patients with COPD receiving the influenza vaccination.

2027-28 – Priorities

- Primary care practitioners conducting respiratory annual reviews should be trained adequately in line with PCRS ‘Fit to Care’ document.
- Neighbourhoods should case-find COPD amongst high-risk patients, linking in with the Targeted Lung Health Programme.
- Patients with Asthma and COPD who live in cold and fuel-inefficient homes should be referred to appropriate services.
- Implementation of asthma guidance, reducing SABA monotherapy and use of appropriate inhalers in COPD and asthma.

Key Metrics and Measures

- Increase the percentage of practitioners performing annual respiratory reviews who have appropriate qualifications.
- Increase in the number of patients with COPD in C&M.
- Increase in the number of patients assessed for fuel poverty.

2028-31 – Priorities

- Respiratory services should integrate primary, community and secondary care on a neighbourhood footprint.
- Pulmonary rehabilitation teams should proactively case-find people who would benefit from Pulmonary Rehabilitation.

Key Metrics and Measures

- Respiratory outpatient transformation.
- Increased number of patients completing Pulmonary rehabilitation.

Health Protection incl. BBV, TB, HCAIs and Outbreak Management

The Case for Change: ICBs have a statutory duty under the Health and Social Care Act 2022 to plan and coordinate the NHS response to infectious disease outbreaks, ensuring service resilience, managing resources and collaborating with public health bodies for population health protection.

Healthcare-acquired infections continue to exceed national targets, although there have been improvements in C.Diff. Significant community outbreaks in the past 12 months include: Measles, Respiratory disease in care homes, Avian Influenza, Tuberculosis, Meningococcal and Hepatitis A.

We will work with partners to support strategies which focus on eliminating Blood Borne Viruses and Tuberculosis.

Impact on Health Inequalities: As detailed in: Health inequalities in health protection report 2025 - GOV.UK Health inequalities in health protection have a high human cost across people and Place. In England, those living in the 20% most deprived areas bear the greatest burden, with emergency hospital admission rates due to infectious disease almost twice as high as those in the least deprived.

Financial and impact on services: Whilst health protection matters have a high human cost across people and places, they have an impact on health services and economic productivity.

We Will: Reduce the number of people harmed by vaccine preventable disease, BBV, TB and HCAI

Our ambitions are:

- Achieve zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030
- 90% reduction in TB incidence by 2035
- To reduce the harms associated with outbreaks of infectious diseases

2026-27 – Priorities

- Continue to review against: Clinical response to local incidents and outbreaks of infectious disease: Commissioning guidance for ICBs agree a preferred delivery model and commission this in 2026/27.
- Support our LRC partners' ambition to become a HIV Fast Track Cities+ area by including viral hepatitis/TB.
- Consider TB service commissioning arrangements models to ensure future sustainability.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.
- Continued support for BBV testing in Emergency Departments programme.

Key Metrics and Measure

- Commissioning cycle for a clinical outbreak response service is complete.
- Increased vaccination rates across all programmes.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

2027-28 – Priorities

- Support mobilisation and/or contract management of outbreak management Provider(s).
- Ensure robust and sustainable commissioning arrangements are in place for TB services.
- Continue to work with Providers in relation to reducing rates of HCAIs and the harms associated with them.

Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Increase in identification of people in EDs with BBV who go onto a treatment plan.

2028-31 – Priorities

- Continue to review and strengthen ICB and wider system preparedness and responses to known and emerging health threats with key partners including UKHSA and Local Authorities.
- Contract management of outbreak management and TB service provider(s).

Key Metrics and Measure

- Improve vaccination uptake and coverage year on year across all eligible cohorts.
- Zero new HIV infections, zero AIDS-related deaths and zero new viral hepatitis infections by 2030.

Neighbourhood Health

The Case for Change: Integrated Neighbourhood Teams (INTs) will become the cornerstone of neighbourhood health delivery, replacing fragmented models with integrated, outcome-focused care. Providers will be expected to organise services around INT footprints rather than historic organisational boundaries. This will prioritise proactive support for residents with high and ongoing needs, ensure continuity of care, and embed collaboration.

The approach will help reduce unwarranted variation in access to GPs and unnecessary non-elective hospital care (inc. for people with frailty or at the end of their life).

Inequalities: We have an inconsistent approach to proactively supporting residents across neighbourhoods and Places, use of consistent risk stratification approaches allows us to proactively target support and those with greatest need and reduce inequality of access and care.

Financial: Through our risk stratification intelligence we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population.

Other Service: Unnecessary attendances/admissions in both planned and unplanned hospital-based services.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Improve outcomes in those areas highlighted in our Population Health Needs Assessment
Reduce the number of hospital non-elective admissions and associated total hospital bed days

2026-27 – Priorities

- Creating joined-up teams (across health and care) in each neighbourhood in line with Neighbourhood Health Framework*.
- Use CIPHA to risk-stratify patients most in need of support and continuity of care with General Practice and Neighbourhood Teams delivering care plans.
- Agree Neighbourhood Footprints: Define footprints that are meaningful to local people.
- Reduce variation in GP Access ·with recovery plans in place where needed*.
- Improving the Primary - Secondary Interface including improving access to diagnostics and specialist opinion.
- Implementing INTs with agreement on which patient groups (cohorts) to focus on.
- Implementing non-elective plans across multiple neighbourhoods with demonstrable impact on GP appointments, ED attendance and length of stay*.
- Implementing a Neighbourhood Outpatient Model of Care.

2027-28 – Priorities

- An expansion in the cohorts and numbers of patients supported by integrated neighbourhood teams.
- Transfer of service/workforce capacity into “out of hospital settings” to enable more planned and early intervention activity.
- Continue to focus on improving the quality and efficiency of all-age continuing care (AACC) services, addressing unwarranted variation and preparing for full transition to AACC Data Set v2.0 by March 2027*.

Key Metrics and Measures 2026-28

- Reduction in risk profile of our population (CIPHA).
- Reduction in unplanned admissions for chronic ambulatory care sensitive conditions.
- Reduction in emergency admissions due to falls in people aged 65+.

2028-31 – Priorities

- Continued expansion of the cohorts being supported and of the community-based services available with a reduction in hospital capacity in prioritised areas.

Key Metrics and Measures from 2026-28+

- Prioritised population health indictors show an improvement in health and wellbeing outcomes.

Neighbourhood Health – Community Services

The Case for Change: There are different models for community healthcare provision, and the providers delivering care don't always align to Place footprints, resulting in variation of care, access and outcomes and increased costs. In line with the NHS 10-Year Plan priority to move from Hospital to Community, ensuring sufficient capability is a core component of developing neighbourhood-based services and supporting a movement of clinical services from hospitals into community settings.

Our ambitions are improved outcomes and reductions in:

- Improve population health outcomes
- Emergency admissions (in line with cohorts identified in NHS Neighbourhood Health Framework
- Hospital length of stay and Delayed Transfers of Care will reduce

Impact on Health Inequalities: A consistent offer and access to services will enable earlier treatment, reduce inequalities and improve outcomes.

Financial: Through our risk stratification intelligence, we know that we spend disproportionate levels of activity on segments of our population in relation to those with multiple health conditions (high complexity – 26% cost to <5% of population and medium complexity >22.39% against <5% and for those identified as frail 7% for 1% of the population.

Other Services: Neighbourhood health models include a range of NHS, Local Authority and Community Partners, and effective models need a shared approach to support communities and prevent escalation of need, including use of hospital and specialist services.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Provide local community-based care that is personalised to meet individual need take a preventative and proactive approach to reduce the need for hospital-based care

2026-27 – Priorities

- Commission neighbourhood partnerships to reduce emergency admissions and other national priority metrics through use of population health management tools with investment targeted through a proportionate universalism approach.
- Implement standard specifications across community services (falls, community nursing, care homes and end of life care) develop specifications for the second phase priorities in 27-28*.
- Waiting list reduction to increase proportion seen within 18 weeks.
- Holistic model for CYP mental health and community services developed & implementation commences as part of C&M Provider Blueprint.

Key Metrics and Measures

- No patients waiting more than 52 weeks for an appointment & At least 78% of people seen in less than 18 weeks*.
- Reduction in emergency admissions against baseline.

2027-28 – Priorities

- Transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital admissions and outpatient activity.
- Implementation of standard specifications for second phase service specifications and develop timeline and third phase for implementation from 2028.
- Delegation of population budgets to "early adopters" and where all neighbourhood partners agree to contractual model.
- Implementation of holistic C&M model for CYP mental health and community services and development of outcomes-based ACO contract.

Key Metrics and Measure

- 79% of people seen in less than 18 weeks.
- Reduction in Emergency Admissions.

2028-31 – Priorities

- Year on year transfer of resources from hospital to community into neighbourhood health models reflective of neighbourhood progress in reducing hospital activity.
- Neighbourhood Partners to agree on their agreed contractual model and commencement of delegation of population budgets to agreed "lead" provider*.
- CYP IHO model (or similar) for programme budget against agreed outcome measures.

Key Metrics and Measure

- 80% of people will be seen in less than 18 weeks.
- Reduction in Emergency Admissions.

Routine immunisations

The Case for Change: Vaccination is one of the most effective ways of protecting ourselves and our children against ill health and death. However, if uptake decreases it's possible for diseases to quickly spread e.g. measles is starting to appear again even though the MMR vaccine is the best protection against this. Without improvements:

- Uptake will continue to fall
- Inequalities will widen
- Outbreaks of Vaccine preventable disease will become more frequent
- Pressure on the NHS will increase

We will commission vaccinations as consistent national programmes delivered locally, embedding equity, quality and safety, addressing unwarranted variation across our places.

Impact on Health Inequalities: Lower uptake persists for::
- Those from the most deprived quintiles
- Some ethnic minority, migrant & transient populations
- Children missing school & those not registered with a GP

Financial and impact on services: Vaccination remains one of the most cost-effective public health interventions. Besides the cost to individuals and their communities, preventing outbreaks reduces pressure on:

- NHS activity including UEC
- Costs associated with outbreak management

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Reduce the incidence and associated morbidity and mortality of vaccine preventable disease.

Our ambitions are:
- Reduction in respiratory-related emergency hospital admissions
- Reduction in paediatric ICU admissions associated with vaccine preventable illness
- Commit to achieving and sustaining ≥95% coverage for MMR vaccination to eliminate measles

2026-27 – Priorities

- Continue to work with NHSE and partner ICBs regarding development of NW OPIC ahead of Section 7a commissioning transfer in 2027.
- Develop robust systemwide plans to increase uptake in all routine vaccination programmes with a focus on:
  - those in Quintile 1 & 2
  - clinical at-risk groups
  - Pregnant cohort
  - Health Care Workers
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs*.

2027-28 – Priorities

- Commission more flexible delivery models, e.g. mobile services, extended access.
- Increase the number of vaccines that can be administered in Community pharmacy*.
- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Strengthen vaccinator workforce
- Strengthen provider resilience and scalability.

2028-31 – Priorities

- Continue to deliver a C&M response to the national vaccination strategy in collaboration with our key partners including LAs.
- Continued focus on strengthening vaccinator workforce and provider resilience and scalability.

Key Metrics and Measures

- Improve uptake and coverage year on year across all eligible cohort.
- Improve equality of uptake and coverage in underserved and Core20PLUS populations.

Oral Health – All Together Smiling supervised toothbrushing programme

Case for Change:

Tooth extraction due to oral decay is the leading cause of hospital admissions for children aged five to nine in England despite it being largely preventable.

Impact:

Inequalities: Tooth decay disproportionately affects those living in our most deprived communities. Children in these areas are three times more likely to have decay than their more affluent peers. Poor oral health also affects children's ability to sleep, speak, socialise and participate in education.

Financial: The cost to the NHS for hospital admissions for decay-related extractions for children aged 0-19 was £50.9 million in 2021/22.

Governance route and Exec Lead:

The All Together Smiling Programme reports into the Beyond C&YP transformation programme board and the ICB Population Health Partnership.

Exec Lead – Executive Director of Health and Integrated Care Commissioning.

We Will: To ensure children and young people have the skills and equipment to brush their teeth

Our ambitions are:

- Increase the number of settings participating in supervised toothbrushing
- Increase the number of children participating in supervised toothbrushing
- Increase the number of oral health packs distributed

2026-27 – Priorities

- Reach and maintain >50% setting participation in the programme as recommended within national evidence (46% achieved at Q3 25/26 end).
- Targeted distribution of oral health packs to: CORE20 General Dental Practices and Community Dental Services, CORE20 PLUS. communities, and CYP within specialist SEND settings/ alternate provisions.
- Enhance programme reach by piloting a universal offer for CYP within SEND settings (supervised toothbrushing [STB] and oral health packs) with a view to roll out in 26/27.

2027-28 – Priorities

- Continued programme alignment to Local Authority commissioned STB programmes, ensuring CORE20 groups remain the focus.

2028-31 – Priorities

- Longer-term commissioning intentions to support transition to business as usual in partnership with Health and Local Authority.

Key Metrics and Measures

- Number of eligible settings taking part in STB.
- Number of children participating.
- Number of oral health packs distributed.

Serious Violence Duty

Case for Change:

The ICB is a statutory partner in the Serious Violence Duty. The ICB plays a key role in the multiagency public health approach to tackling the drivers and impact of serious violence with a focus on prevention and early intervention.

Impact:

Inequalities: Violence disproportionally affects those living in our most deprived communities. We also know that violence against women and girls is a significant driver of gender-based health inequalities. Impacts include direct health burdens as well as impacts on education, employment and quality of life.

Financial: The cost of violence to the NHS in England is approximately £921 million, with a further £1 billion in costs associated with violence towards NHS staff.

Other Services: The impact on other services will include a reduction in the number of serious violence victims presenting to A&E, the number of serious violence victims being admitted to hospital and ultimately an overall reduction in the number of repeat victims of serious violence presenting to services.

We Will: Prevent and reduce serious violence across Cheshire & Merseyside

Our ambitions are:

- Increase NHS staff awareness of serious violence and their role in preventing it
- Reduce the number of serious violence victims presenting to A&E
- Reduce the number of serious violence victims being admitted to hospital
- Reduce the number of repeat victims of serious violence

2026-27 – Priorities

- Develop a plan for delivering training to all frontline staff on identifying risk of violence.
- Begin delivering training to the staff groups identified as the first priority cohort for training.
- Begin to establish referral pathways for frontline staff who identify at risk patients.

Key Metrics and Measures

- Number of staff trained in each NHS Trust.

2027-28 – Priorities

- Develop a population health academy training programme on how to use the C&M violence dashboard.
- Consider how the C&M violence dashboard can be developed to encompass additional NHS data.
- Identify a minimum dataset that clinicians within the NHS should be recording to support the development of violence-related data.

