Draft

#BecauseWeCare
Cheshire East Partnership

The Joint Health and Wellbeing Strategy for the population of Cheshire East 2023-2028

The Cheshire East Partnership Five Year Plan

NHS

Cheshire East Council

Contents

01 Introduction 3

02 Our vision 4

03 The way health and care is organised locally 6

04 The 'building blocks' of good mental and physical health and wellbeing 9

05 What are the challenges 15

06 The strategic outcomes 16

07 Our approach to achieve the strategic outcomes 26

01 Introduction

The Joint Local Health and Wellbeing Strategy sets out our[1] high-level vision and aspirations to:

- Reduce inequalities, narrowing the gap between those who are enjoying good health and wellbeing and those who are not
- Improve the physical and mental health and wellbeing of all of our residents
- Help people to have a good quality of life, to be healthy and happy.

[1]The 'Joint Local Health and Wellbeing Strategy for the population of Cheshire East 2023 – 2028' is written on behalf of the Cheshire East Health and Wellbeing Board and the Cheshire East Health and Care Partnership, forming the latter's 'Five Year Plan'.

02 Our vision

"To enable people to live well for longer; to live independently and to enjoy the place where they live."

Our local focus will be upon:

- Tackling inequalities, the wider causes of ill-health and the need for social care support, through an integrated approach to address worklessness, poverty, debt, poor housing, social isolation and loneliness
- Prevention and early intervention, health improvement and creating healthy environments that support and enable good physical and mental health and wellbeing
- Ensuring our actions are centred around the individual, their goals and the communities where they live, working with, not doing to you
- Developing and delivering a sustainable, integrated health and care system that supports you as close to home as possible

We will take action to help improve the physical and mental health and wellbeing of the population now and in the future, investing in what makes the biggest difference to most people, focussing upon empowering individuals, families and communities to take ownership of their wellbeing with support available when and where it's needed.

We will co-design and deliver safe, integrated and sustainable services that meet people's needs through the best use of all the assets and resources we have available to us.

The Strategy's primary evidence base is the Joint Strategic Needs Assessment, and it is complemented by a number of Cheshire East and NHS Integrated Care Board (ICB) strategies such as those for the Environment, Housing, Transport, Green Spaces and Digital, all of which influence people's health and wellbeing.

It also considers the recommendations of plans across the wider Cheshire and Merseyside Integrated Care System, including the Cheshire and Merseyside Integrated Care Partnership's Strategy and the Integrated Care Board's 'All Together Fairer' and 'All Together Active' strategies.

In addition, other plans will set out in more detail different aspects of how we will deliver our vision and priorities. These will include a Five-Year Health and Care Service Delivery Plan, the Live Well in Crewe Plan, and the Better Care Fund Plan.

Organisational strategies will also be aligned to the local Joint Health and Wellbeing Strategy in due course, with a commitment to work in partnership to deliver against the strategic outcomes set out below.

Outcomes

We have four strategic outcomes that we are working to achieve. These are to:

1. Create a place that supports good health and wellbeing for everyone living in Cheshire East
2. Ensure that our children and young people are happy and experience good physical and mental health and wellbeing
3. Improve the mental health and wellbeing of people living and working in Cheshire East
4. Enable more people to live well for longer in Cheshire East

To enhance our working in partnership and as an integrated care system we will be:

- Demonstrating improved outcomes within a broad vision of health and wellbeing
- Enabling people to be happier, healthier and independent for longer
- Making the connections between wellbeing and economic prosperity
- Supporting people to take personal responsibility for their good physical and mental health and wellbeing and making healthy lifestyle choices
- Co-producing and collaborating with our residents, service users and people with lived experience
- Building the necessary workforce, estate infrastructure and financial capacity
- Providing strategic system leadership

Principles

The principles that will underpin our work are to:

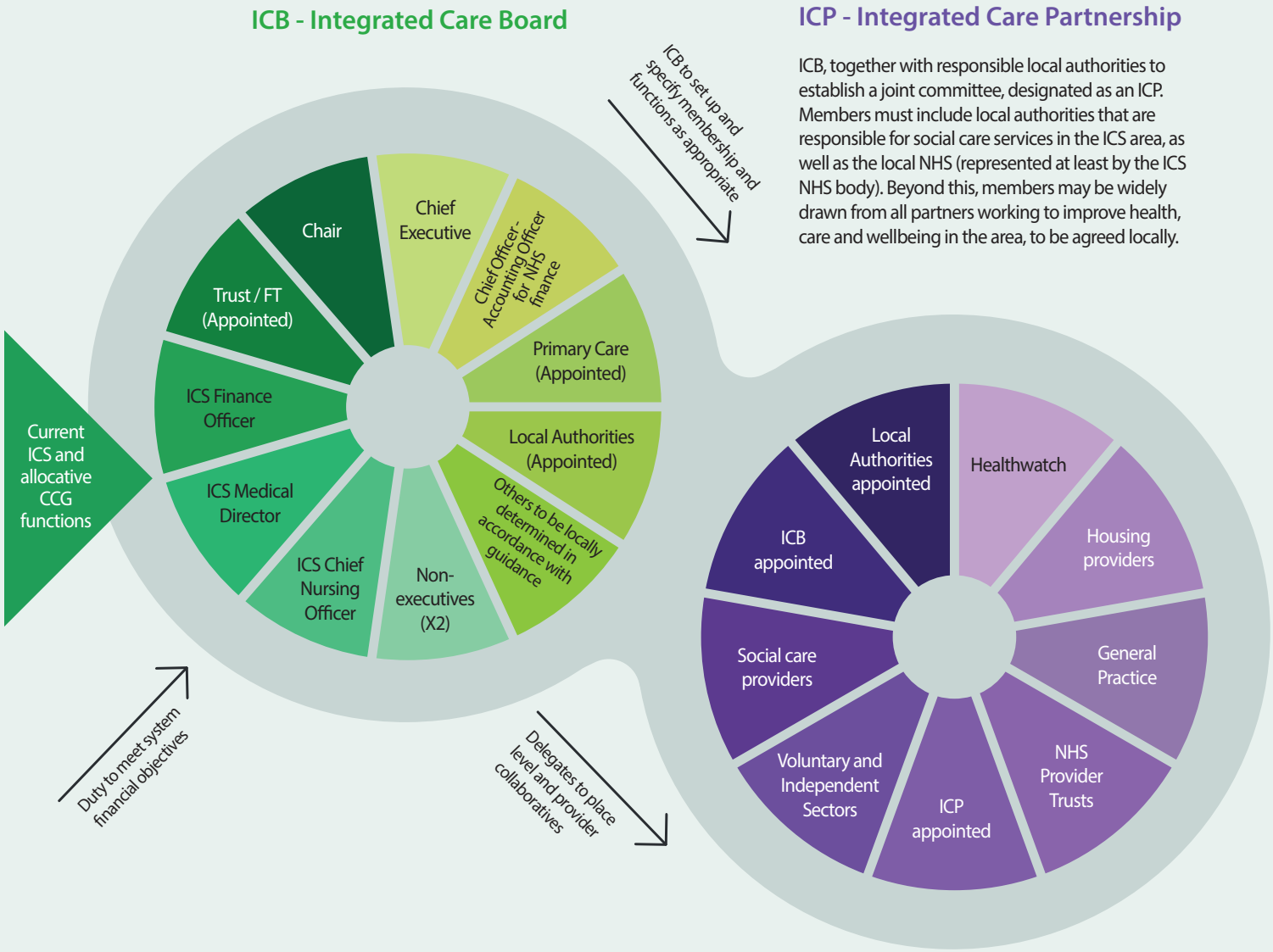
- Put the voices of people and communities at the centre of decision-making and governance, at every level
- Coproduce and redesign services and tackle Cheshire East priorities in partnership with people and communities.
- Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions
- Understand communities' needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect
- Build relationships with excluded groups, especially those affected by inequalities.
- Work with Healthwatch and the voluntary, community, faith, and social enterprise (VCFSE) sector as key partners.
- Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
- Use community development approaches that empower people and communities, making connections to social action.
- Use co-production, insight and engagement to achieve accountable health and care services.

03 The way health and care is organised locally

The Cheshire and Merseyside Integrated Care System

Cheshire East is a partner in the Cheshire and Merseyside Integrated Care System (ICS). The ICS comprises two key components (Figure 1): the NHS Cheshire and Merseyside Integrated Care Board that, since 1st July 2022 has held responsibility for planning and funding most local NHS services, including primary care, community pharmacy and those services previously commissioned by clinical commissioning groups (CCGs); and the Cheshire and Merseyside Integrated Care Partnership (ICP) which brings together a broad set of system partners (including local government, the voluntary, community, faith and social enterprise sector (VCFSE), NHS organisations and others)to develop a health and care strategy for the area.

Figure 1. The Integrated Care System (Hill Dickinson)



The Cheshire East Health and Wellbeing Board

The Cheshire East Health and Wellbeing Board was established in 2013 as a requirement of the Health and Social Care Act (2012). The Board exists to:

- Bring together the key decision makers across the NHS and local government
- Set a clear direction for the commissioning (planning and delivery) of health care, social care and public health services
- Drive the integration of services across communities
- Improve local democratic accountability
- Address the wider determinants of health and tackle inequalities.

In Cheshire East the Health and Wellbeing Board membership includes representatives from: the local authority, local NHS partners, the community and voluntary sector, Healthwatch, the Cheshire Constabulary and Cheshire Fire and Rescue Service (Figure 2).

