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NHS Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

30 November 2023

09:30am - 12:15pm

Macclesfield Town Hall, Market Place, SK10 1EA

Public Speaking Time 09:00 - 09:30am

Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-november-2023/

Agenda

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
09:30am	**Meeting Governance**					
ICB/11/23/01	Welcome, Apologies and confirmation of quoracy		Verbal	Raj Jain *Chair*	For information	-
ICB/11/23/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)*		Verbal		For assurance	-
ICB/11/23/03	Minutes of the previous meeting: • 28 September 2023.		Paper		For approval	4
ICB/11/23/04	Board Action Log		Paper		For note	23
ICB/11/23/05	Board Decision Log		Paper		For note	25
ICB/11/23/06	Resident Story		Film		For information	-
09:45am	**Leadership Reports**					
ICB/11/23/07	Report of the ICB Chair		Paper	Raj Jain *Chair*	For note and approval	32
ICB/11/23/08 **09:55am**	Report of the ICB Chief Executive		Paper	Graham Urwin *Chief Executive*	For note and approval	112
ICB/11/23/09 **10:05am**	Report of the Director of Nursing and Care		Paper	Chris Douglas *Director of Nursing & Care*	For note	128

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
ICB/11/23/10 **10:15am**	NHS Cheshire & Merseyside Finance Report Month 6		Paper	Claire Wilson *Director of Finance*	For note	138
ICB/11/23/11 **10:25am**	NHS Cheshire & Merseyside Quality and Performance Report		Paper	Anthony Middleton *Director of Performance & Planning*	For note	145
10:35am	**Committee AAA Reports - matters of escalation and assurance**					
ICB/11/23/12	Highlight report of the Chair of the Quality and Performance Committee		Paper	Tony Foy *Non-Executive Member*	For note	170
ICB/11/23/13 **10:40am**	Highlight report of the Chair of the System Primary Care Committee		Paper	Erica Morriss *Non-Executive Member*	For note & approval	175
ICB/11/23/14 **10:45am**	Highlight report of the Chair of the Finance, Investment and Resources Committee		Paper	Erica Morriss *Non-Executive Member*	For note	192
10:50am	**ICB Business Items & Strategic Updates**					
ICB/11/23/15	Cheshire and Merseyside Board Assurance Framework - Quarter Two Update	QS1-5, QS7-9, QS10,11,13,14, 15	Paper	Clare Watson *Assistant Chief Executive*	For approval	197
ICB/11/23/16	Women's Hospital Services in Liverpool Programme Governance Refresh	QS1-5, QS7-9, QS10,11,13,14, 15	Paper	Dr Fiona Lemmens *Deputy Medical Director*	For approval	257
ICB/11/23/17	National Children & Young Peoples Programme Update		Presentation	Louise Shepherd, *Chief Executive, Alder Hey NHS FT*	For information	Tabled on day
ICB/11/23/18	Cheshire and Merseyside Children & Young Peoples Committee Establishment	QS1,4,5,7,8,10, 14,15	Paper	Raj Jain *Chair*	For approval	267
ICB/11/23/19	Cheshire and Merseyside Primary Care Access Recovery Improvement Plan	QS1-9, QS10,11,13,14, 15	Paper	Clare Watson *Assistant Chief Executive*	For approval	296
ICB/11/23/20	Cheshire and Merseyside Joint Forward Plan/NHS Delivery Plan development and Reporting for 2024/2025	QS1-17	Paper	Clare Watson *Assistant Chief Executive*	For assurance	389
ICB/11/23/21	Cheshire and Merseyside Winter Plan Update	QS3-10	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	404

AGENDA NO & TIME	ITEM	CQC ICS Theme & Quality Statement	Format	Presenter	Action / Purpose	Page No
12:10am	**Any Other Business**					
ICB/11/23/22	Closing remarks, review of the meeting and communications from it		Verbal	Chair / All	For information	-
12:15pm	**CLOSE OF MEETING**					

Consent items

All these items have been read by Board members and the minutes of the November Board meeting will reflect any recommendations and decisions within, unless an item has been requested to come off the consent agenda for debate; in this instance, any such items will be made clear at the start of the meeting

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/11/23/23	Approved Minutes of ICB Committees: • *Quality and Performance Committee* • *System Primary Care Committee* • *Finance, Investment and Resources Committee.*	For information	415

Date and time of Next Meeting

25 January 2024, 0900 - 12:00, Tower Room, Floral Pavilion Theatre & Conference Centre, Marine Promenade, New Brighton, Wallasey CH45 2JS
A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk/about/

Following its meeting held in Public, the Board will hold a meeting in Private from 12:30pm until 13:45pm.

NHS
Cheshire and Merseyside

Meeting Held in Public of the Board of NHS Cheshire and Merseyside

40/20 Lounge, Warrington Conference Centre, Halliwell Jones Stadium,
Mike Gregory Way, Warrington, WA2 7NE
Thursday 28th September 2023
9:00am to 12:00pm

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB (voting member)
Neil Large MBE	NLA	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Prof. Hilary Garratt CBE	HGA	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Graham Urwin	GPU	Chief Executive, Cheshire & Merseyside ICB (voting member)
Claire Wilson	CWI	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB (voting member)
Prof. Steven Broomhead MBE	SBR	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Adam Irvine	AIR	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Dr Naomi Rankin	NRA	Partner Member, Primary Care (GP) Partner Member (voting member)
Councillor Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member)
Ann Marr OBE	AMA	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital Trust (voting member)
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member)
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Associate Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	AMI	Director of Performance and Improvement, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	CSA	Director of People, Cheshire & Merseyside ICB (Regular Participant)

Clare Watson	CWA	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
John Llewellyn	JLL	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Prof. Ian Ashworth	IAS	Director of Population Health representative (Regular Participant)
Louise Barry	LBA	Chief Executive of Healthwatch Cheshire
Matthew Cunningham	MCU	Associate Director of Corporate Affairs and Governance & Board Secretary
Mark Palethorpe	MPA	Place Director, St Helens
Alison Lee	ALE	Place Director, Knowsley
Jennie Williams	JWI	(Minutes) Senior Executive Assistant
Alison Cullen	ACU	Chief Officer, Warrington Voluntary Action
Dianne Green	DGR	Community Respiratory Nurse, Mersey & West Lancashire Teaching Hospital

APOLOGIES NOTED		
Warren Escadale	WES	Chief Executive, Voluntary Sector North West (Regular Participant)

Item	Discussion, Outcomes and Action Points	Action by
	Preliminary Business	
ICB/23/09/01	**Welcome, Introductions and Apologies**	
	All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was quorate and therefore went ahead. Apologies for absence were received from Warren Escadale.	
ICB/23/09/02	**Declarations of Interest**	
	There were no declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision on the items being considered at today's private Board meeting.	
ICB/23/09/03	**Minutes of the last meeting – 27th July 2023**	
	Members reviewed the minutes of the meeting held on 27th July 2023 and agreed that they were a true reflection of the discussions and decisions made. **The Integrated Care Board approved the minutes of the ICB Board meeting of 27th July 2023.**	
ICB/23/09/04	**Action Log**	
	The Board acknowledged the completed actions and updates provided in the document. Members of the Board discussed the action log and agreed to the	

Item	Discussion, Outcomes and Action Points	Action by
	closure of actions 13, 29, 40, 44, 45, 47, 54, 55, 56. **The Integrated Care Board noted the Action Log which will be revised and sent to board members.**	
ICB/23/09/05	**Decision Log**	
	Members reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 28th September 2023. It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting. **The Integrated Care Board noted the Decision Log**.	
	Standing Items	
ICB/23/09/06	**Chairs Announcements**	
	RJA updated attendees on the following items – Sincere condolences were expressed to the families of the victims of the Lucy Letby case on behalf of the Board and NHS Cheshire and Merseyside. The Countess of Chester Hospital is within the Cheshire and Merseyside patch, and support to families, The Countess of Chester Hospital and the NHS will be unrelenting. The Thirlwell public Inquiry has been launched and NHS Cheshire and Merseyside will play its full part in the Inquiry. Assurance was given to organisations, staff and members of the public that that all members of senior NHS staff will undertake a Fit and Proper Persons test on appointment, and on a regular basis to ensure their experiences, qualifications and track records match the expectations of the public service. **The Integrated Care Board noted the update.**	
ICB/23/09/07	**Report of the Chief Executive**	
	The report presented by GPU provided a summary of issues not otherwise covered in detail on the Board meeting agenda and included - **Lucy Letby Trial** - GPU informed the Board that an application for appeal has been lodged where the Crown Prosecution Service have agreed to prosecute one case again where no verdict was found. Police investigations remain live around other cases. GPU will meet the solicitor appointed to support Lady Justice Thirlwell on 3rd October 2023; draft Terms of Reference have been received in confidence and are not currently for sharing with the Board or in the	

Item	Discussion, Outcomes and Action Points	Action by
	public domain. • Beth Warburton, The Head of Emergency Planning Preparedness and Response has been appointed as the single point of contact for the organisation to liaise with the inquiry. • A small oversight group will be set up to co-ordinate responses. Steps have been taken to secure historic records and access to old IT systems. • Legal representation for the Integrated Care Board has been sought to participate in the inquiry, as routinely the ICB use the same firm of solicitors as the Countess of Chester Hospital, and they cannot represent the same party in one inquiry. **Industrial Action** continues, the rights of our staff to participate in legitimate action are respected, however services are becoming weary of the impact this is having on targets and aspects of improving health care. GPU thanked all staff working in hospitals, Primary Care and the ICB who continue to support the consequence of the industrial action. NLA asked the Board how many outpatient appointments and procedures are cancelled in Cheshire and Merseyside split between elective and non-elective, and how do we know there will be no harm to patients. GPU highlighted the need to take a typical strike day, compared to a typical operating day in a previous week and look at the loss of activity between the dates. Each of our providers categorise patients between very urgent, patients who should have their procedure within a month, routinely and then treat in turn. It is important that the patient with the highest clinical risk is re-booked quickly. Each Trust has an assurance process that those patients with the most urgent clinical need is re-booked. RPJ advised that he is meeting with all Medical Directors daily on the lead up to strike action, there is a clear process to escalate if they are unable to treat patients so that there is a mutual aid offer. Patients can be moved to keep them safe. There is also the opportunity to share best practice to enable system working. **RACC Plank issues** continue in the education sector; this has also affected some premises in Cheshire and Merseyside. The NHS has been manging this for some time, with significant cost to keep services within buildings safe. Leighton Hospital in Cheshire is affected and nine of the hospitals affected in the UK have been promoted to be a first priority within the new hospital build programme. Colleagues from Mid Cheshire Hospital NHS Trust will be invited to November's Board meeting to present a progress report on the development of a business case to replace Leighton Hospital.	

Item	Discussion, Outcomes and Action Points	Action by
	Right Care Right Person – there has been significant news regarding what the police will or will not do from 1st October 2023 in terms of certain calls made to the police. GPU assured the Board that the ICB are working closely with both police forces and both mental health trusts, co-ordinated by Simon Banks, Wirral Place Director. Investment has been made in additional resources for crisis care, alternative places of safety and expanded Section 136 suites, all of which are not yet open. SBR asked if the monies available would be delegated to Place as the is no additional resource to local government. GPU advised that The Department of Health have controlled centrally and the parameters in which bids could be submitted are the areas in which we could bid, there has therefore been no further funding apart from against criteria. NLA asked the Board why rental has been taken out on the Cunard building whilst we already have the Lewis building. GPU advised that we are reducing overheads and costs of buildings and are relocating as many of the place-based teams to work alongside local authority colleagues. The intention is to move Liverpool Place from Lewis's to Cunard at the next break point in the rental contract. JRA discussed item 11 in the report, Health Referrals into Treatment Services. Between 80 & 90% of people with addiction have a dual diagnosis of mental illness, Dame Carol Black, Government Advisor, recently visited Mersey Care and made it clear that addiction services which are trauma informed, tend to have higher levels of recovery. JRA asked IAS if a piece of work could be undertaken to review addiction services to see how many fulfil trauma informed. IAS advised during the period this was looked at, was when local authority public health grants were being reduced, and substance misuse services were being scaled back. However, this is being built back through the new drug strategy through the combating drugs partnerships. **Action – IAS to discuss making re-connections to look at good practice with Public Health Directors.** **Action - RJA asked GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.** **The Integrated Care Board noted the report.**	**IAS** **GPU**

Item	Discussion, Outcomes and Action Points	Action by
ICB/23/09/08	**Resident / Staff Story**	
	RPJ introduced Dianne Green (DGR), Community Respiratory Nurse to the meeting, who shared a presentation to the Board. RJA thanked DGR for her powerful talk and thanked DGR and her colleagues for their impassioned work. DGR thanked the Board for inviting her to attend the meeting and emphasised that there are patients who only go into hospital because they are cold and hungry. ACU advised that there are similar initiatives in each of the nine Places, the voluntary sector are embedded in the hospital discharge team in Warrington and Halton, and this is also currently being set up in Cheshire West; ACU feels that this needs to be embedded into the work of hospital discharge, and investment is needed to reduce hospital admissions. CDO invited DGR to speak at a Director of Nursing forum, which covers acute hospitals, community and social care, to educate nurses within other sectors. IAS advised that The Health Care Partnership held a housing health workshop on 18th September 2023 attended by colleagues from across the region, where they discussed new local energy demonstrated projects being run across Cheshire and Merseyside. RJA again thanked all who attended from the Community Team for their commitment and bravery. RJA asked the Board, Executive Team and Place Directors to bring back how we are spreading this, the progress made at scale and impacts on this subject back to the November 2023 meeting. RPJ notified that a Board has been set up to manage the entire Intelligence into Action Programme supported by IAS and Population Health. **The Integrated Care Board thanked the Community Nursing Team for their contributions.**	
	ICB Key Update Reports	
ICB/23/09/09	**Executive Director of Nursing & Care Update Report (Sept 2023)**	
	The report presented to the board highlighted some current issues which may have an impact on quality and safety within the system. **Rapid Quality Review** In July 2023 it was agreed that due to a lack of progress and improvement at pace, a Rapid Quality Review would be established in line with the National Quality Board Guidance for East Cheshire Hospital Trust, relating to the standard hospital mortality review index performance. It was agreed that further work was required by	

Item	Discussion, Outcomes and Action Points	Action by
	the Trust around prevention of further deterioration. Following discussion and peer challenge from system partners, it was agreed that further work was required by the Trust around prevention of deterioration in patients, early identification of deterioration and prompt response and support as required. This work will be informed by the data provided by C2Ai (data intelligence company) and support from the ICB Business Intelligence Team. It was also agreed that further assistance was required around the impact of out of hospital pathways and services. A subgroup has been established to progress the improvement work which is meeting on 29th September 2023. **Choking / Aspiration Serious Incidents RQR** A system wide Rapid Quality Review meeting was held in August 2023 focussing on choking and aspiration serious incidents. Learning Disability Mortality Reviews (LeDeR) are completed for local areas. A number of reviews have taken place which identify deaths by choking or aspiration. The Rapid Quality Review was undertaken as a system and the next steps are to consider how data is captured and shared. An overarching action plan is to be developed following the RQR and will be presented to a future Cheshire and Merseyside ICB Quality & Performance Committee. **Cheshire and Wirral Partnership Trust** A further Rapid Quality Review for CWP was held during the month of August 2023 and the Trust demonstrated that they had made considerable improvements in the identified key lines of enquiries along with system partners. CWP will continue to work with system partners on the KLOES to ensure continued improvements. The decision was taken to return to a business-as-usual oversight through the Place based governance arrangements ensuring that progress would be made. **SEND** The ICB have a statutory responsibility for Special Educational Needs and Disabilities, two of our systems have written statements of action. There are imminent inspections under the new framework. To date there has been one Local Authority inspected under the new framework. **All Age Continuing Health Care** The ICB has undertaken a review focussing on performance and quality, we are not achieving the 80% threshold of the decision to be made in 28 days of the checklist being completed within the system.	

Item	Discussion, Outcomes and Action Points	Action by
	Working closely with Place Associate Directors to ensure the target is improved. Working with all colleagues within the system to ensure the review is completed to ensure that we develop a system for all age continuing health care that meets the needs of our population. NLA asked what lessons will be learned with regards to East Chesire in terms of the Boards management if the scoring was correct and how many actual excess deaths there were. RPJ highlighted that at the rapid quality review undertaken at Mersey and West Lancashire showed that the rate of in-hospital deaths is a bit higher, when 30-day discharge is added the significant difference is seen. The hospital have clear direction from RPJ with focussed actions around hydration, identifying early deterioration, intensive care, and approaches to nursing ways of prevention. RPJ is interrogating the methodology of deaths and has contacted colleagues who can bring an independent peer-led review at an academy of colleges level. Next steps are planned out to move at real pace. RJA meets with the Chair of East Cheshire Hospital monthly under a single item quality agenda. The Board of East Cheshire Trust have recently begun an externally undertaken well-led review. RJA asked the Board to understand the issues that arise from quality and safety as a system to understand the trends and action. **The Integrated Care Board noted the content of the report which generated discussion.** • **East Cheshire - will be returned to via the Quality Committee.** • **SEND - partnerships are required for improvement.** • **Help the Board to understand through a periodic report to triangulate and identify key topics and trends emergent across the region.**	
ICB/23/09/10	**Cheshire & Merseyside ICB Quality and Performance Update Report (Sept 2023**)	
	AMI provided an overview of the report provided within the meeting pack. **Urgent and Emergency Care** There have been staged improvements in a reduction of the non-criteria to reside and the number of over 14-day length of stays; during that period some of the acute sector have been able to reduce some of its escalation beds. There is still an uptick in admission and occupancy which is still a heated system.	

Item	Discussion, Outcomes and Action Points	Action by
	Work is currently being undertaken with North West Ambulance Service (NWAS) to look at the front door and conveyance levels, where there is significant variation from one part of the system to another. An enormous amount of work is being undertaken in urgent care improvement with providers and across Place, however, there currently isn't the right governance to pull this together across Cheshire and Merseyside. An Urgent Care Improvement Group which runs through The Transformation Group will be established in October 2023, Chaired by an Ex-Medical Director, which will cover all sectors and places. It is recognised that community services and mental health are not as visible, work is being undertaken to drive improvement. **Planned Care** Variation against plan for long wait target is reducing and still has a degree of confidence for delivery over the course of the year. It is significantly impacted on industrial action, however, is higher than the previous year which is a huge credit to the sector having to deal with the disruption that industrial action causes. **Cancer** The backlog is reducing and is ahead of plan, performance will return as expected. A Cheshire and Merseyside waiting list approach to certain conditions is helping to reduce numbers. AMI indicated to the Board that an integrated Board report is being developed which has been shared and will be run in its new format in November's Quality and Performance committee meetings and will be received to the ICB Board in November. The report will help to triangulate across provision finance workforce, patient safety and access. PCU asked AMI when dementia diagnosis will be brought back to the Board and would be interested in learning about incidents of people with learning disability and diagnosis. AMI identified that a report would be brought back to the board in November 2023. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/11	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Aug and Sept 2023)**	
	TFO took the board to section 4 **(Mortality Reporting at East Cheshire Trust – Findings from the Rapid Quality Review**) of the matters escalated in the report, which was an excellent piece of work	

Item	Discussion, Outcomes and Action Points	Action by
	led by RPJ, with active work undertaken by the committee to understand the challenges and support the outcomes. Liverpool Women's hospital is a new avenue to work in with the emerging concerns group model which was put together by Kerri Lloyd and looked at intelligence related to quality, finance, performance and workforce. It was concluded that the Trust should move into an enhanced oversight status that would further support the work being undertaken to improve their performance. The committee requested further information and assurance around risk assessment, waiting times and triage in improving access to psychological therapies, from the lead provider collaborative. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/12	**Cheshire & Merseyside System Month 5 Finance Report**	
	CWI provided the Board with an update to the report, the format of which has been adapted to support the revised reporting cycle, with detailed assurance provided through the Finance, Investment and Resources Committee. As at 31st August 2023 (Month 5), the System reported a deficit of £123.7m against a planned deficit of £73.7m resulting in an adverse year to date variance of £50.0m. The system is forecasting a position in line with its plan by year end of £51.2m deficit, however, has £125m of financial risk identified. Key drivers are – • Continuation of industrial action which has a significant impact across the system and accounts for approximately £11m in year to date. • Much higher levels of inflation in particularly in continuing health care prescribing and drugs costs than nationally expected and funded for. Variance is prescribing inflation which accounts for approximately £19m. It is important to focus clearly on efficiency commitments made in plan and to pursue cost improvements. There are a number of factors making this difficult, however the performance of system is holding up well on Cost Efficiency Improvement Plan recovery. There are some risk mitigations, and conversations at a national level are ongoing around the impact of the strikes and mitigating funding or relaxation of targets that may occur as a result, these are still unknowns and CWI will update the Board once these are known. Conversations are ongoing with organisations to look at what support may need to be put in place to further improve the position	

Item	Discussion, Outcomes and Action Points	Action by
	and take recovery actions. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/13	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee (August 2023)**	
	EMO advised that the change of sequencing of the Board prompted the opportunity to undertake a deep dive of the two most challenged budgets, there is a review of continuing health care and of prescribing. Secondly, is driving consistency of clinical policies across the whole of the system, the ones coming through finance for recommendation are at the ones at zero cost where the emphasis is ensuring that the quality for our patients remains as they are aligned across the system. SBR discussed the £50m position over and above planned deficit and indicated that as the Board matures and develops it would be an ambition to have the Local Authority budget report alongside this financial report. The situation in local government is very difficult. It would be helpful to have a Local Authority report twice a year to the Board. **The Integrated Care Board noted the content of the report.**	
10:35am	**Sub-Committee Reports**	
ICB/23/09/14	**Report of the Chair of the Cheshire and Merseyside ICB Audit Committee (September 2023)**	
	NLA advised the board that the audit plans and counter fraud plans are all up to date with nothing to report. There is an issue with the dental contract which is being investigated. The external audit annual report has been received which was very complimentary, there were twelve recommendations, which were not serious, but helpful. Terms of Reference were reviewed. Recommendations were to note the meeting and amendments to the Terms of Reference. **The Integrated Care Board approved the terms of reference and noted the content of the reports.**	
ICB/23/09/15	**Report of the Chair of the Cheshire and Merseyside ICB Remuneration Committee (August & September 2023)**	
	TFO advised the board that the Remuneration Committee completed a tremendous amount of work in its first year and asked the Board to note the annual report. TFO commended the enthusiasm of the committee for dealing with complex issues and the support received from the Chief People Officer and Associate Director of Governance.	

Item	Discussion, Outcomes and Action Points	Action by
	On call payments and Establishment of the Deputy Chief Executive were approved by the committee. Of note, there are legacy issues with pharmacy, optometry and dental roles. Progress is being made to establish renumeration for these positions. Fit and Proper Persons test is progressing and looks to be on time. Recommended Terms of Reference cannot be progressed satisfactorily due to an issue with a Non-Executive Director renumeration. This is the only issue preventing the Terms of Reference being approved. TFO & MCU will bring this back to Board as soon as possible. **The Integrated Care Board noted the content of the report with the caveat to the Terms of Reference.**	
ICB/23/09/16	**Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee (add 2023)**	
	EMO highlighted that discussion on system pressures takes place at the Primary Care Committee meetings for awareness and assurance across four contractor groups. Winter challenges and return to schools with the added pressures have been discussed. The change in policy regarding covid and the flu national policy were discussed as well as some incidents with security and wellbeing regarding our own staff in premises. Primary care access plan will come to Board in full in November, however conversations are ongoing regarding empowering residents, digital access, self-care, implementing modern systems workforce, recruitment and retention and estates. GP surgery results – unsurprisingly there are issues with access, however there was an increase in satisfaction in care once in front of a clinician. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/17	**Report of the Chair of the Cheshire and Merseyside ICB Women's Services Committee (August 2023)**	
	RJA advised the Board that the main activity of the committee remains to receive updates other bodies such as The Women's Services Programme, Partnership Board between the Women's Hospital and Liverpool University Teaching Hospital. An update was received on the recruitment of the Programme Director and the Clinical SRO for the programme who are now in post.	

Item	Discussion, Outcomes and Action Points	Action by
	A presentation was given on the Care Quality Report of Liverpool Women's Hospital to seek to understand whether it was highlighting any more, or new risks. The committee took further time to look at how governance of programme in place could be embedded. Continue to develop the working of the governance and wider set of organisations involved. CDO noted that the Programme Director is Claire Powell and not Claire Wilson. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/18	**Report of the Deputy Chair of the Cheshire and Merseyside Health and Care Partnership (September 2023)**	
	RJA gave an update to the Board on behalf of Councillor Louise Gittins, the Chair of the Health and Care Partnership Board. The HCP is gathering momentum and coalescing down to a few priorities which were discussed at the September Board and means there can be more impact across Cheshire and Merseyside. Good progress is being made. PCU highlighted that he has received positive comments from colleagues in Local Authority, who are very positive about the partnerships being made. **The Integrated Care Board noted the content of the report.**	
ICB/23/09/19	**Report of the Chair of the Cheshire and Merseyside Transformation Committee (September 2023)**	
	CWA advised the Board that the committee approved the Specialised Commissioning Pre-Delegation Assessment Framework to return to NHS England within the national timeline. A future meeting will be held with more update on the safe delegation framework, the target operating model between NHS England, Northwest and the three systems and the implementation plan for taking on responsibility for the fifty-nine specialised services. An update was received on the current allocation of transformation programme monies for both 22/23 and have been able to bring back funding for the deficit position, and also the programme to invest more funding in transformation programme. CWA thanked IAS in his new role as Director of Population Health. **The Integrated Care Board noted the content of the report.**	

Item	Discussion, Outcomes and Action Points	Action by
	ICB Business Items	
ICB/23/09/20	**Cheshire and Merseyside Clinical and Care Constitution**	
	RPJ gave an update to the report provided and spoke to the presentation displayed to the Board. The Clinical and Care Constitution is a set of principles that underpin all we do. It has been written by clinicians with input from clinical and care colleagues to support the Cheshire and Merseyside Integrated Care System to develop with partners, an overarching population health approach, driven by the needs of our communities, with a clear focus on addressing health inequalities. The Four Pledges are – 1. Quality – designing and delivering high quality resilient services through an evidence-based approach. 2. Collaboration – working collaboratively with relentless patient focus. 3. Health – improving health outcomes. 4. Value – transformation for value. Key Principles are – • We shift the paradigm from reactive to proactive healthcare. • We integrate clinical and care professionals in decision making at every level of the ICS, creating a culture of shared learning, collaboration and innovation, working along side patients and local communities. • We will evidence the return on investment in improving health through measures of both quality and effectiveness. • We will influence the wider determinants of health through collaborating, education and modernisation. CWA felt it would be important to use this and build on it in terms of refresh of HCP strategy; a commitment has been made to revise and build on all together fairer and the Local Authority Health and Well Being Boards Health and Well Being strategies. This document could be used rather than a separate population health strategy to take forward. NLA asked how we ensure that this strategy lives within available resources? GPU advised that he welcomes this piece of work as it underpins the way we work and links directly back to financial strategy. At some point in time decisions will be made about change, however we have worked relentlessly to identify and drive out the unacceptable variations that exist, which will give the	

Item	Discussion, Outcomes and Action Points	Action by
	platform to enable this. CWI identified that as an executive team we need to work through how this is made a reality. RPJ highlighted that the Medical Directorate met on 27th September 2023 to work on the constitution together. Place Clinical Leads will work to ensure that this is in every practice, is visible to everybody who steps into health care and that the voluntary sector also have a role to play in this. All medical directors in secondary care have seen this and will cascade. RPJ would like all coversheets for papers to ask the question how does this project align with the constitution. **Action** **RJA asked RPJ, if in the diagram in appendix 2 of the report could be amended so it, as it can be read as though there is a top-down approach to system place down to neighbourhoods on the left of the diagram.** **Action** **A board development session to be set aside to discuss the Clinical and Care Constitution with lessons learned from the past.** **The Integrated Care Board approved and noted the content of the report.**	RPJ MCU
ICB/23/09/21	**Cheshire and Merseyside Winter Plan**	
	The report presented by AMI is drawn from nine individual winter plans developed at Place level with total inclusion from all system partners. The winter plan was submitted at the start of September 2023 through the NHS pipeline, which is subject to support and stress testing of its development with NHS England, it is not the end of the process. There is a similar process with Local Authorities and the use of social discharge funds. This year, whilst additional funding has been provided to make additional bed capacity recurrent, there has been some additional funding through the social care discharge fund to Local Authorities, a share of tier one monies have been directed to Local Authorities to reflect the particular pressure certain parts of the system are under. There has not been any additional winter funds to draw down on for additional schemes.	

Item	Discussion, Outcomes and Action Points	Action by
	Urgent care is in a very challenged position with some parts of the system featuring in the most pressurised systems nationally. It is worthy of note that against some key metrics Cheshire and Merseyside are in a better position than the same time last year. There are currently 5500 general acute beds open across Cheshire and Merseyside with plans to increase to 5700, which is slightly lower than what we have had at the peak of winter last year. Reasons for this are the restart of maternity in East Cheshire, bed capacity had previously been used for general pressures during last winter, and there are ongoing challenges with RACC. There is a further contingency of 105 beds. The Winter Plan suggests that resource is in place to hang fast in the current position. Virtual ward capacity usage is low at around 60%, a decision was reached earlier this year not to increase capacity until we were able to use the existing capacity to its optimum, which remains a key focus going forward. Mental Health and Learning Disabilities Community Services are organising as lead body. All governance and arrangements in place to set up the winter plan are continuing. Weekly Winter Plan Place Based meetings are taking place. There is also an ICB led Cheshire and Merseyside oversight group which takes place weekly with total inclusion from all parts of the system. CWA noted as a point of accuracy in point 6.2 of the report - system development funding has been made and is available for Primary Care General Practice, but it is not to support Acute Respiratory Infection hubs, there is no additional winter pressure funding for general practice or wider primary care. Place are being encouraged to work closely with Primary Care Networks and practices to look at system pressures. AMI acknowledged and highlighted that the additional social discharge funding made available to localities, plus tier one has been subject to discussions with Place as to what additionality it will bring. EMO expressed surprise that an equality assessment has not been undertaken, even though the plans are quite advanced and questioned if we are missing mitigations by working in this way. AMI indicated that there is evidence of this in the plans and will pick acceleration of delivery up at the next weekly meeting. ALE advised that the winter plan for Knowsley is jointly constructed between the NHS, Local Authority and the voluntary sector. A new falls service has been set up in care homes with equipment and training given, in six months this year this service has avoided 60	

Item	Discussion, Outcomes and Action Points	Action by
	ambulance phone calls. MPA indicated that St Helens Place have an integrated system with a shared care record and an integrated discharge team with contact cares based on-site at Whiston. NRA advised that general practice are already at 255% of telephone consultations and have been over the last month, which is the quiet summer period, and asked how do we meet the demand of winter pressures with no further funding for general practice. System development funding does not cover staff provision. GPU discussed the way in which we will operate this winter, there is a huge amount of opportunity within the winter plans to make small improvements at every part of the patient flow journey. This is also our opportunity to be kind to one another in particularly stressful and challenging times. **Action** **AMA to work with AMI to discuss how bed occupancy rates have been calculated for Mersey and West Lancashire Teaching Hospital Trust.** **The Integrated Care Board noted the content of the report.**	AMA / AMI
ICB/23/09/22	**Cheshire and Merseyside ICS Digital and Data Strategy Update**	
	JLL discussed the report provided to the Board which gives an update against the digital and data strategy. 2022/23 deliverable are – • Establishment of sustainable pop health analytics capability. • Implementation of common OC/VC platform for Primary care. • Creation of digital inclusion toolkit; rollout underway. • ICS wide capacity and demand reporting for urgent care. • Unified performance reporting and service planning tools. 2023/25 headlines are – • Single LIMS. • C&M wide PACS. • Patient Empowerment portals. • Waiting list initiatives. • Deployment of an accredited Digital Social Care record in care providers. • Scale up of RPA. • Scale up of remote monitoring capability. • Shared care records optimisation. • Front line digitisation EPR and eBCMS.	

Item	Discussion, Outcomes and Action Points	Action by
	• Adoption of NHS app "Digital Front Door. The paper seeks endorsement of an approach to review and re-prioritise based on a number of changes in terms of national targets and local context. Proposing to recalibrate the plan. There will be a group dedicated to managing collectively all deliverables within the plan which will include Place Digital representative and local authority colleagues. The Liverpool Clinical Services Review prompts us to think deeply about the building of digital architecture to support patient flow between organisations. There is a big piece of work being undertaken around cyber security with clear expectations in the national strategy which require provider level response, an ICB level capability and national capability to all work together. Added to the challenge, there have been seven short term digital priorities given to us this summer, all focused on secondary care and elective recovery, with ambitious timelines. A smart systems control system needs to be in place by 1st December 2023, which is on track with national funding. Two Trusts have been selected as pilots for an electronic bed management system. The ask of the Board is endorse the approach to a recalibration of the plan, with the proposal to return with a single plan and associated governance. AIR made a plea with the terminology in the document around digital primary care, where it should be digital general practice. JLL noted the comments. **The Integrated Care Board endorsed and noted the content of the report.**	
ICB/23/09/23	**Amendments to the Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation**	
	The report is presented to the Board for approval, it has already been ratified through the Audit Committee. It makes changes to the scheme of reservation and delegation to support further delegation down to place and a number of anomalies identified in the first year of operation, making committees more effective. **The Integrated Care Board were all in agreement for approval and noted the report.**	

Item	Discussion, Outcomes and Action Points	Action by
	Other Formal Business	
ICB/09/23/24	**Closing remarks, review of the meeting and communications from it**	
	Good meeting, with good discussion. Questions have been received from members of the public, responses to the questions will be available on the website.	
	CLOSE OF MEETING	
Date, time, and location of Next Meeting:		
30th November 2023, 09:00am – 12:00 noon Whiston Town Hall, Old Colliery Road, Whiston, Merseyside, L35 3QX		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2023 - 2024

Updated: **03/10/2023**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-11	28/11/2022	**Cheshire & Merseyside System Month 7 Finance Report**	In the absence of a comprehensice provider organisational integrated performance report, members would be sent dashboards that provided the wider financial position and workforce information.	Claire Wilson	Jan 2023		ONGOING
ICB-AC-22-32	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	With regard to the Core20plus5 there were a range of 22 indicators that would be reported through the HCP but could also be presented to this Board.	Andy Thomas	date tbc		ONGOING
ICB-AC-22-33	30/03/2023	**Cheshire & Merseyside ICB Quality and Performance Update Report (Andy Thomas)**	The ICB relative performance compared to other ICBs in the Northwest had not improved as much as they have, yet we continue to invest and put a lot of time and attention. Deep dive into this to be undertaken in April, place-based response to the information presented today in the private meeting. Further report to be brought back to the Board at a future meeting.	Andy Thomas	date tbc		ONGOING
ICB-AC-22-41	27/04/2023	**Cheshire & Merseyside System Month 12 Finance Report**	CWI and SBR to work together on the production of a position paper covering social care provision and funding	Claire & Steven Broomhead	TBC		ONGOING
ICB-AC-22-48	25/05/2023	**ICS Financial Plan for 2023/24 and Proposed Budgets for the ICB**	To assign one of the board development days to provide training on a general overview of system finance.	Claire Wilson	June 2023		ONGOING
ICB-AC-22-50	25/05/2023	**Reports of the Chairs of the Cheshire & Merseyside ICB Committees**	RJA requested that when items were escalated to Board that the risk template was used. This would highlight where and how risks were being mitigated.	All committee chairs	June 2023	Updated Board paper template strengthens links to ICB risk management	COMPLETED
ICB-AC-22-51	23/06/2023	**Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-2024**	JRA to present the delivery plan to the board in autumn 2023	Joe Rafferty	Autumn 2023	date tbc	ONGOING
ICB-AC-22-57	27/07/2023	**NHS Long Term Workforce Plan**	CSA to provide a quarterly update to Board on the progress against the NHS LTP	Chris Samosa	Jan-24		ONGOING
ICB - AC-22-58	28/09/2023	**Report of the Chief Executive**	IAS to discuss with Public Health Directors making re-connections to look at good practice around dual diagnosis services.	Ian Ashworth & Joe Rafferty	Nov-23	date tbc	ONGOING
ICB-AC-22-59	28/09/2023	**Report of the Chief Executive**	Right Care Right Place - GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.	Graham Urwin	Nov-23	date tbc	ONGOING
ICB-AC-22-60	28/09/2023	**Cheshire and Merseyside Clinical and Care Constitution**	RJA asked RPJ, if in the diagram in appendix 2 of the report could be changed so it, as it can be read as though there is a top down approach to system place down to neighbourhoods on the left of the diagram.	Rowan Pritchard-Jones	Nov-23		ONGOING
ICB-AC-22-61	28/09/2023	**Cheshire and Merseyside Clinical and Care Constitution**	A board development session to be set aside to discuss the Clinical and Care Constitution with lessons learned from the past.	MCU	Nov-23	Added to Board development forward planner	COMPLETED

Action Log 2023 - 2024

Updated: **03/10/2023**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-62	28/09/2023	**Cheshire and Merseyside Winter Plan**	AMA to work with AMI to discuss how bed occupancy rates have been calculated for Mersey and West Lancashire Teaching Hospital Trust.	AMA / AMI	Nov-23		ONGOING

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-01	01-Jul-2022	**ICB Appointments (Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Executive Members of the Integrated Care Board:- 1) Claire Wilson, Director of Finance; 2) Professor Rowan Pritchard Jones, Medical Director 3) Christine Douglas MBE, Director of Nursing and Care.. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.	
ICB-DE-22-02	01-Jul-2022	**ICB Appointments (Non-Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Non-Executive Members of the Integrated Care Board:- Neil Large MBE, Tony Foy and Erica Morriss.	
ICB-DE-22-03	01-Jul-2022	**ICB Appointments (Partner Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Partner Members of the Integrated Care Board:- Ann Marr OBE and Dr Joe Rafferty CBE.	
ICB-DE-22-04	01-Jul-2022	**ICB Constitution**		The Integrated Care Board approved:- 1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details). 2) The Standards of Business Conduct of NHS Cheshire and Merseyside. 3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside. 4) The Draft Policy for Public Involvement of NHS Cheshire and Merseyside.	
ICB-DE-22-05	01-Jul-2022	**Scheme of Reservation and Delegation**		The Integrated Care Board approved:- 1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside. 2) The Functions and Decisions Map of NHS Cheshire and Merseyside. 3) The Standing Financial Instructions of NHS Cheshire and Merseyside. 4) The Operational Limits of NHS Cheshire and Merseyside.	
ICB-DE-22-06	01-Jul-2022	**ICB Committees**		The Integrated Care Board approved:- 1) The core governance structure for NHS Cheshire and Merseyside. 2) The terms of reference of the ICB's committees. It also noted the following:- i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. ii) The receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each of the 9 Places.	
ICB-DE-22-07	01-Jul-2022	**ICB Roles**		The Integrated Care Board agreed the lead NHS Cheshire and Merseyside roles and portfolios for named individuals, noting that the Medical Director will be the SIRO and the Executive Director of Nursing and Care will be the Caldicott Guardian.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

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NHS Cheshire and Merseyside

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ICB-DE-22-08	01-Jul-2022	**ICB Policies Approach and Governance**		The Integrated Care Board:- 1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. 2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. 3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. 4) Noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB-DE-22-09	01-Jul-2022	**Shadow ICB Finance Committee Minutes Approval**		The Board agreed that the minutes of the Cheshire and Merseyside Shadow ICB Finance Committee held on 30th June 2022 can be submitted to the first meeting of the ICB's established Finance, Investment and Our Resources Committee.	
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

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Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	**Chief Executive Report**		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	**Welcome to Cheshire East**		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	**Residents Story Update - Social prescribing**		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	**Cheshire & Merseyside ICB Quality and Performance Report**		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	**Executive Director of Nursing and Care Report**		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	
ICB-DE-22-28	27-Oct-2022	**Continuous Glucose Monitoring**		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	
ICB-DE-22-29	27-Oct-2022	**Provider Collaborative update**		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	**System Finance Assurance Report**		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	**Winter Planning 2022-23**		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winder resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee**		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee**		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	
ICB-DE-22-35	28-Nov-2022	**Cheshire and Merseyside ICS Digital Strategy**		Endorsed the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting.	
ICB-DE-22-36	28-Nov-2022	**Consensus on the Primary Secondary Care Interface**		Endorsed the consensus Agreed on the proposed actions for implementation: ongoing promotion to Secondary Care via the Trust Medical Directors recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside	
ICB-DE-22-37	28-Nov-2022	**Report of the Chair of the Finance, Investment and Resources Committee**		Approved the revised terms of reference attached to the paper	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-38	23-Jan-2023	**Report of the Chief Executive - Harmonising Clinical Commissioning Policies Update**		Approved the revised Legal statement as detailed within Appendix Two, as reviewed by Hill Dickinson	
ICB-DE-22-39	23-Jan-2023	**Review of Liverpool Clinical Services**		Noted the content of the report Agreed all the recommendations within the report; however with regards those recommendations to be overseen by CMAST the Board removed from the recommendations the sentence 'the starting point for realising the opportunities identified in this review should be the 6 organisations within Liverpool.' Only once tangible progress is made within this scope should it be broadened to a wider geography Agreed the implementation plan and associated timescales	
ICB-DE-22-40	23-Jan-2023	**Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24**		Noted the contents of the draft interim strategy Endorsed the next steps agreed by the Health and Care Partnership at the meeting of 17 January 2023; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan	
ICB-DE-22-41	23-Jan-2023	**NHS 2023/24 Priorities and Operational Planning Guidance**		Noted: The content of the 2023-24 NHS planning guidance, including the need to develop both 2-year operational plans and an ICB Joint Forward Plan The approach to developing our Cheshire and Merseyside plans including the role of providers in developing and approving plans as well as the need to engage with the HCP partners and HWB in developing the content of the plans. That the submission date for the draft operational plan prevented it from being approved by the Board before submission on 23 February 2023. The need for review by the ICB Executive Team and Provider Collaboratives before submission and review, and ratification at the February Board meeting which takes place on the day of submission. That the final submissions would be presented to the Board for approval in March 2023	
ICB-DE-22-42	23-Jan-2023	**Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs**		Noted the items covered during the Audit Committee of 13 December 2022 report. Approved the Operational Scheme of Delegation Update, December 2022	
ICB-DE-22-43	23-Feb-2023	**Cheshire & Merseyside ICB Equality Diversity and Inclusion Annual Report 2022 – 2023**		Approved the annual ICB proposed Equality Objectives 2023 to 2024 (Appendix One, section six) subject to the amendment the fourth Equality objective (Empower and engage our leadership and workforce) explicitly showing 'to address overall inequalities'.	
ICB-DE-22-44	23-Feb-2023	**Cheshire & Merseyside ICB Risk Management**		Approved the Risk Management Strategy attached at Appendix One Approved the proposed Board Assurance Framework report format Approved the core statement and risk appetite definitions included in the draft Risk Appetite Statement	
ICB-DE-22-45	23-Feb-2023	**Update on NHSE Primary Care Delegation to Cheshire & Merseyside ICB**		Noted and supported the work undertaken to date in relation to the delegation of Ophthalmic and Dental Services on 1 April 2023	
ICB-DE-22-46	23-Feb-2023	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		Approved the legacy policies as described at Section 5 of the report	
ICB-DE-22-47	23-Feb-2023	**Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Our Resources Committee**		Approved the updated Committee Terms of Reference	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-48	30-Mar-2023	**Northwest Specialised Commissioning Joint Working Agreement (Clare Watson)**		• noted the contents of the report • approve the ICB entering into a Joint Working Agreement and progressing the work to establish statutory joint committee arrangements with NHSE and NHS Greater Manchester and NHS Lancashire and South Cumbria ICBs for the 2023/24 period • approve delegating authority to the Assistant Chief Executive to sign the Joint Working Agreement on behalf of NHS Cheshire and Merseyside to enable these commissioning arrangements to 'go live' from April 2023 • note that further engagement will be undertaken with members of the three ICB Boards in developing and agreeing the Joint Committee Terms of Reference.	
ICB-DE-22-49	30-Mar-2023	**Cheshire and Merseyside Cancer Alliance Update**		•noted the contents of this report and ongoing efforts to improve operational performance and outcomes. •approved ongoing constructive conversations with colleagues at place and at corporate ICB around sustaining and embedding some of the improvements discussed. •noted that the alliance is keen to explore how it may support the ICB with its new commissioning duties for specialised cancer services which are to be delegated to the ICB from NHS England.	
ICB-DE-22-50	27-Apr-2023	**Intelligence Into Action: Continued provision of ICS digital and data platforms**		The Integrated Care Board •approved the allocation of funds to support option 2, which will allow for: othe continued provision of the existing population health and data platform and associated shared care record over a transition period of two years. othe continued provision of the integrated (within CIPHA) C2Ai PTL tool across the 10 acute Trusts to support risk-adjusted triage and prioritisation of the Patient Treatment List (PTL).	
ICB-DE-22-51	27-Apr-2023	**NHS Cheshire and Merseyside ICS NHS Staff Survey 2022-23: Results and Actions**		The Integrated Care Board •noted the staff survey results and •endorsed the actions taken to review and respond to the Staff Survey results 2022.	
ICB-DE-22-52	27-Apr-2023	**Briefing on the national maternity and neonatal services delivery plan**		The Integrated Care Board noted the report and endorsed the terms of reference for the Women's Committee.	
ICB-DE-22-53	25-May-2023	**Cheshire and Merseyside Acute and Specialist Trust (CMAST) Provider Collaborative - Annual Work Plan 2023-2024**		•noted the approach and progress made by CMAST •endorsed the commitments made in the workplan as part of C&M's wider delivery undertakings.	
ICB-DE-22-54	25-May-2023	**Cheshire & Merseyside ICB Board Assurance Framework (BAF)**		•approved the adoption of the principal risks proposed at appendix A for inclusion in the Board Assurance Framework and consider whether any further risks should be included. •noted the current risk profile, proposed mitigation strategies and priority actions for the next quarter and consider any further action required by the Board to improve the level of assurance provided. •noted the establishment of the ICB Risk Committee.	
ICB-DE-22-55	25-May-2023	**Marking NHS@75 years and NHS Cheshire and Merseyside@ 1 year**		•noted the content of the report, acknowledging that it represented work in progress •supported related communications and staff engagement activity in line with plans outlined, particularly through key internal meetings and meetings in public, as well as a series of informal gatherings across the ICS estate	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-56	29-Jun-2023	**Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24**		The Integrated Care Board •Approved the publication of the 2023-28 Joint Forward Plan on 30 June, including the 2023-24 delivery plan subject to any changes of non-material nature being delegated to GPU •Endorsed developing the Joint Forward Plan for 2024-2028 to be a document more aligned as a delivery plan for the final Cheshire and Merseyside HCP Strategy with the use of an annual NHS Cheshire and Merseyside ICB delivery plan to reflect any additional NHS specific content which sits outside of the shared priorities within the HCP Strategy	
ICB-DE-22-57	29-Jun-2023	**NHS Cheshire and Merseyside ICB Annual Report and Accounts 2022-23 & Cheshire and Merseyside CCG 3 Month Reports 2022-23**		The Integrated Care Board •approved the nine CCG Annual Reports and Accounts for submission to NHS England by 30 June 2023. •approved the ICB Annual Report and Accounts for submission to NHS England by 30 June 2023.	
ICB-DE-22-58	29-Jun-2023	**Primary Care Strategic framework and update on the Cheshire and Merseyside delivery plan for recovering access to primary care**		The Integrated Care Board: •noted the paper and draft Primary Care Strategic Framework and comment on the content •noted the engagement that has taken place and comment on this, describing any potential gaps •approved the first two chapters of the Framework subject to minor changes. CWA would report on these at Primary Care Committee •approved ongoing work to develop the final two chapters •approved the development of a workplan based on the Framework to inform ongoing plans •noted that the final Framework with all chapters be brought to Board within the next 6 months. •noted the presentation on the Primary Care Access recovery Plan	
ICB-DE-22-59	29-Jun-2023	**Winter Debrief and Urgent Emergency Care Improvement Programme**		The Integrated Care Board noted the contents of this report, in particular the establishment of the Urgent Care Improvement Programme and associated governance.	
ICB-DE-22-60	29-Jun-2023	**Northwest Specialised Commissioning Joint Committee Terms of Reference**		The Integrated Care Board •noted the update provided on the first meeting of the shadow North West Specialised Services Joint Committee •approved the Terms of Reference for the North West Specialised Services Joint Committee •approved the recommendation regarding delegating authority to the Assistant Chief Executive to approve any minor amendments to the Terms of Reference that may be required following consideration by the other two North West ICB Boards.	
ICB-DE-22-61	27-Jul-2023	**Northwest BAME Assembly Anti-Racism Framework**		The Integrated Care Board •approved the adoption of the Northwest BAME Assembly Anti-racism Framework by the ICB and the proposed approach for implementation. •acknowledged that the framework would be used during the development of the 2024-25 (commissioning) Planning Round •noted that the involvement of our clinical leaders, around accountability, was key to success	
ICB-DE-22-62	27-Jul-2023	**Transformation Committee**		The Integrated Care Board: •noted the contents of this report •approve delegated authority to the Transformation Committee to formally approve the Specialised Services PDAF submission being made in September.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2024

NHS Cheshire and Merseyside

Updated: 20 November 2023

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommendation, destination of and deadline for completion / subsequent consideration
ICB-DE-22-63	28-Sep-2023	**Executive Director of Nursing & Care Update Report (Sept 2023)**		The Integrated Care Board noted the content of the report. • East Cheshire - will be returned to via the Quality Committee. • SEND - partnerships are required for improvement. • Help the Board to understand through a periodic report to triangulate and identify key topics and trends emergent across the region.	
ICB-DE-22-64	28-Sep-2023	**Report of the Chair of the Cheshire and Merseyside ICB Audit Committee (September 2023)**		The Integrated Care Board approved the terms of reference and noted the content of the reports.	
ICB-DE-22-65	28-Sep-2023	**Report of the Chair of the Cheshire and Merseyside ICB Remuneration Committee (August & September 2023)**		The Integrated Care Board noted the content of the report with the caveat to the Terms of Reference.	
ICB-DE-22-66	28-Sep-2023	**Cheshire and Merseyside ICS Digital and Data Strategy Update**		The Integrated Care Board endorsed and noted the content of the report.	
ICB-DE-22-67	28-Sep-2023	**Amendments to the Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation**		The Integrated Care Board were all in agreement for approval and noted the report.	

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/11/23/07

Responsible Director: Raj Jain, Chair

Report of the Chair of NHS Cheshire and Merseyside (November 2023)

1. Introduction

1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere in detail on this meeting agenda.

1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the enormity of work that the organisation is accountable for or is a key partner in the delivery of.

2. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **note** the updates within the report
- **support** the proposal for the establishment of an additional ordinary (Partner) Member of the Board
- **approve** the Cheshire and Merseyside Health and Care Partnership Terms of Reference.

3. Key updates of note

3.1 **Appointment of Ruth Hussey CB, OBE, DL**
I am pleased to welcome Ruth to the Board of NHS Cheshire and Merseyside as our fifth Non-Executive Member. Following an expansive advertisement process which resulted in an excellent field of shortlisted candidates, the ICB Stakeholder Panel and Appointments panel came to a unanimous conclusion that Ruth demonstrated the requisite enthusiasm, experience, and commitment to becoming a valuable addition to the Board. Ruths experience and expertise will further add to the ambition and commitment of the ICB to tackling health inequalities and prioritising work and resources around population. I would like to thank colleagues on the Board and from across the system in supporting the recruitment process.

3.2 **Establishment of an additional Ordinary (Partner) Member of the Board**
Prior to the establishment of the ICB it was recognised that the role and voice of the Voluntary, Community, Faith and Social Enterprise (VCFSE) sector. was integral to the successful development of the Cheshire and Merseyside ICB and Integrated Care Systems, and as such it was agreed that a representative from the VCFSE would be invited to be a regular participant at the Board of NHS Cheshire and Merseyside so that the perspective of the sector was front and center in the Board discussions.

3.3 To help further strengthen our commitment to the VCFSE sector and reinforce our position that the VCFSE sector are seen as equal partners in health and care, I am

seeking the support of the Board to make the VCFSE Sector representative a named Ordinary (Partner Member) of the Board. In doing so the main change would be that the representative is now considered as part of the voting membership of the Board.

3.4 If the Board supports this proposal, the ICB Associate Director of Corporate Affairs and Governance will be instructed to progress the necessary engagement with the VCFSE sector around the appointment process as well as progressing the necessary amendments to the ICB Constitution, which will come back to a future Board meeting prior to submission to NHS England.

3.5 The appointment process itself will be in accordance with the existing ICB partner member appointment policy and national regulations and will consider relevant national guidance and requirements as outlined within the ICB Constitution.

3.6 **Associate Non-Executive Member establishment.** The NHS has a number of key objectives around Board development, including strategic objectives to *'develop, maintain and enhance effective boards'* and for Boards *'to reflect the diversity of the people it serves'*. It is with these objectives in mind that I have been supportive of the ICB taking part in national and regional programes to encourage people from a diverse background to consider becoming Non-Executive Members/Directors of NHS Boards. I am pleased to welcome Marc Smith to today's Board. Marc is currently on a six month placement with the ICB as part of the Insight Programme[1], which is national programme that aims to support individuals from underrepresented groups on their journey to becoming effective Non-Executive Directors. NHS Cheshire and Merseyside is one of only two ICBs this year that are hosting an Insight placement. Neil Large has agreed to be Marcs mentor throughout his six month placement with the ICB and Marc will be attending a number of ICB Board and Committee meetings, as well as meeting with key people so as to help Marc in his development journey to becoming a Non-Executive Member/Director.

3.7 Additionally, I have also instructed the ICBs Board Secretary to progress the development of an ICB programme to establish two Associate Non-Executive Member positions with the ICB, further details of which I will look to communicate to Board members and partners in the near future. I am also keen that we also take the opportunity as an Integrated Care System to see what further we can do regionally to develop a pipeline programme of Associate Non-Executive Director development so as to support the strategic NHS Board objectives as outlined above but also to support local NHS organisations with their Non-Executive Director Board succession plans. I have asked the ICBs Chief People Officer and Board Secretary to take this forward with colleagues across the system, many of whom have had or do have Associate Non-Executive Director positions in place, as well as with national colleagues to see how we can utilise such existing schemes as the NexT scheme.[2]

[1] https://theinsightprogramme.com/insight-programme/
[2] https://www.england.nhs.uk/non-executive-opportunities/improving-non-executive-diversity/next-director-scheme-supporting-tomorrows-non-executives/

3.8 **Cheshire and Merseyside Health and Care Partnership**
Over recent months, the Terms of Reference for the Cheshire and Merseyside Health and Care Partnership (HCP) has been considered and approved by each of the nine Local Authorities across Cheshire and Merseyside. As the tenth founding member of the HCP the ICB also needs to approve the TOR, which can be found in Appendix One. I am recommending that the Board approves the Terms of Reference. Once approved the Terms of Reference will be published on the ICB website. I would like to express my thanks to the ICB and Local Authority officers who have progressed the formal approval of the Terms of Reference.

3.9 Since the last HCP update to Board, the HCP has undertaken two themed workshops which have bene well attended by HCP members and other key partners.

3.10 On the 19 September 2023 the focus of the facilitated workshop was for members to discuss health and housing issues. A number of key stakeholders from across the Cheshire and Merseyside footprint were invited to speak at the workshop and the session included two separate facilitated sessions where members were asked to discuss the following:

- considering all the collective challenges faced what can be agreed today to commit to working together to address them?
- how might that work?
- what do we believe the initial priorities should be?
- what can we do by working as partners at a Cheshire and Merseyside footprint to accelerate our work?

3.11 HCP group members were asked to divide into four groups and a Housing representative and facilitator supported each group. Members listened to a number of presentations outlining the key themes of the workshop (Appendix Two) and then participated in two twenty minute workshops. There were lively debates across all groups and there are a number of key themes from these sessions outlined below:

- Finance / funding – issues with non-recurrent funding, shared budget / savings, ‘invest to save’, funding opportunities different in Cheshire and Merseyside
- More retrofitting and funding is needed
- Sharing information / data – not sharing data / best practice, who / how will we coordinate shared data and analysis, this could reduce duplication of services.
- Collaboration across HCP to influence & impact – regional and national, work. together towards shared vision, utilise shared voice of partnership to influence & lobby, shared strategy instead of separate Housing Strategies at place.
- Proactive rather than reactive – identify need & intervene before crisis point, learn from patterns / data of previous years & plan, upstream prevention.
- lack of resource and capacity at a region to progress pieces of work
- opportunities to jointly commission for MH housing/ support.

3.12 It was agreed at the workshop that the following would be next steps for the HCP:

- agreement of Housing as a HCP priority area for action and establishment of a strategic Housing, Health and Care forum for Cheshire and Merseyside. HCP Members are looking at the resources related to establishing that and have met

with housing provider leads and housing strategy leads to discuss some of the key outcomes from the session.
- to establish a regional piece of work to consider how the collection of current data across the system can support the housing priorities and develop a regional report which will be shared with the Housing Health and Care forum.
- establish working principles of what Early Intervention type activity we can do as a collective on housing, including wellbeing and MECC (Making Every Contact Count) type activity and more of the better ventilation messages and cold homes communication challenges. Establish a workstream to address that in a systematic way.
- explore further as a region how we can better support children leaving care or vulnerable children and housing challenges as a joined up system.
- recognise the need for joint commissioning approaches for the Learning Disability / Mental Health Complex needs and housing challenges.

3.13 On the 14 November 2023 the focus of the facilitated workshop was for members to discuss Children and Young People. A number of key stakeholders from Childrens Services across the Cheshire and Merseyside footprint were invited to speak at the workshop and the session included four facilitated sessions where members were asked to discuss:
- what can HCP do to support the Children and Young Peoples agenda?
- how can the HCP influence joint funding models?
- what other areas of health and social care integration for children can be explored?
- how and where can improved outcomes and progress made be reported regionally?

3.14 There were three groups for the facilitated sessions with members and a full summary document from the workshop is being drawn up which will include next steps. Some early key themes that have been picked out from the workshop session so far include:
- exploring opportunities for Cheshire and Merseyside partner organisations to develop better joint working and joint funding models and arrangements.
- ensure that the voice of Childrens and Young People is considered in the future planning for the HCP priorities.
- improvement of data sharing across the system
- improving the prevention offer for Children and Young People across all places.
- creating opportunities to share learning and best practice across region.
- developing the role of corporate mentor for HCP partner organisations

Contact details for more information

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Associate Director of Corporate Affairs and Governance / Board Secretary
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Appendices

Appendix One: Cheshire and Merseyside Health and Care Partnership draft Terms of Reference

Appendix Two: Cheshire and Merseyside Health and Care Partnership Health and Housing Workshop slide deck

Appendix Three: Cheshire and Merseyside Health and Care Partnership Children and Young Peoples workshop slide deck

Cheshire and Merseyside Health and Care Partnership

Terms of Reference

Background

Integrated care systems (ICSs) are statutory partnerships that bring together NHS organisations, local authorities, and others to take collective responsibility for planning services, improving health, and reducing inequalities across geographical areas.

ICSs comprise two key components:

- **integrated care boards (ICBs):** statutory bodies that are responsible for planning and funding most NHS services in the area
- **integrated care partnerships (ICPs):** statutory committees that bring together a broad set of system partners (including local government, the voluntary, community, faith and social enterprise sector (VCFSE), NHS organisations and others) to develop a health and care strategy for the area.

This dual structure was designed to support ICSs to act both as bodies responsible for NHS money and performance at the same time as acting as a wider system partnership.

ICPs are established in legislation by the insertion of a new Section 116ZA to the Local Government and Public Involvement in Health Act 2007. Section 116ZA of the 2007 Act imposes an express obligation on an ICB and all relevant local authorities whose area coincides with or falls wholly or partly within the ICBs area to establish an ICP as a joint committee.

In the Cheshire and Merseyside Integrated Care System, the ICP is named as the Cheshire and Merseyside Health and Care Partnership (HCP).

These Terms of Reference set out the membership, remit, responsibilities, and reporting arrangements of the joint committee.

Role and Purpose

The Cheshire and Merseyside HCP is a broad alliance of organisations and representatives concerned with improving the care, health, and wellbeing of the population, jointly convened by local authorities and the NHS as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

Its primary purpose will be to act in the best interests of residents across Cheshire & Merseyside, rather than representing the interests of any individual organisation.

The role and purpose of the HCP does not duplicate that of the nine Cheshire and Merseyside Health and Wellbeing Boards. The HCP will work in conjunction where appropriate to help achieve common objectives and aims to benefit local populations.

The HCP provides the opportunity for a Cheshire & Merseyside forum to support and enhance work programmes to improve population health outcomes and reduce health inequalities by addressing complex, long term issues which need an integrated approach across Cheshire & Merseyside.

The HCP, as an Integrated Care Partnership, has a statutory responsibility to prepare, approve and publish an Integrated Care Strategy for the Cheshire and Merseyside ICS, setting out how the assessed needs in relation to Cheshire & Merseyside are to be met by the exercise of functions of:

- the Integrated Care Board
- NHS England
- the nine local authorities whose areas coincide with the ICB area.