Key Metrics and Measures

- Number of staff trained in the population health academy from each NHS Trust.

2028-31 – Priorities

- Consider how preventing serious violence can be integrated into service specifications and NHS contracts.

Key Metrics and Measures

- Number of service specifications and contracts that include duties to reduce serious violence.

Smoking cessation (Opt out)

Case for Change: Smoking is the leading cause of preventable illness, premature death and health inequalities in Cheshire and Merseyside, creating significant pressure on health service demand and costs. The NHS can prevent smoking-related illness by identifying patients who access healthcare services and supporting them to access evidence-based treatment services.

Impact:

Inequalities: Smoking is the leading cause of health inequalities in C&M. Rates of smoking are significantly higher among those living in the most deprived communities and among men.

Financial: Smoking costs C&M £1.75 billion each year. The NHS in C&M incurs £75.9 million of these costs each year.

Other Services: Smoking has a negative impact on a range of services including social care (cost £598m per year, productivity £1.06bn per year)

Governance route and Exec Lead: Each provider requires a Senior Responsible Officer for this work. Progress should be reported to the All Together Smokefree Board and Population Health Partnership.

Exec lead - Executive Director of Health and Integrated Care Commissioning

*Medium Term Planning Framework (metric/measure or narrative)

We Will: Ensure all hospital patients who smoke are supported to access tobacco dependency treatment

Our ambitions are:

- 95% of patients have their smoking status assessed when in contact with hospital services
- 75% of patients who are identified as smokers are referred to community smoking cessation services as part of the opt-out pathway
- 60% of referred patients become a treated smoker
- 40% of patients who are a treated smoker quit at 28 days

2026-27 – Priorities

- Implement op-out across all surgical pathways.
- Consider how opt-out can be integrated into the all-new service specifications and existing NHS Trust contracts*.

Key Metrics and Measures

- By the end of 2027 75% of surgical patients who are smokers are referred to community stop smoking services.

2027-28 – Priorities

- Implement opt-out across all outpatient clinics*.

Key Metrics and Measures

- 75% of outpatient patients who are identified as smokers are referred to community stop smoking services.

2028-31 – Priorities

- Implement opt-out across all other hospital-based planned care.
- Implement opt-out in ED.
- Implement in any remaining hospital departments*.

Key Metrics and Measures

- 75% of planned care patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.
- 75% of ED patients who are identified as smokers are referred to community stop smoking services.
- 75% of patients (excluding inpatients) who are identified as smokers are referred to community stop smoking services.

Weight Management Services

Case for Change:

Unhealthy weight places a significant burden on the NHS in C&M. Currently there are a range of specialist weight management services funded by the ICB, but there are inconsistencies across geographical Places in terms of eligibility criteria, staffing models, capacity and access arrangements. To ensure we reduce inequalities and maximise.

Impact:

Inequalities: Overweight and obesity disproportionately affect those living in the most deprived communities. This then leads to poorer health outcomes in these groups due to obesity related health conditions. People from certain ethnic groups are also disproportionately affected by overweight and obesity and the associated health conditions. Obesity can then impact on mental health, the ability to work and participation in education for children and young people.

Financial: Overweight and obesity cost the NHS around £6.5 billion annually and this is projected to increase to £9 billion by 2050.

Other Services: Overweight and obesity can impact on a person's ability to be economically active.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure patients living with obesity can access specialist weight management services.

Our ambitions are:

- 60% of patients lose 5-10% of their body weight
- 75% of patients report an improved quality of life score
- 30% reduction in the prevalence of obesity related comorbidities in this patient cohort

2026-27 – Priorities

Establish a service improvement programme for weight management services across Cheshire and Merseyside that:

- Establishes a single service specification for tier 3 services across C&M (including a minimum dataset and management service dashboard to monitor activity and outcomes for these services).
- Continue work around GLP-1 weight management drugs and managing the pipeline of new drugs*.

Key Metrics and Measures

- Increase in the capacity of tier 3 weight management services.

2027-28 – Priorities

- Explore alternative operating models to maximise the capacity within tier 3 services in C&M.

Key Metrics and Measures

- Increase in referrals for weight management services.
- Increase in patients successfully completing tier 3 weight management interventions.

2028-31 – Priorities

- Implementation of identified alternative operating models.
- Contribute to the national target of 250,000 referrals to the NHS Digital Weight Management programme by Mar 2029*.

Key Metrics and Measures

- Increase in the number and proportion of patients losing weight.
- Reduce in the prevalence of obesity related comorbidities.

NHS
Cheshire and Merseyside

9. Starting Well

- Maternity and Neonatal Care

Maternity and Neonatal Services:

Case for Change: Maternity and neonatal services are facing increasing complexity with more women with co-morbidities, long-term conditions and wider socio-economic factors requiring enhanced care. In addition, there are ongoing workforce pressures, with recent Birthrate Plus reports identifying the need for additional resources to meet care requirements across 8 maternity units with a falling birth rate and national mandates for safety and improvement, which require significant financial resources. Limitations in digital and data capabilities continue to impact service efficiency and hinder effective monitoring. In line with the 10 Year Plan and national reports such as MBRRACE, address disparities in access and outcomes, particularly for women from deprived areas and majority communities, who face higher risks.

Improving services will deliver the following measurable benefits:

- Better health outcomes and patient experience
- Reduced inequalities across ethnicity and deprivation
- Enhanced workforce resilience and retention
- Lower long-term healthcare costs and improved productivity

Inequalities: By standardising best practice, protecting high-risk groups, enhancing access through culturally sensitive and personalised care, and preventing complications, this approach delivers measurable improvements in outcomes, patient experience, and long-term system sustainability.

Financial: Improving services can deliver significant cost savings and system efficiencies. Preventing complications reduces emergency and acute care costs, while avoiding birth injuries and preterm complications lowers long-term health and social care expenses.

Other Services: reduced demand on emergency and acute care by preventing complications, reducing unplanned interventions and neonatal intensive care admissions. Decreasing pressure on paediatric, mental health, and social care services by improving maternal and infant health outcomes.

**Medium Term Planning Framework (metric/measure or narrative).

We Will: Strengthen the quality and safety of local maternity and neonatal services

2026-27 – Priorities

- Implementation of ALL national best practice, safety initiatives and reviews*.
- Develop/implement a transformation plan, incorporating reviews, to ensure providers can sustain and deliver safe, high-quality care.
- Ensure the provision of high-quality patient information and support the implementation of initiatives to improve health literacy.
- Increase awareness of and support for ethnicity-related pregnancy risks with women of the global majority.
- Expand Enhanced Continuity of Carer for women with increased vulnerability and embed personalised care and support.
- Deliver population health improvements and access to neighbourhood health in line with the Maternity/Neonatal Equity Plan*.
- Commission Engagement & Maternity and Neonatal Voice Partnerships (MNVP).
- Commission clinical networks, i.e. Preterm Birth, Foetal Medicine and Maternal Medicine to deliver enhanced care for complex LTC & maternal health conditions in line with national guidance.

2027-28 – Priorities

- Support providers to deliver digital transformation that enables improvements in key areas of maternity care, including triage.
- Implement developments in community hub provision, including low-risk pregnancy triage pathways and postnatal care visits.
- Improve integration between maternity services, primary care, health visiting, mental health and voluntary/community sectors.
- Participate in the Perinatal Equity and Anti-Discrimination Programme to improve culture and practice and implement the Maternity Outcomes Signal System*.

2028-31 – Priorities

- Transform maternity services, through expanding access to community based antenatal and postnatal care, ensuring high quality maternity care for all women and babies, regardless of setting.
- Commission a sustainable maternity workforce, strengthening resilience and retention and the capacity to deliver safe, high quality maternity care.

Key Metrics and Measures 26-27

- Reduced stillbirths, preterm births, maternal and neonatal deaths, maternal morbidity, and brain injuries.
- Improved experiences of care across antenatal, intrapartum and postnatal care.

27-28 See 26-27 metrics plus –

- Reduced harm in maternity and neonatal services by 50% by 31st March 2028.

NHS
Cheshire and Merseyside

10. Growing Well

Children and Young People

- Population Health and Joint Commissioning
- Neighbourhood Health and Accountable Care
- Corporate Parenting
- Mental Health
- Neurodiversity

Children and Young People - Population Health and Joint Commissioning

Case for Change: Around 25% of the population is under 19. Some Children and Young People in Cheshire and Merseyside do not "Start Well", and this translates into poorer outcomes. As examples:

- In C&M we see higher than England averages in the percentage of 5-year-olds with visually obvious dental decay.
- 24.0% of year 6 children in C&M were obese compared with the England average of 22.7%, with one area in the sub-region as high as 30.7%.
- In C&M there are higher than England averages for teenage conceptions, hospital admissions for asthma and mental health conditions among under-18s.

Inequalities: In our subregion we have 100,300 children living in poverty. This amounts to 22.3% of all children and young people, which is higher than the national average of 19.8% and is reflected in the poorer outcomes.

Financial: The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

Other Services: There is a significant opportunity to improve the consistency of services and outcomes across Cheshire and Merseyside through a more holistic model of community and mental health services, as well as developing a service chain model for hospital-based services with an aspiration to create an integrated health organisation (IHO) approach to oversee the health budget for the CYP population. See next slide:

*Medium Term Planning Framework (metric/measure or narrative).

We will: Improve access and outcomes through a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services

2026-27 – Priorities

- Reduce variation in commissioning by aligning with the Families First Model and standardising. multi-agency safeguarding, family hubs and Multi-Agency Child Protection Teams.
- Implement the Sexual Safety in Health Care Charter and Domestic Abuse Policy.
- Pathway improvements to respiratory care in line with the asthma bundle of care including SABA overuse and appropriate inhalers.
- Planning for continuation of Complications in Excess Weight Clinic*.
- Continued delivery of All Together Smiling programme (see Oral Health).

2027-28 – Priorities

- Implement the key requirements of the Children's Wellbeing and Schools Bill including our system response to our corporate parenting role.
- Continuation of programmes on asthma, healthy weight and oral health.

Key Metrics and Measures 2026-28

- Reduction in the number of CYP attending A&E due to asthma exacerbations.
- All Together Smiling delivered to a minimum of 50 per cent of early years settings in Core 20 communities.

2028-31 – Priorities

- Implement outcomes of CYP Urgent and Emergency Care Review.

Key Metrics and Measures

- Progress against key national constitutional and international standards.
- Specific population health and wellbeing priorities will be developed based on local population priorities in neighbourhoods.

Children and Young People – Neighbourhood Health and reducing waiting times

Services for children and young people can feel disconnected, with multiple providers and pathways that are hard to navigate. NHS Cheshire and Merseyside is planning to strategically commission an Integrated Health Organisation (IHO) model to transform services for children and young people. This approach aims to deliver a holistic, joined-up system that brings together our partnerships and community, mental health, hospital, and tertiary services which will complement the expected publication of a national Modern Service Framework for Children and Young People.

Benefits:
The accountable care approach will enable our neighbourhood health model and provide a range of benefits to our children and young people and their families:

- **Coordinated and Seamless Care:** Health and social care professionals will work together, sharing information across GPs, specialists, social care, and voluntary organisations to provide an integrated experience.
- **Proactive and Preventative Focus:** Early identification and intervention will help address health concerns before they become serious, reducing the need for specialist care.
- **Improved Health Outcomes and Reduced Inequalities:** By adopting a population health approach, the IHO will work with partners to tackle wider determinants of health – such as housing, education, and employment – ensuring targeted support for those with the greatest need.
- **Personalised Care**: Each child or young person will have a care plan tailored to their specific needs, preferences, and goals, ensuring a truly person-centred approach.
- **Enhanced Access to Services:** Integrated neighbourhood teams will make it easier to access community and mental health support closer to home, reducing reliance on specialist or emergency services.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Commission a holistic, joined-up system for our children and young people that brings together our partnerships and community, mental health, hospital, and tertiary services

2026-27 – Priorities

- Commission a hosted secondary and tertiary care provider model.
- A single elective waiting list (PTL) with priority on reducing ENT and dental waits.
- A single point of access, including a digital front door.
- Co-design and implement a holistic model for universal community, mental health and neurodevelopmental services, improving access to community paediatrics including ADHD, speech and language, physio and occupational Therapies, and paediatric audiology in line with national standards.
- Establish an MDT in at least one neighbourhood in each Place.
- Develop a Strategy to improve outcomes, reduce inequalities and optimise resources, strengthening collaboration across partners and aligning with national opportunities*.

Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.

2027-28 – Priorities

- Commission secondary/tertiary care services from a Children's Lead provider.
- Commission community and mental health services in line with holistic model.
- Review of C&M wide CYP Urgent and Emergency Care Services and development of a case for change.
- Review of different MDT frameworks and develop outcomes monitoring framework.
- Implement the Paediatric Early Warning System (PEWS) by April 2027 for hospitals with a paediatric inpatient setting, and by April 2028 for all other hospitals*.

Key Metrics and Measures

- Reduction in waiting times in community services and for elective care.
- Reduction in A&E attendances and admissions for urgent care.

2028-31 – Priorities

- Commission community, mental health, secondary and tertiary care services from an Accountable Care Organisation.
- Implement outcomes of CYP Urgent and Emergency Care Review.
- Development of a consistent MDT framework with funding transitioning into neighbourhoods to reflect need. Each neighbourhood will have embedded delivery of CYP MDTs across a range of needs.
- Develop ringfenced CYP capacity using existing NHS estate by running regular dedicated paediatric surgery days in either a day surgery or hub setting, with an aim to increase CYP activity delivered through surgical hubs*.

Key Metrics and Measures

- Further reduction in A&E attendances and admissions for urgent care.
- Specific population health and wellbeing priorities will be developed based on local population priorities in neighbourhoods.

Children and Young People – Corporate parenting

Case for Change: The number of children in care in the UK has doubled over the past 10 years. In C&M there are circa 7,200 children currently in care. The Education and Wellbeing in Schools Bill legislates the role of corporate parent for the ICB/NHS. We will work with partners regarding our corporate parenting duties, including initial health assessments for Children in Care. We need to ensure we can evidence compliance with the United Nations Convention on the Rights of the Child. In addition, we need to focus on meaningful employment and pathways through the care leavers covenant.

Impact:

- Expanded Corporate Parenting duty to the NHS
- Introduction of a Single Unique Identifier (SUI) for children intended to be their existing NHS number
- Young people leaving care to have access to free prescriptions, dental and eyecare services up to age 25
- NHS guaranteed interview scheme and paid internships to break down barriers to opportunity

Inequalities: Most children become “looked after” due to various forms of traumatic events, abuse and/or neglect, they may have the same health issues as their peers, the extent of these is often greater because of their past experiences, an estimated half of CECYP have a diagnosable mental health disorder and two-thirds with special educational needs More than one quarter of those leaving care are not told how to get help with their physical health, including registering with a GP or dentist.

