NHS
Countess of Chester Hospital
NHS Foundation Trust

Our five year Clinical Strategy 2019/2024

Executive Summary

This document describes how our Trust will develop and deliver its clinical services over the next five years to meet the challenges posed in the NHS Long Term Plan (January 2019, www.longtermplan.nhs.uk) which describes and anticipates a fundamentally changed health care offer over the coming five years, with up to one third of existing hospital appointments replaced by an alternative, digitally-facilitated patient offer, a renewed emphasis on same-day models of care, and a comprehensively reconfigured approach to discharge once clinical optimisation of inpatient care has been achieved.

It outlines how we will work with our health and care partners to enact new integrated and flexible models of care, tailored to the needs of our population in terms of ageing, complexity and a population preference for home-based or home-like care. It takes, as its guiding principles, our ongoing commitment to the provision of care that is founded upon the best available evidence, harnessing the skills of an educationally well-supported workforce, and assured in its safety by a sound and consistent methodology of quality governance.

This strategy therefore describes how our services will be aligned to national policy and attuned to our place within a dynamic and evolving local care landscape. It reflects the established shift toward integrated care partnerships and recognises that as an acute provider, we have an important part to play in tackling the significant public health burdens present in our communities – smoking, alcohol, obesity – alongside our provision of complex and specialist services. More than ever before, we are care partners as much as we are care providers.

Introduction

The purpose of this strategy is to describe how The Countess of Chester Hospital NHS Foundation Trust will deliver services over the next five years.

Within that broad intent, it also draws out a range of core services, fundamental to the sustained provision of high-quality care for our demographic and outlines the principles and architecture of how these will be delivered. The needs of the population are continuously changing and our understanding of how to deliver effective and safe care has matured. We know that people wish to have ownership of their own care needs and would prefer to access support and intervention at the most local level possible: enacting this at scale requires a significant change in the provision of community care. Evolving Primary Care Networks (PCNs) seek to address many elements of that change, but the need will remain for enhanced nursing and therapy provision within and between the PCNs to enable sustainable care provision of that type seven days per week.

The appendices to the strategy describe, in detail, the demographic changes that will inform the scale and nature of clinical demand placed upon both our own Trust and that of the members of our Integrated Care Partnership in the time ahead. The challenge to delivery is considerable; so in turn is the significance of the requirement to deliver care via more innovative and forward-thinking methodologies. We have been careful in the development of this document, to accommodate the recommendations of national productivity reviews of those of our services deemed core to care provision. We have also been conscious of the need to reflect rurality, demand growth and other key variables in the determination of the shape of our future service model. The strategy presented here aligns to that of our partners and has evolved in consultation with them.

The purpose of a clinical strategy is not to give full detail about all of the services that are delivered, but to develop proposals for our services, in particular how our working practices will change to support the services we deliver. Subsequent sections of this document elaborate on this principle in order to clarify some specific, and particularly significant, aspects of the care we will provide. The full detail

about individual services – their size, scope and operational capacity – are accommodated within the business planning that underpins year-on-year activity management. It is important to state, however, that the clinical strategy is not operationally nor financially naïve. Once realised, this strategy will, by providing the right care, at the right place, at the right time – supported by peer reviewed productivity metrics, appropriately broad and deep clinical coding, and a shared understanding of everyone's role in effective and efficient delivery – provide a sound basis upon which our compliance with constitutional targets and our ability to function within an agreed financial envelope can be delivered. We know from experience that the alternatives to this approach – do nothing, or do little – are operationally, financially and clinically – unsustainable.

This clinical strategy will, in turn, rely upon key enabling strategies to be formulated in the first year of this strategy – workforce, technology, estates, research, innovation and quality.

Context and background

Most non-specialist acute provider Foundation Trusts have delivered a relatively traditional range of services in recent years. However, the NHS Long Term Plan (2019) has challenged and asked the NHS for the reconfiguration of health and care provision at a place based level, many elements of which have been in a developmental stage within our locality for some time. New ways of working have been described but not yet delivered in our emergent Integrated Care Partnership (ICP), and we have recognised and embraced the changes in our supply of workforce and the new roles afforded to us in how we deliver care.

The full realisation of a mature ICP, as it moves to delivery, will likely have a significant impact on the type and scope of healthcare that is offered to the population of West Cheshire; however importantly, our clinical strategy describes those elements of care that we anticipate will remain core to the acute hospital as the ICP evolves. This strategy will assess the known issues and requirements relating to West Cheshire 'Place' needs in the short term, but will naturally evolve with time as the plans within the wider health and care network of provision reach a state of secure delivery.

The current funding arrangements of the NHS have placed a greater emphasis on delivering efficiency with existing and reducing budgets. We have a growing and important quality and consistency mandate in terms of the national "Getting It Right First Time" (GIRFT) programme and an unprecedented focus upon productivity. This presents a golden opportunity to look at how services are delivered differently, at the same or higher quality but at lower cost. Within and around these challenges, we are committed to the sustained attainment of our constitutional targets, a reduction in unwarranted clinical variation, and the highest possible standards of assurance in relation to the core safety of all that we do in terms of clear and accountable governance.

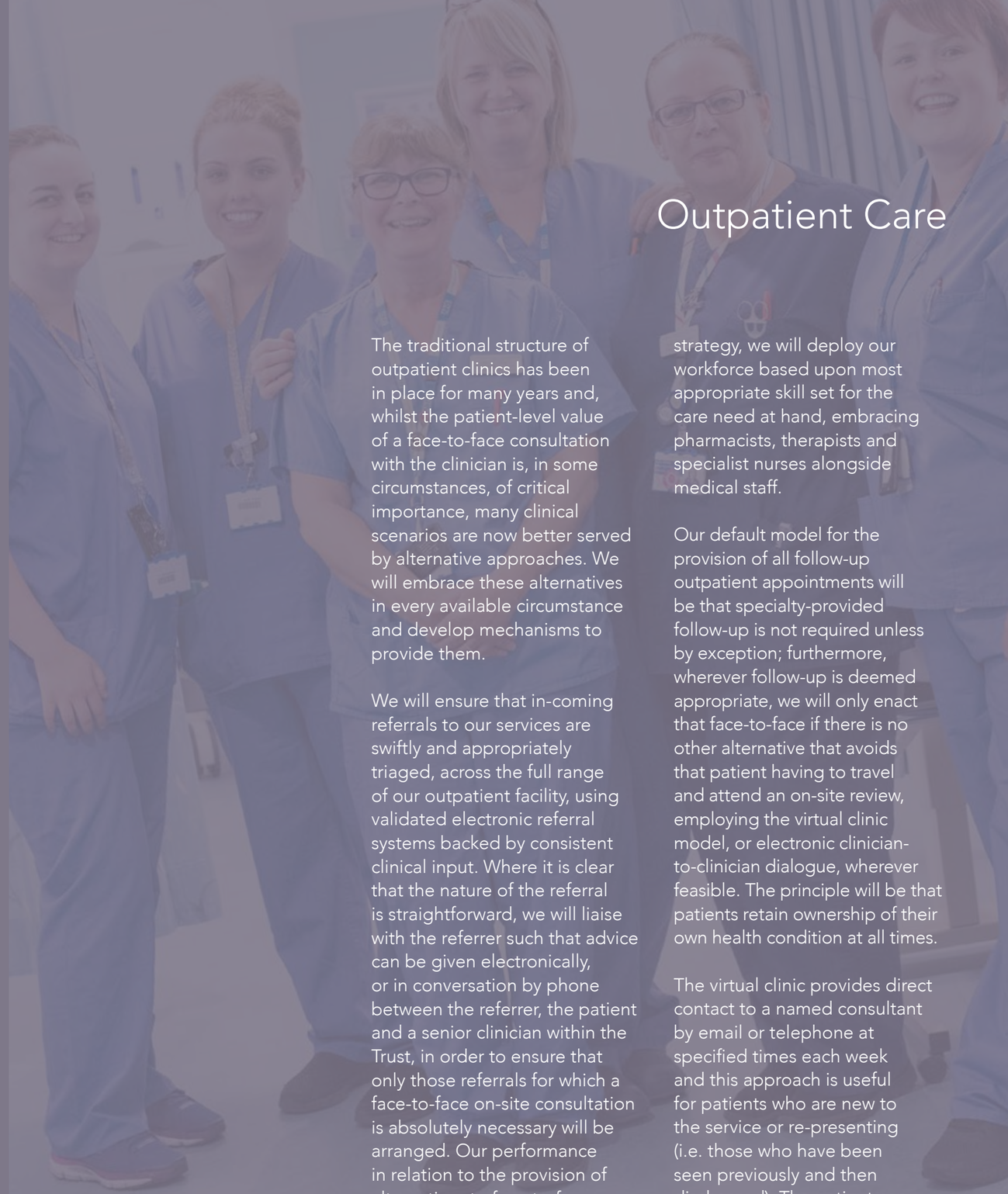
The development of our clinical strategy has considered every circumstance where there is scope to develop our ways of working to provide better services for our patients. We have reviewed different approaches in other organisations and considered best practice models of care from across the UK. This strategy is underpinned and informed by extensive engagement with our clinical and management teams, leading to a truly clinically led proposal. Detailed

specialty-level discussions, data reviews and challenge sessions were supplemented by whole-hospital workshops. The outputs of these sessions have been used in conjunction with other information, described earlier, in the production of this strategy. The clinical strategy has had input from clinicians, non-clinical managers, commissioners and external stakeholders. As has been outlined above, key to the successful realisation of this strategy is that we remember our role as partners within care provision; hence, the time and care taken to consult, and ensure alignment with, our community care colleagues is of particular importance in this endeavour.