In preparing this strategy the HCP must involve:

- the Local Healthwatch organisations whose areas coincide with or fall wholly or partly within its area
- the people who live and work in Cheshire & Merseyside.

The strategy will have due regard to and respond to the Health and Wellbeing Strategies and Joint Strategic Needs Assessments of each of the nine local authority areas.

Membership and Attendees

Members

Membership of the HCP (as an Integrated Care Partnership) is set out in legislation and must have as a minimum:

- one member appointed by the ICB
- one member appointed by each of the nine local authorities.

Legislation also allows for members to be appointed by the HCP itself.

In all cases, HCP membership will be renewable on an annual basis. Each participant organisation or body will be expected to have formally nominated or confirmed their nominated member by 1st August of each year. Changes in membership during the year are allowed and must be notified to the HCP promptly and before attendance at the next meeting.

Where members are not available to attend meetings, a substitute nominated by organisation may attend on their behalf.

The Chair of the HCP will discuss attendance with any member who fails to attend three consecutive HCP Meetings. The Chair of the HCP will refer any ongoing concerns regarding non-attendance of a member to their organisation with a

recommendation that consideration be given to whether it is appropriate for the individual to continue as a member of the HCP.

The full membership of the Cheshire and Merseyside HCP is:

Organisation / Area	Position
NHS Cheshire and Merseyside ICB	ICB Chair
	Chief Executive
	Assistant Chief Executive
	Executive Director of Finance
	Executive Medical Director
Cheshire East Council	x1 Councillor
Cheshire West and Chester Council	x1 Councillor
Halton Council	x1 Councillor
Knowsley Council	x1 Councillor
Liverpool City Council	x1 Councillor
Sefton Council	x1 Councillor
St Helens Borough Council	x1 Councillor
Warrington Borough Council	x1 Councillor
Wirral Council	x1 Councillor
Other Local Authority Representatives	x2 Directors of Adult Social Care – drawn from across the 9 responsible Local Authorities.
	x2 Directors of Public Health - drawn from across the 9 responsible Local Authorities
North West Ambulance Service	x1 Representative
Cheshire Police	x1 Representative
Merseyside Police	x1 Representative
Cheshire Fire and Rescue	x1 Representative
Merseyside Fire and Rescue	x1 Representative
Voluntary, Community, Faith and Social Enterprise Sector	x2 Representatives
Primary Care	x2 Representatives
CMAST Provider Collaborative	x1 Representative
MHLD Provider Collaborative	x1 Representative
Carer	x1 Representative
Housing	x1 Representative
Healthwatch	x2 Representatives
Higher Education / University	x2 Representatives

The Other Local Authority Representatives will be notified to the HCP by the nine local authorities.

Members are expected to adopt a partnership approach to working together, as well as listening to the voices of citizens, patients and the public of Cheshire and Merseyside.

Members will commit to working collaboratively, openly and supportive of the development and role of the HCP.

Attendees
Only members of the HCP, or their nominated substitute, can participate in HCP meetings, but the Chair may invite relevant organisations to send a representative to an HCP meeting as necessary in accordance with the business of the HCP.

Chair Arrangements

The Chair of the HCP will be drawn from one of the nominated HCP members from the nine local authorities.

The Chair will be appointed on an annual basis at the first meeting of the year (in September) by the local authority members of the HCP present at the meeting. Individuals wanting to be considered for the Chair role will need to be nominated and seconded by one other local authority member of the Board and agreed by way of a majority vote.

The HCP will also have two Joint Vice Chairs – one being the Cheshire and Merseyside ICB Chair and the other being an appointed representative of the VCFSE sector. In the absence of the Chair at a meeting of the HCP, it will be agreed in advance which of the two Vice Chairs will Chair the meeting on that occasion.

Quoracy

The meeting will be quorate if at least 50% of the members are present. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by the ICB, or local authorities may be taken unless at least 50% of the Committee members drawn from these two bodies are present.

If any member of the HCP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that member shall no longer count towards the quorum.

Decision making and authority

As far as is possible the HCP will make its decisions by consensus of the members present at the meetings of the HCP.

The HCP has been established as a Joint Committee under S116ZA Health & Social Care Act 2022.

It has not been established under S65Z6 or S75 arrangements between the NHS and Local Authority member organisations of the HCP, and as such does not have the authority as a Committee to exercise joint functions or hold or make decisions on a pooled budget arrangements.

The HCP is authorised to create any relevant sub-groups in order to take forward specific programmes of work considered necessary by the membership.

Meeting arrangements

The HCP will meet up to six times each year. Additional meetings may take place as required.

The HCP Chair, in consultation with and with the agreement of both Vice Chairs, may convene further meetings to discuss particular issues of relevance to the HCP and which cannot wait until the next meeting.

The HCP may meet virtually or in hybrid format when necessary and members attending using electronic means will be counted towards the quorum.

Meetings of the HCP will be held in public. Where meetings are held virtually, arrangements will be made to ensure members of the public can attend and be able to observe the meeting.

The HCP may convene development sessions, which will be held in private, and which will not be formal meetings of the HCP.

A copy of the agenda and related reports for each HCP meeting will be sent to each HCP Member at least five clear days before the date of that meeting. Agendas and papers for meetings held in public will be published on the website of NHS Cheshire and Merseyside Integrated Care Board

The HCP shall be supported with a secretariat function. In addition to publication of agendas and supporting papers the secretariat will prepare and circulate minutes of meetings within 10 working days and maintain an action and decision log, as well as a register of interests of HCP members.

As a Joint Committee of the ICB and the nine Councils, local authority members will be bound by their Council's Code of Conduct for the meeting and should declare any interests under that Code.

The Agenda for meetings of the HCP will be agreed by the Chair and Vice Chairs. Members of the Committee can request items to be considered at meetings of the HCP by contacting the Chair two weeks prior to the publication date of papers for the relevant meeting.

Reporting and Accountability

The HCP will receive reports from the nine Cheshire and Merseyside Health and Wellbeing Boards, which will inform its own priorities and strategy. and the HCP will also provide reports to the Health and Wellbeing Boards on matters concerning delivery of the Integrated Care System priorities and outcomes framework.

The HCP will also provide reports to the ICB, providing a summary of any specific programmes of work undertaken, including the issues considered and recommended actions, and any key outputs (in particular the Integrated Care Partnership Strategy) from its meetings.

Behaviours and Conduct

The HCP shall conduct its business in accordance with any national guidance. The seven Nolan Principles of Public Life shall underpin the committee and its members.

HCP members should:

- Inform the Chair of any interests they hold which relate to the business of the HCP.
- Inform the Chair of any previously agreed treatment of the potential conflict / conflict of interest.
- Abide by the Chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the HCP.
- Inform the Chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- Declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- Abide by the Chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.
- Abide by their own respective organisation's Code of Conduct.

As well as complying with requirements around declaring and managing potential conflicts of interest, HCP members should:

- Attend meetings, having read all papers beforehand
- Arrange for their substitute to attend on their behalf, if necessary
- Act as 'champions,' disseminating information and good practice as appropriate
- Comply with the HCP administrative arrangements including identifying agenda items for discussion, the submission of reports etc.
- Consider the equality, diversity and inclusion implications of the discussions they undertake at HCP meetings.

Review

The HCP will review its effectiveness, including these terms of reference, on an annual basis and earlier if required.

All Together Fairer

Recent Achievements and Health and Housing Data

Prof. Ian Ashworth
Director of Population Health

Working together to improve health and wellbeing in Cheshire and Merseyside

19th September 2023

All Together Further Programme Recent Successes

- **All Together Inspired** - our development programme for C&M
  - 7 Local Authority Leads attended the renowned Institute of Heath Equality (IHE)Social Determinants of Health Summer School in London in July. Development commenced with IHE on social determinants of health workshops to be delivered in C&M

- **Anchor Programme** is progressing at pace with **15** organisations signed up to the charter, **68** signed up to the Social Value Award. **5 Anchor Assemblies** have been held over the Summer to measure progress.
- **Fair Employment Charter – 84 Aspiring Level organisations** of the charter now in Liverpool City Region. Consultation period has now ended for Cheshire.
- **Children and Young People** – Draft framework developed and **300 CYP consulted**, thematically reviewed to ensure views are **reflected in the framework.**
- **Prevention Pledge** - First **Prevention Pledge Summit** being held 26th September – forum for all 17 trusts to share best practice and celebrate successes.

C&M population living in the 20% highest fuel poverty LSOAs that have medical conditions known to be affected by living in cold homes, by Local Authority area.

Population Segmentation - Patient Count

Population	Cheshire	Halton	Knowsley	Liverpool	South Sefton	Southport And Formby	St Helens	Warrington	Wirral	ICB
CVD										
Atrial fibrillation Register	19,494	3,215	3,471	10,514	3,938	4,059	4,615	5,126	8,908	**63,340**
Coronary heart disease (CHD) Register	26,394	5,490	6,589	19,211	6,312	4,989	7,448	7,556	11,234	**95,223**
Heart failure Register	9,637	1,498	1,792	6,091	2,122	1,747	2,184	2,285	4,498	**31,854**
Hypertension diagnosis Register	108,864	19,811	23,407	70,723	22,630	20,515	29,102	31,702	46,816	**373,570**
Peripheral arterial disease (PAD) Register	4,685	1,060	1,342	3,528	1,099	801	1,338	1,290	2,087	**17,230**
Stroke/TIA Register	14,853	2,484	3,030	9,887	3,221	3,086	3,430	4,052	6,281	**50,324**
Deprivation										
Core 20 Population **	86,093	61,090	102,929	325,955	66,727	16,930	78,767	42,067	114,138	**894,696**
Disability										
Learning disability register	3,299	855	1,057	3,140	757	851	1,024	985	2,253	**14,221**
Physical disability	10,121	3,750	2,203	9,029	3,172	2,339	2,608	3,279	6,297	**42,798**
Mental Health										
Depression diagnosis register	94,682	19,908	24,794	75,043	21,346	16,136	28,548	29,278	55,508	**365,243**
Severe Mental Illness register	6,417	1,257	1,910	7,872	1,955	1,414	2,084	2,090	3,508	**28,507**
Population										
Ladies on Pregnancy register **	1,503	669	1,194	2,487	622	432	1,237	874	1,115	**10,133**
Older people aged 65 and over **	145,578	21,930	25,954	75,745	27,616	30,034	33,393	39,311	63,685	**463,246**
Young Households (aged 0-4) **	24,205	4,743	7,118	19,371	5,572	3,483	6,614	7,448	11,505	**89,947**
Respiratory										
Asthma diagnosis Register <= 18	4,688	932	954	2,969	889	751	1,169	1,388	2,595	**16,335**
Asthma diagnosis Register 19+	39,620	7,104	7,495	25,276	7,862	6,729	10,690	10,997	16,935	**132,708**
Chronic obstructive pulmonary disease (COPD) Register	13,171	3,671	5,460	16,080	3,803	2,157	4,719	3,524	7,015	**59,600**
Total Population (LTCs Only)										
Total Population (LTCs Only)	237,580	45,062	53,919	165,518	50,606	42,884	64,517	70,030	114,569	**844,685**
Total	**362,787**	**88,783**	**126,060**	**401,411**	**100,902**	**65,315**	**123,868**	**115,164**	208,247	**1,592,537**

C&M population living in the 20% highest fuel poverty LSOAs that have medical conditions known to be affected by living in cold homes

Fuel Poverty: Conditions

This information is for decision support only, it should not replace full clinical review or be used in isolation to make a clinical decision

NHS

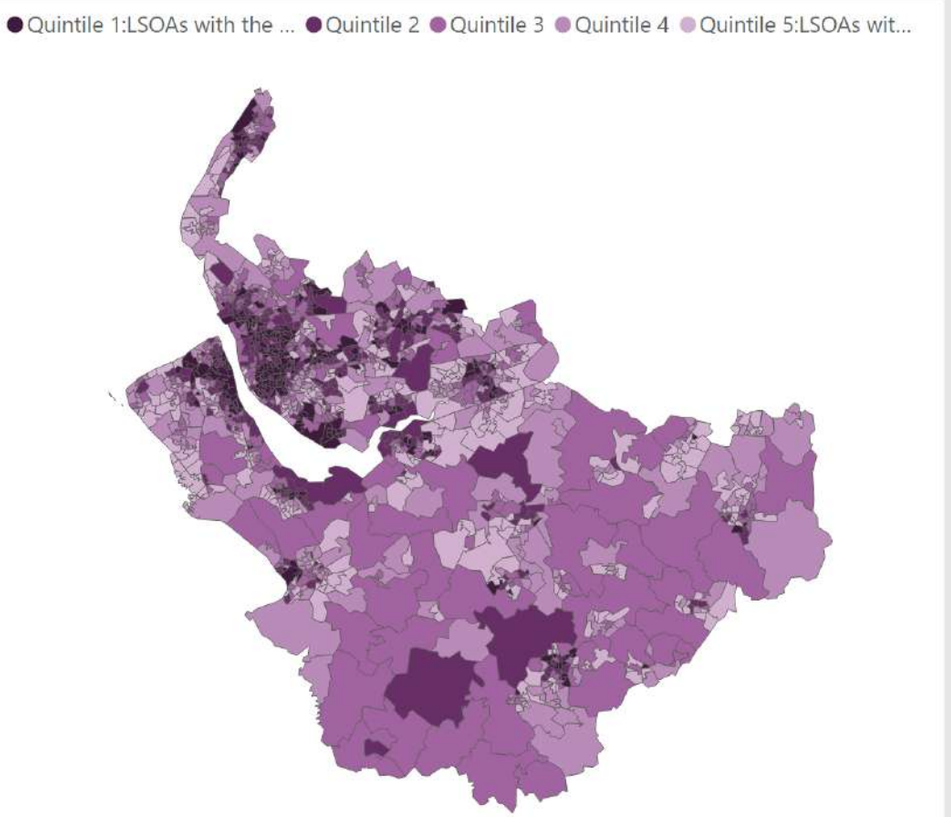
Show Filters | Clear Filters | No Filters Applied

Patient Count | % of Population | Rate Per 100K

Condition By Fuel Poverty Quintile

Cold Homes Condition	Quintile 1:LSOAs with the Highest % of Fuel Poverty	Quintile 2	Quintile 3	Quintile 4	Quintile 5:LSOAs with the Lowest % of Fuel Poverty
CVD					
Atrial fibrillation Register	9,344	11,350	13,311	14,614	13,946
Coronary heart disease (CHD) Register	18,019	19,633	19,549	19,108	17,902
Heart failure Register	5,921	6,380	6,693	6,592	5,924
Hypertension diagnosis Register	64,900	73,366	76,414	77,587	76,761
Peripheral arterial disease (PAD) Register	4,041	4,040	3,442	3,023	2,540
Stroke/TIA Register	9,276	9,938	10,374	10,387	9,782
Disability					
Learning disability register	3,751	3,715	2,688	2,141	1,803
Physical disability	10,868	10,533	8,277	6,838	5,838
Mental Health					
Depression diagnosis register	92,644	87,174	70,424	55,646	54,115
Severe Mental Illness register	8,694	7,396	5,329	3,697	2,985
Respiratory					
Asthma diagnosis Register <= 18	3,928	3,714	3,009	2,613	2,839
Asthma diagnosis Register 19+	27,605	28,380	26,355	24,055	24,462
Chronic obstructive pulmonary disease (COPD) Register	17,132	15,717	11,420	8,230	6,587
Total	**177,124**	**180,553**	**167,986**	**154,326**	**153,321**

Fuel Poverty Quintile By LSOA



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Graphnet Transforming Care

Cheshire and Merseyside HCP – Housing Summit
Meeting the current challenges in partnership

September 2023

Catherine Murray-Howard
Chief Operating Officer

Torus…

- 40,000 properties (Liverpool, Warrington and St Helen's – plus Wirral, Sefton and GM). Operating in some of the most deprived areas.
- Largest in the Northwest, includes £100m contractor and £5m charity (includes Firefit Hub in Toxteth).
- Spend over £100m per year on portfolio
- Building 1,000 new homes per year.
- Result of a merger (Torus and LMH). Mainly general needs…but…
- Lead provider in specialist provision - domestic abuse, mental health, learning disabilities services, extra care and sheltered living.
- Strong partner of other LCR housing associations and for Combined Authority.

Britain's Housing Shame: A story of shocking conditions and tenants' despair at a lack of action

HOUSING | Sunday 12 September 2021, 6:30am

Daniel Hewitt
Political Correspondent

The proposals in this White Paper will make clear the standards that every social tenant in England is entitled to expect from their landlords.

They will ensure that people feel safe and secure in their homes, can get problems fixed before they spiral out of control, and see exactly how good their landlord is at dealing with complaints.

– the idea that social tenants are less worthy of respect or can be ignored when their views are inconvenient – remains all too prevalent today.

The social housing sector…we spend every day trying to get this right…but that's becoming more difficult…

Why?

Challenges faced…'not just a landlord'

Quality of properties – requiring investment (damp and mould) Physical health needs

Increasing antisocial behaviour (ASB) – drugs and alcohol

We're having to intervene at crisis point

Cost of living

Our focus increasingly on being more visible – as other services reduce (prevention) expectation on housing…

Fewer support packages – complex needs living in general needs

Increasing numbers of complex families and individuals

Domestic abuse

Opportunities to work together…

- Shared strategic prioritisation
- Increased ‘in home’ services
- Data sharing opportunities – access to bespoke ideas
- Coalesce around focused themes - solutions

There are some current precedents that we can use to build our confidence…

Opening Doors

A partnership between housing, health and local authorities in Cheshire and Merseyside.

Its aim is to improve the lives of local people and to build the health and social care workforce of the future.

The project brings together tenants and of residents of housing associations and supports them so that they able to work in health, social care and other sectors.

www.torus.co.uk

Progress

- Pathway agreed to refer RSL and DWP clients into Primary Care Network across Greater Merseyside and Cheshire.
- Opening Doors Health and Social Care Employment and Skills event on the 11th October in Warrington.
- Working with NWAS, identified need for 60+ drivers with C1 Licences. Identified a pathway and funding with DWP and the Learning Foundry to remove barrier to access training. Starting work on recruiting people for the training.
- Opening Doors is contributing to three Steering Boards across St Helens, Knowsley, Halton, Sefton , Warrington and Cheshire East/West.
- In the last three months the Opening Doors Programme has assisted 36 people into employment ,30 into training and 25 have been referred into MIAA.

Respiratory/Asthma (Torus Foundation and Beyond)

Improving Indoor Air Quality for Children and Families within Social Housing delivered in St Helens, Warrington & Liverpool by Torus Foundation

- 202 monitor installations complete → Increased knowledge and understanding of indoor air quality
- 169 follow up visits/ phone calls complete → Families empowered to improve home environment
- 148 families receiving full support → Greater impact achieved through holistic wellbeing support
- 149 initial questionnaires complete → Data collected to support future development of Social Housing
- 79 follow up questionnaires complete → Evaluation complete and intelligence gathered

Questions for the discussion…

1. Considering all the collective challenges faced what can be agreed today to commit to working together to address them?
2. How might that work?
3. What do we believe the initial priorities should be?

MAYORAL PROGRAMME
DELIVERY

LCR Retrofit

LIVERPOOL CITY REGION COMBINED AUTHORITY

METRO MAYOR LIVERPOOL CITY REGION

LCRCA Retrofit Introduction

Map of local authorities in LCRCA

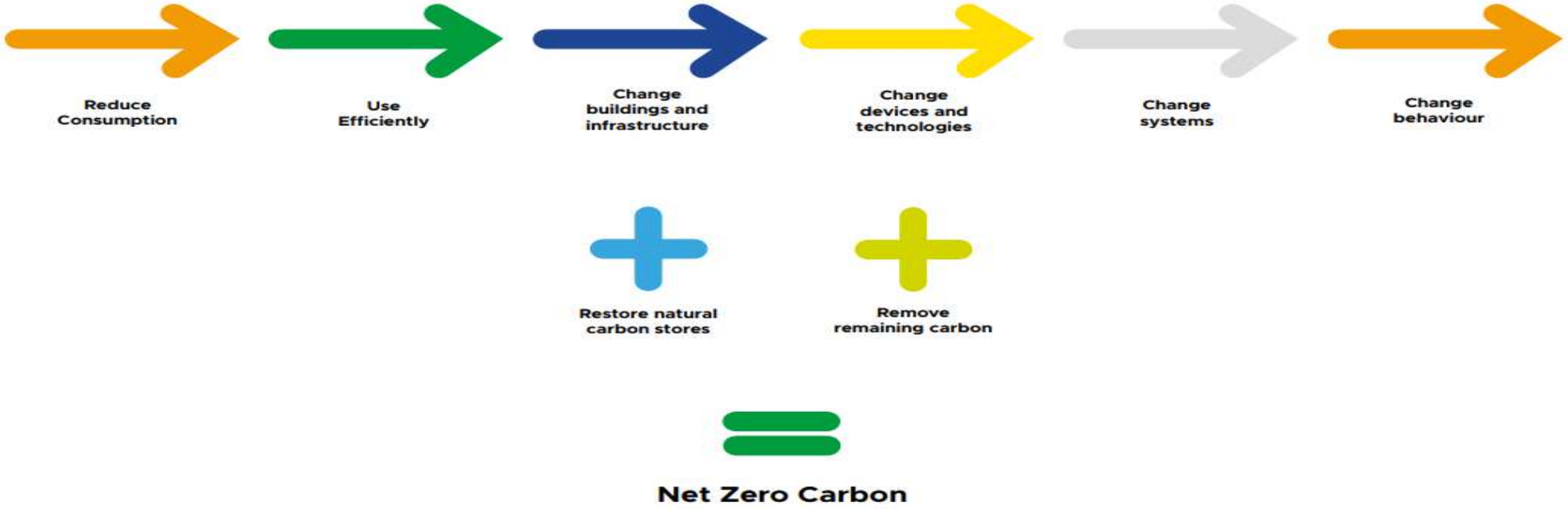
What things look like in the Liverpool City Region Now

There are currently 720,000 houses in the LCR, of which approximately 21% are RP properties

61% of houses in the LCR are EPC (Energy Performance Certificates) band D and below

Lower EPCs ratings mean residents spend more to keep their home warm

Five Year Climate Action Plan



What that looks like for housing in the LCR

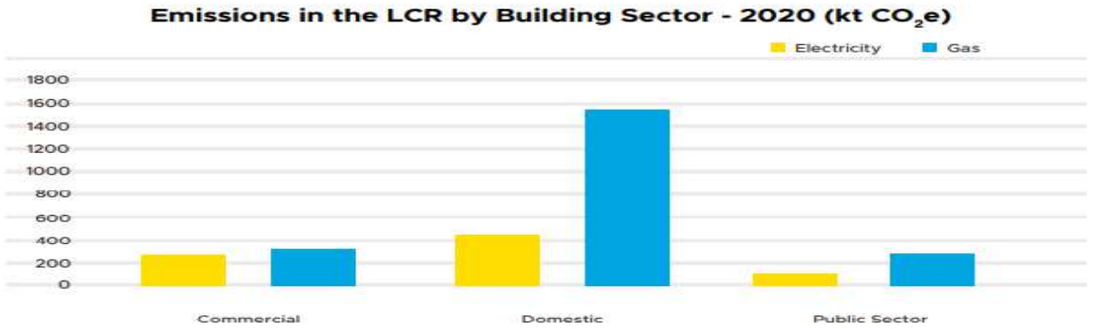
Buildings

Our Ambition

To **decarbonise** our existing housing and commercial stock to ensure that everybody has access to warm, energy-efficient spaces to live and work that produce no carbon emissions.

By 2040, no buildings will use fossil gas for heating or cooking and all grid electricity will be generated from clean, renewable sources. Many buildings will generate their own power using integrated renewable technologies and building energy use will have halved due to improved efficiency (through **retrofit**) and controls.

Upskilling in the LCR will ensure that the knowledge exists to meet demand to deliver large-scale energy-saving changes to buildings. We have launched the Green Jobs and Skills Plan to address the gap in skills that are needed to drive a **net zero** transition as well as improve prosperity in the LCR.



Domestic gas usage in 2020 accounted for the largest proportion of CO_2e emitted within the Liverpool City Region energy demand, within Government data. The Buildings pillar had the largest dependence on gas usage.

The data shows that with domestic properties making up the largest proportion of emissions within the Buildings sector, decarbonising our homes through uptake of energy efficiency and electrification measures will make an enormous contribution to achieving net zero.

What are the LCR doing?

- LAD schemes – delivered 4k retrofit homes improving EPCs
- SHDF
- HUG schemes
- ECO
- Solar Together

North West Net Zero Hub - LEAD

Demonstrator Programme to look at the challenges of energy advice

Learning from nationwide demonstrator will be used to inform and shape future programmes

Energy Projects Plus delivering Retrofit Buddies under the LEAD project in Cheshire and Merseyside

Pure Leapfrog delivering DEERAL specifically targeting private rented sector landlords to overcome the split incentive and encourage uptake with in the private rental sector – this is a Warrington based project

Challenges

- Short term cycles of funding
- Current funding that LCRCA are delivering is not targeted at a health funded focused funding stream
- Potential gap for joined-up thinking and ways of identifying similarities and ways of working

Discussion- Funding Solutions

- Building a pipeline of potential projects
- Prioritisation
- Collaboration

Cheshire and Merseyside Health Care Partnership Board

September 19th 2023

Cheshire and Warrington Housing

Steve Park
Director of Growth, Warrington Borough Council

John Laverick
Head of Housing and Development, Warrington Borough Council

Melissa Crellin
Strategy and Public Affairs Director
Cheshire and Warrington Local Enterprise Partnership

Introduction

- Sub-regional approach, through the Growth Directors and the LEP
- Sub-regional Housing Group – wide range of focus
- Liverpool City Region & Cheshire and Warrington Governance and powers.
- Sustainable & Inclusive Growth Commission.
- Retrofit programs through the Green Homes Grants process.

Green Homes Grant – Purpose and Objectives

Purpose

- Green Homes Grant, Local Authority Delivery (LAD) phases 1&2 was to raise the energy efficiency of low income and low EPC rated households (Bands E,F&G), later some Band D properties were included.

Objectives

- Tackling fuel poverty
- Supporting clean growth
- Supporting green recovery from COVID
- Creating jobs
- and to use learning to inform future schemes
- Average £10k per property

Programme

- 29th October 2020 – Agreement signed for Phase 1
- 29th June 2021 – Agreement signed for Phase 2
- 30th September 2022 – Tools Down
- 21st October 2022 – Draft Final Report
- 31st October 2022 – Draft Final Data
- 16th November 2022 – Underspend returned/final data issued/regional audits undertaken
- 30th December 2022 – Final NW audit complete and returned to BEIS

Green Homes Grant - Approach

- Central co-ordination through Net Zero Hub
- Devolved project management to sub-regions
- Cheshire & Warrington
  - PM on the ground in each – local knowledge
  - Local supply chains
  - Financial control through existing systems
  - Existing Council staff
  - Existing Council oversight and reporting
- Reporting back up through Net Zero Hub to BEIS

Green Homes Grant - Reporting

Key Project Indicators	Cheshire Warrington	Cumbria	Greater Manchester	Lancashire	Liverpool City Region	Totals
Homes targets	**544**	**391**	**1108**	**2,095**	**1,360**	***5,498***
No. homes completed	533	262	798	1,902	1,254	**4,749**
PIPELINE ANALYSIS (RAG)						
current highest no. homes/month installed (CAPACITY)	**123**	**58**	**181**	**488**	**212**	**1,062**
homes/month needed to install to hit target	**7**	**86**	**207**	**129**	**71**	**499**
Homes completed as a % of target	**98%**	**67%**	**72%**	**91%**	**92%**	**86%**
Underspend status?	On track to complete, but underspend due to cancellations and March MOU condition. LCR/Lancs trying to	estimated £1.6-£2.0M underspend	E.ON stating risk of £1.2-1.8m underspend at worst case	Likely to take on an additional £200-500k underspend	Likely to take on an additional £850k underspend	**Minor underspend likely ~£5.5M worst case (~8%), but more likely around ~£4M (~6%)**

north west net zero hub

Observations

- The programme for C&W is a success
  - No real barriers to delivery
  - The objective was to make a real, tangible difference to people, their homes and the environment
  - Rapid mobilisation
  - Achieved nearly all of what we set out to achieve
  - Over delivery following underspend in other regions
  - Resulted in recruitment and training for supplier companies
  - Suppliers were relatively small companies – SME
- The Programme for NW is also a success
  - Spending £52m on improving the thermal efficiency of the worst performing houses across the region
  - Picking up a further £4.34m of expenditure
  - Relatively low admin overhead
  - The lower performance were with the larger contractors
- Nationwide
  - It is understood that there has been significant underspend and therefore criticism.
  - Aecom report on overall impact is awaited

Conclusions

- To Celebrate
  - The measures delivered will have a real impact on carbon emissions and people's lives
  - A fabric first approach
  - 4,800 properties in NW are now significantly more efficient than they were
  - The flexibility in bands (D aswell as E,F & G) enabled added value in this programme rather than start a new one
  - A legacy of skilled people and businesses
  - A programme management approach gave the ability to transfer underspends across regions
  - Method of delivery was left to authorities and has worked well – local knowledge

- To Ponder
  - The lead in time was too short, greater notice would have given greater impact on the underspend
  - The team did not have a great deal of resilience
  - A programme management approach is good but data heavy
  - The short delivery period means more time is proportionately spent on reporting
  - How to take best advantage of the skills legacy
  - Discontinuity in these programmes will lead to loss of skills
  - How to upscale – there are still a huge number of low performing homes to tackle
  - Would be good to see for the C&M approach;
    - a 5 year programme to allow for proper planning, engagement with supply chains and training
    - Same programme management approach to keep control – but adequately resourced and planned
    - A broader range of properties that are eligible
    - Broader outcome metrics - total carbon saving per region from housing - reduction in household bills -

SIGC Retrofit Key Issues & Recommendations

- The sub-region lags behind the national average in terms of its green infrastructure - more houses have an EPC rating of Band ‘D’ or below compared to England
- Poor quality, poorly insulated housing worsens fuel poverty. In some areas in the sub-region, over 20% of households are in fuel poverty

Barriers and opportunities

- Cost and availability of finance for able to pay / cost of living crisis / tenure issues
- Availability of Skills and Supply chain
- Technical
- Consistent policy and funding
- Delivery partnerships with RP’s

The S&I Commission recommended:

- Connect suppliers and housing associations
- Creation of one or more fora for suppliers and housing associations to share policy advice and best practice
- Complete a piece of work to understand the barriers to housing retrofit and produce a roadmap to increase delivery
- Lobby government for consistent longer-term funding for housing retrofit schemes
- Include retrofit skills within green skills approaches

All recommendations are being progressed into delivery by local authority and LEP partners within the resources available and in partnership with the North West Net Zero Hub

Cheshire West and Chester Council Delivery

Scheme	Outputs
Green Homes Grant (GHG) 2021-2023	Phase 1a – 15 park homes Phase 1b – 19 park homes Phase 2 – 221 properties
Social Housing Decarbonisation Fund (SHDF) (2022-23)	Wave 1 - £1.3m grant + contribution 123 properties (average £10,570)
Home Upgrade Grant (HUG) 2022-25 - Off main gas network, so heated by LPG, Oil, electric or solid fuel, - EPC D-G - Insulation, clean heat and renewables	Round 1 - £684,250 completed Round 2 - £2,250,000 current
Solar Together launched across Cheshire and Warrington Group buying scheme (solar/battery)	2.5k+ people signed up across area
ECO - supports energy efficiency measures in the home of those considered to be in fuel poverty via an Energy Company Obligation	Delivery partner identified to increase uptake of energy efficiency measures
Energy Efficiency App	Launching next month

Cheshire East Council Delivery

Scheme	Outputs
Home Upgrade Grant phase 2 being delivered 1/4/23 to 31/3/25 –	Target 175 homes for Cheshire East (plus 125 for CWaC)
Social Housing Decarbonisation Fund Wave 1 is in its final stages	163 social housing properties being upgraded
Social Housing Decarbonisation Fund Wave 2 is underway – being delivered by The Guinness Partnership, Peaks & Plains Housing Trust and Plus Dane Housing.	Approx 200 social housing properties to be upgraded.
Energy suppliers and their supply chain are delivering ECO4 across Cheshire East	15,734 measures installed Jan-Jun 2023
The Council is operating an ECO Flexible Eligibility scheme to extend the reach of ECO4 to more vulnerable households	Additional 339 measures being installed

Workshop 1: Questions for the discussion…

1. Considering all the collective challenges faced what can be agreed today to commit to working together to address them?
2. How might that work?
3. What do we believe the initial priorities should be?

Cheshire and Merseyside Health Care Partnership

Supporting people with more complex needs – Learning Disability and Mental Health

Graham Hodkinson
Director of Adult Care and Health
Wirral Council

Clair Haydon
Consultant Occupational Therapist,
Clinical Director for Mental Health Complex Care for North West England
Interim AHP Lead – Cheshire and Wirral Partnership

Supporting People to live well at home

At a local level there is considerable amount of ongoing work to identify , plan and deliver support and accommodation to help adults and young people to live well in the community.

Understanding local need:

- Through Joint Strategic Needs Assessments

Meeting local needs:

- Commissioning strategies
- Market Position Statement

The range of community support includes:

- residential care
- nursing care
- extra care housing (that provides for vulnerable adults)
- accessible individual housing
- home adaptations (DFG) and Technology Enabled care
- self-contained flats in schemes with support
- home ownership (shared ownership)
- hub and spoke accommodation
- dispersed supported living
- step down provision
- step up or short-term crisis provision/safe spaces

What issues are we all facing?

- Demand for health and care services is increasing in volume and level of complexity
- Both health and care budgets are under pressure
- The level of ASC community provision and spend across C&M is above national average (learning disability and or autism)
- The range of community support, housing and accommodation varies by Place
- Both health and ASC have people in high-cost placements outside Cheshire & Merseyside

An example of local system work to help us to meet our collective challenge.

C&M work to improve housing offer for people with a learning disability and/or autism (LD & autism):

•Transforming Care programme commissioned a housing needs assessment from Campbell Tickell (April 2023), which has provided a comprehensive view of current and future need.

•Key points from the needs assessment include:

- •Good housing offer in each Place for people able to live independently or with support.
- •Challenges for people who live with parents/extended family if they are predeceased.
- •Need to develop offer(s) for people with more complex needs to:
  - •prevent the need for care in more restrictive settings and
  - •facilitate discharge from more restrictive settings.

People with severe autism

Deaf men with ld & a

Men with history of serious offences

Women with unstable personality disorder

Diagnosed mental disorder and ld & a

Using the needs analysis to inform joint work to increase housing choice: C&M Learning Disability & Autism (LD/autism) Housing Strategy

The majority of people with LD/autism across Cheshire & Merseyside are either living in shared supported living accommodation or are living with family. As a subregion we have above average numbers of people with a learning disability in receipt of long-term support, and above national average numbers of people having their housing need met through shared 24hr Supported Living. Whilst the type and volume of accommodation options varies by local authority, the most significant issue identified by all authorities is that housing options are limited and the market is dominated by 24hr shared housing, where residents have their own bedroom and share communal space. Our aspiration is to have a range of housing options, including:

- general needs housing
- extra care housing (that provides for vulnerable adults)
- accessible individual housing (in particular, one and two bed bungalows)
- self-contained flats in schemes with up to 6 flats clustered together
- home ownership (shared ownership)
- hub and spoke accommodation
- dispersed supported living
- step down provision
- step up or short-term crisis provision/safe spaces

C&M ADASS have commissioned Housing Lin to work with local housing providers, housing strategy leads and care and health staff to:

- Understand the housing needs of people with LD/autism and how partners across Cheshire & Merseyside can effectively address those needs based on the resources available,
- Inform a strategic approach to increasing housing options and to support a shift to own front door accommodation rather than shared supported housing
- Identify best practice and new models of care that can support residents in Cheshire & Merseyside to live independently
- Anticipate housing needs and have a proactive rather than a reactive approach
- Inform development of a subregional work programme to deliver strategic change
- Work to create a culture shift that means people with lived experience, their families, carers and professionals (clinical leads, social workers, housing staffs etc) view ‘own front door’ and general needs housing as the preferred choice for independent living

The longer-term desired outcomes for the LD/autism project are to:

- Give people with LD/autism increased options and choice over where they live
- See an increase in the number of people placed in ‘own front door’ and general needs accommodation
- See a reduction in the number of people placed in 24hr Supported Living and residential care
- Help people get their own home which is part of a local community and control over their own front door
- Give people choice and control over how their care and support is provided, with this agreed separately to their accommodation
- Offer timely, appropriate and person-centred care and support which promotes independent living, helps people connect to their family, friends and community, and helps keep them safe
- See a reduction in the number of inappropriate hospital admissions relating to a tenancy breakdown
- Anticipate housing needs and housing environmental changes before a crisis occurs

Timeline

- Housing Lin are currently collating feedback from partners
- An initial summary of feedback will be drafted by October 23
- A draft strategy will be drafted by November 23

Case study – Alex

- Alex is a gentleman in his late 40s who has been well known to NHS mental health and learning disabilities since he was a teenager. He has diagnosed mental health problems and a learning disability.
- As a teenager he had already been admitted to hospital wards on occasions as an informal patient however, in 1990 he was detained under the Mental Health Act 1983 (MHA, 1983).
- Following this initial detention, 3 years later Alex was detained once again where he remained in hospital until 2011.
- Alex was discharged into the community to a supported living model of care but it is reported that this broke down very quickly. He was then detained once again under the MHA1983 later that same year.
- Alex transferred to a specialist independent hospital in 2012 where he continued to be detained under the MHA1983. 2 years later he was then transferred to a locked rehabilitation ward.

"He didn't cope well the last time!" ***"He's very risky!"*** ***"There will be a high level of staff burn out!"*** **"He will likely be readmitted!"** ***"He's dangerous!"*** ***"He won't manage in the community!"*** ***"He will need 4 staff to support him***

- Due to the previous supported living placement being unsuccessful there was a reluctance to discharge Alex as it was felt that Alex required a hospital setting.
- Commissioners were keen to discharge Alex to a least restrictive setting however, some of the Multi-Disciplinary Team were against this transition

- **Where is Alex now….**
- Due to Alex's consistent calm and relaxed presentation, the Community Learning Disability Team have now discharged Alex.
- Alex has now been in the community for nearly 5 years with no significant incidents reported or witnessed

Mental Health context

"For people living with serious mental illness, housing can be a critical factor in helping people to live as independently as possible, while also accessing the support they need to live and thrive in local communities". (NHS Confed 2022)

Current context/challenge

- Increased pressures on Mental Health (MH) services, high bed occupancy and limited local inpatient capacity often leads to people waiting for an admission increasing pressure on the whole system i.e., Social Care, Urgent and Emergency Care including Acute hospitals, Police etc
- Variance across the region in the provision of MH acute care, with CWP having a consistent lower than national average bed base (by both registered and weighted population) and seeing increasing numbers of people needing to access out of area acute inpatient treatment at a significant financial cost to the system and personal cost to the person and their support networks.
- People from across C&M accessing inpatient MH rehabilitation out of area, often due to limited capacity and step down options
- Increased beds results in less money for the community and fewer people being able to access MH support, e.g., 1 adult acute bed = 40 patients on a generic CMHT caseload (NHSBN 2022).
- Systems report higher acuity and more people presenting in crisis needing inpatient care
- Significant issues with workforce (high vacancy and absence rates) in MH inpatient care affecting bed capacity, the therapeutic offer and recovery rates
- Flow has been an issue in the past year with 25% of MH acute inpatients in C&M becoming 'stranded' in MH acute care (having an inpatient stay of over 60 days) and 15% were "super-stranded" (length of stay of over 90 days)
- In C&M on Monday 28th August 2023 approximately 6% of all inpatients in acute adult MH beds were delayed waiting for housing/accommodation. (source- MHLDA SitRep)
- Currently there is no systemwide understanding of what the housing needs of this and wider MH cohorts are and limited data on all inpatient activity, especially outside of main provider trusts to inform strategic planning

A system issue, needs a system solution..

- The Inpatient Quality Programme, MH GIRFT (Getting it Right First Time) programmes and the Community Mental Health Transformation all highlight the role appropriate housing has in reducing reliance on inpatient care and transforming community services to be able to meet people's needs with the right skills, at the right time, in the right place, by working as a system.

- Health has an important role in supporting ASC, Housing and support providers in being able to develop and offer sustainable housing options especially for those with greater needs or whose only previous option would have been hospital, this is illustrated in the NW MH Community Rehabilitation model by providing:

  - **Specialist rehabilitation intervention-** to optimise a person's functioning, well being and time in the community; using personalised care planning to support people transitioning out of hospital and development of activity of daily living skills and responsibilities necessary for maintaining a home. To identify optimum levels of support to enhance the person's well being, ongoing recovery and greater independence
  - **Advice and consultation-** between agencies/ partners including in-reaching into housing and support providers, to increase skills, manage complex situations, provide professional advice and support, and increase resilience
  - **Oversight and effective review of the whole rehab pathway-** in and out of area, always looking to local least restriction. Contributing to the oversight of community complex care packages to enable flow through current provision and increasing local capacity for those that need it
  - **Co-produced pathway development and strategic focus-** working collaboratively to improve data, identify housing needs and gaps in provision, ensure best use is made of resource and explore financial sustainability of new integrated pathways of care and support for the system

Case studies – Mental Health

Where it is working well with MH community rehabilitation wrap around:

- Mr Z
  - 21, complex MH needs, numerous lengthy hospital admissions from a young age- never lived independently
  - Refused supported housing offer due to significant self harm risks
  - Worked with LA and Housing to secure independent flat with wrap around responsive support
  - Discharge early 2012, maintained flat, in paid employment and no further admissions to hospital
- Mr X
  - 30, serious mental illness
  - Inpatient for over 10 years including in secure services
  - Ongoing symptoms, illicit substance misuse and threatening behaviour
  - Supported housing would only accept with 8 hrs daily 1:1 support- which wasn't clinically indicated
  - The team worked with housing provider providing training and coaching
  - Discharged from hospital 2 years ago with 4hrs 1:1- no return to hospital

Ongoing challenges:

- Ms Y
  - A 33 year old with complex mental health history and co-morbid substance misuse issues.
  - She is not ready to address her drug use and this leads to a chaotic lifestyle.
  - Prior to admission she was living independently but set fire to her mattress and is now deemed a fire setting risk
  - She is currently in an acute mental health ward and has been CRFD for over a year
  - The community rehab team are working with her to help her mitigate risks.
  - In terms of her presentation and needs she would be better with an independent tenancy but her lifestyle choices and recent fire risk is making it hard to find her housing.
  - She is with the community rehab team so her health offer in the community will be intensive and responsive

provided by Cheshire and Wirral Partnership

Supporting people with Mental health conditions to live well at home.

Building on the work by the transforming care partnership and C&M ADASS, C&M ICB lead for Mental Health and CM ADASS plan to work together over the next 6-12 months to develop the following:

- An analysis of health, care, accommodation and housing needs across C&M
- Development of a housing and community support strategy,
- Development of a corresponding strategy for community health provision that can support people to remain at home should they become unwell, preventing tenancy breakdown and admission to hospital

Workshop 2:
What can we do by working as partners at a Cheshire and Merseyside footprint to accelerate our work?

HCP Focus Session: Children and Young People Tuesday 14 November 2023

HCP Board – November 2023

Focus of the Session

Children and Young People – A system approach

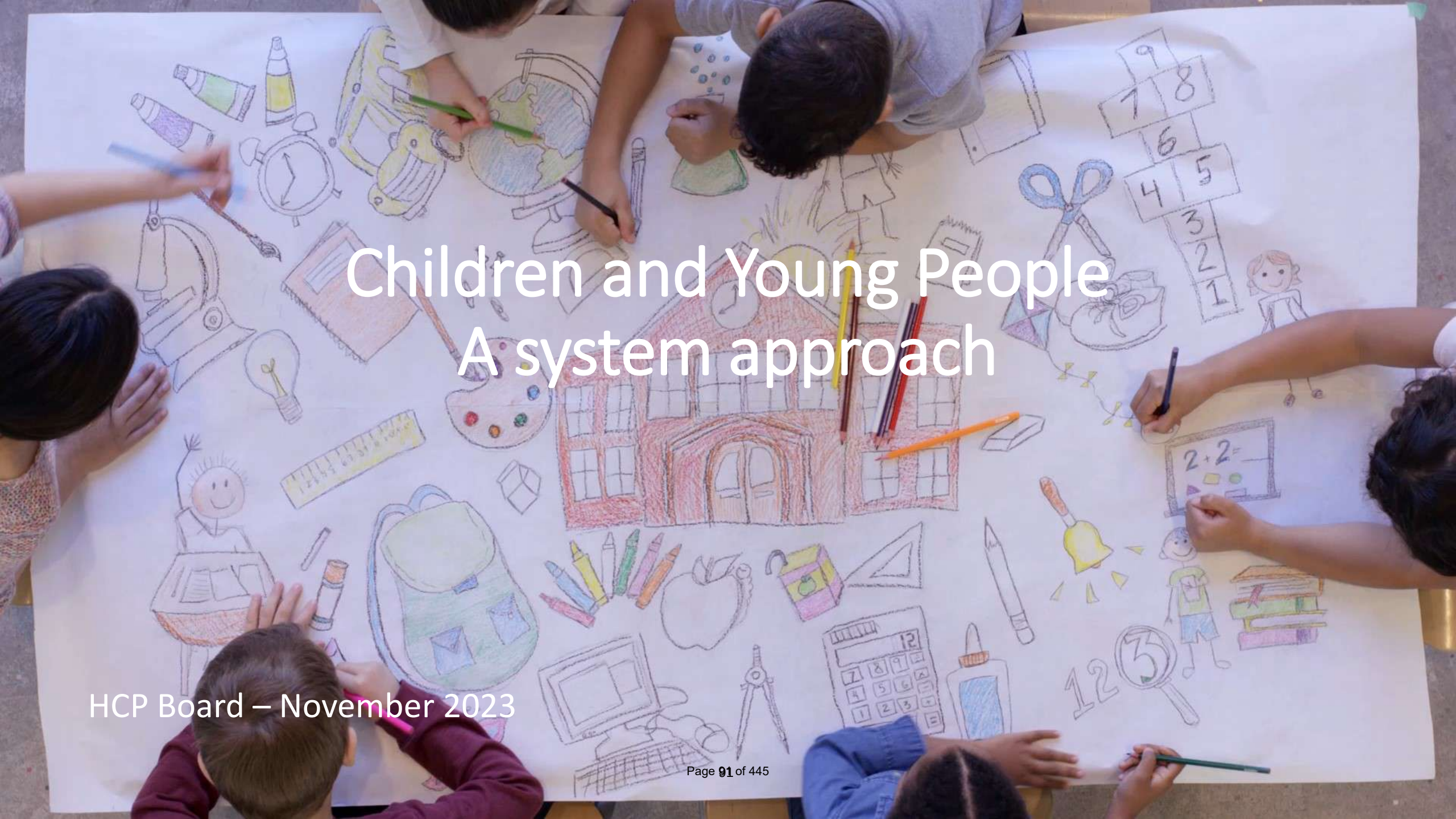
- Introduction to Children's Services including the role of DCS / lead member, statutory legislation/ guidance and the role of the Corporate Parent: **Jenny Turnross (DCS Liverpool)**
- Overview of Beyond Programme: **Liz Crabtree**
- Update on the new CYP ICB Committee: **Dani Jones**

Addressing gaps in care

- Progress update, work to date, forward plans and presentation of a case study**: Liz Crabtree/Amanda Perraton (DCS Warrington)**

Breakout groups and facilitated session

- What can HCP do to support this agenda?
- How can the HCP influence joint funding models?
- What other areas of health and social care integration for children that can be explored?



Children and Young People
A system approach

HCP Board – November 2023

Children's Services - Context

- The Director of Children's Services (DCS) (and lead member) have statutory responsibilities for delivering effective children's services and providing corporate leadership to champion the needs and improve outcomes for children and young people including the most disadvantaged and vulnerable, families and carers.
- The Children Act 2004 established the positions as a clear line of accountability for children's outcomes.
- There are over 200 statutory duties covering education and children's social care.
- The Inspection of Local Authority Children's Services (ILACS) by Ofsted is the external scrutiny. SEND is a joint inspection with ICB. In addition, the Joint Targeted Area Inspection covers partners and including, the Care quality Commission (CQC), Her Majesty's Inspectorate of Constabulary, Fire and Rescue Services (HMICFRS) and Her Majesty's Inspectorate of Probation (HMI Probation).
- Effective child safeguarding arrangements rely on joint working across a number of different agencies. As outlined in Working Together 2018 (factually updated 2022, will be amended as per Stable Homes, Built on Love), there are three statutory safeguarding partners – Local Authority, ICB and Police.

Children's Services – Functions

- Section 10 places a duty on local authorities and certain named partners (including health) to co-operate to improve children's well-being. The DCS must lead, promote and create opportunities for co-operation with local partners - **health, police, schools, housing services, early years, youth justice, probation, higher and further education, and employers -** to improve the well-being of children and young people.
- The DCS will have a clear role in driving the development of the local Joint Strategic Needs Assessment (JSNA) and joint health and wellbeing strategy.
- Section 11 requires local authorities and other named statutory partners to make arrangements to ensure that their functions are discharged with a view to **safeguarding and promoting the welfare of children**. There is a similar requirement imposed on schools. The DCS should ensure that there are clear and effective arrangements to protect children and young people from harm (including those attending independent schools).
- The DCS works with partners to promote **prevention and early intervention** and offer early help so that emerging problems are dealt with before they become more serious. This will help to improve educational attainment, narrow the gaps for the most disadvantaged and promote the wider well-being of children and young people, including at key transition points
- Working with headteachers, school governors and academy sponsors and principals, the DCS **promotes educational excellence** for all children and young people and tackles underperformance
- In addition to that of a provider of services, the DCS is also a commissioner particularly for health services such as public health and mental health provision

Children's Services – Examples of Duties

- More specifically:
  - has a shared responsibility with all officers and members of the local authority to act as effective and **caring corporate parents for looked after children and care leavers**, with key roles in improving their educational attainment, providing stable and high quality placements and proper planning for when they leave care
  - Responsible for **children in need, child protection, fostering and adoption**
  - must ensure that **disabled children** and those with **special educational needs (SEN)** can access high quality provision that meets their needs and fund provision for children with statements of SEN;
  - must ensure arrangements are in place for **alternative provision for children outside mainstream education or missing education** (e.g. due to permanent exclusion or illness) to receive suitable full-time education;
  - should ensure there is coherent planning between all agencies providing services for children involved in the **youth justice system** (including those leaving custody), secure the provision of education for young people in custody and ensure that safeguarding responsibilities are effectively carried out
  - should understand local need and secure provision of services taking account of the benefits of **prevention and early intervention** and the importance of cooperating with other agencies to offer early help to children, young people and families

Children's Services – Examples of Duties

- The DCS promotes the interests of children, young people, parents and families and work with local communities to stimulate and support a diversity of school, early years and 16-19 provision that meets local needs which includes:
  - **fair access to all schools for every child** in accordance with the statutory School Admissions and School Admissions Appeal Codes and ensure appropriate information is provided to parents;
  - suitable **home to school transport** arrangements;
  - **a diverse supply of strong schools**, including by encouraging good schools to expand and, where there is a need for a new school, seeking proposals for an Academy or Free School;
  - **high quality early years provision**, including helping to develop the market, securing free early education for all three and four year olds and for all disadvantaged two year olds10, providing information, advice and assistance to parents and prospective parents.
  - access for young people to **sufficient educational and recreational leisure-time activities** and facilities for the improvement of their well-being and personal and social development;
  - **children's and young people's participation in public decision making** so they can influence local commissioners; and
  - **participation in education or training of young people**, including by securing provision for young people aged 16-19 (or 25 for those with learning difficulties/disabilities)

The importance of the ‘Corporate Parent’

1. **Legal Responsibility**: Corporate parents have a legal duty to safeguard and promote the well-being of children in their care, much like biological parents.

2. **Consistency, stability, and accountability**: Corporate parents aim to provide stability and consistency in a child's life. They ensure accountability for the care and outcomes of children in their care, providing oversight and support to social workers and other agencies responsible for child welfare.

3. **Advocacy**: They act as advocates for the child's rights and needs, working to ensure that they receive appropriate education, healthcare, and emotional support.

4. **Long-Term Planning, monitoring, and review**: Corporate parents often engage in long-term planning for children in care, helping them transition into adulthood with the necessary life skills and support. Regular monitoring and review of the child's progress are essential to ensure that their best interests are met, and necessary adjustments can be made as needed.

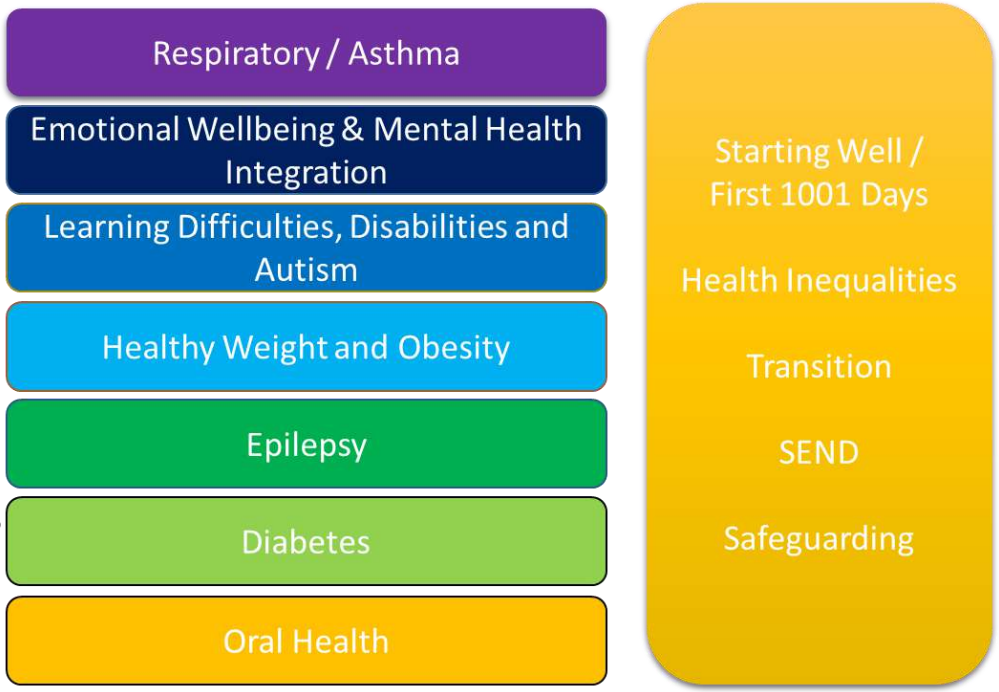
5. **Collaboration and resource allocation**: Corporate parents collaborate with various stakeholders, including social workers, foster families, and schools, to create a comprehensive network of support for the child allocate resources, including financial support, to provide a safe and nurturing environment for children in care.

Update on the Beyond Programme

HCP Board – November 2023

CYP Transformation Programme

- Established April 2021, hosted by Alder Hey from July 2021
- Funded via ICB / NHSE
- Reflective of Place, Partnership, and Programme Priorities reflecting JSNAs and Place plans
- Population health focus
- Shift Left in delivery to prevention and early intervention
- Multi-agency design and delivery – strong links across Social Care and Health
- Facilitative approach – sharing best practice, co-designed solutions, "system knitting"



Main Workstreams	Existing HCP / ICB mandates	NHS Long Term Plan	The National Children's Transformation Programme	CORE20+5 CYP	All Together Fairer	The Health Equity Collaborative
Respiratory / Asthma	✓	✓	✓	✓	✓	✓
EWB & MH	✓	✓	✓	✓	✓	✓
LDD & A	✓	✓	✓	✓	✓	✓
Healthy Weight & Obesity	✓	✓	✓	✓	✓	✓
Epilepsy	✓	✓	✓	✓	✓	✓
Diabetes	✓	✓	✓	✓	✓	✓
Oral Health	✓	✓	✓	✓	✓	✓

- Improving population health including safety and quality improvement
- Tackling impact of health inequalities
- Ensuring the voice of CYP, parents and carers informs design and delivery
- Enhancing productivity and value for money
- Support broader social and economic development

Since its foundation, the Beyond Programme has reached over 44,000 CYP, families and professionals through 32 projects.

beyond
Children and Young People's Transformation Programme

The Beyond23 Conference took place in March 2023 and was attended by 98 colleagues from across C&M. This was informed through engagement events across the region attended by 32 Children and Young People

In 2022/23, the Beyond Programme funded 15 projects.

We have captured feedback from 71 young people, supporting the Health Equity Collaborative

Since 2021, Beyond has been successful in 15 bids, totaling over £1,700,000.

Face to face Team of Life training attended by 185 professionals from NHS, Local Authorities, Third Sector and Schools.

37 attendances at Community Network Neurodevelopmental Access Groups

246 CYP have been supported through Complications of Excess Weight Clinics

200 Indoor Air Quality Monitors have been installed, and 169 follow up visits.

Respiratory Parent Champions have supported over 558 families, and 700 professionals through awareness raising, education-based programmes, early intervention and outreach activities.

83 families of CYP with Neurodevelopmental Needs referred for Sleep Management support

Training has been delivered to 128 early years staff on supporting healthy weight.

261 CYP have been moved onto diabetes tech – including CGM monitors & pumps

351 individuals have benefit from open access to psycho-social education through social care, education and direct community self-referrals.

36 asthma review and inhaler technique checks completed in pharmacies

13,494 calls have been managed by the Paediatric Clinical Advice Service resulting in 7% reduction in Children and Young People being referred to A&E and 6% increase in CYP cases being completed after triage, reducing onward referrals.

57 YP with diabetes have been supported in the transition from Paediatric to Adult Services.

Air Quality Monitoring

- Partnership with Torus Housing
  - 202 installations completed
  - 169 follow up visits/ phone calls completed
  - 148 families receiving the full journey of support
  - 149 initial questionnaires completed
  - 79 follow up questionnaires completed

  - Identification of new and/or monitoring existing concerns about IAQ
  - Using monitor data as evidence; lending authority to complaints
  - Transparency / accountability (relationship with housing provider)

"I feel confident now about indoor air quality, I didn't realise how using things like different sprays can cause issues and the things I can do instead to help my family"

"The red light is really helpful. When this flashes I open my doors and windows to encourage ventilation"

"When I first got the monitor, I wasn't impressed. I have been complaining for months about the damp, so when the team turned up, I thought it was a waste of time …….. It has provided good evidence to cement my complaints,."

The issues have been causing the damp have been repaired:

- Renew kitchen window, reseal all other windows, repaint
- Complete Environment works

"You've been amazing thank you. I really understand it now the way you've explained it all and what it means. I never realised the impact things like sprays and cleaning products could have" (tenant also supported with damp concerns in relation to a roof/ gutter issue.)

Parent Champions Bronchiolitis

- **Koala – Wirral; Cheshire West and Chester**
  - 10 Parent Champions
  - 197 direct support offers
  - 2021 outreach contacts
  - 766 professionals supported
  - 51 ongoing phone support
  - 10,400 social media reach
- **Torus Housing – Warrington**
  - 12 parent champions
  - 289 volunteer hours
  - 79 engagement activities
  - 215 families supported
- **St Helens Wellbeing**
  - 8 Breathe buddies recruited
  - 74 enquiries
  - 68 parents engaged with programme
  - 11 referrals to GP
  - 10 referrals to Asthma team
  - 6 referrals to housing

We delivered a session in partnership with Warrington Voluntary Action. We met a lady who we supported through the Healthy Lungs Project. On the back of this, she opened up about issues with her housing, as well as struggling to put food on the table for her children. As a result, we supported her, linking her in with her landlord to report her issue, as well as locating and generating a food bank voucher, and linking her with the local food pantry, and community shop.

“Thank you for listening to me, I was beginning to think there was something wrong with me and that I might have been depressed now I know I'm just feeling normal things".

“It's amazing that these Mums don't have to go it alone and feel as isolated as we did because we're there for them!”

“I was literally at breaking point, sleepless nights and starting to overthink every little thing.”

We met a lady on 22/5/23 at the new tots group. Her first reaction to us explaining the parent champions project was “oh my gosh, it’s like you’ve been sent to me, this is just what I need!”. She is constantly worrying and cannot sleep as she is listening to her child’s chest at night, scared she will stop breathing, her anxiety is very high. We sat and listened to her, gave her a copy of the breathing games exercises to try at home and encouraged her to make an appointment with her GP. She has since seen the GP and have prescribed her something to relieve the anxiety, and also referred for sleep study support. She has also signed up to be a parent champion herself!