Figure 2. The Cheshire East Health and Wellbeing Board

The Cheshire East Health and Care Partnership

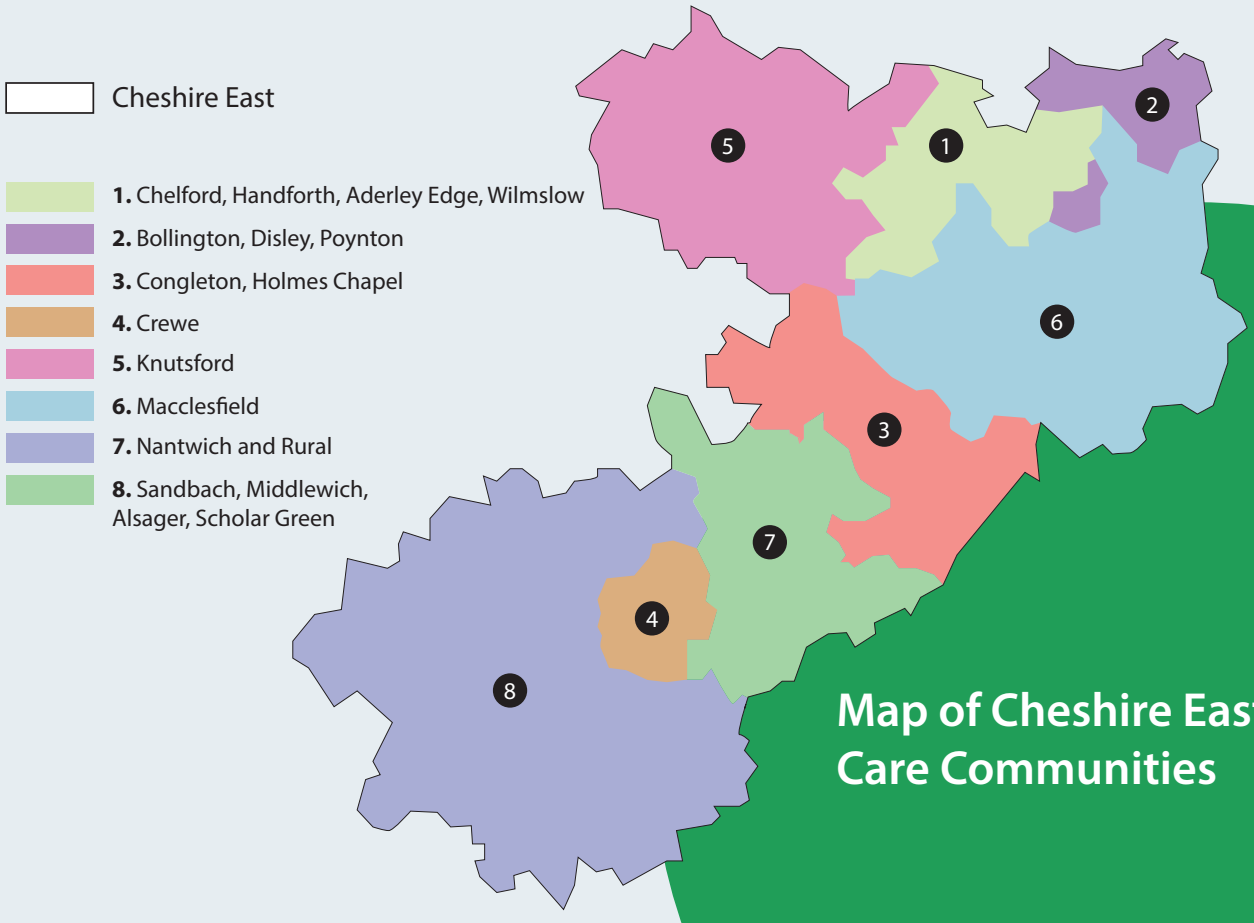
The Cheshire East Health and Care Partnership was established in 2018 and is made up of all parts of the local health and care system: the local authority, NHS Cheshire and Merseyside, NHS provider organisations, GPs, the community and voluntary sector and Healthwatch (figure 3.). The focus is on improving access to and the quality of health and care service provision, through a more integrated approach and working closely with residents, communities and the community and voluntary sector.

Figure 3. The Cheshire East Health and Care Partnership

Cheshire East Council	Cheshire & Merseyside ICB	Cheshire East GP Confederation	Mid Cheshire NHS Foundation Trust	East Cheshire NHS Trust
Cheshire and Wirral Partnership NHS Foundation Trust	Cheshire East Healthwatch	Cheshire East Care Communities	Cheshire East Social Action Partnership	Local Medical Committee

Our Care Communities

Our eight Care Communities are local partnerships based around clusters of GP surgeries, working to meet the needs of residents in their areas. These will form the foundation of the integrated health and care system in Cheshire East.



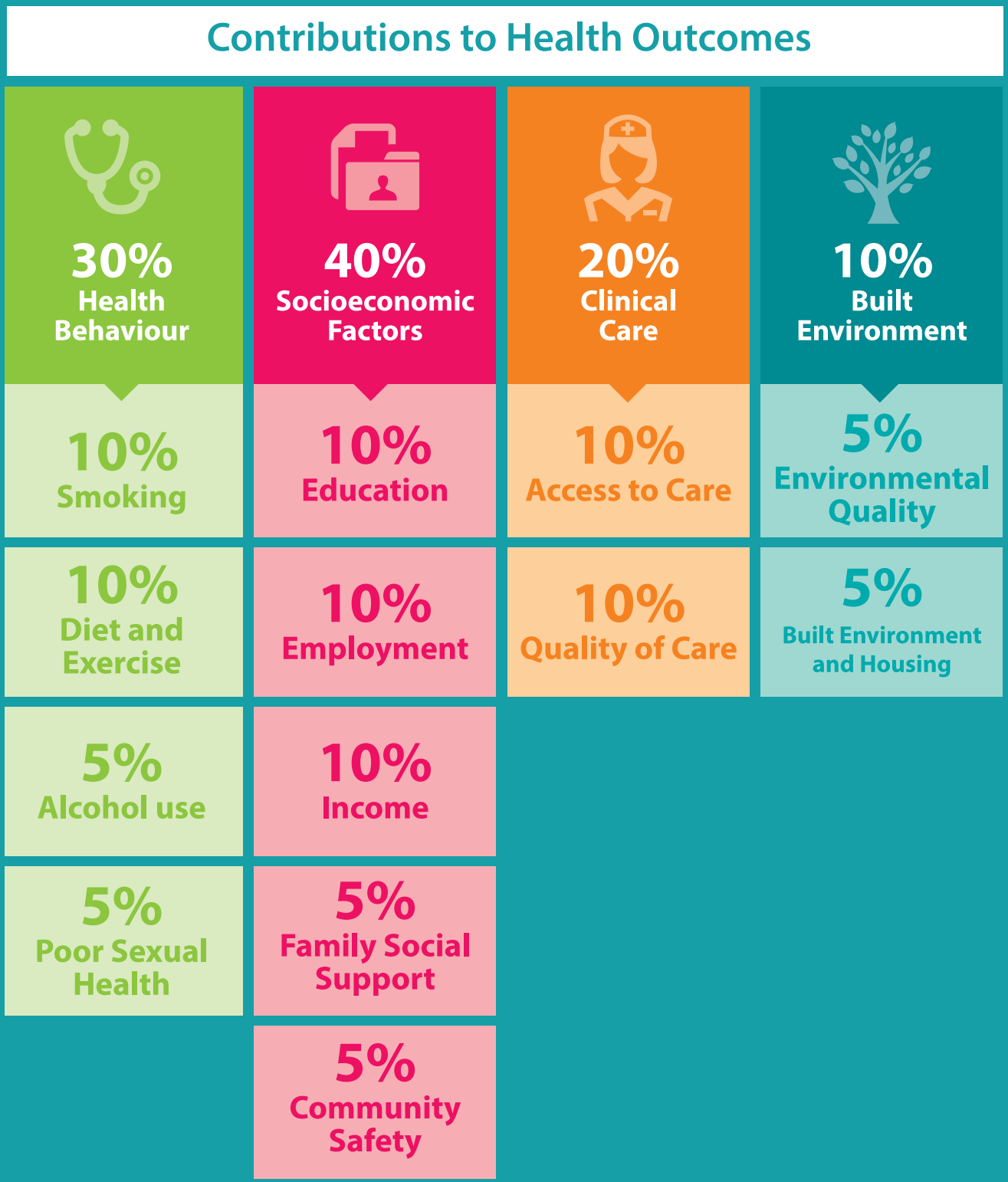
04 The 'building blocks' of good mental and physical health and wellbeing

Good physical and mental health and wellbeing go hand in hand with economic growth and prosperity. Whilst access to good quality health services is important, most of what makes us healthy has nothing to do with health care (figure 4.)

We all need access to suitable housing, education, employment, sufficient income, infrastructure (including green spaces, leisure and cultural opportunities) and good quality information that helps us to make positive choices in relation to our lifestyles. These 'building blocks' of health and wellbeing are connected and complement each other. When we don't have a warm home or healthy food and are worrying about making ends meet, it puts a strain on our bodies.

This can result in increased stress, high blood pressure and a weaker immune system and lead to ill health and the need to access health services.

Figure 4. Relative contributions to population health outcomes (Park H., Roubal, A.M., Jovaag, A. Gennuso, K.P. and Catlin, B.B 2015 - American Journal of Preventive Medicine December 2015)



Despite deteriorating health and widening inequalities across the country and in Cheshire and Merseyside, there is scope for local areas to make a real difference.

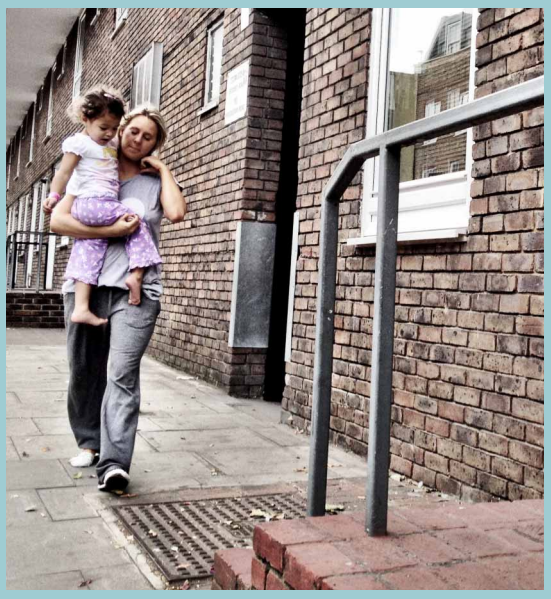
'All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside' [2], published in May 2022, sets out a strong case for reducing health inequalities by focussing upon these building blocks as recommended by the Marmot review (Marmot (2020) Health Equity in England: The Marmot Review 10 Years On[3]).