Structure of this Strategy

The strategy approaches care provision over the next five years on a thematic basis, capturing within that approach the key clinical services we will continue to provide and giving outlines of the models of care that will underpin that core provision. New approaches to traditional models of care are identified; it does not, as has previously been identified, provide detailed service-level planning specifications and it must be read in conjunction with the enabling strategies outlined above.

The strategy is aimed at delivering proposals for our most pressing challenges. In common with many acute sector providers, these challenges revolve around clinical workforce and the financial unsustainability of providing a heterogenous group of site-based specialty teams whose presence is often evolutionary and based on legacy rather than systematic planning. It also tries to identify and capture any opportunities that are available to the Trust. This strategy and its enabling documents will, in turn, be supported by a suite of operational policies that underpin every element of care. The provision of sound and consistent clinical governance is fundamental to the content of the strategy and this assumes a high importance for the patients we serve as innovative integrated models of care evolve to meet their needs.



Outpatient Care

The traditional structure of outpatient clinics has been in place for many years and, whilst the patient-level value of a face-to-face consultation with the clinician is, in some circumstances, of critical importance, many clinical scenarios are now better served by alternative approaches. We will embrace these alternatives in every available circumstance and develop mechanisms to provide them.

We will ensure that in-coming referrals to our services are swiftly and appropriately triaged, across the full range of our outpatient facility, using validated electronic referral systems backed by consistent clinical input. Where it is clear that the nature of the referral is straightforward, we will liaise with the referrer such that advice can be given electronically, or in conversation by phone between the referrer, the patient and a senior clinician within the Trust, in order to ensure that only those referrals for which a face-to-face on-site consultation is absolutely necessary will be arranged. Our performance in relation to the provision of alternatives to face-to-face outpatient consultations will be measured based upon peer evidence within the GIRFT and other programmes as appropriate. As is described in the accompanying workforce strategy, we will deploy our workforce based upon most appropriate skill set for the care need at hand, embracing pharmacists, therapists and specialist nurses alongside medical staff.

Our default model for the provision of all follow-up outpatient appointments will be that specialty-provided follow-up is not required unless by exception; furthermore, wherever follow-up is deemed appropriate, we will only enact that face-to-face if there is no other alternative that avoids that patient having to travel and attend an on-site review, employing the virtual clinic model, or electronic clinician-to-clinician dialogue, wherever feasible. The principle will be that patients retain ownership of their own health condition at all times.

The virtual clinic provides direct contact to a named consultant by email or telephone at specified times each week and this approach is useful for patients who are new to the service or re-presenting (i.e. those who have been seen previously and then discharged). The patient can have a face to face discussion with a clinician, via their phone, tablet or computer. We will embrace and embed this technology within our full range of outpatient service provision

and, in so doing, reduce the quantity of outpatient activity we provide on-site across all of our disciplines whilst maximising the value-added element of virtual consultation. General Practitioners will be able to access specialty clinical advice electronically or by phone, enabling direct communication with a senior clinician based within our teams in order to signpost, advise and support the provision of community-based care without the need for patients to travel to our sites. We will capture and code that virtual support model to ensure that it is operationally and financially viable and sustainable.

We will, as outpatient services evolve, change the traditional workforce model within all of our clinic provision, including face-to-face. Our on-site clinic capabilities will focus upon core clinical services that cannot be provided in alternative settings within the health and care economy and the changes required to enact these alternatives will be developed collaboratively with our community care partners. On this basis, our on-site capacity in respect of dental services, maxillo-facial surgery, dermatology, diabetology, respiratory medicine, elements of plastic surgery and some other services will reduce, and we will signpost patients to alternative care provision in consultation with our ICP partners, if this will safely meet their care needs within a logical geographical area. These alternative sources of provision may be, for example, community care clinics, led and provided by therapists and specialist practitioners with focused clinical expertise available remotely as required.

This changing shape of outpatient provision will see us assessing a progressively more complex, clinically higher-acuity cohort of patients on-site. Naturally, there will be occasions when, within the clinic environment, a patient is considered to require immediate admission to the specialist inpatient facilities we will continue to provide. In such situations, we will arrange the admission of that patient through the specialty assessment unit for that discipline. These patients will not simply be transferred to our Emergency Department unless, by exception, they require immediate resuscitation. They will remain under the care of a senior inpatient clinician at all times, from the clinic setting through to their eventual discharge.

For some clinical outpatient activity, patients may be relatively ambulant even

though their condition warrants face-to-face specialist assessment. These include many orthopaedic, urology, gynaecology, and other patient groups. Where it is clear that the main Chester hospital site is not fundamental to the safe and effective provision of outpatient activity for these assessments, then we will re-provide that clinical activity off the main hospital site, as described in the enabling estates strategy.

Working across the ICP, we will develop and widen the scope of pre-clinic test protocols and patient-completed assessment proforma, so that all patients who do require assessment and care within our specialist services are seen efficiently and swiftly, with their face-to-face contact time spent in actual dialogue with a clinician, rather than collation of information and data. We will develop and implement a suite of agreed protocols of this type that are electronically accessible to referring clinicians and can, in turn, be employed in the community setting to obviate the need for referral in the first place.

Long Term Conditions

We have a significant, demographically driven demand within our patient population related to the effective provision of long-term care. Strategically, the principles upon which we will support this provision are holism, the central importance of therapies, non-medical interventions and patient-determined goals in treatment. We will deploy our resources to support patients with long-term respiratory, endocrine, cardiological and other conditions within their own homes or in home-like settings by providing alternatives to on-site referral assessment and on-site case management.

Where patients with long-term conditions do present to our acute services – most usually through ambulance arrival and very often in the out-of-hours setting – we will deploy therapy and support staff at the point of initial assessment. This reflects radical shifts in workforce modelling that will be described within the accompanying Workforce Strategy.

Exacerbations of known long term conditions will be managed on an assess-to-discharge basis rather than assess-to-admit, or even admit-to-assess. We recognise that for this large and vulnerable patient population, home is almost invariably the care location of choice, and we will reflect that fundamental right in our approach to care.

We will provide comprehensive and responsive palliative care for those of our patients identified as requiring this key intervention. Our workforce strategy describes the deployment of skilled clinical specialists we will use to ensure that this most important element of care is there for patients swiftly and consistently. We will build operational linkages to our hospice partners to enable patients to be managed in the most appropriate settings for their needs.

Our provision of renal care for those of our patients requiring dialysis intervention, currently delivered via a 'hub and spoke' model with Wirral University Hospitals NHS Foundation Trust, will not be re-provided by us at The Countess. It is not our strategic intent to provide any element of acute renal care for our patient population. We recognise the complexity and specific care needs of patients requiring renal dialysis and will work with care providers in the development of a refreshed care model that accommodates the operational and clinical challenges of sustainable delivery.

Inpatient Care

It is now definitively accepted that many patients who present to hospital as an urgency or emergency can be managed safely and to a high quality standard without the need to stay in hospital as an inpatient. Likewise, procedures and interventions once leading to prolonged inpatient spells can now be accommodated safely in same-day or near-same-day discharge models. We will change our approach to care provision such that each patient episode is approached as one suited to ambulatory, assessment-unit or same-day care, unless by exception. Where an inpatient bed is clinically necessary, this exception decision will be based upon assessment of that patient by a senior, experienced clinician.

Our ambulatory care areas will be expanded and managed operationally, in collaboration with community care colleagues, such that they are able to function seven days per week, and we will secure and develop the facility to offer same-day medical and surgical care across seven days for a wide range of interventions. The scope and scale of the services using a same-day approach (day-case) will be informed by best practice evidence from GIRFT and other peer review data. We will keenly monitor and manage our compliance with best-practice models of same-day and near-same-day care on a team and individual clinician basis, minimising variation and managing challenges to that variation in the interests of safety and productivity. We will deploy criteria-led discharge across all suitable services to facilitate swift, safe transfers of care to home or social care settings for our medically optimised patients.