C&M CYP Committee Update for HCP

HCP Board – November 2023

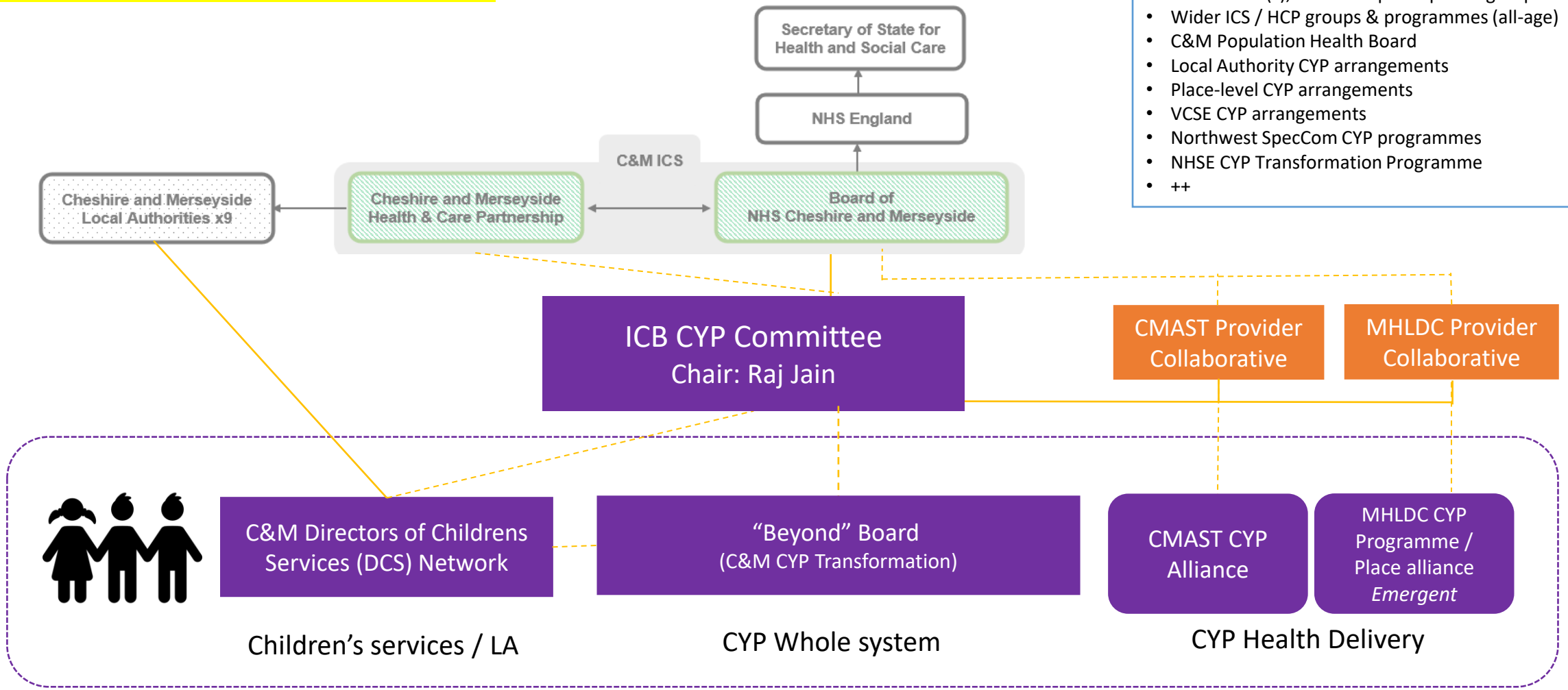
CYP Committee – Terms of Reference

- The Committee's main purpose is to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:
  - **Children and young people (aged 0 to 25)**
  - **Children and young people with special educational needs and disabilities (SEND)**
  - **Safeguarding (children and young people), including looked after children.**
- The Committee will oversee the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensure effective system focus on Children and Young People as a population cohort.
- The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.
- The Committee will have a key role in ensuring that the voice of and needs of Children and Young People are prominent in the discussions and decisions of the Board of NHS Cheshire Merseyside.
- The Committee will provide, seek and receive assurance and intelligence from other key forums and Committees which have a role in the oversight of assurance or planning

Integrated Care System (ICS) CYP Governance – Snapshot @ C&M Level

Key Interdependencies:

- CYPF forum(s), voice and participation groups
- Wider ICS / HCP groups & programmes (all-age)
- C&M Population Health Board
- Local Authority CYP arrangements
- Place-level CYP arrangements
- VCSE CYP arrangements
- Northwest SpecCom CYP programmes
- NHSE CYP Transformation Programme
- ++



CMAST = C&M Acute & Specialist Trust Provider Collaborative
MHLDC = C&M Mental Health, Learning Disability & Community Provider Collaborative

NB: Beyond also currently reports via ICB DCTI Assurance Board to ICB Transformation Committee.

CYP Committee – 1yr Plan

Q3 23/24	Q4 23/24	Q1 24/25	Q2 24/25

CYP Committee Strategy development (6-12 months)
- Alignment with HCP Priorities

CYP Dashboard – Improving our Intelligence (9 months)

Initial Priorities (Now - 6 months +)

Theme	Focus	What does this mean for CYP?
MH & EMW	CYP 'Between the Gaps'	↑ Appropriate Places of Care ++
	MH Transformation Plan	System-wide MH Plan – outcomes TBA
Neurodiversity	CYP Neurodiversity Pathway work	Meeting the needs of CYP & families; addressing demand and variation e.g. New Models of Care ++
	C&M Standards	
Oral Health	CYP Oral Health Improvement Programme	Oral Health @ scale - targeted to high deprivation = fewer caries, less dental pain / missed education, fewer GA's / theatre time ++)
CYP @ Edge of Care	'Thought Leadership' piece (supported by Deloitte)	Influence Strategic Commissioning & CYP / Prevention emphasis and investment ++

High vulnerability, opportunity &/or demand

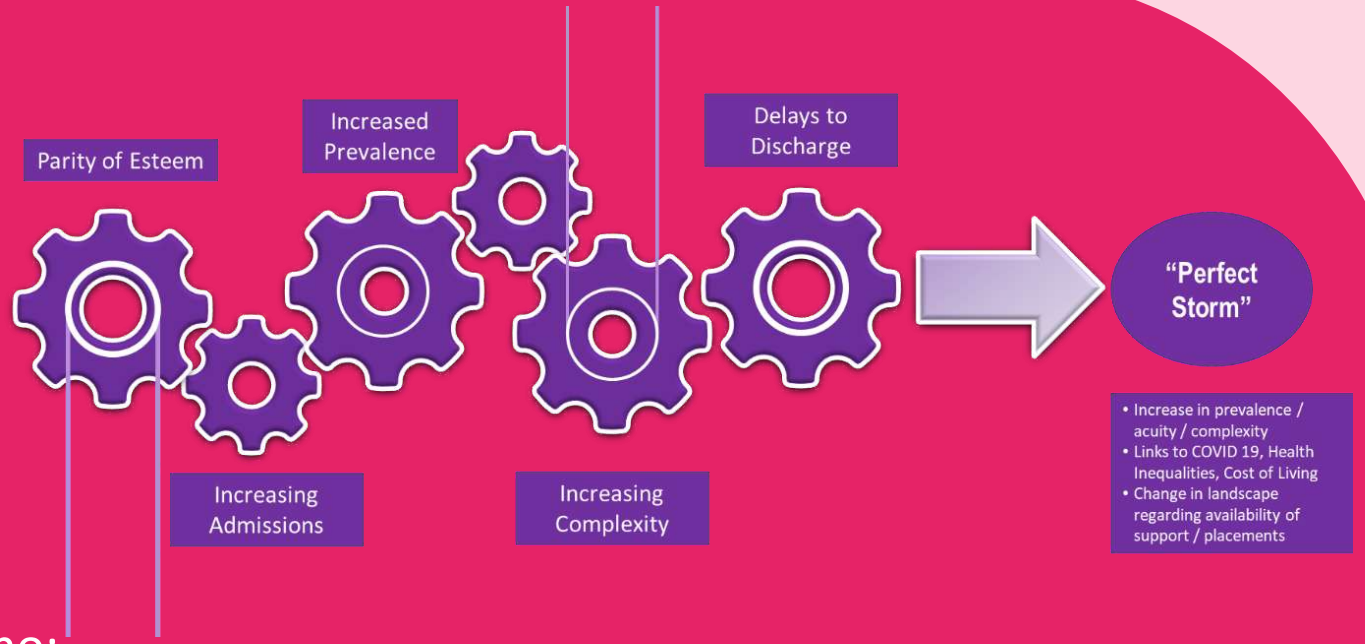
Addressing Gaps in Care

HCP Board – November 2023

Supporting Children who "fall between the gaps"

CAMHS review:

- Agreed Core Offer for CAMHS
- 24/7 Crisis support
- Complex Needs Escalation and Support Tool
- Risk Stratification Tool
- Establishment of Gateway meetings

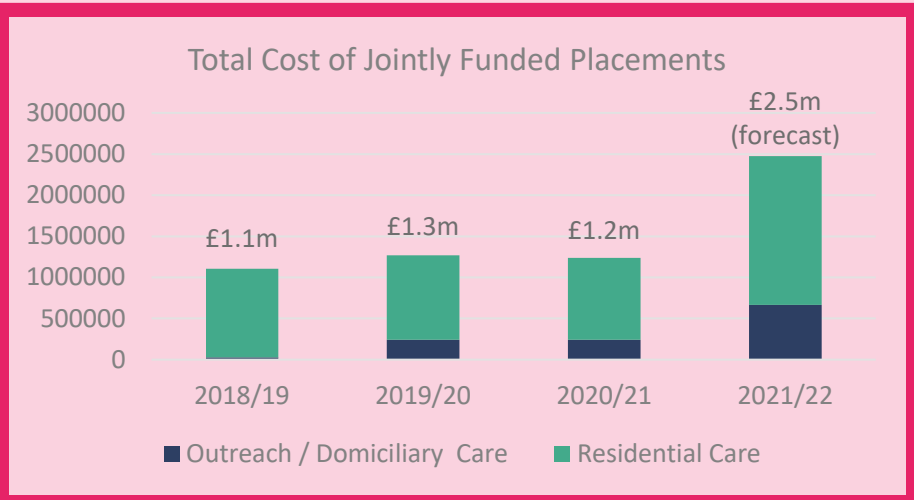


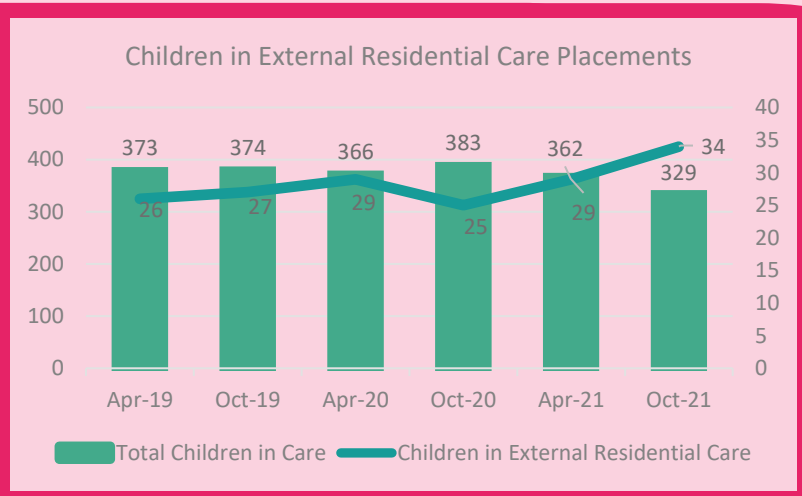
A cohort of children remain who:

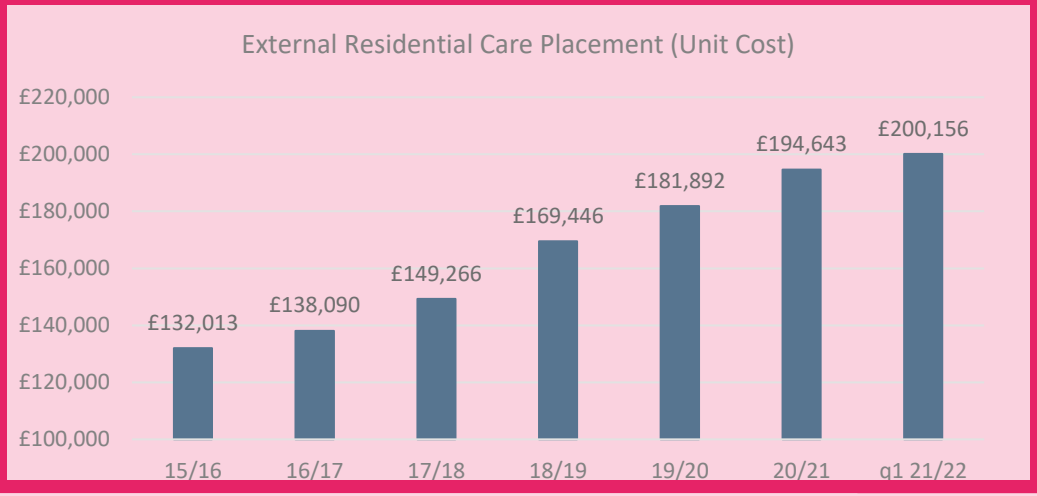
- cannot be supported in their family home
- are not assessed as being suitable for Tier 4 inpatient CAMHs provision
- and where Local Authorities are unable to source regulated provision that can meet the breadth of a child's or young person's (CYP) needs.

There is a clear gap in cross-system commissioning for appropriate models / services to meet the needs of these young people.

Supporting Children who "fall between the gaps"







** Warrington Example*

Supporting Children who "fall between the gaps"

Beyond / DCS Forum Convening System response

Developing Place centred approaches that:

- Prevent avoidable admissions
- Optimise the length of stay / experience if care is required
- Keep solutions local and owned in place within a shared ICS wide model.
- Move from reactive to proactive care – providing anticipatory solutions to health / social care gap

Working Groups to cover:

- The regulatory regime: how do we work as a system to influence Ofsted and CQC.
- Data
- Best Practice: from within and outside of the region
- Model development
- Immediate response – developing short term crisis response model as an interim system solution at place/scale.

Ask of the Children's Committee

- Support for the cross-system approach to finding solutions
- Utilising system support to:
  - Unlock data sharing as needed across health / social care
  - Consider business case/s for innovative solutions
  - "Invest to save" opportunities – need for shared budgets across health / social care
  - Provide support from joint, cross-agency commissioning
  - Work with regulatory bodies to support innovation / new models of delivery

Discussion and Breakout Session

HCP Board – November 2023

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Report of the Chief Executive

Agenda Item No: ICB/11/23/08

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (November 2023)

1. Introduction

1.1 This report covers some of the work which takes place by the Integrated Care Board which is not reported elsewhere in detail on this meeting agenda.

1.2 Our role and responsibilities as a statutory organisation and system leader are considerable. Through this paper we have an opportunity to recognise the enormity of work that the organisation is accountable for or is a key partner in the delivery of.

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates as outlined within the report
- **approve** the Terms of Reference for the ICBs Thirlwall Inquiry Task and Finish Group
- **note** the decisions undertaken by the Executive Team.

3. Key updates of note

3.1 **Thirlwall Inquiry.**

The Terms of Reference for the Inquiry have now been published.[1] These Terms of Reference set out that the Inquiry will investigate three broad areas:

- the experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.
- the conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently
- the effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

Additionally on the 22 November 2023 Lady Justice Thirlwall delivered a video message entitled ‘Chair’s Opening Statement’, which can be accessed via the dedicated Thirlwall Inquiry website: https://thirlwall.public-inquiry.uk/. In the opening statement, Lady Justice Thirlwall indicated that the inquiry is likely to begin hearing evidence in September 2024.

3.2 Since my last update to the Board, the ICB has established a Thirlwall Task and Finish Group, Chaired by Christine Samosa, ICB Chief People Officer. The role

[1] https://www.gov.uk/government/publications/thirlwall-inquiry-terms-of-reference/thirlwall-inquiry-terms-of-reference

of this group is to provide oversight, guidance and assurance to the Board regarding the response for the ICB and its predecessor organisations to the public inquiry into the circumstances surrounding the crimes of Lucy Letby at the Countess of Chester Hospital. It will be responsible for developing the response to the Thirlwall Inquiry, and approving evidence collation and submission to the Chair of the Inquiry. The Task and Finish group will ensure systems and processes are in place to ensure the delivery of the ICB response to the Thirlwall Inquiry and will also review and embed learning from the inquiry and identify improvement opportunities. The Terms of Reference for the task and Finish Group is appended to this report and **Board is asked to approve these Terms of Reference**.

3.3 The ICB has also appointed Mills and Reeve as the ICBs Solicitors for the Inquiry and has applied for Core Participant status. A core participant is an individual, organisation or institution that has a specific interest in the work of the Inquiry, and has a formal role as defined by legislation. Core participants have special rights in the Inquiry process. These include receiving disclosure of documentation, being represented and making legal submissions, suggesting questions and receiving advance notice of the Inquiry's report. It is not necessary to be a core participant in order to provide evidence to the Inquiry, however. We will be notified in the coming weeks regarding our application

3.4 The ICB has now also been in receipt of a Rule 9 request for evidence from the Thirlwall Inquiry. A Rule 9 request is a request for information and can be a request for documents and/or a witness statement. It's called a rule 9 request because it's made under the power set out in Rule 9 of The Inquiry Rules 2006. The request for information is made up of more than 50 questions. Once each question in the Rule 9 has been addressed, the ICB will be required to write a statement based on the answers. A draft copy of the statement and supporting evidence is required to be submitted back to the inquiry in early January 2024. While the ICB applauds the inquiry for wanting to move at pace, we will be seeking an extension to this deadline.

3.5 Throughout the Inquiry the ICB will continue to support its staff who are directly involved, and regular contact is being kept to keep them informed of the asks and expectation of the Inquiry.

3.6 **Provider Selection Regime**

The Provider Selection Regime (PSR) regulations have been introduced into Parliament by the Department of Health and Social Care (DHSC), and subject to scrutiny by Parliament, the DHSC intends for the new regulations to come into force on 1 January 2024. This is the much awaited regulations that will provide us with the ability to via a strict governance process to determine situations where a collaborative and not a competitive solution may better suite our needs. The PSR will be a set of new rules for procuring health care services in England by organisations termed relevant authorities and will replace the existing procurement rules for NHS and local authority funded health care services. Relevant authorities are:

- NHS England
- Integrated Care Boards

- NHS trusts and NHS foundation trusts
- Local authorities and combined authorities.

3.7 The PSR introduces greater flexibility when making decisions about how best to arrange healthcare services, with competitive tendering one of several potential 8 processes that may be followed. To support implementation, NHS England have published draft statutory guidance[2] (subject to parliamentary approval of the regulations) which will be supported by a set of resources including more detailed implementation tools such as process maps and template documents. This will require a significant amount of planning for the ICB over the next eight weeks to ensure that we have our internal processes, contract reviews, and decision-making arrangements in place to implement the new regime.

3.8 ICB staff from our finance and contracting, commissioning and governance functions are linking in to regional and national events that have been arranged to facilitate learning and preparation for the implementation of PSR. We will keep the Board informed of any relevant updates in the lead up to anticipated implementation date.

3.9 **System Pressures**

System pressures still continue to be challenging. In the week commencing 20 November 2023, the percentage of patients not meeting criteria to reside (target 10%) over the course of the week was 20.9%, and the four hour emergency department performance last week was 66.9%. The ambition for winter is 76%.Patients delayed in the emergency department over 12 hours (target 2%) was 18.3% and 35% of patients had a length of stay of 14 days or over against a target of <25%. Mental health pressures resulted in the daily average delays of six patients in Emergency Departments, 14 patients in the community and 6 patients on acute wards who are medically fit and awaiting mental health placement. Within the mental health bed base there were on average an aggregate of 30% patients clinically ready for discharge.

3.10 **Addressing Significant Financial Challenges**

All NHS Trusts and ICBs received a letter from NHS England in early November entitled *'Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take'*[3]and which outlined the funding and actions the NHS has been asked to take to manage the financial and performance pressures created by industrial action following discussions with Government. In summary the asks of the NHS are:

- to respond to the impact of industrial action NHSE are allocating new £800m funding for financial pressures, reducing elective targets (105% to 103% nationally, varies locally with a floor at 100% of 19/20), and agreeing other flexibilities
- expectation that systems deliver (or better) planned financial performance, protect Urgent Emergency Care investments and performance, and the Mental Health Investment Standard. Elective plans to be refocused on driving productivity from core capacity

[2] https://www.england.nhs.uk/publication/the-provider-selection-regime-statutory-guidance/
[3] https://www.england.nhs.uk/publication/addressing-the-significant-financial-challenges-created-by-industrial-action-in-2023-24-and-immediate-actions-to-take/

- rapid exercise to agree actions required to deliver priorities for the remainder of the financial year. Deadline for responses to NHS England by 22 November
- systems are to assume industrial action does not continue in Months 8-12 but consider implications of a scenario where it does, with focus on minimising additional costs.

3.11 There will be a number of meetings with system leaders in November to agree our system approach and implications. I will look to update the Board further at its meeting in November.

3.12 **Neurorehabilitation update**
In November 2022 the Board approved a new two year contract for the Level 3 "slow stream" neuro-rehabilitation service. The contract was awarded to the existing provider (The Priory Group (Oak Vale Gardens)) on the understanding that a review of the current service specification and service delivery model was underway and that the board would receive an update on progress in 12 months.

3.13 Level 2 and Level 3 neuro-rehabilitation services are commissioned by the ICB with level 1 services commissioned by NHS England Specialised Commissioning team. From April 2024 the ICB will take on commissioning responsibility for the majority of specialised services with Level 1 neurorehabilitation identified as one of 3 clinical priorities for transformation.

3.14 This presents an opportunity to integrate the commissioning of the whole neuro-rehabilitation pathway which will give greater oversight and assurance of the quality of services, address the current inequity of access, and improve overall flow with placements based on the needs of the patients.

3.15 It is our intention to work collaboratively with the Cheshire and Merseyside Rehabilitation Network, the Cheshire and Merseyside Neurosciences Network and NHS England Specialised Commissioning team to join up and progress the work on transforming the whole pathway ahead of the ICB formally taking on the commissioning of specialised services.

3.16 **Update on the transfer of Specialised Commissioning Services to ICBs**
As was reported to the Board at its meeting in September 2023 the ICB submitted our Specialised Services Pre-Delegation Assessment Framework in September. This has now been considered at both regional and national panels and a final decision on delegating to the ICB, the identified 57 services, from April 2024 will be made at the NHS England Board Meeting on 07 December 2024. We have been informed that National Moderations Panel recommendation to the NHS England Board will be to support full delegation to ICBs in the North West from April 2024, but with further consideration of any conditions that should be applied to ICBs who were financially challenged to provide greater assurance.

3.17 In preparation for this delegation work continues with partners from NHS England and the North West ICBs to ensure processes are established. This

includes workstreams to develop our future North West Target Operating Model as well as completion of a nationally developed safe delegation checklist assessment covering the thematic areas of:

- Finance (& Contracting)
- Data & Business Intelligence
- Quality
- Governance (including risk management)
- Strategy, Transformation & Commissioning.

3.18 The formal transfer of NHS England Specialised Services employees is not now taking place until April 2025 so work in relation to facilitating this transfer of staff has been deferred. A draft national memorandum of understanding has been developed to outline the requirements of the NHS England Team in supporting the ICBs in delivery of commissioning Specialised Services during 2024-25 and this will be further developed regionally to reflect the implementation of the final agreed Target Operating Model.

3.19 We continue to review and consider the risk of delegation alongside our North West ICB peers and NHS England. We will work with regional colleagues to understand further any potential conditions that could be applied to the delegation arrangements. We will continue to keep the Board informed as and when any further updates are available.

3.20 **NHS IMPACT**

In April 2023 Anne Eden published the findings and recommendations of the NHS delivery and continuous improvement review.[4] The Review's recommendations were consolidated into three actions:

- establish a national improvement board to agree a small number of shared national priorities on which NHS England, with providers and systems, will focus our improvement-led delivery work
- launch a single, shared 'NHS improvement approach' and
- co-design and establish a Leadership for Improvement programme.

3.21 The new NHS Improvement Board met for the first time on 12th September 2023 and David Fillingham, Chair of the Board, requested ICB engagement with the work of NHS IMPACT (**IM**proving **P**atient **C**are **T**ogether).[5] NHS IMPACT is a single, shared NHS Improvement approach that has been established to promote the spread of **continuous** improvement across ICSs, with a focus on five specific domains for improvement sustainability:

- a shared purpose and vision which are widely spread and guide all improvement effort.
- investment in people and in building an improvement focused culture.
- leaders at every level who understand improvement and practice it in their daily work.
- the consistent use of an appropriate suite of improvement methods.
- the embedding of improvement into management processes so that it becomes the way in which we lead and run our organisations and systems.

[4] https://www.england.nhs.uk/publication/nhs-delivery-and-continuous-improvement-review-recommendations/
[5] https://www.england.nhs.uk/long-read/nhs-impact/

3.22 Essentially, IMPACT offers a multidisciplinary approach to improvement drawing on Quality Improvement, organisational design and development, finance, operational planning and leadership and management expertise. Improvement priorities continue to focus on the recovery of Elective Care, Integrated Urgent and Emergency Care and Primary Care.

3.23 Prior to the establishment of NHS IMPACT, the ICB had already:

- identified improvement as a priority and were working with colleagues from the NHSE regional improvement team to explore the creation of a C&M Improvement Hub.
- supported improvement leads from provider organisations to mobilise as the Cheshire and Merseyside Improvement Network (CaMIN) with view to expanding the membership to include primary care and social care colleagues and drawn synergies between the Clinical and Care Professional Leadership Framework and the improvement agenda to enable clinical leaders into front line leadership of initiatives designed to close the gap on health disparity.

3.24 This work will continue and add value to our plans to facilitate the adoption of the IMPACT framework across the region as a system driver of collaboration for the integration of health and care (HCA, 2022) towards improved health outcomes for all.

3.25 The NHS IMPACT framework also requires an assessment of NHS Board capability to lead improvement across its five domains and to that end, we will be undertaking a skills audit to plan for improved resilience over the coming months. Alongside this preliminary data, a full report will be brought to the Board in early 2024 that sets out our ambition and plans in more detail.

3.26 **Staffing boost for patients using GP Practices in Cheshire and Merseyside**
A more detailed report on our Primary Care Access Recovery Plans is being discussed at the Board meeting in November, however I wanted to use the opportunity to raise awareness with the Board and the public regarding some of the successes we have achieved in this already.

3.27 Across Cheshire and Merseyside, there are now 1,150 more staff working in primary care than there were in 2019, helping to provide 20% more appointments than before the COVID-19 pandemic - including the same or greater numbers of face-to-face appointments.

3.28 Many people across Cheshire and Merseyside do not realise that roles such as mental health practitioners, physiotherapists and social prescribers could also be available to them through their GP practice, as well as the more established roles such as GPs and practice nurses. These additional roles are helping to boost and diversify the primary care workforce and ensure more patients get to see the right health professional to meet their needs, first time – which may not always be a GP.

3.29 These new roles are being introduced in response to record numbers of people seeking support from their family doctors - but with one in five GP appointments for non-medical reasons such as loneliness, benefits advice, and housing issues the NHS wants to make sure that the right help is available for every patient.

3.30 An important factor in ensuring that patients do get to the right help quickly is the involvement of the reception team. Many people are unaware that general practice reception teams are professionally trained to assess the information provided by a patient in order to direct them to the right health professional fast. This role is often known as 'care navigation. While not all of the new roles are available in every GP surgery yet across Cheshire and Merseyside, hearing names like care co-ordinators and social prescribers is becoming more commonplace across our GP practices all the time.

3.31 To help explain more about the growing range of care now available, a new film[6] has been released by NHS England, which sees three curious children go behind the scenes at a general practice to meet some of these professionals and learn more about how they help patients get the care they need. I would recommend that all Board members watch this film and recommend that family and colleagues do so also.

3.32 **NHS virtual wards to treat thousands of patients with heart failure at home**
New NHS clinical guidance published last month asks local health systems to expand their use of virtual wards to include heart failure patients who often spend a lot of time in hospital and can now get specialist care from the comfort of their own homes.

3.23 We are proud that two NHS trusts in our region, Liverpool University Hospitals and Mersey Care, have been highlighted nationally as examples of heart failure virtual wards that are already up and running. Together the two trusts so far have supported more than 500 people on virtual wards.

3.24 Virtual wards allow patients to get safe hospital-level care in the comfort of their own home, close to their friends and family. Patients are monitored around the clock by highly skilled clinical staff through home or virtual visits, and staff can use technology like apps, wearables, and other medical devices, to continually monitor patients' vital signs. The team can also provide blood tests, prescribe medication, and administer fluids via an intravenous drip. The scheme not only speeds up recovery times but frees hospital beds for those who need inpatient care.

3.25 The scheme currently being run by Mersey Care was featured on BBC Morning Live and can be viewed at https://www.youtube.com/watch?v=3WOY9Kfu6IM. This is an excellent insight into how a virtual ward works and the benefits to patients, families and the system virtual wards bring.

[6] https://www.youtube.com/watch?v=bJBKDFW3Ysc

3.26 **NHS Cheshire and Merseyside are system leaders for anti-racism are you?** Board will remember that the ICB at its July 2023 Board meeting signed up to the North West Anti-Racism Framework[7] and subsequently we published our anti-racism pledge.[8] As part of our celebration of Black History Month the ICB People team held an online session on Friday 20 October to talk about and discuss anti-racism and the Power of Pledges. The event was very well attended and brought together our local system leaders and the BAME network in discussing the Anti Racist Framework, our anti-racism movement, how one pledge by all our staff can impact people lives and hear from our BAME network and allies how the pledges they have personally made have inspired anti racism in action. At the Board meeting in January 2024 there will be an update report on the ICBs progress around our Equality and Diversity commitments, as well as a focussed Board development session around the Anti-Racist Framework in February 2024.

3.27 **NHS Cheshire and Merseyside continue to lead the way in social value by joining the Social Value Network**
Since being named as a social value accelerator site by NHS England in 2018, Cheshire and Merseyside Health and Care Partnership (HCP) has embedded social value at scale throughout the system by establishing a Social Value Charter, developing an awards scheme and launching an Anchor Institution Charter and Framework.

3.28 Through engaging with those living and working within the Integrated Care System (ICS), NHS Cheshire and Merseyside has coproduced these initiatives to ensure a focus on the issues that really matter to communities and secure broad buy-in from stakeholders. Over 80 local organisations have signed up to the Social Value Charter and more than 70 have successfully achieved the Social Value Award.

3.29 By joining the Social Value Network, NHS Cheshire and Merseyside hopes to not only share this experience with others but also to continue on its journey of benchmarking performance and evidencing impact. More information about this work can be found at: https://www.ardengemcsu.nhs.uk/showcase/news-events/news-events/nhs-cheshire-and-merseyside-continue-to-lead-the-way-in-social-value-by-joining-the-social-value-network/

3.30 **Employers for Carers (EfC) Digital Platform Launch.** The ICB supports working carers and is an active member of Employers for Carers (EfC). EfC has recently launched EfC Digital which is an online support portal for working carers. EfC Digital hosts a wide range of support, advice and information for working carers as well as staff who are line managers and/or have employee wellbeing responsibilities. The ICB is promoting this internally to our staff as part of a number of measures to support our staff who are working carers. More detail about the platform can be found at: https://efcdigital.org/

[7] https://www.england.nhs.uk/north-west/nhs-north-west-bame-assembly/anti-racist-framework/
[8] https://www.cheshireandmerseyside.nhs.uk/about/equality-diversity-and-inclusion/anti-racism-pledge/

3.31 **Surgical Hub.** Wirral University Teaching Hospital's Cheshire and Merseyside Surgical Centre at Clatterbridge (C&MSC) has been successfully accredited as an elective surgical hub delivering high standards in clinical and operational practice. The Cheshire and Merseyside Surgical Centre was recently visited and assessed by NHS England's Getting It Right First Time (GIRFT) team for accreditation and recognition that the hub is working to a defined set of clinical and operational standards on:

- the patient pathway
- staff and training
- clinical governance and outcomes
- facilities and ring-fencing
- utilisation and productivity.

3.32 C&MSC is one of only 24 hubs to date that have been accredited of the 94 hub sites currently in operation in England. While it is not mandatory for trusts to seek accreditation, the long-term goal is for every elective hub to be accredited. The visiting team highlighted several exceptional practices, noting that the C&MSC is an exemplar hub full of innovation and excellent ideas. They also shared that they could see it was well-led and had happy engaged staff, good board level support, along with high and increasing utilisation rates and some imaginative and effective solutions to challenging problems.

3.33 Phase one of the C&MSC opened with two new surgical theatres in November 2022 treating an extra 3,000 elective patients a year, from across Cheshire and Merseyside. These included around 1,500 urology patients, over 800 orthopaedics patients, over 350 general surgery cases, 150 gynaecological patients and 140 breast patients.

3.34 The second phase of the project has now progressed, with two more theatres having now opened. This will increase capacity to treat 6,000 extra elective patients a year. This £25 million innovative development, created through national NHS funding, saw the theatres created as modular buildings, meaning they were largely pre-built before arriving on site, and constructed alongside the current theatres at Clatterbridge Hospital. This reduced time for completion and ensured that the centre was up and running as soon as possible.

3.35 **Covid-19 Update**. The Autumn/Winter 2023 booster campaign started with care homes and housebound from Monday 11 September with the remaining eligible population from Monday 18 September. All Places across Cheshire and Merseyside have good coverage for the autumn/winter eligible population of 1,048,625. Alongside the autumn booster a single primary vaccine dose is being offered to citizens not yet vaccinated and who meet the autumn/winter campaign eligibility criteria.

3.36 Care home vaccination is almost complete with very good uptake against the 651 eligible older and non-older care homes across the system. There will be opportunity to revisit all care homes if needed. Although the ability to book appointment on NBS closes on December there will be then an opportunity for pop-ups, walk-ins and outreach continue until the 31 January 2024. To date we have delivered to over 97% of care homes.

3.37 As of 16 November 2023 Cheshire and Merseyside has delivered 514,595 vaccinations, an uptake rate of 46%. The Northwest position is 1,283,133 vaccinations (an uptake of 43.6%) with uptake for Greater Manchester at 39.4% and for Lancashire and South Cumbia 46.7%.

3.38 Delivery of A primary course vaccination to at risk 6-months to 4-year-old children under prescription/written order is underway with delivery from Cheshire and Wirral Partnership and Central and West Warrington PCN. This service will continue to be offered until mid-December and to date 75 vaccinations have been completed. Uptake continues to be very low in all regions and sub-regions. The services continue to engage with parents and guardians with call and re-call to support uptake, however, some have declined the offer. New searches are currently being completed and renewed offers will shortly be underway.

3.39 **Living Well Buses (LWB).** As at 11th November the LWB has delivered 16 clinics, 3702 covid-19 vaccinations,166 MECC discussions and over 1664 health screenings of which 27% are outside of normal range, triggering a referral to Primary Care. The proof-of-concept migrant health vaccination project ended at the end of September and an evaluation is now being completed. The total individuals vaccinated to date is 380 with 768 vaccination doses over 138 clinics. The LWB service has also been able to offer flu vaccine since 20th October and to date have delivered 183 flu vaccinations. The Living Well buses have been recognised by the national team as a demonstrator service which along with another 11 innovative services nationwide will form part of the national vaccination strategy.

3. Congratulations

3.1 **Queens Nurse Award.** I would like to extend my congratulations to Christine Douglas, MBE our Director of Nursing and Care who will be receiving the Queen's Nurse badge at the Queen's Nursing Institute annual awards ceremony on 08 December 2023. The title of Queen's Nurse is awarded in recognition of a nurse's commitment to ongoing learning, leadership and excellence in healthcare.

3.2 **HSJ Awards**. Congratulations also goes to the Cheshire and Merseyside Acute and Specialist Trust (CMAST) collaborative for winning the HSJ provider Collaborative of the Year Award at the HSJ Awards night on 16 November 2023. The judges praised CMAST for its "strong and effective collaboration" and its potential for further growth and co-production. Additionally, congratulations also to Professor Rowan Pritchard-Jones, our Medical Director who was a finalist in the Clinical Leader of the Year category at the same Awards.

4. Decisions taken at the Executive Committee

4.1 Since the last Chief Executive report to the Board in September 2023, the following items have been considered by the Executive Team for assurance or for discussion:

- **Wegovy Weight Loss Pilot**. The Executive team considered a paper regarding the implementation of the Technical Appraisal for the rollout of Wegovy. As part of the paper there was a request of the Executive Team for the approval of the ICB to put themselves forward as one of 9 national fully funded pilot sites for the delivery of Wegovy via Primary Care.
- **S136/Prometheus**. The Executive team received an updated paper regarding the observational support for people subject to s136 Mental Health Act 1983 service provided by Prometheus service. Work has been undertaken looking at developing an alternative solution to the delivery of the service due to the contract ceasing at the end of October. The paper outlined and the Executive Team supported the alternative arrangements agreed to cover Cheshire and Merseyside. The Executive Team noted the cost implications as well as projected savings and the need for future costs for observational support needing to be factored into 2024/25 financial planning.
- **Health and Safety Policies**. The Executive Team received three Health and Safety policies for review and approval: Safe Driving at Work, Display Screen Equipment, Health and Safety. Minor amends were suggested with approval of policies agreed following final review by the Chief Executive and the Associate Director of Workforce.
- **Medicines Optimisation Target Operating Model.** The Executive Team considered an updated paper from the ICBs Chief Pharmacy Officer outlining the proposed operating model and staffing for the ICBs Medicines Optimisation function. The Executive team approved the recommendations within.

4.2 Additional items were also presented to the Executive Team for assurance or discussion have included:

- All Age Autism Update
- Urgent Emergency Care
- ICB Quarterly Review
- Women's Health Hubs
- Serious Violence Duty
- Primary Care Quality and Safety
- Commissioning Intentions
- Neurodiversity Pathway Development across Cheshire and Merseyside
- NHS Oversight Framework
- Assisted Conception Policy.

4.3 At each meeting of the Executive Team, there are standing items on quality, finance, and non-criteria to reside performance where members are briefed on any current issues and actions to undertake. At each meeting of the Executive Team any conflicts of interest stated are noted and recorded within the minutes.

4.4 **Risk.** The Executive team met on the 09 November as the ICBs Risk Committee. The Risk Committee made suggested amends to the Committees Terms of Reference which will go to the ICBs Audit Committee for approval. The Committee also considered the ICB Board Assurance Framework and Corporate Risk Register. The Committee also received an update from the Cheshire East and the Liverpool Place Directors regarding their top three risks for each Place,

as well as an update of the top three risks for the Assistant Chief Executives Directorate.

5. Officer contact details for more information

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6. Appendices

Appendix One: ICB Thirlwall Inquiry Task and Finish Group Terms of Reference.

Thirlwall Inquiry
Task & Finish Group
Terms of Reference

Name	Details of changes	Version
Joshua Pryce	Initial draft.	0.1
Joshua Pryce	Changes following T&F Group meeting on 23/10/2023.	0.2
Joshua Pryce	Sign-off by T&F Group on 06/11/2023.	1.0

1. Constitution

1.1 The Thirlwall Inquiry Task & Finish group provides oversight, guidance and assurance regarding the response for:

- NHS Cheshire and Merseyside Integrated Care Board

and its predecessor organisations:

- NHS Cheshire Clinical Commissioning Group
- NHS West Cheshire Clinical Commissioning Group
- Western Cheshire Primary Care Trust

to the public inquiry into the circumstances surrounding the crimes of Lucy Letby at the Countess of Chester Hospital.

1.2 Members of the Task & Finish group are collectively and corporately accountable for the compliance and completion of the response.

2. Delegated Powers and Authority

2.1 The Task & Finish group will act with the authority of the ICB covering the scope of its remit through regular reporting, discussions, investigation and action.

3. Membership

3.1 Task & Finish group membership shall be appointed by the Chair of the Task and Finish Group.

3.2 The membership shall be as described below and can be reviewed and amended by agreement of the Task & Finish group.

3.3 Each member will nominate a deputy who will be invited to attend meetings in the event of their absence.

Name	Role
Christine Samosa	Chief People Officer *(Chair)*
Graham Urwin	Chief Executive
Christine Douglas	Executive Director of Nursing & Care
John Llewellyn	Chief Digital and Information Officer
Matthew Cunningham	Associate Director of Corporate Affairs & Governance
Beth Warburton	Head of EPRR *(Inquiry SPOC)*
Joshua Pryce	EPRR Officer *(Inquiry Support)*

4. Frequency of Meetings

4.1 Meetings will be held fortnightly, or monthly at a minimum via MS Teams.

5. Attendance at Meetings

5.1 No business should be transacted at the meeting unless half of the members are present, including the Chair.

6. Purpose of the Group

6.1 The Task & Finish group will provide the ICB Board with assurance regarding the response to the Thirlwall Inquiry.

6.2 The Task & Finish group is responsible for developing the response to the Thirlwall Inquiry, and approving evidence collation and submission to the Chair of the Inquiry.

6.3 The Task & Finish group will ensure systems and processes are in place to ensure the delivery of the ICB response to the Thirlwall Inquiry.

6.4 The Task & Finish group will keep a formal record of requests for evidence, review the requests and approve the submission of evidence.

6.5 The Task & Finish group will review and embed learning from the inquiry and identify improvement opportunities.

6.6 The Task & Finish group will sign-off the Thirlwall Inquiry ICB Communications Plan.

7. Review

7.1 These Terms of Reference will be reviewed annually and earlier if required. Any proposed amendments to the Terms of Reference will be agreed by the membership.

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board of NHS Cheshire and Merseyside

30 November 2023

The Director of Nursing and Care Report

Agenda Item No: ICB/11/23/09

Responsible Director: Christine Douglas Director of Nursing and Care

The Director of Nursing and Care Report

1. Purpose of the Report

1.1 The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current risks, issues and highlights that have an impact on quality and safety within the Cheshire and Merseyside ICS footprint.

1.2 The report will feature information and updates that include: -

- Social Care Nursing Workforce
- Patient Safety Incident Response Framework
- Infection Prevention Control Review

1.3 The Director of Nursing and Care produces a report for each ICB Board Meeting for information and noting and the Board are asked to note the progress made and actions taken to address these areas relating to quality of care and safety.

2. Executive Summary

2.1 Adult Social care aims to help people stay independent, safe, and well so they can live the lives they want to. This includes people who are frail, have disabilities, neurodiversity, mental health issues as well as the people who care for them. Adult social care aims to promote independence and wellbeing, through personalised care and support that focuses upon their strengths, the outcomes they want to achieve and enables choice and control.

2.2 The NHS Confederation Report “Adult Social Care and the NHS, Two Sides of the Same Coin” published in September 2023 focused on the demand for and provision of state funded social care for older people as the largest cohort drawing on care and support. The report highlighted the workforce capacity struggling to meet the demand and the high numbers of vacancies nationally being a consistent challenge, and that post pandemic this has become significantly more acute.

2.3 The long-term workforce plan calls for “urgency” in its recommendation that ICB’s and wider system partners prioritise actions that drive recruitment and retention of their “**one workforce**” across health and care”.

2.4 Across Cheshire and Merseyside, we have put in place several workstreams to raise the profile of social care, encourage student placements, upskill existing staff working in social care and help to provide support networks for new and existing members of the social care staff.

2.5 There are currently 16 Trusts which need to have Patient Safety Incident Response Framework implemented by Autumn 2023. These will be supported

by their Place colleagues to ensure safe implementation. To date fourteen Trusts have been signed off as ready to implement or have implemented PSIRF. The remaining two trusts have a sign off date before the end of the calendar year.

2.6 Once all Trusts are signed and implemented, there will need to be a robust project plan to implement a proportional approach to independent providers (C & M number approximately 800). Due to the vast number this will be a staged approach, risk stratified and proportionate to contract value. Further guidance is awaited regarding implementing PSIRF across Primary Care Services and maternity and neonatal services.

2.7 Infection Prevention & Control is everybody's business and is the golden thread every patients/ service user journey, from birth to death, admission, and discharge from hospital, across primary care and all communities. If the system fails to deploy the correct strategic and operational direction for IPC, the quality impact can be costly, in both human and financial terms. When Integrated Care Boards (ICB) were created in 2022 there was no specific advice set out relating to responsibilities of the deployment and structures of Infection Prevention & Control (IPC) measures.

2.8 To ensure that the ICB is equipped to deliver on the function relating to IPC, the Director of Nursing & Care has commissioned a review to consider this.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- note the content of the report for information.

4. Reasons for Recommendations

4.2 This is current work that is taking place within the C&M ICB related to quality and safety and is for information.

5. Background

5.1 **Social Care Workforce/Nursing.** Adult Social care aims to help people stay independent, safe, and well so they can live the lives they want to. This includes people who are frail, have disabilities or neurodiversity, mental health issues as well as the people who care for them. Social care is often broken down into two categories of short term care and long term care. Short term refers to support that is time limited with the intention of maximising the independence of the individual using the care service and eliminating their need for ongoing support. Long term support is provided for people with complex and ongoing needs either in the community or accommodation such as a nursing home.

5.2 Adult social care aims to promote independence and wellbeing, through personalised care and support that focuses upon their strengths, the outcomes they want to achieve and enables choice and control. This means: -

- looking at what people can do rather than what they can't do.
- having a conversation rather than focusing on prescribed assessment questions
- understanding what is most important to the person, their concerns, what they have tried and the next steps.
- listening carefully to "what matters" to them rather than "what's the matter" with them.
- being creative and helping people to build upon their strengths.

5.3 The NHS Confederation Report "Adult Social Care and the NHS, Two Sides of the Same Coin" published in September 2023 focused on the demand for and provision of state funded social care for older people as the largest cohort drawing on care and support. The report highlighted the workforce capacity struggling to meet the demand and the high numbers of vacancies nationally being a consistent challenge, and that post pandemic this has become significantly more acute.

5.4 The NHS Long Term Workforce Plan (LTWP) states three things that we must do as health & care systems as we move forward;

- **Train** - increasing education and training including apprenticeships and alternative routes into professional roles.
- **Retain** - ensuring that we keep more staff by providing better support and being flexible to help improve culture and leadership.
- **Reform** - change education and training and ensure staff have the right skills.

5.5 The long-term workforce plan calls for "urgency" in its recommendation that ICB's and wider system partners prioritise actions that drive recruitment and retention of their "**one workforce**" across health and care". We do not have "one workforce" yet and recognise that this is a longer-term piece of work but nevertheless, we should be taking all opportunities to ensure that one workforce becomes more than a suggestion to serve the people of C&M.

5.6 The long-term workforce plan also assumes that the balance of care between NHS and Social Care will remain broadly the same. Table One illustrates staff numbers and bed availability across Cheshire and Merseyside (as at end Oct 2023). It shows the stark contrast in numbers between Healthcare and Social Care. If we follow the assumptions made in the Long-Term Workforce Plan and things stay broadly the same, (even with an ageing population) we still have a glaring inequity.

Table One: Workforce comparison across service provision

Area	Headcount	Nurses	HealthCare/support workers	Beds provided to system	Staff ratio per bed *(no staff div by no beds)*
Secondary Care	81,809 (34,169)	23,874	10,295	5734	5.959
ICB	1,075	140	0		
Primary Care	8,843	1,037	349		
Social Care	70,000 (19,600)	1,900	17,700	22,474 (G+O15,515 + I+RI 6,959)	0.872
Total	161,727	26,951	28,344	28,208	

(not included here are c.30,000 care workers in non-residential care i.e., homecare, results show that 79.6% of all beds are in social care, in context on average secondary care has 5.17 more staff per bed than in social care)

5.7 Across Cheshire and Merseyside, we have put in place several workstreams to raise the profile of social care, encourage student placements, upskill existing staff working in social care and help to provide support networks for new and existing members of the social care staff. The aim of this is to try and address some of the recruitment and retention issues to bridge some of the gaps evident above.

5.8 They link in not only with the Long-Term Workforce Plan, but support Directors of Adult Social Services (DASS) plans and have the potential to address issues around retention identified in the latest Skills for Care report.

5.9 **Current Workstreams**

Social Care Nurses Forum

This was started in September 2022, it meets monthly and aims to provide peer support alongside an avenue for members of staff working within social care organisations to have a direct link into the ICS, to be able to discuss issues and concerns as they arise. Feedback from the members of the group is that this is very beneficial as it allows them dedicated time and space to come together. They have appreciated the opportunities that have been directed towards the group that they previously would not have been included in. This meeting has also directly provided students with placements within the social care sector, those students have fed back to the group about the amazing experiences that they had and that it has opened their eyes to the opportunities available within the sector. This group continues to flourish. They were directly involved in the decisions made around the CPD offer that has been extended to the social care sector across Cheshire and Merseyside. This group already shows the fundamentals of co-production, collaboration, and support.

CPD (Continuing Professional Development) Opportunities
An allocation of £330,000 of non-recurrent year end monies in 2022/23 was provided by HEE (now NHS England – Workforce, Training & Education Directorate) to support the registered workforce within social care across C&M. Existing links with our higher education institutions (HEI's) and health and social care academies were utilised. The list of CPD requirements that had been formulated within the social care nurses forum was built on to provide the required training. A mixture of approaches has been used to ensure best use of the monies allocated. This includes

- 1 to 1 session
- mobile skills lab use
- digital platforms, trainers using training rooms provided by social care organisations and virtual reality technology.

Although monies were spent within the required parameters the training opportunities did not start until July this year from the Health and Social Care Academy, and October this year for University of Chester sessions. However, we have a time frame for delivery extending well in to 2024. To date there have been 252 training opportunities taken up. With expressions of interest for future dates are increasing daily. The use of training rooms within social care organisations is leading to sessions being opened to that staff from different organisations within the same geographical area.

Preceptorship
This is being run in conjunction with the primary care training hub. It is providing an opportunity for nurses new to social care to have the preceptorship experience that colleagues within other avenues may already benefit from. This will provide approximately 30 opportunities across our 9 places and is a pilot at this time. The hope behind this is, that it will impact on retention. This is currently being recruited to.

PEF (Practice Education Facilitator) Social Care
In 2023/24 £81,000 was provided through C&M People Board funding, which allowed us to secure a full time Practice Education Facilitator to work exclusively for Social Care to open placements for pre-registration students and provide support for registered staff who are allocated assessors/supervisors for students in placement areas.
Feedback to date is that the sector really wants to take students, but require the support they are now getting to be able to do so. This has led to support for 75 placement areas, 28 new placement opportunities opened, 13 in discussion to open. Funding for this position is due to run out summer 2024.

Social Care Nurses Advisory Council
This is a national piece of work that is looking to raise the profile of social care nursing. Its purpose is to encourage ICB's and the social care sector to work together to impact locally, exploring processes that can provide connectivity across sectors and influence system reform. The first meeting was held on 21st November with representation from social care organisations, ADASS, ICB and

NHSE and a presentation from Deborah Sturdy Chief Nurse, Adult Social for England. The Advisory Council will meet 3 to 4 times a year.

Student Ambassadors
Students who have been given placement experience within social settings through the Social Nurses Forum have fed back what a wonderful experience that they had. They were energised due to the experience that they had and the exposure to the variety of different professionals and the skill base of the staff they had worked with. It had changed the perception that they held about social care. They have agreed to work with us as champions within their HEI base. This is still being developed, but the hope is that this provides more willingness from other students to consider social care.

5.10 Challenges / Considerations. We are making a good start in Cheshire and Merseyside, utilising relatively small amounts of money. The plans that have been put in place have been done quickly and have been discussed and made in collaboration with our social care sector. We have shown that the systems can work together to produce some excellent opportunities, however we face some challenges: -

- How will we as a system continue to provide support to the sector to ensure placement opportunities are not lost, leading to a backward move in understanding of the social care sector? A report recently shared by NW Regional Nursing Team (Report summarising social care placement activity for pre and post graduate nurses and AHPs) recommended that we need to ensure there is enough support for current placement activity and consider how that can increase to accommodate safe placement growth.
- How will we as a system continue to offer CPD opportunities to ensure that people working within the social care sector continue to have their needs met by appropriately trained staff?
- How they are working towards integration? How can we as a system prove our integration agenda if we do not prioritise and continue the work started?

6. Patient Safety Incident Response Framework

6.1 There are currently 16 Trusts which need to have PSIRF implemented by Autumn 2023, these will be supported by their Place colleagues to ensure safe implementation. To date fourteen Trusts have been signed off as ready to implement or have implemented PSIRF. The remaining two trusts have a sign off date before the end of the calendar year.

- Countess of Chester Hospital implementation date Dec 23
- Alder Hey Childrens Hospital: implementation 1st Jan 2024.

6.2 Once all Trusts are signed and implemented, there will need to be a robust project plan to implement a proportional approach to independent providers (C & M number approximately 800). Due to the vast number this will be a staged approach, risk stratified and proportionate to contract value.

6.3 Further guidance is awaited regarding implementing PSIRF across primary care services. Pilot work remains underway across Halton place & Warrington place to implement the Learning from patient safety events system as a replacement to previous systems available. It is envisaged the learning from this pilot can be spread and adopted throughout C & M once received.

6.4 There have been some challenges in relation to maternity incidents under PSIRF, as now providers do not need to share their 72 hour reviews as they did whilst under the Serious Incident Framework. This means it is difficult to know what actions have been taken and how we are capturing learning at an early stage. The LMNS have established a task and finish group which has been extended to seven regions. A series of meetings are planned which will look at developing principles by February 2024. This will be shared with provider Boards for review, and then can be signed off across the North West region by April 24. In addition, a maternity chapter is to be developed as an addendum to PSIRF principles. This will fit into Providers current plans, and will include what needs reporting, how and when, and also what will need investigating.

6.5 The Health Innovation Team are providing support to C & M ICB in implementing PSIRF. There are two key areas of focus, the first is team development and then this will be followed by supporting the implementation of communities of practice for Trusts who have implemented PSIRF. The communities of practice will be a key piece of work as this is around supporting the cultural change needed, now the Serious Incident Framework is replaced.

6.6 Further work is needed to develop the Patient Safety Partner (PSP) role. This role is mandated in organisations and C & M ICB will need to develop how they will implement this role moving forward. PSP roles should be open to members of the public to work as an advisor to help support the delivery of safe healthcare across the Integrated Care Systems. The level of involvement for this role may vary depending on skills and experience.

7. Infection Prevention Control Review

7.1 Infection Prevention & Control is everybody's business and is the golden thread through every patients/ service user journey, from birth to death, admission, and discharge from hospital, across primary care and all communities. If the system fails to deploy the correct strategic and operational direction for IPC, the quality impact can be costly, in both human and financial terms.

7.2 When Integrated Care Boards (ICB) were created in 2022 there was no specific advice set out relating to responsibilities of the deployment and structures of Infection Prevention & Control (IPC) measures. In the most recent National Quality Board (NQB) guidance relating to quality functions of an ICB (July 2023, a high-level overview of how functions relating to IPC should be constructed, this overview included:

- Each ICB should have an executive lead to hold accountability for IPC across their ICS

- Each ICB should have an established IPC meeting where learning and risks are shared and aligned improvement actions agreed with clear lines of escalation to both the ICB Board and NHS England regional partners.
- The ICB should work with partners / providers to translate national policy and guidance to local delivery.
- Seek assurance that local services are commissioned against, and are working to, national IPC guidance and policy.
- Oversight of local IPC and Director of IPC capability and capacity.
- Oversight of local compliance with IPC training.
- Support to local networks re professional development opportunities and succession planning.
- Oversight and scrutiny of ICS and individual provider progress against IPC related ambitions / thresholds / regulatory and contractual requirements / intelligence and improvement programmes.
- Triangulation with broader intelligence e.g., service changes / staffing challenges / trend data to provide context and inform improvement programmes.

7.3 To ensure that the ICB is equipped to deliver on the function relating to IPC, the Executive Director of Nursing & Care has commissioned a review that will:

- Review the current IPC structure within the C&M ICB and define responsibilities for delivery of the C&M ICB IP&C Strategic Plan (AMR and IPC priorities)
- Define the legal and statutory requirements for C&M ICB and the wider Integrated Care System
- Define the governance structure required in terms of regulation and good practice.
- Identify the gaps within the C&M ICB benchmarked against the NQB guidance, the Northwest region and England.
- Recommend options to ensure that legal and statutory requirements are met along with the delivery of a strategic plan.

7.4 The review is due to commence in December 2023 and once completed, its outputs will be included in future Board reporting.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 This report covers the following CQC ICS themes and quality statements, namely:

Theme One (T1) - Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	Learning culture. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.

QS3	Safe and effective staffing. We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
QS6	Safeguarding. We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm, and neglect. We make sure we share concerns quickly and appropriately
Theme Two (T2) - Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
QS9	How staff, teams and services work together. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
Theme Three (T3) - Leadership	
QS10	Shared direction and culture. We have a shared vision, strategy, and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
QS11	Capable, compassionate and inclusive leaders. We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty
QS14	Partnerships and communities. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
QS15	Learning, improvement and innovation. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

9. Next Steps and Responsible Person to take forward

9.1 The next steps are to continue the work with the social care nursing workforce to ensure that we continue to develop this aspect of care delivery.

9.2 To ensure the implementation of PSIRF and await the guidance about further development within primary care and maternity/neonatal services.

9.3 To await the review of the Infection Prevention Control and following recommendations to ensure the ICB can deliver on the functions required.

10. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Finance Report for Month 6

Agenda Item No: ICB/11/23/10

Responsible Director: Claire Wilson, Director of Finance

Finance Report for Month 6

1. Purpose of the Report

1.1 This report provides an update to the Board of NHS Cheshire and Merseyside on the financial performance of the Cheshire and Merseyside ICS ("the System") at Month 6 the risks to delivery of the financial plan resulting from excess levels of inflation and industrial action.

1.2 At the time of writing, a national announcement on managing the in-year costs of industrial action was imminent and an update will be provided verbally in the meeting.

2. Executive Summary

2.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee of the ICB who undertake detailed review and challenge on behalf of the Board. The chairs report from these meeting is reported separately on the agenda.

2.2 This report updates the Board on the financial performance of the Cheshire and Merseyside ICS ("the System") for 2023/24, in terms of relative position against its financial plan as submitted to NHS England in May 2023, and utilisation of available Capital resources for the financial year. The revised System plan for 2023/24 submitted on 04 May 2023 as a combined £51.2m deficit consisted of a £68.9m surplus on the commissioning side (ICB) partially offsetting an aggregate NHS provider deficit position of £120.1m.

2.3 As of 30 September 2023 (Month 6), the ICS 'System' is reporting a deficit of £128.2m against a planned deficit of £71.5m resulting in an adverse year to date variance of £56.7m.

2.4 The System continues to formally forecast a position in line with its £51.2m deficit plan, however, has £139.3m of unmitigated risk identified, primarily relating to the impact of industrial action and excess levels of inflation. This risk value is reported within our finance returns to NHS England and discussed via the monthly regulator assurance meetings.

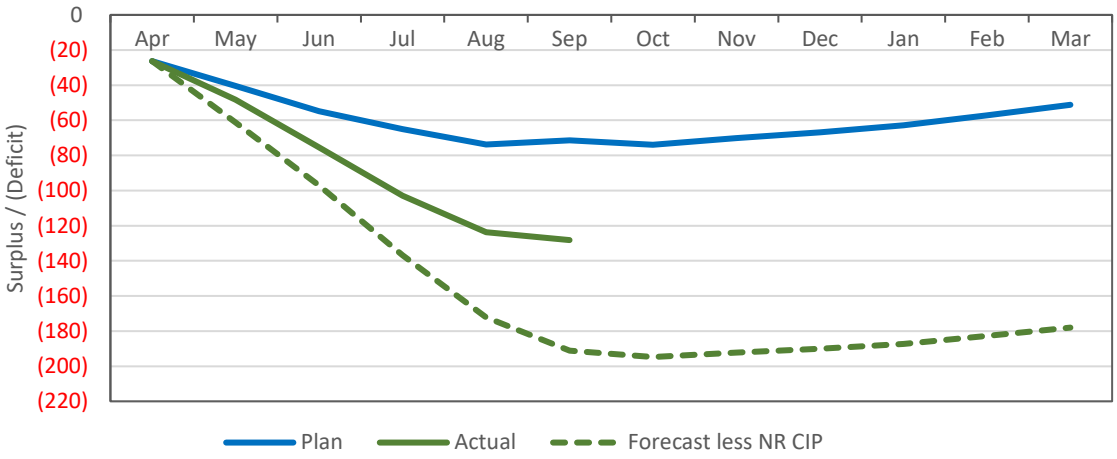
2.5 The financial position for the year is set out in Table One:

Table One

	M6 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
ICB	34.5	(4.7)	(39.2)	69.0	69.0	0.0
Total Providers	(106.0)	(123.5)	(17.5)	(120.1)	(120.1)	0.0
Total System	(71.5)	(128.2)	(56.7)	(51.2)	(51.2)	0.0

2.6 Chart One below shows the profile of the Investment and expenditure plan with and without impact of non-recurrent Cost Improvement Plans (CIP). The dotted green line shows crude exit run-rate adjusting only for non-recurrent CIP.

Chart One



3. Financial Performance Month 6

3.1 **ICB Performance.** The ICB has reported a deficit of £4.7m compared to an original planned surplus of £34.5m, resulting in an adverse variance to plan of £39.2m as per Table Two.