The inequalities are unnecessary and unjust, harm individuals, families, communities and place a huge financial burden on services, including the NHS, the voluntary and community sector and on the economy. Changes in approach, allocation of resources by need and strengthened partnerships are essential. The recommendations of the 'All Together Fairer…' report will inform our thinking and delivery plan.

Many residents of Cheshire East have good levels of physical and mental health and wellbeing. However, there are still very significant issues affecting our population, some of which have been exacerbated by the pandemic and cost of living crisis.

Amongst these are:

- Increasing the number of people who maintain a healthy lifestyle – e.g., are physically active, have good mental wellbeing and enjoy a balanced diet
- Preparing for an increasingly ageing population (by 2029 it is estimated the number of people aged 65 or over will have increased to 107,374)
- Improving the mental health and emotional wellbeing of residents
- Addressing some stark differences across Cheshire East that are illustrated in the 'Tartan Rug' (which shows the relative performance in the wards of Cheshire East against a series of health indicators - see pages 12 and 13).



[2]All Together Fairer, Champs Public Health Collaborative

[3]Health Equity in England: The Marmot Review 10 Years On - The Health Foundation

Figure 5. Health profiles for electoral wards plus primary health and social care areas February 2021

The chart below shows the health of people in Cheshire East compares with the rest of England.

				Nantwich					Crewe										SMASH							
		Data Type	Time Period	Wrenbury	Bunbury	Audlem	Nantwich South and Stapeley	Nantwich North and West	Wybunbury	Shavington	Willaston and Rope	Wistaston	Crewe South	Crewe West	Crewe Central	Crewe St Barnabas	Crewe North	Crewe East	Leighton	Haslington	Sandbach Ettiley Heath and Wheelock	Sandbach Elworth	Sandbach Town	Sandbach Heath and East	Middlewich	Brereton Rural	Alsager
1	Total Population	Number	Mid-2017	4628	5156	5412	9485	8698	5667	4162	4782	8908	11999	10721	6587	5865	4737	15250	5245	8022	4998	5146	4940	4398	14138	5393	11839
2	BME Population	%	2011	1.2	0.9	1.4	2.4	1.8	2.8	1.7	1.6	1.9	8.5	4.4	7.3	4.1	3.3	3.7	3.9	1.4	2.0	2.2	2.2	1.4	1.5	1.0	2.4
3	Proficiency in English	%	2011	0.1	0.2	0.1	0.1	0.2	0.1	0.2	0.2	0.3	4.9	2.1	5.3	2.5	1.6	1.0	0.7	0.1	0.3	0.1	0.1	0.0	0.3	0.1	0.2
4	Population under 16	%	Mid-2017	14.8	16.7	16.1	19.2	15.9	19.5	15.6	15.8	15.0	19.3	20.7	23.7	26.0	22.0	18.8	20.3	14.8	19.2	18.4	15.1	15.7	18.5	18.0	17.3
5	Population aged 65 and over	%	Mid-2017	25.4	21.2	27.8	22.6	26.6	18.8	26.5	25.3	27.0	12.3	15.7	9.7	13.3	18.5	19.0	10.3	24.7	15.8	20.5	28.8	26.2	19.1	22.5	27.5
6	Pensioners living alone	%	2011	22.6	28.5	23.3	30.0	40.4	23.3	31.5	24.4	26.5	35.6	34.3	46.4	39.4	32.7	33.6	15.7	25.1	28.2	27.4	28.8	37.7	30.2	21.8	32.1
7	Older people with low income	%	2015	8.3	7.4	8.1	8.5	13.0	5.9	6.8	5.3	7.5	17.7	15.4	27.5	30.6	13.5	15.0	5.6	7.6	7.9	7.3	7.5	13.5	12.2	7.9	8.2
8	People with low income	%	2015	6.8	6.2	5.8	6.0	12.2	4.3	5.0	4.1	6.2	16.9	15.7	24.1	28.8	18.9	15.3	4.0	5.3	4.7	7.3	7.1	10.8	9.2	7.3	9.1
9	Children in poverty	%	2015	8.0	8.0	5.0	6.5	15.3	3.7	5.2	4.5	7.4	23.4	23.4	32.4	36.6	31.6	26.0	5.5	6.5	4.9	11.7	9.6	13.6	11.2	10.4	12.0
10	Long term unemployment	Rate	2017/18	1.8			0.6	1.3		2.1		0.7	4.5	2.9	8.5	4.8	2.2	3.0		1.0	0.9			0.2	1.1	0.5	1.5
11	Fertility rate	Rate	2011 - 2015	46.6	45.5	45.3	54.7	63.5	50.3	53.5	46.1	48.1	67.4	61.8	89.5	81.9	73.0	58.1	57.7	40.0	60.7	58.3	50.3	56.0	60.0	52.0	53.2
12	Low birth weight	%	2011 - 2015	1.0	0.8	0.9	1.7	2.6	1.1	2.2	1.8	1.7	2.3	2.4	2.7	1.4	2.5	2.5	2.1	2.3	2.4	2.3	2.4	3.0	1.8	2.2	2.5
13	Deliveries to teenage mothers	%	2011/12 2015/16	1.2	1.2	1.2	1.2		1.2			3.1	1.7	2.2	2.3	3	2.4	3.8							0	0.2	0
14	A&E attendances age 0-4	Rate	2013/14 2015/16	251.5	273.5	256.6	324.7	365.5	307.2	298.2	305.3	345.2	364.4	394.9	414.4	423.1	406.0	435.4	361.4	345.9	310.7	312.2	316.3	314.8	363.6	361.6	292.0
15	Admissions for injury age 0-4	Rate	2011/12 2015/16	132.1	150.4	136.3	168.4	170.3	159.0	114.3	134.6	180.7	171.0	209.3	231.6	247.9	213.3	184.5	128.5	142.1	121.5	125.1	135.7	133.9	125.0	153.8	109.9
16	Emergency admissions age 0-4	Rate	2013/14 2015/16	138.5	167.1	145.1	222.5	257.1	201.2	188.0	203.7	226.0	221.6	222.7	217.7	223.5	212.3	253.0	201.5	227.5	211.0	200.9	172.7	182.5	279.7	196.2	155.1
17	Child development at age 5	%	2013/14	59.1	61.4	60.1	64.0	61.7	66.0	61.5	61.6	56.8	50.6	57.1	51.9	54.5	48.2	50.7	46.6	68.9	69.8	72.5	76.0	66.7	62.4	63.7	59.3
18	GCSE achievement	%	2013/14	77.5	77.7	77.5	65.1	54.0	76.3	53.5	65.3	65.4	49.8	45.8	41.1	31.5	48.6	49.5	67.0	71.9	69.8	71.1	71.1	61.7	56.9	71.3	68.1
19	Excess weight age 4-5	%	2015/16 17/18	20.1	17.0	18.9	19.6	25.4	16.0	16.9	17.2	20.7	24.2	21.9	24.5	23.8	25.5	21.9	22.4	20.3	19.6	19.3	19.3	21.5	22.2	19.0	22.8
20	Excess weight 10-11	%	2015/16 17/18	27.7	27.1	27.4	27.9	29.8	29.8	29.2	28.0	29.1	36.9	35.4	39.1	40.5	38.6	39.6	32.4	36.0	27.1	27.3	27.8	27.7	32.0	31.5	35.1
21	Smokers age 11-15	%	2009 - 2012	3.3	1.8	2.6	4.3	3.2	2.7	3.2	2.6	2.8	4.2	3.8	8.0	4.4	4.2	3.3	2.9	2.5	2.3	2.4	3.0	2.9	2.1	2.6	3.2
22	Smokers age 16-17	%	2009 - 2012	15.9	15.9	14.5	15.0	18.1	13.3	13.4	12.9	12.6	17.6	16.7	24.3	23.2	16.1	16.0	12.1	13.9	14.2	13.6	15.3	16.5	15.3	14.5	14.8
23	Healthy Eating (adults)	%	2006 - 2008	34.4	33.9	34.3	30.7	30.3	33.2	31.9	32.3	29.1	25.0	24.3	22.5	20.7	23.6	24.0	28.2	31.5	29.0	30.5	32.2	29.3	28.6	32.0	32.4
24	Obese adults	%	2006 - 2008	21.1	20.9	21.1	22.0	22.5	21.0	23.7	22.3	23.0	24.9	25.5	27.1	27.4	26.8	25.8	24.7	23.2	21.4	21.3	21.9	23.1	23.5	22.0	18.7
25	Binge drinkings (adults)	%	2006 - 2008	20.6	20.8	20.6	21.0	21.1	21.7	23.0	21.2	19.5	26.7	24.5	24.2	23.1	23.0	21.8	23.2	25.7	21.8	20.6	19.1	21.2	21.8	19.2	23.3
26	Admissions for alcohol	SAR	2013/14 17/18	74.3	75.9	74.5	99.2	111.2	79.9	91.0	84.8	89.7	154.3	136.0	161.2	146.5	147.1	144.0	102.2	86.7	100.3	95.2	93.8	110.8	121.0	77.1	97.0
27	Self-reported bad health	%	2011	4.4	4.0	5.4	4.3	6.5	3.1	5.4	3.6	4.6	5.0	6.9	6.7	7.9	6.2	6.0	2.3	4.9	4.2	3.4	5.3	6.4	5.3	3.4	5.0
28	Self-reported illness	%	2011	16.1	14.9	18.6	16.6	21.4	13.3	20.8	16.4	18.2	15.6	19.5	19.0	19.1	19.2	19.9	9.9	18.3	14.2	16.0	19.7	22.4	17.1	15.4	19.5
29	Hospital stays for self-harm	SAR	2013/14 17/18	55.9	51.2	55.2	102.7	150.8	50.7	103.8	84.2	93.8	176.9	175.3	170.6	211.4	144.1	167.0	106.2	63.4	107.2	102.0	97.5	117.0	160.6	77.5	152.8
30	Emergency admissions heart attack	SAR	2013/14 17/18	85.2	86.6	85.4	86.6	87.5	85.7	85.6	76.3	86.5	139.9	137.9	138.7	144.3	124.2	120.2	87.3	77.7	73.3	79.9	88.2	82.5	108.1	81.0	85.0
31	Emergency admissions stroke	SAR	2013/14 17/18	83.1	83.3	83.2	98.3	106.6	83.2	90.5	92.1	101.4	125.2	134.5	129.0	114.0	121.6	111.6	138.3	82.3	109.7	105.3	103.4	113.7	106.0	81.7	88.7
32	Emergency admissions respiratory	SAR	2013/14 17/18	48.7	49.9	48.8	62.5	67.6	52.1	47.8	42.7	64.3	168.5	197.1	186.8	203.6	145.4	195.2	96.6	53.6	67.9	62.9	63.1	79.5	123.7	49.4	53.7
33	Emergency admissions hip fracture	SAR	2013/14 17/18	104.2	104.2	104.2	94.4	97.6	104.1	102.6	84.1	86.8	124.5	125.4	124.2	110.4	97.1	118.6	86.7	103.8	101.4	97.8	100.9	118.4	101.1	92.7	99.1
34	Emergency admissions all causes	SAR	2013/14 17/18	90.6	95.9	91.3	119.4	126.8	101.1	110.1	101.6	108.4	150.9	153.8	164.4	163.2	152.7	154.1	125.3	98.3	114.3	110.6	108.4	118.6	147.2	86.5	100.8
35	New cases - breast cancer	SIR	2012 - 2016	99.9	102.7	100.2	105.7	117.0	107.5	104.0	108.5	110.0	131.9	92.6	78.6	103.0	88.9	115.0	111.6	110.9	121.5	113.0	105.5	122.0	63.6	118.2	83.6
36	New cases - bowel cancer	SIR	2012 - 2016	94.4	95.0	94.5	102.4	108.2	91.1	97.0	99.3	100.9	98.2	119.9	110.6	96.4	96.2	99.1	102.7	77.4	66.3	94.0	123.7	92.7	113.4	100.7	126.9
37	New cases - lung cancer	SIR	2012 - 2016	78.6	69.0	77.7	65.8	65.7	60.2	87.1	69.2	79.3	120.1	142.4	180.6	161.3	167.6	145.6	85.8	75.5	111.5	91.4	78.9	116.9	121.1	71.1	73.5
38	New cases - prostate cancer	SIR	2012 - 2016	110.3	102.8	109.5	77.3	69.5	95.2	95.5	103.4	101.7	104.7	78.9	83.0	74.9	96.6	93.3	123.0	104.9	107.1	117.6	125.7	108.0	89.1	106.5	108.3
39	All new cases cancer	SIR	2012 - 2016	100.3	96.9	99.9	93.8	94.5	91.8	101.5	98.0	100.1	107.8	105.2	108.4	101.1	112.5	110.9	116.5	90.9	105.9	105.3	106.7	111.2	103.4	93.8	99.8
40	Cancer deaths under 75	SMR	2013 - 2017	61.2	83.1	107.4	81.9	86.0	64.5	112.8	91.3	68.7	159.4	103.9	203.5	148.1	133.8	135.0	72.5	70.0	87.5	100.8	115.4	93.3	94.6	58.9	80.4
41	Heart deaths under 75	SMR	2013 - 2017	104.5	51.9	80.6	97.9	82.0	44.8	133.2	50.2	112.4	185.1	133.1	216.9	166.1	190.9	123.8	67.1	73.2	94.5	84.7	70.1	145.9	124.7	91.3	90.9
42	All deaths under 75	SMR	2013 - 2017	81.1	65.0	98.2	79.5	91.8	56.5	104.7	66.7	81.4	151.9	129.4	220.1	153.7	129.6	129.5	63.3	81.5	93.1	96.2	100.5	129.7	102.1	71.0	75.5
43	Deaths from respiratory diseases	SMR	2013 - 2017	116.5	83.0	118.8	82.4	83.1	75.3	93.1	80.6	75.0	131.8	128.4	268.8	179.8	129.3	144.1	92.5	104.6	95.4	106.7	98.0	125.5	115.7	67.2	70.9
44	All deaths all ages	SMR	2013 - 2017	87.3	72.1	120.6	96.7	91.7	66.1	83.6	68.1	79.2	121.7	123.6	191.9	123.4	111.0	113.3	91.8	98.0	78.4	99.0	87.3	94.7	106.6	69.1	79.1
45	Female life expectancy	Years	2013 - 2017	84.4	87.2	81.5	82.7	83.5	89.1	86.3	86.9	85.6	80.0	79.6	76.7	80.0	82.5	81.6	83.4	83.6	87.2	83.8	83.6	86.3	82.9	86.5	85.8
46	Male life expectancy	Years	2013 - 2017	81.7	82.8	78.9	81.6	80.2	81.6	81.0	82.8	80.9	77.1	77.4	71.7	75.4	77.3	77.4	82.1	81.3	81.7	78.8	80.5	75.4	78.9	83.3	81.1

