Foreword

Most of us get on with our lives with little or no contact with health and social care services. But when we do, whether as patients, carers or family members, we know there is more that could be done to improve them.

That is why the NHS came together at the end of 2012 with Cheshire East Council and launched the Caring Together programme to look at new ways of providing high quality care services locally.

Since then we have been speaking to local people and care staff about what we can all do to improve care for everyone.

We heard that you often found connections between care services to be disjointed and difficult to navigate, that you do not want healthcare or social care – you just want the best care. It should not matter who provides the different care services – whether the NHS, the local council or a voluntary organisation – what is important is that those services should work together to raise standards and provide a joined-up system of care that presents no barriers and works for the people using them, their carers and those that provide them.

We also heard that you want more information and help to take responsibility for your own health and wellbeing, and that you want more services close to where you live and to only use a hospital when absolutely necessary. Above all, you said you wanted to be actively involved in designing the services you use and may need in the future.

Your input has helped us agree plans for a new way of working that rewards care service providers for the positive differences they can make to the lives of patients and their carers. This is an important change to the old system which sometimes saw providers being paid for activity rather than results.

You have helped us design the outline of our new care model, based on the needs of people in Eastern Cheshire, which will meet the challenges in the NHS Five-Year Forward View published in December 2014 by NHS England and partners. The document says that the NHS cannot continue as it is and that the only way in which health and wellbeing can be improved with limited funding is to get care services working more effectively together to prevent illness, empower patients to look after themselves better, and provide integrated joined-up care that allows rapid recovery when people become unwell.

This document sets out our collective plans for putting the Caring Together programme into practice to achieve the delivery of our ambitions and strategies over the next five years.

Importantly, this document explains why we need your help in designing and implementing care services that deliver the Caring Together ambitions and standards. We look forward to you joining us.

The figures in this document are based on the latest estimates and are therefore subject to change.
The Caring Together programme began by working with local care organisations and local people to draw up a vision and accompanying values and principles so as to provide a framework for developing proposals for local care service changes.

During 2013/14 working alongside local people and care staff we developed and agreed the vision and values for the Caring Together programme. Figure 1 illustrates the Caring Together programme vision and values and what this means for local people and for our care staff.

We also agreed to adopt the principles for person centred co-ordinated care (‘integrated’) as developed by National Voices, a leading coalition of health and social care charities. These state that local joined-up care should:

1. be organised around the needs of individuals (patient-centred)
2. always focus on the goal of benefiting service users
3. be evaluated by its outcomes, especially those which service users themselves report
4. include community and voluntary sector contributions
5. be fully inclusive of all communities in the locality
6. be designed together with the users of services and their carers
7. deliver a new deal for people with long term conditions
8. respond to carers as well as the people they are caring for
9. be driven forward by those responsible for buying, or commissioning, health and care services
10. be encouraged through incentives
11. aim to achieve public and social value, not just to save money
12. last over time and be allowed to experiment.

The vision, values and principles are at the heart of and are what drive the Caring Together programme.
Vision and values (Figure 1)

Joining up local care for all our wellbeing

**House of Values**

**Self Care**
Promote self-care and self-management, health promotion, individual responsibility

**Empowerment**

**Collaboration**

**Innovation**

**For care staff, joined-up care means**
“Supporting people to live well. By supporting people to access joined-up care when it is needed we support them to stay well.”

**For service users and carers, joined-up care means**
“I am supported to live well and stay well because I can access joined-up care and support when I need it.”

**What does this mean for me?**

Chapter One | Vision, values and principles
Chapter Two
Ambitions for care

Local people can be sure that the design of future care services will always be based on the foundation of better, higher quality care.

At an early stage, eight Caring Together ambitions were developed to help describe how care services should be provided.

The eight Caring Together ambitions are:
• people are empowered to take responsibility for their own health and wellbeing
• access that is designed to deliver high quality, responsive services
• appropriate time in hospital, with prompt and planned discharge into well organised community care
• a prompt response to urgent needs so that fewer people need to access urgent and emergency care
• the highest quality care delivered by the right person regardless of the time of day or day of the week
• carers are valued and supported
• simplified planned care as pathways delivered as locally as possible
• staff working together with the person at the centre to proactively manage long term physical and mental health conditions.