Table Two

	Plan £m	M6 YTD Actual £m	Variance £m	Variance %
System I&E Analysis	**(3,283.9)**	**0.0**	**0.0**	
ICB Net Expenditure:				
Acute Services	1,667.9	1,669.5	(1.7)	(0.1%)
Mental Health Services	321.2	326.6	(5.4)	(1.7%)
Community Health Services	333.3	335.9	(2.6)	(0.8%)
Continuing Care Services	174.9	190.0	(15.1)	(8.7%)
Primary Care Services	305.2	324.3	(19.2)	(6.3%)
Other Commissioned Services	7.3	6.5	0.8	11.4%
Other Programme Services	26.0	24.6	1.4	5.5%
Reserves / Contingencies	1.4	0.0	1.4	100.0%
Delegated Primary Care Commissioning	386.8	385.8	1.1	0.3%
Primary Medical Services	248.9	247.9	1.1	0.4%
Dental Services	89.4	89.4	0.0	0.0%
Ophthalmic Services	13.5	13.5	0.0	0.0%
Pharmacy Services	35.0	35.0	(0.0)	(0.0%)
ICB Running Costs	25.4	25.3	0.1	0.3%
Total ICB Net Expenditure	**3,249.4**	**3,288.6**	**(39.2)**	**(1.2%)**
Allocation adjustment for reimbursable items		0.0	0.0	
TOTAL ICB Surplus/(Deficit)	**34.5**	**(4.7)**	**(39.2)**	**(1.2%)**

3.2 This adverse year to date performance is driven by the following issues:

- **Mental Health Services** – overspend relating to packages of care linked to cost and volume of service users.

- **Continuing Health Care** - overspend relating to increases to volume and price for continuing care including the impact of inflation above national planning assumptions. This is an area of significant focus by each place team.
- **Prescribing** – estimated overspend based on July 2023 prescribing data (latest available) and reflecting inflationary pressure above national planning assumptions. The medicines management team are progressing each of the nationally identified optimisation schemes and the ICB efficiency target is expected to be achieved.
- **Efficiency savings** are reflecting under-delivery in the year to date but are forecasted to achieve the planned position. Progress and delivery on schemes are being monitored through the ICB place review meetings and non-recurrent mitigations are being identified where recurrent delivery is delayed.

3.3 **Place Performance**. Details of ICB performance split by place is shown below with detailed reporting shared at Finance Investment and Resources Committee. ICB central budgets are currently showing a positive variance to plan due to slippage on centrally funded programmes. Place recovery plans have been developed and are now being progressed. ICB financial position by place is set out in Table Three:

Table Three

	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m
Cheshire - East	(18,189)	(24,556)	(6,366)
Cheshire - West	(13,650)	(23,355)	(9,705)
Halton	(4,287)	(4,450)	(163)
Knowsley	5,603	2,853	(2,749)
Liverpool	3,578	(4,242)	(7,820)
Sefton	(2,840)	(8,611)	(5,772)
St Helens	(4,290)	(8,606)	(4,315)
Warrington	(3,921)	(5,866)	(1,945)
Wirral	(3,585)	(13,633)	(10,047)
ICB	76,062	85,756	9,694
Total ICB	**34,480**	**(4,708)**	(39,188)

3.4 **NHS Provider Performance.** Table Four summarises the combined NHS Trust position to the end of September 2023, reflecting a year to date cumulative deficit position of £123.5m compared to a deficit plan of £106m, giving an adverse variance of £17.5m. Further detail is provided in the table below.

3.5 In summary, key pressures relate to underachievement of CIP, lost income or additional costs associated with industrial action, pay award pressures and out of area costs arising from delayed transfers of care.

3.6 All NHS Trusts are forecasting achievement of plan but have identified risk to this resulting from industrial action, escalation beds and unachieved efficiencies. It is anticipated that these risks are likely to be partially mitigated, leaving an unmitigated risk of £69.4m. Table Four provides a breakdown by provider.

Table Four

	M6 YTD			2324 Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Alder Hey Children's NHS Foundation Trust	(1.5)	(1.5)	0.0	12.3	12.3	(0.0)
Bridgewater Community Healthcare NHS Foundation Trust	0.0	0.0	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	(0.2)	(1.3)	(1.0)	0.0	0.0	(0.0)
Countess of Chester Hospital NHS Foundation Trust	(12.5)	(19.1)	(6.5)	(25.2)	(25.2)	0.0
East Cheshire NHS Trust	(4.2)	(5.0)	(0.8)	(4.4)	(4.4)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.9	4.9	0.0	9.8	9.8	(0.0)
Liverpool University Hospitals NHS Foundation Trust	(54.1)	(54.1)	0.0	(60.7)	(60.7)	(0.0)
Liverpool Women's NHS Foundation Trust	(8.4)	(10.2)	(1.7)	(15.4)	(15.4)	0.0
Mersey Care NHS Foundation Trust	4.0	4.0	0.0	6.4	6.4	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(11.1)	(16.7)	(5.5)	(18.9)	(18.9)	0.0
Southport And Ormskirk Hospital NHS Trust	(2.0)	(2.0)	0.0	(2.0)	(2.0)	0.0
Mersey and West Lancashire Teaching Hospitals NHS Trust	0.6	0.6	0.0	7.6	7.6	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.2	0.6	0.4	0.4	0.4	(0.0)
The Walton Centre NHS Foundation Trust	2.5	2.6	0.0	4.1	4.1	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(10.8)	(13.7)	(2.9)	(15.7)	(15.7)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.2	0.2	0.0	0.2	0.2	0.0
Wirral University Teaching Hospital NHS Foundation Trust	(13.5)	(13.0)	0.5	(18.6)	(18.6)	(0.0)
Total Providers	**(106.0)**	**(123.5)**	**(17.5)**	**(120.1)**	**(120.1)**	**0.0**

3.7 The following Trusts are currently reporting year to date adverse variances to plan.

- **Cheshire and Wirral Partnership NHS Trust**
  £1m adverse variance YTD
  Pressures resulting from numbers of patients who are clinically ready for discharge to the community but remaining in inpatient beds. This has also resulted in a high number of Out of Area placements.

- **Countess of Chester NHS Foundation Trust**
  £6.5m adverse variance YTD
  Key drivers include undelivered CIP of £4.9m, as the Trust has not been able to step down the winter escalation beds as planned and the costs of industrial action of £2.3m.

- **East Cheshire NHS Trust**
  £0.8m adverse variance YTD
  The variance is mostly driven by industrial action costs of £1.3m.

- **Mid Cheshire Hospitals NHS Foundation Trust**
  £5.5m adverse variance YTD
  Key drivers of the adverse variance are; CIP under delivery of £0.9m, industrial action costs of £1m, excess inflation £0.9m, pay related pressures of £1m, PDC pressures of £0.8m and RAAC £0.6m.

- **Warrington and Halton Teaching Hospital NHS Trust**
  £2.9m adverse variance YTD, forecast to plan
  Key driver of the adverse variance is industrial action costs of £3.5m.

- **Liverpool Women's NHS Foundation Trust**
  £1.7m adverse variance YTD, forecast to plan
  Key drivers of the variance is £1.2m shortfall on efficiency schemes and £0.9m industrial action costs.

3.8 The variance on pay compared to plan reflects the additional costs of the pay award agreed shortly after the planning submission but this is funded by NHSE and is reflected on the overperformance in income reported (Table Five).

Table Five

	M6 YTD Plan £m	M6 YTD Actual £m	M6 YTD Variance £m	M6 YTD %
Total Income	**(2,961.2)**	**(3,076.4)**	**(115.2)**	**(3.9%)**
Pay	2,006.0	2,098.3	92.3	(4.6%)
Non Pay	1,011.2	1,063.1	51.9	(5.1%)
Non Operating Items (excl gains on disposal)	49.9	38.4	(11.5)	23.0%
Total Expenditure	**3,067.1**	**3,199.9**	**132.7**	**(4.3%)**
Total Provider Surplus/(Deficit)	**(106.0)**	**(123.5)**	**(17.5)**	**(16.6%)**

3.9 Provider Agency Costs. ICB Providers set a plan for agency spend of £117.6m, compared to actual spend in 2022/23 of £155.9m. The System is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2023/24 is £127.3m.

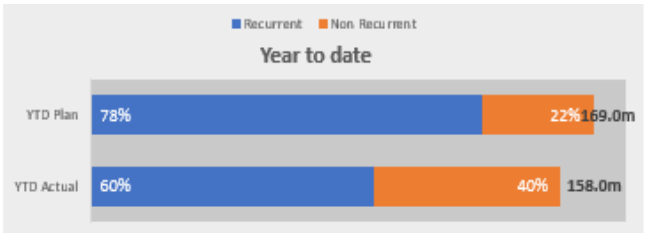
3.10 Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency. At Month 6, year to date agency spend is £66.8m (£2.8m above plan), equating to 3.18% of total pay. 9 Trusts are reporting a year to date adverse variance to plan.

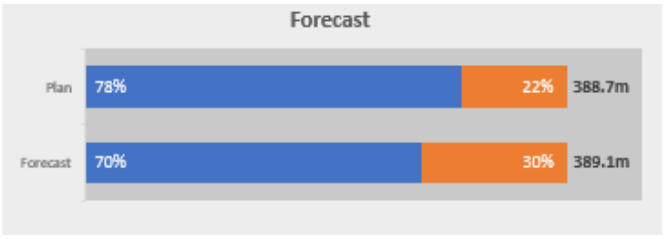
3.11 Trusts are forecasting agency spend to be £122.4m, which is a £4.8m deficit variance to a plan of £117.6m. This is still below the overall ICS agency ceiling of £127.3m. 7 Trusts are forecasting a full year adverse variance to plan for agency spend.

3.12 **Efficiencies.** Chart Two shows the ICS is not achieving its planned CIP and is more dependent on non-recurrent efficiencies than planned. This increases the risk in the underlying financial position of the ICS.

3.13 In month 6 more efficiency programmes are falling into the developed category than in month 5. However, the rate is not sufficient to ensure full development by year end.

Chart Two





4. Ask of the Board and Recommendations

4.1 The Board is asked to note the financial position reported at month 6 and the risks to delivery of the financial plan resulting from excess levels of inflation and industrial action, which are described in the paper.

5. Officer contact details for more information

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Meeting of the Board of NHS Cheshire and Merseyside

30th November 2023

Integrated Performance Report

Agenda Item No: ICB/11/23/11

Responsible Director: Anthony Middleton, Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

1.1 To inform the Board of the current position of key system, provider and place level metrics against the ICB's Annual Operational Plan.

2. Executive Summary

2.1 The integrated performance report for November 2023, see appendix one, provides an overview of key metrics drawn from the 2023/24 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

2.2 For metrics that are not performing to plan, the integrated performance report provides further analysis of the issues, actions and risks to delivery in section 5 of the integrated performance report.

3. Ask of the Board and Recommendations

3.1 The Board is asked to note the contents of the report and take assurance on the actions contained.

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

5.1 The Integrated Performance report is considered at the ICB Quality and Performance Committee. The key issues, actions and delivery of metrics that are not achieving the expected performance levels are outlined in the exceptions section of the report and discussed at committee.

Implications and Comments

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience
Reviewing the quality and performance of services, providers and place enables the ICB to set system plans that support improvement against health inequalities.

Objective Two: Improving Population Health and Healthcare
Monitoring and management of quality and performance allows the ICB to identify where improvements have been made and address areas where further improvement is required.

Objective Three: Enhancing Productivity and Value for Money
The report supports the ICB to triangulate key aspects of service delivery, finance and workforce to improve productivity and ensure value for money.

Objective Four: Helping to support broader social and economic development
The report does not directly address this objective.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The integrated performance report monitors the organisational position of the ICB, against the annual delivery plan agreed with NHSE and national targets.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
The integrated performance report provides organisational visibility against three key quality and safety domains: safe and effective staffing, equity in access and equity of experience and outcomes.

Theme Two: Integration
The report addresses elements of partnership working across health and social care, particularly in relation to care pathways and transitions, and care provision, integration and continuity.

Theme Three: Leadership
The report supports the ICB leadership in decision making in relation to quality and performance issues.

9. Risks

9.1 The report provides a broad selection of key metrics and identifies areas where delivery is at risk. Exception reporting identifies the issues, mitigating actions and delivery against those metrics. The key risks identified are ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience, which all correspond to Board Assurance Framework Risk P5.

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

10.1 The report provides an overview of financial performance across the ICB, Providers and Place for information.

11. Communication and Engagement

11.1 The report has been completed with input from ICB Programme Leads, Place, Workforce and Finance leads and is made public through presentation to the Board.

12. Equality, Diversity and Inclusion

12.1 The report provides an overview of performance for information enabling the organisation to identify variation in service provision and outcomes.

13. Climate Change / Sustainability

13.1 This report addresses operational performance and does not currently include the ambitions of the ICB regarding the delivery of its Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Actions and feedback will be taken by Anthony Middleton, Director of Performance and Planning. Actions will be shared with, and followed up by, relevant teams. Feedback will support future reporting to the Q&P committee.

15. Officer contact details for more information

15.1 Andy Thomas: Associate Director of Planning:
andy.thomas@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: Integrated Quality and Performance report

Appendix One

NHS
Cheshire and Merseyside

Integrated Quality & Performance Report

30th November 2023

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS

COCH	COUNTESS OF CHESTER HOSPITAL NHS FT
ECT	EAST CHESHIRE NHS TRUST
MCHT	MID CHESHIRE HOSPITALS NHS FT
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT

SPECIALIST TRUSTS

AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT
LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT
LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST
TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT
TWC	THE WALTON CENTRE NHS FT

COMMUNITY AND MENTAL HEALTH TRUSTS

BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT
WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT
MCFT	MERSEY CARE NHS FT
CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT

KEY SYSTEM PARTNERS

NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE

OTHER

OOA	OUT OF AREA AND OTHER PROVIDERS

Key:

Data formatting

	Performance worse than target
	Performance at or better than target
*	Small number suppression
-	Not applicable
n/a	No activity to report this month
**	Data Quality Issue

C&M National Ranking against the 42 ICBs

≤11th	C&M in top quartile nationally
12th to 31st	C&M in interquartile range nationally
≥32nd	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

C&M National Ranking against the 22 Cancer Alliances

≤5th	C&M in top quartile nationally
6th to 17th	C&M in interquartile range nationally
≥18th	C&M in bottom quartile nationally
-	Ranking not appropriate/applied nationally

Notes on interpreting the data

Latest Period: The most recently published, validated data has been used in the report, unless more recent provisional data is available that has historically been reliable. In addition some metrics are only published quarterly, half yearly or annually - this is indicated in the performance tables.

Historic Data: To support identification of trends, up to 13 months of data is shown in the tables, the number of months visible varies by metric due to differing publication timescales.

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory for 2023/2024 and may differ to the national target

RAG rating: Where local trajectories have been formalised the RAG rating shown represents performance against the agreed local trajectories, rather than national standards. It should also be noted that national and local performance standards do change over time, this can mean different months with the same level of performance may be RAG rated differently.

National Ranking: Ranking is only available for data published and ranked nationally, therefore some metrics do not have a ranking, including those where local data has been used.

Target: Locally agreed targets are in **Bold Turquoise**. National Targets are in **Bold Navy**.

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time	Oct-23	70.5%	69.6%	65.2%	72.7%	72.0%	72.0%	73.5%	73.7%	74.5%	73.6%	73.2%	71.0%	69.7%	72.3%	**76%** by Year end	69.0%	70.2%	22/42
	Ambulance category 2 mean response time	Oct-23	01:11:47	00:57:57	01:53:03	00:41:20	00:28:00	00:43:54	00:24:39	00:25:30	00:32:55	00:31:56	00:35:13	00:39:13	00:39:41	00:33:00	**00:30:00**	00:27:19	00:31:30	-
	A&E 12 hour waits from arrival	Oct-23	13.3%	12.9%	16.4%	16.3%	15.5%	16.2%	13.9%	13.6%	13.9%	14.0%	14.6%	16.5%	17.0%	-	-	13.8%	10.7%	39/42
	Adult G&A bed occupancy	Oct-23	96.6%	96.7%	96.2%	97.3%	97.0%	97.2%	95.8%	95.3%	95.40%	94.7%	95.0%	96.0%	96.5%	94.4%	**92.0%**	90.8%	93.7%	27/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-23	20.7%	20.7%	19.3%	19.9%	20.4%	20.2%	18.3%	18.0%	17.3%	17.7%	19.2%	20.6%	20.0%	12.8%	**5.0%**	16.6%	14.3%	40/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Aug-23	10,458	9,438	9,910	8,561	6,515	4,807	4,867	4,762	4,528	4,332	4,888			5,004	-	21,548	109,523	-
	Total incomplete Referral to Treatment (RTT) pathways	Sep-23	339,746	339,619	336,835	343,092	340,484	344,912	360,819	361,747	362,417	367,634	375,312	372,005^		334,686	-	1,093,809	7,747,069	-
	Patients waiting more than 6 weeks for a diagnostic test	Sep-23	21.5%	20.0%	24.3%	24.9%	19.1%	18.9%	22.1%	20.9%	21.2%	21.8%	23.3%	23.0%^		14.9%	**10.0%**	27.5%	26.3%	16/42
Cancer	Cancer patients receiving treatment within 62 days of referral	Sep-23	71.2%	69.2%	67.6%	57.3%	62.2%	67.2%	63.9%	63.6%	62.4%	68.0%	67.6%	68.0%		70.0%	**85.0%**	60.5%	59.2%	5/42
	Patients receiving definitive treatment for cancer within 31 days of diagnosis	Sep-23	94.8%	94.2%	95.9%	92.0%	93.5%	94.0%	94.2%	91.5%	94.5%	92.5%	93.9%	93.3%		96.0%	**96.0%**	90.8%	89.7%	10/42
	Patients receiving a diagnosis for cancer or a ruling out of cancer, or a decision to treat within 28 days	Sep-23	65.7%	66.1%	66.2%	62.5%	71.9%	70.2%	67.0%	67.7%	69.9%	70.3%	69.4%	68.6%		70.0%	**75.0%**	69.7%	71.6%	29/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Jul-23	69.0%	72.0%	44.0%	76.0%	78.0%	81.0%	94.0%	100.0%	106.0%	95.0%				100.0%	**100.0%**	110.0%	129.7%	18/42
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Aug-23	59.0%	62.0%	50.0%	65.0%	55.0%	59.0%	66.0%	71.0%	70.0%	67.0%	65.0%			60.0%	**60.0%**	-	69.0%	-
	Access rate for Talking Therapies services	Jul-23	60.0%	61.0%	51.0%	67.0%	58.0%	70.0%	60.0%	62.0%	59.0%	61.0%				100.0%	**100.0%**	63.7%	70.1%	32/42
	Dementia Diagnosis Rate	Sep-23	64.1%	65.0%	65.2%	64.5%	64.5%	65.1%	65.2%	65.2%	65.6%	65.8%	66.0%	66.2%		66.7%	**66.7%**	69.1%	64.3%	16/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Sep-23	100	100	100	100	100	105	100	100	100	95	95	95		≤ 60	-	280	1,840	34/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Aug 23 YTD	29.3%	37.6%	43.3%	54.8%	68.5%	80.4%	2.8%	6.6%	11.3%	16.0%	21.3%			18.7%	**75%** by Year end	21.5%	21.3%	17/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Sep-23	76.2%	76.7%	73.9%	80.6%	83.3%	78.7%	86.5%	83.2%	83.4%	87.0%	86.0%	81.0%		70.0%	**70.0%**	84.0%	85.0%	34/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Aug-23	74.0%	91.9%	72.6%	80.0%	86.5%	97.7%	56.9%	75.4%	76.1%	81.7%	87.3%			100.0%	**100.0%**	95.0%	92.3%	25/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Aug-23	104.9%	100.9%	107.1%	115.5%	107.1%	102.4%	98.7%	98.4%	111.8%	105.5%	105.9%			-	-	104.6%	106.5%	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Jun-23	8.0%	8.0%	7.7%	7.5%	7.4%	7.4%	7.3%	7.3%	7.3%					10.0%	**10.0%**	7.4%	7.7%	10/42
	Total volume of antibiotic prescribing in primary care	Jul-23	1.001	1.003	1.045	1.071	1.087	1.093	1.088	1.086	1.084	1.079				0.871	**0.871**	1.088	0.985	33/42
Note/s	^ Excludes AHCH who did not submit data for Sep-23																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Jul-23	76.0	79.6	88.7	80.7	81.2	75.4	86.9	79.8	85.9	79.1	78.6			-	-	-	68.0	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Aug-23	93.4%	92.9%	92.8%	91.9%	92.0%	92.3%	92.3%	92.7%	92.8%	92.5%	92.8%	92.7%		-	-	92.7%	93.2%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Jul-23	191.0	184.5	182.0	207.7	183.7	172.2	173.2	170.7	202.8	153.8	166.2			-	-	-	146.8	-
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028.	Jun-23	58.9%	59.4%	60.2%	59.7%	59.6%	58.6%	58.9%	62.0%	60.8%	55.0%				70.0%	75% by 2028	55%	58%	16/22
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1-23	59.63%	60.76%			66.70%			65.99%						77.0%	77.0%	-	66.72%	-
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Jul-23	76.0%	74.6%	76.9%	65.2%	78.6%	80.2%	82.0%	83.2%	84.0%	86.0%	87.0%			100.0%	100.0%	102.6%	89.30%	20/42
Quality & Safety	Still birth per 1,000	Jun-23	3.50	3.36	3.14	3.16	3.05	3.25	2.76	2.80	3.30	3.30				-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	Aug-23	122.5%	123.3%	126.5%	131.0%	132.7%	134.4%	134.0%	144.4%	142.4%	143.8%	135.8%	132.3%		100%	100%	135%	130%	27/42
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Aug-23	124.7%	127.4%	128.9%	129.4%	128.9%	133.9%	131.2%	141.7%	142.1%	150.6%	150.4%	153.1%		100%	100%	147%	125%	41/42
	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalisation	May-23	1.017	1.021	1.026	1.027	1.033	1.029	1.033	1.026	1.027					1.0	1.0	-	1.0	-
	Never Events (by month)	Sep-23	4	1	3	5	5	2	2	2	2	2	0	0	5	0	0	-	-	-
	21+ day Length of Stay	Sep-23	1,475	1,551	1,467	1,377	1,528	1,485	1,449	1,365	1,425	1,244	1,260	1,295	1,227	1,594	-	-	-	-
Workforce / HR (ICS total)	Staff in post	Aug-23	69,730	70,303	70,619	70,568	71,141	71,504	71,766	72,150	72,089	72,205	71,950	72,298		71,153	-	198,623	-	-
	Bank	Aug-23	4,562	4,520	5,035	4,785	4,977	4,956	5,340	4,798	4,596	4,633	5,036	5,372		3,948	-	16,424	-	-
	Agency	Aug-23	1,826	1,778	1,958	1,815	1,881	1,656	1,524	1,182	1,434	1,381	1,252	1,363		1,166.9	-	4,206	-	-
	Sickness	Aug-23	6.4%	6.4%	6.3%	6.3%	6.2%	6.1%	6.0%	5.8%	5.8%	5.8%	5.6%	5.6%		6.3%	-	6.0%	4.6%	35/42
	Turnover	Jun-23	15.1%	14.8%	14.7%	14.4%	14.1%	14.0%	13.3%	13.1%	12.2%	12.4%				13.7%	-	12.3%	-	-

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Plan (£m)	Dir. Of Travel	FOT (£) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	Sep-23	-55	-56.8	-63.2	-71.9	-63.6	-47.8	-29.6	-	48.2	-75.3	-103	-123.65	-128.2	-71.5	↓	-51.2	-51.2	0.0
	Financial position £ms (ICS) VARIANCE	Sep-23	-24.7	-31.9	-34.9	-36.9	-29.6	-14	0.7	-	-7.8	-20.5	-38.1	-49.9	-56.7					
	Efficiencies £ms (ICS) ACTUAL	Sep-23	136.7	182.6	217.5	240.1	263.6	288.0	335.6	-	43.2	68.7	97.9	132.7	158.0	169.0	↔	388.7	389.1	0.4
	Efficiencies £ms (ICS) VARIANCE	Sep-23	-11.2	-0.3	9.0	5.6	-3.0	-10.8	4.7	-	-7.3	-8.2	-7.7	-4.6	-11.0					
	Capital £ms (ICS) ACTUAL	Sep-23	60.1	80.9	89.8	110.6	112.8	169.1	237.5	-	15.3	24	38.8	42.8	53.9	76.5	↔	230	235.0	5.0
	Capital £ms (ICS) VARIANCE	Sep-23	32.6	31.7	43.2	42.1	62.6	29.6	-12.7	-	2.6	6.3	6.0	16.8	22.6					

ICB Mental Health (MH) and Better Care Fund (BCF) Overall Financial Position:

Category	Metric	Latest period	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	Sep-23	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	↔
	BCF achievement (Places achieving expenditure target)	Sep-23	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	n/a	↔

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	ICB *
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other	
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time	Oct-23	53.0%	53.5%	53.4%	61.8%	67.1%	68.0%	68.8%	69.5%	-	84.8%	-	-	94.5%	97.9%	89.3%	-	-	69.7%
	A&E 12 hour waits from arrival	Oct-23	18.2%	10.9%	17.2%	17.6%	20.9%	16.4%	16.7%	**	-	**	-	-	-	-	-	-	-	17.0%
	Adult G&A bed occupancy	Oct-23	99.3%	95.6%	95.7%	94.8%	97.0%	95.2%	98.7%	-	86.7%	63.0%	87.3%	80.2%					-	96.5%
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Oct-23	18.9%	9.8%	19.5%	16.6%	20.0%	24.7%	19.2%										-	20.0%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Aug-23	975	95	771	345	917	416	396	148	26	304	0	9	0	0	0	-	710	4,888
	Total incomplete Referral to Treatment (RTT) pathways	Sep-23	34,809	13,683	42,372	44,146	33,445	77,933	73,695	**	5,055	19,949	947	15,317	3,201	121	43	-	26,338	372,005^
	Patients waiting more than 6 weeks for a diagnostic test	Sep-23	24.7%	30.0%	16.8%	6.0%	22.5%	18.6%	33.6%	**	8.6%	7.4%	0.0%	0.6%	25.4%	0.0%	-	-	-	23.0%^
Cancer	Cancer patients receiving treatment within 62 days of referral	Sep-23	72.0%	57.1%	67.2%	77.7%	64.3%	62.3%	73.4%	n/a	91.7%	11.1%	87.0%	n/a	85.7%				-	68.0%
	Patients receiving definitive treatment for cancer within 31 days of diagnosis	Sep-23	97.8%	97.8%	84.9%	94.7%	98.9%	90.5%	94.7%	100.0%	100.0%	82.8%	99.2%	100.0%	87.5%				-	93.3%
	Patients receiving a diagnosis for cancer or a ruling out of cancer, or a decision to treat within 28 days	Sep-23	53.6%	75.2%	68.7%	73.4%	75.1%	73.0%	70.3%	100.0%	70.0%	33.9%	82.4%	100.0%	89.7%				-	68.6%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Sep-23	Mental Health service providers only														63.0%	100.0%	-	*
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	Sep-23	75.0%	84.0%	90.0%	Community service providers only									73.0%	89.0%	81.0%	-	-	81.0%
Quality & Safety	Still birth per 1,000	Apr-23	3.27	-	0.33	1.36	3.19	-	3.48	-	-	3.59	-	-						2.80
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	Aug-23	126.8%	266.7%	132.3%	176.1%	130.6%	124.1%	107.1%	200.0%	150.0%	0.0%	107.7%	100.0%						132.3%
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Aug-23	114.3%	137.0%	212.5%	162.3%	140.7%	166.1%	137.2%	212.5%	83.3%	120.0%	280.0%	70.0%						153.1%
	Summary Hospital-level Mortality Indicator (SHMI): Deaths associated with hospitalisation **1** = Higher than expected, **2** = As expected	May-23	2	1	2	2	2	2	2											
	Never Events (rolling 12 month total)	Sep-23	2	1	2	2	6	6	3	2	0	1	0	1	1	1	0	0	1 **	29
	21+ day Length of Stay (ave per day)	Sep-23	89	53	95	158	124	441	232	2	19	0	28	28						1,227
Workforce / HR (Trust Figures)	Staff in post	Aug-23	4,457	2,345	4,858	5,816	4,118	13,897	9,420	3,956	1,820	1,628	1,701	1,453	1,315	1,462	10,258	3,797	-	72,298
	Bank	Aug-23	312.7	186.1	452.4	446.7	353.3	1,054.3	966.3	240.5	51.4	68.9	36.1	87.5	4.8	51.1	904.0	156.3	-	5372.4
	Agency	Aug-23	59.0	89.0	103.1	65.6	95.6	157.3	273.6	15.6	7.9	5.4	12.0	4.4	75.0	11.7	286.6	101.1	-	1362.8
	Sickness (via Ops Plan Monitoring Dashboard)	Aug-23	5.4%	5.5%	5.1%	6.0%	5.7%	6.4%	3.6%	6.0%	4.7%	6.7%	4.9%	5.9%	5.6%	6.1%	7.8%	6.5%	-	5.6%
	Turnover	Jun-23	13.7%	12.7%	11.6%	12.1%	12.4%	11.7%	11.1%	12.3%	14.2%	12.6%	14.8%	14.3%	12.5%	21.0%	11.3%	13.3%	-	12.4%
Finance	Overall Financial position Variance (£m)	Sep-23	-6.5	-0.8	-5.5	0.5	-2.9	0.0	0.0	0.0	0.0	-1.7	0.4	0.0	0.0	0.0	0.0	-1.0	-39.2	-56.7
	Efficiencies (Variance)	Sep-23	-4.9	0.0	-0.9	0.7	0.1	2.6	0.0	-1.0	-1.1	-1.2	0.0	0.0	-0.1	-1.1	0.0	-0.4	-3.7	-11.0
	Capital (Variance)	Sep-23	9.0	1.1	0.6	1.7	1.9	-0.7	0.1	0.5	2.9	1.6	-0.4	0.5	0.4	2.4	-0.5	1.1	0.0	22.6
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data deadlines of NHSE. Please see slides 4 and 5 for the ICB's latest position on the above metrics ^ Excludes AHCH who did not submit data for September ** Independent Providers / Other providers (Alternative Futures - Weaver Lodge)																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time	Oct-23	60.8%	67.7%	54.6%	64.3%	73.7%	70.3%	75.8%	78.0%	67.1%		69.7%	72.3%	**76%** by Year end
	Ambulance category 2 mean response time	Sep-23	00:36:56		00:42:43	00:38:26	00:39:32	00:41:52	00:40:22	00:42:37	00:41:09		00:39:41	00:33:00	**00:30:00**
	A&E 12 hour waits from arrival	Oct-23	14.5%	17.8%	16.4%	20.1%	15.3%	16.0%	13.4%	18.6%	13.1%		17.0%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	Aug-23	545	996	389	621	520	217	152	410	204		4,888	5,004	-
	Total incomplete Referral to Treatment (RTT) pathways	Sep-23	36,870	40,731	48,683	31,074	63,353	30,292	25,177	22,280	38,663		372,005^	334,686	n/a
	Patients waiting more than 6 weeks for a diagnostic test	Sep-23	23.2%	21.7%	6.4%	18.4%	18.6%	35.8%	31.5%	39.0%	16.6%		23.0%^	14.9%	**10%**
Cancer	Cancer patients receiving treatment within 62 days of referral	Sep-23	63.5%	70.2%	76.7%	72.3%	62.2%	72.4%	64.2%	55.2%	73.2%		68.0%	70.0%	**85.0%**
	Patients receiving definitive treatment for cancer within 31 days of diagnosis	Sep-23	90.8%	91.3%	96.8%	96.1%	89.6%	95.3%	93.0%	96.8%	93.7%		93.3%	96.0%	**96.0%**
	Patients receiving a diagnosis for cancer or a ruling out of cancer, or a decision to treat within 28 days	Sep-23	70.7%	63.4%	71.3%	77.0%	68.2%	64.7%	65.5%	68.5%	71.3%		68.6%	70.0%	**75.0%**
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Sep-23	100.0%		*	66.0%	66.0%	54.0%	78.0%	50.0%	67.0%		*	60.0%	**60.0%**
	Access rate for Talking Therapies services	Jul-23	57.0%		77.0%	62.0%	53.0%	103.0%	67.0%	44.0%	46.6%		61.0%	100.0%	**100.0%**
	Dementia Diagnosis Rate	Sep-23	66.9%	66.2%	65.7%	72.7%	62.0%	69.8%	60.3%	66.8%	66.8%		66.2%	66.7%	**66.7%**
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Jul-23	30		5	5	25	10	5	10	10		95	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Jun-23	22.7%		22.7%	21.1%	23.4%	11.5%	24.4%	19.8%	18.0%		21.3%	18.7%	**75%** by Year end
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	Aug-23	107.5%		104.6%	107.9%	103.8%	106.2%	105.6%	95.6%	108.3%	114.7%	105.9%	-	-
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Jun-23	6.9%		9.2%	6.3%	7.7%	5.7%	6.9%	6.1%	8.1%		7.3%	10.0%	**10.0%**
	Total volume of antibiotic prescribing in primary care	Jul-23	0.978		1.145	0.983	1.104	1.171	1.212	1.162	1.138		1.079	0.871	**0.871**
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions	Q1 23/24	180.1	188.2	195.0	195.3	361.2	272.1	334.5	261.7	214.6		-	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Aug-23	88.8%	88.8%	94.1%	95.3%	94.2%	94.3%	95.3%	95.5%	92.4%		92.7%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000	Q1 23/24	564.5	460.5	465.8	382.5	637.6	632.2	687.4	394.9	518.7		-	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q1-23	68.64%		65.03%	64.63%	64.82%	67.00%	62.41%	66.20%	58.92%	69.02%	65.99%	77.0%	**77.0%**
	Improve access rate to Children and Young People's Mental Health Services (CYP MH) (12 Month Rolling) **	Jul-23	43.7%		41.7%	79.2%	46.2%	60.0%	76.2%	92.6%	84.3%	92.9%	n/a ***	-	-
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation	Aug-23	135.3%		142.0%	144.4%	106.4%	127.7%	80.9%	118.2%	81.0%	104.8%	132.3%	100.0%	**100.0%**
	Healthcare Acquired Infections: E.Coli (Hospital onset)	Aug-23	114.1%		144.4%	153.8%	137.9%	106.6%	130.0%	127.0%	140.5%	124.8%	153.1%	100.0%	**100.0%**
Finance	Overall Financial position Variance (£m)	Sep-23	-6.37	-9.71	-2.75	-7.82	-0.16	-5.77	-4.32	-10.05	-1.95		9.96	0.0	**0.0**
	Efficiencies (Variance)	Sep-23	1.90	-0.80	-0.80	-0.40	-1.60	-0.80	-1.30	0.00	0.00		0.00	0.0	**0.0**
	Mental Health Investment Standard met/not met (MHIS)	Sep-23	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		Yes	Yes	**Yes**
	BCF achievement (Places achieving expenditure target)	Sep-23	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9		9/9	9/9	**9/9**
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels, please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is NOT the same as the NHS Oversight Framework indicator used in ICB table														

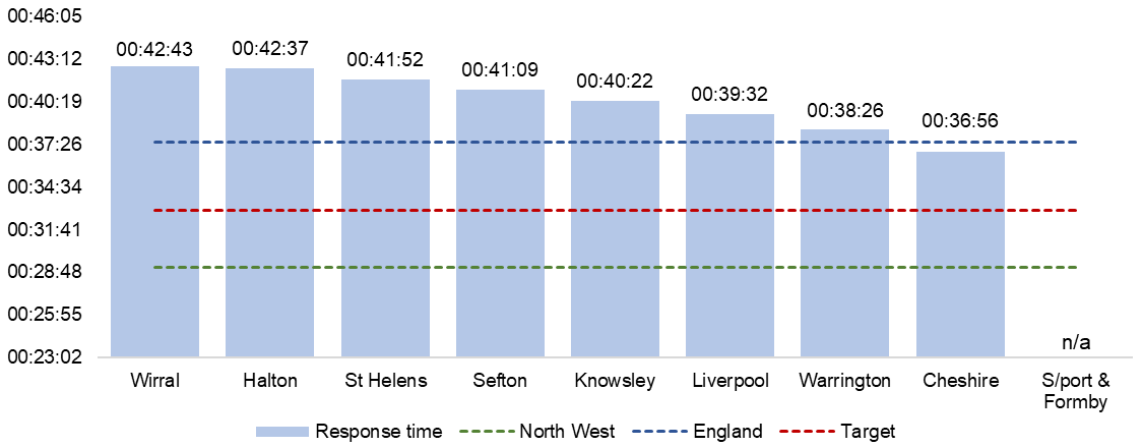
5. Exception Report – Urgent Care

Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Oct-23)	00:39:41	National Ranking	n/a

Place Breakdown (Sep-23)



Issue

- The national category 2 mean response time target for 2023/24 is <30 minutes. NWAS has set a plan to achieve 33 minutes. Ambulance handover is a key dependency.

Action

Particular challenges at COCH, LUFT, WUTH, and the Whiston Site of MWL with targeted actions in response at Place/Trust.

- COCH: Improvement programme supported by ECIST includes Ambulance Handover. Rapid Improvement week (Oct to drive direct conveyances to SDEC).
- LUFT: ECIST Tier 1 work, includes handover, direct conveyance to SDEC and Direct Pathway Areas across UEC pathway and a new UTC streaming area at Royal site.
- Whiston Site of MWL: System actions focus on ED, admission avoidance and discharge. Use of frailty and ARI case finders, improved use of UCR via NWAS referrals.
- WUTH: System ambulance improvement group established. Ambulance Arrival Zone implemented. Working to increase NWAS UCR referrals.

Delivery

- Achieve 33 minutes by March 2024

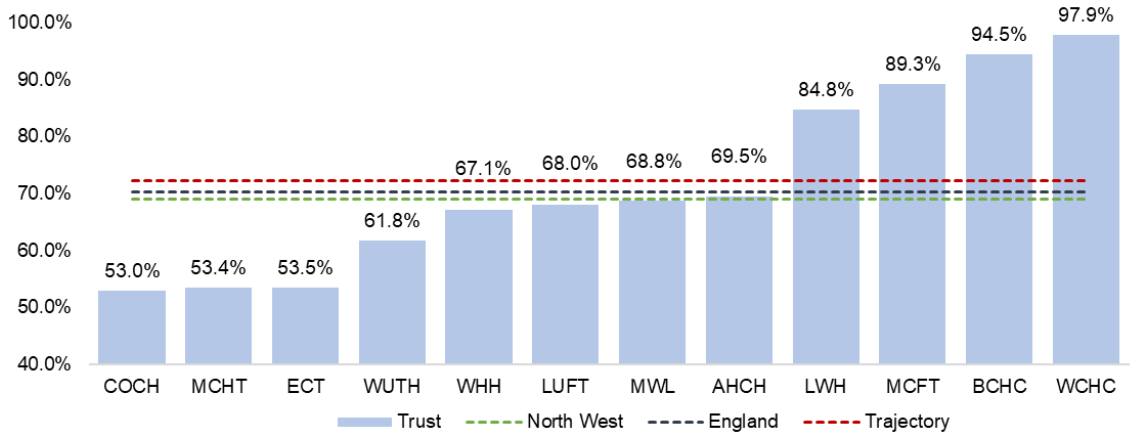
5. Exception Report – Urgent Care

Cheshire and Merseyside

A&E 4 hour waits from arrival

Latest ICB Performance (Oct-23)	69.7%	National Ranking	22/42

Provider Breakdown (Oct-23)



Issue
- Cheshire and Merseyside performance dipped in October and is falling 2.6% short of the in-year operational planning trajectory of 72.3% for the month, although performance is close to the median for ICBs across England
- Performance has been particularly challenged in the Wirral and Cheshire systems.

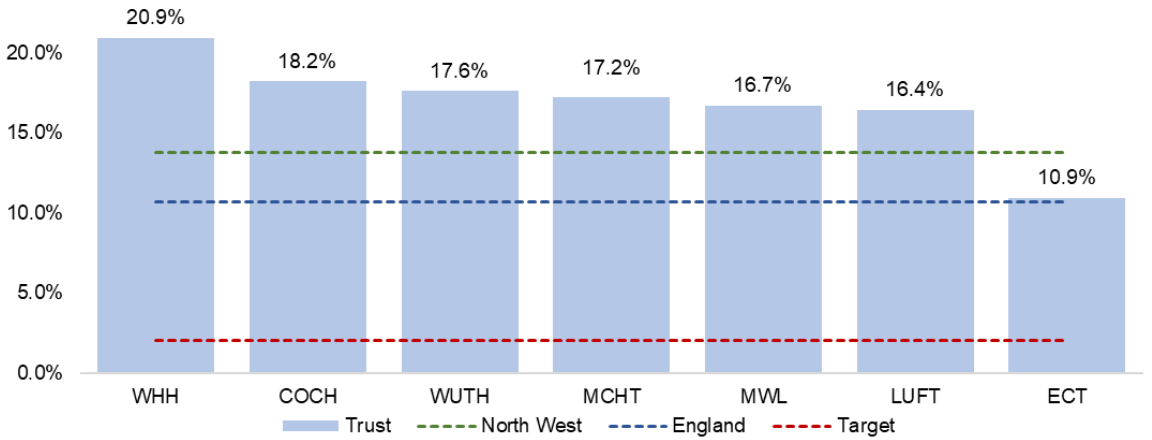
Action
- East Cheshire: Cheshire East Home First workstream and UEC improvement work streams in place with focus on streaming to SDEC, and wider system operational processes e.g. reablement and frailty
- West Cheshire: System focus on patient flow, Type 3 activity/discharge, creating See and Treat space (estate),utilising SDEC, discharge lounge and focusing on support from AACP and community teams, domiciliary care providers
- Wirral: Initiatives focusing on ED 4-hour improvement include: Non-admitted care pathway; SDEC/specialty in-reach and maximising UTC streaming.

Delivery
- C&M continues to plan for achievement of 76% by March 2024, this remains a challenging trajectory within the context of emerging winter pressures and ongoing industrial action.

A&E 12 hour waits from arrival

Latest ICB Performance (Oct-23)	17.0%	National Ranking	39/42

Provider Breakdown (Oct-23)



Issue
- 17.0% of Cheshire & Merseyside A&E patients are delayed over 12 hours compared to the England average of 10.7%.

Action
- C&M trusts' actions are focused on direct access pathways to enable NWAS conveyance to SDEC and other UEC services.
- Improved flow within ED supported by in-reach from specialties and social care teams.
- Urgent community response (UCR): trusts/places working with NWAS to drive up direct referral into UCR. These are patients who would likely have otherwise sought care through the Emergency Department.

Delivery
- Improvement by March 2024 in line with delivery of key UEC metrics

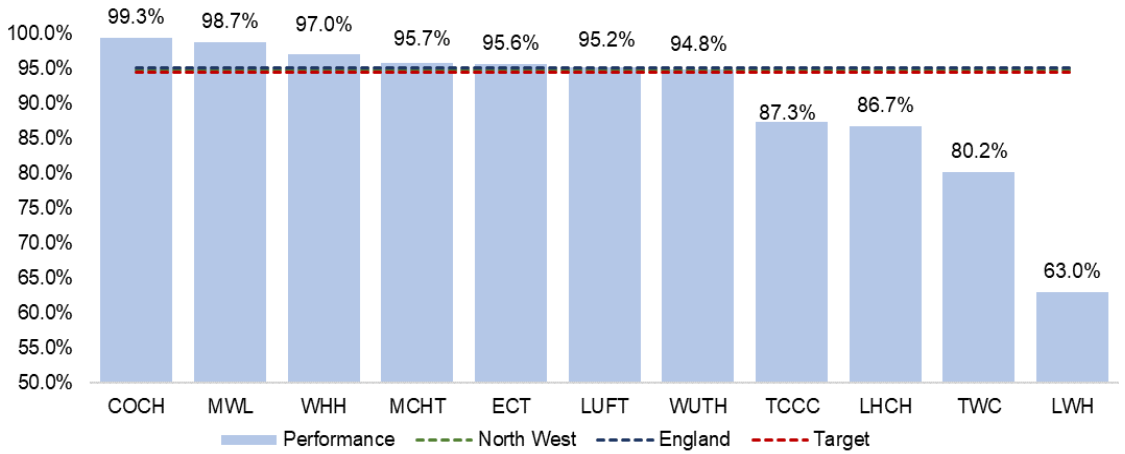
5. Exception Report – Urgent Care

Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Oct-23)	96.5%	National Ranking	27/42

Provider Breakdown (Oct-23)



Issue
- G&A bed occupancy is consistently high across acute trusts in C&M. The national ambition for winter is to achieve 92% occupancy, Cheshire and Merseyside have set a plan to achieve 93.4% by March 2024.
- NCTR: Long length of stay and patients no longer meeting criteria to reside in hospital are a key driver of high occupancy.

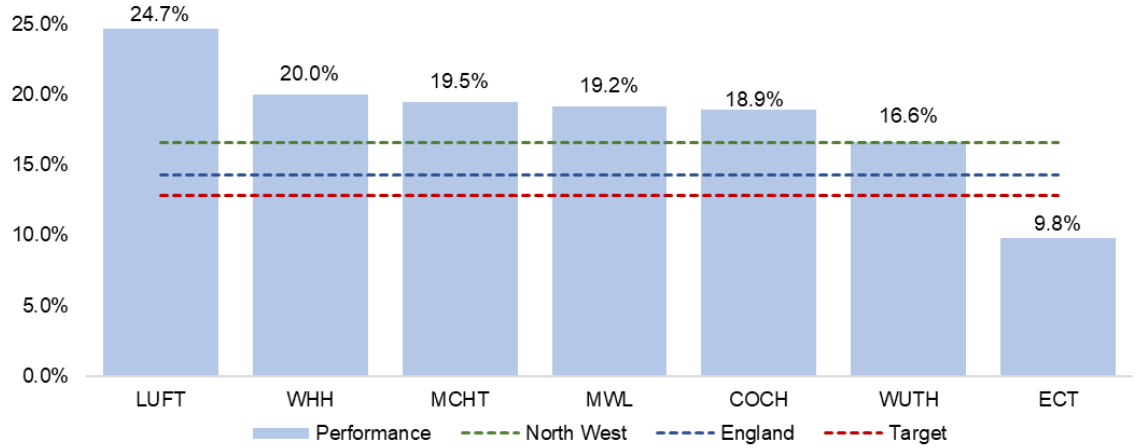
Action
- Place and providers have worked together to update winter demand and capacity assumptions, these indicate that providers plan to achieve 93.4%, but this is predicated on the improved NCTR position being maintained

Delivery
- Achieve 93.4% bed occupancy by March 2024

No Criteria To Reside (NCTR)

Latest ICB Performance (Oct-23)	20.0%	National Ranking	40/42

Provider Breakdown (Oct-23)



Issue
- NCTR is at 20.0%, higher than England (14.3%) and NW (16.6%)

Action
- Places and Providers have reviewed their assumptions and plans regarding NCTR
- Winter plans are aligned to Tier 1 / 10 high impact UEC interventions.
- This includes aligning processes across the 9 C&M care transfer hubs, addressing capacity gaps in intermediate care, improving community bed productivity, and deploying this year's discharge fund to improve staffing e.g. in care transfer hubs and care arranging teams.
- This has resulted in a plan for NCTR to average 19% over the second half of 2023/24, compared to 21.3% in the original 2023/24 plans, reflecting improved plans from East Cheshire, Countess of Chester and LUFT.

Delivery
- Winter plans span October 2023 to March 2024, with a plan to average 19% over this period

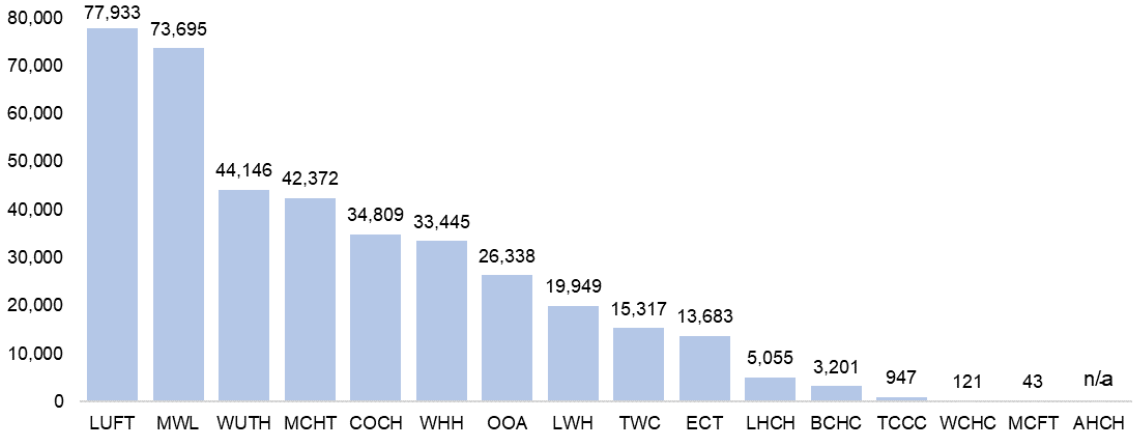
5. Exception Report – Planned Care and Diagnostics

Cheshire and Merseyside

Total incomplete Referral to Treatment (RTT) pathways

Latest ICB Performance (Sep-23)	372,005 ^	National Ranking	n/a

Provider Breakdown (Sep-23)



Issue
- The number of incomplete pathways in C&M has risen by 4% since April 2023 compared with 4.4% nationally.
- Year on year 12-month growth in total referrals is 6% year to date (5.9% for England).

Action
- Trusts are delivering higher levels of Value Weighted Activity (VWA) compared to 19/20 baseline, despite industrial action (IA). National targets have been adjusted to reflect the impact of IA down from 105% to 103% for C&M.
- Trusts have been proactive in rebooking activity cancelled due to IA.
- The elective recovery programme has been focusing eliminating 65 week waits by March 2024, and is on track with 40,000 patients in the "potential breach" cohort left to clear.

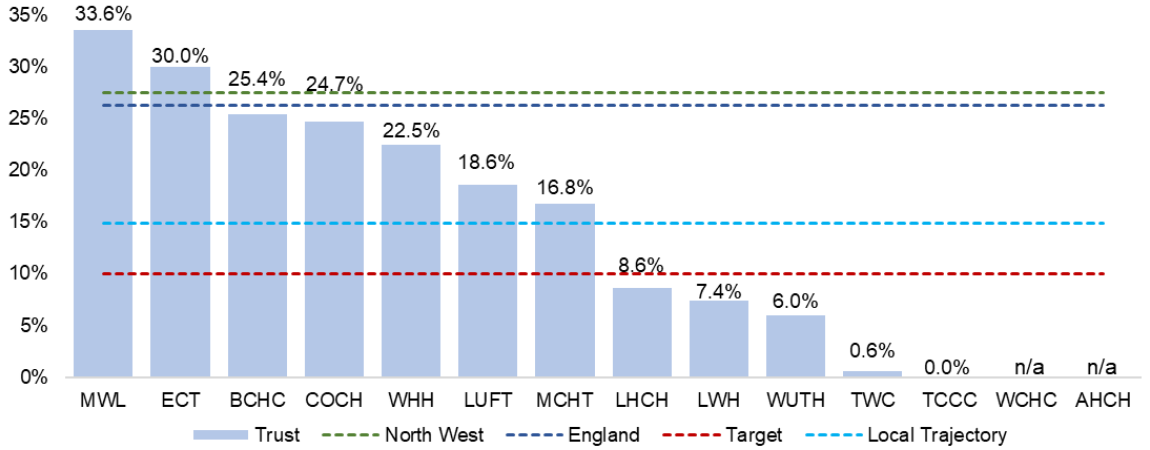
Delivery
- The ICB target to reduce incomplete pathways to 323,190 by March 2024 is not expected to be delivered, with the primary focus on reducing long waiters.

^ *Excludes AHCH who did not submit data for September*

Patients waiting more than 6 weeks for a diagnostic test

Latest ICB Performance (Sep-23)	23.0% ^	National Ranking	16/42

Provider Breakdown (Sep-23)



Issue
- C&M is not yet achieving the 10% 6-week standard required by end of March 2024

Action
- In August C&M recorded the highest level of diagnostic activity per month, post March 2020
- YTD activity is 9% above plan with most over performance driven by imaging tests. Weekly data shows improvement in Oct-23, particularly for ultrasound.
- C&M have delivered the third highest levels of Community Diagnostic Centre (CDC) activity nationally. 10 C&M CDCs are open, 5 of which opened in 2023/24.
- C&M national ranking has improved from 18th in July to 16th in September, out of 42 ICBs
- BCHC: performance relates to a waiting list of 221 audiology patients with 84 waiting longer than 6 weeks, additional support to be offered.
- M&WL: 30% of patients waiting longer than 6 weeks (4,796 patients) require an ultrasound. CDC capacity has been mobilised to reduce this number during October.
- 16% (2,523) patients require a colonoscopy, primarily at COCH and MCHT where waiting times are longest. Endoscopy list utilisation support is in place.

Delivery
- C&M expect to meet the target for 90% of patients seen within 6wks by 31st March 2024.

^ *Excludes AHCH who did not submit data for September*

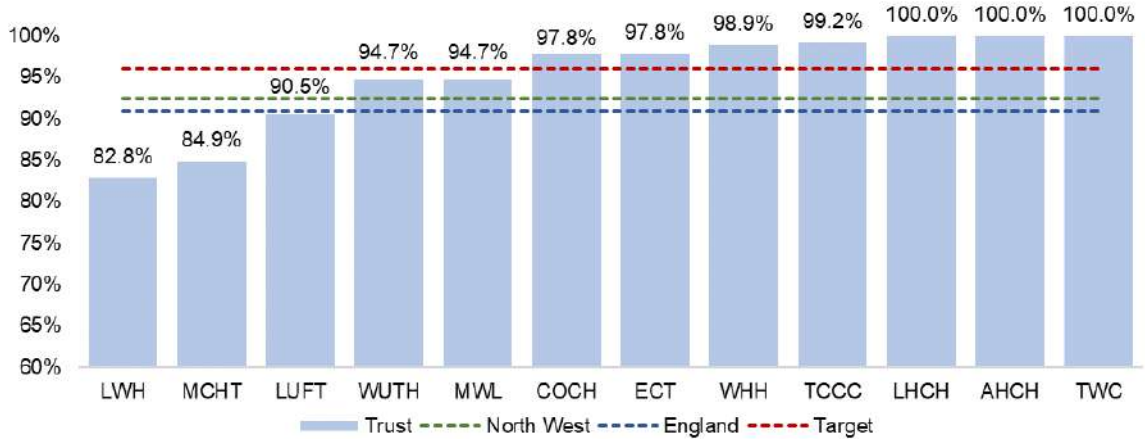
5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

Patients receiving definitive treatment for cancer within 31 days of diagnosis

Latest ICB Performance (Sep-23)	93.3%	National Ranking	10/42

Provider Breakdown (Sep-23)



Issue
- C&M did not meet the 96% standard in August.

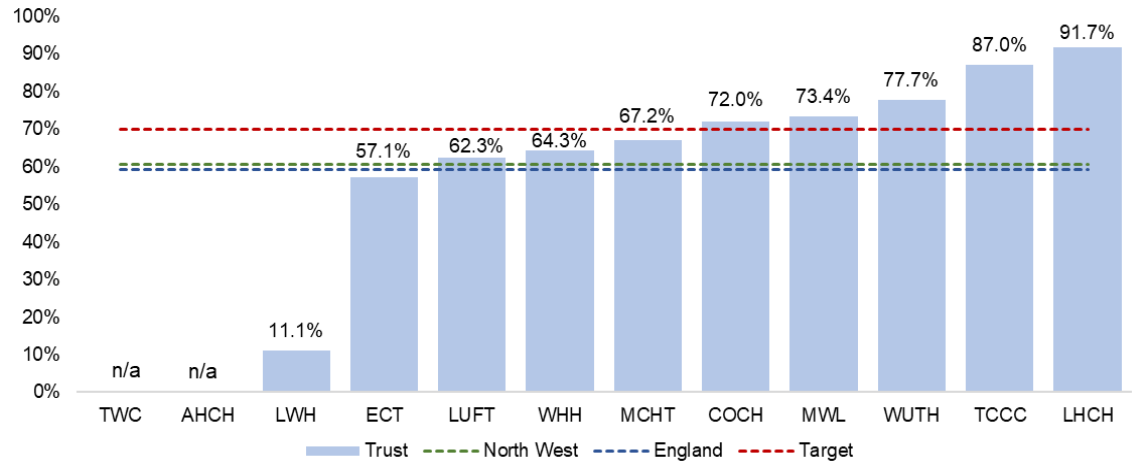
Action
- LWH: CMCA funded additional analyst to be recruited to help with capacity visualisation and planning, new Cancer Coordinator & Support worker recruited to support off-site surgery and patients with additional needs to reduce waiting times for the most complex patients started on 6th November, 2 Consultant posts advertised and 1 Agency Locum started on 23rd October, additional general Gynaecologist started on 2nd October
- LUFT: additional theatre sessions including weekend operating and increased robotic lists
- MCHT: recruited additional colorectal surgeon, undertaken high-risk pre-operative assessment clinic (POAC) capacity review to increase decision to treat (DTT) compliance.
- Additional investments secured as noted opposite.

Delivery
- C&M expects to meet the 96% performance standard by the end of Q3 23/24.

Cancer patients receiving treatment within 62 days of referral

Latest ICB Performance (Sep-23)	68.0%	National Ranking	5/42

Provider Breakdown (Sep-23)



Issue
- C&M currently does not meet the 70% target.

Action
- LWH, MCHT and LUFT in receipt of Tier 2 support. Improvement action plans in place with access to additional resources through the Cancer Alliance.
- LWH is working with the NHS Transformation Unit to identify and transform their most challenged pathway (hysteroscopy) CMCA has funded additional hysteroscopes which are in procurement.
- CMCA has secured an additional £850k for cancer operational performance improvement to be invested in Tier 2 trusts and other challenged pathways including at COCH
- TWC and AHCH had no (0) patients on the 62 day pathway

Delivery
- C&M is on track to meet 70% by the end of March..

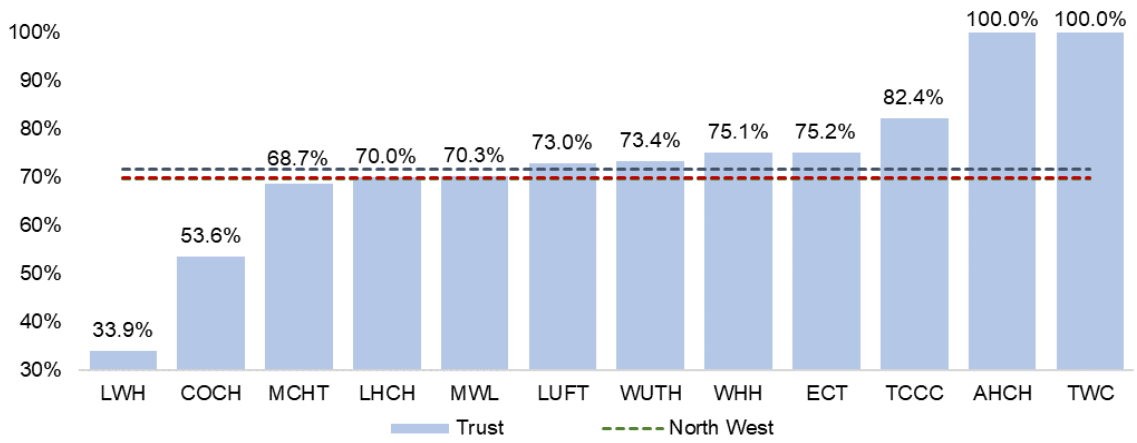
5. Exception Report – Cancer Care and Mental Health

Cheshire and Merseyside

Patients receiving a diagnosis for, or a ruling out of, cancer within 28 days

Latest ICB Performance (Sep-23)	68.6%	National Ranking	29/42

Provider Breakdown (Sep-23)



Issue
- C&M FDS is below target and marginally behind trajectory for September 2023, underperformance is due to known issues in a small number of Trusts, notably COCH skin due to seasonal demand and LWH hysteroscopy pathway bottlenecks.

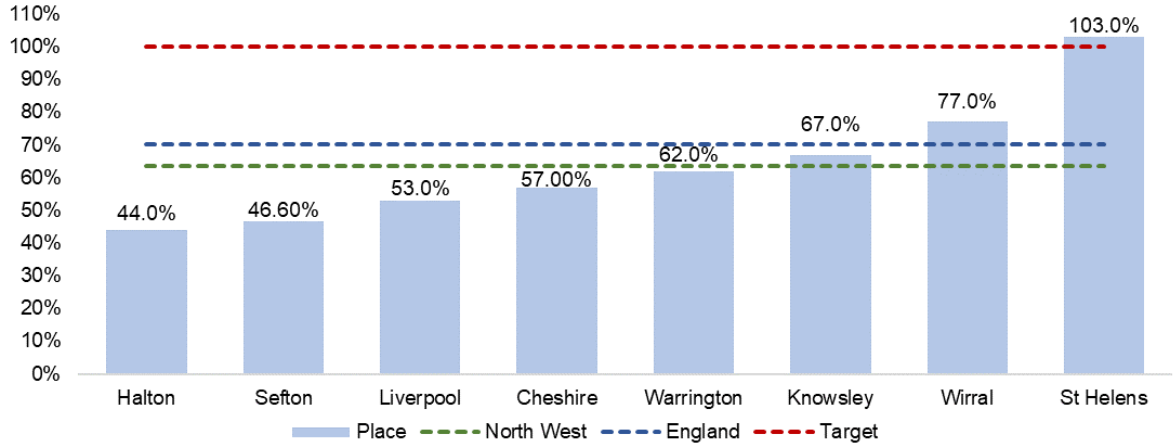
Action
- CMCA acted on behalf of providers to produce and present bids for additional transactional funding schemes to address FDS problem areas, including:
  - COCH: admin staff funding to address skin, specifically FDS letters.
  - LWH: additional hysteroscopes and pathway analysis, funding for the NHSTU.
  - MCHT: continue colorectal recovery plan and pathway transformation for a Triage Nurse, Nurse Consultant for LGI and CSW, and Nurse funding for the Haematuria pathway.
- Improvement should be supported by the improved backlog position in C&M, which is significantly ahead of trajectory.