Quintile 1 - Highest 20% of wards nationally

Quintile 2

Quintile 3

Quintile 4

Quintile 5 - Lowest 20% of wards nationally

Data suppressed to prevent disclosure

Shades of blue used when an indicator has no preferred polarity. I.E when it is not appropriate to say whether a high/low value is good or bad.

Indicator Notes - Data extracted during March 2020 and up to date as of February 2021.

Population 1 Total resident population, 2017 2 % people stating their ethnicity as not White (not any White category), 2011 Census 3 % people whose main language is not English and cannot speak English well or cannot speak English, 2011 Cens
Income 7 % of people aged 60 or over living in a household receiving means-tested benefit & low income (pension credits), 2015 8 % people in this area living in 20% most deprived areas in England, 2015 9 % children (under 16) in families receiv
Young People 11 Total live births per 1000 females aged 15-44, 2011 – 2015 12 % of live and stillbirths weighing less than 2,500 grams, 2011-15 13 % of delivery episodes, where the mother is aged under 18 years, 2011/12 -2015/16 (financial year
crude rate per 1,000 population from 2013/14-2015/16 (financial years pooled) 17 % children achieving a good level of development within Early Years Foundation Stage Profile at the end of the academic year in which they turn 5 by pupil residen
20 % school children measured in Year 6 (age 10-11) who were classified as overweight or obese, 2015/16-2017/18
Lifestyle 21 % children aged 11-15 who regularly smoke, Modelled estimates 2009-12 22 % children aged 16-17 who regularly smoke, Modelled estimates 2009-12 23 % adults aged 16 and over that consume 5 or more portions of fruit and vegetab
2013/14-2017/18
Illness 27 % of people who reported their heath as bad or very bad in the 2011 Census 28 % of people who reported their day-to-day activities were limited by ill health or disability, 2011 Census 29 Hospital admissions for intentional self harm, st
Cancer 35, 36, 37, 38, 39 Standardised incidence ratio for new cancer diagnoses, 2012-2016
Death 40, 41, 42 Standardised mortality ratio for deaths aged under 75, 2013-2017 43, 44 Standardised mortality ratio for deaths all ages, 2013-2017 45 Female Life Expectancy at birth, 2013-2017 46 Male Life Expectancy at birth, 2013-2017

More information and full metadata available www.localhealth.org.uk

Abbreviations
SMASH = Sandbach, Middlewich, Alsager, Scholar Green, Haslington
SAR = Standardised Admissions Ratio
SIR = Standardised Incidence Ratio
SMR = Standardised Mortality Ratio
Ratios are calculated by dividing the observed total number of admissions, new cases or deaths in the area by the expected nu mber and multiplying by 100. Expected numbers are calculated by applying age-sex-specific rates for England in th