These ambitions describe how care services in Eastern Cheshire should be provided, changing from reactive unplanned care to more proactive planned care. Wherever possible care will be delivered locally, to the highest quality, delivered by the right person regardless of the time of the day or the day of the week.

Using the eight ambition statements illustrated in Figure 2 as a framework, care staff and local people have worked together to combine the best international and national care standards with locally developed standards to produce over 500 Caring Together quality standards. These standards define the care that all providers of health and social care must meet. The standards are underpinned by a set of quality ambitions, examples of which are given in Figure 2 overleaf.

Easy Access
• My care staff will have access to the information, support and advice they need from care colleagues
• I will be able to use the most suitable method to access information and services
**EMPOWERED PERSON**
People are supported to take more responsibility and accountability for their own health and wellbeing

**EXAMPLE OF QUALITY STANDARD**
I can access effective and helpful joined-up care and support when I need it and I can readily find accurate information in order to remain mentally and physically well and healthy

**AMBITION**
Staff working together with the person at the centre to proactively manage long term physical and mental health conditions

**EXAMPLE OF QUALITY STANDARD**
I will have the fewest number of assessments required, involving as many agencies as needed to deliver

**AMBITION**
Simplified planned care pathways delivered as locally as possible

**EXAMPLE OF QUALITY STANDARD**
Care pathways will be based on national standards adapted for local use where appropriate for me

**AMBITION**
Access that is designed to deliver high quality, responsive services

**EXAMPLE OF QUALITY STANDARD**
I will be able to use the most suitable method to access information and services

**AMBITION**
Appropriate time in hospital, with prompt and planned discharge into well organised community care

**EXAMPLE OF QUALITY STANDARD**
My GP will always be informed of my hospital admission and will receive details of my care whilst in hospital

**AMBITION**
A prompt response to urgent needs so that fewer people need to access urgent and emergency care

**EXAMPLE OF QUALITY STANDARD**
I and my carers will have access to a response for an urgent care need from one point of access, 24 hours a day 7 days a week

**AMBITION**
The highest quality care delivered by the right person regardless of the time of day or day of the week

**EXAMPLE OF QUALITY STANDARD**
I will be dealt with in a courteous and respectful manner

**AMBITION**
Carers are valued and supported

**EXAMPLE OF QUALITY STANDARD**
As a carer I am valued, involved and informed throughout the care process
The Eastern Cheshire region has a population of 204,000 people living in the towns of Congleton, Disley, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow as well as the many surrounding villages and rural areas. The region covers 53% of the Cheshire East Borough Council area.

The main commissioners (or buyers) of care services for the people of Eastern Cheshire are the GP led NHS Eastern Cheshire Clinical Commissioning Group, NHS England and Cheshire East Council. In the main, general acute hospital and community health services including some public health services are delivered within Eastern Cheshire by East Cheshire NHS Trust and mental health services by Cheshire and Wirral Partnership NHS Foundation Trust. Children’s, families and adult social care services are commissioned by Cheshire East Council.

The proximity of Eastern Cheshire to areas such as Greater Manchester and Staffordshire provides the people of Eastern Cheshire with significant access and choice of general acute hospital services and access to a range of specialist care providers.

Key facts about Eastern Cheshire are illustrated in Figure 3.
More than one in five people in Eastern Cheshire are over 65, which is higher than the national average, and this will be nearer to one in four people by 2021.

If carers are not supported, they are likely to become unwell. This has an impact on whoever they are caring for.

Over a third of people in Eastern Cheshire say they have to wait too long to see their GP.

Over 22,000 bed days per year (at an estimated cost of £5.5m) in Macclesfield District General Hospital could be avoided.

But there are large variations between and within our towns.

If demand for care services continues at the current rate there will be a financial shortfall in Eastern Cheshire of nearly £80m by 2018/19.
Chapter Four
Why care in Eastern Cheshire needs to change

If we do nothing, access to the best care will get worse and care will get fragmented and unresponsive.

People in Eastern Cheshire deserve services that are of the highest quality that are provided as locally as possible. Leaders of local care services believe that people should sit at the heart of a proactive care system, centred on them and their carers. They also believe that local people should be supported to take responsibility for their own health as much as possible. This belief in what is right for the people of Eastern Cheshire is matched by their ambition to achieve it.