Delivery
- C&M expect to achieve 75% by March 24 in anticipation of a rise to 80% in the next 2 years

Access rate for Talking Therapies (TT) Services (formerly IAPT)

Latest ICB Performance (Jul-23)	61.0%	National Ranking	32/42

Place Breakdown (Jul-23)



Issue
- Talking Therapies (TT) is not achieving the access ambition set out in the Long-Term Plan.

Action
- Comms: Increase awareness of TT services, supported by a Q4 National Campaign, simplify self-referral and pathways for people with long term conditions, prioritising cancer pathways.
- Service Models: Share learning between services, develop optimum service model and improve efficiency with a single service specification across C&M TT Services.
- Place: Review contracts and financial commitments. Cost analysis taking place, outcomes to be discussed between Place commissioning leads and providers (CWP, MCFT and non-NHS services, e.g. Big Life Group (C/East), MH Matters (Warrington and Sefton)).

Delivery
- C&M has a recovery access target of 72,724 based on a reprofiled national trajectory, recognising services have experienced workforce recruitment and retention challenges. Longer term plans relate to workforce: increase trainee numbers in 24/25 by identifying wider resource/recruitment pools, increase High Intensity Therapist (HIT) trainee numbers and Psychological Wellbeing Practitioner (PWP) apprenticeships.

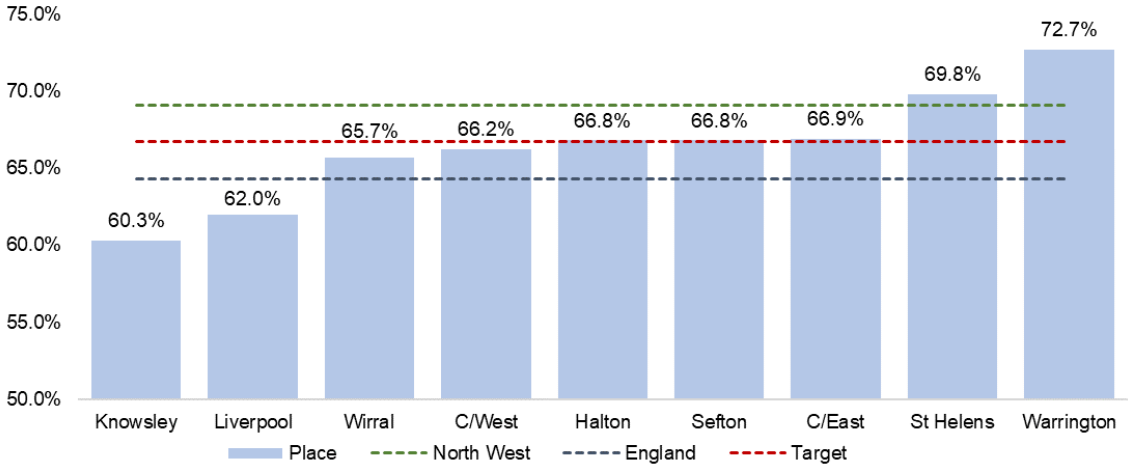
5. Exception Report – Dementia and Learning Disabilities

NHS Cheshire and Merseyside

Dementia Diagnosis rates

Latest ICB Performance (Sep-23)	66.2%	National Ranking	16/42

Place Breakdown (Sep-23)



Issue
- Dementia diagnosis rates remain below pre-pandemic levels and are not achieving the national target of 66.7% in 4 ICB places.
- Delivery of target rates in Knowsley and Liverpool will be challenging for this year within the context of emerging winter pressures and the scale of recovery required.

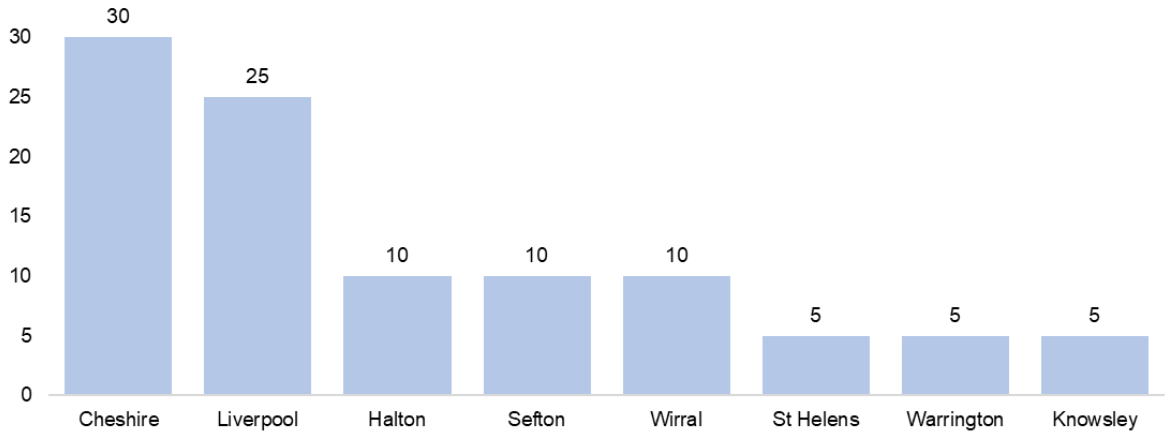
Action
- Wirral place continue to progress actions associated with their Dementia Strategy
- Capacity being identified to support development of a C&M action plan which will review:
  - place-based data and information to better understand baseline provision (including risks and issues) across the whole pathway
  - place-based dementia strategies, key objectives and progress
  - the status of any place-based dementia groups and involvement of key partners to ensure that the recommendations of the APPG report, Raising the Barriers, are addressed

Delivery
- Access rates have increased between April and September 2023 in each of the 4 places who remain below the national target

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Sep-23)	95*	National Ranking	34/42

Place Breakdown (Sep-23)



Issue
- There are currently 95* adult inpatients, of which 60* are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE. The target identified for C&M (ICB and Spec Comm) is 60 or fewer by the end of Q4 2024.

Action
- In 22/23 we undertook 107 inpatient Care & Treatment Reviews (CTR), in 23/24 there is capacity for 112
- New Housing Lead: New in post, with responsibility for identifying community housing and voids in the system, in order to build housing capacity.
- Transition funding is in place for double running of NHS inpatients and LA community services, to support the discharge of delayed and long stay individuals with complex needs.

Delivery
- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2023/24, with further reductions in 24/25.

** Data rounded up/down to nearest 5: therefore Place subtotals may not add up to the ICB total.*

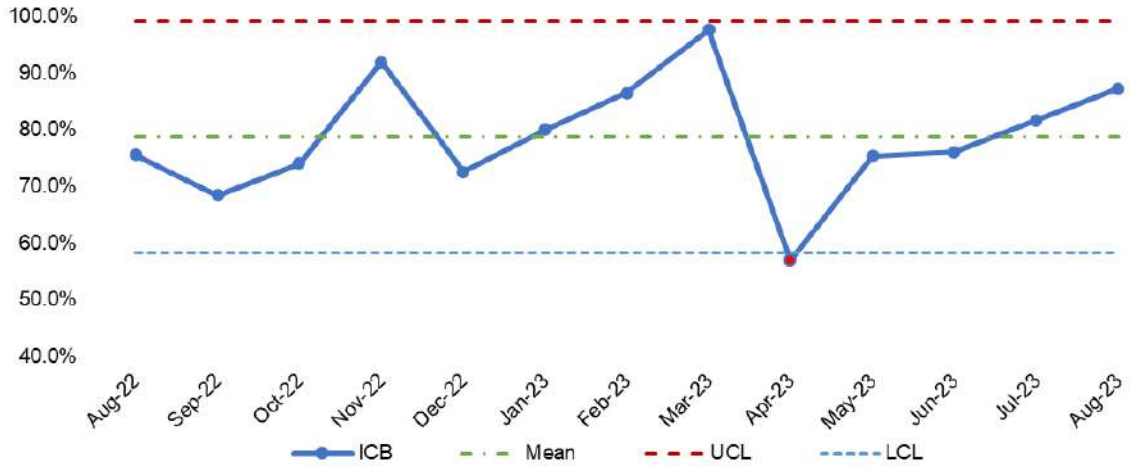
5. Exception Report – Primary Care

NHS Cheshire and Merseyside

Units of dental activity delivered as a proportion of all units of dental activity contracted

Latest ICB Performance (Aug-23)	87.3%	National Ranking	25/42

ICB Trend (Aug-23)



Issue
- C&M does not currently meet the 100% target

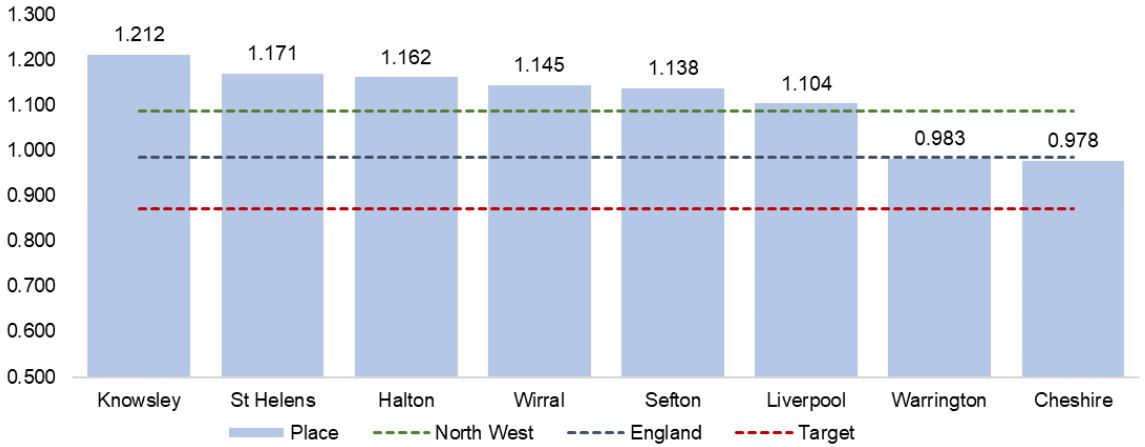
Action
- Support contractors to step up activity in primary care using the mid-year and end of year national contracting process and commission additional activity where providers are in agreement.
- Implement latest NHSE guidance (October 23) on flexible commissioning approaches and make additional contract delivery attractive to providers.
- Focus delivery on areas of highest need where there is poor oral health.
- Recruitment and retention of dentist and wider dental workforce in line with the C&M Workforce Strategy and NHS Workforce Plan.

Delivery
- Work is ongoing to establish a forecast trajectory for March 2024.
- Continued implementation of Dental Improvement Plan 2023-2025.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Jul-23)	107.9%	National Ranking	33/42

Place Breakdown (Jul-23)



Issue
- C&M does not currently meet the target set for the overall volume of prescribing of antibiotics in primary care.

Action
- All places working with primary care on the cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- An antibiotic prescribing data dashboard has been set up which supports targeting of work and the monitoring of outcomes.
- A C&M Antimicrobial Stewardship Working Group enables the sharing of good practice across primary and secondary care, including wider learning and agreeing actions.
- The promotion of infection prevention recommendations, self-care options for minor ailments and safe disposal of prescribed medicines, are being promoted and communicated during November 2023 in support of World Anti-Microbial Resistance Week.

Delivery
- C&M expect to see an improvement in Q4 of 2023/24 for the overall volume of prescribing of antibiotics in primary care, assuming the current levels of infection remain static.

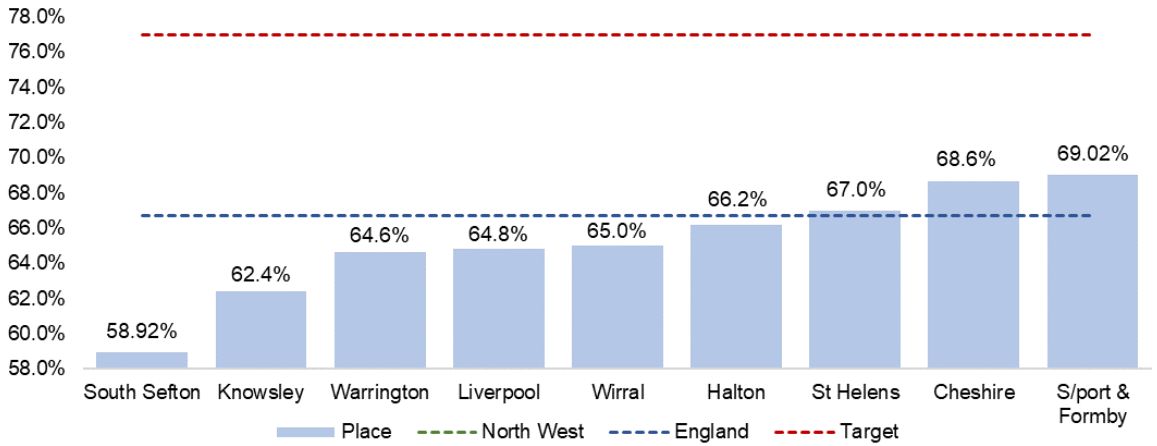
5. Exception Report – Health Inequalities & Improvement

Cheshire and Merseyside

% of patients (18+), with GP recorded hypertension, BP below appropriate treatment threshold

Latest ICB Performance (Jun-23)	66.7%	National Ranking	28/42

Place Breakdown (Q1 23)



Issue
- C&M figures mask significant variation between places with South Sefton, Knowsley, Warrington, Wirral and Liverpool all below the C&M average for Treatment to Target (TTT).
- Reductions in capacity at Academic Health Science Network (AHSN), NHSE reorganisation on the Cardiac Network and reduced investment from the digital programme to Primary Care.

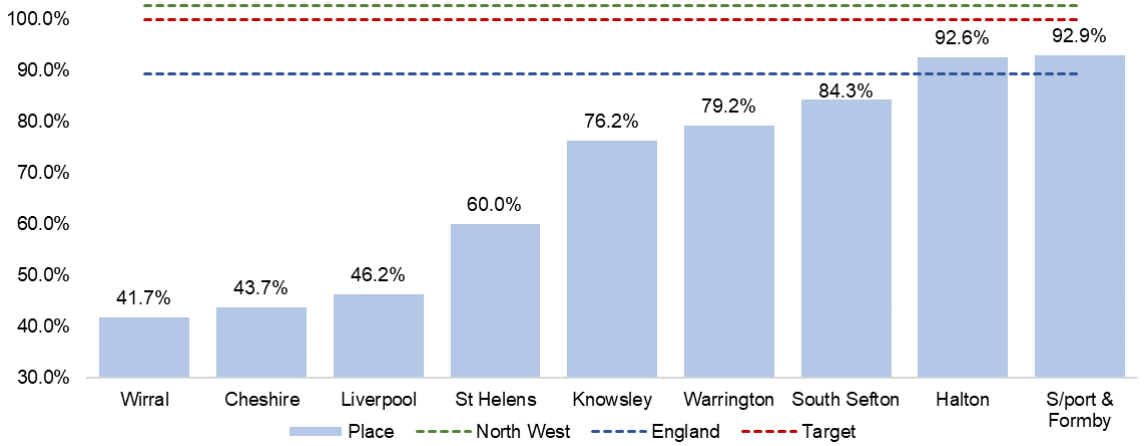
Action
- A combination of national and local initiatives continue to be offered (e.g., BP@Home, BPQI).
- BPUK's Know Your Numbers week and a recent social media campaign shared messaging about home BP monitoring, which LAs supported with outreach work. Happy Hearts website has public and professional information on BP optimisation & home monitoring
- AQUA are evaluating the BP optimisation initiatives, key findings include the need to scale up interventions and establish links between the CVD prevention group and the Digital programme. Pathways are being developed accordingly.
- Establish system solutions to improve performance over the current timescales.

Delivery
- Under the current trajectories and available resources, the original 80% TTT by 2029 remains the more realistic outcome.

Improve access rate to CYP Mental Health Services (12 Month Rolling)

Latest ICB Performance (Jul-23)	87% *	National Ranking	20/42

Place Breakdown (Jul-23) **



Issue
- The CYP Access target is 36,072 to be achieved by 31st March 24 (LTP Period), the national NHS Mental Health Service Data Set (MHSDS) indicates that the C&M CYP Access target is not currently being met.

Action
- Historically CYP Access has been led at Place level. Work is underway to bring together CYP Place Leads to consider Access to mental health support for CYP across Place and ICB System with collective oversight.
- A data quality plan is in place to ensure data capture of all CYP mental health providers to reflect a more accurate picture.
- C&M CYP Access Development Workstream developing plans to recover the trajectory.

Delivery
- As of July 2023, data reported via MHSDS illustrates a performance of 31,140 1+contacts. This is the highest access level for C&M over the last 2 years and performance is steadily increasing.

** ICB data uses number treated verses target*
*** Place data uses number treated verses no. referred*

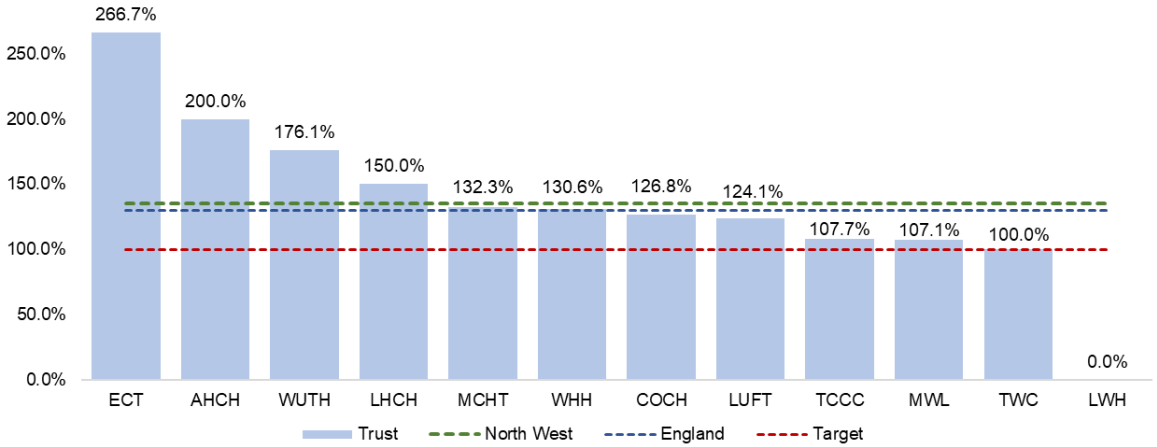
5. Exception Report – Quality

Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (Aug-23)	132.3%	National Ranking	27/42

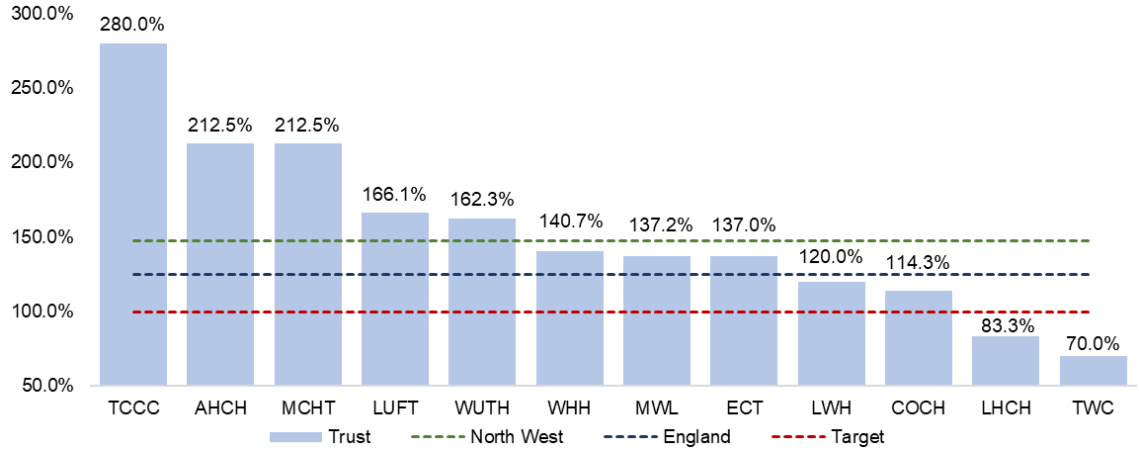
Provider Breakdown (Jun-23 – slight lag)



Healthcare Acquired Infections: Clostridium E.Coli (Hospital onset)

Latest ICB Performance (Aug-23)	153.1%	National Ranking	41/42

Provider Breakdown (Jun-23 – slight lag)



Issue

- Majority of C&M trusts are worse than national and regional performance, it should be noted that where expected numbers are low, eg 1 (one) or 0 (zero) on or two infections will impact the percentages reported adversely

Action

- All place-based teams are receiving assurance from those Trusts identified as outliers (full Q2 position awaited at time of writing)
- All Trusts undertaking post infection reviews, with some Trusts suggesting an absence of avoidability (ECT) in reviewed cases.
- ECT is implementing a diarrhoea management plan in Q3 and a relaunch of their updated anti-microbial guidelines.
- Trusts undertaking review and refresh of aseptic non-touch techniques.
- LUFT reviewing a range of measures based upon learning from reviews that include use of isolation and a 'gloves off campaign'.
- MCHT focus is on IPC fundamentals- education and training, aseptic technique, focus on safe and clean environment, AMS, relaunch of HOUDINI catheter care and hydration.

Delivery

- Performance will be monitored on a monthly basis via place-based reporting into Quality & Performance Committee and improvement plans assessed for efficacy and impact at end of Q3 23/24

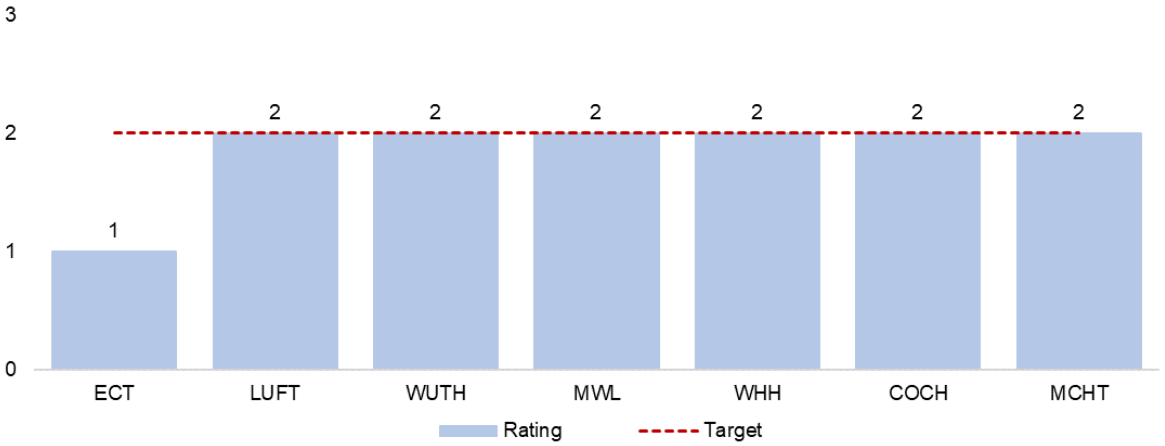
5. Exception Report – Quality

Cheshire and Merseyside

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (May-23)	1.027	National Ranking	n/a

Provider Breakdown (Apr-23 – slight lag)



Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.1768 against the upper control limit for ECT of 1.1411.

Action/s (ECT)
- Two Rapid Quality Review meetings have taken place, with a third due at the beginning of Nov 23.
- A SHMI Improvement Plan is being finalised by the Trust with the view to sign off at the next RQR meeting. Ongoing oversight and monitoring will then be agreed.
- In hospital: work is focusing on prevention of deterioration and deconditioning, maintenance of hydration and care delivery (of pneumonia/ AKI/ Stroke) and rapid escalation if required.
- Out of hospital: a review of deaths within 30 days of discharge in the community has been carried out. This has shown that the cohort were predominantly frail elderly people who received appropriate palliative care at home but not being coded as palliative.

Delivery
- Measurable improvement by Q3 2023/24.

Never Events

Latest ICB Performance (Sep-23)	5	National Ranking	n/a

ICB Trend (Sep-23)

Issue
- C&M have had 29 Never Events over the last 12 month rolling period, which is consistent with the number in the previous year. The majority of these incidents relate to wrong site surgery (11) & retained foreign object post procedure (8), consistent with the highest reporting of Never Events for the previous year.
- The largest reporters are WHH (6) & LUFT (6), LUFT was a high reporter last year also.

Action/s
- WHH have appointed an Associate Medical Director who will be working on human factors and procedural safety. Analysis did not identify any thematic trends regarding site or department.
- LUFT have reviewed the WHO checklist with associated audits completed. LocSIPPS been reviewed and audited – with evidence of a positive outcome from shared learning. Staffing has been reviewed, and identification of potential additional staffing requirements and an escalation process has been established and shared with shift leaders and managers.

Delivery.
- Measurable improvement by Q4 2023/24

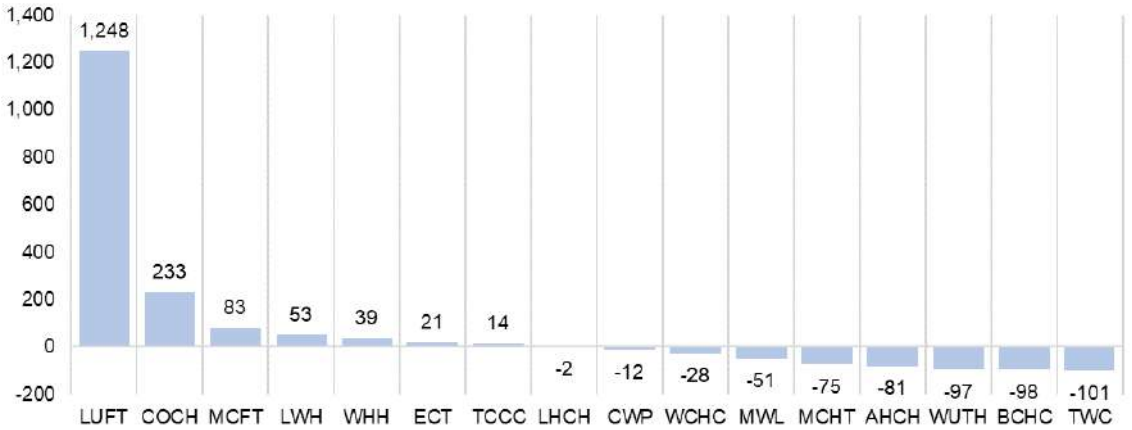
5. Exception Report – HR/Workforce

Cheshire and Merseyside

Staff in post (WTE)

Latest ICB Performance (Aug-23)	+1,145	National Ranking	n/a

Provider Breakdown (Aug-23)



Issue
- There are a number of Trusts with a variance to the original workforce plan, due to a range of issues, including the in housing of facilities management staff, the opening of additional community diagnostic centres and the proactive recruitment of substantive posts to reduce bank and agency use and reduce long standing vacancies.

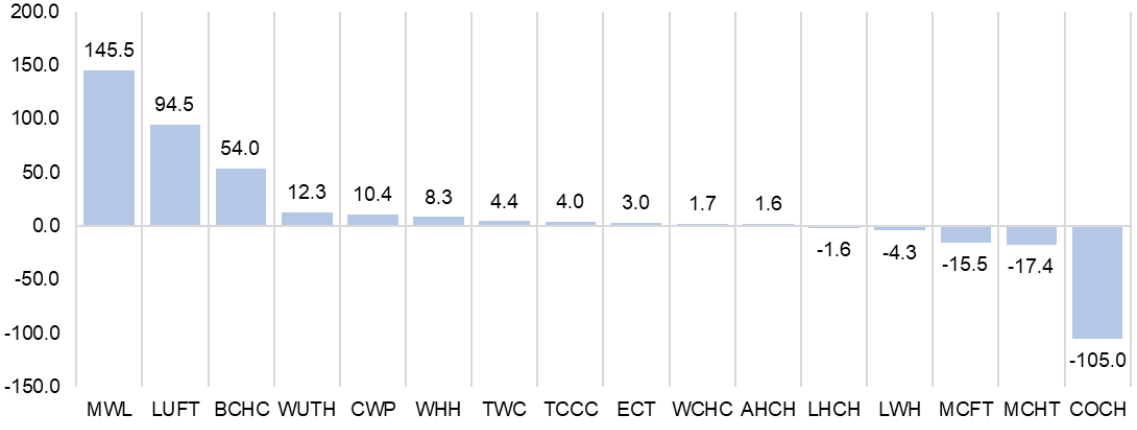
Action
- The Trusts have in place robust vacancy authorisation processes . Greater scrutiny of workforce and productivity data at organisational and system level is now taking place

Delivery
- The workforce plans will be refreshed as part of the operational planning process . Proactive monitoring of workforce data now takes place with Chief People Officers

Agency Usage (WTE)

Latest ICB Performance (Aug-23)	+196	National Ranking	n/a

Provider Breakdown (Aug-23)



Issue
- The increase in agency staff is largely due to gaps in medical rotas, sickness absence and the need for staff to support the opening of community diagnostic centres.

Action
- Trusts with significant reductions have seen increases in substantive staff which is positive
- The Trusts have in place authorisation processes for the use of agency staff and have plans for the reduction of agency use.
- Trust are required to use ‘on framework ‘ agencies and to adhere to price cap limits is also monitored and shared

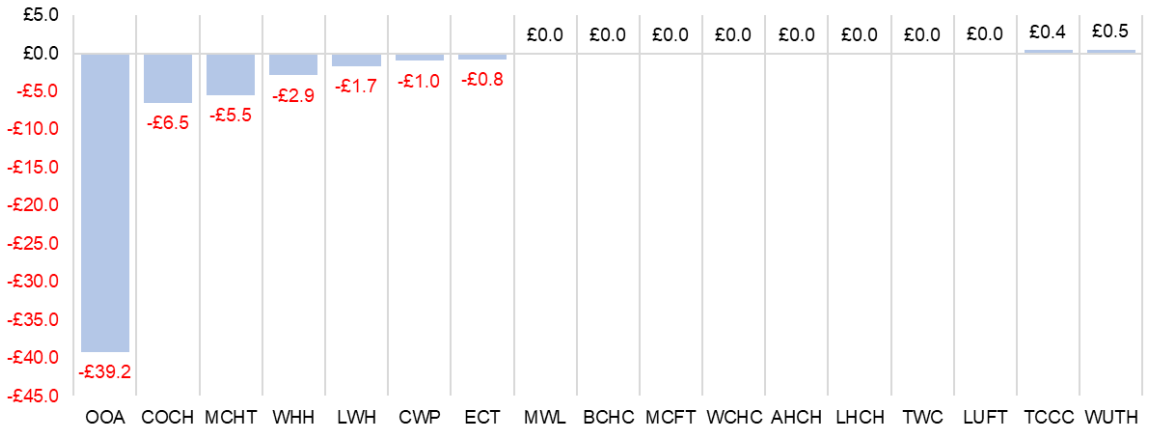
5. Exception Report – Finance

Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (Sep-23)	-56.7	National Ranking	n/a

Provider Breakdown (Aug-23)



Issue
- The ICS is £56.7m adverse to plan at the end of September.
- The ICB adverse variance YTD (£39.2m) is primarily driven by prescribing inflation outstripping national planning assumptions and inflation and growth in CHC budgets and packages of care exceeding planned levels.
- The Provider adverse variance YTD (£17.5m) is driven by 6 Trusts where key pressures include - £7.4m is Unachieved CIP, £7.7m Industrial action, £1.3m Pay Award, £1.3m Emergency pressures and £4m other costs including RAAC, Band 2-3 concerns and excess inflation.

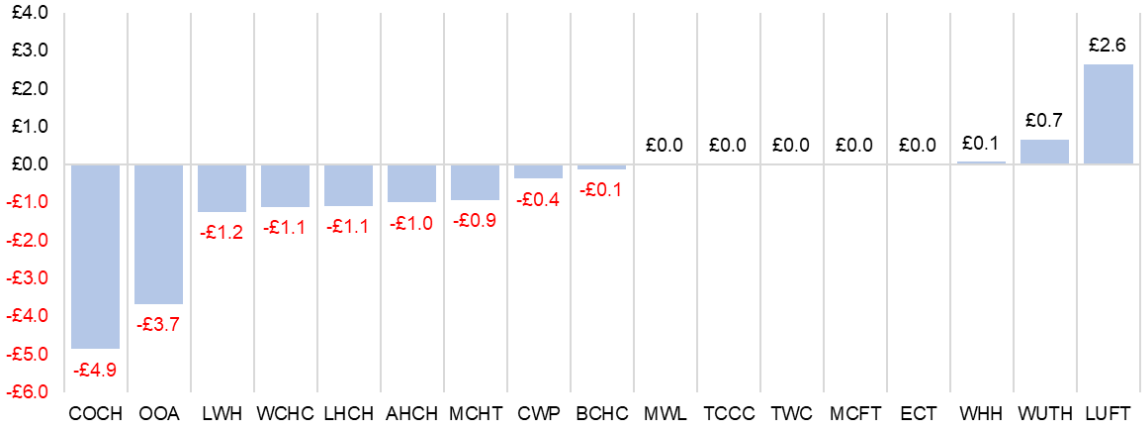
Action
- The ICB has submitted additional detailed reports to NHSE in relation to these key, high-risk areas. In addition, both place and provider recovery plans have been submitted and are currently being reviewed.

Delivery
- Recovery plans to be agreed by the end of October.

Efficiencies Variance (£m)

Latest ICB Performance (Sep-23)	-11.0	National Ranking	n/a

Provider Breakdown (Aug-23)



Issue
- £158m achieved YTD, £11m away from planned levels. Forecast achievement of £389m total system efficiencies in line with plan.
- COCH Non-delivery related to bed base remaining open to accommodate NCTR patients. £7.7m of identified schemes remain high risk.

Action
- concerns over level of recurrent v non recurrent CIP identified, need to be monitored to ensure forecast trajectories are met.
- Expenditure Controls Group set up to ensure providers off plan are implementing grip and control measures.

Delivery
- Review continuously as part of the monthly reporting process and will form part of 24/25 planning processes.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Highlight report of the Chair of the Quality & Performance Committee

Agenda Item No: ICB/11/23/12

Committee Chair: Tony Foy, Non-Executive Member

Highlight report of the Chair of the Quality & Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	16 November 2023

Key escalation and discussion points from the Committee meeting

Alert

The Quality and Performance Committee (QPC) received reports at its meeting on 16 November 2023 which highlighted the following areas of concern. They were noted and mitigations were discussed.

Maternity LMNS

- delays in care – inductions of labour **-** Midwifery band 5/6 staff shortages are cited as the cause of delay 2 hrs. or more between admission and commencement of IOL procedures. This contributes to the main type of delay 'awaiting 'artificial rupture of membranes' (ARM)' - a procedure which requires one to one care in labour and a bed on the delivery suite / labour ward. 27% increase in awaiting commencement of IOL from 86 in August to 109 in September

System Oversight Board (SOB) Monthly Exception Report – Safeguarding Focused Paper

- at the end of Q1, the performance for completion and return of IHAs within the statutory 20-day timescale remained significantly below the 100 % threshold for children and young people across C&M
- operational issues within providers e.g., sickness.
- late notifications that the child had entered care from the Local Authority

(CiC) Annual report 2022-23

- the ICB is not meeting its statutory requirements for completion of Initial Health Assessments and Review Health Assessments- this has now been put on the corporate risk register as a new risk.
- children in care placed out of area - no consistent or standardised approach leading to inequalities and inequity of delayed assessments.
- increasing number of children in care and unaccompanied asylum seekers and almost half of all unaccompanied asylum seekers placed in C&M ICB are placed in Liverpool placing increasing pressure on health services locally.
- significant differences exist in the number of CiC and complexity of need across the 9 Places. There is marked variation in the commissioning arrangements and investment for CiC health services across the ICB.

Medicines supply

The Chief Pharmacists report highlighted the following:

- medicines shortages affect both primary and secondary care. Medicine shortages have significant impact on NHS resources and patients.
- a conservative estimate of the financial impact of medicine shortages within the primary care prescribing budget for Cheshire and Merseyside (C&M) ICB is £6m up to month 5 of 2023/24.
- due to the increasing number of medicines shortages, quality of care has also been impacted significantly in ADHD medicines.

The risks are exacerbated by varied commissioning arrangements.

Quality Performance Dashboard/Performance Report

Key Issues reviewed (Winter pressures theme):

- Ambulance category 2 mean response time - The national category 2 mean response time target for 2023/24 is 33 minutes, aggregate performance being 35:13 minutes. Halton, S&O, St Helens, and Warrington Places are above the aggregated performance.
  Areas where performance is particularly challenging across all acute trusts includes.
- A&E 4 hour waits from arrival.
- A&E 12 hour waits from arrival.
- Adult G&A bed occupancy
- No Criteria to Reside (NCTR).

Additional areas discussed.

- Cancer patients receiving treatment within 62 days of referral. – although the ICB is ranked 8/42, aggregate performance is 67.6% with 4 of the 10 relevant Trusts performing below the 70% target.
- Patients receiving definitive treatment for cancer within 31 days of diagnosis – stronger performance ranked 7/42 at 93.9% against the target of 96% with 5/10 Trusts below target.

Key Risks:

- impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience.
- long waits for cancer and elective treatment could result in poor outcomes.

The Director of Performance and Planning will provide a detailed report to the Board.

Advise

Maternity LMNS

- At next QPC a report and more analysis on staffing/sickness/workforce issues affecting Delays in Care measure

(CiC) Annual report 2022-23

The Committee supported the following:

- establish the NHS Universal Family (Care Leaver Covenant) Programme and advertise the offer on the Care Leaver Covenant by October 2023.

- standardise the care leaver, offer across the ICB to include provision of pre-payment prescription certificates and Health Passports

Medicines Shortage

- QPC approved a review of the risk relating to ADHD assessment waiting times due to the impact of the current ADHD medicines shortages.
- QPC considered the addition of a new risk relating to medicines shortages.
- QPC supported a joint review by the ICS Chief Pharmacist and Director of Nursing and Care of the support and oversight by the ICB in response to the ADHD medicines shortage alert.

Patient Experience

The establishment of the People and Communities Insight and Experience Group (PCIEG) is a step forwards for the ICB in bringing together the teams responsible for the delivery and oversight of key ICBs functions that receive this intelligence and who have a duty to ensure the learning from this intelligence contributes to improvements in patient care and experience.

- PCIEG Paper, TOR agreed in principle.
- QPC supports establishment of the People and Communities Insight and Experience Group (PCIEG).

Assure

Maternity LMNS

- **Triage as highlighted in previous reports** - there has been a significant improvement in the timeliness of women seen in Triage across C+M since January 2023 improving early assessment and safety. 39% decrease in triage breaches from 197 in August to 120 in September
- LWH reported triage breaches continue to decrease from 263 in April to 25 in September 2023 since adopting the C&M standard of 15-minutes (from the previous 30 minutes) in May 2023

System Oversight Board (SOB) Monthly Exception Report – Safeguarding Developments included:

- Annual safeguarding self- assessment for commissioned providers against the contractual safeguarding standards
- oversight of statutory C&M Safeguarding Partnership Section 11 audits across the 9 Places
- Quality and safeguarding provider assurance visits
- training sessions are to be arranged with LA to facilitate education and training to social workers and team managers regarding the process.
- for Liverpool, Sefton, and Knowsley a Hybrid IHA initiative commenced in September and the pilot of GP's assisting with IHA's and a weekend clinic initiative.

East Cheshire Trust Mortality Rapid Quality Review

The Committee received a detailed report from the Medical Director and Associate Director Quality and Safety. Significant progress was noted, and a full report will be presented to the Board.

Committee risk management

The following risks were considered by the Committee and the following actions/decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
Emerging risk of medicine shortages	Detailed risk profile to be developed

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P5 Urgent and Emergency Care	Winter Pressures review

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual delivery plan.

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Current performance review – Board report

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Highlight report of the Chair of the System Primary Care Committee

Agenda Item No: ICB/11/23/13

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the System Primary Care Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	19 October 2023

Key escalation and discussion points from the Committee meeting

Alert

The System Primary Care Committee considered a number of key papers resulting in:

- Escalation of a Primary Care Risk relating to dental service provision across C & M due to low UDA performance and resultant potential impact on C & M residents. Full review being undertaken following 6 months (mid-year) contractual activity and will report to SPCC/Audit.
- Internal Audit (as part of the ICB's annual audit programme) are reviewing how all primary care contracts are managed. Recent dental contract issues will be contained within this agreed audit.
- Following a review of the robustness of TOR & SORD the Committee supported a number of amendments to be approved at C&M ICB Board meeting November. Amendments centred around:
  - ability of Committee to establish sub-committees and approve their terms of Reference
  - ability of Committee to approve delegation of its functions and decision making responsibilitires to its sub-committees or named ICB individuals, supported by an agreed decision making framework
  - updated membership composition
  - updated references to NHS Regulations.

The Board is asked to approve the amended Terms of Reference for its System Primary Care Committee (Appendix One).

Advise

The System Primary Care Committee considered a number of key papers and:

- agreed to the proposal to support the establishment of a consistent evidence based oral health improvement programme across C & M with funding from the primary care dental underspend.
- agreed to the request to support the Pathfinder Programme , to support the further development in line with EOI proposal & approve development of this programme and commissioning of up to 7 CPIP pathway sites. It was noted that funding is a National Allocation up to 7 CPIP but a risk was outlined around unknown funding for future increased support of this programme.
- Noted the Community Pharmacy minutes and outcomes of PRSC. Impact of closures, change in opening hours and impact on Out of Hours provision are being reviewed by commissioners and Meds Mgt.

Assure

The System Primary Care Committee considered a number of key papers and:

- all 4 Primary Care related risks discussed with approval given to changes to 2.

- Primary Care Workforce update received – interim paper whilst collection of appropriate data across all 4 contractor groups is achieved.
- presentation received from Nick Armstrong Head of Estates on Primary Care, again remains in an interim position whilst all data is accumulated across the 4 contractor groups and further update to be received in Feb 2024.
- discussion undertaken across all 4 contractors groups and lead by local contractor Committee members. Good understanding around key challenges. Opportunity for reflection against plans – recovering access to primary care, dental improvement plan and Primary Care strategy.

Committee risk management

The following risks were considered by the Committee and the following actions / decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
4 current PC Risks **1PC – resilience & sustainability of workforce** **2PC – Extension of APMS Contracts** **6PC – identified dental provider Halton Place.** **7PC – provision of primary dental services**	Discussion held around all risks, 1 de-escalated (2 PC) and proposed closure confirmed and 1 escalated for alert to Board (7PC). Discussion held around the maturing landscape of the SPCC Corporate Risks although all acknowledge that Place SPCC risks still require more focus/consistency of reporting to ensure transparency to SPCC and Board.
Patient Safety/Quality	Good progress on appropriate process to ensure Committee has consistency/transparency/speed of reporting and clinical focus. Standardised template currently under review across all 4 contractor groups with agreed delivery into Q & P. SPCC to undertake themed reviews 3 times a year following escalation reports from Q & P.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF P1//P6/P9 **Annual Plan Primary Care.**	Discussions around recovering access to PC and delivering overall programme of work related to National Policy, Post Pandemic restoration, improving Dental Access & Community Pharmacist Consultation Service. Focused discussion on health inequalities formula for new ICB growth/investment in 2024/25 and the need to ensure resources are targeted where we can make greatest difference.

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Internal Audit for Contracting and Commissioning underway	Will be a detailed agenda item for Dec 2023 SPCC meeting with action plan
Finance Update	Remains extremely challenging, particularly the impact of prescribing inflationary costs. SPCC reviewed all the budgets and have a task & finish finance group that will look for consistency / efficiencies across the Places in C&M.
Capital Update	Current allocations discussed and agreed
Recovering Access to Primary care & Dental Improvement Plan	Comprehensive papers noted and discussed, further update in Dec23.

Appendices

Appendix One: System Primary Care Committee Terms of Reference v1.2

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside Integrated Care Board

System Primary Care Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
January 2022	1.0	Initial ToRs		Ben Vinter
25.8.2022	1.1		Revisions following first meeting of System Primary Care Committee	Christopher Leese
October 2023	1.2		Revisions following October 2023 meeting of System Primary Care Committee	Matthew Cunningham

Review due
01 October 2024
V1.2 approved by the Board of NHS Cheshire and Merseyside (add date)

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1. Introduction

The System Primary Care Committee (the Committee) is established by the Board of NHS Cheshire and Merseyside (the Board) as a Committee of the Board and in accordance with its Constitution, Standing Orders, Standing Financial Instructions and its Scheme of Reservation and Delegation (SORD).

These Terms of Reference (ToR), will be published on the ICB website, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board.

2. Purpose

The Committee has been established to enable collective decision-making on review, planning, procurement, commissioning and management of primary care services in relation to primary medical services, community pharmacy, primary dental and primary (General Practice) ophthalmic services in accordance with the ICB's statutory commissioning responsibilities across Cheshire and Merseyside and its functions exercised under delegated authority from NHS England. In performing its role, the Committee will exercise its functions in accordance with the delegation agreement entered into between NHS Cheshire and Merseyside and NHS England (NHSE).[1]

The Committee will also provide oversight and assurance to the Board of the effective planning and provision of primary care services across Cheshire and Merseyside.

Providing assurance involves:

- **Triangulating multiple sources** of appropriate internal and external information, including:
  - data analysis and contract performance intelligence
  - patients', service users' and carers' reports, surveys, complaints, and concerns
  - evidence from key system leaders
  - other intelligence agreed to be important and reliable.

- **Remedial action:** Where assurance cannot be provided in part or in full, to provide the Board with details of remedial actions being taken and or being recommended.

- **Considering efficacy and efficiency:** Things are not only in place, but the right things are being done in the right way to achieve the right objectives, which support the ICS aims.

The functions of the Committee are undertaken in line with NHS Cheshire and Merseyside desire to promote an increase quality, efficiency, productivity, and value for money and to remove administrative barriers.

[1] https://www.cheshireandmerseyside.nhs.uk/media/cyknidfl/cm-primary-care-and-dental-delegation-agreement-2023-final-version-issued-230323.pdf

3. Authority

The Board of NHS Cheshire and Merseyside has delegated authority to the Committee as set out in these Terms of Reference and the ICB SORD, and which may be amended from time to time. Delegations are in line with the ICBs functions within the ICB Constitution and NHS Act 2006 (Annex One) and its delegated functions from NHSE (Annex Two). The Committee is also subject to any directions made by NHSE or by the Secretary of State for Health and Social Care.

The duties of the Committee will be driven by the organisation's strategic objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee is authorised by the Board to:

- investigate and approve any activity as outlined within its terms of reference
- seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- commission any reports it deems necessary to help fulfil its obligations
- obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice
- establish sub-committees in order to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee. The Committee has the authority to agree the Terms of Reference of these sub-committees, including approving any decision making authority that is normally reserved to the Committee and that can be delegated to and undertaken by the sub-committee and its members, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision making matrix, approved by and overseen by the Committee. Decisions undertaken by these sub-committees will be reported back to the Committee
- approve named positions within the ICB with the delegated authority to undertake any of the functions of the Committee were considered appropriate and/or necessary by the Committee, in accordance with the ICB's constitution, standing orders, standing financial instructions, SORD and OSORD. This authority will be outlined within a decision making matrix, approved by and overseen by the Committee. Decisions undertaken by these individuals for and on behalf of the Committee will be reported back to the Committee
- establish task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups
- commission, review and approve policies where they are explicitly related to areas within the remit of the Committee as outlined within the TOR, or where specifically delegated to the Committee by the ICB Board.

4. Role and Responsibilities of the Committee

In carrying out its role, the Committee will work alongside any of its established sub-committees where decision making authority has been delegated. These sub-committees will also provide regular reports to the Committee outlining what activity and decision have been undertaken.

The Committee will provide regular assurance updates to the Board in relation to activities and items within its remit, as well as provide the Board with any items for escalation.

Commissioning of Primary (GP) Medical Services
The Committee shall approve decisions on the review, planning, procurement, commissioning and management of primary medical (GP) services, subject to any decision-making authority that is delegated by the Committee to sub-committees.

The Committee shall establish nine sub-committees across the nine Places of Cheshire and Merseyside to undertake any of the functions, responsibilities and decisions of the Committee relating to primary medical care services considered appropriate and/or necessary to be taken at Place level. The Committee will agree the Terms of Reference of these sub-committees, including approving any decision making authority. Such decision making authority will be outlined within a decision making matrix, approved by and overseen by the Committee.

The Committee shall oversee, coordinate and promote alignment of the functions exercised amongst the nine Places of Cheshire and Merseyside relating to the commissioning of primary medical (GP) services (the ICB's statutory functions under the NHS Act 2006 and the functions delegated from NHS England). This includes the following:

- develop a system-wide Primary Care Strategy including implementing the GP Forward View, or successor, through robust contractual arrangements with general practices and appropriate developmental support.
- review and consider the aggregate position of agreed service specifications and contractual proposals for all NHS C&M commissioned services from primary care providers
- develop outline framework/ expectations in regard to GMS, PMS and APMS contracts (including the oversight and monitoring of contracts, approving material contractual action such as removing a contract)
- Oversee the system obligations in relation to the Delegation Agreement with NHS England and the Policy and Guidance Manual and other directed enhanced service type national regulatory frameworks as centrally mandated.
- oversee the strategic direction for newly designed enhanced services and agree new specifications where appropriate
- Performance monitoring, oversight and assurance on agreed schemes and services, and compliance to NHSE; escalating issues on to NHSE in line with first level Delegation
- making recommendations related to alignment of decisions on 'discretionary' payment in Place (e.g., returner/retainer schemes).
- co-ordinate a common approach to the commissioning, contracting and delivery of primary care services
- manage the overall budget for commissioning of primary care services, including delegated rents and rates in line with Premises Directions.

- Overseeing delivery of national primary medical services policy at system level and ensuring compliance at place level.

Commissioning of Community Pharmacy
The Committee shall:
- develop outline framework/ expectations in regard to Community Pharmacy essential, advanced and national enhanced services, including associated budgets, quality assurance and all existing NHSEI functions.
- develop and agree local discretionary/ non-core schemes.
- oversee national Community Pharmacy policy at system / local level.

Commissioning of Dental Services
The Committee shall:
- develop outline framework/ expectations in regard to the national general dental, community, personal dental and orthodontic contracting, overseeing the central contracting function is discharged in line with the Dental Policy Book and national rules/frameworks
- responsible for overseeing national dental policy at ICB system and local level
- develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Commissioning of Optometry
The Committee shall:
- develop outline framework/ expectations in regard to the national general ophthalmic services (GOS) contractual regulations and policy
- Responsible for overseeing national GOS policy at ICB system and local level
- Develop and agree local improvement schemes to support delivery of the national contract and policy asks.

Additional responsibilities. The Committees additional responsibilities include:
- support Primary Care development across Cheshire & Merseyside including oversight of:
  - primary care networks (PCNs) ongoing development as the foundations of out-of-hospital care and building blocks of place-based partnerships
  - Workforce, resilience and sustainability
  - Maximisation of GP Contract opportunities such as ARRS (Additional roles) and QOF outcomes
- plan, including needs assessment, for primary care services across Cheshire & Merseyside and to support planning at scale for primary care
- have oversight of the development of an integrated Estates programme across Cheshire & Merseyside and at local level using flexibilities available through PCN arrangements, mixed estates with other partners, premises improvement grants and capital investment monies
- to consolidate risk reviews of primary care services, aggregating findings and supporting solutions/ mitigations at places
- to ensure contract proposals achieve health improvement and value for money
- to oversee quality and safety of services delivered in primary care – receiving regular reports from the ICB Quality and Performance Committee and Finance, Investment and Our Resources Committee providing updates and assurance on primary care related quality, finance and performance issues

- ensure that conflicts of interest have been mitigated in line with the NHS C&M Conflicts of Interest Policy, and all actions/ decisions involving consultation with Committee members or GPs will record any declarations of interest.
- ratifying time limited Place based recommendations related to this committee's remit or determining to 'call-in' such a recommendation and provide an alternative course of action.

Risk Management. The Committee will also ensure the appropriate management of risks in relation to primary care; receiving regular reporting of primary care related Corporate Risks, and relevant Board Assurance Framework (BAF) risk – these will include reference to relevant Place Delivery Assurance risks – both strategic and corporate as per NHS C&M Risk Management Strategy.

5. Membership & Attendance

The Committee members drawn from the Board of NHS Cheshire and Merseyside shall be appointed by the Board in accordance with the ICB Constitution. Committee members drawn from outside of the Board of NHS Cheshire and Merseyside shall be appointed by the Committee, in line with the approved membership outlined within the TOR.

The membership shall consist of the following voting members:

- at least two ICB Non Executive Member (Chair)
- at least one ICB Partner Member (1 to be the Deputy Chair)
- ICB Assistant Chief Executive (or Deputy)
- Associate Director of Primary Care
- ICB Director of Nursing & Care
- ICB Director of Finance
- ICB Medical Director (or Associate Medical Director for Primary Care)
- Independent GP
- at least one Place Director or designated individual from Place.

In attendance by invitation (non-voting):

- Healthwatch nominated representative
- Public Health representative
- Local Medical Committee (LMC) representative
- Pharmaceutical Services Regulations Committee (PSRC) representative
- LOC (Local Optical Committee) representative
- LDC (Local Dental Committee) representation
- LPC (Local Pharmacy Committee) representation
- Membership of other Professional Groups to be agreed/discussed further dependant on agenda item.

All Committee members may appoint a deputy to represent them at meetings of the Committee. Committee members should inform the Chair of their intention to nominate a deputy to attend/act on their behalf and any such deputy should be suitably briefed and suitably qualified (in the case of clinical members).

The Committee may also request attendance by appropriate individuals to present agenda items and/or advise the Committee on particular issues.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite relevant staff to the meeting as necessary in accordance with the business of the Committee.

Meetings of the Committee may also be attended by other individuals, by the agreement of the Chair, who are not members of the Committee for all or part of a meeting as and when appropriate.

The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

6. Meetings

Leadership
The Committee is Chaired by an ICB Non Executive Member of the Board.

Committee members may appoint a Deputy Chair drawn from its voting membership.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Quorum
A meeting of the Committee is quorate if the following are present:

- at least five Committee members in total, including;
  - at least one ICB Non Executive Member or ~~system~~ ICB Partner Member
  - at least one Clinically qualified Member
  - at least two ICB Directors (or their nominated deputies).

If the named Chair, or Deputy Chair, are both unable to attend a meeting, and the meeting is required to proceed on the agreed date, then an alternative suitably experienced ICB Non-Executive Member will be asked Chair the meeting. Where these quorum requirements are unable to be met the meeting date will be rearranged.

If any member of the Committee has been disqualified from participating in an item on the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If on an occasion a Committee meeting is due to start but the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken. Alternatively, the meeting can be called to a halt and an agreement reached to rearrange an additional meeting.

Decision-making and voting

Decisions will be taken in accordance with the Standing Orders and within the authority as delegated to the Committee, and as outlined within the ICBs SORD and Standing Financial Instructions.

The Committee will ordinarily make decisions by consensus. Where this is not possible, the Chair may call a vote.

Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote. Each member is allowed one vote and a majority will be conclusive on any matter.

A person attending a meeting as a deputy of a Committee member shall have the same right to vote as the Committee member they are representing.

In accordance with ICB policy, no member (or deputy) with a conflict of interest in an item of business will be allowed to vote on that item.

Where there is a split vote, with no clear majority, the Chair will have the casting vote.
If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication. Decisions will be recorded and formally minuted and ratified at a subsequent formal meeting of the Committee.

Frequency
The Committee will normally meet in private. However, on occasions due to commercial, legal or employee sensitivities for certain some agenda items the meeting may be held in private for all or part, to be agreed by the Chair depending on advice received and agenda item to be discussed. Due process in relation to Patient Consultation requirements should be considered when making this decision.

The Committee will normally meet up to six times each year and arrangements and notice for calling meetings are set out in the ICB Standing Orders. Additional meetings may take place as required.

The Board, ICB Chair, Committee Chair, or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want advice.

In accordance with the Standing Orders, the Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Papers for the meeting will be issued ideally one week in advance of the date the meeting is due to take place and no later than 4 working days.

Administrative Support
The Committee shall be supported with a secretariat function. Which will include ensuring that:

- the agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements

- Records of declarations of conflicts of interest, members' appointments and renewal dates are retained and the Board is prompted to renew membership and identify new members where necessary
- good quality minutes are taken in accordance with the ICB standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- the Chair is supported to prepare and deliver reports to the Board
- the Committee is updated on pertinent issues/ areas of interest/ policy developments; and
- action points are taken forward between meetings.

Accountability and Reporting Arrangements
The Committee is accountable to the Board and shall report to the Board on how it discharges its responsibilities.

The minutes of the meetings shall be formally recorded by the Committee secretary and approved minutes and a key issues report submitted to the Board, following each of its meetings, which will draw to the attention of the Board any issues that require disclosure to the Board or require action.

The Committee will also provide a key issues report to each of the place-based primary care sub-committees of the Committee and will receive an equivalent report from each of the place-based primary care committees.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

The outputs of the group may be reported to NHSE/supporting assurance, awareness and interaction.

7. Behaviours & Conduct

Members will be expected to conduct business in line with the ICB value s and objectives and the principles set out by the ICB.

Members of, and those attending, the Committee shall behave in accordance with the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy.

All members shall comply with the ICB's Managing Conflicts of Interest Policy at all times. In accordance with the ICB's policy on managing conflicts of interest, Committee members should:

- inform the chair of any interests they hold which relate to the business of the Committee.
- inform the chair of any previously agreed treatment of the potential conflict / conflict of interest.
- abide by the chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.

- inform the chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- abide by the chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- comply with the ICB's policies on standards of business conduct which include upholding the Nolan Principles of Public Life
- attend meetings, having read all papers beforehand
- arrange an appropriate deputy to attend on their behalf, if necessary
- act as 'champions', disseminating information and good practice as appropriate
- comply with the ICB's administrative arrangements to support the Committee around identifying agenda items for discussion, the submission of reports etc.

Equality diversity and inclusion

Members must demonstrably consider the equality, diversity and inclusion implications of decisions they make.

8. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board for approval.

Annex One: Statutory Framework

The Health and Care Act 2022 amends the NHS Act 2006 by inserting the following provisions:

13YB Directions in respect of functions relating to provision of services
(1) NHS England may by direction provide for any of its relevant functions to be exercised by one or more integrated care boards.
(2) In this section "relevant function" means—
(a) any function of NHS England under section 3B(1) (commissioning functions);
(b) any function of NHS England, not within paragraph (a), that relates to the provision of—
(i) primary medical services,
(ii) primary dental services,
(iii) primary ophthalmic services, or
(iv) services that may be provided as pharmaceutical services, or as local pharmaceutical services, under Part 7;
(c) any function of NHS England by virtue of section 7A or 7B (exercise of Secretary of State's public health functions);
(d) any other functions of NHS England so far as exercisable in connection with any functions within paragraphs (a) to (c).

82B Duty of integrated care boards to arrange primary medical services
(1) Each integrated care board must exercise its powers so as to secure the provision of primary medical services to such extent as it considers necessary to meet the reasonable requirements of the persons for whom it has responsibility.
(2) For the purposes of this section an integrated care board has responsibility for— (a) the group of people for whom it has core responsibility (see section 14Z31), and (b) such other people as may be prescribed (whether generally or in relation to a prescribed service).

In exercising its functions, NHS C&M must comply with the statutory duties set out in NHS Act, as amended by the Health and Care Act 2022, including:

Having regard to and acting in a way that promotes the NHS Constitution (section 2 of the Health Act 1989 and section 14Z32 of the 2009 Act);
Exercising its functions effectively, efficiently, and economically (section 14Z33 of the 2006 Act);

- section 14Z34 (improvement in quality of services),
- section 14Z35 (reducing inequalities),
- section 14Z38 (obtaining appropriate advice),
- section 14Z40 (duty in respect of research),
- section 14Z43 (duty to have regard to effect of decisions)
- section 14Z44 (public involvement and consultation),
- sections 223GB to 223N (financial duties), and
- section 116B(1) of the Local Government and Public Involvement in Health Act 2007 (duty to have regard to assessments and strategies).

In addition, NHS C&M will follow the Procurement, Patient Choice and Competition (no2) Regulations 2013 and any subsequent procurement legislation that applies to the ICB.

Annex Two: Schedule 1 – Delegated Functions

A. Decisions in relation to the commissioning, procurement, and management of Primary Medical Services Contracts, including but not limited to the following activities:

- decisions in relation to Enhanced Services
- decisions in relation to Local Incentive Schemes (including the design of such schemes)
- decisions in relation to the establishment of new GP practices (including branch surgeries) and closure of GP practices
- decisions about 'discretionary' payments
- decisions about commissioning urgent care (including home visits as required) for out of area registered patients.