Our community care teams play a vital role in the care of patients as an alternative to, or a complementary element of, inpatient care. We will widen the scope of our community teams working with our ICP partners, in order to deliver as much care as is safely permissible in non-hospital settings, fostering and supporting seamless clinical management protocols provided as close to home as is practicable. We will ensure that all such pathways are backed by rigorous, shared and agreed governance processes that can be enacted across and between care providers. Where patients being managed within a community setting are assessed as requiring specialist, hospital-based care due to deterioration, complexity of need or some other factor, then liaison for assessment will follow the same approach as with any other referral. The default care option will be assessment

within our medical, surgical or gynaecological assessment area (or our paediatric assessment area for children), rather than admission into an inpatient bed. Our workforce strategy will describe the staffing models appropriate for the assessment unit approach, but these will be areas managed, and in some cases led by, non-traditional clinical roles such as specialist therapists. Patients who require care within one of our inpatient beds will be clinically reviewed by a senior member of their clinical team each day, seven days a week, and their discharge planning will commence even before they are admitted as part of the inpatient management plan, irrespective of specialty.

The number of patients accessing Emergency Departments (ED) who require on-going emergency care has been increasing in recent years. This is recognised to have arisen not simply from higher acuity within the attending patient population, but from concomitant constraints within the inpatient and step-up and step-down capacity of most health economies. We will address that challenge in our Trust by ensuring that we provide a model of onward clinical assessment and pathway management that safely, consistently and appropriately identifies the best place for patient care for all ED attenders. Based on the analysis of our demand profiles in Chester, this means that we will enhance and improve the scale and scope of our acute and geriatric medicine assessment teams to enable our high-acuity and/or frail elderly patients to be cared for in an appropriate facility by an appropriate workforce. Our acute medicine service will become the 'backbone' of the medical assessment and admission pathway across the seven days of the week, providing care for the first 48 hours of the patient journey.

Our elderly care assessment and inpatient model will be improved and expanded to enable rapid identification and transfer of all appropriate patients out of the acute assessment space into age-appropriate care, seven days per week, in collaboration with our ICP partners. We will work synergistically with colleagues in mental health to ensure and, in turn, assure, timely and responsive support for patients requiring non-physical care input as part of their journey to clinical optimisation.

These improvements will enable us to re-focus our Emergency Department as the core care area for the very sickest and most vulnerable of our patients, with a rapid stabilisation and intensive treatment function provided by a multi-disciplinary core of highly skilled clinicians.

Patients who have received specialist care within our on-site facilities but who have been optimised for transfer home or to an alternative community care area are, by definition, no longer gaining benefit from inpatient hospital care and this can result in further deterioration of the patient if they remain there. These 'stranded' patients may often still have significant care needs best met outside the hospital. We will develop and enact multidisciplinary processes across all our inpatient wards to ensure that optimised, stranded patients are afforded definitive re-provision of their care in the appropriate setting with the same assertiveness as patients arriving into the assessment areas from the community or ED.

We will also improve our provision of end-of-life care within our specialist services and seek to position ourselves as exemplars of end-of-life care provision. All patients whose clinical condition suggests that end-of-life care will form an important element of their stay with us will be sensitively involved in conversations on that basis; both the patient, their families and/or care-givers, and their community healthcare teams will be incorporated into management planning for end-of-life care. Our clinical teams will be trained in end-of-life care across all disciplines. We have described above how our provision for palliative care will be strengthened through clear, accessible pathways and linkages to our hospice facilities, backed by an enhanced palliative care team who will 'in-reach' into all areas caring for patients on-site according to agreed, consistent referral criteria.

Frailty and Elderly Care Services

Our local demographic (see appendices) demonstrates that many more people are, thankfully, living full and active lives in our area even with a wide range of chronic illnesses. However, relatively minor clinical conditions - a fall or urine infection – can readily precipitate decompensation in older people, in whom background health resilience is naturally compromised and this in turn can trigger the need for a step-up in care. We will provide a model for assessment and clinical management of such patients that assumes semi-ambulatory, same-day or near-same-day on-site care, backed by an enhanced elderly care clinical team. Where frail or elderly patients present to ED, our elderly care team will in-reach and identify this vulnerable patient cohort and assume clinical management of those patients until the point of optimisation and transfer.

Referrals from the geriatric service to other, highly specialist clinical specialties – our respiratory, endocrinology, gastroenterology, cardiology and surgical teams – will only be made where there is demonstrable added clinical value for that patient and will be enacted through a direct referral between senior clinicians within our teams. We will minimise such inter-team referrals, focussing instead on early, consistent and multi-disciplinary case management, with pro-active discharge planning, attention to detail on holistic elements of care, and sensitive end-of-life conversations where appropriate.

Where our much older patients require bed-based interventional specialist care within our surgical services – be they general surgery, gynaecology, orthopaedics or any other discipline – then we will develop a care model that places the focus of management with our geriatric teams, re-providing specialist surgical intervention as an 'in-reach' element of care rather than the traditional surgical in-patient stay. We will enable our surgical specialists to maximise their skills in the provision of procedures, including decision making and the provision of post procedure advice.

Respiratory Conditions

Respiratory disease presents a very significant challenge to our patient population; together with cancer and cardiovascular disease, it is a leading cause of death amongst adults in Cheshire West and Chester (see appendices).

Based upon the age and comorbidity profiles of our population in respect of respiratory disease, we will develop and deliver an integrated respiratory service that meets the needs of the respiratory population and the health care teams in West Cheshire. We will ensure that our on-site specialist respiratory services provide care for patients based on population need, making full use of virtual and electronic patient management wherever possible and tailoring our inpatient model of care to reflect those changes. Our respiratory medicine team will provide specialist in-reach to other areas of the hospital in liaison with senior clinicians within other disciplines. Specialised elements of respiratory care will be re-modelled where safe and appropriate to do so, in partnership with neighbouring Trusts and other care providers, enabling us to offer a swift and effective service to our core population.

We will work with our ICP partners to enable a system-wide respiratory network that will serve the professional community by producing guidance, guidelines and pathways for all aspects of non-malignant adult respiratory care. Reference has been made elsewhere to the need for strong and consistent clinical governance of our multi-disciplinary pathways; nowhere more so is this required than in the management of respiratory disease. We will develop and deliver care based upon best practice guidance. Our default care model will be one of virtual, ambulatory, same-day or near-same-day assessment and management.

We will work with primary care networks and community teams to develop and deliver locality-based specialist respiratory medical and nursing clinics, according to population need. We will in addition ensure that home oxygen assessment services are provided according to national guidelines, reducing the need for on-site outpatient visits wherever possible, using near-patient blood gas technology to determine care need and plan management in the best possible care setting for the patient, including home-based non-invasive ventilation for those patients with an identified need for that degree of support.

Diabetes

Our patient demographic suggests an existing 5% disease prevalence for diabetes, with the trend being upwards. On that basis, we will improve and remodel our care for this significant patient population. Our approach to diabetes case management will be one of community and primary care as the fulcrum of provision with specialist clinical support as required for that small proportion of patients who require inpatient care at points of acuity or complexity.

Our approach to care will be one of advice and support delivered virtually or via in-reach into community settings. Where patients are under the care of other teams within our organisation, we will enable specialist diabetology advice and support to be provided to those clinical teams as required, based upon senior clinical liaison. As a result of this suite of interventions, we do not anticipate the need for an inpatient bed base for diabetology within our service model.

Cardiovascular

As a health economy, Chester and West Cheshire has a lower death rate from stroke and heart disease than the national average amongst those aged under 75 (see appendices), we still face significant care challenges in relation to the effective management of heart failure, valvular heart disease and arrhythmia amongst our older patient population, many of whom may require intervention within the context of other long-term health needs. We will develop our cardiology services as an in-reach model of care, tailoring our specialist services to reflect a virtual or ambulatory approach to patient management and working across our ICP to provide community-focussed care.

We will provide focussed inpatient cardiology care only for those patients in whom alternatives are inappropriate and for whom care within the acute or care of the elderly teams' inpatient facilities does not adequately address the clinical need. We will work with health and care partners in the realisation of cardiology service reconfiguration at scale across the wider economy, but do not anticipate the provision of complex cardiology care on our site. Where there is a clinically identified need for complex cardiological care, we will support hub provision of that care in specialist centres, reducing our bed base whilst securing the provision of local, medium-acuity cardiology services enacted via non-bed-based care.