Financial: The cost of the poorer outcomes is not just personal to the children and their families but also costs the health and care system and economy.

Other Services: There is a significant opportunity to improve the consistency of services and outcomes through an integrated lens with both ICS and integrated health and care systems.

Outcome: "Would this be good enough for my child?”

Our ambitions are:

- To develop an integrated system approach to improving the experience and health outcomes of
- Care Experienced Children and Young People (CECYP) within Cheshire and Merseyside

2026-27 – Priorities

- Clarify the ICB offer regarding corporate parenting duties in line with the proposed.
- Develop ICS response to the corporate parenting role
- Develop an ICS approach to Initial Health Assessments for Children in Care (CiC) (including workforce review of current approach, commissioning intentions and development of integrated dashboards).
- C&M baseline audit of IHA processes, timelines, and outcomes.
- Updated training model and resources for social workers and health professionals.

Key Metrics and Measures

- Baseline understanding of Place level offers.
- Promote care experienced as protected characteristic in local policy and practice.
- C&M Corporate parenting workplan (ICB and LA).

2027-28 – Priorities

- Collaborate with Regional Improvement Partnership to develop an integrated C&M IHA performance dashboard CECYP led revision of current IHA process ensuring Voice of the child is clear and informs future commissioning practice.
- Scale work under the Care Leavers Covenant building capacity seek additional funding opportunities.
- Work with Edge Hill University and CWP to develop a set of NHS corporate parenting principles based on lived experience.
- Workforce model redesign to address surge capacity and CECYP access needs.
- Scope where possible integrated/ pooled funds to managing all applications for IHA.

Key Metrics and Measures

- Dashboard design and development.
- I-Support auditing / pilot / implementation.
- Full implementation of C&M model and service.
- Care leavers covenant in place with positive outcomes.

2028-31 – Priorities

- Develop a standardised regional IHA pathway (referral, assessment, follow-up, info sharing).
- Implement digital solutions for referral/tracking and data sharing.
- Remove disparities and standardise entitlements and processes.
- Ensure access to CAMHS, dental, and expedited NHS pathways.
- Ensure all CiC and CECYP have access to support for their Emotional wellbeing and mental health.
- Scale work under the Care Leavers Covenant and build capacity across the system, seek additional funding for growth.
- Support work for transitions into employment for care leavers, CECYP implementing employability offer.
- Targeted work with virtual schools & NEET for into training and apprenticeships.

Key Metrics and Measures

- Launch and implementation of integrated performance dashboard.
- Review and modernisation of workforce model.
- Publish collaboration with Edge Hill.

Children and Young People – Mental Health

Case for Change: At any one time, 1 in 5 children and young people have a diagnosable mental health problem. Most adult mental health illness can be traced back to childhood. The Ten-Year Plan recognises the importance of early intervention and community-based support for children and young people with mental health needs. It also recognises that, when specialist help is need, it should be available in a timely manner to avoid escalation to more expensive interventions.

Inequalities: There is evidence that appropriate mental health support in childhood and adolescence improves life expectancy, outcomes and experience.

Financial: reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services. Maintaining children and young people in their own homes, with access to good education and social support opportunities will improve their ability to move into employment in adult life.

Other Services: Opportunity to reduce unnecessary attendances at EDs due to breakdowns in care. Enhance Special Educational Needs and Disabilities (SEND) support. Reduce admissions to CAMHS inpatient beds.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Widen access to services closer to home, reduced unnecessary delays and the delivery of mental health care based on a clear understanding of the needs of children and young people. Our ambitions are :

- All children and young people have timely access to mental health support appropriate for their needs.
- All schools and colleges in Cheshire and Merseyside to have access to a Mental Health Support Team (MHST)
- Admissions to Child and Adolescent Mental Health Services (CAMHS) inpatient beds and crisis attendances at Emergency Departments (EDs) are reduced.

2026-27 – Priorities

- Implement refreshed 1-year CYP MH Strategy for 2026/27 and develop future strategy.
- Mobilise waves 15 and 16 of MHST's in schools and colleges.
- Strengthen inclusive mental health pathways so that children and young people with neurodiversity, learning disabilities and autism can access the right support at the right time, aligned with SEND reform.
- Develop alternatives to CAMHS inpatient admission and ED attendance (Appropriate Places of Care).
- Ensure that the mental health needs of children and young people are considered in the Neighbourhood Health model and in the roll out of Young Futures hubs.

Key Metrics and Measures

- 77% coverage of MHST's and teams in training by March 2027*.
- Reduce long waiting times for access community mental health.
- Increase number of direct/indirect contacts per whole time equivalent practitioner.

2027-28 – Priorities

- Implement refreshed MH Strategy
- Mobilise waves 17&18 of MHST's in schools and colleges.
- Continue to improve access, reduce waits, expand early help and strengthen prevention.
- Increase consistent use of clinical outcomes and patient/carer-reported measures to inform improvements.
- Develop integrated 16–25 pathways that support transition, continuity and preparation for adulthood.
- Embed best practice Eating Disorder model, including ARFID pathway.
- Reduce avoidable attendances and inpatient admissions with safe, timely, community alternatives to crisis care.
- Strengthen early identification and intervention for 0-5's focusing on attachment and early development.

Key Metrics and Measures

- 94% coverage of MHST's and teams in training*.
- Increase the % of CYP receiving first contact within 6/12/18 weeks.
- % CYP mental health episodes with a paired outcome measure recorded.

2028-31 – Priorities

- Mobilise waves 19 to 21 to ensure full coverage of MH support teams.
- Create an integrated MH pathway that is easy to navigate, reduces. fragmentation, and supports CYP at the right level, at the right time.
- Use digital tools and data to enable proactive, needs-led identification, navigation and delivery of MH support through blended models of care.
- Reduce self-harm and suicide risk through a whole-system approach to prevention and crisis response.
- Build strong lifelong foundations through joined-up perinatal, infant and family mental health support (0–5).
- Address inequalities by ensuring mental health support is equitable, culturally responsive and proportionate*.

Key Metrics and Measures

- 100% coverage of MHST's in training by March 2029*.
- Reduction in CYP emergency department attendances for self-harm.
- Improved uptake of support among families in deprived communities and those under-served by services.

Children and Young People – Neurodiversity

Case for Change: The current service model is diagnosis rather than needs-led, meaning individuals are not getting the early support they need. The number of referrals to assessment services significantly exceeds commissioned capacity, leading to long and growing waiting times. Right to choose referrals to Independent Sector Providers is increasing, however this offers a variable experience for patients, with some experiencing incomplete pathways and difficulty receiving subsequent support through NHS services.

There has been a lack of investment into NHS provision in terms of capacity for assessment, as well as digital technology to streamline processes and improve communication with parents/carers and families.

Our aim is to improve the identification and access to early and ongoing support for neurodivergent Children and Young People. This includes the roll out of the Knowing Me profiling tool to identify needs early, multi-disciplinary triage of referrals, standardised stratification, streamlined assessment processes and more comprehensive ongoing support.

Inequalities: there is significant variation in access and waiting times across Cheshire and Merseyside, in particular when accessing independent sector provision, where waiting times are significantly shorter. This means some of our most complex patients are waiting the longest.

Financial: increased noncontract activity on Right to Choose activity, creating financial pressure.

Other Services: unmet and delays in meeting need impacts on the NHS (e.g. urgent care/MH demand) and wider society (e.g. school attendance, youth offending behaviour).

We Will: Ensure **ALL** neurodivergent children and young people have improved access to early and ongoing support and when needed wait no longer than 28 weeks for assessment and diagnosis by 2029.

2026-27 – Priorities

- Continue implementation of needs-led pathway across all Places.
- Complete rollout of Knowing Me profiling tool including digital version.
- Address gaps in early / ongoing support.
- Agree and pilot shared care framework.
- Consistent implementation of stratification tool for waiting lists and streamlined assessment.
- Develop digital tools to support patients while waiting.
- Expand capacity for assessment inc. within CAMHS.
- Develop lead Provider model.

Key Metrics and Measures*

- Increase number of staff trained and number of profiling tools completed.
- Increase number of patients accessing early support.
- Reduce number of patients referred on for assessment following triage.
- Reduce numbers on waiting list by 30%.
- Reduce average waiting time for assessment.
- Reduced independent sector spend.
- Eliminate over 52-week waits.

2027-28 – Priorities

- Embed new model across all Places including profiling tool.
- Roll out shared care framework and annual reviews in primary care.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- Ensure an integrated offer for patients under MH services with ADHD/Autism.

Key Metrics and Measures

2026-27 metrics and measures plus

- Reduce number of patients on waiting list by 20%.
- Shared care uptake.

2028-31 – Priorities

- Eliminate over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of care model to support wider neurodevelopmental need.

Key Metrics and Measures

Ongoing metrics as outlined 2026-28 plus

- Number of patients triaged for diagnostic assessment.
- Eliminate waits for assessment of over 28 weeks.

*Note: baselines and targets to be confirmed.

NHS
Cheshire and Merseyside

11. Living Well

- Mental Health
- Learning Disability & Autism
- Neurodiversity
- Diagnostics
- Community Pharmacy
- General Practice
- Optometry
- Planned Care
- Primary Care Dental
- Stroke
- Women's Health

Mental Health (Adults Page 1 of 2):

Case for Change: In line with the 10 Year Plan we are continuing a programme of reform to transform services with the aim of putting mental health on an equal footing to physical health. The plan continues the expansion of a mental health urgent and emergency care offer and the development of community-based services, aligning this to neighbourhood health. We will apply the proposed modern service frameworks for severe and enduring mental illness and dementia alongside enhanced support to reduce ill-health related inactivity, as well as a focus on digitalisation, prevention and tackling health inequalities.

Inequalities: 1 in 4 adults experiences at least one diagnosable mental health problem in any given year. People in all walks of life can be affected at any point in their lives. Mental health problems represent the largest single cause of disability in the UK.

Financial: reduced spend on clinical interventions, such as inpatient care, will allow for investment in community services. Talking Therapies and Individual Placement and Support, along with community and preventative services, will support people to remain as economically active as possible.

Other Services: Reductions in unnecessary attendances at A&E and improved access to primary care support and preventative care helping support more people in community settings with access to social care and housing support when needed.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure support is provided for people with mental health needs, improving their health outcomes and ensuring access to services meeting their needs.

Our ambitions are:

- Fewer people with a mental health need will require inpatient care and present to services in crisis.
- More people with a mental health need will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with mental health needs will be improved.

2026-27 – Priorities

- Build on existing mental health Urgent and Emergency Care (UEC) plan to scope single offer for C&M.*
- Improve the care and treatment of individuals who require an intensive and assertive approach from health services.
- Ensure parity on discharges to reduce numbers who are Clinically Ready for Discharge (CRFD) in MH inpatient beds.
- Use ring-fenced funding to support the delivery of effective courses of treatment within Talking Therapies and expand Individual Placement and Support (IPS).

Key Metrics and Measures

- Reduce the number of Mental Health A&E attends by 50% from 24/25 base.
- 50% reduction in >12 hour and > 24 hour MH waits in A&E.
- No inappropriate out-of-area placements.*
- Reduce length of stay and delayed discharges (50% reduction).
- Increase Reliable Improvement Rate for Talking Therapies to 69% and Reliable Recovery to 51%.*
- Increase access to IPS based on agreed recovery plan.*

2027-28 – Priorities

- Continue to develop single health UEC offer.*
- Assertive outreach care and treatment expansion.
- Maintain focus on reducing CRFD and lengths of stay.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.

Key Metrics and Measures

- As a minimum, subject to further guidance, maintain delivery in reduced A&E attendances and achieve MH waiting time standards, out of area placements, length of stay and CRFD.*
- Increase Reliable Improvement Rate for Talking Therapies to 70% and Reliable Recovery to 52%.*
- Increase access to IPS in line with trajectories (as determined by future guidance).*

2028-31 – Priorities

- Implement single Cheshire and Merseyside mental health UEC offer.*
- Assertive outreach care and treatment. expansion.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.
- Implement capacity management software and digitised Mental Health ACT (MHA) pathways by 2030.

Key Metrics and Measures

- Comprehensive mental health UEC offer to support system, including for Type 1 Emergency Departments.
- Expand NHS Talking Therapies and Individual Placement and Support in line with planned growth.*
- 100% coverage of Assertive Outreach Care and Treatment.
- Increase Reliable Improvement Rate for Talking Therapies to 71% and Reliable Recovery to 53%.
- Increase access to IPS in line with trajectories.*

Mental Health (Adults Page 2 or 2):

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Develop a model for an integrated inpatient and community mental health rehabilitation offer.
- Implement the personalised care framework.
- Develop 24/7 Neighbourhood Mental Health Centre in Cheshire West.
- Review HACT housing recommendations and co-produce plans to implement where possible without additional resource.
- Develop a common approach to management of complex mental health and s117 cases.
- Develop a C&M plan to respond to the Modern Service Framework for mental health when published.
- Ensure mental health practitioners across all providers undertake training and deliver care in line with the *Staying safe from suicide* guidance.
- Improve control of "slow stream" Acquired Brain Injury (ABI) and neurorehabilitation pathways to reduce clinical and financial risk.
- Develop options to reduce reactive spend on mental health secure transport.

Key Metrics and Measures

- Reduction in out of area, spot purchased and locked rehabilitation placements for mental health rehabilitation.
- Establish first 24/7 neighbourhood mental health centre.

2027-28 – Priorities

- Commence delivery of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres.
- Deliver a common approach to management of complex mental health and s117 cases across Cheshire and Merseyside.
- Commence implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- *Staying safe from suicide* embedded in provider's training offer.
- Enhance collaborative approaches for improved control of "slow stream" Acquired Brain Injury (ABI) and neurorehabilitation pathways.
- Implement options to reduce reactive spend on mental health secure transport.

Key Metrics and Measures

- Sustained reduction in out of area and spot purchased rehabilitation placements for mental health rehabilitation. Move to zero locked rehabilitation placements.
- Establish next four 24/7 neighbourhood mental health centres.

2028-31 – Priorities

- Full implementation of integrated inpatient and community mental health rehabilitation model.
- Develop a further four 24/7 Neighbourhood Mental Health Centres to ensure one in every place by March 2029.
- Common approach to management of complex mental health and s117 cases across Cheshire and Merseyside fully implemented.
- Continue implementation of Cheshire and Merseyside plan to deliver the Modern Service Framework for mental health.
- Responding to impact of MHA Reform.

Key Metrics and Measures

- No out of area, spot purchased and locked rehabilitation placement for mental health rehabilitation.
- Establish final four 24/7 neighbourhood mental health centres.