B. The approval of practice mergers
C. Planning primary medical care services in the Area, including carrying out needs assessments
D. Undertaking reviews of primary medical care services in the Area
E. Decisions in relation to the management of poorly performing GP practices and including, without limitation, decisions, and liaison with the CQC where the CQC has reported non-compliance with standards (but excluding any decisions in relation to the performers list)
F. Management of the Delegated Funds in the Area
G. Premises Costs Directions functions
H. Co-ordinating a common approach to the commissioning of primary care services with other commissioners in the Area where appropriate; and
I. Such other ancillary activities as are necessary in order to exercise the Delegated Functions.

SCHEDULE 2 – RESERVED FUNCTIONS OF NHSE

A. Management of the national performers list
B. Management of the revalidation and appraisal process
C. Administration of payments in circumstances where a performer is suspended and related performers list management activities
D. Capital Expenditure functions
E. Public Health Section 7A functions under the NHS Act
F. Functions in relation to complaints management
G. Decisions in relation to the Prime Minister's Challenge Fund; and
H. Such other ancillary activities that are necessary in order to exercise the Reserved Functions.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Highlight report of the Chair of the ICB Finance, Investment and Resources Committee

Agenda Item No: ICB/11/23/14

Committee Chair: Erica Morris, Non-Executive Member

Highlight report of the Chair of the Finance, Investment and Resources Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	14 November 2023

Key escalation and discussion points from the Committee meeting

Alert

The Finance, Investment and Resources Committee considered the Financial Position for Months 6 & 7 and the ask of the recent 'Addressing the financial challenge arising from industrial action' letter from NHS England.

Paper with more detail to be presented to November Board meeting by Executive Director of Finance

Advise

The Finance, Investment and Resources Committee:

- considered and approved the extension of the NHS 111 service for Cheshire and Merseyside as part of the agreed position for the North West Region and agree publication of the VEAT on a North-West wide basis
- considered and noted the current progress on the 2023/24 healthcare and non-healthcare Procurement Decision Plan.
- considered and noted the assurance on the decisions reviewed at the new Procurement Decision Review Group in October
  - Mersey & region stoma service extended for 2 years
  - Electronic Eye Care referral service – further work required on the development of the new national service.
- considered and noted the update on the introduction of the amended Procurement regulations and the future implications for the ICB.
- considered and approved the soft market testing process for community equipment and wheelchair services in Liverpool Place
- endorsed the non-recurrent costs and TUPE Liabilities received for Midlands and Lancashire Commissioning Support Unit (MLCSU) for All Age Continuing Care and Medicines Management
- endorsed the issue of a termination notice to MLCSU for All Age Continuing Care and Medicines Management in order to terminate the contract so mobilisation of in-housing can progress with a transfer target date of 31 March 2024.
- agreed to pause the termination notice to MLCSU for the Individual Funding Request service until the new costed service model is available and can be endorsed by FIR Committee.
- agreed to pause the termination notice to MLCSU for the FOI/SARs service until a revised recommendation has been made and endorsed by FIR Committee.
- endorsed the non-recurrent costs and TUPE Liabilities received from MLCSU for the Information Governance service.
- endorsed the issue of a termination notice to the MLCSU Information Governance service giving MLCSU notice of termination with the intent that it is not applicable until 30th June 2024

Assure

The Finance, Investment and Resources Committee considered:

- **People Committee (draft)**
  Timing of committee to be reviewed as doesn't quite match up with FIRC. Minutes noted

- **Finance Month 6 detailed report**
  Deficit in line with prior reports – significant pressures in Continuing care and prescribing as well as the Providers showing a challenged position related to high levels of non-criteria to reside patients, unachieved CIP and inflation above funded levels.
  Cash showing a varied position, but masked by cash support provided to 4 Providers struggling with cashflow.

- **Finance Month 7 Heads-up report**
  £144m deficit compared to a £74m plan. Similar position to month 6, deficit drivers remain: industrial action, undelivered CIP, Mental Health packages of care and inflation above funded levels.

- **Additional Funding and delivering the plan**
  Letter received advising of some additional funding, a change to the ERF thresholds, flexibilities allowed for some SDF schemes and a further request to confirm financial positions by 22nd November.
  Discussion recognized that this was a very challenging position still requiring difficult decisions and the need to ensure Local Authority understanding and collaborative working.

- **Operational focus required on 3 areas:**
  - Patients not meeting criteria to reside in hospital
  - Opening the beds that Providers have committed to
  - Ensuring NWAS staff & vehicles are available to see patients.

- **Strategy**
  Work on understanding the exit run rate and deficit drivers presented and discussed. Recognised that current position contains a significant amount of non-recurrent risk and that there is significant uncertainty around allocations.

  Recognised the need to agree spatial footprints to allow for more in-depth work to be carried out at Place.

Committee risk management

The following risks were considered by the Committee and the following actions / decisions were undertaken.

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
F2: Health inequalities continue to drive increased demand for services with financial pressures resulting in failure to achieve financial duties, currently rated as extreme (16)	Current rating of 16 agreed.
W8 – not having an inclusive NHS workforce means we are not reflective of the communities served, particularly at senior levels and risks the ability to deliver against the ICB strategic objectives.	Current rating to 12 agreed
F5 – Scale of procurement requirements exceeds available capacity resulting in legal challenge and increased costs.	Discussed and recognised – Val At to do further work on this
F7 – The ICB does not allocate the operational capital budget in a way that address capital investment risks across secondary and primary care.	Highlighted that there is a further risk regarding the availability of capital resource, not just the allocation methodology. FM and CWi to work on this
Place Financial Risks above 15	Reviewed and considered
Information data flow risk	Identified and to be worked up for next FIRC

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
BAF P7: The Integrated Care System is unable to achieve its statutory financial duties.	Current rating of 16 agreed. Some discussion over whether rating should be increased.
BAF P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Current rating of 12 agreed

Achievement of the ICB Annual Delivery Plan

The Committee considered the following areas that directly contribute to achieving the objectives against the service programmes and focus areas within the ICB Annual Delivery plan

Service Programme / Focus Area	Key actions/discussion undertaken
Development and delivery of a Cheshire and Merseyside system-wide financial strategy during the first half of 2023-24	Strategy paper presented
Delivery of the Finance Efficiency & Value Programme	Performance on CIP for Providers and ICB noted in month 6 and 7 finance reports. Part of work required for “Delivering the 23/24 plan”.
Development and delivery of the Capital Plans.	Spend to date noted in month 6 and 7 finance reports.
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	N/a to be considered at a future meeting.

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Board Assurance Framework – Quarter Two Update

Agenda Item No: ICB/11/23/15

Responsible Director: Clare Watson, Assistant Chief Executive

Board Assurance Framework – Quarter Two Update

1. Purpose of the Report

1.1 The purpose of the report is to provide an update on the Board Assurance Framework (BAF).

2. Executive Summary

2.1 The 2023-24 BAF and principal risks were approved by the Board in May 2023 and a Quarter One update was received in July 2023 . The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives.

2.2 There are currently 10 principal risks, including 4 extreme risks, 5 high risks, and 1 moderate risk. The most significant risks are:

- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience, currently rated as extreme (20).
- P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population, currently rated as extreme (16).
- P7 - The Integrated Care System is unable to achieve its statutory financial duties, currently rated as extreme (16).
- P3 - Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes, currently rated as extreme (15).

2.3 Since the July 2023 report:

- P2 - The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities, **current rating has reduced** from high (9) to moderate (6) in line with the target score. This follows the approval of the 'data into action' business case, establishment of the Digital Design Authority and appointment of the Chief Technical Officer. The focus will shift to assurance that controls continue to be effective.
- P8 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services, **current rating has increased** from high (8) to high (12). This reflects

heightened risk in relation to affordability and deliverability of the key supporting programmes.

- P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population. **Target score has increased** from high (9) to high (12) reflecting what is realistically achievable with planned control action in the current annual BAF cycle, while continuing to aim for a moderate level over the lifecycle of the access recovery plans.
- P10 - ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population. **Target score has increased** from moderate (6) to high (9) reflecting heightened financial and operational challenges in the current annual BAF cycle, while continuing to aim for a moderate level over the lifecycle of the strategic plan.
- P3 **risk description has been updated** from '*Service recovery plans for Planned Care are ineffective in reducing backlogs and meeting increased demand which results in poor access to services, increased inequity of access, and poor clinical outcomes'* to a revised description at 2.2 above reflecting that the cause has shifted from a demand side risk post COVID to a supply side risk in the context of industrial action and other pressures.

2.4 The report and appendices set out the controls in place, an assessment of their effectiveness and further control actions planned in relation to all principal risks. Planned assurances have been identified in relation to each principal risk and these will be provided through the work of the Committees and through Board reports over the course of the year.

2.5 The priority activity over the last quarter has continued to be the strengthening and implementation of controls with the aim of reducing the likelihood or potential impact. As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the current risk profile, progress in completing mitigating actions, assurances provided and priority actions for the next quarter; and consider any further action required by the Board to improve the level of assurance provided or any new risks which may require inclusion on the BAF.

- **APPROVE** the amended risk description for P3, changes to current risk ratings for P2 and P8 and increased target scores for P6 and P10 as described in section 2.3.

4. Reasons for Recommendations

4.1 The Board has a duty to assure itself that the organisation has properly identified the risks it faces and that it has processes in place to mitigate those risks and the impact they have on the organisation and its stakeholders. The Board discharges this duty as follows:

- identifying risks which may prevent the achievement of its strategic objectives
- determining the organisation's level of risk appetite in relation to the strategic objectives
- proactive monitoring of identified risks via the Board Assurance Framework and Corporate Risk Register
- ensuring that there is a structure in place for the effective management of risk throughout the organisation, and its committees (including at place)
- receiving regular updates and reports from its committees identifying significant risks, and providing assurance on controls and progress on mitigating actions
- demonstrating effective leadership, active involvement and support for risk management.

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. The principal risks identified for 2023-24 were approved for adoption by the Board in May 2023 and form the basis of the Board Assurance Framework reported quarterly to the Board.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to risks which is acceptable in general, and this is set out in the core risk appetite statement.

5.3 The Risk Management Strategy incorporates the board assurance arrangements and sets out how the effective management of risk will be evidenced and scrutinised to provide assurance to the Board. The Board Assurance Framework (BAF) is a key component of this. The Board is supported through the work of the ICB Committees in reviewing risks, including these BAF risks, and providing assurance on key controls. The outcome of their review is reported through the reports of the committee chairs and minutes elsewhere on the agenda.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**
Objective Three: **Enhancing Productivity and Value for Money**
Objective Four: **Helping to support broader social and economic**

6.1 The BAF supports the objectives and priorities of the ICB through the identification and effective mitigation of those principal risks which, if realised, will have the most significant impact on delivery.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks. The Annual Delivery Plan and its associated risks can be found at: https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: **Quality and Safety**
Theme Two: **Integration**
Theme Three: **Leadership**

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to Theme Three: Leadership, and specifically QS13 – governance, management, and sustainability:
"We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment, and support. We act on the best information about risk, performance, and outcomes, and we share this securely with others when appropriate."

9. Risks

9.1 There are currently 4 extreme risks, 5 high risks and 1 moderate risk. There has been little movement in current risk scores since the July report, but progress has been made in completing actions to improve both controls and assurances.

9.2 The most significant risks are:

9.2.1 **P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals, and social care) results in patient harm and poor patient experience**, currently rated as extreme (20). This is to be mitigated through the delivery of operational plans spanning urgent and emergency care, virtual wards, admissions avoidance, no criteria to reside, and bed occupancy. The national delivery plan for recovering urgent and emergency care spans the next 3 years to 2024/25 e.g., an improvement to 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvements in 24/25. The risk is expected to diminish over this timeframe and the target score for 23/24 (15) reflects that improvement to pre-pandemic constitutional standards e.g., 95% of patients being admitted, transferred, or discharged within four hours will span multiple years. Oversight and assurance will be provided through the work of the C&M Urgent Care Improvement Group.

9.2.2 **P6 - Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population**, currently rated as extreme (16). This is to be mitigated through the development and delivery of the Primary Care Strategic Framework, Primary Care Access Recovery Plan, and Dental Improvement Plan over a 2- to 3-year period. This is in the context of significant and increased post Covid-19 demand which continues to exceed supply despite the substantial progress in recovering activity levels. Oversight and assurance will be provided through the System Primary Care Committee supported by the work of the programme delivery governance structure.

9.2.3 **P7 - The Integrated Care System is unable to achieve its statutory financial duties**, currently rated as extreme (16). This is to be mitigated in the short term through the 23-24 System Financial Plan which has now been agreed and approved. During the course of the year cost improvement plans and a long-term financial strategy will be developed. This is in the context of a significant underlying system deficit which is reflected in the risk score. Oversight and assurance will be provided through the work of the Finance, Investment and Our Resources Committee and the monthly system finance reports to the Board.

9.2.4 **P3 - Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes**, currently rated as extreme (15). This is to be mitigated through the delivery of operational plans, including the elective recovery programme, diagnostics programme, Cancer Alliance programme and place delivery plans. The updated description reflects that capacity constraints are currently the

key driver, and this is reflected in the risk score. The national delivery plan for tackling the COVID-19 backlog of elective care spans the next 3 years to 2024/25 and the risk is expected to diminish over this timeframe. Oversight and assurance will be provided through the work of the Quality and Performance Committee and Transformation Committee and the monthly performance reports to the Board. External assurance with be through the NHS System Oversight Framework.

9.3 Mitigation strategies are having an impact in relation to a number of the risks as illustrated by the heat map at Appendix Two and summarised below:

9.3.1 **P1 - the ICB is unable to progress meeting its statutory duties to address health inequalities**. Mitigated from extreme (16) to high (12) through strategy and plans to implement Marmott principles and focus on Core 20+5 supported by ringfenced funding for health inequalities & transformational programmes. Key further actions are to finalise prioritisation framework, and re-focus Population Health Board.

9.3.2 **P2 - The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities**. Mitigated from high (12) to moderate (6) through the Digital and Data Strategy 2022-25 and key contracts for population health management and shared care record integrated health and care data platform and analytical services. This is now in line with the target score and the focus will shift to assurance that controls continue to be effective.

9.3.3 **P4 - Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience**. Mitigated from extreme (15) to high (10) through contractual standards and extensive infrastructure for quality review, analysis, learning and assurance. Key further actions include development of clinical quality strategy, standardised quality contracting model and further improvement of existing controls.

9.3.4 **P8 - The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services**. Currently rated as high (12). Planned mitigations through the transformation programmes in Liverpool, East Cheshire, and Sefton and for women's services and clinical pathways. Key further actions are to develop the clinical improvement hub, establish governance and progress the Liverpool urgent care pathways.

9.3.5 **P9 - Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives**. Mitigated from extreme (16) to high (12) through a range of programmes developed and supported by the Cheshire and Merseyside People Board. Key further

actions are to develop and enhance system workforce planning, deliver the C&M retention plan, and maximise apprenticeships.

9.3.6 **P10 - ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**. Mitigated from extreme (16) to high (9) through the development of the Interim HCP Strategy and the Joint 5-Year Forward Plan, together with the associated consultation and engagement. Key actions are the next iterations of the HCP Strategy and Joint 5-Year Forward Plan and concluding the ICB operating model.

Further detail is provided in the risk summaries at Appendix Four.

9.4 The priority activity over the last quarter has been the strengthening and implementation of controls with the aim of reducing the likelihood or potential impact. The significant actions to improve controls completed since July are:

- Prioritisation framework completed to inform investment bids for transformation programme funding during the financial year 2023-24. (P1, P10)
- Cheshire and Merseyside Digital Design Authority established (P2)
- Chief Technical Officer in post (P2)
- 2023-24 Winter Plans finalised (P3, P5)
- C&M organisations have implemented the Patient Safety Incident Response Framework (P4)
- Clinical and Care Constitution signed off by Board (P4)
- Sentinel quality metrics and dashboard for Board and Quality and Performance Committee implemented (P4)
- C&M UEC Recovery Programme established (P5)
- Operational Scheme of Reservation and Delegation updated to reflect final structures (P7)
- Shaping Care Together Programme in Sefton Place re-launched (P8)
- Women's Services Committee established (P8)
- Workforce dashboard framework implemented (P9).

9.5 As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level. Planned and actual assurances have been identified in relation to each principal risk and these are summarised in Appendix Three and detailed in the risk summaries at Appendix Four.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does cover a number of financial risks which are described in section 9 above and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Principal risks P3, P4, P5, P6, P8 and P9 have the potential to impact on equality, diversity and inclusion in service delivery, outcomes, or employment. The mitigations in place and planned are described in more detail in the risk summaries at Appendix Four.

12.2 Principal risks P1 and P2 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at Appendix Four.

13. Climate Change / Sustainability

13.1 There are no identified impacts in the BAF on the delivery of the Green Plan / Net Zero obligations.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the priority actions and assurance activities as identified in Appendix One and in the individual risk summaries at Appendix Four. Updates will be provided through the regular BAF report to the Board.

15. Officer contact details for more information

Dawn Boyer
Head of Corporate Affairs & Governance
NHS Cheshire and Merseyside ICB

16. Appendices

Appendix One: Board Assurance Framework Summary
Appendix Two: Heat Map
Appendix Three: Risk Assurance Map
Appendix Four: Risk Summaries

NHS
Cheshire and Merseyside

Board Assurance Framework 2023/24 – Updated at November 2023

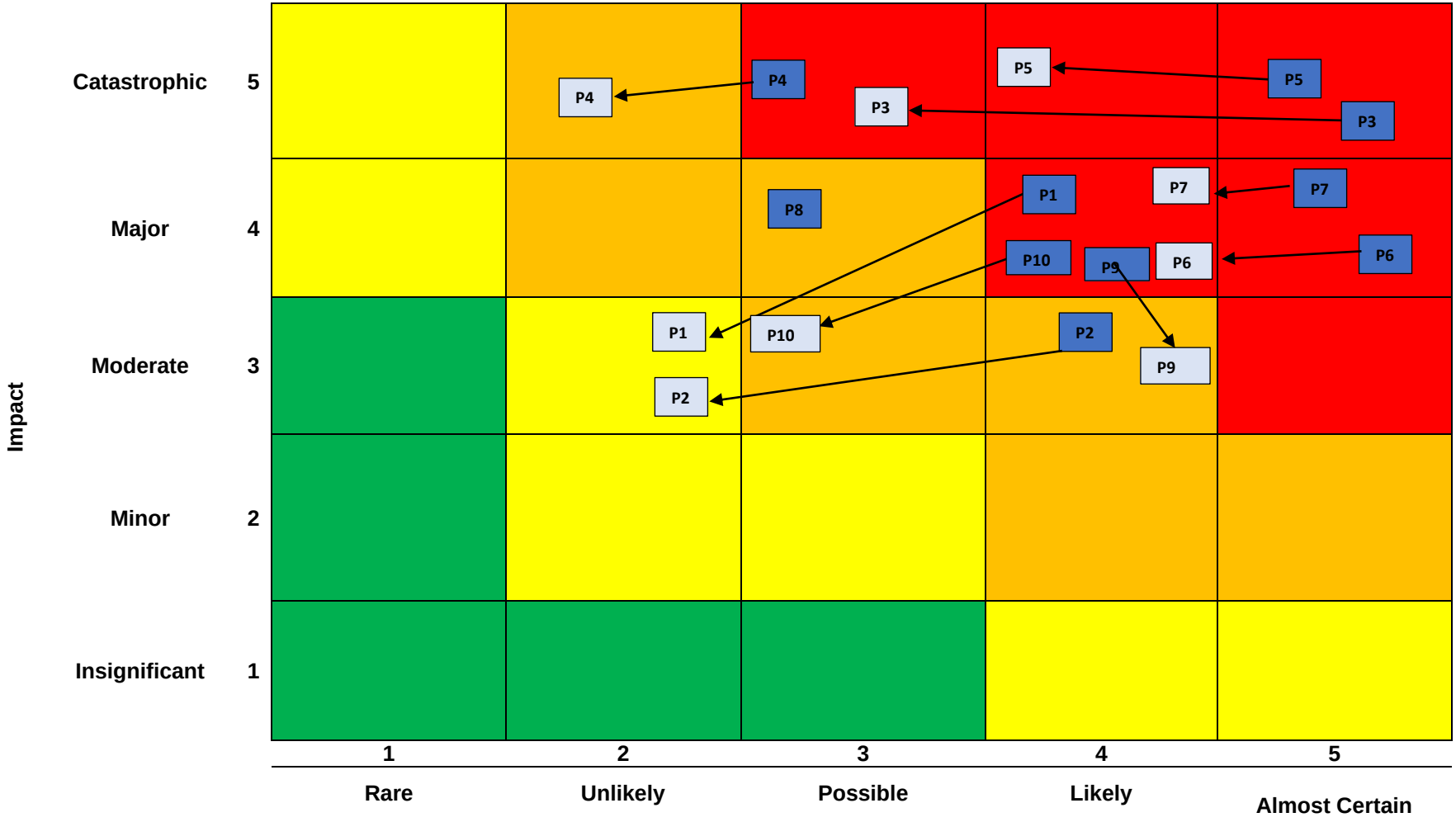
Appendix One – Summary

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience						
P1: The ICB is unable to meet its statutory duties to address health inequalities	Transformation Committee Clare Watson	**4x4=16**			**2x3=6**	Further action to strengthen controls. Key actions are to finalise prioritisation framework, and re-focus Population Health Board.
P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities	Transformation Committee Rowan Pritchard-Jones	**4x3=12**	**2x3=6**	Score reduced from 9 to 6	**2x3=6**	Currently at target score. Key focus should be on assurance. It is planned that this is provided through Intelligence into Action programme governance and reporting via Transformation Committee.
Strategic Objective 2: Improving Population Health and Healthcare						
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased	Quality & Performance Committee Anthony Middleton	**5x5=25**	**3x5=15**	No change	**2x5=10**	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic Centres and elective capacity through elective hubs

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
inequity of access, and poor clinical outcomes						
P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Quality & Performance Committee Chris Douglas / Rowan Pritchard-Jones	**3x5=15**	**2x5=10**	No change	**1x5=5**	Significant controls in place with some actions for further improvement, including development of clinical quality strategy and standardised quality contracting model. Priority will be to provide assurance on continuing effectiveness of control framework.
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Quality & Performance Committee Anthony Middleton	**5x5=25**	**4x5=20**	No change	**3x5=15**	Further action to strengthen controls. Key actions are implementing operational plan for urgent emergency care, virtual wards, admissions avoidance, no criteria to reside, and bed occupancy; and C&M UEC Recovery Programme.
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Primary Care Clare Watson	**5x4=20**	**4x4=16**	No change	**3x4=12**	Further action to strengthen controls. Key actions are to conclude and establish delivery of primary care plans.
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
P7: The Integrated Care System is unable to achieve its statutory financial duties	Finance, Investment & Our Resources Committee Claire Wilson	**5x4=20**	**4x4=16**	No change	**2x4=8**	Further action to strengthen controls. Key actions are to finalise cost improvement plans and a long-term financial strategy.

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score	Priority Actions / Assurance Activities
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Transformation Committee Rowan Pritchard-Jones	**3x4=12**	**3x4=12**	Score increased from 8 to 12	**2x3=6**	Further action to implement and strengthen controls. Key actions are to develop the clinical improvement hub, establish governance and progress the Liverpool urgent care pathways.
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives	Finance, Investment & Our Resources Committee Chris Samosa	**4x4=16**	**4x3=12**	No change	**2x3=6**	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and deliver the C&M Retention Plan.
Strategic Objective 4: Helping the NHS to support broader social and economic development						
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population	ICB Executive Graham Urwin	**4x4=16**	**3x3=9**	No change	**3x3=9**	Further action to strengthen controls. Key actions are the next iterations of the HCP Strategy and Joint 5-Year Forward Plan and the ICB operating model.

Appendix Two – Heat Map



Appendix Three – Risk Assurance Map

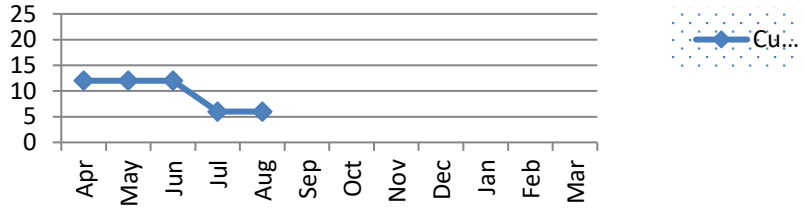
Principal Risks	Current Risk Score	Controls				1st line of defence		2nd line of defence	3rd line of defence	Assurance Rating
		Policies	Processes	Plans	Contracts	Reporting				
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience										
P1: The ICB is unable to meet its statutory duties to address health inequalities		G	G	G	G	G	Management oversight of the development & implementation of the prioritisation framework. Appraisal of health inequalities funding bids / allocations.	Progress reports to C&M HCP Board on delivery & implementation of programmes and projects aligned to Marmott principles - ***Planned***	Core 20+5 & health inequalities stocktakes by NHSE/I reported to Population Health Board & C&M HCP Board - ***Planned***	**Reasonable**
P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities	**6**	G	G	G	A	G	Management scrutiny and prioritisation of requests. Management oversight of programme delivery.	Approval of 'intelligence into action' investment case by ICB Board – ***In place*** Programme delivery reporting to Transformation, Quality & Performance Committees, Population Health Board – ***Planned***		**Reasonable**

Strategic Objective 2: Improving Population Health and Healthcare										
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes	**15**	**G**	**A**	**G**	**G**	**G**	Executive sign off to the operational plan Management oversight of operational and programme planning and delivery	Performance reporting to Quality & Performance Committee, ICB Board – ***In place*** Programme delivery reporting to Transformation Committee, ICB Board – ***In place***	NHSE/I Systems Oversight Framework – ***In place***	**Reasonable**
P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	**10**	**A**	**A**	**A**	**A**	**G**	Executive oversight through system-wide quality governance structure and reporting	Executive Nurse report to ICB Board – ***In place*** Quality reporting and dashboard to Quality and Performance Committee – ***In place***	Regional Quality Group reporting - ***Planned***	**Reasonable**
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care,	**20**	**G**	**A**	**A**	**G**	**A**	Executive sign off to the operational plan	Urgent Care Recovery and Improvement Group - ***In place***		**Reasonable**

community, mental health, acute hospitals and social care)results in patient harm and poor patient experience							Management oversight of activity and performance	Performance reporting to Quality & Performance Committee, ICB Board – ***In place***		
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	**16**	**G**	**A**	**A**	**G**	**G**	Executive sign off to the primary care strategic framework and plans and to the operational plan Management oversight of operational and programme planning and delivery	ICB Board approval of primary care strategic framework and plans – ***Planned*** Programme delivery reporting to System Primary Care Committee, ICB Board – ***In place*** Performance reporting to Quality & Performance Committee, ICB Board – ***In place***	NHSE/I Systems Oversight Framework – ***Planned*** NW Regional Transformatio n Board oversight - ***Planned***	**Reasonable**
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money										
P7: The Integrated Care System is unable to achieve its statutory financial duties	**16**	**G**	**G**	**A**	**A**	**G**	Management oversight of financial planning & budget setting Management oversight of contract development & negotiation	System Finance Reports to ICB Board – ***In place*** ICB Board approval of 23-24 Financial Plan – ***In place***	NHSE/I Systems Oversight Framework – ***Planned***	**Reasonable**
P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the	**12**	**G**	**G**	**A**	**A**	**A**	ICB Executive & Place representation on programme boards	Programme delivery reporting to Transformation Committee, ICB Board – ***Planned***	NHSE/I Major Service Change Process - ***Planned***	**Reasonable**

population due to loss of services								ICB Women's Services Committee oversight of LCSR - ***Planned***		
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives	**12**	**A**	**A**	**A**	**G**	**A**	Executive sign off of workforce plans Management oversight of operational and programme planning and delivery	Workforce performance reporting to the People Board – ***Planned***	CQC Well Led Review – ***Planned*** NHSE/I Systems Oversight Framework – ***Planned***	**Reasonable**
Strategic Objective 4: Helping the NHS to support broader social and economic development										
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population	**9**	**G**	**G**	**A**	**A**	**G**	Executive oversight of strategic planning process & associated engagement activity	Review and approval of joint strategy & plans by ICB & HCP Boards – ***Interim approved***	NHSE/I Systems Oversight Framework – ***Planned*** CQC Well Led Review - ***Planned***	**Reasonable**

Appendix Four – Risk Summaries

ID No: P1	Risk Title: The ICB is unable to meet its statutory duties to address health inequalities			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	2	3	**6**	
Target Risk Score	2	3	**6**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Professor Ian Ashworth-Director of Population Health	Assistant Chief Executive	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	C – beyond the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	26/10/23	26/11/23

Risk Description
There are longstanding social, economic and health inequalities across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for HI. Population health is shaped by the social, economic, and environmental

conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across the multiple organisations, agencies and the communities covered by the ICB.

Linked Operational Risks	The ICB receives national Health Inequalities funding. This funding has been ring fenced to ensure the financial investment occurs in each financial year to support addressing the Health Inequalities that the ICS, and local places face within their populations.

Current Controls		**Rating**
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer' (Marmot Review), Core 20+5, Prioritisation Framework, Public Engagement / Empowerment Framework.	**G**
Processes	Strategic planning, consultation & engagement, HCP & Place-based partnership governance, financial planning, and workforce planning for Population Health Team of the Director of Population Health will provide greater capacity to support system wide work on Health Inequalities. The ICB are considering the formalisation of the Population Health board as a committee within the HCP governance structure.	**G**
Plans	C&M HCP Interim Strategy, Joint 5-year Forward Plan, Joint Health & Wellbeing Strategies x 9 places, ringfenced funding for health inequalities & transformational programmes, continued focus on Core 20+5 for adults and children, implementation of Marmot principles within formal ICB documentation. The Director of Population Health's vision and programmes (Social Determinants, Healthy Behavior's Health Care Inequalities (Core20Plus5), Strategic Intelligence, Cross Cutting enablers – Communications, Workforce Development, Research & Development programmes), has been approved by the HCP Board and the All together Fairer Board.	**G**
Contracts	The use of NHS Standard Contracts includes requirements on our service providers to also focus on addressing health inequalities.	**G**
Reporting	C&M HCP Partnership Board has oversight of health inequalities, Population Health Board, Place-based partnership boards, ICB Board.	**G**
Gaps in control		
Work underway to form a Strategic Population Health Board, and Programme Group meetings. The Strategic Board will commence in the autumn once confirmation of the formal committee status for this board is known. The current board will hold its last meeting 14/9/23 and this will continue as a Network for information sharing as the group currently has sixty-nine members, evidencing the systemwide commitment to		

population health. There will also be programme group meetings in line with programmes set out in Plans section above. These will be initiated during the autumn period.

The Director of Population Health's target operating model is currently being reviewed for formal approval to progress recruitment of the Population Health team which will provide the capacity to expedite programme growth, along with the provision of strategic leadership that will enable transformation programmes to be informed by C&M population health intelligence, best evidence based practice, that achieves a return on investment, as well as reductions in the Health Inequalities experienced at place and community levels.

Actions planned	Owner	Timescale	Progress Update
Finalise Joint 5-year Forward Plan	Neil Evans	Completed	Approved by ICB Board in June.
Re-focus Population Health Board	Ian Ashworth	31/10/23	Director of Population Health commenced in post 26/06/23. Plans for a Strategic Population Health Board formed. Engagement with Population Health board members and LA DsPH have taken place in September and October 2023. This covered priorities and proposals around the new structure of programme oversight. The Population health Board will remain a key system assurance board for the ICB and a driver for the HCP work programme, linking strongly with the new CYP Committee. It will continue to be focal point within any review of ICB Governance structures.
Agree MOUs with place-based partnerships	Ian Ashworth	31/11/23	The Director of Population Health Target Operating model has been developed and is currently under review for programme approvals planned for the November Transformation Committee. Following this recruitment of the Population Health team will be undertaken. We will also develop guidance and forms for reporting and performance monitoring of financial investment at place through the Health Inequalities ring fenced funding.
Finalise & secure partner sign off to the Population Health Vision and strategic programme approach for C&M ICB / ICS	Ian Ashworth	31/03/24	A formal programme report was presented at the HCP Board July 2023 on this programme. This board will receive regular updates on Population Health themes, this has included a Health and Housing workshop in September Board meeting, and aa CYP workshop focus for November HCP.

Develop & implement prioritisation framework	Neil Evans	Completed	Prioritisation framework completed to inform investment bids for transformation programme funding during the financial year 2023-24. This framework will also inform the approach to Health Inequality investment at place. The prioritisation framework is monitored to ensure the latest data and any change is reflected in the prioritization framework. This framework will also be shared with place.

Assurances		
Planned	**Actual**	**Rating**
ICB Board approval to Joint 5 Year Forward Plan	Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 – 29/6/23 (reasonable) Completed.	**Reasonable**
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects aligned to Marmot principles (place & system where appropriate) (quarterly)	Regular reporting to the HCP Board on Population Health and progress in reducing health inequalities is established and will continue for each Board that occurs. The intention to realign the HCP strategy with the All Together Fairer Strategy document.	
Core 20+5 & health inequalities stocktakes by NHSE/I reported to Population Health Board & C&M HCP Board (quarterly)	Quarterly submissions made to NHSE – to be reported to the Population Health Board, and to the Health and Care Partnership through the. Director of Population health's programme report.	

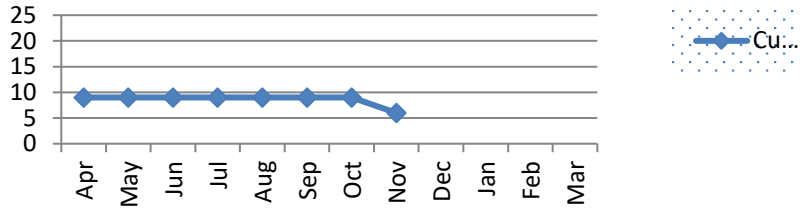
Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Work underway to form a Strategic Population Health Board / Committee under ICB governance structure.
The Director of Population Health's target operating model once confirmed will enable recruitment of the population health team.

Actions planned	Owner	Timescale	Progress Update
Finalise & seek approval to population health strategy & plans	Ian Ashworth	Completed	Reported to the HCP Board July 2023. Completed.
Population Health programme resource allocation paper to be taken to November Transformation Board	Ian Ashworth	23/11/23	Paper scheduled to Transformation committee will seek approval for population health and health inequality investment programmes.

Further develop business intelligence monitoring processes to assess the impact of our work on outcomes and report this through ICB governance structures to provide assurance.	Ian Ashworth	31/03/2024	Reporting to track delivery has been developed over recent years. This will be reviewed and updated to provide assurance on progress and to allow mitigating action where required.

ID No: P2	Risk Title: The ICB is unable to address inadequate digital and data infrastructure and interoperability, which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	3	**12**	
Current Risk Score	2	3	**6**	
Target Risk Score	2	3	**6**	
Risk Appetite	In the short term (3 months) the ICB can accept the risk because existing arrangements are supporting a reduced capability for data and intelligence. In the medium and longer term The ICB cannot accept the risk at the current level because resolution is required to fulfil its core objectives.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard-Jones	John Llewelyn	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services	Transformation	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	30/10/23	30/11/23

Risk Description
Understanding the health and care needs of our population and our ability to bring focused and meaningful interventions to those who most need it, and therefore improve health and care outcomes of our population in an equitable way, is dependent on a robust interoperable infrastructure to deliver high quality data and intelligence. Developing consistent at scale capabilities will require a levelling up, and rationalisation, of our digital and data infrastructure across places, communities, partner and provider organisations. This risk relates to the potential inability of the ICB to deliver equitable access to a common set of technologies and services across the whole system.

Linked Operational Risks	Operational risks are being finalised

Current Controls		Rating
Policies	What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies, Data Saves Lives	G
Processes	Digital and data maturity assessment, programme & project management, training, communication & engagement, academic validation,	G
Plans	Digital and Data Strategy 2022-2025, System P programme, 2 year funding plan now approved and associated procurements are progressing well.	G
Contracts	IT provider contracts, data sharing agreements, AGEM CSU Data Services for Commissioners Regional Office (DSCRO), CIPHA (Graphnet contract for: population health management and shared care record integrated health and care data platform; Johns Hopkins Population Health risk stratification tools; and analytic services) Liverpool University Civic Health Innovation Lab (CHIL) including Civic Data Cooperative and analytic resource from Faculty of Health and Life Sciences , C2Ai tools	A
Reporting	Digital Transformation & Clinical Improvement Assurance Group, Transformation Committee	G

Gaps in control
Gaps in data coverage – e.g. social care

Actions planned	Owner	Timescale	Progress Update
Complete shared governance arrangements, including pipeline process for analytics requests, prioritization process and progress reporting.	John Llewelyn	November 23	Draft Governance being consulted on. Recommended Proposal for Governance model to be presented to Digital Transformation and Clinical Improvement Assurance board in July 2023

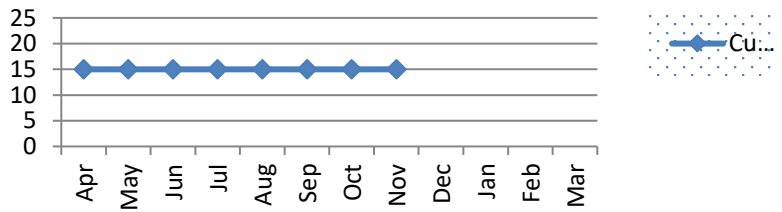
			On 7th July, a Data into Action meeting agreed a T.O.R.for the new DiA Board including T.o.R. for all DiA sub-groups. On 2nd August, Medical Director chaired a shadow DiA board. On 22 August a meeting of senior stakeholders discussed prioritization and delivery mechanism of the programme Meeting planned for 6 September to follow up with stakeholders and agree Governance route to formally establish the programme. Paper formalizing Data into Action programme will be taken to Executive Team in September, prior to extended socialization. Will come to Transformation Committee in November .
Conduct review of data and intelligence assets (including Social Care) and platforms to identify rationalization opportunities	John Llewelyn/Anthony Middleton	Dec 2023	Initial desk-based assessment complete. More detailed review and consultation with users is in planning stage July 23 Opened discussion with DDAS C&M lead around alignment with Digital & Data Strategy and increased data sharing.
Establish C&M Digital Design Authority	John Llewelyn	Sept 2023	Draft T.O.R written Meeting scheduled for November C&M CIO Away day September – session planned to agree scope of DDA and supporting process. Interim CTO will subsequently take forward to establish the group. **Completed**
Appoint Chief Technical Officer (CTO)	John Llewelyn	Sept 2023	Digital TOM and Org structure under staff consultation until end April. Structure agreed and establishment approved. Some key posts (inc. CTO) under vacancy control consideration.

			p/t CTO appointed on an interim p/t basis. Perm requirements for role will be refined over next few months. **Completed**

Assurances		
Planned	**Actual**	**Rating**
ICB Board April 2023 Board to consider the 'intelligence into action' investment case with recommendation from FIRC to approve.	ICB Finance Investment and Resources Committee (FIRC)agreed the 'data into action' investment case to continue 2 further years funding of the Graphnet contract, SystemP and C2AI. FIRC recommendations approved at ICB Board **Complete** Full review of Existing BI Solution contracts to be completed.	**Reasonable**
Through the Medical Director establish a collaborative programme of delivery for 'intelligence into action' that will maximize the use of existing analytic and transformation resource across ICB, Academia and Providers. The ICB will use this programme to set objectives consistent with CM joint forward plan and receive assurances on delivery through Transformation Committee, Quality and performance Committee and Population Health Board.	ICB Medical Director appointed Senior Academic from University of Liverpool as Associate Director of Research. Programme architecture developing in draft. Approval in August/Sept. ICB Director of Population Health in post mid July 2023 and engaged with governance design work.	
Gaps in assurance		

Actions planned	Owner	Timescale	Progress Update
ICB Board April 2023 Board to consider the 'intelligence into action' investment case with recommendation from FIRC to approve.	Rowan Pritchard-Jones	n/a	Investment case has been approved by FIRC. FIRC recommendations approved by ICB Board in April. **Completed**
Due Diligence and IG compliance work underway alongside procurement process to secure PTL risk stratification capability.	Rowan Pritchard-Jones	n/a	IG model agreed for continuation of PTL work. With system IG leads for consideration and approval at next IG steering Group. **Completed**
Establish a collaborative programme of delivery for 'intelligence into action' that will maximize the use of existing analytic and transformation resource across ICB, Academia and Providers.	Rowan Pritchard Jones	n/a	Draft proposition for discussion at existing 'data into action' meeting on 21 April 2023 Paper to be prepared for Corporate Executives meeting before end of April 2023 Programme to be established during May 2023. Programme Board has been established in and is agreeing the T.O.R. and outline programme of work for 2023/24 and beyond. Arrangements will be ratified Sept 6th and reported through DTCIAG and Transformation Committee New Governance established . Initial Board met during October **Completed**
Socialise the governance model and establish pipeline and delivery methodology across wider C&M system	Rowan Pritchard Jones	Dec 2023	Once ratified the Governance, outline programme and pipeline management process will be communicated through the appropriate channels across the ICS JL presenting governance model to CMAST CEOs 3rd November

ID No: P3	Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	**25**	
Current Risk Score	3	5	**15**	
Target Risk Score	2	5	**10**	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Andy Thomas	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Performance	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	17/11/2023	17/12/23

Risk Description
The COVID 19 pandemic generated significant backlogs due to reduced capacity and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes.

Supply side constraints, in particular the ongoing impact of industrial action, impact on the available capacity in the system to tackle the longest waits. There is evidence that C&M has been relatively more impacted by industrial action than most other ICBs in terms of the volumes of elective activity that have been cancelled.
The Cheshire and Merseyside Operational Plan sets out service recovery plans to deliver significantly more elective care and diagnostic activity to tackle the elective backlog, reduce long waits and improve performance against cancer waiting times standards and to improve timely access to primary care.
This risk relates to the potential inability of the ICB in this context to deliver these plans against national targets for recovery of electives, diagnostics and cancer services, which may result in patient harm and increased health inequalities.

Linked Operational Risks	

Current Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, NHS elective recovery plan published February 2022 '**Delivery plan for tackling the COVID-19 backlog of elective care'**	G
Processes	System level operational planning, performance monitoring, contract management, system oversight framework	A
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan	G
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	G
Reporting	Programme level reporting, Quality & Performance Committee, Primary Care Committee, ICB Board, Regional Elective Board (chaired by NHSE)	G

Gaps in control

- Industrial Action: IA to date in 2023/24 has had significant impact, with evidence that C&M has been been relatively more impacted by industrial action than most other ICBs in terms of the volumes of elective activity that have been cancelled, and performance on planned care would have been better if not for this impact.
- The scale and frequency of IA going forward is unknown. We work to mitigate through EPRR processes on days of IA, and Trusts/programmes seek to mitigate impact overall through a range of measures to maintain elective activity levels to the best of their ability.

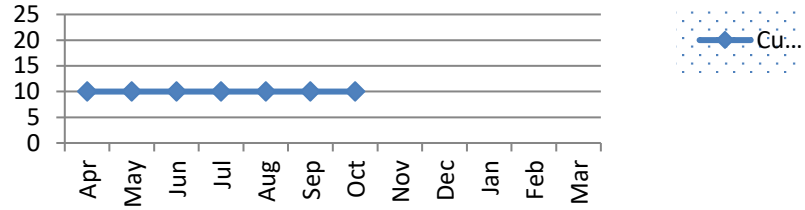
- Winter Pressures: All Trusts and the wider system have winter plans which seek to mitigate urgent care demand, but depending on the level of urgent care winter pressures, elective care bed capacity will be impacted at times in order for Trusts to meet UEC demand.
- On overall elective activity, despite industrial action C&M providers have continued to deliver more activity than in the baseline year 2019/20 (value weighted)
- On elective long waits (65+ weeks) C&M has managed to remain ahead of trajectory from April-August 2023, but in September the number of patients waiting over 65 weeks exceeded trajectory for the first time in 23/24. However, delivery remains on track at present in terms of clearing all 65 week waits by the end of March
- In relation to reducing the cancer treatment backlog, overall C&M remains ahead of trajectory as at September 2023, providing some contingency against both IA and winter pressures

Actions planned	Owner	Timescale	Progress Update
Elective Recovery Improvement Team	AM	Ongoing	23/24 Plans set out in operational plans, winter plans in development, finalised 31/08/2023
Increasing diagnostics capacity through CDCs and elective capacity through elective hubs	AM	Ongoing	23/24 Plans set out in operational plans, winter plans in development, finalised 31/08/2023
Self assessment against the OP letter (Jim Mackey)	AM	1 month	Self-assessment undertaken by trusts, submitted to region mid-September.

Assurances		
Planned	**Actual**	**Rating**
Implementation of C&M SOF Framework in 23/24	New 23/24 framework not published or expected imminently. C&M is implementing its approach to the existing NHS Oversight Framework from Q3 23/24	**Reasonable**
Performance reporting to Quality & Performance Committee, ICB Board (monthly)	Reporting against 23/24 trajectories incorporated into Q&P/Board report	
Programme delivery reporting to Transformation Committee, ICB Board	Programme reporting in place	

Gaps in assurance			
OP follow up target of 25% reduction has not been signed up to by trusts and is deemed unachieveable for most specialties. Mitigations in place to implement effective PIFU and personalised follow up pathways.			
Actions planned	**Owner**	**Timescale**	**Progress Update**
Modelling around OP conversion rates, to target high conversion specialties to avoid breaches at end of March.	AM	Ongoing	Trusts to work on progressing new OP during September and October, particularly specialties with high conversion rates.
Development of mutual aid mechanisms for diagnostics to support achievement faster diagnosis standard (FDS) in cancer and 90% of patients being seen within 6 weeks by March 2024.	Diagnostics Programme	Ongoing	

ID No: P4	Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	5	**15**	
Current Risk Score	2	4	**10**	
Target Risk Score	2	3	**5**	
Risk Appetite	The ICB has a low appetite for risk that impacts upon patient safety and experience			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Douglas / Rowan Pritchard-Jones	Kerry Lloyd	Nursing & Care / Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	25/10/23	25/11/23

Risk Description	
The ICB has a statutory responsibility to improve the quality of commissioned services and safeguard the most vulnerable, the quality governance framework that has been established supports early identification and triangulation of risks to quality and safety. This risk pertains to the potential failure of the established framework, with the consequence of a major impact on the safety and experience of services by our population. The current score is reflective of the mitigations in place which support in reducing the likelihood and potential impact of a major quality failure.	
Linked operational risks	

Current Controls		Rating
Policies	National Quality Board guidance on risk management and escalation Safeguarding legislation and policy alignment Patient Safety policy alignment - Patient Safety Incident Response Framework and Serious Incident Framework	**A**
Processes	System Quality Group Place based quality partnership groups Place based serious incident panels (Maternity panel at C&M level) Quality Assurance Visits Rapid Quality Review Desktop reviews Responses to national enquiries and investigations Safeguarding practice reviews and serious adult review Multi- agency safeguarding boards/partnerships Clinical effectiveness group Infection Prevention Control/Anti-Microbial Resistance Board Independent Investigations Emerging Concerns Group Established 09/23 Establishment of System Oversight Group 10/23	**A**
Plans	Development of clinical quality strategy Development of Clinical and Care Professional Leadership Framework & Associated Steering Group Approach to NHS Impact	**A**
Contracts	Place based quality schedule within NHS standard contract Development of standardized C&M quality schedule Service specifications Safeguarding commissioning standards	**A**

Reporting	Quality & Performance Committee System Oversight Board Quality and Performance Dashboard National quality reporting requirements	**G**

Gaps in control

1. *Alignment and maturity of PSIRF development*
2. *Development of ICB governance and interface with place based governance*
3. *Clinical quality strategy not yet in place*
4. *C&M wide quality schedule under development in 23/24, with full implementation planned in 24/25*
5. *Development of data and intelligence platforms to identify and triangulate quality concerns / failures.*

Actions planned	Owner	Timescale	Progress Update
1. Oversight and implementation of PSIRF, with close down of Serious Incident Framework	CD	April 2024	C&M steering group established Panel process to sign off individual organization priorities pan underway Closing down of legacy serious incidents in progress Dates listed for organizational sign off, first organization goes live in July 2023, assurance given to QPC re organisationsal readiness. • 4 organisations have now undergone ICB sign off for PSIRF, with others scheduled by end of 11/23 • Delay noted nationally in introduction of Learning from Patient Safety Events (LFPSE) and double running of STEIS system until October 2024 • Thematic Workshop convened to learn from maternity safety events in 08/23 – outputs to QPC in 10/23 • Quarterly update to Quality & performance Committee for assurance on progress 19th October 2023 • 12 organisations have now undergone ICB sign off for PSIRF implementation, timelines on track for end of November 2023 completion of all large providers.

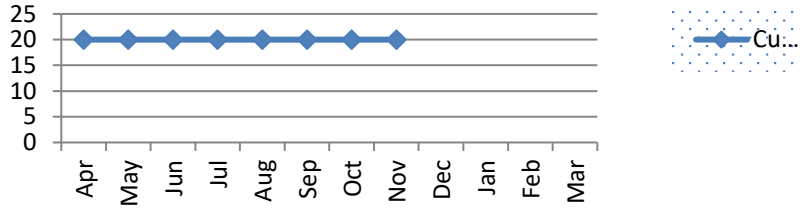
			• ICB compliant with national directive to 'double run' STEIS and LFPSE system until October 2023 • Close down of Serious Incident Framework continues to be managed by place based teams, with additional resource provided for administrative support by Midlands and Lancashire Commissioning Support Unit until 03/24
2. Ongoing and iterative maturity of ICB level and place based roles and responsibilities	CD/RPJ	Ongoing	Continuous review and evaluation of governance, with place based maturity assessment in development MIAA audit submitted April 2024 Participation in Grant Thornton VFM Audit completed – findings to 0923 Audit Committee
3. Development of clinical quality strategy	RPJ	January 2024	Initial meeting of senior system clinical leaders (primary care, ICB corporate and CMAST) took place on 17.4.23 with next meeting planned for May 23. A review of Provider Trust clinical strategies is underway to look for themes and to assess alignment between system strategy and provider strategies. A Clinical and Care Constitution has been developed which outlines the principles that will underpin our Clinical Strategy. This document on a page is currently being socialised and refined based on feedback. It will be presented to ICB board in September. Clinical and Care constitution finalised and on agenda for ICB Board in September. Ongoing discussions re development of clinical strategy led by ICB Medical Director. Presentation to and discussion with System MDs and Directors of Strategy in September. Oct 23 update: Clinical and Care Constitution signed off by board in September and a Clinical and Care professional leaders conference is taking place on 1st November 2023 to launch the constitution into wider system. Outputs from the conference will inform next steps in writing clinical strategy.

4. C&M group established to standardize quality contracting model for NHS Standard Contract for 2024/2025.	CD/KL	April 2024	C&M group mapping exercise completed 09/23 Strategic and ops group established and meeting monthly with target date for standardized quality schedule for April 2024 Standardisation reviews completed. Streamlining reporting requirements Provider forum to be established in Quarter 3 23/24
5. Ongoing review and alignment of quality reporting requirements	CD/AM	Ongoing	Iterative review of national, regional and local quality reporting requirements National Quality Board updated in July 2023 was considered in annual review of Quality & Performance committee meeting in 08/23 Development of sentinel quality metrics/dashboard for Board and QPC reporting 08/23 – completed and presented to Quality & Performance Committee in 10/23. October 10/23: Standardisation of Place Based Quality Related Governance to align to National Oversight Framework and Proportionate to Risk for Implementation Q1 2024/25 Further refinement of risk management approach – implementation Q1 2024/25

Assurances		
Planned	**Actual**	**Rating**
Executive Director of Nursing & Care report to ICB	Executive Director of Nursing & Care report to ICB – Apr to Sept (reasonable)	**Reasonable**
Monthly quality report to Quality & Performance Committee	Monthly quality report to Quality & Performance Committee – Apr to Sept (reasonable)	
Monthly quality and performance dashboard to quality and performance committee	Monthly quality and performance dashboard to quality and performance committee – Apr to Sept (reasonable)	
Regional quality group reporting (quarterly)		
Board Development Sessions	*June and September 2023*	
Establishment of Emerging Concerns Governance & System Oversight Group	*September 2023*	
Development of National Oversight Framework Governance (end of Q4 2023/24)		

Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			
Actions planned	**Owner**	**Timescale**	**Progress Update**
Development of digital strategy and alignment of place based reporting	CD/RPJ	April 2024	

ID No: P5	Risk Title: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience.

	Likelihood	Impact	Risk Score	Trend
Inherent Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	**25**	
Current Risk Score	4	5	**20**	
Target Risk Score	3	5	**15**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Claire Sanders	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	17/11/2023	17/12/2023

Risk Description
• The wider urgent and emergency care system, spanning primary care, community and mental health care and social care is under significant pressure with similar demand, capacity and flow challenges impacting on the ability of patients to access the right urgent or emergency care at the right time in the right place.

- Within the acute sector, high bed occupancy, driven by excess bed days due to delayed discharges and increased length of stay compared to pre-COVID is resulting in reduced flow from emergency departments into the acute bed base, and is in turn impacting on waiting times in ED, ambulance handover delays and failure to meet ambulance response time standards.
- Delays in ambulance response times and delays in ED are associated with patient harm and poor patient experience, and increased health inequalities as people living in more deprived areas are more likely to present at E.Ds.

Linked Operational Risks	As acute hospitals must accommodate urgent and emergency care this may impact on the delivery of elective care and cancer care.

Current Controls		**Rating**
Policies	NHS Delivery plan for recovering urgent and emergency care services ("the recovery plan") Jan 2023, UEC Tiering, Winter Planning Guidance (Annex A ten high impact interventions and Annex B System Roles and Responsibilities) (Aug 2023), SCC Review of Standards (Aug 2023), revised OPEL framework (July 2023)	**G**
Processes	System Coordination Centre, ICB level operational plans, provider and Place level plans, performance monitoring, contract management, NHS Oversight Framework, national UEC Tiering and associated support including ECIST, GIRFT, national UEC Universal Improvement Offer, 23/24 Winter Planning process.	**A**
Plans	C&M Operational Plan, Place Delivery Plans – 23/24 operational planning round concluded, and plans signed off 04/05/2023. Plans in development in response to national discharge visit/UEC tiering, 3 initial priorities agreed between NHSE and ICB in response to Tier 1. Overall UEC recovery programme of work is in development and includes the 10 high impact interventions running through provider, place and reports into the new UEC Recovery and Improvement Group Winter plans developed for 23/24, final plan submitted to NHSE on 27September 2023	**A**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**

Reporting	SCC reporting; Winter Plan reporting; UEC Recovery Programme level reporting via UEC Recovery and improvement Group (sitting under Transformation Committee), UEC operational performance reported via Quality & Performance Committee, ICB Board; regular touch points with regional/national NHSE teams regarding Tier 1 actions.	**A**

Gaps in control

- Industrial Action. IA to date has had significant impact thus far primarily on elective care, as resource has been redirected to support the UEC pathway. The scale and frequency of IA going forward is unknown. We work to mitigate through EPRR processes on days of IA, and Trusts seek to mitigate impact overall
- Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required
- Variation in processes C&M wide, e.g. application of patient choice, discharge processes

Actions planned	Owner	Timescale	Progress Update
UEC and wider actions within operational plans, spanning UEC, Virtual Wards, Admissions Avoidance, NCTR, Bed occupancy	Provider, Place and ICB	23/24	Operational plans signed off 04/05/2023, contracting round completed
Further to operational plans, national discharge visit, Tier 1 and wider UEC recovery plan ask, a C&M UEC Recovery Programme is being established to address the ten high impact interventions, with a particular focus on 5 specific areas (1,2,3,5 & 9 as agreed with NHSE as part of Tier 1 (SDEC, Frailty, Inpatient Flow and Length of Stay, Care Transfer Hubs and Single Point of Access for care coordination.	Provider, Place and ICB	Q2 23/24	• C&M UEC Recovery Programme established with first meeting on 21 November 2023. • 5 of the 10 high impact areas agreed and improvement work under way in conjunction with NHSE/ECIST as part of Tiering . • Prioritisation of Tier 1 trusts (LUHFT and WHH) agreed • ECIST report for LUFT and WHH (acute diagnostic) received 22/08, with trusts for sign off • Fortnightly Tiering meeting in place with NHSE national UEC team, NHSE NW region team and ECIST director • Initial discharge task and finish group held, and will be the fortnightly steering group for UEC/discharge priorities, fortnightly meeting set up with national UEC Tiering team

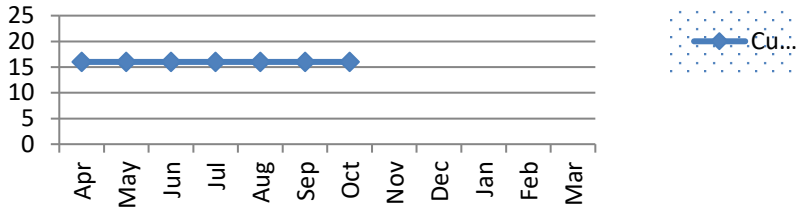
C&M 23/24 Winter Plan in development – completed	Provider, Place and ICB	Q2 23/24	ICB Winter Planning Group established, working to 11 September initial submission and end of September final submission to NHSE, **now completed**

Assurances		
Planned	**Actual**	**Rating**
C&M Urgent Care Recovery and Improvement Group is being established from November	Chair and governance agreed Aug 2023, first meeting November 2023	**Reasonable**
Winter Plan in development and to be brought to September Execs and Board	Winter plan went to execs and Board in September, further update to come to Board on 30/11/2023	
Performance reporting to Quality & Performance Committee, ICB Board (monthly)	Reporting against 23/24 trajectories incorporated into Q&P/Board report	

Gaps in assurance

Actions planned	**Owner**	**Timescale**	**Progress Update**
Implementation of revised national OPEL Framework for acute trusts	Claire Sanders	06 December 2023	Trust and place leads identified, task and finish group set up, working with NHSE to agree assurance process, working with place and provider leads on localisation of action cards. On track to meet go-live date
Implementation of Requirement of Standards (RoS) for System Coordination Centre	Claire Sanders	01 November 2023	As at Phase 2 of compliance C&M at 47%, key dependency is implementation of real time reporting software solution, see below.
Procurement and implementation of supplier for real time reporting in line with SCC RoS	Claire Sanders	01 November 2023	C&M has now concluded the procurement process, in line with a wider national process to identify suitable suppliers, using nationally provided funding (£1.075m). A supplier has been selected (SHREWD) and now in implementation phase.

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16**	
Target Risk Score	4	3	**12**	
Risk Appetite	Our longer-term aim is to limit to a moderate level of risk over the life cycle of the access recovery plans			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	27/10/23	27/11/23

Risk Description

The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions. There is evidence that this has exacerbated existing inequalities in access to care and health outcomes. While general practice is delivering more appointments than pre-pandemic, this increase is not keeping pace with demand and there are financial sustainability pressures in general practice in some places. Primary Care dentistry is slowly recovering and patients are presenting in greater need than pre-COVID. Access for new patients seeking an NHS dentist remains an ongoing issue. Community Pharmacy continues to play a key role in managing patient demand and creating additional GP capacity but is also under considerable pressure. The national delivery plan for recovering access to primary care focuses initially on streamlining access to care and advice. This risk relates to the

potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients. We continue to work with optometry colleagues to understand risk in this area.

Linked Operational Risks	PC1, PC6, PC7

Current Controls		**Rating**
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, Core 20 plus 5	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework, dental reporting mid year/end year performance	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan, Place Level Access Improvement Plans x 9	**A**
Contracts	GMS PMS APMS Contracts (note no specific ask in terms of number of appointments), Local Enhanced/Quality Contracts (poss stretch asks within), Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS PDS Contracts nationally determined	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Primary Care Strategic Framework version 2 to be completed & formally signed off

Primary Care Access Recovery Plan yet to be completed

Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap

Actions planned	**Owner**	**Timescale**	**Progress Update**
Secure approval to Primary Care Strategic Framework	Jonathan Griffiths	Nov 2023	General Practice & Community Pharmacy agreed by ICB Board in June. Optometry & Dental to be completed for Board review in November.

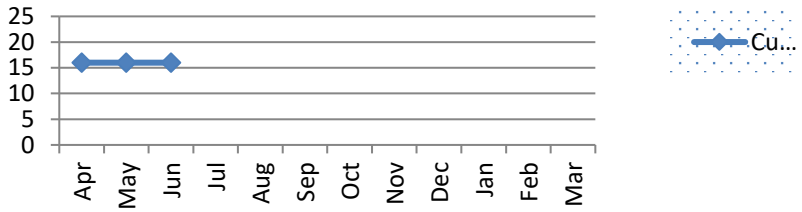
Complete & secure approval to Primary Care Access Recovery Plan	Chris Leese	November 2023	In development. Update to System Primary Care Committee in June on Access Recovery Plan
Delivery of Access Recovery and Improvement Plans	Corporate & Place Primary Care Leads	Ongoing to 2025	

Assurances		
Planned	**Actual**	**Rating**
Sign off plans by ICB Board	System Primary Care Committee & ICB Board approval to Primary Care Strategic Framework & Dental Improvement Plan (June) (reasonable)	**Reasonable**
Reporting on delivery to System Primary Care Committee & ICB Board	System Primary Care Committee & ICB Board reports, Dental Improvement Plan Update – Oct 2023 (reasonable)	
Performance Reporting to ICB Board (monthly)	Performance reporting	

Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Plans yet to be approved

Actions planned	Owner	Timescale	Progress Update
Secure approval to plans	Jonathan Griffiths, Chris Leese & Tom Knight	November 2023	Primary Care Strategic Framework will be going to ICB Board in June and System Primary Care Committee in August. Dental Improvement Plan will be going to System Primary Care Committee in June. Primary Care Access Recovery Plan is in development for completion in November.