As with our approach to respiratory and diabetes-related disease, we will ensure that the governance of our multidisciplinary and community-focussed clinical model for cardiovascular disease management is clear, accountable and consistent across all elements of the service.

We will, in addition, develop and deliver services for the care of venous thrombo-embolic disease that enable us to maximise ambulatory and community management. Our model of care will see close integration between primary, emergency and acute medicine, and specialised surgical services, such that we identify, assess and manage patients receiving care within our organisation who are at risk of thrombo-embolic pathology quickly, safely and with consistency.

We will continue to provide and develop our stroke services within existing partnership arrangements and work with other care providers across the regional network to ensure that our pathways of care,

especially in relation to the surgical management of carotid arterial disease and stroke rehabilitation, best meet the needs of residents of Chester and West Cheshire. Where changes to existing pathways make sense for our population, we will lead the introduction of those changes and ensure that the implications for supporting diagnostic and therapy services are fully understood, addressed and realised.

Surgical Services

We will provide a wide range of surgical specialist services to meet the clinical needs of our patient population, including ophthalmic, colorectal, urology, orthopaedics, gynaecology, breast and onco-plastic surgery and will develop the scale of this provision to ensure that we accommodate the challenges of increasing demand for these core elements of surgical care. Surgical care will be administered effectively and yielding maximal productivity, and our enabling estates strategy will describe the realisation of this. We will provide care using same-day or near-same-day models wherever safe to do so supported by best practice guidance and peer review evidence from GIRFT and other bodies. In the context of an increasingly elderly and more clinically complex patient population, we will support the safe provision of surgical care by in-reach medical specialist support as required; where it is clear that the primary care needs of patients are medical, but a surgical procedure is required, we will adopt a surgical in-reach methodology such that the primary provider of inpatient care is within the medical team irrespective of the surgical intervention required.

Some other aspects of existing surgical care will change, to be accommodated in partnership with other regional acute service providers, backed by collaboration within our ICP and, where relevant, the input of specialised commissioning. These areas of practice include our non-onco-plastics services, our ENT service, maxillofacial surgery and dental care. For some of these services, effective and productive models of care will be delivered through shared service agreements and hub-spoke arrangements that enable us to maximise the availability of specialist expertise for our patient population at scale. This will include the re-fashioning of services through outpatient delivery, on our own site or on that of an alternative care provider, as determined from our demographic data and the needs of our patient population. The age and acuity profile of our catchment area mandates us to widen our provision for ophthalmic and orthopaedic surgery. The complementary workforce and estates strategies will set out the prospectus for these changes, contextualised by the revised core clinical offer described in other sections of this document.

We will support and strengthen our provision of acute emergency surgery on a seven-day basis. This is a fundamental element of the architecture of our acute and emergency care offer as an organisation. We will provide emergency surgery within the requirements of NHS England Seven Day Services clinical standards supported by appropriate diagnostics as described elsewhere in the strategy. Furthermore, we will develop our vascular arterial hub model with specialised commissioner support, working with our spoke sites to ensure full realisation of the potential of this hosted service. The strategic intent to develop our vascular model carries with it an equally clear intent to bring forwards a hub approach for our delivery of interventional radiology, not just for vascular services but in support of our emergency surgery, urology and maternity services as described elsewhere. The accompanying estates strategy is of key significance in this aspect of care model development for the organisation, as the execution of a mature vascular hub has important implications for the site and the facilities required in practice.

Family Services

Our clinical strategy sees us developing and affirming our commitment to the delivery of high-quality care for women in Chester and West Cheshire. We will provide safe, effective and productive maternity services, working in partnership within our health economy to ensure that our care provision is supported and guided by best practice evidence and national peer review. We will be active participants in higher-level care model revision within the ICP and beyond; our provision of neonatal services will be guided by regional reconfiguration within which we will advocate for a care model that sees us providing high-acuity maternity services on site, supported by our interventional radiology hub as described above.

In relation to paediatric services, we will develop and provide a care model that enables us to offer support to hub and spoke community-focussed patient management. Our specialist inpatient paediatric services will afford a responsive clinical support model to primary and community clinicians, enabling the vast majority of paediatric care to be provided at, or close to, home, family community hubs, within spoke units, or, where clinical need dictates, within our on-site care area. We will collaborate with neighbouring specialist units in the delivery of key elements of paediatric care, including paediatric surgery, enabling us to offer effective and efficient specialist care across a wider footprint. We will provide neonatal care at Level 2 acuity, supported by allied maternity and anaesthetic services as outlined elsewhere in the strategy and supported by our ongoing close links to regional neonatal specialist centres and the neonatal retrieval team.

Anaesthesia and Critical Care

Our shift toward higher-acuity clinical care brings with it a need to ensure we provide round-the clock, high quality theatres, anaesthetics and critical care support for our patient population. We will continue to ensure that the scale and scope of our provision of these services is aligned to demand. Where appropriate, we will deploy outreach care to mitigate clinical deterioration of any patient within our organisation, reducing the need for intensive therapy by early intervention.

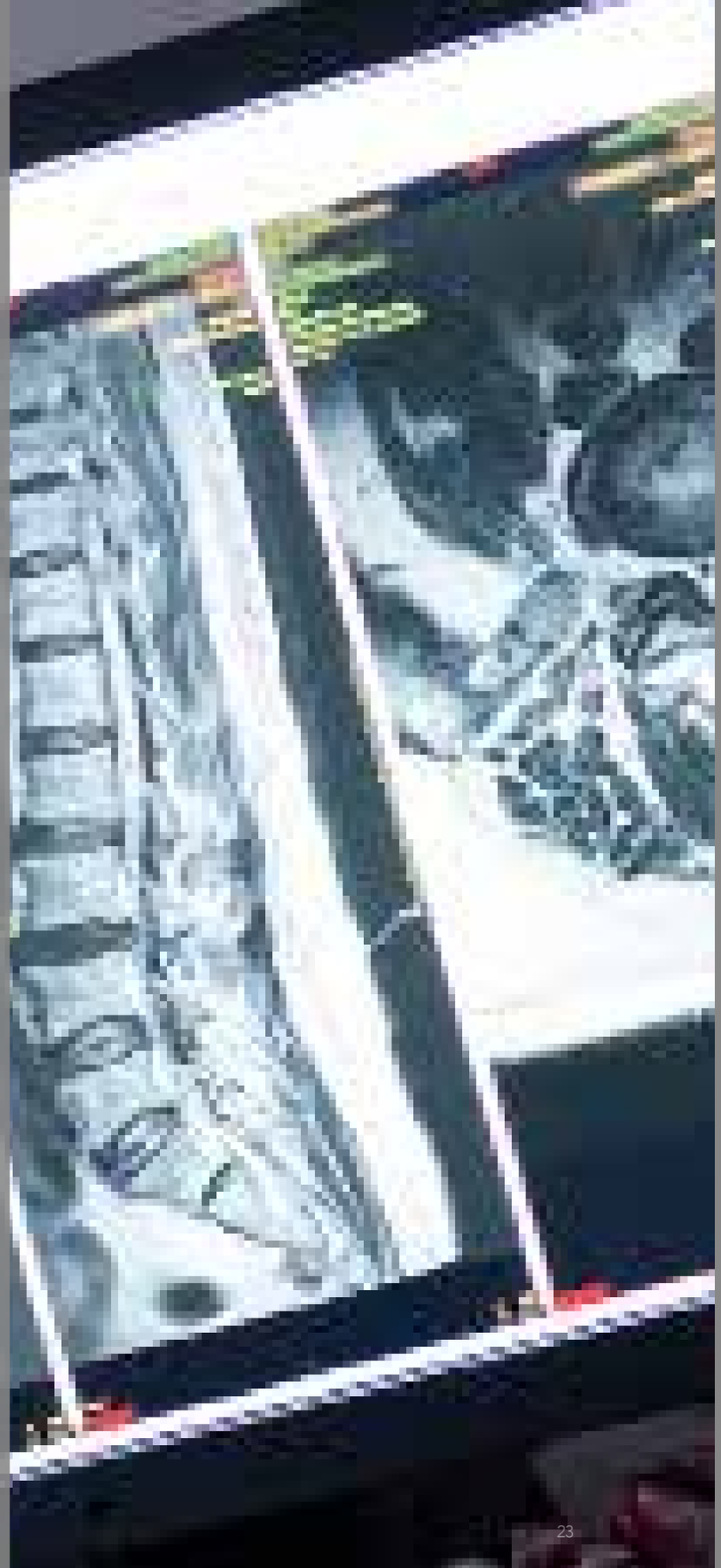
We will develop and deliver programmes of care for the specific clinical scenarios of sepsis and acute kidney injury (AKI) to ensure that we are well placed to deliver timely, consistent clinical intervention for these critical conditions, reducing morbidity and mortality wherever possible.