Learning Disability and Autism:

Case for Change: Improving care and support for people with a learning disability and autistic (LDA) people is part of a national programme known as Transforming Care. It covers people with a learning disability and autistic people of all ages. Reducing inpatient numbers through increased discharges and admission avoidance, through improved community support. Improved access to health checks, primary care services, and appropriate prescribing will improve outcomes. There is also learning from the lives and deaths of people with a learning disability and autistic people (LeDeR).

Impact:

Inequalities: People with a learning disability and autistic people too often experience avoidable health inequalities and can also be inappropriately admitted to mental health hospitals for long periods. People with a learning disability are dying on average nearly 20 years younger than people without a learning disability. Almost 2 in 5 deaths are avoidable.

Financial: reduced spend on expensive clinical interventions, such as inpatient care, will allow for investment in community services.

Other Services: Improved access to primary care and prevention. More people maintained in community settings with social care and housing support as appropriate.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Ensure comprehensive support is provided for individuals with autism and learning disabilities, improving their health outcomes and ensuring access to necessary services.

Our ambitions are:

- Fewer people with a learning disability and autistic people will need mental health inpatient care.
- More people with a learning disability and autistic people will be supported to in the community and close to home.
- The health outcomes and life expectancy of people with a learning disability and autistic people will be improved.

2026-27 – Priorities

- Reduce longest lengths of stay in mental health hospitals.*
- Reduce admissions to mental health hospitals for LDA & Autism.*
- Improved management of packages of care in community settings.
- Develop an integrated inpatient and community rehabilitation offer within transition.
- Adult Dynamic Support Databases to be fully established to meet revised Mental Health Act (MHA).
- C(E)TRs fully coordinated to meet MHA.
- Agree new delivery model for LeDeR.
- Establish agreed CYP LD Pathway
- Establish new units of LDA Crisis Accommodation.
- Implement and embed Green Light Toolkit.

2027-28 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Continue to develop a Community LDA Crisis /Respite provision.
- Develop integrated community Rehabilitation model for LDA.
- A DSD to be fully commissioned for people with Autism.
- Implement new delivery model for LeDeR.

2028-31 – Priorities

- Reduce longest lengths of stay in mental health hospitals.
- Reduce admission rates to mental health hospitals.
- Established integrated inpatient and community rehabilitation offer.
- To have a fully commissioned/implemented community offer for LDA crisis provision.

Key Metrics and Measures 26-27

- Min 10% year on year reduction in number of people with LDA in mental health inpatient care.*
- Deliver on 75% of Annual Health Checks and complete 100% of Health Action Plans.
- Meet Length of Stay targets for CYP, restricted and unrestricted patients.

2028-31

- Delivery on the Annual Health checks and Health Action Plans.
- Deliver on LOS target for CYP, restricted and unrestricted patients.

Neurodiversity – Adults

We Will: improve the identification and support for neurodivergent individuals our initial focus will be around a needs led model for those with Attention-Deficit/Hyperactivity Disorder (ADHD).

Case for Change: Our aim is to improve the identification and support for neurodivergent individuals with an initial focus on a needs-led Attention-Deficit/Hyperactivity Disorder (ADHD) model. The current model is diagnosis rather than needs-led, meaning patients are not getting the early support needed. This drives growth in demand for assessments when not all patients referred for assessment meet a formal diagnosis threshold. The number of referrals for assessment exceeds commissioned capacity, leading to long and growing waiting times.

There are many NHS and Independent Sector organisations providing assessments, which is leading to inconsistencies in the way care is accessed and provided, including provision of partial pathways of care.

Inequalities: there are significant variations in access and waiting times specifically when accessing independent sector provision, where waiting times are significantly shorter, meaning some of our most complex patients are waiting the longest.

Financial: The rising right to choose referrals are driving significant increases in spend on adult ADHD services – from £11 million in 2023/24 to £35 million in 2025/26.

Other Services: unmet and delays in meeting need impacts on the NHS (e.g. urgent care / Mental Health demand) and wider society (e.g. economic inactivity and offending behaviour)

2026-27 – Priorities

- Continue implementation of needs-led model across all Places, including new primary care service.
- Agree and launch revised shared care framework.
- Consistent implementation of local specification and diagnostic assessment referral criteria.
- Commence repatriation of ongoing treatment to primary care service.
- Revise secondary care provision and stratify secondary care waiting lists.
- First phase of enhancements to needs-led community-based support.
- Set Indicative activity plans with providers of assessment services.

Key Metrics and Measures

- 92% of patients referred for diagnostic assessment have their first appointment within 52 weeks of referral.
- 75% of patients report they understand their needs and that they are better met.
- 75% of patients report a positive experience of adult ADHD services.
- 95% of ADHD activity is provided by locally commissioned providers.

2027-28 – Priorities

- Conclude implementation of new model across all Places.
- Shift patients on secondary care waiting lists to primary care service.
- Further repatriation of ongoing treatment to primary care service.
- Further enhancements to needs-led community-based support including alternatives to medication.
- Set Indicative activity plans with providers of assessment services.
- Implement digital tools that improve patient access and experience and provider and system efficiency.
- An integrated offer for patients under MH services with potential ADHD.

Key Metrics and Measures

- % of PCNs operating primary care model.
- Number of patients referred for diagnostic assessment.
- Number of patients on waiting lists.
- Average waiting time for assessment.
- Independent sector activity / spend.
- Shared care uptake.
- Reduction in ADHD treatment costs.

2028-31 – Priorities

- Reducing over 52-week waits.
- Continue to balance needs-led support, primary and secondary care provision.
- Consider further expansion of primary care model to support wider neurodevelopmental need.

Key Metrics and Measures

- As per 26-28 metrics

Diagnostics

Case for Change: We know it is important to our residents to reduce the length of time people wait to be diagnosed and treated and that addressing long waits will support improved outcomes and deliver greater system resilience and performance on behalf of our population.

Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions.

Impact: Access to diagnostics is a major source of health inequality, with deprived groups, minorities, and rural populations facing barriers like distance, cost, digital exclusion, and discrimination, leading to later-stage diagnoses, worse outcomes, and underdiagnosis

Financial: Early diagnosis offers significant financial benefits by enabling less intensive, cheaper treatments, reducing the need for costly emergency care, delaying expensive long-term care and unlocking crucial government benefits and support for patients and caregivers, ultimately saving money for individuals, families, and healthcare systems

Other Services: Work to implement straight-to-test pathways will help to reduce avoidable Outpatient appointments. Rapid access to locally delivered diagnostic services will support earlier intervention and decision making for patients requiring planned care, cancer and treatment for long-term conditions

Improving access as part of a multidisciplinary team approach with clinicians from primary, community and secondary care will provide more effective, timely treatment.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Improve performance against diagnostic waiting times working towards diagnostic services being delivered as a single provision, ensuring service consolidation for critical diagnostics tests whilst ensuring local provision.

2026-27 – Priorities

- Straight to test pathways to reduce avoidable outpatient appts.*
- New service models to minimise risk, maximise efficiency and ensure services are delivered in line with activity and performance and best practice guidance i.e. interventional radiology, phlebotomy, pathology hubs and integration of paediatric and neuro pathology.*
- Deliver the recommendation outlined in the high-level Phlebotomy review including maximum waiting time KPIs.
- Improve the early and accurate diagnosis of respiratory conditions, promote the use of technology and enable more care to move from hospitals to community settings.
- Prioritise diagnostic (including CDC) and treatment capacity for urgent suspected cancer (USC) pathways, stratifying referrals in primary care, identifying alternative pathways and diverting lower-risk people to more appropriate access routes for their condition.*

2027-28 – Priorities

- Service consolidation for critical diagnostic tests to be provided in several sites to ensure local provision but hosted by a single provider.
- Implement networked C&M service model for Interventional Radiology to minimise patient risk, maximise efficiency and ensure that service development in line with guidance.
- Implement recommendations of the review for phlebotomy (inc. standardised commissioning across primary and acute care and standardised Key Performance Indicators (KPI) of max waiting times of 2 weeks for routine patients & 2 days for urgent patients.
- Implement 3 hub pathology service and phased approach of integration for Paediatric and Neuro pathology to ensure maximum efficiency and resilience.
- Implement hub model for Imaging services to fit with Provider Collaborative Blueprint and LAASP plans. Will network services to allow great efficiency.

2028-31 – Priorities

- Move to Diagnostic Services being delivered as a single provision across C&M to include single-hosted services; Hubs could be run by wholly owned subsidiaries.
- Implement a single PTL and diagnostics waiting list across which will be embedded in contracts and coordinated through our collaborative embedding risk stratification to prioritise based on clinical risk and broader population health priorities.
- Mitigate demand growth in excess of agreed growth assumptions, increasing the role of neighbourhood health teams over time.*

Key Metrics and Measures

- Continue to deliver performance of 95% of patients seen within 6 weeks Targeting tests below 95%.*
- 80% of cancer biopsies processed within 10 days.
- 70% of cancer biopsies are processed within 10 days and imaging is reported in line with national guidelines.

Community Pharmacy

Case for Change: Position community pharmacy as the front-line prevention and early intervention service. Described in the 10-year plan, 'from hospital to community' positions the Neighbourhood Health Service, to which community pharmacy will be integral. Contribute to the traditional model of outpatient care and take on new roles in relation to secondary care prescribing – consistent with a shift left approach.

Impact: Pharmacies are flexible health anchors, tackling inequalities, supporting ageing populations, and adapting to growth pressures.

Inequalities: Inequalities concentrated in Core20PLUS5. Rising CVD, cancer, respiratory and mental health burden. Local PNAs highlight different priorities depending on population needs.

Financial: Annual budget £96 million – potential for reduced demand on pressured services.

Other Services:

- CVD: Hypertension case-finding and management, statin adherence, lifestyle support.
- Contributor to weight management and alcohol brief interventions
- Cancer: Early symptom recognition, smoking cessation, mould/mask checks
- Respiratory: Inhaler technique checks, rescue pack optimisation
- Mental Health: Medication adherence, physical health checks
- Neurodiversity: Sensory-aware consultations and tailored medication support
- Pharmacy Needs Assessments (PNA) determine the commissioning of community pharmacy, and the PNA is a statutory local authority function.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Position community pharmacy as the front-line prevention and early intervention service for Cheshire & Merseyside.

2026-27 – Priorities

- Increase Pharmacy First Consultations.*
- Continue developing the relationships between general practice and community pharmacy to support access to pharmacy services.*
- Introduce prescribing-based services into community pharmacies during 2026/27.*
- Develop and shape role of Community Pharmacy in Neighbourhood health Services.*
- Preventing ill health and supporting wellbeing
- Providing clinical care for patients and system resilience.

Key Metrics and Measures

- Plan total 456,151consultations (2.9%).
- Clinical Pathway – 155,881 (5.0%).
- Oral Contraception – 57,779 (10.0%).
- Blood pressure – 242,490 (0.0%).

2027-28 – Priorities

- Become the primary access point for prevention.
- Deliver high-volume contact points for underserved groups.
- Act as clinical risk-detector for CVD, cancer, respiratory, mental health.
- Become trusted community anchors in deprived areas
- Act as data-rich contributor to population health management.
- To contribute to the traditional model of outpatient care, and to take on new roles in relation to secondary care prescribing.
- Expand access to emergency contraception through community pharmacies.*

Key Metrics and Measures

- Plan total 464,495 consultations (1.8%).
- Clinical Pathway - 161,337 (3.5%).
- Oral Contraception - 60,668 (5.0%).
- Blood pressure 242,490 (0.0%).

2028-31 – Priorities

- Lead for hypertension case-finding.
- Lead for smoking cessation.
- Contributor to weight management and alcohol brief interventions.
- Provider of rapid access advice for minor conditions.
- Key partner in medicines optimisation and polypharmacy reduction.*
- Single neighbourhood provider and multi-neighbourhood provider contracts referenced in 10-year plan align with refreshed contract for community pharmacy services.

Key Metrics and Measures

- Plan total - Increase
- Clinical Pathway - Increase
- Oral Contraception - Increase
- Blood pressure – Maintain/Increase

General Practice (Primary Medical Services)

Case for Change: Increasing demand for general practice services and gaps between demand and capacity, acknowledging workforce challenges.

Variation of patient experience and key indicators for measuring access to general practice results in an unequal offer for our residents, including in our most deprived wards.

Increasing patient complexity and needs are compounded by remaining barriers between system provider and patient pathways.

Clinical areas: Focus driven by population health data: CVD, Respiratory, Diabetes, Frailty/Falls, Cancer, Immunisations.

Inequalities: Current variation linked to deprivation with both access and clinical outcomes including mortality.

Financial: SDF allocation, local noncore spend, digital and estates spend.

Other Services: Reduction in unnecessary attendances at A&E; referrals to Pharmacy First maximised.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Ensure Primary Care first model of delivery as part of a neighbourhood health offer / Timely access to services for the whole population via a consistent commissioned approach / Harnessing/maximising digital technology to support and improve all outcomes, patient experience and productivity / High quality care driven by measurement of and improvements in continuity particularly for our most vulnerable patients

2026-27 – Priorities

- Complete review of investment streams (SDF/Noncore) and Enhanced Services.
- Establish a consistent, outcomes-based contractual framework of local enhanced services aligning contracts with population health needs.*
- Prioritising use of Advice and Guidance prior to/instead of a planned care referral where clinically appropriate (excluding referrals for urgent suspected cancer).*
- Implement national contract / policy asks, including red tape challenge recommendations.*
- Identify GP practices where demand is above capacity and create a plan to reduce variation in access.*
- Support/underpin neighbourhood working
- Review work to align prescribing incentives in key areas of financial efficiency, medicines safety and antimicrobial stewardship.

Key Metrics and Measures

- 2.2% growth in appointments (Planning guidance) (16,691,997).*
- 90% of appointments within 2 weeks min.
- Measurement of continuity indicators with improvement in-year.
- Number of clinically urgent appts. and % seen same day (Indicative 90%).
- QOF/local quality clinical indicators.
- Patient Experience measures via GPSS and ONS data.*

2027-28 – Priorities

- First full commissioning year of new enhanced offer for PC.
- General practice/neighbourhood health ambitions formalised into an ongoing arrangement, full realisation of impact of new contractual forms implemented during 26/27.
- Delivery/contract methods fully in place to deliver at scale solutions.