ID No: P7	Risk Title: The Integrated Care System is unable to achieve its statutory financial duties			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	**20**	
Current Risk Score	4	4	**16**	
Target Risk Score	2	4	**8**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Claire Wilson	Rebecca Tunstall	Finance	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	30/10/23	30/11/23

Risk Description
There is a substantial underlying financial gap across the Cheshire and Merseyside healthcare system between current spending levels and the national formula-based allocation. If the ICB is unable to secure agreement to and deliver a long-term financial strategy which eliminates this gap whilst also enabling delivery of statutory requirements and strategic objectives, then it will fail to meet its statutory financial duties. This is further exacerbated by the relative' distance from target' and convergence adjustments for both core ICB allocations and future specialised services and inflationary pressures anticipated in the short -medium term compared to funding settlements.

Linked Operational Risks	

Current Controls		Rating
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	G
Processes	Financial planning	G
Plans	23-23 System Financial Plan, Cost Improvement Plans	A
Contracts	NHSE/I Funding allocations (Revenue & Capital), NHS Standard Contracts	A
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	G

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

23-24 Contracts yet to be signed

ICB / ICS Long Term Financial Strategy

Operational scheme of reservation and delegation (SoRD) doesn't yet reflect final structures

Cost improvement plans need to be fully identified

Actions planned	Owner	Timescale	Progress Update
Finalise 23-24 System Financial Plan	Claire Wilson	Complete	Now agreed
Conclude 23-24 contracts	Claire Wilson	Nov 23	Still ongoing, target date deferred from May 23 to Nov 23. Financial values have been agreed so for purposes of this risk, substantially complete.
Update Operational SoRD	Rebecca Tunstall	Complete	Approved by Audit Committee 5/9/23.
Finalise cost improvement plans	Place Directors	Nov 23	Still ongoing, target date deferred from May 23 to Nov 23. Places are working to confirm their final cost improvement plans including recurrent delivery

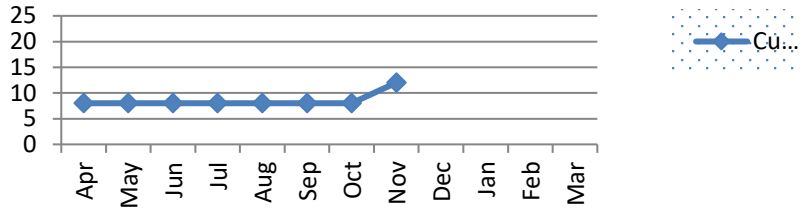
Develop long term financial strategy	Claire Wilson	Dec 23	Project initiated and system working group confirmed to support development of strategy

Assurances		
Planned	**Actual**	**Rating**
ICB Board approval of 23-24 Financial Plan (annual)	ICB Board approved 23-24 Financial Plan – 25/5/23 (Reasonable)	**Reasonable**
System Finance Reports to ICB Board (monthly)	System Financial Report to ICB Board – 29/6/23 (Reasonable)	
NHSE/I ICB Assessment (annual)		

Gaps in assurance
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Actions planned	**Owner**	**Timescale**	**Progress Update**
ICB Board & system partners sign off to 23-24 System Financial Plan	Claire Wilson	Complete	The system financial plan is now finalised and agreed

ID No: P8	Risk Title: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	4	**12**	
Current Risk Score	2	4	**12**	
Target Risk Score	2	3	**6**	
Risk Appetite	The ICB has a low appetite for risk that impacts on patient outcomes.			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard Jones	Fiona Lemmens	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	14/11/23	14/12/23

Risk Description

There are significant service sustainability challenges across the Cheshire and Merseyside system.

- The Liverpool Clinical Services Review (LCSR) identified significant clinical risks for Women's, Maternity and Neonatal Services both locally in secondary care services provided to the population of Liverpool and North Mersey, and for specialist tertiary services provided to the whole C&M population, due to the configuration of hospital services in Liverpool.

- The LCSR also identified challenges with both timely access and poor outcomes in the urgent and emergency care pathways particularly in acute cardiology which affects the entire C&M population.
- Liverpool University Hospital Foundation Trust (LUHFT) is at SOF4 indicating critical quality and / or finance issues
- 4 other trusts in C&M are at SOF3 indicating significant support needs.
- Southport and Ormskirk Hospital (S&O) Trust has several services classed as fragile due to workforce issues and service configurations that do not meet national specifications
- East Cheshire Trust (ECT) has several services classed as fragile due to workforce issues and service configurations that do not meet national specifications.
- There are a number of services identified as fragile due to national workforce shortages and require providers to work collaboratively to identify mitigations.

This risk concerns the potential inability to maintain services in their current configuration and inability to deliver the necessary transformational business cases in relation to our most challenged services.

Linked Operational Risks	

Current Controls		Rating
Policies	NHSE Major Service Change Guidance NHSE Standard Operating Framework	G
Processes	NHSE Major Service Change Process	G
Plans	C&M Clinical Improvement Hub Liverpool Place Provider collaboration on Urgent care pathways CMAST Clinical Pathways Programme Shaping Care Together Programme in Sefton Place (to oversee the S&O services transformation). ECT/Stockport Foundation Trust (SFT) Programme in East Cheshire Place Women's Services Programme in Liverpool Place	A
Contracts	Provider contracts held at Place. NHSE Specialist Commissioning Contracts held at NHSE region	A
Reporting	Provider Boards and internal governance arrangements, Programme Boards, Liverpool Provider Joint Committees, ICB Women's Services Committee, ICB Transformation Committee, ICB Board	A

Gaps in control
[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness] The C&M ICB Clinical Improvement Hub (C&M IMPACT) is still under development and the Medical Directorate currently does not have capacity to progress this at the speed it would like. NHSE regional team re-organisation means there is uncertainty over the transfer of NHSE regional improvement team staff into the ICB to support Improvement Hub Revised governance proposals for Women's Services Committee and Women's Services Programme are in process of development and approval

Actions planned	Owner	Timescale	Progress Update
Clinical Improvement Hub (C&M IMPACT) Development	RPJ	January 2024	C&M IMPACT is developing in line with National IMPACT guidance. Regular communications established with NHSE Improvement Team, clinical network colleagues and local provider improvement leads. Baseline assessments have been completed for all C&M providers in line with national guidance and the ICB IMPACT team will be reviewing these throughout October. Next step is completion of NHS IMPACT self- assessments which we expect will be sent out from national team during October. An update is scheduled for Executive Team and Board ICB in January. Resource within the medical directorate is constrained further due to sickness in the senior team until the end of November.
AMD for Transformation and East Cheshire Place team to support the ECT programme	Fiona Lemmens (FL) Mark Wilkinson (MW)	Complete	ECT/SFT Programme Board established and meeting bimonthly, attended by ICB representatives. The SHS Board has agreed a revised scope for the programme. The Pre Consultation Business Case (PCBC) will include General surgery, T&O, Emergency Department, Imaging, and critical care

			services, with an estimated timeline for completion of PCBC by June 2024. ICB Director of Finance and CEO meeting with GM ICS to discuss financial implications of proposed service moves which will cross ICS boundaries.
AMD for Transformation and Sefton Place team to work with provider to re-launch the SCT programme	Deb Butcher Fiona Lemmens	Complete	StHK and S&O transaction complete and new Mersey and West Lancs Hospital Trust established. SCT Programme Board in place and meeting regularly, with ICB representatives in attendance. Revised scope of programme agreed and will focus on urgent and emergency care. An internal system stakeholder workshop is planned for 20th October to update leads in the three organisations. A paper for ICB boards in C&M and LSC that explains the scope and programme plan, is expected over the next 2-3 months.
Establish Women's Services Committee	Chris Douglas/ Fiona Lemmens	Complete	Committee now established, chaired by Raj Jain. Programme working groups have been established, as subgroups of the Committee, and have now all met and discussed their TOR and workplans.
Revise governance arrangement for Women's Services Programme	Chris Douglas/ Fiona Lemmens	November 2023	A Programme Director and an independent Clinical SRO are now in post. James Sumner was appointed as interim CEO of LWH and will commence on 1/12/23. Liverpool Place has identified some admin support for the programme. Programme planning now progressing with executive teams at both LWH and LUHFT. The WSC was cancelled on 26/9/23 in order to allow a review of current governance arrangements. A proposal to establish a

			Programme Board separate to the Womens services committee is being developed and will be presented to ICB Board meeting on 30.11.23 for approval. In the meantime subgroups are continuing with tasks to progress the work of the programme.
Liverpool Place Team to support the development of the programmes of work and governance arrangements to progress the urgent care pathway improvements	Mark Bakewell Fiona Lemmens	April 2024	A single integrated UEC plan for Liverpool developed with oversight from a Liverpool Urgent Care Executive Group, which is established and meets monthly. Cardiology Partnership Board meets bimonthly chaired by Fiona Lemmens to consider 4 workstreams 3 of which related strongly to Urgent care pathways. 3 pilots currently live. Liverpool Trusts Joint committee established and 3 site based sub committees set up, responsible for implementing the urgent care pathway improvements recommended in the Liverpool Clinical Services Review. LUHFT SOF4 rating enabled national support from ECIST, GIRFT and Newton Europe, all of which are in progress.

Assurances		
Planned	**Actual**	**Rating**
ICB Womens Services Committee	Report of the Chair of the Women's Services Committee to the ICB Board – 28/9/23 (reasonable)	**Reasonable**
ICB Exec (FL) and Place Director (DB) attendance at SCT Programme Board ICB Exec (FL) and Place Director (MW) attendance at ECT/SFT Programme Board		
Programme plans approval – Transformation Committee		
Programme Delivery reporting – Programme Boards for S&O, ECT and Clinical Pathways to report to the ICB - Transformation Committee		

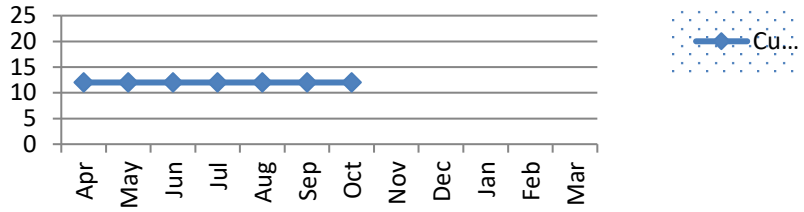
NHSE Major Service Change Process is being followed in all these programmes which includes compliance with gateway reviews.	Secretary of State approval to transactions to create Mersey and West Lancashire Hospital (WMLH)	

Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes

Actions planned	Owner	Timescale	Progress Update
Discussion at ICB Execs re LCSR SRO Role	FL C.Watson	Complete	
SCT Programme Board to confirm programme scope and delivery plans	FL & DB	Complete	
ECT Programme Board to confirm programme scope and delivery plans	FL & MW	Complete	
Oversight and assurance of pre consultation business cases	FL, DB, MW & MB	TBC	ICB represented on relevant programme boards and work on PCBCs is progressing

ID No: P9	Risk Title: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	3	4	**12**	
Target Risk Score	2	3	**6**	
Risk Appetite				

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Samosa	Vicki Wilson	Nursing & Care	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity & Value for Money	Workforce	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	02/11/23	02/01/24

Risk Description
Ensuring that we have a workforce with the necessary skills and experience, and that is reflective of our local population, is essential to the delivery of our strategic objectives. The C&M system has significant workforce challenges including recruitment, retention and sickness absence

Linked Operational Risks	

Current Controls		Rating
Policies	Provider Recruitment & Selection, Apprenticeship, Retention Strategies.	**A**
Processes	Organisational development, workforce planning, PDR, training & development, communication & engagement, recruitment, demographic profiling, international recruitment, apprenticeship levy, C&M retention forum	**A**
Plans	C&M People Plan, NHS People Promise, provider workforce plans	**A**
Contracts	TRAC, ESR, Occupational Health, Payroll, EAP	**G**
Reporting	WRES, WDES, Staff survey, reporting to People Board. System workforce dashboard (manual).	**A**

Gaps in control

System Workforce dashboard in development. Manual dashboard has been developed, need still exists for broader automated options.

Maturity of collaborative working at system level

Inconsistent workforce planning process/methodology across the system

Links to educational institutions and local authorities

Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)

Actions planned	Owner	Timescale	Progress Update
Develop workforce dashboard framework	Paul Martin	July 2023 Completed	Current available data being reviewed along with the metrics reported within provider Trusts. Following benchmarking, first draft dashboard will be developed. Draft Dashboard is complete. Timetable is ready for collating and analysing data in collaboration with Trusts. Online tools to capture Trust narrative and share data has been developed.
Data on available supply through NHSE/ HEIs	Emma Hood	September 2023 Completed	Data on attrition from programmes available – ongoing promotion and training of the NHSE Workforce Intelligence Portal which provides training supply trends and future workforce investments through the NHS Education Contract.

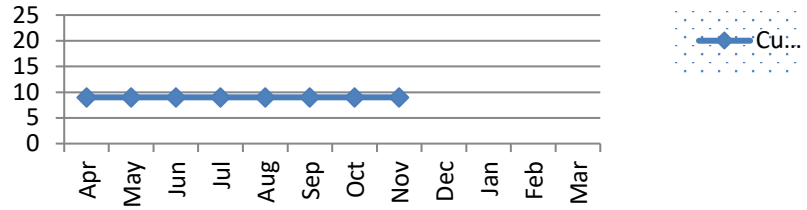
Develop and enhance workforce planning capabilities across the system	Emma Hood	April 2024	New posts to support development of workforce planning capability funded by People Board, delayed - job matching complete awaiting confirmation to go out to recruitment. CMPB funding on hold – request to FIRC to release in 2023/24 to be able to progress.
Delivery of the C&M retention plan	Paul Martin	April 2024 (Ongoing)	Good progress continues to be made in line with retention plan. Retention strategy developed, shared and agreed with Trusts. Timetable of regular meetings scheduled with all Trusts coupled with a quarterly forum to review progress. In addition, subgroups for Legacy Mentors and People Promise Exemplar leads are well established. Regular e-newsletter for updates/case studies etc. is under development and first edition is due early November.
Maximise the use of apprenticeship levy	Emma Hood / Paul Martin	April 2024	In progress - NHS England WTE funding in 2023/24 ringfenced for a C&M Trust to develop a proposal to expand & develop a C&M model for Apprenticeships in H&SC across C&M, in line with the LTWP commitments.

Assurances		
Planned	**Actual**	**Rating**
CQC Well Led review (annual)	People Board	**Reasonable**
	ICB Integrated Performance Report	
	WRES & WDES reporting (annual)	
	NHS Equality Diversity and inclusion improvement plan	

Gaps in assurance

Actions planned	**Owner**	**Timescale**	**Progress Update**

ID No: P10	**Risk Title: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population**			
	Likelihood	**Impact**	**Risk Score**	**Trend**

Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	**16**	
Current Risk Score	3	3	**9**	
Target Risk Score	3	3	**9**	
Risk Appetite	Our longer term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26			

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Graham Urwin	Clare Watson	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Helping the NHS to support broader social & economic development	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	14/11/23	14/11/23

Risk Description
Delivery of our shared aims, strategy and 5-year plan is dependent on collective ownership and collaborative effort by communities and organisations across Cheshire & Merseyside. The ICB has a key role in system leadership and promoting greater collaboration across the NHS and with local partners. This risk relates to the potential that focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of the population. This is in the context of the changing operating model of NHSE and the ICB, and current national and local quality, safety, performance and financial pressures during the post COVID recovery period and the impact this is having on patients.

Linked Operational Risks	

Current Controls		Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework	**G**
Processes	Strategic planning, consultation & engagement, public / stakeholder / local media communications & campaigns, programme & project management, culture & organisational development, Provider Collaboratives, CQC well led review, attendance at C&M wide and/or sub regional leadership / partnership forums & networks	**G**
Plans	C&M HCP Interim Strategy, Joint 5-year Forward Plan, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative business plans, allocation of resources for health inequalities & transformation programmes, , Dental Improvement Plan	**A**
Contracts	MOU with NHSE for system oversight	**A**
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board	**G**

Gaps in control

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Work is still ongoing to finalise & secure agreement to the strategy

MOUs with place-based partnerships / ICB operating model to be agreed in relationship to delivery at place

Joint committee with Cheshire and Merseyside local authorities to be formally established in 2023

Actions planned	Owner	Timescale	Progress Update
Planning for next iterations of HCP Strategy & ICB Joint Forward Plan & Health Inequalities investment proposals	Neil Evans & Ian Ashworth	30/11/23	Board Development session & ICB Executives presentation. Report will be taken to ICB Board in November.
Continue to evolve HCP governance in conjunction with partners	Matthew Cunningham	30/11/23	Updated terms of reference reviewed and approved at HCP in November. Will go to ICB Board in November.

Conclude Primary Care Access Recovery Plan	Clare Watson	30/11/23	Board on 30/11/23. Further iteration in March.
Agree MOUs with place-based partnerships / proposed ICB operating model	Clare Watson	31/01/24	Executive Team workshop mid-November Thursday on ICB operating model. Communications and engagement plan on proposed model with staff, partners and wider stakeholder over next 2 months. Following this engagement it is planned to bring the operating model to the ICB Board in January.
Identify ICB health inequalities funding that could be overseen by the HCP Committee to support delivery of Marmott	Clare Watson	31/01/24	Work is underway to determine the extent of the ICB Health Inequalities funding that could identified as pot that would be under the authority of the HCP Committee to decide on how to allocate

Assurances		
Planned	**Actual**	**Rating**
C&M ICB Quality & Performance Report to ICB Board (bi-monthly)	C&M ICB Quality & Performance Report - 27/4/23, 25/5/23, 29/6/23, 27/7/23, 28/9/23 (reasonable)	**Reasonable**
Joint Overview & Scrutiny (as required)		
Approval and review of joint strategy & plans (annual)	C&M HCP Interim Draft Strategy – 26/1/23, Joint Forward Plan – 29/6/23, Cheshire and Merseyside Joint Forward Plan 2023-28 and Delivery Plan 2023-24 – 29/6/23 (reasonable)	
NHSE Systems Oversight Framework (annual in June)		
CQC ICB review (annual TBC 24/25)		

Gaps in assurance

[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]
Work is still underway to finalise HCP strategy & plan
CQC approach to assessing integrated care systems is still evolving

Actions planned	**Owner**	**Timescale**	**Progress Update**
Planning for next iterations of HCP Strategy & ICB Joint Forward Plan &	Neil Evans &	30/11/23	Report will be taken to ICB Board in November.

Health Inequalities investment proposals	Ian Ashworth		
Respond to CQC framework as it evolves & build evidence base as required	Clare Watson	Ongoing	Not be participating in pilots of CQC assessment in Q3. A number of other assessments underway – working with regional and national teams on segment 2 to 3 assessment & ICB partnership governance self-assessment. Plans developing for CQC review in 24/25.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Women's Hospital Services in Liverpool Programme Governance Refresh

Agenda Item No: ICB/11/23/16

Responsible Directors: Chris Douglas, Director of Nursing and Care
Dr Fiona Lemmens, Associate Medical Director

Women's Hospital Services in Liverpool Programme Governance Refresh

1. Purpose of the Report

1.1 A Women's Services Committee (WSC), a sub-committee of the Cheshire and Merseyside ICB, was set up in February 2023 to oversee the Women's Services work programme, following the recommendations of the Liverpool Clinical Services Review. This paper recommends a refresh of the current Women's Services Programme Governance.

1.2 In August 2023, an Independent Clinical Lead and Programme Director were appointed and have been supporting mobilisation of the programme, including making the programme scope and content more defined, and considering the operational arrangements for delivery. In September, the interim Chief Executive arrangements for Liverpool Women's FT were confirmed, and it was agreed that these arrangements would also need to be considered in the organisation of the programme.

1.3 Consequently, the Chair of the Women's Services Committee requested that during October 2023, further discussions were held to reflect on the current programme structure and governance and to consider how these could be improved to ensure clarity of roles and responsibilities and ultimately successful delivery of the programme.

1.4 A proposal for an alternative programme structure and governance was shared with Women's Service Committee members and other supporting officers. This paper reflects the proposals and the feedback received to date.

2. Executive Summary

2.1 The primary purpose of the Women's[1] Hospital Services in Liverpool Programme is to:

Develop a clinically sustainable model of care for hospital-based maternity and gynaecology services that are delivered in Liverpool.

[1] It is important to acknowledge that it is not only people who identify as women (or girls) who access women's health and reproductive services to maintain their sexual and reproductive health and wellbeing. The terms 'woman' and 'women's health' are used for brevity, on the understanding that transmen and non-binary individuals assigned female at birth also require access to these services. Delivery of care must therefore be appropriate, inclusive, and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

2.2 This will involve:

- understanding all the clinical sustainability challenges hospital-based maternity and gynaecology services in Liverpool face;
- exploring potential solutions for how those challenges can be addressed and resolved;
- undertaking an options appraisal of the viable solutions for making these hospital services clinically sustainable for the future; and
- making recommendations to the Board of NHS Cheshire and Merseyside (C&M).

2.3 A wide range of stakeholders will be involved in the work to ensure that there are no unintended consequences for women, their families and other C&M providers that are served by Liverpool's tertiary (specialised) services, and a full impact assessment will be completed on any future proposals.

2.4 The programme will follow the process set out in the NHS England Guidance for Planning, Assuring and Delivering Service Change (2018)[2].

2.5 In order to create the right conditions for successful delivery of the programme, it is now proposed that:

a) The Women's Services Committee narrows its existing terms of reference to the following key functions:

- seeking assurance on delivery of the programme plan including following due process;
- management and oversight of commissioner service change functions (e.g., engagement with OSCs, managing public consultation if required);
- stakeholder engagement across Cheshire & Merseyside and the North West; and
- considering proposals coming from the programme in the wider strategic context of C&M.

b) A provider-led Programme Board is established to manage the development and delivery of the programme plan. The Programme Board will take on some of the current functions described in the Terms of Reference of the WSC such as overseeing the development of the case for change and the future model of care and exploring viable options for the future of maternity and gynaecology hospital services. The Programme Board will be accountable to the Women's Services Committee and will provide progress reports to the provider Trust Boards (Liverpool Women's FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre FT, Alder Hey Children's FT) as well as the Committee. The Programme Board will establish working groups as required to fulfil its terms of reference.

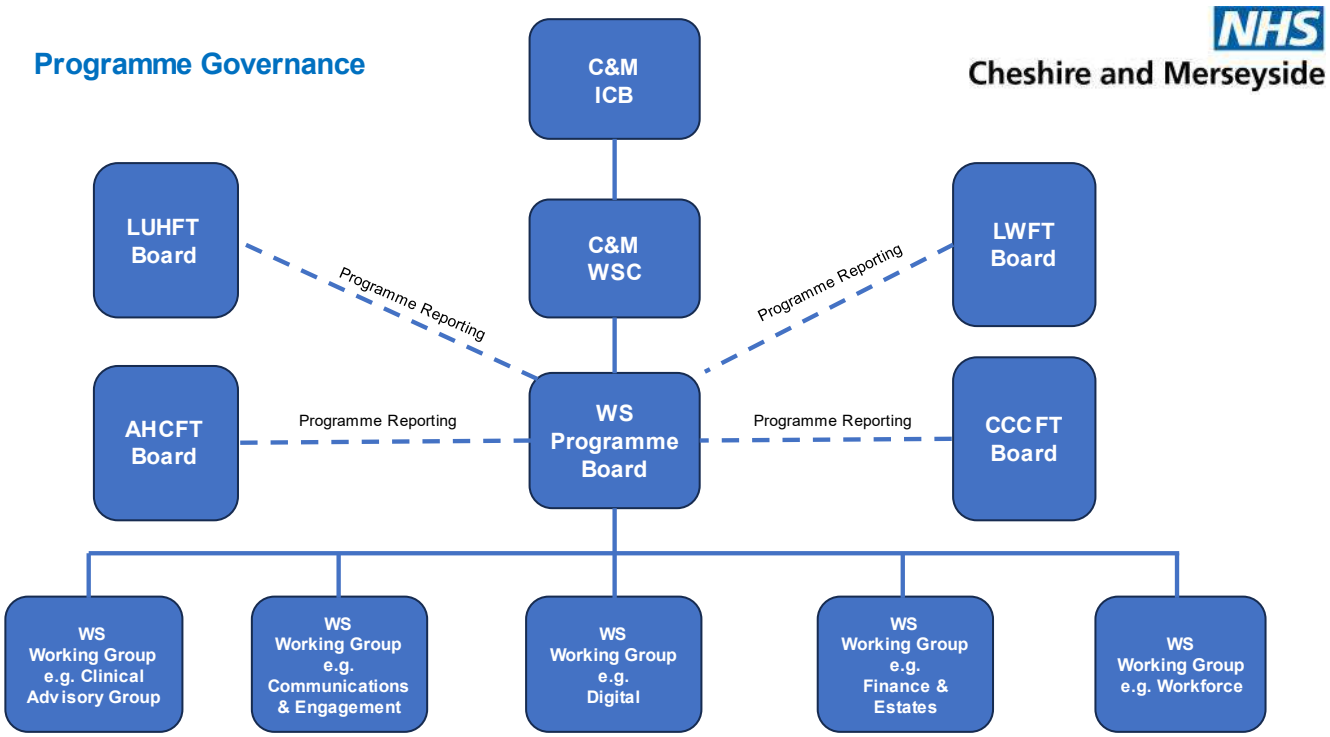
c) The System Oversight Group for Liverpool Women's FT, currently being established, is ***not*** part of the programme governance; its role is to manage the here and now, and to agree and oversee delivery of an improvement plan for

[2] https://www.england.nhs.uk/publication/planning-assuring-and-delivering-service-change-for-patients/

the Trust. This group is a formal part of the ICB Quality Governance structure.

d) A risk-based approach is taken across the women's services governance described above. This will require that the relevant clinical and service risks and issues are considered and agreed, and that short, medium and long term controls and mitigations are identified. The System Oversight Group will be concerned with the short to medium term controls and mitigations; the Programme Board and Women's Services Committee will be concerned with the medium to long term controls and mitigations.

2.6 The proposed governance is illustrated below.



3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- Approve the proposed changes to the current Women's Services Programme governance as described above.

4. Reasons for Recommendations

4.1 The current terms of reference for the Women's Services Committee are very broad and can be found at https://www.cheshireandmerseyside.nhs.uk/media/cgijodly/cm-icb-womens-services-committee-tor-v11.pdf

4.2 The establishment of a provider-led programme board will enable the separation of programme delivery and assurance functions.

4.3 The Women's Services Committee can therefore focus on:

- Seeking assurance on the work of the programme board including delivery of the programme plan and following due process.
- Managing the commissioner aspects of the service change assurance process.
- Engaging with system stakeholders including local authorities and OSCs.
- Appraising the programme business case including the case for change, proposed model of care, options appraisal, financial modelling and impact assessments.

4.4 The Women's Services Committee will also approve the programme plan developed by the programme board and will receive regular progress reports on delivery.

4.5 If the changes are not approved, the Women's Services Committee will continue to fulfil both delivery and assurance functions and could be criticised for 'marking its own homework'.

5. Background

5.1 NHS Cheshire and Merseyside Integrated Care Board (C&M ICB) is the lead commissioner for hospital-based maternity and gynaecology services in Liverpool, along with specialised commissioners from NHS England.

5.2 A Women's Services Committee (WSC), a sub-committee of the Cheshire and Merseyside ICB, was set up in February 2023 to oversee the Women's Services work programme, following the recommendations of the Liverpool Clinical Services Review. The Women's Services Committee is chaired by Raj Jain, who is also chair of the ICB. The original Terms of Reference for the WSC were approved by the C&M ICB on 25 May 2023.

5.3 In August 2023, an Independent Clinical Lead and Programme Director were appointed and have been supporting mobilisation of the programme, including developing the draft programme definition and considering the operational arrangements for delivery.

5.4 In September 2023, the interim Chief Executive arrangements for Liverpool Women's FT were confirmed, and it was agreed that these arrangements also need to be considered in the organisation of the programme.

5.5 During October 2023, further discussions were held to reflect on the current programme structure and governance and to consider how these could be improved to ensure clarity of roles and responsibilities and ultimately successful delivery of the programme. A draft proposal for changes to the governance was shared with Committee members for comment. The proposals presented in this paper are the result of those discussions and include feedback from WSC members.

5.6 As the Women's Services Committee is a formal sub-committee of NHS Cheshire and Merseyside, the Board must approve any changes to the current governance.

5.7 Assuming the Board approves the proposed changes, revised Terms of Reference will be considered at the next meeting of the WSC in January; these will be based on the key functions described above in 2.5a, 4.3 and 4.4.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience

The key purpose of the programme is about improving access, outcomes and experience in /to women's services, specifically maternity and gynaecology hospital services, delivered in Liverpool. Liverpool is the only city in the country that has women's hospital services delivered separately from other adult hospital services; this is a significant inequality for the women and families accessing these services from Cheshire and Merseyside and beyond.

Objective Two: Improving Population Health and Healthcare

Women make up 50% of the population; improving women's hospital services (maternity and gynaecology) in Liverpool will therefore have a significant impact on the population health and healthcare for women across Chesire and Merseyside. There are opportunities through the programme to improve the integration of women's services with other adult services such as A&E and intensive care.

Objective Three: Enhancing Productivity and Value for Money

There are likely to be some opportunities to enhance productivity and value for money in the operational delivery of women's services if they are more integrated with other adult services e.g., reducing transfers of women from hospital to hospital to access services, more rapid access to intensive care.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 This programme of work supports delivery of the following ICB objectives:

- Women's Health & Maternity – in particular, reducing maternal mortality.
- Liverpool Place objectives:
  - Implement the opportunities identified in the Liverpool Clinical Services Review of acute and specialist services. The objective of the Liverpool Clinical Services review is to realise opportunities for greater collaboration between acute and specialised trusts to optimise clinical pathways in acute care in Liverpool. There are three critical priorities out of the 12 opportunities one of which is resolving the clinical sustainability challenges faced by women's hospital services.

  - Strengthen integrated working arrangements at place with system partners to align plans, resources, governance to support delivery.

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 Resolving the clinical sustainability challenges in maternity and gynaecology hospital services will improve the quality and safety of those services for women and their families. The programme will be seeking to improve the clinical integration of women's hospital services and other adult hospital services in Liverpool.

8.2 The Women's Services Programme covers the following key quality themes and statements

Theme One (T1) - Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	Learning culture. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
QS3	Safe and effective staffing. We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
QS4	Equity in access**.** We make sure that everyone can access the care, support, and treatment they need when they need it.
QS5	Equity in experience and outcomes. We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support, and treatment in response to this
Theme Two (T2) - Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity

QS9	How staff, teams and services work together. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
Theme Three (T3) - Leadership	
QS10	Shared direction and culture. We have a shared vision, strategy, and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
QS11	Capable, compassionate and inclusive leaders. We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty
QS13	Governance, management and sustainability. We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
QS14	Partnerships and communities. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
QS15	Learning, improvement and innovation. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

9. Risks

9.1 As described in 2.5d above, the programme and its governance is concerned with managing, mitigating and wherever possible, resolving, the clinical risks and issues that are currently being experienced in women's hospital services.

9.2 A programme risk register is in development and will be managed by the programme board, in the event it is established.

9.3 Programme risks and issues will be reported to the WSC at regular intervals and escalated, as necessary.

10. Finance

10.1 Proposed changes to women's hospital services are likely to have some financial consequences, both revenue and capital, however as noted above there may be opportunities to drive out productivity gains through greater clinical integration.

10.2 It is expected that there will be a finance and estates subgroup of the programme board. This group would be responsible for supporting the financial analysis and modelling of any proposed solutions to changes in services.

11. Communication and Engagement

11.1 The WSC and the current programme is already of significant interest to the public, patient groups, staff and stakeholders.

11.2 A comprehensive communications and engagement plan will be developed as part of the programme.

12. Equality, Diversity and Inclusion

12.1 Any proposed changes will be subject to the relevant impact assessments.

12.2 It will also be important for the programme to identify the current equality issues faced by women and their families accessing women's hospital services in Liverpool. This baseline position will be integral to the case for change and the future model of care. The future model of care should be aiming to improve equality, diversity, and inclusion and to drive out health inequalities.

13. Climate Change / Sustainability

13.1 The future model of care and in particular, any proposals relating to NHS estate, will consider climate change and sustainability.

14. Next Steps and Responsible Person to take forward

14.1 Assuming the Board agrees to the proposals the following actions will be taken:

December / January – James Sumner / Fiona Lemmens / Clare Powell

- Establish the programme board;
- Agree programme board terms of reference;
- Draft programme plan and further develop programme risk register;
- Establish working groups as required.

17 January – Raj Jain / Chris Douglas

- Women's Services Committee terms of reference reviewed at Committee meeting;
- Women's Services Committee approve programme board terms of reference and receive progress report from Programme Board.

15. Officer contact details for more information

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Establishment of the ICB Children and Young Peoples Committee

Agenda Item No: ICB/11/23/18

Responsible Director: Christine Douglas, Director of Nursing and Care
Clare Watson, Assistant Chief Executive

Establishment of the ICB Children and Young Peoples Committee

1. Purpose of the Report

1.1 This report provides an overview of the Committees remit and seeks the approval of the Board for its establishment as a formal Committee of the ICB. The proposed establishment of the ICBs Children and Young Peoples Committee will support the Board in meeting its statutory commitments as well as ambitions for the Children and Young People of Cheshire and Merseyside.

2. Executive Summary

2.1 The health and wellbeing of our Children and Young People is paramount to the ICB. In a country where the health and care system is often seen to prioritise the treatment of illnesses and focus on services for adults and older people, it is essential that we do not lose sight of the need to plan and to provide for future generations and our current Children and Young People, who make up 30% of our population.

2.2 Planning for and providing services for Children and Young people is a multi-agency, multi-sector requirement and commitment, and as such the establishment of this Committee is a step forward to ensuring that as a system we can work together as partners to do what is best for our Children and Young People, capitalising on the existing infrastructure that is in place around Children and Young People's health and care services, as well as working towards transforming how we do things in Cheshire and Merseyside.

2.3 Engagement has been undertaken with a number of system partners to help develop the establishment of this Committee, and a clear commitment has been given to ensure that this Committee becomes more than just an assurance Committee and that its membership benefits from the learned experience and insight of Children and Young People and those who use services for Children and Young People. It is anticipated that this Committee will continue to evolve and that further updates to its Terms of Reference will be needed as it matures as a forum.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- **consider** and **approve** the Terms of Reference of the Children and Young Peoples Committee and its establishment as a Committee of the Board.

4. Reasons for Recommendations

4.1 The Board of NHS Cheshire and Merseyside has the authority to approve the establishment of and the Terms of References of Committees of NHS Cheshire and Merseyside.

5. Background

5.1 The development of these initial Terms of Reference have been done in collaboration with partners across the system so as to ensure that there is no duplication of remit and authority that already feature in existing Committees and forums, such as the ICBs Quality and Performance Committee, the Beyond Programme Board and the Cheshire ad Merseyside Population Health Board, however there will need to be robust connections and reporting arrangements between these forums.

5.2 The Committee's proposed main purpose is to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (children and young people), including looked after children.

5.3 The Committee will oversee the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensure effective system focus on Children and Young People as a population cohort. The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.

5.4 The Committee will have a key role in ensuring that the voice of and needs of Children and Young People are prominent in the discussions and decisions of the Board of NHS Cheshire Merseyside, ad that the Committee will provide, seek and receive assurance and intelligence from other key forums and Committees which have a role in the oversight of assurance or planning

5.5 There have been two informal meetings of the Committee (September and November 2023) so far where attendees have considered the draft Terms of Reference and have contributed to its content. Attendees have also started to agree some of the key areas of work that would form the workplan of the Committee (Appendix Two).

6. Link to delivering on the ICBs Strategic Objectives and the Cheshire and Merseyside Priorities

6.1 The establishment of the Children and Young Peoples Committee and its workplan will touch upon and contribute to all four of the ICBs strategic objectives:

- Objective One: Tackling Health Inequalities in access, outcomes and experience
- Objective Two: Improving Population Health and Healthcare
- Objective Three: Enhancing Productivity and Value for Money
- Objective Four: Helping to support broader social and economic value.

6.2 The Committee and its workplan will also take into account and take a leadership role for the system in meeting key ambitions and Marmot principles as outlined within the All Together Fairer report[1] and the Cheshire and Merseyside Joint Forward Plan[2], namely:

- give every child the best start in life.
- enable all children, young people, and adults to maximise their capabilities and have control over their lives.
- ensure a healthy standard of living for all.
- create and develop healthy and sustainable places and communities.
- strengthen the role and impact of ill health prevention.

6.3 Figure One also demonstrates the key Cheshire and Merseyside priorities that the Committees remit will also encompass and workplan look to deliver against.

Figure One

HCP Strategic Objectives	Cross reference to the HCP areas of focus	Priorities	Core plans *	Metric
Tackling Health Inequalities in outcomes, experiences, and access (our eight Marmot principles)	• Give every child the best start in life • Enable all children, young people and adults to maximise their capabilities and have control over their lives • Ensure a healthy standard of living for all • Tackle racism, discrimination and their outcomes • Pursue environmental sustainability and health equity together.	All our Places are actively engaged in the All Together Fairer Programme	2	Increase % of children achieving a good level of development at 2-2.5 years OR at the end of Early Years Foundation Stage Reduce hospital admissions as a result of self-harm (15-19 years)
		Supporting the safety of vulnerable Women and Children	2	Deliver the agreed shared outcomes through our partnership working within Cheshire and Merseyside in identifying and addressing violence against women and girls
Improve population health and healthcare	• Improve early diagnosis, treatment and outcome rates for cancer • Improve satisfaction levels with access to primary care services • Provide high quality, accessible safe services • Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.	In relation to preventing ill Health we will focus on: • Increase rates of early detection of cancer • Work towards MECC (Making Every Contact Count) • Encourage *'Healthy Behaviours'* with a focus on smoking/alcohol/ physical activity • Ensure access to safe, secure, and affordable housing	1,2,3	Core20PLUS5 priorities including cancer, cardiovascular disease and children and young people's mental health services
			2,3	Increased sign up to the NHS prevention pledge
			2,3	Reduction in smoking prevalence. Reduction in the % drinking above recommended levels. Increase the % who are physically active.
			2	Improved access to safe Housing (metric to be agreed)

[1] https://www.cheshireandmerseyside.nhs.uk/your-health/tackling-health-inequalities/
[2] https://www.cheshireandmerseyside.nhs.uk/about/cheshire-and-merseyside-joint-forward-plan/

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The Committee will also have oversight of the work underway across Cheshire and Merseyside in delivering against the ICB Annual Delivery Plan[3], namely:

Service Programme	Focus Area
How we work as partners for the benefit of our population	Delivery plans to ensure the Safeguarding our population with a focus on Safe at Home, Safe in our Communities and Safe Safeguarding Systems across C&M
Population Health	Social determinants of health: Continue to deliver the 5 year All Together Fairer (Marmot) Programme with a focus on development of a Children and Young People's Health Equity Framework, Supporting Anchor and Social Value Organisations, Improved utility of the Beacon indicators and delivery of All Together Inspired, a development programme on the Social Determinants of Health for system leaders
	Establish C&M oversight and accountability for Core20PLUS5 (adult and Children and Young People) and the Healthcare Inequalities Improvement (HIIP) programme.
Children & Young People (CYP)	Emotional Wellbeing and Mental Health - reducing MH admissions, improving access and equity of services, reduction in delayed discharges and development of a single Digital point of access. Healthy Weight and Obesity - Flattening the curve on obesity rates for CYP at both Reception and Year 6 assessments and increasing physical activity. Learning Difficulties, Disabilities and Autism: (LDD&A) - Increased number of neurodevelopmental & Autism CYP Referrals where reasonable adjustments are made with a care plan and or intervention Epilepsy - Delivery of support plans including alignment with line with Core20PLUS5 Diabetes - Delivery of support plans including alignment with line with Core20PLUS5 Respiratory - Delivery of support plans including alignment with line with Core20PLUS5 Oral Health - Delivery of support plans including alignment with line with Core20PLUS5 Implement the NHS Universal Family (Care Leaver Covenant) Programme so that care experienced young people have opportunities to be supported into roles within the NHS

[3] https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 It is envisaged that the Committee will have oversight on the areas for Children and Young People that will contribute towards the ICB meeting the requirements and expectations as outlined within the CQC ICS themes and quality statements, namely:

Theme One (T1) – Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS4	Equity in access. We make sure that everyone can access the care, support and treatment they need when they need it
QS5	Equity in experience and outcomes. We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support and treatment in response to this
Theme Two (T2) – Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
Theme Three (T3) – Leadership	
QS10	Shared direction and culture. We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
QS14	Partnerships and communities. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
QS15	Learning, improvement and innovation. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

9. Risks

9.1 The Committee will develop its own risk register and will have oversight of the key risks in relation to Children and Young People that impact on the ICB managing its key strategic risks as identified within its Board Assurance Framework (BAF) and Corporate Risk Register. Key strategic risks that the Committees areas of focus will contribute to include:

Strategic Priority	BAF Risk	
Tackling Health Inequalities in access, outcomes and experience	**P1**	The ICB is unable to meet its statutory duties to address health inequalities
Improving Population Health and Healthcare	**P3**	Service recovery plans for Planned Care are ineffective in reducing backlogs and meeting increased demand which

Strategic Priority	BAF Risk	
		results in poor access to services, increased inequity of access, and poor clinical outcomes
	P4	Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
	P6	Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population

10. Finance

10.1 There are no financial implications related to the establishment of the Committee.

11. Communication and Engagement

11.1 The Committee will report its discussions to the ICB Board via a Chairs report and minutes, which will be published on the ICB website.

12. Equality, Diversity and Inclusion

12.1 Reports received by the Committee and the Committee discussions and deliberations will be informed by and be mindful of the requirements to consider the impact of decisions on Children and Young People and those from seldom heard groups and communities and those with protected characteristics.

13. Climate Change / Sustainability

13.1 There is no direct link between the establishment of the Committee and the ambitions and commitments of the ICB towards climate change and sustainability, however in considering the information it receives and any reports and recommendations it may make, the Committee will cross reference with the ICBs Green Plan to see if there is any connectivity.

14. Next Steps and Responsible Person to take forward

14.1 Subject to the approval of the Terms of Reference, a cycle of bi-monthly meetings will be formally established.

15. Officer contact details for more information

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16. Appendices

Appendix One: draft Committee Terms of Reference
Appendix Two: Presentation developing the Children and Young Peoples Committee and Strategy

NHS
Cheshire and Merseyside

NHS Cheshire & Merseyside Integrated Care Board

Children and Young Peoples Committee

Terms of Reference

v1.1

Document revision history

Date	Version	Revision	Comment	Author / Editor
08.09.2023	1.0	First draft presented to informal CYP Committee		Matthew Cunningham
	1.1	Amendments made following Informal CYP Committee 08.09.23		Matthew Cunningham

Review due:
(add date)

V (add) approved by the Board of NHS Cheshire and Merseyside (add date)

Children and Young Peoples Committee

Terms of Reference

1. Introduction

The Children and Young Peoples Committee (the Committee) is established by NHS Cheshire and Merseyside Integrated Care Board ('NHS Cheshire and Merseyside') as a Committee of NHS Cheshire and Merseyside in accordance with its Constitution.

These Terms of Reference (ToR), which must be published on the website of NHS Cheshire and Merseyside, set out the membership, the remit, responsibilities and reporting arrangements of the Committee and may only be changed with the approval of the Board of NHS Cheshire and Merseyside

The Committee is a sub-committee of the Board of NHS Cheshire and Merseyside and its members, including those who are not employees or members of NHS Cheshire and Merseyside, are bound its Standing Orders and other key policies.

When referring to 'children and young people' throughout this document, this covers ages 0 to 25 and refers to babies, children and young people.

It is anticipated that the Committees scope, purpose, authority, membership and governance arrangements will evolve over time as it is established and as a Cheshire and Merseyside Children and Young Peoples Strategy is produced and implemented.

2. Role and Purpose

The Committee's main purpose is to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:

- Children and young people (aged 0 to 25)
- Children and young people with special educational needs and disabilities (SEND)
- Safeguarding (children and young people), including looked after children.

The Committee will oversee the development and delivery of the Cheshire and Merseyside Children and Young Peoples Strategy and ensure effective system focus on Children and Young People as a population cohort. The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.

The Committee will have a key role in ensuring that the voice of and needs of Children and Young People are prominent in the discussions and decisions of the Board of NHS Cheshire Merseyside.

The Committee will provide, seek and receive assurance and intelligence from other key forums and Committees which have a role in the oversight of, assurance or planning

delivery of services for Children and Young People across Cheshire and Merseyside, including:

- Cheshire and Merseyside Health and Care Partnership
- Cheshire and Merseyside ICB Quality and Performance Committee
- Cheshire and Merseyside ICB Women's Services Committee
- Cheshire and Merseyside ICB Finance, Investment and Our Resources Committee
- Cheshire and Merseyside ICB Transformation Committee
- Place Safeguarding Childrens Partnerships
- Cheshire and Merseyside Beyond Childrens and Young Peoples Transformation Programme Board
- North West Children and Young People Transformation Programme.
- CMAST Provider Collaborative
- MHLDC Provider Collaborative
- Cheshire and Merseyside DCS Network
- Cheshire and Merseyside Population Health Board (Marmot link re Start Well etc, Core20+5CYP)
- Strategic Clinical Network(s)
- North West NHSE Specialist Commissioning Women and Children's Transformation Board.

Whilst established as a formal committee of NHS Cheshire and Merseyside, its membership will be drawn from a variety of system partners with the ambition that the Committee will harness and help co-ordinate a collective system focussed approach to improving the health, wellbeing and care of Children and Young People. Whilst the Committee itself does not have the authority to make binding decisions on the duties and functions of partner organisations in relation to Children and Young People, representatives of these organisations who are members or who are in attendance will be encouraged to use the meetings of the Committee to seek a collaborative and consensual view to help inform their decisions.

3. Responsibilities / duties

The duties of the Committee will be driven by the organisation's objectives and the associated risks. An annual programme of business will be agreed before the start of the financial year; however, this will be flexible to new and emerging priorities and risks.

The Committee's duties for and on behalf of NHS Cheshire and Merseyside and its functions can be categorised as follows:

- set out and agree the steps NHS Cheshire and Merseyside is taking to address the needs of children and young people, with a focus on improving their physical and mental health outcomes and reducing inequalities, and as included within the Cheshire and Merseyside Joint Forward Plan
- ensure there is visible and effective leadership for addressing issues faced by the groups outlined as in scope of the Committee
- ensure that NHS Cheshire and Merseyside has resources in place so as to champion and work in co-production with children, young people and their families so that the Board of NHS Cheshire and Merseyside is informed by and understands the issues which affect children and young people.

- ensure that NHS Cheshire and Merseyside plays a pivotal role in leading relationships with key partners across the Integrated Care System as regards children and young people, and their families
- ensure that NHS Cheshire and Merseyside plays a pivotal role in delivering on the strategy and priorities of the Cheshire and Merseyside Health and Care Partnership as regards children and young people, and their families
- develop Cheshire and Merseyside key performance indicators for the quality of services for children and young people, and the impact these services have on outcomes for children and young people and their families/carers
- have oversight of and make plans to mitigate any associated risks identified against the delivery of the ICBs functions and responsibilities for Children and Young People. The Committee will be responsible for any associated risks that feature on the Board Assurance Framework of NHS Cheshire and Merseyside.

4. Authority

The Committee is authorised by the Board of NHS Cheshire and Merseyside to:

- have oversight of and approve the strategy and priorities for NHS Cheshire and Merseyside with regards Children and Young People
- have oversight of, agree and approve the prioritisation of ICB funding and allocations for Childrens and Young Peoples functions and services that NHS Cheshire and Merseyside has responsibility for, as agreed and outlined within the Scheme of Reservation and Delegation, and as approved within the Financial Plan and Budget book, and in line with the ambitions of the NHS Long Term Plan
- have oversight of and agree recommendations to the Board of NHS Cheshire and Merseyside with regards the further delegation of responsibility and authority to individuals or forums within NHS Cheshire and Merseyside to make decisions on and commit funding in relation to the Children and Young Peoples functions and responsibilities of NHS Cheshire and Merseyside
- consider and make recommendations to the Board of NHS Cheshire and Merseyside regarding the delegation of functions, budgets (including pooled budget arrangements) and responsibilities in the relation to Children and Young People to any parties outside of NHS Cheshire and Merseyside.

In making its decisions the Committee is acting on behalf of the Board of NHS Cheshire and Merseyside.

In making its decisions the Committee will also be mindful of and be informed by the corresponding statutory duties, functions and funding requirements of partner organisations in relation to Children and Young People.

5. Membership & Attendance

Membership
The Committee membership shall be approved by the Board in accordance with the Constitution.

When determining the membership of the Committee, active consideration will be made to diversity and equality.

The Committee Membership will be composed of:

- ICB Chair
- ICB Executive Director of Nursing and Care
- ICB Assistant Chief Executive
- x1 ICB Non-Executive Director
- x1 NHS England representative
- x2 Provider Collaborative representatives
- x4 ICB Place representatives
- x1 Local Authority Chief Executive
- x2 Local Authority Director of Children Services representative
- x2 Beyond Board Representative
- x1 Director of Public Health representative / Population Health representative
- x1 Healthwatch Representative
- x2 VCFSE Representatives
- x2 Youth Board Representatives.

It is expected that members will prioritise these meetings and make themselves available. Where this is not possible a nominated deputy may attend of sufficient seniority. Deputy attendance needs to be agreed in advance with the Chair.

Attendees
Only members of the Committee have the right to attend Committee meetings, but the Chair may invite other relevant staff to all or part of a meeting as necessary in accordance with the business of the Committee. Such attendees will not be eligible to vote. The Chair may ask any or all of those who normally attend, but who are not members, to withdraw to facilitate open and frank discussion of particular matters.

It is expected that there will be a number of regular attendees to meetings of the Committee, including Senior Responsible Officers leading on core work programmes in relation to Children and Young People.

6. Meetings

Leadership
Committee members may appoint a Deputy Chair from amongst the standing members.

The Chair will be responsible for agreeing the agenda and ensuring matters discussed meet the objectives as set out in these ToR.

Quorum
For a meeting or part of a meeting to be quorate a minimum of 50% of the membership must be present, including the Chair or Deputy Chair:

If any member of the Committee has been disqualified from participating on an item in the agenda, by reason of a declaration of conflicts of interest, then that individual shall no longer count towards the quorum.

If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions may be taken.

Decision-making and voting
The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote.

Only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

Frequency and meeting arrangements
The Committee will meet in private.

The Committee will meet up to six times per year. Additional meetings may take place as required.

The Committee may meet virtually when necessary and members attending using electronic means will be counted towards the quorum.

Administrative Support
The Committee shall be supported with a secretariat function. Which will include ensuring that:

- the agenda and papers are prepared and distributed having been agreed by the Chair with the support of the lead Executive for the Committee
- good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- a log of stated conflicts of interests is kept
- the Chair is supported to prepare and deliver reports to the Board of NHS Cheshire and Merseyside
- the Committee is updated on pertinent issues / areas of interest / policy developments; and
- action points are taken forward between meetings.

7. Accountability and Reporting Arrangements

The Committee is accountable to the Board of NHS Cheshire and Merseyside and shall report to the Board on how it discharges its responsibilities, as delegated by, and authorised by the Board.

A Committees Chair Summary Briefing will be collated and issued to all members of the Committee following each meeting so that the discussions and decisions of the Committee can be readily communicated to partner organisations within the Integrated Care System.

A Committees Chair Report which summaries key issues discussed and concluded shall also be produced and formally submitted to the Board of NHS Cheshire and Merseyside following each meeting of the Committee. The report will be structured to alert, assure and advise the Board. The Chairs Report will also be provided to meetings of the Cheshire and Merseyside Health and Care Partnership.

The minutes of the meetings shall be formally recorded by the Committee secretary and also submitted to the Board in accordance with the Standing Orders. Minutes and assurance reports of a confidential nature from the Committee will be reported to a subsequent meeting of the Board in private.

Reporting will be appropriately sensitive to personal circumstances and contain no personally sensitive or personally identifiable information.

The Committee will provide the Board with an Annual Report. The report will summarise its conclusions from the work it has done during the year.

8. Behaviours and Conduct

The Committee shall conduct its business in accordance with any national guidance. The seven Nolan Principles of Public Life shall underpin the committee and its members.

Members should:

- inform the Chair of any interests they hold which relate to the business of the Committee.
- inform the Chair of any previously agreed treatment of the potential conflict / conflict of interest.
- abide by the Chair's ruling on the treatment of conflicts / potential conflicts of interest in relation to ongoing involvement in the work of the Committee.
- inform the Chair of any conflicts / potential conflicts of interest in any item of business to be discussed at a meeting. This should be done in advance of the meeting wherever possible.
- declare conflicts / potential conflicts of interest in any item of business to be discussed at a meeting under the standing "declaration of interest" item.
- abide by the Chair's decision on appropriate treatment of a conflicts / potential conflict of interest in any business to be discussed at a meeting.
- abide by their own respective organisation's Code of Conduct.

As well as complying with requirements around declaring and managing potential conflicts of interest, Committee members should:

- attend meetings, having read all papers beforehand
- arrange for their substitute to attend on their behalf, if necessary
- act as 'champions', disseminating information and good practice as appropriate

- comply with the Committee administrative arrangements including identifying agenda items for discussion, the submission of reports etc.
- consider the equality, diversity and inclusion implications of the discussions they undertake at Committee meetings.

9. Review

The Committee will review its effectiveness at least annually

These terms of reference will be reviewed at least annually and earlier if required. Any proposed amendments to the terms of reference will be submitted to the Board of NHS Cheshire and Merseyside for approval.