Our care offer for patients with chronic pain will be redeveloped to reflect a collaborative model with our community partners, harnessing alternatives to traditional medically-led provision by widening the scope of specialist nurses, complementary therapies and alternatives to drug-based management of pain wherever clinically appropriate and supported by sound and reproducible evidence. As an acute care provider, we will ensure that all our staff are well equipped not only in the identification of how pain may declare itself differently within elderly patients or dementia, but in the appropriate options available to reduce discomfort and alleviate pain whatever the scenario at hand.

Radiology, Pharmacy and Clinical Support Services

The refashioned clinical care model described within this strategy requires robust and well-resourced support from a range of disciplines allied to patient-facing activity. We recognise the fundamental importance of these allied services and will ensure that our radiology, pharmacy, endoscopy, pathology and theatre provision meets the requirements of our core patient population. In some specialties, such as interventional radiology and pathology, this means that we will build upon existing and emerging collaborative networks of care in order that we align expertise with efficiency and productivity. We are fully committed partners in the Cheshire and Mersey sustainability programmes in relation to support services but will advocate for the needs of our local population and ensure, within regional reconfiguration, that the requirements we have as an organisation for radiology and pathology in particular are rigorous and clear.

We will continue to offer a high-quality clinical haematology service to our patient population, working in partnership with other acute and long-term care providers, and community colleagues to develop a care model that shares senior clinical expertise across a regional footprint. We will utilise virtual consultations, electronic data sharing and telephone advice to primary and community care to ensure that we maximise the ability of haematology patients to receive their care at home or close to home but will retain a haematology bed base for those limited numbers of patients for whom care alternatives are inappropriate based upon a senior clinical determination. We will ensure that the inpatient haematology provision is supported by rigorous productivity metrics and will attune the inpatient model to regional service reconfiguration at the appropriate time.



Monitoring and Review of the Clinical Strategy

This strategy relies upon supportive, productive and efficient work within our Divisions to translate its aspirations into operational plans. As was stated within the introduction, the clinical strategy is founded upon a measured assessment of future developments at this time and, in line with our approach of continuous improvement, will be subject to continuous evaluations as healthcare nationally and locally continues to develop. The strategy will be led by the Medical Director, who holds executive accountability for its development and execution.

A governance framework will be established enabling clear accountability for the delivery of the strategy and reporting to the Board. This will include detailed implementation plans with lead accountable individuals and timelines for completion. Quarterly reports will be received by the Quality and Safety Committee and six-monthly reports by Trust Board. This will provide assurance that we are achieving the commitments set out in the strategy.

Next Steps and Communicating the Strategy

The Strategy will be reviewed by the Trust Board and will from that point form the basis of the Corporate Strategy thereafter. We will engage with key stakeholders to seek their support, and to ensure alignment with the place based strategies.

The enabling strategies will be developed and published according to a separate timetable.

Appendix

Glossary of Abbreviations

AHP	Allied Healthcare Professional
AKI	Acute Kidney Injury
C&M	Cheshire & Mersey
CCG	Clinical Commissioning Group
CHD	Coronary Heart Disease
CoCH	Countess of Chester Hospital NHS Foundation Trust
CQC	Care Quality Commission
CRS	Cost Reduction Strategy
CVD	Cardio Vascular Disease
CWAC	Cheshire West and Chester
CWP	Cheshire and Wirral Partnership NHS Foundation Trust
ED	Emergency Department (A&E)
ENT	Ear, Nose & Throat
FT	Foundation Trust
GIRFT	Getting It Right First Time
GP	General Practitioner
HCP	Health & Care Partnership
HDU	High Dependency Unit
ICP	Integrated Care Partnership
ICU	Intensive Care Unit
IR	Interventional Radiology
LA	Local Authority
LHB	Local Health Board
LTC	Long Term Condition
NHS	National Health Service
NHS E	NHS England
NHS I	NHS Improvement
ONS	Office for National Statistics
PBR	Payment By Results
PESTL	Political, Economic, Social, Technological & Legal
PMO	Project Management Office
R&I	Research & Innovation
SLR	Service Line Reporting
SMArt	South Mersey Arterial (Centre)

Process of Strategy Development

- Clinical Strategy development commissioned by Acting Chief Executive
- Specialty & Department Meetings with Medical Director
- Workshop 1 – to review outputs of meetings and key messages
- Follow up meetings with specialties and departments
- Workshop 2 – to review key strategic messages and goals
- First draft of Clinical Strategy produced
- Approval by Board of Directors of final Clinical Strategy

Referral Growth

Speciality	2017/18 Referrals	2018/19 Referrals	Change	Change %
Breast Surgery	2,485	2,449	-36	-1.4%
Cardiology	2,163	1,973	-190	-8.8%
Chemical Pathology	160	151	-9	-5.5%
Clinical Haematology	1,032	1,201	169	16.4%
Colorectal Surgery	3,006	3,467	491	15.3%
Dermatology	4,421	5,112	691	15.6%
Diabetic Medicine	722	575	-147	-20.4%
Dietetics	1,275	1,063	-212	-16.6%
Endocrinology	457	408	-49	-10.7%
ENT	6,487	7,247	760	11.7%
Gastroenterology	2,754	2,503	-251	-9.1%
General Medicine	401	241	-160	-39.9%
General Surgery	2,026	2,410	384	18.9%
Geriatric Medicine	927	829	-98	-10.6%
Gynaecology	7,023	7,400	377	5.4%
Hepatology	192	242	50	26.3%
Midwife Episode	1,530	1,399	-131	-8.5%
Nephrology	211	270	59	28.0%
Obstetrics	1,278	1,280	2	0.2%
Occupational Therapy	105	106	1	0.6%
Ophthalmology	4,715	4,892	177	3.8%
Oral Surgery	565	727	162	28.7%
Orthotics	318	382	64	20.0%
Paediatrics	4,216	3,286	-930	-22.1%
Pain Management	950	1,162	212	22.3%
Physio	2,407	2,687	280	11.6%
Plastic Surgery	1,529	2,030	501	32.8%
Respiratory Medicine	1,431	1,228	-203	-14.2%
Rheumatology	1,486	1,570	84	5.6%
SALT	652	617	-35	-5.4%
Trauma & Orthopaedics	3,289	3,472	183	5.6%
Upper Gastrointestinal Surgery	1,095	800	-295	-26.9%
Urology	2,786	2,995	209	7.5%
Vascular Surgery	1,856	1,786	-70	-3.8%
Total Referrals	*65,950*	*67,960*	*2,010*	*3.0%*

Activity Change

Activity Change	2016/17	2017/18	2018/19
Elective Inpatients	4,900	4,905	4,690
Elective Day Case patients (same day)	32,834	32,902	37,395
Non-elective (urgent) inpatients	31,916	31,991	32,682
Outpatients - first attendance	69,243	67,767	65,142
A&E	69,254	70,743	75,645

Demographic Analysis

To inform the Strategy we have analysed the projected demographic shifts in our West Cheshire and Flintshire populations over the next ten and twenty years. Currently West Cheshire (CCG catchment) has a population of 233,600, split 48.5% males and 51.5% females. Flintshire (LHB catchment) has a population of 155,700 with approximately the same gender split. The population has a higher proportion of people aged over 45, with nearly 18% of the population over 65 compared to 16% nationally. Life expectancy is improving in Cheshire West & Chester, men at 79.2 years and women at 82.3 years, the trend for life expectancy in the borough has been improving for the last 10 years.

The rural localities in the borough have a higher percentage of people aged above 60 than the borough or nationally, together with a corresponding dip of those aged 20-39. Rural localities generate one third of fall admissions with an injury in the over 65 year olds. In Cheshire West & Chester 13.2% of households are single pensioner households, this compares to 12.4% in England and Wales. Rural localities have the highest percentage of older people living alone in the borough, 14.6% of those aged 65+ and 9.2% aged 75+.

Circa 14% of our over 85s are living in a care setting with adult social care currently providing services to circa 1,600 people over 85, of which 40% are in permanent long term care and 60% are receiving services in the community.

In the first ten years up to

2028, population projections show our total catchment growing by a relatively modest 0.33% per year – equivalent to an increase of c1,300 additional people each year living within West Cheshire and Flintshire.

In West Cheshire however, over the next ten years we will see a startling increase in our more elderly populations which will increase significantly the demand pressure on the Trust.