	Congleton			Knutsford			Wilmslow								Macclesfield								Poynton						
Odd Rode	Congleton West	Congleton East	Dane Valley	Knutsford	High Legh	Mobberley	Chelford	Wilmslow West and Chorley	Wilmslow Lacey Green	Handforth	Wilmslow Dean Row	Wilmslow East	Alderley Edge	Prestbury	Gawsworth	Sutton	Broken Cross and Upton	Macclesfield West and Ivy	Macclesfield South	Macclesfield Central	Macclesfield East	Macclesfield Hurdsfield	Macclesfield Tytherington	Bollington	Poynton West and Adlington	Poynton East and Pott Shrigley	Disley	Cheshire East	England	
8301	13116	13406	9350	13286	4408	4666	3905	10011	4875	9573	4619	4429	5033	4338	3919	4166	8937	7965	8466	9288	4427	4448	8664	8599	8313	7589	4573	378846	55619430	
1.1	2.3	1.7	1.9	3.5	3.2	2.5	2.5	3.8	6.6	8.4	11.9	8.6	6.0	3.7	1.4	1.3	5.9	2.8	3.7	6.3	2.2	3.2	3.5	1.6	2.3	1.4	2.1	3.3	14.6	
0.1	0.2	0.1	0.1	0.2	0.2	0.5	0.1	0.4	0.5	0.3	0.6	0.6	0.3	0.1	0.1	0.1	0.3	0.2	0.6	0.5	0.3	0.5	0.3	0.1	0.1	0.1	0.1	0.6	1.7	
14.0	16.3	18.6	15.8	19.6	16.5	14.5	15.3	20.4	17.6	19.1	18.4	17.8	17.0	15.4	13.8	15.1	19.9	17.5	19.8	16.5	18.2	17.5	16.2	18.2	17.6	14.9	16.0	17.8	19.1	
29.2	26.9	23.0	29.8	24.5	27.1	28.9	28.7	20.9	20.2	20.0	17.3	26.9	25.8	31.3	30.4	28.0	19.4	22.0	19.1	15.6	19.8	18.3	23.0	22.2	27.8	32.5	26.3	22.5	18.0	Population
24.7	30.5	25.6	27.1	32.6	21.7	23.7	27.9	31.5	28.6	39.6	22.5	30.2	34.0	24.0	21.8	25.2	28.4	35.6	28.1	42.3	34.9	45.2	29.4	33.5	26.1	24.9	27.3	30.0	31.5	
7.5	12.3	12.2	6.2	10.5	7.5	6.5	7.5	7.4	15.2	18.0	5.8	2.5	7.9	3.3	5.8	6.9	8.6	16.2	16.8	17.3	10.2	19.3	6.7	9.7	6.6	6.9	6.5	10.2	16.2	
6.3	9.1	12.1	4.5	9.3	5.2	4.6	6.2	4.3	12.3	16.5	4.2	2.2	5.2	2.9	4.7	4.8	8.3	13.7	14.3	10.9	9.8	16.6	4.9	7.4	4.9	5.3	6.2	9.4	14.6	
8.1	8.9	17.4	4.4	11.2	4.4	4.1	4.8	3.9	16.0	20.7	4.3	1.9	4.0	3.4	6.5	2.4	9.8	15.8	17.1	12.9	12.6	20.1	4.9	9.1	4.4	5.7	6.2	12.4	19.9	Income
1.1	1.1	0.7	1.0	0.7	0.3			0.4	0.8	0.9						0.9	1.7	3.4	3.5	2.7	2.6	3.5	0.9	0.5	1.1	1.3	1.9	1.5	3.6	
53.3	59.3	69.2	47.2	77.2	73.6	69.0	56.2	73.5	58.1	68.8	56.4	59.3	56.6	48.6	40.9	49.9	62.3	66.4	70.3	69.4	78.0	61.8	45.5	58.3	50.4	52.7	63.4	60.8	63.2	
2.5	2.2	2.2	1.7	1.4	1.6	1.8	2.4	1.8	2.7	3.0	3.0	2.1	3.3			2.7	2.6	1.9	2.7	3.1	4.0	4.1	2.5	2.3	2.0	2.6	2.7	2.2	2.8	
0		1.3	0	0	0	0	0	0	0			0	0	0	0	0.4	0	0	1.8	1.4	1.3	1.3	0	0	0	0		1.0	1.1	
381.6	394.6	423.3	301.6	327.6	402.7	399.8	391.2	377.3	423.6	474.5	445.1	380.4	377.0	379.8	384.6	397.0	480.3	500.6	456.3	429.7	460.6	463.9	364.5	400.2	416.5	351.1	422.1	385.6	551.6	
167.7	189.4	181.3	124.1	182.8	151.0	157.0	174.5	189.1	149.8	192.9	156.6	199.3	203.6	143.9	123.1	134.3	166.6	193.0	182.9	156.2	177.6	179.9	79.0	213.5	129.7	147.3	146.8	168.1	138.8	
204.0	220.0	203.5	192.6	171.3	182.1	183.6	188.0	174.9	166.3	210.7	178.2	169.6	195.2	141.9	205.4	215.5	263.9	284.0	263.8	249.8	274.1	276.8	186.7	206.3	204.3	149.7	202.4	213.8	149.2	
65.2	53.0	57.8	68.6	64.0	60.2	61.4	63.6	80.7	67.7	59.5	65.2	78.8	69.5	71.7	60.7	59.3	64.1	60.5	55.4	55.9	60.6	61.1	76.9	63.7	72.0	73.4	67.2	61.8	60.4	Young People
69.0	64.6	56.4	69.7	66.1	71.1	71.3	72.2	74.5	56.0	52.2	51.9	73.1	73.7	80.4	68.1	63.2	74.8	51.9	44.8	60.9	48.7	46.7	75.9	66.2	75.7	73.3	69.0	62.2	56.6	
20.4	23.0	22.6	17.3	14.3	18.1	18.3	19.3	12.9	14.0	17.2	15.1	12.4	21.2	16.8	17.8	18.9	18.2	25.2	23.4	18.0	16.7	16.7	20.2	19.7	16.8	15.1	13.6	20.0	22.4	
35.7	30.8	31.0	22.8	26.5	25.4	25.5	25.7	16.2	23.7	30.9	26.7	15.9	25.9	21.4	21.6	22.8	29.7	26.9	28.9	30.2	33.6	33.8	23.3	16.1	29.5	26.5	27.1	29.8	34.2	
4.3	2.7	3.0	4.7	4.2	2.9	2.5	2.3	3.0	3.1	4.3	2.3	3.0	3.0	2.8	2.2	5.1	3.3	3.7	4.6	6.0	3.4	4.8	2.1	3.6	3.0	3.3	3.0	3.2	3.1	
14.5	15.4	15.9	21.1	15.5	15.3	14.7	14.4	13.0	15.4	16.8	11.5	12.0	14.0	12.9	15.4	18.5	13.7	17.2	17.7	17.2	16.0	20.4	13.1	16.1	13.5	12.5	13.9	15.2	14.8	
29.9	30.2	29.5	37.0	34.5	37.7	37.7	37.9	39.3	35.9	29.6	32.1	40.2	38.2	40.8	38.3	36.2	31.5	27.2	26.9	30.4	28.6	28.3	34.9	33.6	36.2	36.7	35.6	31.4	28.7	
23.3	23.2	23.6	19.0	17.9	19.9	19.5	18.5	16.1	19.0	21.0	20.1	15.7	17.2	16.5	19.2	19.7	20.2	22.8	21.9	20.3	21.6	21.8	18.2	20.0	19.6	20.5	20.5	21.5	24.1	
19.5	22.3	20.0	21.4	20.9	20.8	20.6	20.1	20.7	22.7	21.9	22.9	20.7	19.4	16.6	17.9	19.2	24.9	23.4	25.5	31.3	25.6	24.7	21.8	28.3	21.1	20.5	25.0	22.3	20	Lifestyle
82.5	86.5	85.5	66.0	73.9	72.5	71.2	68.4	56.2	70.4	101.2	84.9	55.1	64.4	51.5	62.2	71.9	78.7	115.6	124.2	108.8	113.5	113.9	65.3	78.8	76.9	75.2	80.3	93.3	100	
5.3	5.6	5.0	3.7	4.4	4.7	5.8	3.8	2.9	6.0	6.3	2.6	2.3	5.0	3.2	3.6	4.2	4.4	6.2	5.9	4.7	4.8	7.2	3.3	4.6	4.3	4.8	4.4	4.9	5.5	
20.2	19.6	18.1	15.0	17.2	15.7	21.5	14.8	13.2	19.0	19.8	11.6	13.5	17.4	14.9	17.2	17.8	15.0	21.6	19.4	15.5	15.9	21.7	14.6	17.1	17.0	18.4	17.3	17.5	17.6	
79.9	105.9	145.9	79.9	56.8	62.2	63.0	64.5	33.4	53.6	113.1	78.7	31.7	66.8	36.4	68.9	90.2	95.4	163.1	171.5	180.9	208.4	211.7	88.3	62.6	69.5	51.3	51.3	112.1	100	
86.1	108.9	106.3	70.1	83.1	80.8	77.6	71.1	74.5	74.2	111.2	91.5	67.0	62.2	57.1	64.1	72.9	94.0	108.4	123.7	105.0	72.6	68.8	86.8	89.2	95.2	91.9	89.2	92.4	100	
85.3	98.6	104.0	72.5	90.5	90.5	90.9	91.7	83.9	88.2	96.3	90.1	88.4	92.8	76.9	87.6	92.0	93.9	95.4	114.6	111.7	86.2	83.1	65.0	78.2	80.9	103.2	67.5	95.3	100	
51.1	60.7	60.8	37.2	49.9	43.6	42.4	40.0	41.1	47.2	89.0	68.8	37.8	36.7	19.7	27.0	40.5	57.6	131.4	128.4	102.7	131.7	134.8	50.2	48.6	55.3	52.4	82.7	75.6	100	
96.2	91.4	111.2	81.5	76.5	98.3	100.7	103.7	86.3	86.6	84.7	79.7	94.7	107.8	111.8	72.3	91.6	109.8	98.2	131.6	121.7	86.6	81.6	86.3	91.6	99.3	87.8	88.4	98.4	100	
91.7	87.8	90.6	79.9	77.9	85.0	81.9	75.7	68.6	80.0	106.1	91.4	68.9	67.1	63.9	69.0	77.0	91.7	109.5	114.8	101.9	106.3	106.7	72.0	81.2	86.6	83.7	88.1	103.2	100	Illness
116.1	76.8	73.9	110.6	132.4	97.1	97.3	97.7	108.6	97.6	124.2	105.4	114.7	98.2	111.6	128.9	123.8	122.5	120.2	97.9	101.5	99.0	98.7	102.6	102.6	127.8	96.8	130.7	105.4	100	
97.8	103.9	97.1	113.0	122.2	101.0	99.2	95.4	83.1	124.2	144.7	143.4	88.7	90.2	126.9	96.3	97.1	109.2	93.7	98.7	87.4	94.2	94.9	92.2	69.9	94.9	112.2	112.4	102.8	100	
75.7	94.3	87.9	64.0	96.2	74.3	69.4	59.2	55.6	96.5	141.5	127.8	57.4	44.9	48.4	43.9	52.9	67.4	139.0	115.4	76.4	109.6	113.3	51.2	104.2	46.0	47.3	76.9	87.3	100	
101.3	89.4	93.8	97.9	107.4	108.2	106.3	101.8	88.2	90.4	86.5	87.1	82.5	95.2	115.3	67.6	68.5	81.5	104.4	78.0	61.8	121.2	127.9	74.9	72.9	138.2	97.1	97.9	95.9	100	Cancer
91.5	95.8	92.2	92.0	103.6	99.5	97.5	93.2	92.0	93.8	108.1	97.5	95.3	87.3	91.4	85.6	88.1	96.5	109.6	103.4	89.3	103.0	104.5	90.1	87.7	97.4	90.3	97.6	98.2	100	
77.6	108.8	88.3	70.8	89.2	67.0	92.3	56.3	67.5	118.4	81.0	75.5	53.1	62.4	52.5	68.7	85.5	76.5	113.5	112.9	88.0	79.4	141.8	74.2	76.7	69.8	65.7	72.0	89.2	100	
93.2	96.0	94.7	58.7	92.3	35.1	52.3	88.0	52.1	97.3	125.0	33.6	49.5	52.4	58.7	61.3	55.0	74.7	72.9	133.0	89.7	74.5	102.6	57.1	93.2	48.4	79.1	56.1	90.6	100	
78.7	108.2	89.5	60.4	84.4	60.1	89.3	62.3	57.1	119.3	92.2	55.9	55.4	71.1	48.0	63.4	78.5	92.5	108.5	134.2	101.0	90.4	137.4	64.6	84.4	65.3	63.7	71.7	90.4	100	
101.4	106.0	100.0	77.2	88.9	71.2	85.0	43.3	67.1	139.6	97.2	101.2	48.6	82.7	56.6	65.4	72.5	101.1	90.7	119.0	123.1	124.6	146.8	82.5	107.3	86.0	77.8	63.2	96.9	100	
96.7	105.0	97.1	71.6	78.7	103.3	114.1	65.5	68.9	138.8	83.6	93.5	55.7	97.8	64.4	64.8	87.7	127.4	87.9	128.9	102.7	92.1	95.5	74.9	92.7	95.4	97.7	75.9	94.0	100	
83.3	83.1	83.7	86.4	86.9	83.1	82.0	84.7	88.0	80.5	85.8	85.1	89.8	83.8	86.6	86.7	85.3	81.8	84.8	81.2	83.9	84.7	82.5	86.6	83.9	84.5	83.1	85.1	83.8	83.1	
81.4	78.4	80.5	83.8	81.1	83.2	77.7	84.3	83.1	77.8	80.5	81.6	84.7	82.4	82.4	85.1	80.1	79.1	79.6	75.6	79.0	79.1	78.4	83.1	80.6	80.7	82.0	82.4	80.2	79.5	Death