In Eastern Cheshire there is in fact much to be proud of. Our staff continue to work hard to provide good care of a high standard, local people are relatively healthy compared with other parts of the country and local organisations have a track record of working well together to meet the needs of local people. However, the fact remains that services have been delivered in the same way for many years and, increasingly, this way of delivering services simply no longer meets the needs of our local people and care staff.

Local people and care staff tell us:
• services are fragmented, reactive and difficult to access
• staff can sometimes find it difficult to respond to the needs of the people they support in the way they would like
• some carers feel they do not have enough support in their caring role
• some people do not get enough support to be independent, are going into hospital unnecessarily and they stay in hospital beds when they do not need to be there. When people leave hospital they sometimes find it difficult to get the services and support they need to recover and stay healthy.

Why care services that are provided need to evolve:
• medical and technological advances mean that not only do fewer people need to go to hospital for routine treatment nowadays, but also that people can take more care of their own conditions at home or in the community, avoiding hospital altogether
• many conditions do not need to be treated in hospital at all, but can be treated in the community by teams of integrated care staff working alongside local people and carers. This is better for the individual and is a better way of providing care – but it does need different ways of working in order to be done effectively
• when a hospital stay is required, it can now be much shorter. If more complex care is needed, for major illnesses or accidents, it is better to go to a larger more specialist centre rather than just the nearest local hospital, whereas for simple and intermediate care this can be provided in a patient’s local area
• our local hospitals are struggling to provide care for the most seriously ill people because our medical staff need to treat a minimum number of cases to maintain and develop their skills. If they do not treat enough people with a specific condition on a regular basis, their skills and knowledge about treating that condition – and any equipment needed – are not up to date. Some specialist tests are either not available locally or not available 24 hours a day, seven days a week.
Evidence shows us that...

- the number of over 65s is growing faster in Eastern Cheshire than anywhere else in the North West with more than one in five of the population in this age group. This ratio is higher than the national average, and will become nearer to one in four people by 2021.
- the number of very elderly people (over 80) is growing rapidly, with a higher estimated average annual growth rate when compared to England (2.7% vs. 2.3%).
- as the population gets older more and more people are suffering from long term conditions such as high blood pressure, liver failure, diabetes, cancer, dementia and other mental health problems.
- nearly half of beds at local hospitals are occupied by someone with a long term condition.
- most of the 366 premature deaths in Eastern Cheshire each year are caused by cancer, heart disease, stroke, lung disease and liver disease – diseases that are largely preventable by following a healthy lifestyle.
- although Eastern Cheshire is generally affluent, more than 9,000 of local people live within areas that are among the 20% most deprived in England. There are some quite big differences in health outcomes – or health inequalities – between some of these areas and more affluent areas. For example, a woman living in Macclesfield Town South will, on average, die almost 13 years earlier than a woman living a couple of miles away across town in Tytherington.
- one in six people aged 18-64 living in Eastern Cheshire has a common mental disorder such as anxiety or depression, whilst more than 1,500 people in Eastern Cheshire live with serious mental health problems such as schizophrenia.
- people in Eastern Cheshire aged under 75 living with a serious mental illness are four times more likely to die at an earlier age than the general population.
- senior doctors at Macclesfield District General Hospital are only available in A&E for 12 hours a day during the week and nine hours a day at the weekend.

- there are an estimated 21,000 people in Eastern Cheshire who identify themselves as carers.
- many other people care for family members full time but do not see themselves as carers because they are acting out of love, not duty. Yet these people still deserve the support of the health and social care system.
- one in four carers decline a needs assessment because they think there will not be enough services to help them.
- around half of hospital expenditure and around half of spending on adult social care is used for people aged over 65, even though they represent only one fifth of the Eastern Cheshire population.
- an estimated one in four adults in Macclesfield are binge drinkers compared with one in five adults nationally.
- over a third of people in Eastern Cheshire say they have to wait too long for a GP appointment.
- local research indicates one third of men and two thirds of women over the age of 75 live alone. Loneliness is a major cause of ill health.

We cannot afford to do nothing:
The cost of providing health and social care is increasing due to demand from, amongst others, the increasing age and ill health of local people and the costs associated with keeping pace with new technology offering opportunities for improved care. Funding for health and social care is limited, as it is across the entire UK economy. If demand for care services continues at the current rate there will be a financial shortfall in Eastern Cheshire of nearly £80m by 2018/19.