West Cheshire Age Range	2018 Population 000's	2028 Population 000's	Change 000's	% Change
0-19	50.4	51.9	1.5	2.98%
20-59	117.6	110.6	-7.0	-5.95%
60-79	51.6	58.6	7.0	13.57%
80+	14.1	19.9	5.8	41.13%
Total	*233.7*	*7.3*	*7.3*	*3.12%*

The table above demonstrates that West Cheshire will see a small (3%) increase, in the population age 0 to 19 years, a significant reduction (-6%) in the next cohort below the age of 60 (which traditionally are the lowest utilisers of our services). After this however those in the age bands 60 to 79, and those aged over 80, will see significant increases of 14% and 41% respectively. Combined those over 60 we will see an increase of 12,800 or 20% (the highest current utilisers of our services).

Extrapolating the same growth to Flintshire adds another 8,500 to those over 60 years, giving a catchment total increase of 21,300.

Such increases in our elderly population of c2% per year will have a significant impact in the demand on our services, and how they are provided. The population we serve is increasing in number, and it is living significantly longer, with much greater co-morbidity challenges. Already 80% of our inpatient acute beds have patients in them over the age of 75, and this will only increase in the coming years with the demand described above. This clinical strategy must describe how we will address this challenge.

In the 10 years from 2028 both the increase in overall population size, and the rate of increase in the more elderly populations slows down.

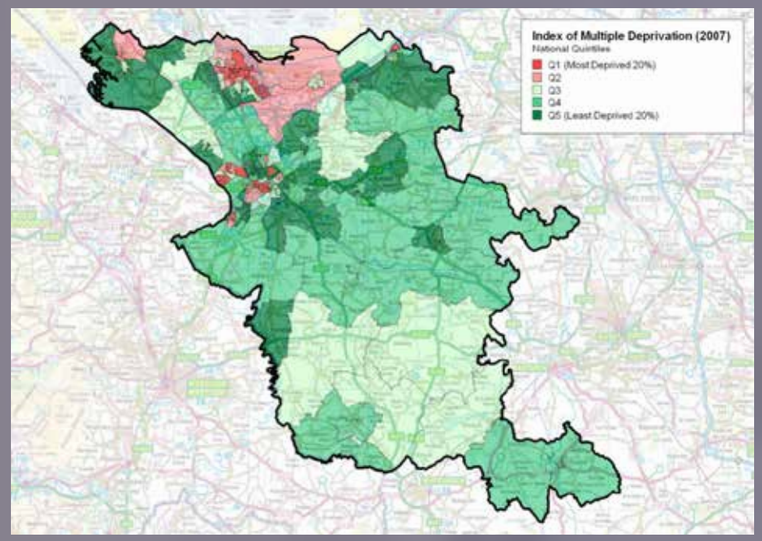
West Cheshire Age Range	2028 Population 000's	2038 Population 000's	Change 000's	% Change
0-19	51.9	51.1	-1.1	-2.12%
20-59	110.6	110.4	0.6	0.54%
60-79	58.6	60.0	0.6	1.02%
80+	19.9	24.4	4.2	21.11%
Total	*241.0*	*245.9*	*4.3*	*1.78%*

The most significant increase is in those aged over 80 years, with a 21% increase in the 10 years up to 2038, with this cohort accounting for almost all of the total change in the West Cheshire population size (increase of 4,200 people).

Data Source – Office for National Statistics (ONS) – 2016 Based Population Projections

Socio-economic Analysis

Cheshire West & Chester has a less deprived population profile compared to England, although some 14% of Cheshire West & Chester residents live within the 20% most deprived areas in England, with a further 13% living in the second most deprived 20%. These areas are predominantly in Chester and Ellesmere Port. These communities experience a disproportionate amount of preventable poor health.



IMD 2007 Quintiles, Date: August 2011. NHS Western Cheshire, Paul Wright. Contains Ordance Survey data © Crown copyright and database right 2011. Licence No 100050534

Almost 1 in 15 babies are born to mothers under the age of 20 who are at a higher risk of poor mental health and living in poverty. High teenage conception rates are linked with deprivation, however the teenage rates of conception are higher than expected. The number of children and young people aged 0-19 was 74,000 in 2012, and is forecast to increase by 5% to over 77,500 by 2022.

At a local level in West Cheshire some small areas record rates of child poverty at around 40% and around 1 in 3 children and young people live in more deprived areas. We also know that children in our more deprived areas have significantly higher rates of excess weight and hospital admissions for accidental injury and health conditions.

There is a significant educational achievement gap between those children who are eligible for free school meals and those who are

not, children who are in care and those who are not, and those who receive any form of special educational needs support compared to those who do not. For example, in 2014 28% of children eligible for free school meals achieved five GCSEs graded A*-C (including English and Maths) compared to 62% for children not eligible for free school meals.

The average property price in Cheshire West and Chester is more than £207,000, significantly higher than the national average of £184,000 and the regional average of £166,000. This shows the challenges that exist for residents wanting to get on the property ladder in the borough. We also know that the average price of property has increased by over £6,000 in the past 12 months, showing how it is increasingly becoming difficult for first time buyers locally.

However, the challenges of affordable housing are much broader than those facing prospective buyers. There are currently 3,000 applicants registered on the waiting list for Social Housing in the borough, last year 204 people presented as homeless, and over 200 people were placed in temporary accommodation. There are approximately 4,000 residents in the borough with dementia who require support and services now, and in future years. CWAC also provides support to approximately 580 residents with mental health conditions, a further 900 residents with a learning disability, and about 1,000 residents with a physical disability.

Cheshire West & Chester's ageing demographics mean that we will have more people living long enough to develop conditions of ageing, becoming frail and developing impairment. The number of people with more than one long term condition will increase with this ageing, as it is currently estimated that 12% of people over 65 years of age have three or more long term conditions and 82% of over 85 year olds have multi-morbidity as demonstrated in the graph below.

	CHD (4.7%)	Hypertension (13.4%)	Heart failure (1.1%)	Stroke / TIA (2.1%)	Diabetes (4.3%)	COPD (3.2%)	Cancer (2.5%)	Painful condition (7.2)	Depression (8.2%)	Schisophrenia / bipolar (0.7%)	Dementia (0.7%)	Any other (30.5%)
Coronary heart disease		52	14	13	22	13	8	24	17	1	3	71
Hypertension	18		5	10	18	8	7	19	14	1	2	61
Heart failure	59	57		16	23	18	9	23	17	1	4	81
Stroke / TIA	29	61	8		19	12	8	22	21	1	5	63
Diabetes	23	54	6	9		8	6	21	18	2	2	63
COPD	19	33	6	8	11		7	23	18	1	2	70
Cancer	14	34	4	7	10	8		19	14	1	2	60
Painful condition	16	36	3	6	13	10	7		31	2	3	70
Depression	10	23	2	5	9	7	4	27		4	3	64
Schizophrenia / biopolar	6	16	2	4	9	6	3	15	45		3	75
Dementia	21	41	6	18	13	9	8	19	32	3		83
Any other condition	11	27	2	5	9	7	5	17	17	2	2	

There are circa 3,000 deaths per year in Cheshire West & Chester, three quarters of which are caused by three main diseases -

- circulatory diseases,
- cancer
- respiratory disease

Just over 1,000 deaths are under 75s, a great proportion being from cancer.

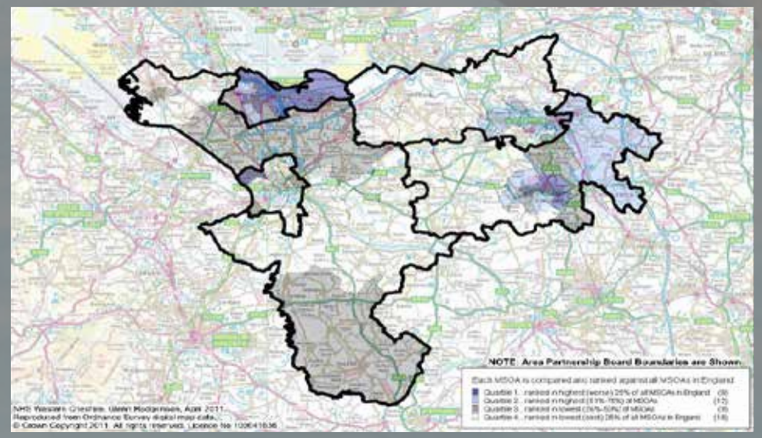
The largest burden of ill health in Cheshire West & Chester are heart disease, stroke, cancers and mental health, with the key risk factors being smoking, raised blood pressure, alcohol and unhealthy weight. Additionally and significantly for CoCH the demand for service is changing due to the demographic change together with changing lifestyle behaviours such as smoking, increasing weight and excess drinking.