Key Metrics and Measures

- 2% growth in appointments.*
- Agreed care plans for patients with complex needs.
- Developing measurement for proactive personalised care.
- Key metrics from new enhanced service offers including clinical targets/areas.
- Developing digital targets.
- Revised June 2025 plan access. variation targets including stretch access targets in deprived areas (TBC).
- Equalisation of access entry modes.
- Shift of £ resources from secondary to primary care.
- Improvements in continuity measures.
- Progress against patient experience measures.*

2028-31 – Priorities

- Digitally-enhanced, team-based model with increased workforce.
- More patient choice in consultation methods (digital/in-person) – including management of medicines online.*
- Focus on complex care and continuity.
- supported by digital methods for triage, and models which better manage growing demands with new technology and tools.
- Realisation of primary care at scale ambitions.

Key Metrics and Measures

- Mix of appointments.
- QOF and local quality clinical indicators.
- Demand and referrals between services as part of NH models.
- Shift of £/f resources from secondary to community/primary services.
- Routine measurement of proactive, personalised care leading to improved outcomes and reduction in avoidable admissions.
- Progress against patient experience measures.*

Optometry

Case for Change: Pressure on hospital eye services and GPs – Reducing unnecessary hospital / GP visits

Prevalence of age-related eye conditions such as glaucoma increasing overall demand for eye care services.

Inconsistency of enhanced services throughout Cheshire and Merseyside leading to disparities based on geographic location.

Underutilisation of key optometry skill set and supporting more preventative work.

Impact:

Inequalities: disparities in eye health outcomes / access to care equalised.

Financial: Local enhanced services, Special Education Settings Services (SES) allocation, General Ophthalmic Services (GOS) budget flexibilities.

Other Services: Unnecessary attendances at A&E, referral pathways into Secondary Care, and reduced presentations at GP surgeries.

Governance route and Exec Lead: System Primary Care Committee Executive Lead Clare Watson.

We Will: Further enable optometrists as first-contact practitioners and expand access supported by high quality eye health pathways delivering better care – with a focus on prevention and early detection.

2026-27 – Priorities

- Improving access to GOS services and delivery quality of care maximising national and local contract opportunities.
- Embed optometry as key part of neighbourhood health plan and priorities.
- Review and expand services for homeless and other vulnerable groups including SES for children.
- Review and embed outcomes and learning from CVD pilot.

Key Metrics and Measures

- SES services outcomes and measures within spec year 1.
- Reduction in GP eye-related consultations.
- Reduced acute presentation for eye-related symptoms in emergency care.
- Specific patient pathway rollout – Glaucoma Enhanced Referral Services (GERS) measurements.

2027-28 – Priorities

- First full commissioning year of enhanced eye care services offer.
- Optometry/neighbourhood health ambitions formalised and in place.
- Implement national contract/policy asks (TBC).
- Year 2 of commissioned schemes for SES and other vulnerable groups.

Key Metrics and Measures

- Eye tests for vulnerable groups.
- SES numbers year 2.
- Reduction in GP eye related consultations.
- Reduction in acute presentation for eye related symptoms.
- Specific patient pathway target (e.g. glaucoma monitoring pathways across all hospitals in Cheshire and Merseyside).

2028-31 – Priorities

- Digitally integrated, community-focused service, shifting more care from hospitals to high streets.
- Expanded roles for optometrists, advanced diagnostics (e.g. remote monitoring), integrated electronic systems (EERS).
- Focus on prevention, supported by better workforce planning and training for a wider scope, including enhanced prescribing and specialist pathways to tackle increasing demand and reduce hospital pressure.

Key Metrics and Measures

- Equitable Access: Reduction in geographic variation for core and enhanced services.
- Reduced Hospital Referrals: Decrease in unnecessary referrals for minor eye conditions to hospital.
- Chronic Disease Management: Improved outcomes in glaucoma/medical retina managed in primary care.

Planned Care

Case for Change: Our NHS Providers are leading work with partners to address clinical, workforce and financial challenges across C&M ICB, reducing the fragility of clinical services and unwarranted variation of quality in care, improving health inequalities across populations and making services more sustainable for the future. This will see us develop and implement a system capacity management process (for adults and CYP) that will significantly increase the level of inter-organisational support provided for elective care, improve utilisation of system assets (mainly elective hubs) and enable the development of a 'business as usual' model for the longer term.

Appropriately manage waiting lists, including thorough validation and the application of referral to treatment guidance and local access policies.*

To implement clinical pathway changes at the point of referral to safely reduce the level of demand on acute services by increasing self-care and utilisation of primary and community-based services to deliver care closer to home.

Inequalities: The consistency of offer and use of analytics to target interventions to those with the greatest clinical benefit will help address current inequalities.

Financial & Other Services: Through streamlining pathways, the total costs of treatment will start to reduce as well as a transfer of resources to prevention and early intervention. This will include the integration of clinical teams across hospital, community and primary care teams to support prevention and early intervention.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Make the improvements needed to return to delivery the NHS waiting time standard

2026-27 – Priorities

- Undertake pathway optimisation of Gynaecology, Ophthalmology, MSK, Dermatology and ENT, including community-based options and implementing Single Point of Access and Referral Triage.
- Implement a single PTL and diagnostics waiting list for agreed pathways.*
- Delivery of national efficiency measures including outpatients digital first, patient led model; expanding the use of Advice and Guidance and digital triage tool and follow-up care including access to patient-initiated follow-up (PIFU), remote consultations and digital monitoring.*
- Commissioning a North West Complex Termination of Pregnancy Service.
- Specialised Services specification review.

Key Metrics and Measures

- Every trust delivering a minimum 7% improvement in 18-week performance or a minimum of 65%, whichever is greater (to deliver national target of 70%).
- Reduce the number of people waiting over 52 weeks.
- An increase Advice and Guidance rates baseline to be confirmed.*
- Outpatient follow-up rates improve in line with national standards.*

2027-28 – Priorities

- Expand whole pathway optimisation to further specialties.
- Implement a single PTL and diagnostics waiting list for agreed priority pathways.
- Implement recommendations from Specialised Services specification review.
- Significantly reduce the number of routine, clinically low- value follow-up appointments.*
- Conduct comprehensive reviews of clinic templates and standardising these in line with GIRFTs. specialty-level good practice and job planning guides.*

Key Metrics and Measures

- Achieving the standard that at least 92% of patients are waiting 18 weeks or less for treatment.
- Reduce the number of people waiting over 52 weeks.

2028-31 – Priorities

- Expand whole pathway optimisation to remaining specialties and pathways to have single standard model across C&M.

Key Metrics and Measures

- Improvement in defined population health outcomes in line with our population health needs assessment.
- Maintain delivery of national waiting time standards.
- Upper quartile delivery of NHS efficiency standards across C&M Providers.

Primary Care Dental

Case for Change: NHS dental access remains a major challenge. Contract reform needed to unlock dentistry's role in prevention and Neighbourhood care. Oral health integration supports wider system dividends.

Impact: Improvement of oral health and related benefits to the Cheshire and Merseyside population.

Inequalities: 31.2% of 5-year-olds have tooth decay. Oral health inequalities concentrated in Core20PLUS5. Links to rising CVD, cancer, respiratory and mental health burden.

Financial: £15m ring-fenced dental budget; potential for local "shift left" funding.

Other Services:

- Early oral cancer detection and digital referrals.
- GP cancer referrals routed to urgent dental care.
- Dental homes for vulnerable groups.
- Trauma-informed pathways for SMI; sensory-adapted care for neurodiverse patients.
- Improved outcomes in diabetes and COPD.

*Medium Term Planning Framework (metric/measure or narrative).

We Will: Transform NHS dentistry into a population health prevention platform, expanding access, embedding oral health into neighbourhood models, and shifting resources to where need is highest.

2026-27 – Priorities

- Deliver 46k additional urgent dental appointments against baseline
- Ensure routine access and vulnerable groups.
- Implement dental reforms. Review Units of Dental Activity (UDA) rates to create a fairer system, but with caveats attached for providers* where their UDA rate is increased.
- Implement locally driven quality improvement approaches for dentistry.*
- Prevention and integration of oral health within Neighbourhood services.
- Data Dashboard to encompass end-to-end pathway.

Key Metrics and Measures

- 85% units of Dental activity delivered.*
- 42% of resident population seen by an NHS Dentist (Adults).
- 64.41% of resident population seen by an NHS Dentist (Children).
- 46,617 Urgent Care appointments.*

2027-28 – Priorities

- Deliver 46k urgent dental appointments.
- Ensure routine access and vulnerable groups.
- Develop Dental as a Neighbourhood frontline provider.
- Integrate Dentistry into the Neighbourhood MDT model.
- Develop local PDS contract with core outcome framework.

Key Metrics and Measures

See 26-27

2028-31 – Priorities

- Build shared data flows and shift from "services" to "platforms" driven by population health management.
- Commission through a single provider model, not separately from GP Pharmacy and Optometry.
- Dental as the Neighbourhood's proactive outreach engine.
- Dental to contribute to Neighbourhood level inequalities reduction*

Key Metrics and Measures

- An increase in units of Dental activity An increase % of resident population seen by an NHS Dentist (Adults).
- An increase % of resident population seen by an NHS Dentist (Children).
- Outcome measures from local PDS contract.

Stroke

Case for Change: Stroke is a major health challenge in the Uk with 152,000 strokes annually, with 1.2 million survivors. It is among the top four causes of death and a leading cause of adult disability. Current care is fragmented, creating health inequalities and inefficiencies. Key Solution: Integrated Community Stroke Service (ICSS) Early Supported Discharge (ESD): Enables specialist rehabilitation at home, reducing disability and improving outcomes. ICSS provides rapid access to hyper-acute units, consistent inpatient therapy, and robust community rehabilitation.

Our ambitions are:

- Improvement of patient-reported experience measures
- Reduction in length of stay in acute inpatient setting.
- Reduction in secondary stroke
- Improved survival and functional independence for patients.
- Faster access to thrombectomy and thrombolysis
- Embed digital imaging and AI (e.g. Brainomix) to support rapid diagnosis and equitable access.

Inequalities: ICSS addresses disparities by proactive screening for high-risk groups (e.g. ethnic minorities, cardiometabolic disease, severe mental illness, learning disabilities).

Financial: ESD can halve inpatient stays, saving ~£325 per patient. ICSS is highly cost-effective (£10,000–£18,000 per Quality-Adjusted Life Year QALY), reducing long-term dependency and admissions.

Other Services: Reduces pressure on acute stroke units and emergency departments. Improves continuity of care, lowers complications, and prevents unnecessary residential placements. Provides psychological and vocational support, reducing mental health referrals. Streamlines therapy provision, minimising duplication and gaps.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Enhance quality of life, reduce long-term disability, and deliver substantial cost savings through integrated, standardised stroke care and delivery of a consistent, high-quality 24/7 thrombectomy and hyperacute stroke pathway across Cheshire and Merseyside in line with the 2023 guidelines.

2026-27 – Priorities

- Establish consistent thrombectomy and hyperacute stroke pathways across all sites.
- Secure commissioning of AI-enabled imaging and review standardised SOPs.
- Gap analysis of current post-discharge rehabilitation services to understand the services better and where inequalities etc. are. Work up of existing “Case for Change” paper.
- Commission a sustainable NROL model to bolster current post-discharge rehab offer.
- Pre-hospital video triage and remote follow-up in selected sites.
- Increase use of best value and correctly dosed DOACs across the system.*

Key Metrics and Measures

- NROL available at all post-discharge rehabilitation teams across Cheshire and Merseyside.
- Increase in mechanical thrombectomy %.
- SSNAP (Stroke Sentinel National Audit Programme).

2027-28 – Priorities

- Expand community rehabilitation services with equitable access.
- Strengthen secondary prevention programmes (AF detection, hypertension).
- Develop regional workforce plan for stroke specialists.
- Pan ICB-Workforce planning and hub integration.

Key Metrics and Measures

- 10% increase in access to community rehab.
- Prevention KPIs (AF/hypertension) tracked across all sites.

2028-31 – Priorities

- Integrate stroke rehabilitation into ICS community hubs.
- Pilot virtual MDTs for complex cases.
- Implement virtual monitoring with wearables across ICB.
- Scale up digital-first pathways (tele-rehab / NROL, remote monitoring).
- Embed patient-reported outcome measures (PROMs) into routine care.
- Achieve region-wide equity in thrombectomy access and outcomes.
- Deliver measurable reduction in stroke-related disability. Publish regional outcomes report.

Key Metrics and Measures

- 50% of community teams delivering stroke rehab / ICSS.
- Workforce gaps identified and recruitment underway.
- PROMs embedded in 80% of stroke pathways.
- 20% reduction in readmissions.
- Equity in thrombectomy access.
- Reduction in avoidable hospital admissions by 10% by 2031.

Women's Health Services

Case for Change: Women make up over half the UK population and live longer than men yet spend **25% more of their lives in poor health**. Systemic gaps persist – only **7% of healthcare research** focuses on women-specific conditions. Women also face longer waits for care, with those in deprived areas waiting the longest. Gynaecology waits remain among the **second highest in England** (RCOG Elective Recovery Tracker), leading to worsening physical and mental health.

- **Health Equity**: Women experience conditions such as endometriosis, heavy menstrual bleeding, and menopause that are frequently underdiagnosed or undertreated, affecting overall wellbeing.
- **Economic Impact: Poor** health limits participation in work and education, reduces productivity, and increases financial pressures.
- **Quality of Life:** Women spend more years in poor health, affecting their ability to work, care for families, and maintain independence.
- **Systemic Efficiency:** Early diagnosis and preventive care reduce long-term healthcare demand and costs.
- **Social Justice:** Meeting women's health needs is fundamental to fairness and societal progress.

Financial: Reduced resource demand: Long waits (18+ weeks) increase GP visits, prescriptions, and hospital use. System-wide savings: Neighbourhood women's health hubs offer more cost-effective care than reliance on acute secondary services.

Other Services: Less outpatient demand through care in neighbourhood hubs. Fewer A&E attendances through faster diagnosis and treatment. Reduced non-elective admissions via improved clinical pathways.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Ensure timely and equitable access to diagnosis and treatment for key women's health conditions across the life course, addressing health inequalities and informed by women's experiences and needs.

2026-27 – Priorities

- A sustainable neighbourhood hub model to increase the proportion of diagnosis, treatment, and care of conditions managed in the community.
- Expand training for primary care and community professionals supporting early diagnosis, reducing delays, improving care co-ordination and quality of care.
- Implement system-wide Endometriosis pathways across primary and secondary care, enabling early identification and referral, diagnostics, co-ordinated care, and faster access to treatment.
- Support delivery of the National Equity Framework for Menopause and Heavy Menstrual Bleeding.
- Implement women's health group consultations, use of digital platforms to support the delivery of virtual patient clinics, virtual clinician Advice & Guidance and peer support networks.
- Ensure women and girls have input into and access to information on key conditions to support and improve health outcomes.