Although many of these facts and figures are worrying, if not alarming, they throw up the same problems and challenges faced by many other parts of the country. Those leading local care services are very familiar with them.

If we do nothing, access to the best care services will get worse and services will continue to be fragmented and unresponsive. Lives will not be saved and inequalities will not only continue but will become more extreme. Financial pressures will rise, putting at risk the availability of local services. Action MUST be taken to avoid this.

Local leaders know that achieving this kind of transformation within the funding that is available will not be easy, but they also know that by working together they can get the best possible outcomes for our local people whilst saving money which will be put back into further improving care services in Eastern Cheshire.
Chapter Five
What future care will look like

Caring Together will deliver improvements across all forms of care – hospital care, care in GP practices, mental health services and social care.

Empowerment

Everything we do will seek to encourage the empowerment of our local population to take responsibility for their own health, namely:

- people will be supported in prevention measures (e.g. stop smoking) and to take more personal responsibility to self-care. This will involve improved patient education and public health programmes as well as the use of web based resources
- people will have a consistent and easier way of contacting health and social care services 24 hours a day, 7 days a week, through a single phone call or other means, offering support, signposting and prioritising their needs appropriately and quickly
- there will be appropriate signposting to support people to self-care and a directory of services available to professionals and people to assist this
- there will be support and investment in more information and community resources to help empower people
- a communication campaign will inform and engage people to help them understand what being more empowered will mean for them
- personal budgets will be offered increasingly to enable people needing joined-up health and social care to plan and pay for the support that is right for them.

Empowerment

- I will be actively involved in decisions about my care
- I will be supported by care staff to make fully informed choices about my care
- I can access effective and helpful joined-up care and support when I need it
**Joined-up care**

A new model of joined-up care will be introduced that brings together many of the current services that exist independently across physical health, mental health and social care. This new approach to delivering care will require a whole system partnership in Eastern Cheshire that is able to plan, co-ordinate and deliver urgent and routine care for our local population.

This new joined-up care system could mean:

- Care professionals will be responsible for maintaining continuity for all care needs, especially in older people or those with complex care needs. This may be the usual GP, or a local nurse, a social worker or a consultant. They will have the ability to navigate the system with you to get the care and information you need.

- Specialists will provide support in the community for our local population and their care staff specifically to increase local accessibility to the highest quality of care.

- Care staff will be able to use new technology to proactively assess peoples care needs (risk stratification) to enable services to be prioritised for those who need them most.

- People will receive a single assessment focused on their lifestyle, goals and care needs using a joint assessment employed across health and social care.

- For those most at risk, a care co-ordinator will be identified from within an integrated community team.

- A care plan will be created jointly with the individual to include goals, required interventions, provider details, and information on whom to contact in case of change or crisis.

- Integrated community care teams and care co-ordinators will work with patients, service users, families and carers to undertake case management to ensure that the most appropriate services are available in the right place at the right time.

- Where a need is urgent but does not require hospital treatment, people will have access to an urgent care assessment and services at an appropriate time and location. This might be at a GP surgery, an urgent care centre or at a specialist rapid access clinic.

- Rapid assessment will be provided at home or as close to home as possible, as an alternative to admission to hospital or care homes by responding to a person’s need in situations of crisis.

- Care staff will be able to directly access specialist services such as physiotherapy or hospital-based diagnostics as an alternative to referring patients to A&E.

**Elective and specialist care**

To achieve our ambitions and deliver the quality standards we aspire to; local people will need to access improved specialist services delivered both locally and through specialised centres in Greater Manchester and North Staffordshire, 24 hours a day 7 days a week. This could include:

- Planned care delivered as locally as possible and routine surgery that needs to take place in a hospital will happen at dedicated surgical centres with access to doctors with specialist skills and equipment. Individuals will continue to have a choice about where they receive planned care.

- Where more specialist services are needed, people will be able to access high quality hospital services where senior doctors are available 24/7, supported by specialist equipment and teams, e.g. as already introduced for patients in the hyper-acute phase of stroke.

- Regional specialised services will be networked with local services to make sure that specialist support is available locally when required.

- The most specialist services such as major trauma, cancer, renal transplant and heart attack centres will continue to be provided by specialist hospitals across the North West and further afield.

**Highest Quality Care**

- I will receive assessment and recommendations for care based on current best practice.