Just less than three quarters of adults in Cheshire West &

Chester do not participate in at least 30 minutes of moderate intensity activity at least three times per week, in addition physical activity levels decrease with age. Lack of physical activity increases the risk of poor health outcomes such as coronary heart disease (CHD), stroke, type 2 diabetes, depression, dementia, some cancers and increased risk of falls and hip fractures in older adults.

It is estimated that 72% of adults in Cheshire West & Chester do not eat the recommended number of portions of fruit and vegetables each day, and that 23% of 4-5 years olds are overweight or obese, increasing to 34% in 10-11 year olds. These children are at risk of adult obesity. 22.7% of adults in the borough are obese. In Cheshire West & Chester diseases related to overweight or obesity are estimated to be £90m per year.

Comparison of MSOAs in CWaC against All England MSOAs: Adult Obesity Estimates (2006-08)



Source: Association of Public Health Observatories.

Prevalence of obesity related ill-health such as diabetes is increasing. Half the recent increases in the prevalence of diabetes are due to trends in obesity and half due to the ageing population.

Disease register	% obese (no)	% overweight (no)
Diabetes	49% (4,500)	34% (3,400)
CHD	34% (2,100)	39% (2,600)
Stroke	30% (860)	37% (1,100)

Source: Population - NHSIA (Exeter) Register as at June 2009 - 2011; BMI recording - Graphnet Primary Care Database

Circa 12,500 adults have been diagnosed with diabetes (5%) this prevalence is quickly increasing with circa an additional 600 people per year, this trend is expected to continue.

In Cheshire West & Chester circa 14% of the population are identified as having hypertension, some 51,170 patients of whom 82% are considered to have their blood pressure under control. 28% of adults in the area have not had their blood pressure checked in the last five years.

The World Health Organisation estimates that raised blood pressure causes around 11% of our burden of ill-health, as it is a significant risk factor for stroke, CHD. The number of people with hypertension will increase as the population ages and becomes more overweight. There are circa 5,350 patients on the stroke register and 2,100 on the heart failure register, emergency rates for CHD are slightly higher than nationally, however death rates from heart disease and stroke in the under 75s are lower than the national average. The prevalence of disease is significantly higher in our most deprived areas most likely due to lifestyle behaviour. It is estimated that there are 16,500 higher risk drinkers and over 60,000 increased risk drinkers living in the area.

Mortality from alcohol-specific disorders is significantly higher than the national average with hospital admissions that are alcohol attributable at 8% per annum; this has been rising by around 40% over a five year period. There are about 2.4 times more alcohol-related hospital admissions compared to alcohol-specific conditions. Admissions for alcohol related conditions peak in the 65+ age group and are significantly higher in the most deprived areas.

Around 60 people under the age of 75 die each year in Cheshire West & Chester from liver disease, rates are significantly higher in the more deprived areas of the borough. It is estimated that 20% of adults in Cheshire West & Chester smoke, circa 54,000 adults, with smoking prevalence highest among 20-24 year olds. In 2010/11 12% of pregnant women were smoking at time of delivery. It is expected that smoking prevalence will follow the national downward trend. A watchful eye on research regarding e-cigarettes may impact on the health system in future years.

Cancer accounts for 43% of deaths in the under 75s in Cheshire West & Chester. The top ten cancers locally are -

- Upper GI
- Colorectal
- Trachea, Bronchus and Lung
- Malignant melanoma of skin
- Breast
- Female genital organs
- Prostate
- Bladder
- Non-Hodgkin's lymphoma
- Leukaemia

Although incidence of breast cancer is high, the five year survival rate for breast cancer is 89%, better than nationally. Lung cancer incidence is in line with the national average but is the boroughs biggest cancer killer. Incidence of prostate cancer is high, but probably due to opportunistic PSA testing, these men will need ongoing surveillance. Similarly colorectal cancer incidence has been rising likely due to increased screening, survival rates have been increasing and therefore there will be a need for routine surveillance by colonoscopies.

The primary risk factor is age, beyond the age of 65 the prevalence of dementia doubles with every 5 year age band. 3% of our over 65s have been diagnosed with dementia which is similar to the national average, but is probably an under estimate as research suggest this could be as high as 7%. The detected prevalence of dementia is increasing by circa 75 patients per year with the local demographics this trend is only set to increase. Those with a secondary diagnosis of dementia admitted to hospital are staying three days longer than other patients. It is expected that the number of people diagnosed with dementia will increase by nearly 1,820 by 2021 about 30% over the next 10 years.

The most common sexually transmitted infection (STI) diagnosed are chlamydia and genital warts, except for gonorrhoea. The number of diagnosed STI cases has fallen and rates of infection are lower than nationally. HIV numbers have been steadily increasing over the last 10 years but the area has a low prevalence rate in comparison to the North West. The leading causes of sight loss are uncorrected refractive error, age-related macular degeneration, cataract, glaucoma and diabetic retinopathy. Additionally there are large numbers of people living with a sight threatening eye condition. Over the last 10 years there has been an increase of 27% in the number of eye tests. Ophthalmology has the second highest number of outpatient attendances nationally accounting for 8.9 per cent of all OP attendances. Over 60 per cent of those outpatients are aged over 60.

Summary

The two main catchment areas for CoCH (Cheshire West and Flintshire) have very similar lifestyle patterns and behaviours, the most distinctive elements of both areas is the significant increase in our ageing populations which will have substantial impacts on the health system into the foreseeable future, and therefore a driving force to ensure a future focused clinical strategy for CoCH.

Other Providers

The predominance of other providers within CoCH's environment are other NHS Trusts. This section will provide an overview of those organisations at a macro level, focusing more in depth on those geographically closest.

Wirral University Teaching Hospital NHS Foundation Trust (WUTH)
WUTH main hospital site Arrowe Park is 19 miles away from COCH, it serves predominantly the Wirral locality which is a peninsula between Liverpool and Wales. WUTH is a district general hospital with two sites, 752 beds serving a population of 320,000 which is expected to increase by just over 2% over the next ten years.

Similarly to CoCH, WUTH is serving a relatively high elderly population with a relatively low proportion of people in their 20's and 30's. Additionally Wirral is amongst the 20% most deprived districts in England. WUTH's previous strategy was to be the top NHS Hospital Trust in the North West for patient, customer and staff satisfaction, leading on integrated shared pathways of care, delivering high quality secondary care services and partnering for value. Therefore WUTH have stated that their strategy focus is on retaining and building their service portfolio by ensuring they have competitive services, providing new services to meet core needs, broadening their footprint across which they provide care and through partnering with providers in the Liverpool conurbations to bring tertiary services closer to their patients.

Warrington & Halton Hospitals NHS Foundation Trust (WHHFT)
WHHFT is a district general hospital with three sites, namely Warrington Hospital, Halton General Hospital, and Cheshire & Merseyside Treatment Centre only 24 miles away from CoCH, this organisation is a competitor housing 552 beds serving a population of 328,400 across two CCG's.

WHHFT's strategy is to reform both their emergency care and elective care together with developing community based care. The reforming of elective care is looking to utilise the Halton Hospital campus to release capacity on the Warrington site enabling them to increase elective capacity and grow income through peripheral areas.

Cheshire & Wirral Partnership NHS Foundation Trust (CWP)
CWP provides inpatient and community mental health services for adults and children, learning disability, drug & alcohol services across 95 sites within Cheshire and Wirral. The Trust is also the main provider of physical community health services in Western Cheshire. Partnership working with CWP through the new ICP is essential to delivery of change in the Western Cheshire health system.

The Robert Jones & Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (RJAH)
RJAH has the strategic intention of being the leading national specialist orthopaedic Trust in the UK currently being one of five specialist orthopaedic hospitals, therefore they are looking to increase their market share in both specialised and general activity through choice. In conjunction with CoCH one of their commissioners is Betsi Cadwaladr University Health Board in North Wales who contracts 19% of their orthopaedic activity with RJAH.

The challenge that RJAH face is their capacity to deal with the high demand for orthopaedic services, together with being a specialist centre and therefore the constraints within specialised commissioning budgets.

Mid Cheshire Hospitals NHS Foundation Trust (MCHT)
MCHT manages Leighton Hospital (Crewe), Victoria Infirmary (Northwich) and Elmhurst Intermediate Care Centre (Winsford), it is a medium sized district general hospital with 540 beds.

Mid Cheshire has been developing partnership working with other acute providers as follows;

- East Cheshire Trust – Ophthalmology, ENT, Diabetes, Pathology
- University Hospital of North Staffordshire – UGI, Clinical Haematology, Cardiology, Neurology
- Stockport – Urology

Their preferred partner for tertiary partnership has been University Hospital of North Staffordshire and they have been exploring partnerships with East Cheshire Trust and Stockport Foundation Trust.