2027-28 – Priorities

- Increase access to specialist menstrual health and gynae service provision within the community, starting with national 'pioneer' areas for the development of neighbourhood health.
- Strengthen 'train the trainer' model for primary care and community health professionals.
- Develop and implement a collaborative model of care to improve the mental and emotional health of women with key women's health conditions, to help address psychological and emotional impacts alongside physical symptoms.
- Improve health literacy among women to promote prevention and access to women's health services to help close gaps in health inequalities.*
- Support the roll-out of national and local integrated clinical care pathways developed for key women's health conditions to enable prompt diagnosis and management.

2028-31 – Priorities

- Increase access to specialist menstrual health and gynae service provision within the community.
- Deliver a model of care where health maintenance in the community becomes 'business as usual' with women with specific conditions referred to the right service and seen by the right clinician optimising care.

Key Metrics and Measures 26-27

- Increased HPV and cervical screening rates to achieve national targets.
- Increased utilisation of Advice and Guidance for gynae conditions.
- Reduced number of patients on elective waiting lists for gynaecology.
- Reduced average wait to first appointment for gynae conditions.
- Reduced the proportion of patients waiting over 52 weeks for treatment.
- Meet the 18-week referral to treatment standard by March 2029 for gynae conditions.
- Increased proportion of patients diverted to neighbourhood hubs to receive care.

NHS
Cheshire and Merseyside

12. Aging Well

- Prevention of frailty escalation
- Dementia
- Prevention of falls
- Urgent and emergency care

Prevention of frailty escalation

Case for Change: Older people living with frailty are the highest users of health and social care services and have the highest levels of emergency admissions. Our over-75 population is forecast to grow by 45% by 2040.

Our Ambitions:

- Shifts the focus from reactive to proactive care.
- Prevents avoidable deterioration through early identification and intervention.
- Enables timely crisis response when required.
- Supports recovery and rehabilitation close to home, promoting independence and quality of life.

Inequalities: The highest percentage of people living with moderate or severe frailty lives in deprivation quintile one.

Financial: Our frailty population consume 10.7% of the healthcare costs in Cheshire and Merseyside. Older people with frailty are more likely to have a delayed transfer of care. Federated data platform projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

Other Services: People with frailty are likely to require significant health, social and informal support over a considerably longer period than those dying of a single condition.

*Medium Term Planning Framework (metric/measure or narrative).

We will:: Deliver a coordinated, person-centred frailty pathway

2026-27 – Priorities

- Develop the target operating model for system frailty services.
- Map out frailty services across Community and Acute providers, including falls pick-up services, *frailty-at-the-front-door* and care home services.*
- Collect quantitative and qualitative evidence about the impact of existing services.
- Implementation of the polypharmacy strategy – rapid polypharmacy reviews for the top 200 high-risk patients as per development and deployment of ICB polypharmacy dashboard.*
- Strengthen discharge-to-assess by prioritising frailty cases with reablement needs and embedding discharge planning across the patient journey.

Key Metrics and Measures

- An increase in the percentage of polypharmacy reviews completed for high-risk cohort.
- A reduction in the rates of readmission within 30 days.
- A reduction in people aged 65+ being discharged into long-term care after an acute hospital stay.

2027-28 – Priorities

- Implement standardised frailty screening in primary care, community, ambulance, and acute settings.
- Introduce a frailty 'flag' in the shared care record, accessible to all providers.
- Provide frailty training for all front-line staff in ED, ambulance, primary care, and community teams.
- Develop, agree, and commence implementation of frailty assessment and management guidance for patients with suspected or diagnosed cancer.
- Improve identification of people who may be in their last year of life, increasing the number of end-of-life patients with care plans in place.

Key Metrics and Measures

- An increase in the number of patients screened for frailty within 30 mins of arrival.
- An increase of 15% in the number of people who die who had an end-of-life care plan in place (EPACCS or ACP).
- A reduction in non-elective admissions for patients on gold standards framework (GSF).

2028-31 – Priorities

- Establish co-located multidisciplinary teams delivering prevention, assessment, and ongoing support.
- Ensure universal access to strength and balance programmes, nutrition support, and loneliness interventions.
- Implement real-time frailty data dashboards to track performance, outcomes, and health inequalities.*
- Redirect a proportion of acute expenditure to early intervention and prevention programmes.
- Complete phased roll-out of frailty assessment and management guidance for patients with suspected or diagnosed cancer.

Key Metrics and Measures

- Achieve a 10% reduction in non-elective admissions for patients 65+ with frailty.
- Achieve a 15% reduction in length of stay for patients 65+ with frailty.
- A reduction in patients 65+ being discharged onto pathway 3 after an acute hospital stay.

Dementia

We will: Ensure comprehensive support for people living with dementia, improving health outcomes and guaranteeing equitable access to timely diagnosis, personalised care, and community-based services.

Case for Change: In line with the NHS Long Term Plan and the C&M Dementia Strategy (2025–2030), we are continuing a programme of reform to transform mental health and dementia services, ensuring parity between mental and physical health. Dementia is a growing public health challenge, with over 35,000 people currently living with dementia in C&M and prevalence projected to rise significantly over the next decade.

Our ambitions are:

- Fewer people with dementia will require inpatient care or present in crisis, through proactive support, virtual wards, and urgent community response.
- More people with dementia will be supported in the community and close to home, via integrated neighbourhood teams, social prescribing, and assistive technology.
- Health outcomes and quality of life for people with dementia will be improved, reducing inequalities and enabling people to live well with dignity and purpose.

Inequalities: Significant disparities exist in diagnosis and support, particularly for deprived communities, global majority populations, LGBTQ+ individuals, and those with Young Onset Dementia. Rural isolation and digital exclusion further widen gaps.

Financial: Investing in prevention, early diagnosis, and community-based support will reduce reliance on costly inpatient care and avoidable hospital admissions.

Other Services: Plans will reduce unnecessary A&E attendances and improve urgent care through virtual wards and UCR services. Integrated neighbourhood teams will strengthen links with social care, housing, and voluntary sector support, enabling people to live well in their communities.

2026-27 – Priorities

- Improve Diagnosis and close diagnostic gaps through Dementia 100 toolkit analysis, expand timely care home diagnosis using DiADeM, standardise physical checks and neuroimaging.
- Enhance Access and Involvement – providing clear guidance on dementia services and establishing Place-level involvement groups for people with dementia and carers.
- Strengthen Post-Diagnostic Support – Implement shared care protocols and minimum standards and promote NHS Talking Therapies for ongoing support.
- Improve Hospital Care and Transitions – Deliver delirium protocol training and embed improved hospital discharge and transition planning.

Key Metrics and Measures

- Achieve ≥67% Dementia Diagnosis Rate.
- Increase timely diagnosis in care homes.
- Ensure person-centred care plans for all diagnosed individuals.
- Reduce avoidable hospital admissions.
- Embed dementia risk messaging in NHS Health Checks.
- Operational Place-level involvement groups and complete Equality Impact Assessments.

2027-28 – Priorities

- Training – Roll out tiered training across health, social care, and the third sector, with targeted programmes for unpaid carers, palliative care staff, and Young Onset Dementia support.
- Prevention – Embed messaging into NHS Health Checks and campaigns, supported by an ICB dashboard to identify at-risk populations and targeted monitoring through frailty pathways.
- Personalised Care – Improve development and annual review of personalised care plans, ensuring consistent standards.

Key Metrics and Measures

- Achieve 80% workforce completion of tiered dementia training across health and social care.
- 100% of NHS Health Checks include dementia risk messaging.
- 90% of people with dementia have an annually reviewed care plan.
- Reduce social isolation among people with dementia (Place-level surveys).

2028-30 – Priorities

- Promote engagement in dementia research and embed NICE guidelines.
- Commission services for underserved populations and implement health inequality plans.
- Awareness campaigns in schools, universities, and public events, alongside peer-led storytelling and counselling initiatives.
- Grow Dementia Action Alliance, deliver inclusive toolkits, and host cross-sector summits to strengthen partnerships.
- Prepare for disease-modifying treatments, embed integrated palliative care models with seamless end-of-life coordination and bereavement support.

Key Metrics and Measures

- Growth in Dementia Action Alliance and dementia-inclusive organisations.
- Equality Impact Assessments and tailored services for underserved groups.
- Increased participation in research and readiness for disease-modifying treatments.
- Reduction in emergency admissions for dementia-related crises and improved end-of-life care.
- Annual audit of performance and equality metrics – strategy refresh for post-2030.

Prevention of falls

Case for Change: Falls in over-65s creates a significant burden on both the individual, their family and the health and care system through lose of independence, injury and death, hospital admissions and a precipitating factor for a person going into long-term care. Need to develop a single pathway for frailty and falls across Cheshire and Merseyside with a clear plan for commissioning these services consistently across C&M in partnership with local authorities and the VCFSE sector

Impact:

Inequalities: People aged 65 and over have the highest risk of falling, with around half of those aged 80 plus falling once a year. A third of falls emergency admissions live in the 20% most deprived communities.

Financial: Falls-related emergency admissions in over-65s cost £116 million in 24/25. Opportunity to improve case finding to ensure at risk patients are identified and receive interventions to prevent progression. FDP projections identify 45,000 patients at risk of transitioning to high frailty by 2027 at a cost of £266.1m and 106,000 patients at risk of transitions into intermediate frailty by 2027 at a cost of £260.9m.

Other Services: Falls increase a person's risk of losing their independence and can therefore create a significant burden on both informal care demand and formal adult social care services. Taking this approach is key to improving patient outcomes, reducing demand on secondary care and releasing funding to invest in community.

We will: Reduce falls-related hospital admissions –

Our ambitions are:

- To ensure all patients 65+ opportunistically have their history of falls assessed
- 100% of patients with a history of falls receive a comprehensive falls risk assessment
- Increase the number of patients referred to falls prevention interventions

2026-27 – Priorities

Identify programme management capacity and through this capacity:

- Establish a task and finish group to agree the contents of a comprehensive falls risk assessment.
- Map the commissioning of falls prevention services across C&M.
- Develop a standard service specification for falls prevention exercise interventions in C&M.
- Implement a consistent approach to responding to falls and diagnosis in the community.

2027-28 – Priorities

- Develop a standard service specification for falls prevention services in C&M.

2028-31 – Priorities

- Commission integrated community-based falls prevention services across C&M.

Key Metrics and Measures

- Increase in comprehensive falls risk assessments.
- A reduction in falls related emergency hospital admissions.

Urgent and Emergency Care

We will: Deliver an integrated, left-shifted urgent and emergency care system through early decision-making, strong neighbourhood services and system-wide coordination.

The Case for Change: Urgent and Emergency Care demand continues to rise earlier in the year, with increasing acuity, complexity and health inequalities. Hospital-centric models are no longer sustainable. Performance challenges in ED waits, ambulance handover delays and delayed discharges reflect system flow constraints rather than isolated provider issues. A step-change is required to shift care upstream, strengthen neighbourhood and community capacity, and deliver safe, timely urgent care.

Impact:

- Improved patient experience and safety.
- Reduced avoidable ED attendances and admissions.
- Improved ambulance response and handover performance.
- Better flow through acute, community and social care.
- Reduced health inequalities and unwarranted variation.

Inequalities:

- Targeted approaches for frailty, Children and young people and high intensity users. Improved access to urgent care alternatives in deprived and rural communities.

Financial and other services:

- Reduced non-elective length of stay. Improved productivity through reduced escalation and stranded patients. Better use of community and intermediate care / virtual capacity.
- Reduced reliance on premium escalation measures.
- The Shaping Care Together Programme remains a key priority, reviewing urgent and emergency care (UEC) services across Southport, Formby and West Lancashire.

*Medium Term Planning Framework (metric/measure or narrative).

2026-27 – Priorities

- Stabilise 4-hour and 12-hour ED performance through early senior decision-making, SDEC-first pathways, redirection and streaming.*
- Strengthen urgent care alternatives (UTC, NHS 111 CAS, mental health crisis response) to reduce avoidable ED demand.*
- Enhance early decision-making and same-day options for CYP, including. improved front-door streaming, paediatric advice/assessment outside ED, and clearer CYP mental health crisis routes.*
- Improve Category 2 ambulance response times and reduce handover delays
- Deliver proactive joint health-and-care risk assessment for frail populations.*
- Optimise intermediate care capacity, prioritising home-first and reducing acute/community length of stay.*
- Embed system-wide UEC leadership and shared data discipline.
- Implement a single North West Adult Critical Care Transport Service.
- Agree and plan implementation from Shaping Care Together Review.

Key Metrics and Measures

- ≥ 82% 4-hour A&E by March 2027 (no month below 80%).*
- Reduce patients >12 hours in ED by 20%.*
- Reduce paediatric Type 1 attendances by 5% and achieve ≥80% of CYP streamed to an age-appropriate pathway/same-day assessment.
- Category 2 mean response time ≤25 minutes.*
- Reduction in corridor care by 50%.
- Reduced adult G&A occupancy trajectory aligned to <92%.
- Reduce NCTR to 12%.

2027-28 – Priorities

- Shift from stabilisation to sustained improvement.
- Deliver whole-pathway frailty models at scale, including prevention, same-day assessment and community follow-up.*
- Scale neighbourhood urgent care to support left shift. Fully integrate urgent care, intermediate care and community services within neighbourhood teams.*
- Redesign UEC for CYP, expanding same-day assessment and age-appropriate alternatives to ED.*
- Embed home first and discharge to assess as standard practice.
- Strengthen integrated working with local authorities and VCSFE partners.
- Reduce reliance on escalation beds and reactive surge responses.
- Embrace new standards and guidance including Model Emergency Department and clinical operational standards for the first 72 hours in hospital.*

Key Metrics and Measures

- 85% 4-hour standard as the annual average.*
- Reduce patients spending >12 hours in ED by further 20%.*
- Reduced delayed discharges and stranded patients.
- Category 2 mean response time <20 mins*
- Reduce NCTR to 10%.
- Intermediate care bed base LOS in line with best practice (<21 days).

2028-31 – Priorities

- Deliver a fully left-shifted, neighbourhood-led urgent and emergency care model with hospital care reserved for those who need it most.*
- Prevent avoidable crisis through proactive, neighbourhood-based care.
- Embed personalised urgent care for frailty, CYP and high-intensity users
- Deliver resilient, equitable urgent care aligned to population need.
- Operate UEC as one system, using shared data, improvement discipline and system accountability to sustain performance.
- Move from recovery to high-performing, sustainable UEC services.
- Accelerate the transition to a more structured, digital-first model, with appointments and scheduling according to clinical prioritisation.*

Key Metrics and Measures

- Sustained ≥85% 4-hour A&E performance.*
- Category 2 mean response time ≤18 minutes, with 90% within 40 minutes.*
- Reduced emergency admissions per 1,000 population.
- Reduced inequalities in urgent care access and outcomes through a reduction in attendances from patients in IMD 1-4 (To confirm %).*
- Consistent system resilience with minimal escalation periods.