- I will receive the highest quality care regardless of the time of day or day of the week.
Measures of Success

We will know that we have improved the Eastern Cheshire care system if we:

- have increased the number of people having a positive experience of care
- have reduced health inequalities across Eastern Cheshire
- have ensured local people can access care to the highest standards and are protected from avoidable harm
- have ensured that all those living in Eastern Cheshire will be supported by new, better integrated, joined-up community services
- have increased the proportion of older people living independently at home and who feel supported to manage their condition
- have improved the health related quality of life of people with one or more long term conditions, including mental health conditions
- have secured additional years of quality life for the people of Eastern Cheshire with treatable mental and physical health conditions.

Our vision of the future of care services for the people of Eastern Cheshire to help us achieve these improvements is illustrated in Figure 5.

Examples of how we are starting to make a difference in the way care services are delivered and in the way people experience care are shown in Chapter Six. These examples have been matched against our eight Caring Together ambitions.
Eastern Cheshire
Integrated Care System
(Figure 5)

Chapter Five | What future care will look like 26 / 27
Chapter Six
How we are starting to make a difference

(Figure 6)

EXAMPLE
People in Eastern Cheshire, with long term conditions such as Arthritis, Diabetes and Epilepsy are being helped by Practice Nurses, Community Nurses, Wellbeing Co-ordinators and GPs to look after themselves better. This is being achieved by care professionals being jointly trained to help people with long term conditions.

EXAMPLE
Each GP practice in Eastern Cheshire is part of a neighbourhood team which is made up of a range of health and care professionals – including nurses, social workers, therapists, mental health workers and GPs. In collaboration with Age UK Cheshire East, a new role of Wellbeing Co-ordinator has been introduced, working with patients to develop their own goals, agree plans to improve wellbeing and address the lifestyle issues they face.

EXAMPLE
The Integrated Respiratory Team is made up of specialist nurses and physiotherapists that specialise in treating people with chronic (long-term) lung conditions seven days a week. The team see patients in hospital, in community and hospital clinics and in the patient’s own homes. They work together with other professionals to ensure that patients can access the care they need, when they need it.

EXAMPLE
The Neighbourhood Pharmacy Outreach Team is part of the approach to better joining up care in the community. Pharmacists and a technician work together with GPs and other health and social care professionals to support individuals to successfully manage their own medicines either through home visits or advice given over the telephone.

EXAMPLE
The Eight Caring Together Ambitions

EXAMPLE
The Working Together partnership in Bollington, Disley and Poynton helps people return home safely and happily after a stay in hospital. Managed by Care Co-ordination Administrators based in the locality, the programme puts in place a wide range of support which may include home visits and contacting the family to ensure that ongoing health and care needs are understood and met.

EXAMPLE
The intermediate care service, (such as nurses, social workers, therapists and GPs) will work together to ensure patients can return from hospital as soon as it is safe to do so, and are provided with the appropriate short term support that will enable them to live independently at home.

EXAMPLE
NHS Eastern Cheshire CCG has developed a system to provide a real-time view of the local care system to enable people to receive excellent, timely care. Information such as the availability of GP appointments, available beds in hospitals and care homes and ambulance turnaround times is fed into a system that enables decision makers to see at a glance which parts of the system are under pressure and which have spare capacity. By joining up data, the care system is working together to ensure that patients receive the care they need at the right time, in the right place.

EXAMPLE
Carers groups across Eastern Cheshire are working with Cheshire East Council and the CCG to ensure that strategic plans include consideration of the needs of carers, from helping them manage the long term condition that the person they care for may have to improving access to helpful information and their own support.
We have identified seven enablers that need to be in place if the Caring Together programme is to successfully deliver on its ambitions.

These seven enablers describe what resources are currently available, how we can use these resources more productively and what we believe will be required in the Caring Together model of care.

These enablers also describe how important it is to engage with, communicate with and empower care staff and local people to make the necessary changes in culture, ownership and accountability, and how technology, estates, contracting and commissioning can lead to transforming the way care is delivered in Eastern Cheshire.

The enablers have been informed by more than 18 months of conversations with clinicians, care staff, the public and carers.

Our seven enablers for change are illustrated in Figure 7.