St Helen's & Knowsley NHS Trust
Whiston Hospital provides acute care with St Helens providing some day case, outpatient and intermediate care. The Trust is looking to secure additional market share to ensure its longer term viability of its PFI developments. A number of partnership projects have taken place between Whiston & Warrington, such as pathology and stroke services.

Nuffield
In Chester is The Grosvenor Nuffield Hospital which is a not for profit organisation where

profits are reinvested into improved facilities for patients. The Nuffield is a private hospital with all rooms being private en-suite facilities which deliver a range of services where numerous CoCH employed consultants work at privately. The Nuffield does provide NHS work.

Spire Healthcare
There are two Spire hospitals in the locality that are competitors of CoCH namely, Spire Cheshire and Spire Murrayfield. They are both independent hospitals based in Warrington and Wirral respectively. Spire Cheshire has commissioned NHS capacity from Warrington CCG and is utilised by Warrington for additional contingent capacity.

Summary
There are a number of other local providers to CoCH in the health arena, in addition to social services provided by the local authority – Cheshire West & Chester (CWAC).

There are strong drivers for collaboration across the West Cheshire ICP, recognising that the whole health economy is relatively efficient, but still facing significant financial pressures. All of the NHS Trusts are in close proximity servicing similar population numbers with a full range of DGH services.

PESTL Analysis

A PESTL (Political, Economic, Social, Technological & Legal) analysis allows us to get a clearer understanding and analysis of the key factors influencing our Trust, both externally and internally. The table below describes each in turn, and how they might impact on our organisation.

1. Political
Traditionally the Political factor in a PESTL analysis considers how central or local government intervenes in the economy and impacts on individual organisations. Here we will consider the political factor in its widest sense, including the impact our regulatory bodies NHS I and CQC have on our activities such as funding, performance and quality standards etc.

Factor	Impact & Mitigation
National political healthcare agenda, impact of Brexit, +£20bn funding pledge to 2023/24, potential change in government, purdah.	The ten year plan will describe the future strategy of the NHS, and we will need to refresh our plans accordingly.
The NHS has significant political connotations, both locally and nationally. There is significant local history of attempted reform and cynicism about service change in West Cheshire. Any strategy needs to be politically realisable. This does not mean avoiding any service moves but it does mean that they have to be acceptable to the local population.	The Trust is the host of the ICP and will continue to play its part in how healthcare services are shaped and delivered across West Cheshire.
Regulatory – NHS I & CQC reviews.	The Trust had both 'Use of Resources' and 'Well Led' reviews during November and December 2018. The outcome of these will also influence the long-term strategy of the Trust moving forward.

2. Economic
Here we will consider the economic factors that will influence the Trust over the next 5 years

Factor	Impact & Mitigation
The Trust must both continue to seek its own efficiencies, and also co-operate in system-wide efficiency improvements. The capacity constraints in the acute bed base make this a particularly pressing challenge for CoCH; whilst financially a strategy of continual growth might mitigate some of these pressures, this is operationally unviable and the future success of the Trust is dependent on lower demand for acute unscheduled care.	i. Strategic initiatives that require a growth in demand for beds would have to identify reductions elsewhere, or would only be actionable in a demand scenario where the bed requirement reduced significantly ii. Large-scale capital investment will require changes to the strategic investment plan iii. The overall strategy should make a net contribution to meeting the recurrent 2% per year efficiency challenge iv. The overall strategy should not increase the costs of like-for-like provision of services to local Clinical Commissioning Groups
PBR & tariff changes.	New tariff for 2019/20 reflecting the extra £20bn over 4 years promised to the NHS. Clearly tariff is still here to stay for some years, whilst at the same time the expectation is that health economies move to locality services

3. Social
Here we will consider the social factors that will influence the Trust over the next 5 years

Factor	Impact & Mitigation
It is expected that changes in societal expectation will lead to greater demand for accessibility in service provision.	It is not anticipated that any strategic initiative will lead to a reduction in the accessibility to planned elective services. Accessibility to emergency and urgent care services will need to keep pace with expectation and demand, however they are provided.

4. Technological
Here we will consider the technological factors that will influence the Trust over the next 5 years -

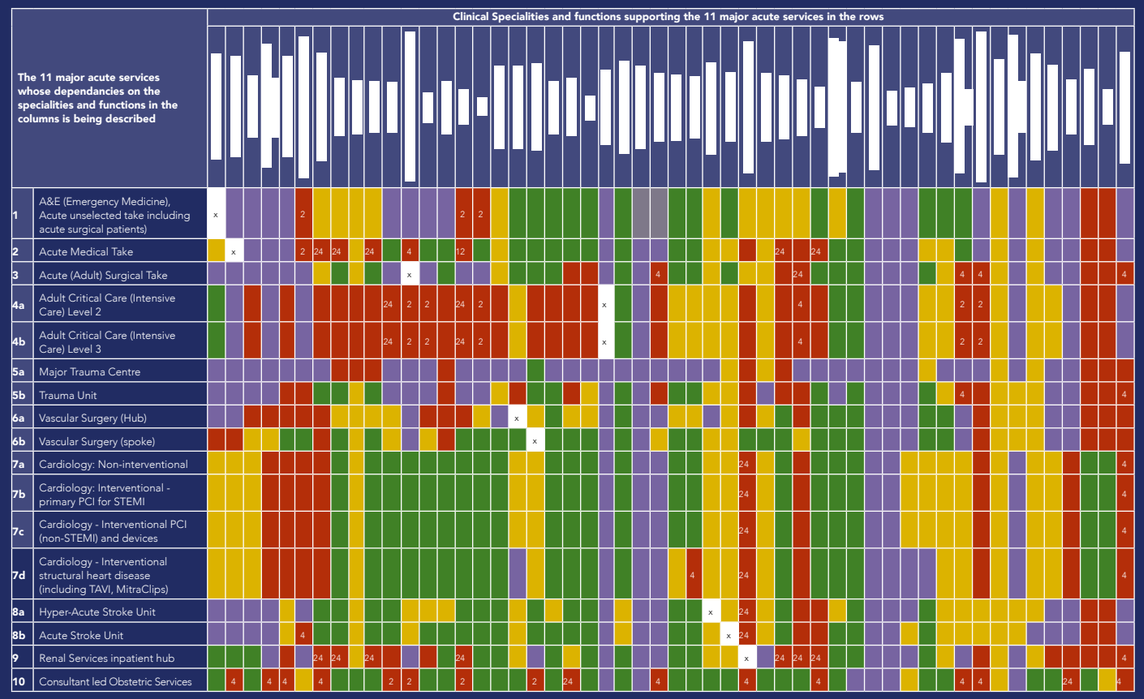
Factor	Impact & Mitigation
Changes were identified in a number of specific areas including the increase in rates of survival in many serious diseases including renal disease and oncology, leading to increased long-term reliance on service provision such as dialysis.	i. Any strategic initiative must be consistent with current known commissioning standards and NICE guidance ii. Specifically known clinical co-dependencies must be respected i.e. the requirement for certain specialties, types of intervention and diagnostic tests to be on the same site. iii. The implementation of the Cerner system from 2020 is both a key risk and opportunity for the Trust.

5. Legal
Here we will consider the legal factors that will influence the Trust over the next 5 years -

Factor	Impact & Mitigation
A key test for the strategy is its compliance with NHS legislation and the wider law.	Any merger, acquisition or other significant organisational change, as a material transaction, would require regulatory clearance.

Clinical Co-dependancies

Mapping undertaken in 2014 by the South East Coast Clinical Senate described the 11 core clinical services normally provided by NHS acute trusts, the specialties that support them, and their ideal location and access times. Note that not all of the 11 core services are provided by CoCH.



Co-dependancies Definitions: Colour Key
The colour describes the dependency of the service in the service in the row, and the support service in the column. Note that both purple and red dependencies describe services that should not require patient to move hospitals.

- **Purple -** Service should be co-located (based) in the same hospital.
- **Red -** Service should come to patient (patient transfer not appropriate), but could be provided by visiting/inreach from another site (either physically, or via telemedicine links) if not based in the same hospital. 2 (within two hours), 4 (within four hours), 24 (within 24 hours) or blank (not specified).
- **Amber -** Ideally on same site but could alternately be networked via robust emergency and elective referral and transfer protocols.
- **Green -** Does not need to be on same site. Appropriate arrangements are inplace to obtain specialist opinion or care.

This clearly demonstrates the ideal physical location of our key clinical specialties and functions, and the access requirements needed by the 11 core clinical and acute services.

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