us4 % resident population aged under 16, 2017 5 % resident population aged 65 and over, 2017 6 % people aged 65 and over living alone, 2011
g means-tested benefits & low income, 2015 10 Average monthly claimants of jobseekers allowance who have been claiming for more than 12 months, rate per 1000 of the working age population (age 16-64 years), 2017/18
s pooled) 14 A&E attendance for children aged 0-4 years, crude rate per 1,000 resident population, 2013/14-2015/16 (financial years pooled) 15 Hospital admissions following injury in children aged 0-4 years, crude rate per 10,000 resident population, 2011/12-2015/16 (financial years pooled) 16 Emergency hospital admissions for children (aged 0-4 years),
cy, 2013-14 academic year 18 % Pupils achieving 5 or more GCSEs at grades A*-C (including English and Maths) or equivalent end of Key Stage 4 in schools maintained by the Local Authority, 2013-14 academic year 19 % school children measured in reception year (age 4-5) who were classified as overweight or obese, 2015/16-2017/18

les per day, Modelled estimates 2006 -08 24 % adults aged 16 and over classified as obese (BMI of 30+), Modelled estimates 2006-08 25 % adults aged 16 and over who binge drink, Modelled estimates 2006 -08 26 The number of admissions involving an alcohol-related primary diagnosis or an alcohol-related external cause, standardised admission ratio,

tandardised admission ratio, 2013/14-2017/18 30, 31, 32, 34 Emergency admissions, standardised admission ratio, 2013/14-2017/18 33 Emergency hospital admissions for hip fractures, persons aged 65+, standardised admission ratio, 2013/14-2017/18

e same time period to each area's population.

To improve the physical and mental health and wellbeing of our residents and reduce the demand for health and social care, there needs to be a focus on preventing ill health at the heart of all our strategic plans, actions and service provision. This is also where the role of individuals, families, schools, housing, workplaces, leisure facilities and communities is vital, contributing to good health and wellbeing and preventing or delaying a need for health or social care arising.

We want to make it as easy as possible to stay healthy, supporting and enabling people where needed. And we want to promote a shared understanding of individual and community responsibility to enable wellbeing and more people living well for longer.

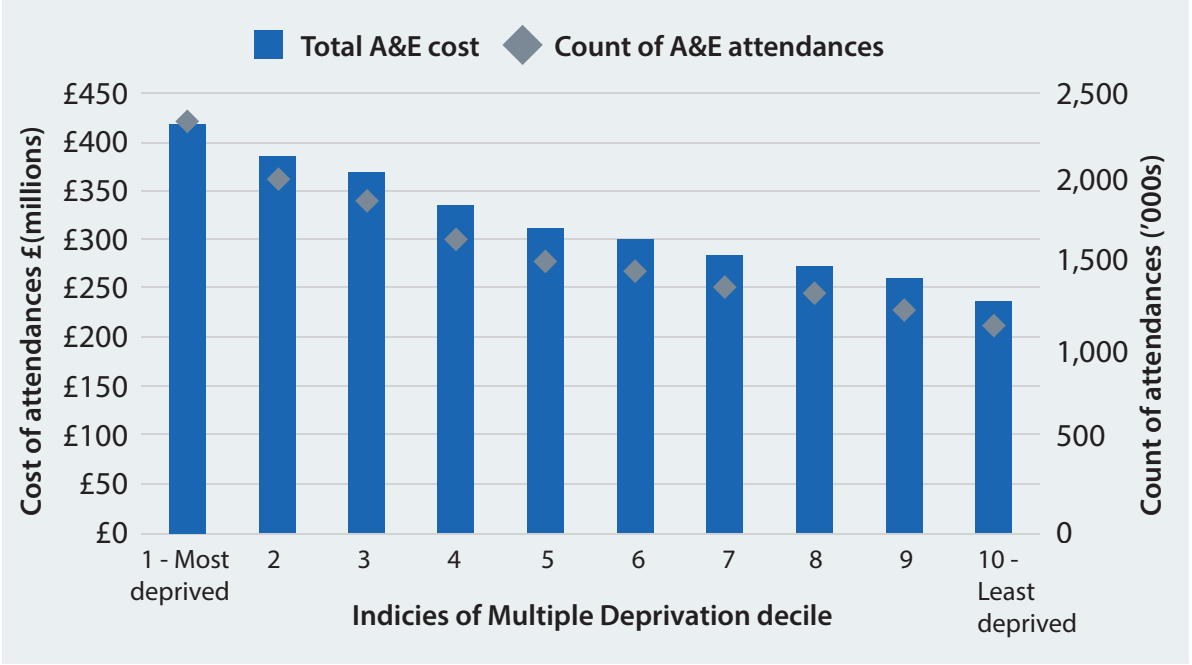
05 What are the challenges

Many of us are living longer, in better homes, with good social networks and in supportive communities. But we are experiencing increasing fragility and vulnerability in older age and the increasing numbers of older people means that more demand is being placed upon health and care services. The number of over 65 year olds has increased by 25% since 2011 and now form 22.4% of the population, compared to an England average of 18.4%[4].

For those living in our more deprived areas, health and wellbeing is often poor. Evidence[5] shows that they live shorter lives than those in less deprived areas, and that they spend more of their lives experiencing ill health. This inevitably leads to more use of - and a greater cost to - the health and care system.

For example, Accident and Emergency usage and costs are higher in more deprived areas:

Figure 6. Impact of Deprivation on Acute Patient Level Activity and Costing – all England[6]



The pandemic has worsened existing challenges and created new ones, with potentially long-term health consequences for many people, adding to the demand pressures that health and social care services were already facing.

These demand pressures are stretching the workforce capacity and financial resources of all parts of the health and social care system, to the point at which it will become unsustainable if we do not change the way things are done. They are also leading to long delays for many people who need to access health and care services.

[4]Census 2021 Available from: https://www.ons.gov.uk/visualisations/censuspopulationchange/E06000049/

[5]Marmot et al. (2020) Build Back Fairer: The COVID-19 Marmot Review

[6]Acute Patient Level Activity and Costing, 2019-20, NHS Digital, published online 11 Feb 2021

Causes of death

Across the United Kingdom, 2001-2018, leading causes of death have included lung cancer, Ischaemic heart diseases, influenza and pneumonia, dementia and Alzheimer disease, chronic lower respiratory diseases and cerebrovascular diseases. In 2018, the leading cause of death in the UK was dementia and Alzheimer disease, accounting for 12.7% of all deaths registered. The leading cause of death in males in 2018 was ischaemic heart disease, whilst in females, it was dementia and Alzheimer disease[7].

Overall rates of healthy lifestyle behaviours are better in Cheshire East than the England average, but we have some communities where they are much worse . The mortality rates for heart diseases in Cheshire East are similar to the England average[7]. However, people in some areas of Crewe and Macclesfield have a significantly higher risk of early death from heart disease[7,10].

Again, rates of cancer death are lower than the England average[7,8], but higher in some areas of Crewe and Macclesfield[7,9]. Additionally, those living in our more deprived communities are more likely to die from a respiratory related disease[7,9]. The excess under 75 mortality rate in people with severe mental illness in Cheshire East is worse than the England average[7].

Our residents' views

Healthwatch Cheshire East's annual report 2021-2022 sets out several issues that are of most concern to our residents.

- Accessing GP services, including long waits to get through to reception and to get an appointment and mixed experience of telephone and video consultations
- Delays in referrals to other services and lack of information regarding timescales with a lack of clarity as to where the ownership lay to get the referral appointment sorted
- Concerns regarding the referral and waiting times to access mental health services
- The physical accessibility of health services because of limited or poor public transport links
- Lack of NHS dentistry provision and being pressured into paying for treatment as a result
- Limited support for carers

[7]Office for National Statistics. Leading causes of death, UK: 2001 to 2018.Registered leading causes of death by age, sex and country.

[8]Cheshire East Council (2022) Health Profiles for Electoral Wards Plus Primary Health and Social Care Areas. February 2021. Available from: https://www.cheshireeast.gov.uk/pdf/jsna/ward-profile-tartan-rug/tartan-rug-cec.pdf (Accessed 3 November 2022).

[9]Office for Health Improvement and Disparities. Mortality Profiles. Available from: https://fingertips.phe.org.uk/profile/mortality-profile/data#page/1 (Accessed 3 November 2022).

[10]Office for Health Improvement and Disparities. Local Health Profiles. Available from: https://fingertips.phe.org.uk/profile/local-health/data#page/0/gid/1938133183/pat/401/par/E06000049/ati/8/are/E05008610/yrr/5/cid/4/tbm/1 (Accessed 3 November 2022).