13. Dying Well

- Palliative and End of Life Care (PEOLC)

Palliative and End of Life Care (PEOLC)

Case for Change: The number of people who die each year is expected to rise from around 27,000 to 34,000 by 2035. Most people die from long-term health conditions such as cancer, dementia, heart failure, or liver disease, and rates are expected to rise.

Rates for identifying people likely to be end of life and agreeing Advance Care Plans are below ambition. Rates vary greatly from locality to locality and practice to practice.

The proportion of people dying in hospital is higher than the national average – and the gap is getting wider. Cheshire and Merseyside is the 7th highest area (out of 42) for this key metric.

Unplanned hospital activity in the last 3, 6 and 12 months of life is higher than the national average. Put simply, too many people attend A&E and are admitted unnecessarily.

Inequalities: There are significant differences in life expectancy, outcomes and experience dependent on deprivation, ethnicity, disability and learning disability.

Financial: Each year Cheshire and Merseyside ICB spends at least £300m on unplanned hospital care for people in their last 12 months of life.

Other Services: Unnecessary attendances at A&E: We know that the 27,000 people who died in C&M in 2023 attended A&E around 60,000 times in their final 12 months of life. Non-Elective Admissions (NEL): The number of people admitted, and admitted multiple times, is higher than the national average.

*Medium Term Planning Framework (metric/measure or narrative).

We will: Enable access to good quality end of life care equitably across Cheshire & Merseyside

Our ambitions are:

- 60% of people who die to have been on a palliative care register (referred to as Gold Standards Framework or GSF).
- Our ambition is for 60% of people who die to have had an Advance Care Plan or discussion.
- Our ambition is to reach the England average of proportion of deaths in hospital (currently 42.7%).
- 10% reduction in A&E attendances and Non-Elective Admissions by people in the last 12 months of life by year 5 of the plan.

2026-27 – Priorities

- Development of a C&M PEOLC Strategy.
- Improve early identification and advance care planning.*
- Work in partnership with providers to support and strengthen the learning and development for all staff involved in palliative and end-of-life care.
- Refresh and align commissioning for specialist palliative and end-of-life care, including a review of hospice provision.
- Implementation of aligned ICB contracts and palliative drug stock holding in community pharmacy.

Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 1 target 37% (Current performance 33%).
- By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. Year 1 target 44% (Current performance is 40%).

2027-28 – Priorities

- Address inequalities in end-of-life care outcomes as outlined in the Population-based Needs Assessment.*
- Transform All Age Continuing Health Care Fast Track pathways into a fully integrated, proactive model offering coordinated 24/7 support.
- Work with General Practice to embed early identification and advance care planning.
- Incorporate babies', children and young people's care in service design: early identification, 24/7 access, and family choice of care setting.

Key Metrics and Measures

- By 2031 60% of people who die to have been on a palliative care register. Year 2 target 41% .
- By 2031 60% of people who die to have had an have an Advance Care Plan or discussion. Year 2 target 48%.
- Place of Death – England average 42.7% year 2 target 45.5% (currently 47.5% of people die in hospital in C&M).

2028-31 – Priorities

- Shared Care Record for PEOLC to be fully interoperable to co-ordinate the wishes of people who are at end of life.
- Ensure palliative care is fully integrated into developing neighbourhood models providing single points of access, treatment escalation plans, and co-ordinated touch points.

Key Metrics and Measures

- 10% reduction in unnecessary A&E attendances by year 5 of the plan.
- Non-elective, and admitted NEL multiple times, is higher than the national average. Our ambition is to meet the national average by year 5 of the plan. (target 60.3% and 6.2%).

14. System Enablers

We have identified the following system wide enablers that support the delivery of our population health plan

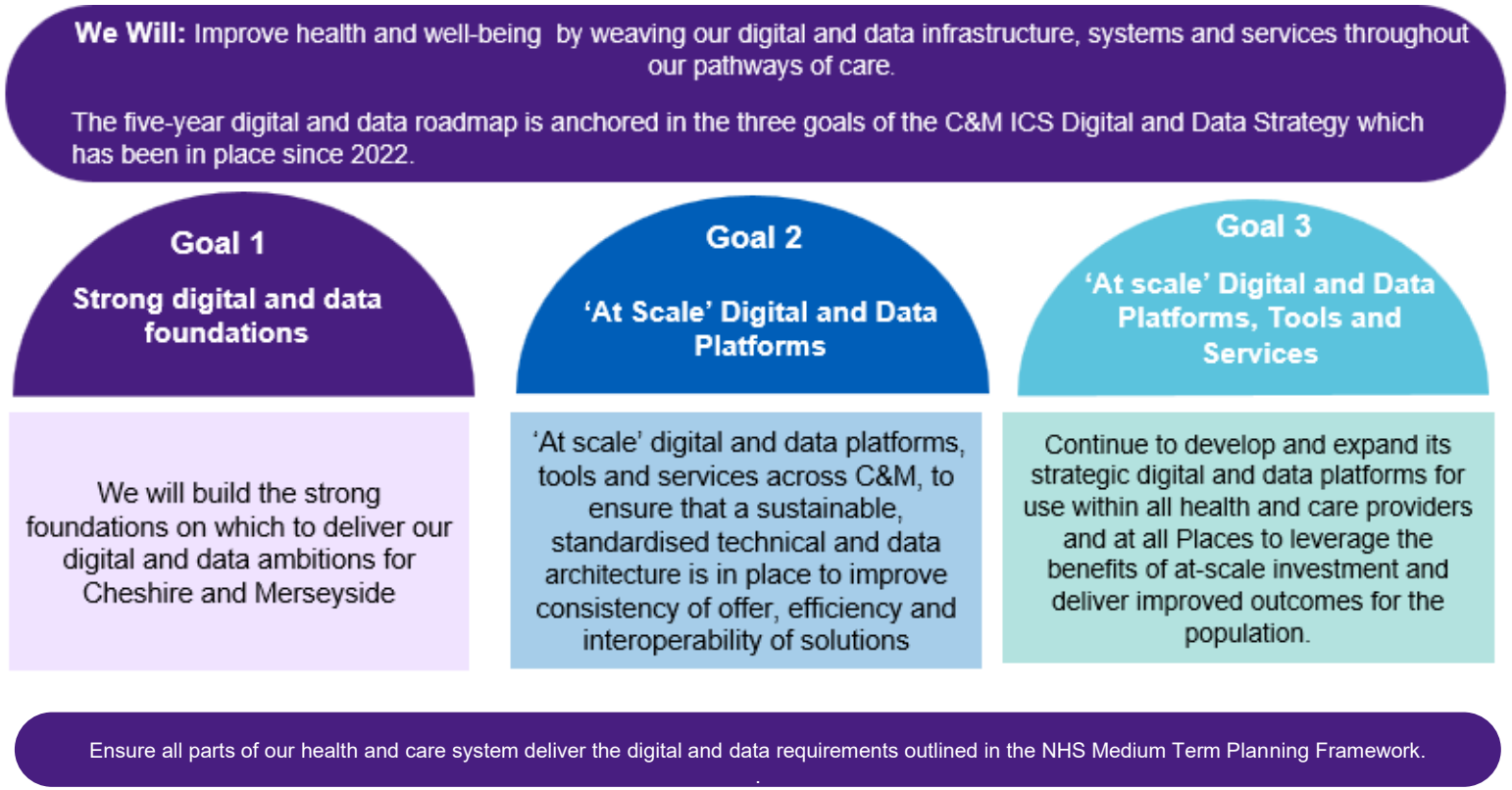
- Digital and Data
- Workforce
- Estates and infrastructure
- Governance and Executive accountability

Enablers: Digital and Data

We have identified a number of system wide enablers that support the delivery of our population health plan. Innovation and technology and specifically, Digital and Data is a significant contributor.

The Cheshire and Merseyside Provider Collaborative (CMPC) reset and the creation of a shared multi-year Digital workplan will be a key enabler for the collaborative's priorities It will enable significant economies of scale; Support a phased consolidation of digital infrastructure and Digital support teams and allow us to organise and deploy our transformation resources more effectively by innovating and scaling faster and more consistently to deliver measurable benefits.

The five-year digital and data roadmap is anchored in the three goals of the Cheshire and Merseyside Digital and Data Strategy which has been in place since 2022.



Enablers: Digital and Data

Goal 1. Build Strong Digital and Data Foundations

Phase 1 Immediate Actions 26-27

Electronic Patient Record (EPR) implementation:

- Liverpool University Hospitals NHS Foundation Trust: EPR build and implementation
- MWL and W&H: EPR ITT, Procurement and Full Business Case

Digital and Data Service Consolidation:

- Develop CSU exit plan and risk mitigation strategy
- Develop General Practice IT strategy
- Develop a data strategy

Cyber Security

- Accelerate Cyber Plan

Phase 2 Transition and consolidation 27-28

EPR implementation:

- LUHFT: EPR build, implementation & operational
- Other LAASP Trusts: EPR Build and implementation
- MWL and W&H: EPR build and implementation

Digital and Data Service Consolidation:

- Review shared service desk options
- Migrate CSU services to federated/shared models
- Implementation of rationalised General practice IT infrastructure

Phase 3 Integration and Innovation 28-29

EPR implementation:

- Other LAASP Trusts: Phased EPR rollout
- MWL and W&H: Go Live (2029)

Digital and Data Service Consolidation:

- Launch Digital Centre of Excellence
- Delivery of shared IT services models
- Rollout digital workforce development programme

Phase 4 Full System integration 30-31+

EPR implementation:

- Other LAASP Trusts: Phased EPR rollout

Digital and Data Service Consolidation:

- Maintain continuous improvement and annual strategy refresh

System Cyber Optimisation

Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

Goal 2. Design and deliver 'at scale' digital and data architecture and infrastructure

Phase 1 Immediate Actions 26-27

- Establish Architecture governance and Task and Finish Group
- Map digital estate, contracts and workforce
- Comprehensive review of non-pay contracts
- Rationalisation and harmonisation of hardware
- Review current usage of core national products and services (through the national dashboard)*

Phase 2 Transition and consolidation 27-28

Implement joint procurement and contract harmonisation

Begin infrastructure rationalisation

Plan and deliver migration over to core national product and services in line with other elements of their digital roadmap and existing contract expiry dates

Phase 3 Integration and Innovation 28-29

Phase 4 Full System integration 30-31+

- Achieve unified digital estate and standardised architecture*
- Maintain continuous improvement and annual strategy refresh

Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

Goal 3. Deploy 'at scale' digital and data platforms, tools and services

Phase 1 Immediate Actions 26-27

- Agree System Priorities for Federated Data Platform (FDP) including Population Health Management (PHM)*
- Mobilise Ambient Voice Technology (AVT) deployment across all providers. *
- Undertake Agentic AI Pilot in Elective Care to automate waiting list management
- Deploy 'at scale' clinical Artificial Intelligence (AI) solutions into Clinical Networks including Radiology
- Confirm high priority use cases for Shared Care Record
- Confirm requirements for 'at scale' Neighbourhood Health Platform

Phase 2 Transition and consolidation 27-28

Complete onboarding of FDP core products most appropriate to the care setting and develop FDP as a strategic commissioning tool for the ICB*

- Evaluate AVT programme and deploy long term AVT solution.*

Continued mobilisation of digital innovation programmes involving the use of AI solutions (e.g.. AI assisted triage, digital therapeutics)

- Maximise adoption & use of Shared Care Record (ShCR) in line with agreed priority use cases

Rollout and optimise single 'at scale' platform to support Neighbourhood Health requirements including support for remote monitoring & virtual ward

Deliver improved system integration & information flow with North West regional & other cross C&M boundary services, in particular NWAS

Phase 3 Integration and Innovation 28-29

- Review ShCR Strategy and approach in line with national Single Patient Record Plans

Maintain continuous improvement and annual strategy refresh

Phase 4 Full System integration 30-31+

- Embed advanced analytical research capabilities into FDP*
- Maintain continuous improvement and annual strategy refresh
- Migrate to national Single Patient Record
- Maintain continuous improvement and annual strategy refresh

Enablers: Digital and Data

*Medium Term Planning Framework (metric/measure or narrative)

Goal 3. Deploy 'at scale' digital and data platforms, tools and services

Phase 1 Immediate Actions 26-27

- Optimise use of the C&M single Referral Management system for independent sector referrals
- NHS Providers and GP Practices to review existing patient communication services

Phase 2 Transition and consolidation 27-28

- Investigate opportunities to utilise this system in other care settings and for other purposes
- Transition to NHS Notify as existing patient communication services contract expire*

Phase 3 Integration and Innovation 28-29

- Maintain continuous improvement and annual strategy refresh

Phase 4 Full System integration 30-31+

- Maintain continuous improvement and annual strategy refresh

Implement single C&M wide order communications, laboratory information management and diagnostic test booking systems

Optimise use of 'at scale' digital diagnostic solutions and continue to rollout in line with digital diagnostics roadmap

Maintain continuous improvement and annual strategy refresh

Continue to expand the availability of information and services available to patients through the NHS App through continued development of NHS Provider Patient Empowerment Portals (PEPs). This will include patients' abilities to manage their medicines, to view waiting times and contact information, to receive and complete pre and post-appointment questionnaires, and to implement digital PIFU in line with GIRFT guidance*

Maintain continuous improvement and annual strategy refresh

Drive forward other system wide 'at scale' projects, identified and agreed by system partners, that deliver productivity improvements and cost savings (e.g.. scanning and storage of paper records)

Maintain continuous improvement and annual strategy refresh

Enablers: C&M Strategic Workforce Plan

The ambition of our workforce plan:

We Want: Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online

The NHS Cheshire and Merseyside ICB system workforce plan frames the workforce as a critical strategic enabler for care closer to home.

It articulates a system-wide ambition to diversify, strengthen and modernise the health and care workforce, enabling a deliberate shift from hospital-centric treatment towards sustained disease management, prevention and personalised, community-based care.

This positions the workforce plan as a catalyst for improving long-term population health outcomes through the:

*Pursuance of affordable workforce models based on supply and demand congruence

*Rationalisation of workforce resources and

* Workforce transformation to support new integrated neighbourhood working models of care.

The NHS C&M ICB System Workforce Plan is supported by the NHSE C&M Workforce Plan: the latter maintaining a specific focus on oversight of acute and secondary care workforce planning.

Affordability

Demand analysis based on population health data, the JSNA and wider health intelligence including the CORE20PLUS5.

Supply and demand planning to achieve optimal affordability and reduced waste across integrated neighbourhood teams.

Workforce gap analysis and remedial action planning to build a futureproof workforce with the capacity and capability to facilitate integrated neighbourhood models of care.