**Planned pathways**
- Care pathways will be shared with me and my carers
- My information and care records will be shared with my consent
Seven enablers to make Caring Together happen

(Figure 7)

ENABLER 1
INFORMATION & COMMUNICATION TECHNOLOGY
- flow of information across settings to support clinical decision making combined with transparency in performance, drives compliance with clinical and professional protocols and performance improvement

ENABLER 2
CONTRACTING & COMMISSIONING
- incentives aligned across all providers of care, with funding mechanisms tied to co-ordinated and shared delivery of outcomes for a defined population

ENABLER 3
ESTATES
- locality based model to allow the community based workforce to co-locate and share knowledge and best practice

ENABLER 4
ENGAGEMENT WITH LOCAL PEOPLE
- partnership with local people in the co-development and ownership of care plans, and supporting them in managing their own care
- increasing the accountability and responsibility of local people

ENABLER 5
WORKFORCE
- resourced and empowered workforce to deliver both new and existing care models
- workforce is trained to ensure existing skills are used as effectively as possible to provide the best possible care to the local population

ENABLER 6
ORGANISATIONAL DEVELOPMENT & STRUCTURE
- board-level sponsorship and transparent decision-making
- form follows function in order to deliver integrated team working in each locality of Eastern Cheshire with high levels of productivity, flow of information and ability to manage risk

ENABLER 7
LEADERSHIP & CULTURAL TRANSFORMATION
- senior clinical, professional, managerial and political leaders articulate a clear vision and empower teams to collaborate
- respected individuals from each professional group and within each locality to act as role models for the new ways of working
Chapter Eight
How can I get involved in Caring Together?

CHECK OUT OUR WEBSITE
WWW.CARINGTOGETHER.INFO

COME TO OUR ENGAGEMENT EVENTS

FOLLOW US ON TWITTER
@CARING_TOGETHER

FOLLOW US ON FACEBOOK
CARING TOGETHER

SCAN OUR QR CODE:

CALL US ON
01625 242 511

EMAIL US AT
ECCCG.CARINGTOGETHER@NHS.NET

SIGN UP TO OUR NEWSLETTER AT
WWW.CARINGTOGETHER.INFO

DOING NOTHING IS NOT AN OPTION

FOLLOW US ON GOOGLE+
CARINGTOGETHER

FOLLOW US ON INSTAGRAM
CARING TOGETHER

BECOME A CARING TOGETHER CHAMPION

Chapter Eight | How can I get involved in Caring Together?
Future communications

We are planning to communicate regularly with you to let you know how we are getting on with the programme, how it will impact on you, your family and your friends, and also what we may need your help with.

Early in 2015 we will be launching a new animation which tells the story of two people receiving care in Eastern Cheshire and how life will be different for them through the Caring Together programme.

Look out also for our monthly Caring Together newsletter that shows how integrated care is already helping the people of Eastern Cheshire and making working life more rewarding for health and social care professionals. You can subscribe to the newsletter at www.caringtogether.info

We are always keen to celebrate examples of great care and to share best practice so please let us know if you’re involved in work you’re proud of or if you or someone you know has benefited from integrated care. Just drop us a line at join@caringtogether.info or contact us via any of the ways shown on the back of this document.

Equality Impact Assessment

Caring Together has a duty under the Equality Act 2010 called a Public Sector Equality Duty (PSED), which means it needs to ensure that, in considering changes to local health services, it has sought to:

- eliminate unlawful discrimination, harassment and victimisation
- advance equality of opportunity between different groups of people
- foster good relations between different groups

This involves:

- removing or minimising any disadvantages faced by groups of people with particular characteristics, sometimes called ‘protected characteristics’
- taking steps to meet the needs of such groups where those needs are different from the needs of other people
- encouraging people from such groups to take part in public life, or take part in other activities which they would not typically be involved in.

The Caring Together programme is currently conducting a study called an Equality Impact Assessment to ensure it has carried out this kind of work in the right way. This first phase of this study was reported to the programme’s Executive Board in August 2014.

Support for carers

- I can balance my caring roles and maintain my physical, mental and emotional wellbeing
- As a carer I am valued, involved and informed throughout the care process

Glossary

A&E

Accident & Emergency is a service available 24 hours a day, seven days a week where people receive treatment for medical and surgical emergencies, whether through illness or accident.

Acute Care

Usually pre-planned treatment that requires a short stay in hospital.