Being a carer

We acknowledge the pressure that being a carer can bring and will ensure that the All Age Carers Strategy for Cheshire East 2021-2025[11] guides our work and that we support the key delivery actions.

Figure 7. Key Delivery Actions, Cheshire East All Age Carers Strategy

Key delivery actions

To enable us to successfully deliver the All-Age Carers Strategy for Cheshire East, several key delivery actions have been identified.

We will develop an outcomes-based approach to carers and their cared for. Where services are provided for a carer they will alsoachieve a set of results for the cared for.

We will deliver outcomes through working with the joint commission of the Carers Hub Service and by the development and co-production of the All-Age carers Strategy:

- Identifying the outcomes that are expected to be achieved prior to making referrals to services
- Contracting for services based on outcomes and then monitoring based on those outcomes e.g. joint commissioned carers service
- Work collaboratively with our health partners to ensure seamless pathways to support our carers

[11]What is a carer (cheshireeast.gov.uk)

06 The Strategic Outcomes

Outcome one

Create a place that supports good health and wellbeing for everyone living in Cheshire East
Where we spend our daily lives, living, attending school, relaxing or playing, working, socialising has a significant influence on our health and wellbeing. We will work together to:
• Ensure our local communities are supportive with a strong sense of neighbourliness
• Support people to develop the life skills and get the education that will help them to thrive
• Help people to live independently for as long as possible
• Provide access to good cultural, leisure and recreational facilities
• Support active travel initiatives across the borough
• Ensure people have housing that is not detrimental to their health and wellbeing
• Support key employment sectors and local supply chains
• Pay particular attention to supporting those in our more deprived and rural communities and addressing specific issues they may face.

Key deliverables
• Ensuring that health and wellbeing considerations are regarded as a core part of all work related to spatial planning, transport, housing, skills, employment and economic development
• Delivering the recommendations of the 'Living Well in Crewe Plan'
• Working together to support residents, staff, businesses and other partners through the cost-of-living crisis in particular those facing fuel and food poverty
• Working with local residents and partners to improve quality of and access to existing green spaces in areas of higher deprivation
• Prioritising new walking and cycling infrastructure in areas with higher levels of deprivation and promoting active travel
• Further developing our approach to social value and our organisations' roles as 'anchor institutions'

Indicators for success include to:
• Increase the percentage of people aged 16 to 64 in good employment
• Increase the number of people using outdoor spaces for exercise and physical activity
• Reduce the number of households that experience fuel poverty

Outcome two

Ensure that our children and young people are happy and experience good physical and mental health and wellbeing.

We want our children and young people to get the best start in life and to be supported at each stage of their development. This begins with:

- Supporting expectant mothers to have a healthy pregnancy
- Supporting new mothers with breastfeeding
- Having networks and services for families with pre-school children and prioritising school readiness
- We will focus upon reducing childhood obesity and building emotional wellbeing
- We will provide the right care for children with a learning disability and reduce waiting times for autism assessments
- For children with cancer, we will ensure that the best treatments are available
- We will focus on the health and wellbeing of our most vulnerable children and young people, looked after children and care leavers

Key deliverables

- Completing the roll out of Family Hubs
- Working as a system to improve school readiness for all
- Reducing the inequalities in educational attainment between those children eligible and not eligible for free school meals
- Reducing school exclusions, offending and drug and alcohol abuse in young people
- Maximising the numbers of young people in education, training or employment, boosting aspiration and engagement

Indicators for success include to:
• Reduce child poverty and its impact on health and wellbeing
• Reduce the numbers of children with tooth decay
• Increase the rates of infants that continue to breastfeed at 6-8 weeks of age
• Increase the number of children reaching expected level of development at 2 - 2.5 years of age
• Reduce the numbers of 4 to 5 (reception) and 10 to 11 (Year 6) year olds who are overweight or obese
• Increase the numbers of 15 year olds meeting the recommended 'five a day' fruit and veg
• Reduce the proportion of school pupils with social, emotional and mental health needs
• Maintain the low numbers of 16-17 year olds not in education, employment or training or whose activity is not known

Outcome three

Improving the mental health and wellbeing of people living and working in Cheshire East

Mental health includes our emotional, psychological and social wellbeing. It affects how we think, feel and act. It also determines how we handle stress, relate to others, make choices and our level of resilience. It is important at every stage of life. We want to ensure that:

- Our residents have improved emotional wellbeing and mental health through a focus upon prevention and early support
- There is access to mental health services that meet the needs of our population
- People do not feel isolated or lonely
- Communities provide opportunities for all people to integrate and feel a part of their 'place'
- We will provide the right care for children with a learning disability and reduce waiting times for autism assessments
- For children with cancer, we will ensure that the best treatments are available
- We will focus on the health and wellbeing of our most vulnerable children and young people, looked after children and care leavers

Key deliverables
• Assessing the levels of isolation across the borough and the impact of the Pandemic
• Improving access to prevention and early intervention signposting, guidance and advice
• Addressing the health inequalities faced by people with learning disabilities and autism
• Undertaking the severe mental illness health check self-assessment and draft an improvement action plan
• Ensuring we are well connected to the Cheshire and Merseyside ICB Mental Health Programme and Cheshire and Wirral Partnership's Community Mental Health Services Transformation Programme
• Responding to the Cheshire and Merseyside Suicide Prevention Strategy

Indicators for success include to:
• Increase the numbers of adults who report good wellbeing
• Increase the proportion of adult social care users who have as much social contact as they would like
• Increase the proportion of adult carers who have as much social contact as they would like
• Increase the proportion of adults in contact with secondary care mental health services living independently and who are in employment
• Reduce the levels of depression in adults
• Reduce the number of hospital stays for self-harm
• Reduce the number of suicides

Outcome four

Enable more people to live well for longer

As has already been mentioned, we need to focus upon the causes of ill health (e.g. poor diet, smoking, drinking alcohol, lack of physical activity), rather than on the illness or disease that these cause (e.g. smoking increases the likelihood of heart disease, stroke, lung cancer and vascular dementia). Preventing ill health and disease enables more people to live well for longer.

We will act across the life-course, from childhood to older age focusing upon prevention and early intervention to address:

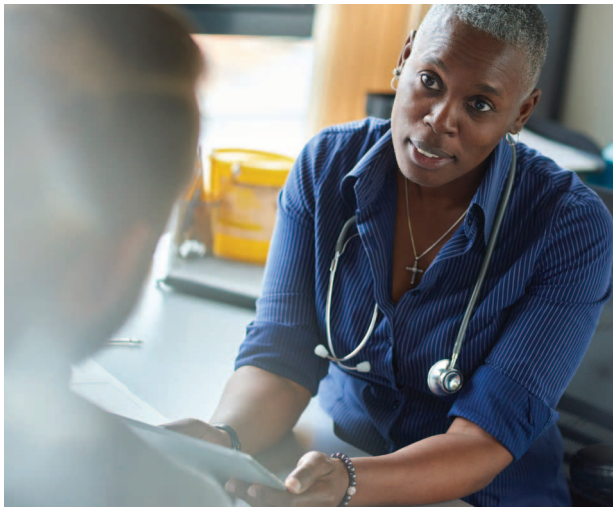
- Alcohol and substance misuse
- Smoking
- Physical activity
- Healthy eating

When people have been unwell, we will work as a system to ensure that they return home with the appropriate support to continue their recovery and to help them maintain their independence for as long as possible.

Key deliverables
• Delivering four collaborative health and wellbeing campaigns across all partners each year
• Continue our focus on cardiovascular and respiratory health, both preventative activity and more integrated support for those affected
• Improving the availability and quality of green spaces in areas with higher levels of deprivation
• Evidence based commissioning of public health and preventative services in primary and secondary care
• Rolling out 'Making Every Contact Count' across the workforce within the health and care system (including the voluntary, community, faith and social enterprise sector)
• Delivering the Home First Programme: Hospital prevention, which includes the Community 2 Hour Response, Virtual Wards, Falls Prevention, Rapid Home Care and Community Voluntary Sector support
• People dying in their preferred place of death

Indicators for success include to:
• Reduce the number of adults who are overweight or obese
• Increase the number of adults that are physically active
• Reduce the number of alcohol related admissions to hospital
• Increase the number of people successfully completing alcohol or drug treatment
• Increase the numbers of people eating the recommended 'five a day' fruit and veg on a 'usual day'
• Increase the number of people offered and accepting an NHS Health Check
• Improve the health-related quality of life for older people
• Reduce the numbers of older people who fall and need to be admitted to hospital

07 Our approach to achieve the strategic outcomes



Promoting wellbeing and preventing ill health

We want to support people to stay healthy with good mental and physical wellbeing for as long as possible. We want to enable people to live well for longer in their communities without the need for health and care services, where possible.

Empowering people to take responsibility for their own health and wellbeing throughout their lives will require coordinated work to ensure that people feel motivated and capable to promote their wellbeing. The provision of accessible information, advice and guidance, including through the Live Well Directory and via our system of social prescribers and community connectors will be core to this. It will also be important to ensure sufficient opportunities exist within people's local area that enable people to follow healthy lifestyles such as being more physically active.

As a system, we will also need to focus on addressing some of the root causes of ill health including **poor housing, poverty and poor education**, and work to build consensus on how each part of the system can play their part in addressing these causes, whether it is through more systematically signposting individuals to the support they need in relation to the root causes, working harder to reach people experiencing these challenges, or fundamental shifts in planning and regeneration work.

Wealth and Wellbeing

The strength of the economy of an area and its vitality and wealth generation directly contribute to the health and wellbeing of the community. We are making education, jobs and skills a key part of our strategic approach and will engage our businesses in conversations about their role in boosting the health and wellbeing of their workforce and the communities they serve.

As partners we will invest in our own community whenever this gives us the best outcomes and provides best value. We will maximise the additional benefits that can be created by delivering, procuring or commissioning goods and services in Cheshire East.