Rationalisation

Rationalisation of non-clinical corporate support services to achieve economies of scale so far as possible.

Workforce redesign to integrate and optimise the benefits of AI, digital capability and technology solutions.

Efficient and effective management of change to maintain clinical quality and safety and optimal wider workforce productivity.

Transformation

Workforce modelling in collaboration with system partners to cultivate integrated neighbourhood multidisciplinary teams.

Workforce innovation informed by epidemiology, public health and the CORE20PLUS5.

Workforce capability planning to enable effective risk management of transitioning from existing to new ways of working.

As an ICB, we will partner with our staff and system partners to deliberately create ways of working that enable human ingenuity to flourish by:

- **Setting clear accountability for anti racism and social inclusion.**
- **Ensuring safe and supportive ways to raise concerns about practices that may harm our staff, patients, or the public.**
- **Taking a population health approach to staff health and wellbeing.**
- **Putting people at the centre of how we lead and manage.**
- **Reducing unnecessary bureaucracy so staff at all levels can take part in decision making through networks or engagement forums.**
- **Embedding Board level oversight of organisational culture and employee experience, aligned with the NHS Constitution and the Nolan Principles for public service.**

To deliver our system workforce plan, we will:

- **Look after the health and wellbeing of our workforce**
- **Cultivate anti-racist and anti-discriminatory ways of working**
- **Nurture a values-based culture**
- **Demand personal and communal accountability for health justice**
- **Create opportunities to learn and continually develop**
- **Engender civility in the workplace**
- **Deliver on the NHS People Promise**
- **Develop psychologically safe places of work where staff can speak up, be heard and challenge without fear of retribution and**
- **Provide meaningful platforms for staff engagement with organisational decision making.**

We want: Cheshire & Merseyside to be a great place to train, work & be an outstanding place for compassionate care; whether in the community, in one of our hospitals or online.

Enabler: NHSE C&M Workforce Priorities

Immediate Priorities: Operational Planning 26-27

- Affordable workforce planning based on supply & demand forecasting, focusing on temporary staffing spend efficiencies & agility.
- Harmonising corporate services & HR&OD through re-design of corporate support functions & incorporating digital solutions for greater efficiency & effective management of resources
- Exploring and understanding root causes of absence – aiming to reduce sickness absence by 1% in 26/27.
- Conducting workforce capacity reviews to understand current ways of working and potential areas of waste, distraction, duplication or efficiency to inform and contribute to delivering 2% average annual productivity growth in 2025/26 and over the Spending Review Period.
- Streamlining People Services across the health economy to achieve economies of scale wherever possible.

Foundational Priorities: 27-28

- Embedding the new National Management and Leadership framework and programmes which actively contribute to delivering the strategic ambitions laid out in the 10-year Health plan.
- Creating close alignment and collaborative working with quality improvement teams and Professional Leads to ensure clinical and professional standards and safe staffing thresholds are met, with a particular focus on Maternity workforce and Mental Health investment standards.
- Overseeing accountability for the performance of the NHS People Promise to ensure we care for those who care.
- Ensuring understanding and quantification of reasonable workloads and that longer term effects on individuals and teams are recognised and addressed within financial recovery plans.

Foundational Priorities: 27-28 Continued…

- Generating good employment opportunities for our local populations through apprenticeship pathways in hard to fill roles.
- Understanding future skills requirements and building responsible talent and progression pathways.
- Protecting student and learner placement opportunities, and appropriate trainer/supervision and education & training capacity required for longer term staffing needs.
- Adapting skill mix and accelerating functional redesign activities, maximising the utility of new and non-medical consultant roles.
- Conducting robust workforce establishment reviews and demonstrating robust establishment control measures.
- Accelerating robust Job Planning and rostering practices to enhance sustainable and agile deployment. Building in flexibility and ownership for staff as well as enhanced pay cost forecasting.

Longer Term 28-31+

- Delivering national ambitions to enhance employment from local communities and reduce international recruitment to <10% by 2035.
- Embedding skills aligned to digital and technological capabilities & innovation to support efficiency ambitions.
- Translating digital transformation and AI (Artificial Intelligence) integration programmes into readiness and capability programmes for staff.
- Embedding new ways of working, including integrated workforce models, cross-sector, and collaboration across system networks.
- Developing system level solutions to address workforce challenges - prioritising workforce diversity as a key asset in achieving health justice
- Strengthening the interface between hospital and community care pathways, sustaining the transition from hospital to community, treatment to prevention and analogue to digital.

NHS Medium Term Plan - Operational headline targets:

- Trusts to reduce agency and bank use in-line with individual trust limits as set out in planning templates, working towards zero spend on agency by 29/30.
- Annual limits will be set for trusts individually based on a national target of 30% reduction agency in 26/27 and 10% year on year reduction in spend on bank staffing.

Enablers: Estates and Infrastructure

Goal 1 – We will continue to develop and expand the programme; including leadership and governance to enable the delivery of the ICS Infrastructure Strategy

Immediate priorities 26-27

- Setting of Corporate and System KPIs and SMART Objectives for the Estates Programme
- Integrate and refine the system governance mechanisms for Estates into a singular reporting forum
- Develop MOUs for Collaboration at Scale opportunities with NHS and Non-NHS partners
- Implement consistent Core, Flex and Tail classifications within Partner Organisations i.e. Local Authority and VCFSE

Immediate priorities 27-28

- Develop a Leasing Strategy for Primary Care
- System Capital and Resource Group established
- One Public Estates Board's established in Devolution Regions

Longer Term 28-29

- Development of a Cheshire and Merseyside Estates and Facilities Management Workforce Strategy
- Continued collaboration on programme delivery across Health and Social Care

Longer Term 30-31+

- Establish stabilisation of fragile services
- Maintain financial sustainability
- Deliver effective governance and leadership within System

Continued improvement and collaboration with regional ICBs processes to ensure consistency of approach

Maintain continuous improvement and annual strategy refresh

Delivery of KPI's and SMART Objectives

Enablers: Estates and Infrastructure

Goal 2 – Creating fit for purpose, sustainable physical estate

Immediate priorities 26-27

- Outline Business Case Submission of new Neighourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Refine the System Estates and Infrastructure Investment Strategy to include Neighbourhood Hub opportunities including identified Pioneer and future Neighbourhood development sites
- Creation of an Estates Asset Management Plan to support better utilisation and cost improvement proposals via disposals
- Develop an Improvement Plan for Modern General Practice where access to the physical Estate is a prevailing factor
- Develop a Utilisation and Optimisation Plan for NHS Property Services and Community Health Partnerships

Immediate priorities 27-28

- Evaluate Full Business Cases for new Neighourhood Health Centre proposals including, Knutsford, Aintree, Maghull and Handbridge
- Comprehensive review and implementation of a LIFTco End of Concession strategy for our CHP Portfolio
- Support the development of Decarbonisation Plans within Existing Estate
- Develop an ICS Design and Development Standards for New Builds
- Review opportunities for rationalisation and optimisation because of vertical integration (Community to Acute)

Longer Term 28-29

- Deliver New Neighbourhood Health Centres in Key Service Areas including but not limited to: Knutsford, Aintree, Maghull and Handbridge.
- Reduce the level of Tail Estate by 10-15% via rationalisation, optimisation or new investment.
- Support the Full Business Case Submission of a New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)
- Review opportunities for increasing the capacity and provision of existing Community Diagnostic Centres to support more outreach services

Longer Term 30-31+

- Refresh System Estates and Infrastructure Investment Strategy
- Continue improving access to service and health outcomes
- Completion on construction on the New Hospital for Mid Cheshire Hospitals Foundation Trust (MCHFT)

Deliver Neighbourhood Health Centre's (existing or new)

Enablers: Estates and Infrastructure

Goal 3 – Data Driven Approach

Immediate priorities 26-27

- Develop an Activity Driven Estates Tool (ADEPT) to support clinical redesign of Neighbourhood Health
- Develop the SHAPE ICS Strategy ATLAS to include Neighbourhood Planning and All Estates Data for Health Partners
- Vacant and Void Space reporting from NHS Property Services (NHSPS) and CHP transformed into a Cost Improvement Plan
- Utilise data to develop Plan on Pages for Estates enablement in Places

Immediate priorities 27-28

- Enhance the utilisation of CIPHA and other population health management tools to support investment prioritisation
- Undertake Pilot for implementing a digital twin in Provider Estate to replace paper based reporting and improve space optimisation and asset management.
- Delivery of PACE (Productivity Acceleration in Community Estates) Programme in conjunction with CHP

Longer Term 28-29

Longer Term 30-31+

Maintain continuous improvement and annual strategy refresh

Implement continued change in existing Business as Usual processes to enhance productivity

Governance and Executive Accountability Summary

Life Course Stage	Programme	Committee (Programme Board reporting through to ICB Board Sub Committee)	Accountable Executive Director
Living Healthy Lives	• Cancer • Long Term Conditions (Cardiovascular-Renal Metabolic, Respiratory Disease) • Healthy Behaviours • Screening and Immunisation • Outbreak Responses • Serious Violence Duty	Cancer Alliance Board into Strategic Commissioning Committee. Programmes reporting to Population Health Board into Strategic Commissioning Committee.	Clinical Director Director of Health and Integrated Care Commissioning
Starting Well	• Maternity and Neonatal Care	Programme Board into Strategic Commissioning Committee.	Clinical Director
Growing Well (Children and Young People)	• Neighbourhood Health and accountable care approaches • Mental Health • Neurodiversity • Joint Commissioning and Partnerships	Programme Board into Strategic Commissioning Committee. *(Review to be undertaken for system CYP Governance including development of ACO)*	Director of Health and Integrated Care Commissioning
Living Well	• Mental Health (including community) • Learning Disability & Autism • Neurodiversity (Adults) • Integrated Neighbourhood Teams • Community Services • Elective (Planned) Care • Diagnostics • Primary Care (General Practice, Dental, Optometry and Pharmacy) • Stroke • Women's Health	Programme Board into Strategic Commissioning Committee. Primary Care Committee. Programme Board into Strategic Commissioning Committee.	Director of Health and Integrated Care Commissioning Clinical Director
Ageing Well	• Prevention of Frailty Escalation • Dementia • Falls Prevention • Urgent and Emergency Care	Programme Board into Strategic Commissioning Committee.	Director of Strategy and Transformation
Dying Well	• End of Life and Palliative Care	Programme Board into Strategic Commissioning Committee.	Clinical Director
Enablers	• Digital and Data • Workforce • Estates and Infrastructure	Programme Boards to Strategic Commissioning Committee. *Notes: ICB role in Workforce has changed and arrangements need confirming from April.* *Capital decisions via Finance Investment and Resources Committee*	Clinical Director TBC Director of Finance and Contracting

Glossary

- ABC = Atrial fibrillation, high Blood pressure and Cholesterol
- ACO = Accountable Care Organisation
- ADHD = Attention Deficit Hyperactivity Disorder
- AI = Artificial Intelligence
- AIDS = Acquired immunodeficiency syndrome
- ATLAS = Part of the Strategic Health Asset Planning and Evaluation Tool
- BBV = Blood Born Virus
- CAMHS = Child Adolescent Mental Health Services
- CDC = Community Diagnostic Centre
- CETR = Care Education Treatment Review
- CDif = Clostridioides difficile
- CGM = Continuous Glucose Monitoring
- CHC = Continuing Health Care
- CHP = Community Health Partnerships
- CIPHA = Combined Intelligence for Population Health Action
- CMCA = Cheshire and Merseyside Cancer Alliance
- COPD = Chronic Obstructive Pulmonary Disease
- CVD = Cardiovascular Disease
- CSU = Midlands and Lancashire Commissioning Support Unit
- CYP = Children and Young People
- DIA = Data Into Action
- DiaDEM = Diagnosing Advanced Dementia Mandate
- DOAC's = Direct Oral Anticoagulants
- EDC = Elective Diagnostics Cancer
- EDI = Equality Diversity Inclusion
- ENT = Ear Nose and Throat
- EPR = Electronic Personal Record
- FDP = Federated Data Platform
- FDS = Faster Diagnosis Standard
- FeNO = fractional exhaled nitric oxide
- GIRFT = Getting it Right First Time
- HACT = Housing Associations' Charitable Trust
- HCAI's = Healthcare-associated infections
- HIV = Human immunodeficiency virus
- HPV = Human papillomavirus
- ICU = Intensive Care Unit
- IHA = Initial Health Assessment
- IHO = Integrated Health Organisation
- IMD = Index of Multiple Deprivation
- INT = Integrated Neighbourhood Team
- ITT = Invitation to Tender
- KPI = Key Performance Indicator
- LA = Local Authority
- LAASP = Liverpool Adult Acute and Specialist Providers

Glossary

- LD&A =Learning Disability and Autism
- LeDeR = Learning from lives and deaths programme
- LGI = Lower Gastrointestinal
- LIFTco = Local Improvement Finance Trust Company
- LUHFT = Liverpool University Hospitals NHS Foundation Trust
- LOS = Length of Stay
- LRTI = Lower respiratory tract infection
- LTC = Long Term Conditions
- MDT = Multi-disciplinary Team
- MMR = Measles Mumps Rubella
- MOU = Memorandum of Understanding
- MSK = Musculoskeletal
- MWL= Mersey and West Lancashire Teaching Hospitals NHS Trust
- NDH = Non-Diabetic Hyperglycaemia
- NEET = Not in Employment Education or Training
- NEL = Non-Elective
- NROL = Neuro-Rehabilitation On-line
- NWAS = North West Ambulance Service
- OPIC = Office of the Public Independent Conciliator
- PCN = Primary Care Network
- PCRS = Primary Care Respiratory Society
- PHIP = Population Health Improvement Plan
- PTL = Patient Tracking List
- PREM's = Patient-Reported Experience Measures
- PROM's = Patient Reported Outcome Measures
- PTL = Patient Tracking List
- QaLYS = Quality-Adjusted Life Years
- RPA = Robotic Process Automation
- SABA = Short-Acting Beta-Agonists
- SEND = Special Educational Needs
- SHAPE = Strategic Health Asset Planning and Evaluation
- ShCR = Shared Care Record
- SMART = Specific, Measurable, Achievable (or Attainable), Relevant, and Time-bound
- SOP = Standard Operating Procedure
- SRO = Senior Responsible Officer
- STB = Supervised Teeth Brushing
- STT = Straight to Treatment
- TB = Tuberculosis
- UNICEF BFI = United Nations Children's Fund UK Baby Friendly Initiative
- VCFSE = Voluntary Community Faith Social Enterprise
- VPD = Vaccine Preventable Disease
- W&H = Warrington and Halton Teaching Hospitals NHS Foundation Trust