AHP

Allied Health Professionals are a distinct group of health professionals, such as Occupational Therapists, Physiotherapists, Dieticians, etc.

Ambulatory care

Hospital treatment that does not require an overnight stay.

Bed-days

A bed-day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital.

Carers

A carer is a person giving assistance to an ill, disabled or frail person, usually a relative or friend.

Cardiothoracic

Cardiothoracic surgery is a surgical specialty, which deals with the diagnosis and management of surgical conditions of the heart, lungs and oesophagus.

Care Records

The records held about your health and care by your local GP practice, local Hospital or social care provider.

Care Plan

A written plan, setting out the care needs of a person and the services on offer to support that person.

CCG

Clinical Commissioning Group. See NHS Eastern Cheshire CCG.

Cheshire East Council

Local authority area with a 372,000 population, covering the former boroughs of Macclesfield, Congleton and Crewe and Nantwich. www.cheshireeast.gov.uk

Cheshire and Wirral Partnership NHS Foundation Trust

Provider of NHS children’s and adults mental health services. www.cwp.nhs.uk

Commissioners

Organisations responsible for planning and funding health and social care services needed for a local area. See also Cheshire East, NHS Eastern Cheshire CCG, and NHS England.

East Cheshire NHS Trust

Provider of acute/secondary healthcare and community healthcare. Operates hospitals in Macclesfield, Knutsford and Congleton and provides community services across Cheshire East. www.eastcheshire.nhs.uk

Elective Centre

A centre where care is planned in advance as a day case or inpatient.

Enablers

The processes or things that are needed to ensure that Caring Together becomes a reality in Eastern Cheshire.

Equality Impact Assessment

A statutory process to ensure that any public policy, project or scheme does not discriminate against any disadvantaged or vulnerable people.

High Dependency Care

A high dependency unit is an area in a hospital, usually pre-planned treatment that requires a short stay in hospital.

Integrated Community Team

A team working in the community that includes, Doctors, Nurses, Social Workers, Matrons, Pharmacists and Physiotherapists who work together to discuss patients in a co-ordinated way.

Long Term Condition

Long term conditions are health conditions that last a year or longer, impact on a person’s life, and may require ongoing care and support.

Macclesfield Town South

Encompasses the Moss Estate and Lyme Green areas of Macclesfield.
National Voices The independent voice of patients, service users and carers to influence national health and social care policy in England. Find out more at www.nationalvoices.org.uk

NHS 111 A national programme that provides a fast and easy way to get the right help, whatever the time. NHS 111 is available 24 hours a day, 365 days a year. Calls to 111 are free from landlines and mobile phones.

NHS Eastern Cheshire CCG A GP led NHS organisation responsible for planning and buying health services for the 204,000 population residing in the surrounding areas and towns of Alderley Edge, Bollington, Chelford, Congleton, Disley, Handforth, Holmes Chapel, Knutsford, Macclesfield, Poynton and Wilmslow. www.easterncheshireccg.nhs.uk

NHS England The executive arm of the Department of Health which oversees the budget, planning, delivery and day-to-day operation of the commissioning side of the NHS. (See Clinical Commissioning Groups) Find out more at www.england.nhs.uk

NWAS North West Ambulance Service – provider of ambulance services across the North West of England www.nwas.nhs.uk

Obstetrics A hospital service concerned with childbirth and midwifery.

Pathways A route that a patient will take from their first contact with an NHS member of staff, through to referral, to the completion of their treatment.

Paediatrics Services dealing with children and young people.

Primary Care Health services delivered in or near to a person’s home to which patients have direct access. These services include those provided in GP surgeries, Opticians, Dentists and Pharmacists.

Planned Care Inpatient or outpatient appointments for procedures or surgeries.

PSED - Public Sector Equality Duty A statutory duty to eliminate discrimination, harassment and victimisation.

Risk Stratification A systematic assessment of each patient’s health risk status based on information from various sources to develop a personal care plan to help them stay well for longer and prepare for their future care needs.

Social Care Services Social services is the department of a local authority which helps people who are in need of support due to illness, disability, old age and poverty.

Social value Social Value is about maximising the impact of public expenditure to get the best possible outcomes. It is about what we value in the public realm and is now recognised in legislation through the Public Services (Social Value) Act 2012. Social value considers more than just the financial transaction. It includes, amongst many other things, Happiness, Wellbeing, Health, Inclusion and Empowerment.