We want our local economy and workforce to benefit from the funds we have to spend and through that spending that we:

- Enable people to be well in work by directly supporting their mental wellbeing
- Removing complex barriers to employment and financial independence
- Ensuring that the skills strategy opportunities extend to people who are not in work and face the greatest challenges in securing a job
- Promote employment and economic sustainability
- Raise living standards for local people
- Maximise digital inclusion
- Ensure that individuals and families have housing suitable for their needs
- Build the capacity and sustainability of the voluntary, community, faith and social enterprise sector
- Promote equity and fairness
- Promote environmental sustainability

Tackling Inequalities

Health inequalities are avoidable and unfair differences in health status between groups of people or communities.

There are stark differences across Cheshire East that need to be addressed. For example, there is a noticeable difference in life expectancy of around 12.6 years between the lowest rates in Crewe Central and the highest in Gawsworth for women[12] and a 12.7 year gap between the lowest rate in Crewe Central and the highest in the Sandbach, Ettiley Heath and Wheelock ward for men[13].

In general, there is more ill health in Crewe and parts of Macclesfield than in other areas. We know that this coincides with areas of deprivation, poorer housing, and lower educational achievement and employment. The numbers of people who smoke, drink and are obese are also correspondingly higher and pressures on primary, secondary and social care services are similarly higher.

Tackling these long-standing inequalities is not easy but is more likely through a holistic system wide approach that recognises and responds to the different inter-related challenges.

NHS England has introduced a new approach to tackling healthcare inequalities for adults[14] and children[15]. In addition the Cheshire and Merseyside Integrated Care System has committed to reducing inequalities and endorsed the 'All Together Fairer: health equity and the social determinants of health in Cheshire and Merseyside' report and its recommendations. Each 'Place' will be supported to address its local inequalities and implement the recommendations most useful to the issues that need addressing locally.

Our approach to reducing inequalities in Cheshire East will be led through the Increasing Inequalities Commission.

Identifying sentinel markers of success and monitoring these through the Joint Outcomes Framework

A consensus building process has been undertaken to identify 11 key "sentinel" outcome indicators through which to monitor progress, towards our vision, across the Cheshire East health and care system.

These include:

Overarching indicators

- Life expectancy
- Healthy life expectancy

Creating a place to promote health and well being

- Unemployment
- Fuel poverty

Physical and mental wellbeing in children

- Good development at 2.5 years (as a key contributor to mental wellbeing)
- Overweight and obesity at year 6

Mental wellbeing

- Isolation in our social care users
- Isolation in adult carers
- Emergency admissions for self harm

Live well for longer

- Physical activity
- Alcohol

These indicators will form the first of two parts of a Joint Outcomes Framework. The second part of the Framework will focus on additional indicators to monitor local progress in relation to the Cheshire East Five-Year Health and Care Service Delivery Plan. The Joint Outcomes Framework as a whole, will continue to evolve over the coming years, influenced by: emergent findings within the Joint Strategic Needs Assessment; community insights; Cheshire and Merseyside intelligence, progress in relation to the Delivery Plan; and developments in what we are readily able to measure.

Importantly, the purpose of the Outcomes Framework is **not to** monitor and evaluate all core activity and transformation across the health and care system. However, there is a recognition across Cheshire East Place, that sustained focus on the above 11 specific outcomes, and inequalities across these, is required in order to actualise the overarching vision outlined in this strategy.

[12]https://fingertips.phe.org.uk/profile/localhealth/data#page/3/gid/1938133185/pat/401/par/E06000049/ati/8/are/E05008610/iid/93283/age/1/sex/2/cat/-1/ctp/-1/yrr/5/cid/4/tbm/1/page-options/car-do-0

[13]https://fingertips.phe.org.uk/profile/localhealth/data#page/6/gid/1938133185/pat/401/par/E06000049/ati/8/are/E05008610/iid/93283/age/1/sex/1/cat/-1/ctp/-1/yrr/5/cid/4/tbm/1/page-options/car-do-0

[14]NHS England » Core20PLUS5 (adults) – an approach to reducing healthcare inequalities

[15]NHS England » Core20PLUS5 – An approach to reducing health inequalities for children and young people

A new model of care to meet changing needs

The make-up of our population continues to change and our plans for services need to reflect this. The economic regeneration of Crewe, arrival of HS2 and significant levels of housebuilding will bring in working age families to parts of the borough. Elsewhere we have fast growing cohorts of older people and our health and care services need to be ready to meet the needs of people with increasing frailty, multiple medical conditions and increasing levels of dementia.

New ways of working will be key to achieving better outcomes for our residents and meeting the changing and increasing demands. We also need to make the most of new technology, medicines and treatments that will improve health and wellbeing and make it easier to access health and care services when needed.

Our assumptions and planning will be tailored to promoting wellbeing and preventing illness, where possible and to supporting and empowering people to live with and manage frailty and several health conditions more effectively at home and in their communities. Local teams of health and social care professionals, working in partnership with families and carers, partners, will enable better co-ordinated care.

Through a detailed analysis of our population and local health and care needs, the new 'model of care' has been designed around the individual and will feature four elements:

Figure 8: The new model of care

This 'model of care' will inform and influence how we develop our service improvement work. To achieve our aspirations new ways of working, enhanced workforce skills and a commitment to delivering differently will all be required. A set of system 'capabilities' have been identified that will enable this transformational approach.

Figure 9: The Cheshire East system capabilities

Our Care Communities

We have established eight Care Communities across Cheshire East, with staff from GP practices, community and hospital services, social care, other public sector organisations and the voluntary, community, faith and social enterprise sector beginning to work together more effectively. These have already proved their worth through the pandemic. They have a common 'core offer' but can add to that to reflect specific local priorities, needs and difference.

A tailored local service will be on offer which means:

- We can proactively identify people at high risk of needing services, intervene early and quickly to prevent their situation worsening
- We can help people to self-care and better support their families and carers
- We can make better use of the different professionals working in therapies, pharmacies, social and primary care
- We can recognise the existing strong local relationships, skills and connections and support them to grow and flourish.

The Care Communities will be providing services that will result in fewer people needing to be in hospital and their hospital stays being shorter because there is more service provision in the community. The hospitals will be able to focus on those with the most serious health issues and those needing urgent emergency treatment.

Our Care Communities model will allow services to focus upon the individual, supported by family and friends within their local communities. We will be able to link in more closely and in partnership with other resources and assets in the community that can impact upon health and wellbeing, such as housing, leisure activity, green spaces, community transport and local social groups.

We will increase our support to communities and opportunities to volunteer by providing information, infrastructure, networks and skills to help local groups and social enterprises to grow. This will enable our communities to become more enterprising and resilient, reducing dependency and enable the more deprived areas to address the inequalities impacting on their lives.

The 'Next steps for integrating primary care: Fuller stocktake report[16] sets out several recommendations as part of its 'Framework for shared action' that will influence the development of the Care Communities and the work of the Primary Care Networks. These will be incorporated into the delivery plan.

Integrated health and care services – working together for you

At the heart of the Care Community ethos is integration, joining up different parts of the health and care services to provide a better experience and better outcomes for those we care for.

This approach will bring teams together for their local populations. We will match the right care with a patient's needs and use integrated case management to allow people who are older, with longer term conditions, complex needs or mental illness to access services through a single point of contact and benefit from a co-ordinated multi-agency team of professionals working to a single assessment, a single care plan and through a single key worker.

The same approach will be taken as people near the end of their life. The care provided through community teams, hospices and hospitals will whenever possible, be planned and personalised for people with life limiting conditions, allowing them to live well before dying with peace and dignity in the place of their choice.

[16]NHS England. Next steps for integrating primary care: Fuller stocktake report

Going digital

Achieving the step-change in prevention and early intervention and the delivery of services will require effective use of technology and digital solutions. We will use technology to support people to take responsibility for their own health and wellbeing. Our teams and services will be equipped with the data, digital tools and equipment that they need to work efficiently and effectively in an agile and flexible way.

However, we are very conscious that some people are digitally excluded. Our Digital Inclusion Strategy will set out how we will support people to get online and, where that is not possible, ensure that they are not excluded from being able to access or receive services.

Taking action

This Joint Health and Wellbeing Strategy will be supported by a Five-Year Delivery Plan that will bring together the key elements of our system improvement plans.

There is significant demand and need for services in Cheshire East, a combination of local demographic pressures, coupled with the impact of preventable premature morbidity and mortality and reducing funding, all of which combines to put pressure on all parts of the health and care system.

There is already a lot of work taking place to ensure greater collaboration (for example through the Care Communities and closer working between our hospitals and social care colleagues) and we will build upon this to connect programmes of work to achieve improved health and wellbeing.

The term 'place-based' health is becoming increasingly used and recognises the need to focus on support and services for communities and that are 'closer to home'. It also acknowledges the importance of education, jobs and housing in shaping people's health and wellbeing, more so than any health and care services that might be accessed.

Our focus will be upon individuals, supported by families and friends and the wider community. All the resources and assets available in a 'Place' should be used to establish and maintain those building blocks of good health and wellbeing.

The increased emphasis on prevention and early intervention will require us to organise our services differently and work more collaboratively as a system, helping people to stay independent and to live well for longer.

Every community in Cheshire East is different and local solutions will reflect local circumstances and challenges, but **our actions will be underpinned by four shared commitments:**

Integrated and empowered communities:

Individuals will be enabled to live healthier and happier lives in their communities with minimal support. Our services will focus on people's capabilities, what they can do, not what they can't! We will have a joint approach to community capacity building with a focus upon reducing social isolation. We will extend the use of personalisation and assistive technology. We will look to address the root causes of disadvantage.

Integrated case management:

Individuals with complex needs - including older people with longer term conditions, families with different and complicated needs and those with mental illness will access services through a single point of contact and benefit from their needs being managed and co-ordinated through a multi-agency team of professionals working to a single assessment, a single care plan and with a single allocated key worker.

Integrated commissioning:

People with complex needs will have access to services that have a proven track record of reducing the need for longer term care. This will be enabled by interventions such as intermediate care, reablement, mental health services, drug and alcohol support and housing with support options.

Integrated enablers:

We will ensure that our plans are enabled by a joint approach to information sharing and digital solutions, a funding and contracting model that focuses upon outcome or population-based commissioning models and utilises pooled budgets to enhance community-based services and a joint approach to workforce development to recruit, develop and retain staff.

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