The 6 Cs The values of patient care as set out in the national nursing strategy and which all health professionals are asked to embrace in their everyday work. The 6 Cs are:

1. Care
2. Compassion
3. Competence
4. Communication
5. Courage
6. Commitment

Readers’ Panel

We wish to thank NHS Eastern Cheshire CCG’s Readers’ Panel for acting as our critical friend and improving the document in numerous ways.

Caring Together Executive Board

Dr Paul Bowen
Clinical Chairman, Caring Together, NHS Eastern Cheshire CCG
Lorraine Butcher
Executive Director of Strategic Commissioning, Cheshire East Council
Sheena Cunmiskey
Chief Executive, Cheshire and Wirral Partnership (CWP)
NHS Foundation Trust
Stephen Downs
Senior Business Consultant, NHS Trust Development Authority
Dr Heather Grimaldston
Director of Public Health, Cheshire East Council
Jenny Hawker
Chief Officer, NHS Eastern Cheshire Clinical Commissioning Group (CCG)
Justin Johnson
Chief Executive, Vernova Healthcare CIC
Dr Patrick Keorns
Chair, Vernova Healthcare CIC
Alex Mitchell
Chief Finance Officer, NHS Eastern Cheshire CCG
Roger Nielsen
Senior Responsible Officer, Caring Together Transformation Workstream
Dr Alison Rylands
Deputy Medical Director (Clinical Strategy), Cheshire, Warrington & Wirral Area Team, NHS England
Dr Anushta Sivanathan
Medical Director, CWP
Dr Rob Sted
Former Medical Director, East Cheshire NHS Trust
Bill Swann
Patient and Carer Representative, NHS Eastern Cheshire CCG
Alison Tonge
Area Director, NHS Cheshire, Warrington & Wirral
John Wilbraham
Chief Executive, East Cheshire NHS Trust

Caring Together Communications and Engagement Group

Rachel Alcock
Communications Manager, Peaks & Plains Housing Trust
Usman Aqib
Health and Wellbeing Officer, Plus Done Group
Jennie Watkins
Senior Communications and Involvement Officer, CWP

Acknowledgements

Helena Binder
Communication and Community Engagement Lead, Healthwatch Cheshire East
Jayne Cunningham
Network Co-ordinator, CVS Cheshire East
Matthew Cunningham
Corporate Services Manager, NHS Eastern Cheshire CCG
Fiona Doorey
Head of Communications, Engagement and Marketing, East Cheshire NHS Trust
Charles Maltkin
Communications Manager, NHS Eastern Cheshire CCG
Rebecca Patel
Public Engagement Manager, NHS Eastern Cheshire CCG
Abigail Rushton
Communications Officer, Cheshire East Council

Caring Together Programme Management Office

Bernadette Bailey
Transformation Manager, NHS Eastern Cheshire CCG
Jane Miller
Transformation Manager, NHS Eastern Cheshire CCG
Hadleigh Stoller
Senior Programme Manager, NHS Eastern Cheshire CCG
Marie Ward
Transformation Manager, NHS Eastern Cheshire CCG

NHS Eastern Cheshire CCG Governing Body

Gill Boston
Lay Member for Patient and Public Involvement
Dr Michael Clark
General Practice Locality Peer Group Lead - Macclesfield
Neil Evans
Commissioning Director, NHS Eastern Cheshire CCG
Gerry Gray
Lay Member for Governance & Audit, Deputy Chair of the Governing Body
Dr Jennifer Lann
General Practice Locality Peer Group Lead - Knutsford
Duncan Matheson
Secondary Care Doctor
Joanne Morton
General Practice Locality Peer Group Lead - Alderley Edge, Chelford, Handforth & Wilmslow
Sally Rogers
Registered Nurse
Julie Sercombe
General Practice Locality Peer Group Lead - Congleton & Holmes Chapel
Dr Julie Sin
Consultant in Public Health Medicine, Cheshire East Council
Angela Wales
General Practice Locality Peer Group Lead - Bollington, Disley & Poynton

Glossary / Acknowledgements
To provide feedback about this document, become a Caring Together Champion, or if you have any other need to contact the Caring Together programme, call us on: **01625 242 511**
or email: **ecccg.caringtogether@nhs.net**

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