What should the CYP Committee prioritise…

ICS CYP Committee October 2023

CYP Committee – Terms of Reference

- The Committee's main purpose is to have oversight of, shape and provide assurance to the Board of NHS Cheshire and Merseyside regarding its responsibilities and functions for:
    - Children and young people (aged 0 to 25)
    - Children and young people with special educational needs and disabilities (SEND)
    - Safeguarding (children and young people), including looked after children.
- The Committee will oversee the development and delivery of the Cheshire and Merseyside Children and Young People's Strategy and ensure effective system focus on Children and Young People as a population cohort.
- The Committee will also be responsible for oversight of the delivery of the ambitions and priorities within the Cheshire and Merseyside Joint Forward Plan, in relation to Children and Young People.
- The Committee will have a key role in ensuring that the voice of and needs of Children and Young People are prominent in the discussions and decisions of the Board of NHS Cheshire Merseyside.
- The Committee will provide, seek and receive assurance and intelligence from other key forums and Committees which have a role in the oversight of assurance or planning

Developing a proposal re CYP Strategy

Core group established:

- Population Health (Ian Ashworth)
- Children's Services / Local Authority (Carly Brown)
- CMAST / Alder Hey / CYP Committee (Dani Jones)
- Beyond (Liz Crabtree)
- C&M VCFSE Network (Dave Packwood)
- SEND (Julie Hoodless)
- ICS - SRO for CYP, ICB Q&S Improvement (Denise Roberts)

Focus:

- Understanding priorities (we have a reasonably good idea of these!)
- Data availability / shared knowledge

Aim: Small number of clear priorities needed

- One = 'today's burning platform'
- One = longer term dial-shift (interlinked or complimentary)

Proposed Structure of Committee Agendas

- **CYP / Family Voice**
- **Developing the Strategy:** Providing a coherent narrative of key issues that require a system approach, addressing the ICB strategies
- **CYP Data Dashboard:** Driving development of CYP data / BI and Intelligence. Using data to inform prioritisation and identify gaps
- **Business Item:** Deep dive into key area of focus e.g Children Between the Gaps
- **Single Line of Sight:** Place, Transformation Programmes, VCFSE, Statutory Delivery, Provider Collaboratives
- **Links to HCP & Key Strategic Networks:** Ensuing connectivity across HCP & ICB prioirites / focus
- **System Influence:** e.g. DeLoittes, Finance ……

CYP Key Metrics – A reminder

Key

- 2023-28 Strategic Aims – HCP & Joint Fwd View
- 23/24 Operational Aims - Y1 Joint Fwd View

Use CYP Voices to Improve their experiences of care

Marmot CYP Metrics ***All Together Fairer***

Give every child the best start in life

- ↑ % CYP achieving **good level of development at 2-2.5yrs**
- ↑ % CYP achieving **good level of development** @ end of **Early Years** Foundation stage
- ↓ Hospital admissions as a result of **self-harm** (15-19yrs)
- ↑ in pupils who go on to **achieve a L2 qualification** @ age 19
- ↓ proportion of **children in workless households**

PHE & Beyond

- ↑ **Readiness for School**
- ↓ **Obesity** rates @ Reception & Y6
- ↑ **Oral Health** in 5yo
- ↑ Brief interventions for **CYP Emotional Health**

Statutory DCS & Beyond & MHLDC (including MH Prog, Tx Care)

- ↑ **CYP Looked After** receiving high quality, timely health services
- ↑ Effective Joint Service Delivery for **CYP with SEND**
- ↑ **Safeguarding** and **Ofsted** Social Care and **SEND** inspection outcomes/judgements

Beyond

- ↓ **Paed SALT** Wating times
- ↑**ASD** Diagnostic Pathway
- ↑**ADHD** Diagnostic Pathway

- ↓ **ED attends for MH** presentations
- ↓ **delayed discharges** CYP needing Safe **alternative to Tier 4 / Social Care**
- ↓ CYP **'between the gaps'** – C&M Standard
- ↑ **Crisis Care** – 24/7 access
- ↑ **Eating Disorder** access – 95% RTT
- ↓ CYP in **LD Inpatient** Beds

- ↑ CYP w. **Epilepsy** access Specialist Nurse in Y1 of treatment
- ↑ CYP using **Diabetes** tech to manage condition
- ↓ ED attendances for **Asthma**
- ↓ **SABA inhaler** prescription (3+ p.m.)
- ↑ **Complications of Excess Weight (CEW)** Referral Std

CMAST

- ↓ **Paed 104 & 52 Week Waits**
- ↑ **ED / Urgent Care** timely access
- ↑CYP **Virtual Ward**
- ↓ Backlog **Tooth Extractions** in u.10's

VCFS Involvement

CYP Care & Support Continuum

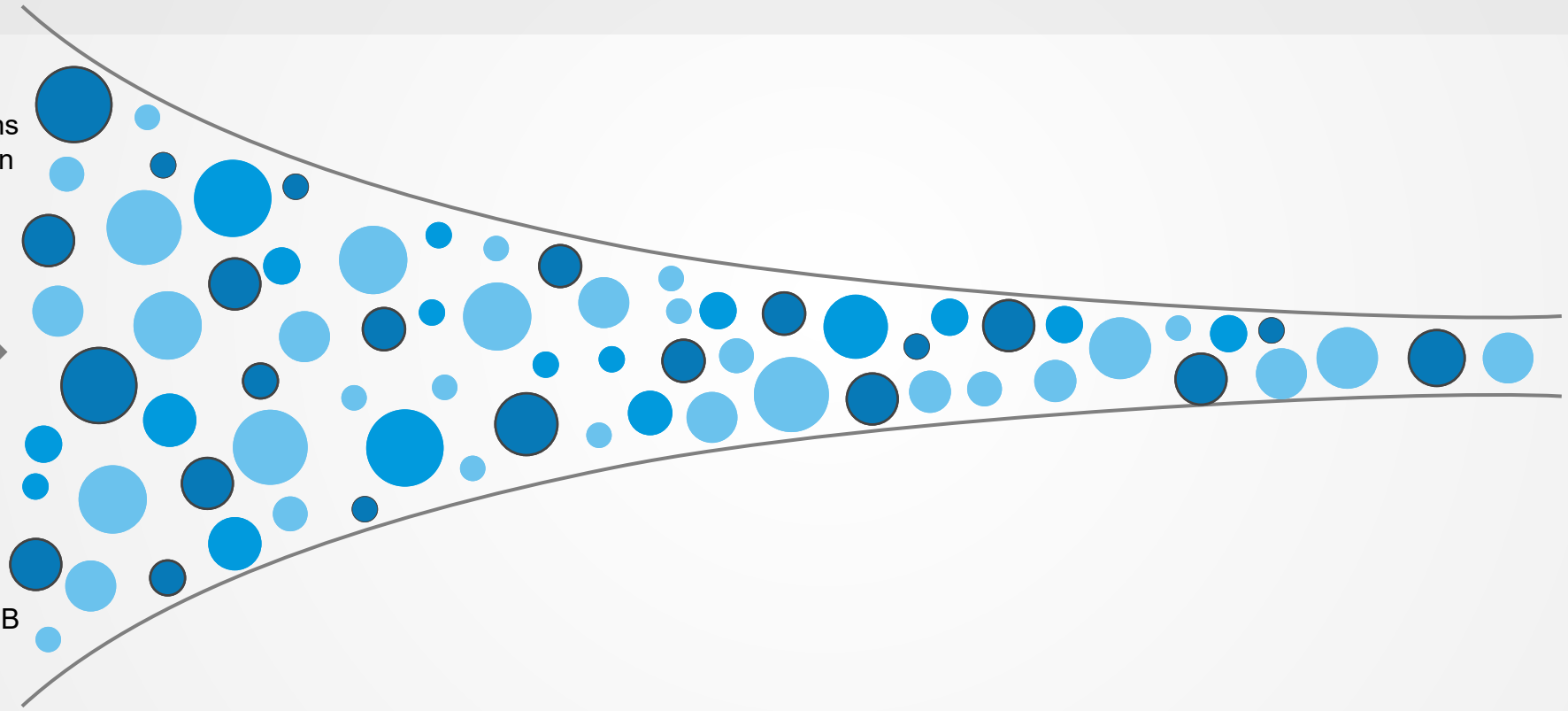
Prevention | Early Intervention | Early Help | Education | Safeguarding | Community | VCSE sector | Mental Health & Emotional Wellbeing | Children's Services | Primary Care | Urgent / Emergency | Hospital Care | Specialist Acute

Choosing Key Priorities for the Committee

- SALT
- Transition
- Neuro-diversity
- Access
- Recovery
- Long-Term Conditions
- Looked After Children
- Care Leavers

National Programmes | Population Health | System | Place

Multiple Priorities



Committee Focus

- SEND
- Housing
- Safeguarding
- Mental Health / EWB
- Oral Health
- LDD&A
- Starting Well
- School Readiness
- Healthy Weight

Criteria

Committee focus area must …

- Be important to CYP & Families
- Be shared / cross-sector priority
- Be relationship building
- Improve Statutory burning issues

Committee focus area must …

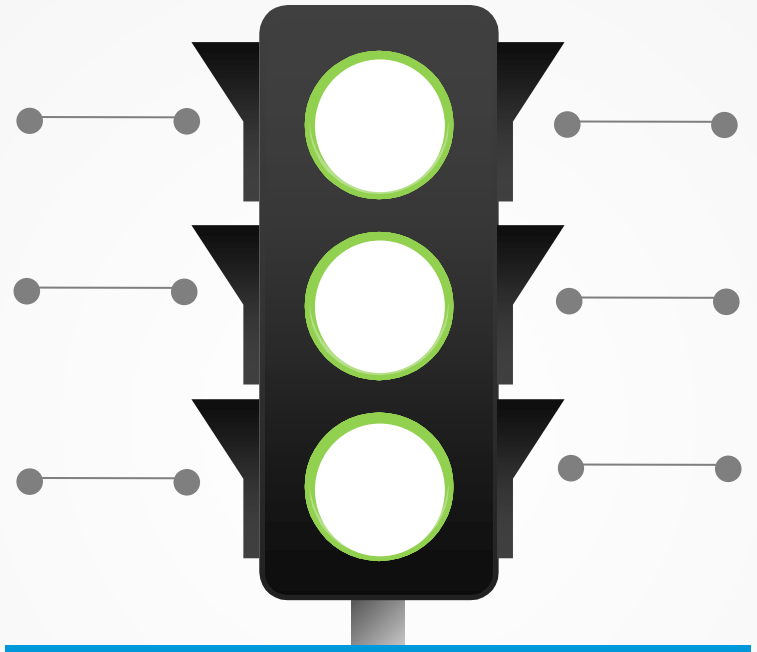
- Address Health Inequalities
- Achieve some Quick Wins
- Be Data-driven (inc. addressing data gaps)
- Be resourced for Delivery

Benefit of CYP Committee Focus

Set C&M standards for CYP ‘between the gaps’

Holds the children and young people system to account

A mechanism to resolve difficult, but critical issues



Drive shared data and intelligence standards – shine a light

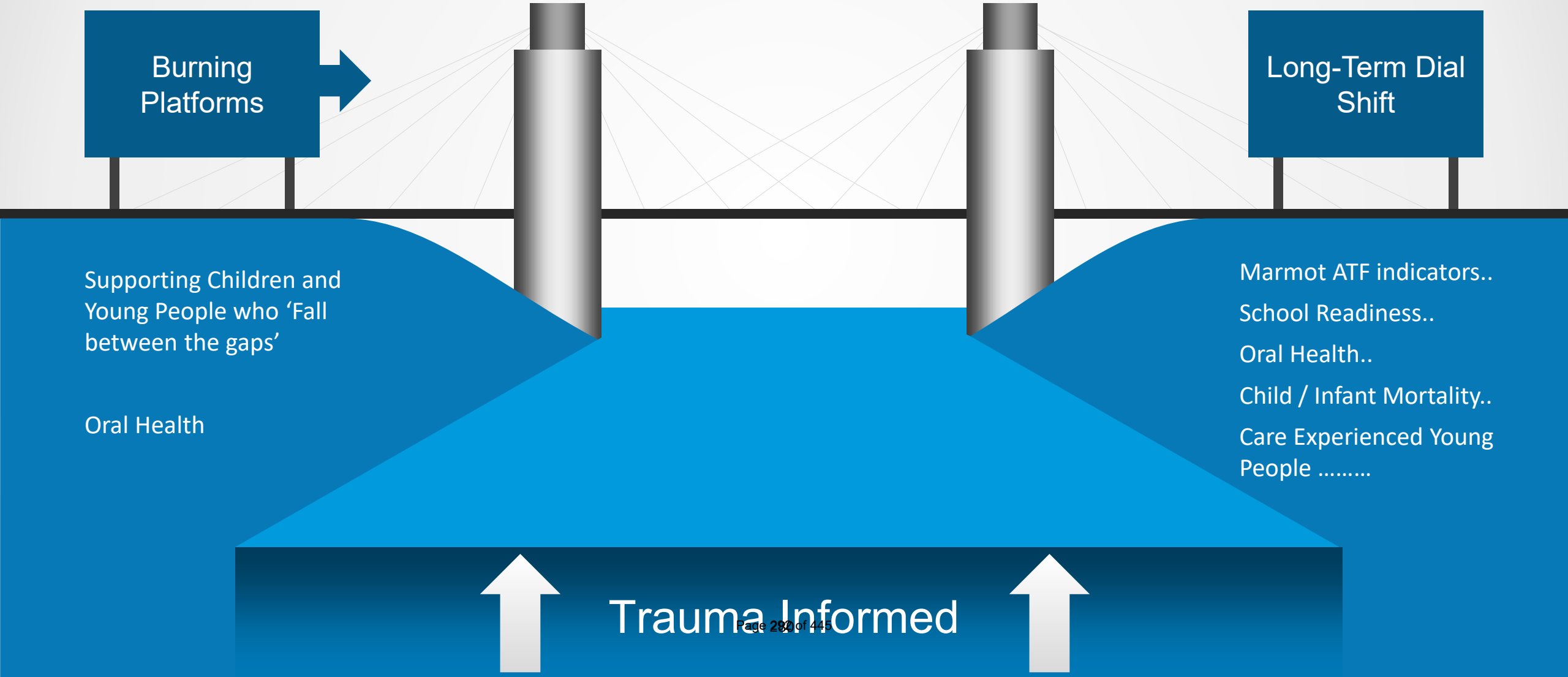
Participation & voice of CYP and Families – raise our game

Pull system levers e.g., commissioning / strategic finance

Encourage participation / equal emphasis from all 9 Places including VCFSE

Ambitious & Pragmatic

- Today's **CYP see mental & physical health as 'one'**
- CYP Committee can drive **ambitious** improvements for CYP population
- **Shared priorities** that would benefit from **greater strategic input / levers / resource**…



CIPHA - Combined Intelligence for Population Health Action

Users from Care Settings Contribute near real-time data on their patients

Integration of Data Sets to a clinical data store

Care Centric Highway

Information is used to support care, population health analytics and research which improves ownership & data quality

CYP - starting from a low base-line (capture and sharing)

- Public Health National Data
- GP Systems (inc EMIS, System One, RIO etc)
- Acute Systems – EPR
  - *Emergency Care Data*
  - *Inpatient Care Data*
  - *Outpatient Care Data*
- Mental Health Data MHSDS
- Community Health Data CSDS

Care Centric Data Store

Analytics Population Health

?? ?

- Education
- Child Specific Data Sets
- VCFS Data
- Single Identifier
- + + +

Cross Sector Priority – CYP Between the Gaps

Key

- 2023-28 Strategic Aims – HCP & Joint Fwd View
- 23/24 Operational Aims - Y1 Joint Fwd View

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CYP 'Between the Gaps'

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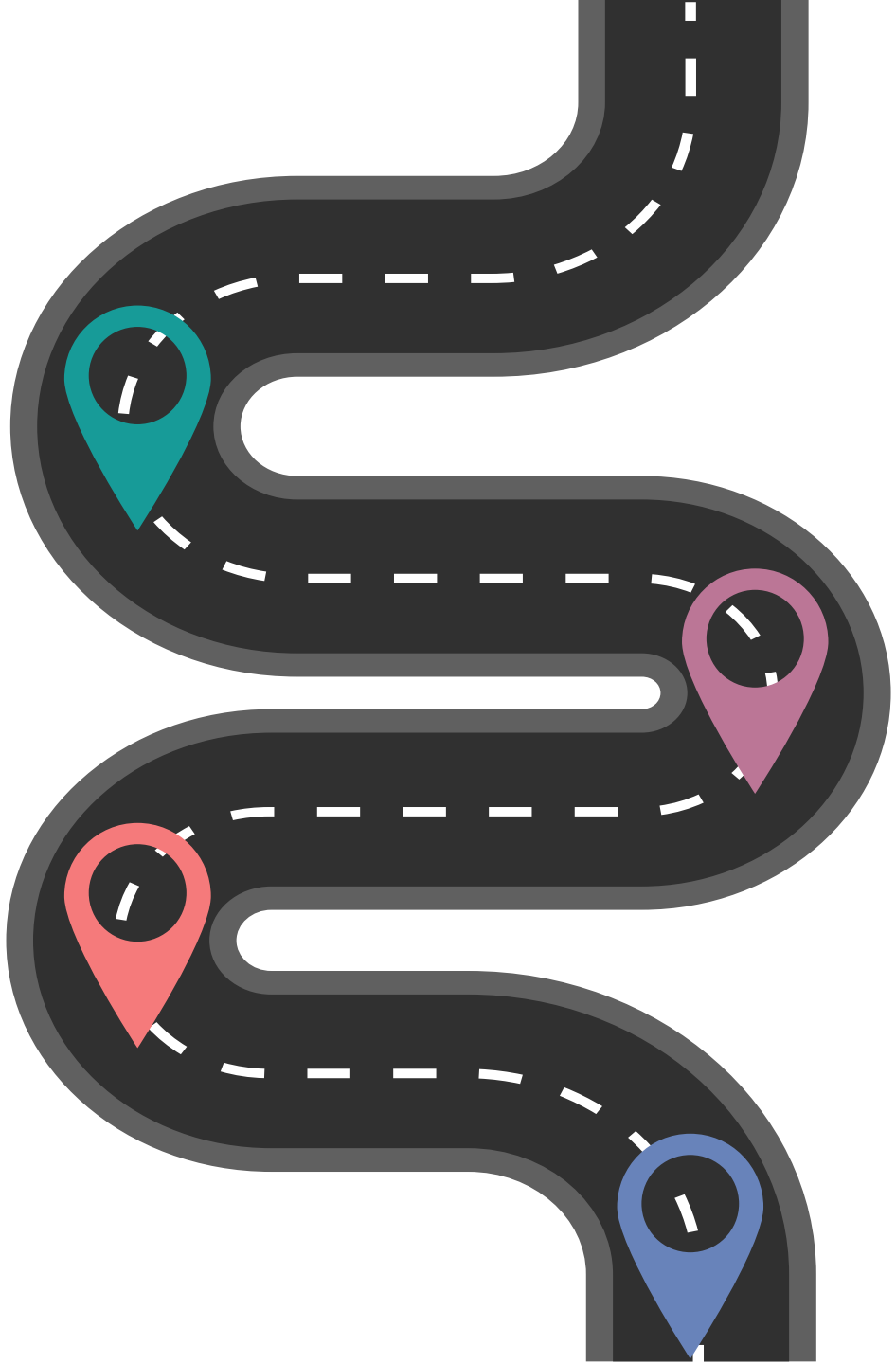

RECOMMENDATIONS

Initial Priorities

Approval from CYP Committee to progress with immediate priorities: e.g., CYP between the gaps, Neuro-diversity pathways, Oral Health.

CYP Intelligence / Data Analysis

Need to understand data & gaps in intelligence / variation / standards. Support the development of priorities for the CYP Committee. Data workplan needs to be developed for CYP with dedicated resource.

CYP Committee Strategy

6-12 month: Development of 3yr co-created, broader C&M CYP strategy – dependent on high quality information / intelligence.

C&M CYP MH Transformation Plan update

Support development of CYP MH Transformation Plan as a Chapter of broader CYP Committee 3-year strategy

Governance of CYP MHTP via CYP Committee - approve

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Cheshire and Merseyside Primary Care Access Recovery Improvement Plan

Agenda Item No: ICB/11/23/19

Responsible Directors: Clare Watson, Assistant Chief Executive

Cheshire and Merseyside Primary Care Access Recovery Improvement Plan

1. Purpose of the Report

1.1 The report describes NHS Cheshire and Merseyside Integrated Care Board response to supporting recovering access to Primary Care and seeks approval from the Board for the implementation of the Cheshire and Merseyside Primary Care Access Recovery Improvement Plan (Appendix One).

1.2 Our ambition is not only to improve access to general practice services for our population, but to achieve a single more consistent offer of Primary Care (General Practice) access.

2. Executive Summary

2.1 This plan seeks to support recovery by focusing on four areas:

- **Empower patients** to manage their own health including using the NHS App, self-referral pathways and through more services offered from community pharmacy. This will relieve pressure on general practice.

- **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response, and avoid asking patients to ring back another day to book an appointment.

- **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.

- **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

2.4 Like many parts of the NHS, general practice is under intense pressure. Where demand is greater than capacity it means general practice cannot always be effective, and patient experience and access are negatively impacted. It also means that stresses appear in other parts of the health system as patients seek alternative routes to get NHS care.

2.5 The Cheshire and Merseyside Primary Care Access Recovery Improvement Plan (PCARP) also describes accountability for delivery, transformation support, and how we will ensure choice and equity of access. It outlines the actions for NHS Cheshire and Merseyside, Primary Care Networks, our practices, and how to make the most of the funding and support offers to reduce unwarranted variation in patient experience.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- approve the Primary Care Access Recovery Improvement Plan

4. Reasons for Recommendations

4.1 As part of the national delivery plan for recovering access to primary care, Integrated Care Boards are required to develop a system-level access improvement plan. The Board has the authority to approve the improvement plan and the associated financial implications.

5. Background and further information

5.1 In May 2023, NHS England published the Delivery Plan for Recovering Access to Primary Care. This was a key commitment in the government's Autumn Statement and the plan sits alongside NHS England's delivery plans for recovery of elective and urgent and emergency care services.

5.2 In the Delivery Plan for Recovering Access to Primary Care, NHS England recognised how hard general practice and GPs are working to deal with an unprecedented demand for appointments in challenging circumstances. To be able to respond to this demand and ensure the National Health Service best meets the needs of our local communities, NHS England sets out a vision to expand capacity and transform the way we deliver services. Nationally supported by significant investment of more than £1 billion, the plan covers four key areas.

5.3 The plan sets out a series of measures to enable transformation and support general practice to address the challenges it faces and improve patient access. It outlines the actions for Integrated Care Boards, Primary Care Networks, and practices, and how to make the most of the funding and support offers to reduce unwarranted variation in patient experience. NHS England expects an update from Integrated Care Boards to their public board by December 2023.

5.4 **National plan headlines.** The national plan seeks to support recovery by focusing on four areas to tackle the 8am rush and make it easier and quicker for patients to get the help they need from primary care:

- **Empowering patients**.
  By rolling out tools they can use to manage their own health and invest up to £645 million over two years to expand services offered by community pharmacy.

  Enable patients in over 90% of practices to see their records and practice messages, book appointments and order repeat prescriptions using the NHS App by March 2024.

Ensure integrated care boards expand self-referral pathways by September 2023, as set out in the 2023/24 Operational Planning Guidance.

Expand pharmacy oral contraception (OC) and blood pressure (BP) services this year, to increase access and convenience for millions of patients, subject to consultation.

Launch Pharmacy First so that by end of 2023 community pharmacies can supply prescription-only medicines for seven common conditions. This, together with OC and BP expansion, could save 10 million appointments in general practice a year once scaled, subject to consultation.

- **Implement Modern General Practice Access** to tackle the 8am rush, provide rapid assessment and response and avoid asking patients to ring back another day to book an appointment.

  Patients will know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message. The re-targeting of £240 million nationally – for a practice still on analogue phones this could mean ~£60,000 of support over 2 years.

  Support all practices on analogue lines to move to digital telephony, including call back functionality, if they sign up by July 2023.

  Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.

  Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.

- **Build capacity** to deliver more appointments from more staff than ever before and add flexibility to the types of staff recruited and how they are deployed.

  Make available an extra £385 million in 2023/24 to employ 26,000 more direct patient care staff and deliver 50 million more appointments by March 2024 (compared to 2019).

  Further expand GP specialty training – and make it easier for newly trained GPs who require a visa to remain in England.

  Encourage experienced GPs to stay in practice through the pension reforms announced in the Budget and create simpler routes back to practice for the recently retired.

Change local authority planning guidance this year to raise the priority of primary care facilities when considering how funds from new housing developments are allocated.

- **Cut bureaucracy** and reduce the workload across the interface between primary and secondary care, and the burden of medical evidence requests so practices have more time to meet the clinical needs of their patients.

  Reduce time spent liaising with hospitals – by requiring Integrated Care Boards to report progress on improving the interface with primary care, especially the four areas we highlight from the Academy of Medical Royal Colleges report, in a public board update this autumn.

  Reduce requests to GPs to verify medical evidence, including by increasing self-certification, by continuing to advance the Bureaucracy Busting Concordat.

  Streamline the Investment and Impact Fund (IIF) from 36 to five indicators – retarget £246 million – and protect 25% of Quality and Outcomes Framework (QOF) clinical indicators.

5.5 **NHS Cheshire and Merseyside Access Improvement ambitions.** Our ambition is not only to improve access to general practice services for our population, but to achieve a **single more consistent offer of Primary Care (General Practice) access**. In 23/24 we will have invested circa £90 million in access related support and developed a single set of performance measures to support and quantify 'improvement' across the system. Our key aims are;

- **Enabling better, easier access to more appointments:**
  - **Access to a routine appointment within two weeks**
    Using the IIF indicator measurement and data collection from booking to appointment, to achieve measurable increases in 23/24 and beyond.

  - **Same day appointments for patients who require them**, with all patients provided with an appropriate response following initial contact, that same day, in line with the recent national contract amendments.

  - **That patients can easily access the practice by all available means**, but noting the specific feedback via the GP Practice Survey and our Healthwatch colleagues that patients want to see the biggest improvement in **telephone access.**

  - **Delivering more appointments overall** by all available means, with an agreed target and trajectory for 24/25 and beyond.

  - Using the work of the EIHIA to **ensure equality of access for all patients, communities, and vulnerable groups.**

- **Investing in our primary care workforce** including wellbeing offers, retaining GPs and responding to the asks in the National Long-Term Workforce Plan

- **A clear plan to retain GPs within NHS Cheshire and Merseyside** – patients tell us they value direct contact with their 'GP', and there are a considerable percentage of GPs in their 50s who may be considering leaving the profession in the next few years.

- **Maximising ARRS (Additional roles)** to maximise spend and recruitment by March 2024.

- **Increasing our headcount GPs** based on the national ambition.

- **A clear delivery plan 1/4/2025 to respond to the NHS Long Term Workforce plan.**

- **Prioritisation of Wellbeing offers,** recognising the huge pressures facing our primary care workforce, working with our Local Medical Committees and practice staff.

- **Support all our practices to have the key elements of the 'Modern General Practice Access Model'** in place by December 2024 **-** this model underpin(s) all of our access ambitions and as part of this we need to ensure best practice and progress is shared and celebrated.

- **'Measuring success'** not just by using our performance dashboard, but by working with Healthwatch and other key stakeholders to collect meaningful patient feedback, particularly in our most challenged areas and populations.

5.6 **Governance and delivery.** At a system Level, a fortnightly Programme Board is chaired by the Assistant Chief Executive Clare Watson, as Executive Lead for Primary Care, with each of the four areas of the guidance led by an identified Senior Responsible Officer (SRO), with identified leads for the cross cutting theme areas such as digital, and place executive representation.

5.7 The Board will report to the System Primary Care Committee, who have received reports and updates at each meeting. Programme Management Office (PMO) structures and process are supporting this with key documents such as a risk register.

5.8 Each Place was asked to agree a Place level Access Improvement Plan, signed off by the Place Director, managed through place structures and oversight, based on their local patient intelligence, their Primary Care Network improvement plans, practice plans and other access information gathered in line with the national guidance.

5.9 Each Place was asked to share/liaise and work with their local Healthwatch, Local Medical Committee and other key stakeholders in delivering their plan. Place plan summaries are included in Appendix 2-10 noting key other information held at place is available on request.

5.10 An investment overall locally of circa £90 million in Access Improvement through several different sources of funding, are summarised in the plan.

6. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

6.1 The PCARP and its implementation will play a considerable role in the ICB achieving its strategic objectives around:
- Tackling Health Inequalities in access, outcomes and experience
- Improving Population Health and Healthcare

6.2 Health inequalities related impacts have been considered to ensure that NHS Cheshire and Merseyside has given regard to the need to reduce inequalities between patients in access to, and outcomes from healthcare services and to ensure services are provided in an integrated way where this might reduce health inequalities. A number of health inequality related impacts and risks have been identified and how they will be mitigated and managed. Key mitigation/actions are outlined in Sections 5 and Section 7 of the Equality and Health Inequality Impact Assessment (EHIA) (Appendix Two) to support further development of plans around Equality Diversity and Inclusion and addressing Health Inequalities and supporting practices in deprived areas with a range of initial Stage 1 recommendations described in Section 10 of the EHIA for consideration.

6.3 Implementation of the PCARP will also contribute towards achieving our focus on improving satisfaction levels with access to primary care services.

7. Link to achieving the objectives of the Annual Delivery Plan

7.1 The Cheshire and Merseyside PCARP will contribute to the ICB delivering against the ICB Annual Delivery Plan[1], namely:

Service Programme	Focus Area
How we work as partners for the benefit of our population	Delivery of actions around communications and engagement and compliance with the guidance on working with people and communities Delivery our Equality Diversity & Inclusion (EDI) obligations

[1] https://www.cheshireandmerseyside.nhs.uk/media/2kvcnuzm/summary-version-of-the-jfp-delivery-plan-260623.pdf

Service Programme	Focus Area
Primary Care	Delivery of the ICBs plan response to address the national Delivery plan for recovering access to primary care and deliver overall programme of work related to the national policy development programme on the Social Determinants of Health for system leaders Post Pandemic Restoration /and increase of available General Practice appointments in line with the NHS planning guidance

8. Link to meeting CQC ICS Themes and Quality Statements

8.1 The PCARP will contribute towards the ICB meeting the requirements and expectations as outlined within the CQC ICS themes and quality statements, namely:

Theme One (T1) - Quality and Safety	
QS1	Supporting to People to live healthier lives. We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	Learning culture. We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
QS3	Safe and effective staffing. We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
QS4	Equity in access**.** We make sure that everyone can access the care, support, and treatment they need when they need it.
QS5	Equity in experience and outcomes. We actively seek out and listen to information about people who are most likely to experience inequality in experience or outcomes. We tailor the care, support, and treatment in response to this
Theme Two (T2) - Integration	
QS7	Safe systems, pathways and transitions. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services
QS8	Care provision, integration and continuity. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
QS9	How staff, teams and services work together. We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services
Theme Three (T3) - Leadership	
QS10	Shared direction and culture. We have a shared vision, strategy, and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these
QS11	Capable, compassionate and inclusive leaders. We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively. They do so with integrity, openness and honesty
QS13	Governance, management and sustainability. We have clear responsibilities, roles, systems of accountability and good governance. We use these to manage and deliver good quality, sustainable

	care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
QS14	Partnerships and communities. We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
QS15	Learning, improvement and innovation. We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research

9. Risks

9.1 A number of risks to delivery with mitigations have been identified by the Programme Board and have been included in the improvement plan. In summary the main ones are:

- Patients and the public will not understand the improved access offer and the new arrangements
- Delivery requires engagement and action from Secondary Care who may not see this as a priority at this time
- Introduction of several self-referral pathways could increase demand and therefore increase pressure on available capacity.

10. Finance

10.1 Funding for the delivery of the PCARP is outlined in Table One.

10.2 In 2022/23, there were eight separate funding allocations. For 2023/24, there is now one single Primary Care transformation allocation (with the aim of reducing bureaucracy). Whilst there is one funding pot, the funding and support available covers the following:

Transformation, which incorporates:

- Local GP retention fund
- Primary Care estates business cases
- Training hubs
- Primary Care flexible staff pools
- Practice Nurse measures
- Practice resilience
- Transformational support (which included the previous Primary Care Network (PCN) development and digital-first primary care funding lines)
- PCN leadership and development (£43 million).

Workforce programmes, which covers:

- The Additional Role Reimbursement Scheme
- General Practice fellowships
- Supporting mentor's scheme
- International GP recruitment

GPIT, which covers:

- GPIT – infrastructure and resilience

Capacity and Access Support Fund (CAP and CAIP) paid in 2 parts. The aim of the CAP funding is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led.

Table One

SDF and Primary Care Access Recovery Funding	Total
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Cloud Based Telephony	1,178,000
ARRS Support	65,782,087
Pharmacy Offer (£TBC)	TBC
Primary Care Access Recovery Support Funding	**80,605,461**
Total Funding	**89,212,709**

11. Communication and Engagement

11.1 The Stage 1 Equality Impact and Health Inequality Assessment (EIHIA) provides a clear steer on the communities and patients that need to be involved in co-designing approaches to improve access from health inclusion groups and people who share protected characteristics. Place leads and Primary Care Networks will be supported to develop a stakeholder analysis/ matrix.

11.2 NHS Cheshire and Merseyside's Communication & Empowerment function have developed the Cheshire and Merseyside's Primary Care Patient voice project that will begin by working with Primary Care Network leads across

Cheshire and Merseyside to understand how they already engage patients via their constituent GP practices – and the wider community, where relevant – and where there might be opportunities to further develop this. We want to develop the skills and confidence of primary care teams to increase engagement and maximise the way the insights gathered are utilised. This will include raising awareness of the principles set out in the Working with People and Communities guidance.

11.3 The project will be community-led, so that solutions are geared towards those who will be using them – Primary Care Networks. After carrying out our initial research, we will organise events which bring together Primary Care Network representatives, as well as members of the public already involved with practice participation.

12. Equality, Diversity and Inclusion

12.1 An EIHIA has been completed (Appendix Two). The purpose of the EIHIA document is to address the national NHS England guidance, which requires NHS Cheshire & Merseyside to look at:

- how the recovery plan supports equality, diversity, and inclusion.
- how will practices in areas of deprivation and practices disproportionally affected by health inequalities be supported.

12.2 The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. The region has areas of substantial wealth and substantial deprivation.

12.2 Overall, a third (33%) of Cheshire and Merseyside's population live in the most deprived 20% of neighbourhoods in England, with significant negative implications for health. The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England.

12.3 This iteration of EIHIA (Stage one, November 2023) is part of an ongoing process of ensuring Equality Diversity and Inclusion and tackling health inequalities are aligned to the improvement plan and aims to support system wide and local Place commissioners and Primary Care Networks to:

- consider the issues and barriers to access and poorer outcomes in relation to the four focus areas to alleviate pressure (access and engagement; structures and processes of care; patient experiences; staff training and development).
- define the group(s) experiencing inequity and discrimination in relation to primary care access and recovery. Understand the characteristics and needs of people in inclusion health groups.

13. Climate Change / Sustainability

13.1 Any proposals relating to NHS estate, will consider our climate change and sustainability commitments.

14. Next Steps and Responsible Person to take forward

14.1 The Programme Board will oversee implementation of the access improvement plan and report progress on a regular basis to the System Primary Care Commissioning Committee. Clare Watson, Assistant Chief Executive will be the lead ICB Director responsible for overseeing the implementation of the improvement plan.

15. Officer contact details for more information

Chris Leese – Associate Director of Primary Care
Chris.leese@cheshireandmerseyside.nhs.uk

Tom Knight – Head of Primary Care
tom.knight1@nhs.net

16. Appendices

Appendix One: Cheshire and Merseyside Primary Care Access Recovery Plan
Appendix Two: Equality and Health Inequalities Impact Assessment of the PCARP

NHS
Cheshire and Merseyside

NHS Cheshire and Merseyside ICB Access Improvement Plan

Report Author and Contact email	Christopher Leese
Author Contact email	Chris.leese@cheshireandmerseyside.nhs.uk
Version	Final
Date	November 2023

1.0 Contents

2. National Policy – Recovering Access to Primary Care

2.1 National Aims & Ambitions

- National guidance document can be found here https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
- Aimed at General Practice but with some Community Pharmacy actions due out of ongoing national negotiations.
- Aim to tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice.
- Enabling patients to know how their needs will be met when they contact their practice.
  A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022.*
- Integrated Care Boards (ICBs) have to ensure their plans are submitted to Boards in October/November using the following document as guidancehttps://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/
- The plan focuses on four areas to alleviate pressure and support general practice further;

  i. **Empowering Patients**
  Improving Information and NHS App Functionality
  Increasing self-directed care
  Expanding Community Pharmacy

  ii. **Implementing Modern General Practice Access**
  Better digital telephony
  Simpler online requests
  Faster navigation, assessment and response

  iii. **Building Capacity**
  Larger multidisciplinary teams
  Increase in new doctors
  Retention and return of experienced GPs
  Primary Care estates

  iv. **Cutting bureaucracy**
  Improving the primary/secondary care interface
  Building on the bureaucracy busting concordat

3. ICB response

3.1 Healthwatch

The 9 Healthwatch organisations across Cheshire and Merseyside have continuous conversations with our public about health and care services in each of our Places.

People have told Healthwatch the challenges they currently face in accessing GPs. Healthwatch would expect the improvements being made as a result of the Access Improvement Plan to ensure that people:

- Feel valued and important/understood from their first point of contact with their GP surgery by encountering less hurdles and receiving friendly, clear information about how to access appointments and services - avoiding people feeling isolated and disenfranchised.
- Feel confident when calling their General Practice and that unpaid carers are listened to and included when appropriate.
- Are able to make or manage appointments by visiting the Surgery; by an uncomplicated telephone system that is answered in a timely manner; or by online systems where appropriate and accessible to people. Each of these methods should respect people's privacy.
- Understand what the process/system is for apps and technology for those that want to use it, with clear information of when it is available and what the alternative is, particularly for those that require reasonable adjustments for access.
- Have assurance that language & translation services are included effectively, which could reduce the *did not attends* (DNAs) and cancelled appointments.
- Have a choice of appointments available to them, recognising the merits of face-to-face and online methods.
- Get an appropriate appointment from first contact with a date, time and name of who they will be seeing, and they understand the different roles within practices. With so many different language/names/titles used it is important that people know why they are seeing someone other than a GP, and that they know what they can do, both possibilities and limitations.
- Be given a set time for online consultations, rather than long periods of time that require time off work to wait.
- Be able to make follow-up appointments at the time of original/next appointment.
- Know what the next step/action is, when that is likely to take place, and how they can keep track of any referral.

NHS Cheshire and Merseyside has worked with our 9 Healthwatch organisations and will ensure that they are part of implementation and review process.

3.2 Access Improvement Ambitions

Our ambition is not only to improve access to general practice services for our population, but to achieve a **single more consistent offer of Primary Care (General Practice) access**. In 23/24 we will have invested circa £90 million in access related support and developed a single set of performance measures to support and quantify 'improvement' across the system.

Our key aims are;

- **Enabling better, easier access to more appointments:**
    - **Access to a routine appointment within two weeks**
      Using the IIF (Investment and Impact Fund) indicator measurement and data collection from booking to appointment, to achieve measurable increases in 23/24 and beyond.
    - **Same day appointments for patients who require them**, with all patients provided with an appropriate response following initial contact, that same day, in line with the recent national contract amendments.
    - **That patients can easily access the practice by all available means**, but noting the specific feedback via the GP Practice Survey and our Healthwatch colleagues that patients want to see the biggest improvement in **telephone access.**
    - **Delivering more appointments overall** by all available means, with an agreed target and trajectory for 24/25 and beyond.
    - Using the work of the Equality and Health Inequality Analysis (Appendix 1) to **ensure equality of access for all patients, communities, and vulnerable groups.**
- **Investing in our primary care workforce** including wellbeing offers, retaining GPs and responding to the asks in the National Long-Term Workforce Plan:
    - **A clear plan to retain GPs within the ICB** – patients tell us they value direct contact with their 'GP', and the ICB has a considerable percentage of GPs in their 50s who may be considering leaving the profession in the next few years.
    - **Maximising ARRS (Additional roles)** to maximise spend and recruitment by March 2024.
    - **Increasing our headcount GPs** based on the national ambition.
    - **A clear delivery plan 1/4/2025 to respond to the NHS Long Term Workforce plan.**

- **Prioritisation of Wellbeing offers,** recognising the huge pressures facing our primary care workforce, working with our Local Medical Councils (LMCs) and practice staff.

- **Support all our practices to have the key elements of the 'Modern General Practice Access Model'** in place by December 2024 **-** this model underpins all of our access ambitions and as part of this we need to ensure best practice and progress is shared and celebrated.

- **'Measuring success'** not just by using our performance dashboard, but by working with Healthwatch and other key stakeholders to collect meaningful patient feedback, particularly in our most challenged areas and populations.

3.3 PCARP Finance

The overall aim of the funding outlined in the table below, is to deliver an improved experience of access for patients, better continuity of care where most needed, and improved job satisfaction for staff.

SDF and Primary Care Access Recovery Funding	Total
GP Practice Fellowships	1,667,000
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Total Funding	**89,212,709**

In 2022/23, there were eight separate funding allocations. For 2023/24, there is now one single Primary Care transformation allocation (with the aim of reducing bureaucracy).

Whilst there is one funding pot, the funding and support available covers the following.

1. Transformation which incorporates:
    - Local GP retention fund
    - Primary Care estates business cases
    - Training hubs
    - Primary Care flexible staff pools
    - Practice Nurse measures
    - Practice resilience
    - Transformational support (which included the previous Primary Care Network (PCN) development and digital-first primary care funding lines)
    - PCN leadership and development (£43 million)
2. Workforce programmes which cover:
    - The Additional Role Reimbursement Scheme
    - General Practice fellowships
    - Supporting mentors scheme
    - International GP recruitment
3. GPIT which covers:
    - GPIT – infrastructure and resilience
4. Capacity and Access Support Fund (CAP and CAIP) paid in 2 parts.

The aim of the CAP funding is to provide the space, funding, and licence for PCNs to focus on making improvements to help manage demand and improve patient experience of access, so patients can access care more equitably and safely, prioritised on clinical need. It also supports the accurate recording of general practice activity, so that improvement work can be data-led.

3.4 ICB governance and delivery

- At a System Level, a fortnightly Programme Board chaired by the Assistant Chief Executive Clare Watson, as executive lead for Primary Care, with each of the four areas of the guidance led by an identified Senior Responsible Officer (SRO), with identified leads for the cross-cutting theme areas such as digital, and place executive representation. The Board reports to the System Primary Care Committee, who have received reports and updates at each meeting. Programme Management Office (PMO) structures and process are supporting this with key document such as a risk register, in place. The outcome from this Board will be the final product (System Access Improvement Plan) and the Primary Care Access Performance Dashboard, to ensure a metric base of evidence to support the delivery of actual improvements, in line with the national guidance.

- Each place was asked to agree a place level Access Improvement Plan, signed off by the Place Director, managed through place structures and oversights. The plan was based on their local patient intelligence, their Primary Care Network improvement plans, practice plans and other access information gathered in line with the national guidance. Each Place was asked to share/liaise and work with their local Healthwatch, LMCs and other key stakeholders in delivering their plan. Place plan summaries are included in Appendix 2-10 noting key other information held at place is available on request.

- An investment overall of circa £90 million in Access Improvement through several different sources of funding, summarised in section.

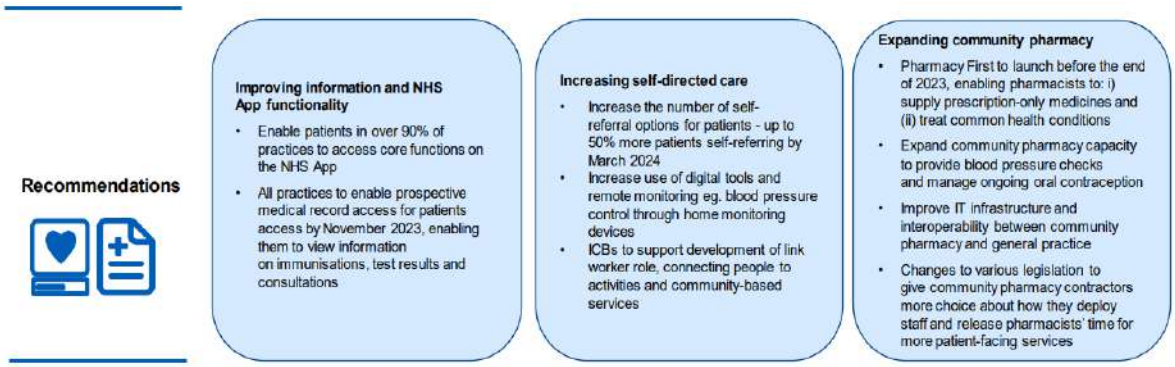
- **Access Improvement Leads – System and Place**

Clare Watson, Assistant Chief Executive	Executive Lead
Lorraine Weekes / John Adams	Finance Leads
Tim Caine	BI Lead
John Llewellyn / Colette Morris	Digital Leads
Vicki Wilson	Workforce Lead
Ian Ashworth	Population Health Lead
Helen Johnson	Communications Lead
SRO: Christopher Leese	Overall Delivery Lead
SRO: Tom Knight	Empowering Patients
SRO: Tony Leo	Implementing MDGPA
SRO: Christopher Leese	Building Capacity
SRO: Dr Jonathan Griffiths	Cutting Bureaucracy
Tricia Cavanagh-Wilkinson	PMO Support

4. Empowering Patients

Increasingly sophisticated technology continues to change many aspects of our daily lives. Technology can empower us with information to make decisions, make processes more efficient, give staff more flexibility and reduce costs.

Summary of national asks



4.1 Improving information and NHS App functionality

Our ambition

We want the public to have access to health information they can trust, find local services, and use the NHS App where this is their preference to see their medical records, order repeat prescriptions, manage routine appointments with their practice or local hospital and see messages from their practice. The NHS App ambitions are already a reality for people registered with around 20% of practices, so this plan focuses on how to increase that to over 90% by March 2024.

Progress so far

Good levels of engagement at all levels and working with IT providers to support practices with enablement has led to steady progress as illustrated in the table below.

NHS App Function	National Target	Cheshire & Merseyside Position September 2023 (POMI Data)
Appointments	90%	84%
Detailed Coded Records	90%	97.4%
Secure NHS App Messaging	90%	POMI data does not report on messaging at present
Prescriptions	90%	97.1%

Key next steps

- Continue to work with Place teams to ensure system enablement. Focus on patient level enablement and use age of NHS App functions. Continue to engage with key stakeholders.

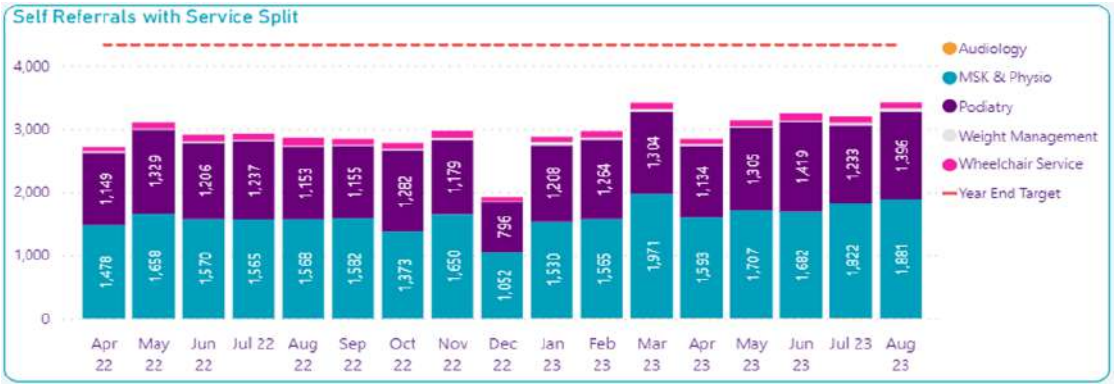
4.2 Increasing self-directed care

Our ambition

For some conditions general practice involvement is not necessary if it is clear to patients where to get care and it is clinically safe to do so directly. This is more convenient for patients and frees up valuable practice time. This is already a reality for some conditions, but we will increase the number of self-refer options, guided by clinical advice.

Progress so far

C&M target is 4,314 referrals per month based on average referrals April to October 2022 and monitoring is through Community Services Data Set (CSDS). NHS Digital published figures show August performance as 3,420 (actual) vs. 3,685 (plan). The majority of self-referrals come from MSK & Physio Services and Podiatry Services.



Key next steps

- Building on our initial analysis that identified a number of data anomalies we will be working with the Provider Collaborative to improve performance and bring together service commissioners. Commissioners at Place will be required to review existing service specifications/monitoring information, identify gaps in provision and support the uptake in demand.
- A data improvement group has been established as there are inconsistencies and anomalies that are reflected nationally. The group has been established, meets monthly and includes representation from the NHS England Regional team and NHS Cheshire and Merseyside Business Intelligence team.
- Ensure expansion of the specified self-referral pathways to reduce variation, address gaps and meet the 50% target increase required.

4.3 Expanding community pharmacy services

Our ambition

Community pharmacy is an essential part of primary care and offers people easy access to health services in the heart of their communities. 80% of people in England live within a 20-

minute walk of a pharmacy and there are twice as many pharmacies in areas of deprivation.

We now know that the Pharmacy First service will be launched on 31 January 2024 subject to the appropriate digital systems being in place to support these services. Pharmacy First will be a new advanced service that will include 7 new clinical pathways and three elements consisting of:

- Pharmacy First (clinical pathways)
- Pharmacy First (urgent repeat medicine supply)
- Pharmacy First (NHS referrals for minor illness)

This will be alongside the expansion of Pharmacy Contraception Service and relaunch of the Blood Pressure Check Service on 1 December 2023.

Progress so far

A Cheshire and Merseyside Task and Finish Group was established at an early stage and is ready to support implementation prior to the recent announcements confirming the conclusion of national negotiations.

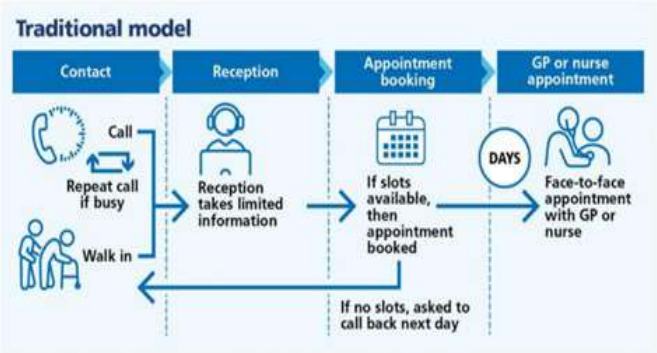
We already have the majority of community pharmacies delivering the hypertension service.

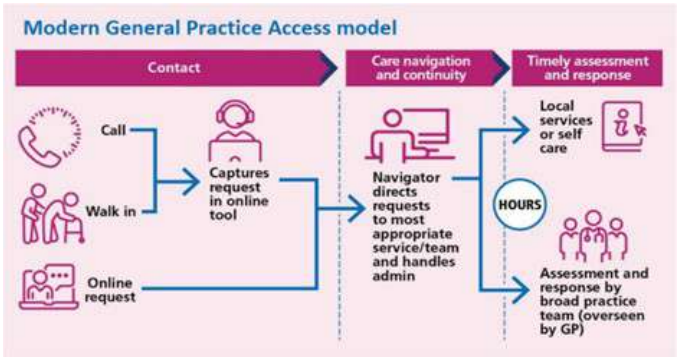
Key next steps

- Planning for implementation of the Common Conditions Service once national negotiations have been completed underway including engagement with Cheshire and Merseyside Local Pharmaceutical Committees and Local Pharmacy Network.
- Expand the existing contraceptive pilot service and the established hypertension service.

5. Modern General Practice Access

Modern General Practice Access then and now.





Summary of national asks

Recommendations

Better digital telephony

- All practices to transition to digital telephony by December 2025 to make full use of i) multiple call management; (ii) call-back functionality; (iii) call-routing and (iv) integration with clinical systems
- NHSE to support transition to digital telephony to those practices that commit by 1st July 2023
- 1000 practices to be utilising this technology by the end of 2023

Simpler online requests

- NHSE to provide general practices with high quality online-consultation, messaging and booking tools by July 2023
- ICBs, Primary Care Networks and GPs to agree most appropriate tools to support transition to new model

Faster navigation, assessment and response

- NHSE to invest in new National Care Navigation Training programme for up to 6500 staff starting in May 2023
- NHSE to fund higher-quality tools that enable the shift to online requests and enable all practice team to contribute to rapid assessment and response
- NHSE to support practices committing to transformation with extra capacity over the next two years - £13,500 per practice

5.1 Our Ambition

We will implement *'Modern General Practice Access'* so patients know on the day how their request will be handled, based on clinical need and continuing to respect their preference for a call, face-to-face appointment, or online message.

Through available national funding and support offers, NHS Cheshire and Merseyside will:

1. **Support all practices on analogue lines to move to digital telephony, including call back functionality where they signed up by July 2023 (national deadline).**

   Ambition: *to see an end to long call waits or engaged tones when patients call their practice. The new approach will allow multiple call handling, call back functionality as well as call routing to direct patients to the most appropriate team member. The national ambition is to transition 1,000 practices to new digital telephony before the end of 2023, so that around 65% of all practices nationally will be using this technology. This includes managing queuing, call back and call-routing processes.*

2. **Provide all practices with the digital tools and care navigation training for Modern General Practice Access and fund transition cover for those that commit to adopt this approach before March 2025.**

   Ambition: *to support and enable patients to access their practice via other digital routes such an online requests as well as by telephone; to support practices with training in care navigation, assessment, and response processes so that when patients contact their practice getting a response on the same day will be the norm and they will be directed to the most appropriate member within the whole practice team; transition funding will be available to support practices to enable them to clear existing work as they transition to the modern general practice access model.*

3. **Deliver training and transformation support to all practices from May 2023 through a new National General Practice Improvement Programme.**

   Ambition: *to continue to encourage practices to access the voluntary national improvement programme via the Support Level Framework to enable them to make the changes needed to deliver improvements in access; this programme contains a range of different support offers to build capacity, capability and resilience over the next 12+ months.*

5.2 Current Progress and Plans

Better Digital Telephony

General practices with legacy & traditional telephone systems are struggling with managing high and peak demands, with patients being held in long queues waiting for calls to be answered or constantly encountering engaged lines, leading to poor patient experience. Advanced (smart) telephony systems for GPs are seen as an efficiency enabler and a significant services transformation enabler, offering:

- Practice resilience and accessibility (as cloud hosted)
- Remote, mobile and home working capabilities for clinical staff as staff are able to answer calls from wherever they are, with seamless access for patients through use of a single number
- Support for new ways of working including total triage and digital consultations
- Supports patient choice in method of consultation
- Improved patient experience (as no limits on accessible lines)
- Better effectiveness and efficiency by integrating telephony with practice clinical system patient records;
- Support for at-scale working - including Primary Care Network (PCN) operations (and potentially future Integrated Care System working arrangements);
- Compliance with GP Contract conditions for telephony;

The 2023/24 GP Contract requires practices to use the nationally set Advanced (Cloud/Digital) Telephony Framework for procuring digital telephony with effect from 1st April 2023. This framework includes suppliers who can provide the functionality required to support the transformation described within the recovery plan. All analogue phone systems across the country are due to be switched off by December 2025 so this change is a prerequisite ahead of this date.

The table below summarises the phases and ambition of the national programme to deliver Better Digital Telephony:

Across Cheshire and Merseyside, there are 349 general practices who will transition to better digital telephony:

Good progress is being made with both Phase 1 and 2 practices actively engaged in the process and being supported by the National Commercial and Procurement Hub with selecting a new supplier, negotiating associated fees and contract documentation.

More ambitious deadlines have been set during the early part of November which require phase 1 practices to complete all contract documentation by the end of November with all contracts to be signed by 15th December 2023.

Position against these targets on 17th November 2023 is shown in the table below:

Phase 1	Completed	In progress
Practices engaged with the Hub	36	0
Practices selected a new supplier	21	15
Practices with contract drafted	13	8
Practices with contract signed	1	12
Practices with agreed go live date	1	0

Alongside the national offer commissioned by NHS England (NHSE), the ICB's GP IT teams also support practices with technical queries and understanding infrastructure requirements to enable implementation.

Transitioning to a new telephony supplier involves multiple stakeholders working together, which presents complexity and several challenges to delivery within the timescales set out. Key to meeting the delivery ambitions is ongoing engagement with Places, IT service providers and other stakeholders whilst maintaining the stability of service provision across general practices.

At scale approach to digital telephony systems is being encouraged at PCN/Place level according to need and where it makes sense to do so. Early feedback from the National Commercial and Procurement Hub suggests the number of PCNs exploring this approach is encouraging.

Next steps

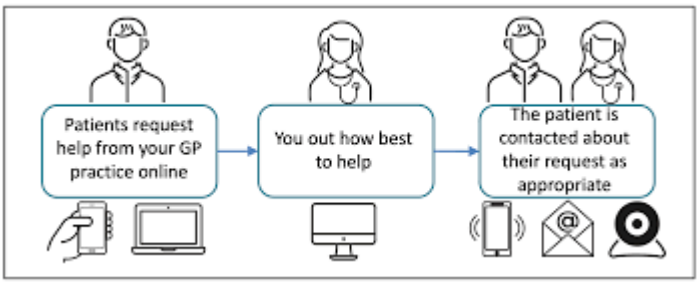
- All Places to continue to encourage practices to contact Procurement hub well in advance of their contract expiry date and utilise the Advanced Telephony Better Purchasing Framework to select a new supplier.
- Progress being monitored closely (Weekly) by NHSE against local delivery targets with oversight maintained by the Primary Care Access Recovery Plan Programme Board.

Simpler Online Requests

Online consultation tools provide increased choice and flexibility for patients in how they access care and provide benefits to practices in managing and prioritising their workload.

All practices must offer and promote the ability to access and use an 'online consultation tool', which is a software system that enables patients to contact their practice online to seek health advice, describe their symptoms, ask a question, follow up on a previous issue, or make either a clinical or administrative request.

This is the minimum functionality required, but the online systems generally provide additional functionality; the ability to send a message to a patient as a reply to their query or request, or to ask the patient for further information.

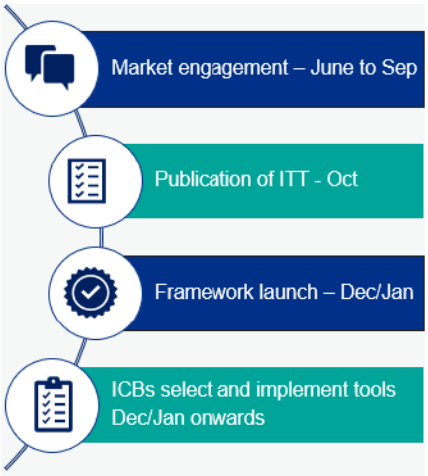


All practices within Cheshire and Merseyside have been providing online access to patients in line with contractual requirements. The majority implemented online access during the pandemic and utilisation increased dramatically. During 2022, a new online consultation tool was procured and commissioned on behalf of all former CCGs within Cheshire and Merseyside. This solution (PATCHs) has now been implemented and is live in 78% of

practices with the remainder deciding to use and now live with either E-consult, Blinx or AccuRx.

The optimisation of online consultation tools is an ongoing workstream across general practice to ensure functionality is fully utilised and patients have a good experience when using online tools to contact their practice.

The optimisation of online consultation tools is an ongoing workstream across general practice to ensure functionality is fully utilised and patients have a good experience when using online tools to contact their practice.
Through the new Digital Pathway Framework expected to be launched in January 2024, NHS England will make available high quality online consultation, messaging and booking tools to support practices to shift to the Modern General Practice Access Model.



NHS Cheshire and Merseyside is working with Place Digital Leads to understand requirements and procurement approaches to align with local need. The first of these is underway to understand SMS requirements across all 9 Places. The outcome of this review will inform commissioning intentions from 1st April 2024 with tools selected from the Digital Pathway Framework outlined above.

Care Navigation

We want to make it easier for people to contact their practice and to get a response on the same day the norm, so that patients know how their request will be dealt with. Care navigation is critical to achieve this and supported by a national Care Navigation Training programme for up to 6,500 staff nationally.

Since May 2023 NHS Cheshire and Merseyside has had two care navigation training offers available:

1. Local offer provided by Conexus which supports training for up to 6 members of staff in each practice in Cheshire and Merseyside. Note that the numbers of individuals trained per practice varies according to size.

Places report good uptake of the local offer which is popular with both PCNs and practices with approximately **220 practices** engaged in the on-going programme so far with more practices due to on-board from November onwards.

2. National Training Programme which supports training for 1 person in each practice. The national training offer started in May 2023, is voluntary and exists alongside the local Cheshire and Merseyside offer. Currently **146 practices** within Cheshire and Merseyside are participating in the national offer.

Alongside this training support there is also provision available for each PCN for the recruitment of a Digital and Transformation Lead role within the Additional Roles and Reimbursement Scheme (ARRS) framework. Currently **36 PCNs** have an identified Digital and Transformation Lead with other PCNs in the process of recruitment.

Next Steps:

- All Places continue to actively encourage practices and PCNs to engage in the available training at both national and local levels and monitor local uptake reporting progress to local Place Primary Care Committees and through other local governance routes. These issues are regularly discussed at various local Place engagement forums such as: PCN Clinical Director forums; Practice Managers forums; Protected Learning Time sessions etc.
- Note that uptake continues to increase as more practices join programmes.
- The Primary Care Access Recovery Programme Board (PCARPB) will continue to maintain oversight and reporting of uptake.

5.3 Support for Transformation

The transformation of general practice access will only be achieved through a range of support measures. Tailored 'hands on' support is available to practices and primary care networks (PCNs) to help implement the modern general practice model and realise benefits as quickly as possible.

This is divided into 'universal', 'intermediate' and 'intensive' offers:

- Universal: a range of 5 "how to guides" identifying quick wins for practices
- Intermediate (practice): three months of support with a facilitator.
- Intermediate (PCN): 12 half-day sessions over a flexible time period.
- Intensive (practice): six months of support with a facilitator.

All Places within NHS Cheshire and Merseyside continue to actively encourage their practices to take up the whole range of offers within the national support level framework and the current position is as follows:

ICB Level Summary - As at 30 September 2023									
Area	ICB Name	ICB Code	Number of Current PCNs PLEASE NOTE - U41591 / Coast And Country PCN has practices split across 2 different ICSs	Number of Current Practices	Number of Current Practices who are currently engaged / have completed Practice Level Support (Current Uptake)	Current uptake as % of Total National Uptake (510) to date	% Fair Share of Available Capacity for NW	Actual Share of Available Capacity	% Uptake of Available Share
ICB	NHS Cheshire and Merseyside Integrated Care Board	QYG	48	349	40	7.80%	36%	63	63.10%
North West	North West Region	N/A	155	961	80	15.70%	100%	176	45.50%
England	All England	N/A	1271	6353	510	100%	100%	1150	44.30%

* Total capacity available for England = 1150
* Total capacity available for NW England = 176
* Total National Uptake = 510
* Total capacity for NW Region = 15% of 1150 (total national capacity) = 176

This data shows that the total available support capacity for England is 1,150 practices with the NW Regional share of that capacity equating to 176, and NHS Cheshire and Merseyside's share of the North West regional capacity at 63. According to latest data provided by NHSE to the end of September 2023, NHS Cheshire and Merseyside has made good progress to date with 40 practices participating against a fair share of 63 which is a 63.1% uptake rate.

Whilst participation in the national programme is voluntary for practices, NHS Cheshire and Merseyside will continue to encourage all practices to take up offers of available support. A number of practices have already completed/are completing local place based capacity and resilience projects so are not signing up to the national offer as this is seen as duplication.

Next Steps:

- Each Place continues to actively encourage their practices to participate in the General Practice Improvement Programme and monitors local uptake, reporting progress to their local Place Primary Care Committee.
- The Primary Care Access Recovery Programme Board (PCARPB) will continue to maintain oversight and reporting of uptake.

5.4 Support Level Framework Visits

Place Teams are undertaking individual Practice Visits as part of a more structured and comprehensive approach to identify and implement any further individual practice support needs.

The Support Level Framework (SLF) supports organisations to understand their development needs and where they are on the journey to embedding modern general practice. The SLF has been co-produced with general practice teams. It has been clinically developed based on knowledge and experience, together with academic research and documented best practice where available. It allows organisations to understand what they do well and opportunities for improvement so the ICB can provide the right type of on-going support for practices. A number of Places have already identified initial cohorts of practices for a support level conversation and commenced visits with **17 practices** visited so far.

Next Steps:

- Places to identify and prioritise practices for a support level framework visit where they have not already done so to identify key themes/actions for further support.
- Places to report progress and key themes to their Place Primary Care Committee.
- The PCARPB will collate and review key themes periodically to identify any areas for sharing and learning. PCARPB will continue to maintain oversight and reporting of uptake.

5.5 Transition Cover and Transformation Support Funding

Practices that have made the change to a modern general practice access model have shared the importance of clearing backlogs of work so new processes and ways of working can start from a clean slate. For practices looking to implement a modern general practice access model the transition cover and transformation support funding – an average of £13,500 per practice – is available to provide additional capacity to help smooth the transition to a new model.

Funding of c£2m has been made available mid-year to NHS Cheshire and Merseyside on a draw down basis by 31 March 2023 with a further £2m available in 2024/2025. The funding is to be deployed on the basis of greatest need, with reimbursement of costs rather than distribution on an individual fair share basis, managed through Place.

Key issues so far include:

- The need to increase staff capacity to clear backlog of appointments. Note, however, that this relies upon finding staff to undertake sessional work or the availability of existing staff to undertake additional work which is challenging.
- The need to use funding to target and address support needs for those practices within Place where significant health inequalities exist.
- Practice Visits will help to inform how practices can be better supported as part of a co-production approach. As funds are released on a draw down basis and likely to be reliant upon engaging staff for additional sessions to clear backlogs, it may be a challenge to deploy the whole £2m within year.

Next Steps:

- Places to identify and prioritise practices for transformation funding. Key activities to be supported by an agreed clear action plan and outcomes.
- Places to track expenditure, report progress and key themes to their Place Primary Care Committee.
- The PCARPB will collate and review key themes periodically to identify any areas for sharing and learning across NHS Cheshire and Merseyside. PCARPB will continue to maintain oversight and reporting of uptake and spend.

6. Building Capacity

The ICB's Primary Care Workforce Steering Group oversees this work and reports to the People Board and System Primary Care Committee. At place level this is managed through place primary care fora and any associated workforce groups.

Summary of National asks

Recommendations

Larger multidisciplinary teams

- 26,000 more professionals in general practice and 50 million more appointments by 31 March 2024
- Funding for up to £385m for Additional Roles Reimbursement Scheme (ARRS) in 2023/24
- All primary care staff to be able to access suite of health and wellbeing offers and the Practitioner Health Service

Increase in new doctors

- Up to £35 million of SDF funding available for GP fellowships in 2023/24
- Further expansion of GP specialty training – and make it easier for newly trained GPs who require a visa to remain in UK
- NHSE to work with partners to identify opportunities for other doctors, eg SAS doctors, to work in general practice multidisciplinary team

Retention and return of experienced GPs

- DHSC agreement to make retire and return easier and protect NHS staff from higher tax charges driven by inflation
- Encourage experienced GPs to stay through the pension reforms announced in the Budget
- NHSE to launch campaign to encourage GPs to return to general practice and invest in GP retention schemes

Primary care estates

- ICBs to work with local partners to better anticipate where housing developments are putting pressure on existing services
- Changes to local authority planning guidance this year to ensure due consideration of primary care capacity

6.1 Larger Multi-Disciplinary Teams

2023/24 national target of 26,000 extra staff by employing more staff through the Additional Roles Reimbursement Scheme (ARRS)

Cheshire and Merseyside target by March 2024, 759 wte staff (over the 330 baseline, March 19)
Cheshire and Merseyside performance at June 2023, 1,784 wte (including 330)

The March 2024 target has already been exceeded by **an additional 695 (63.8%)**.

We are the 5th highest ICB increase nationally, with the England increase at 14.4%.

Table 1 Performance against Target – ARRS

Table 2 Full list of ARRS roles contributing to national target.

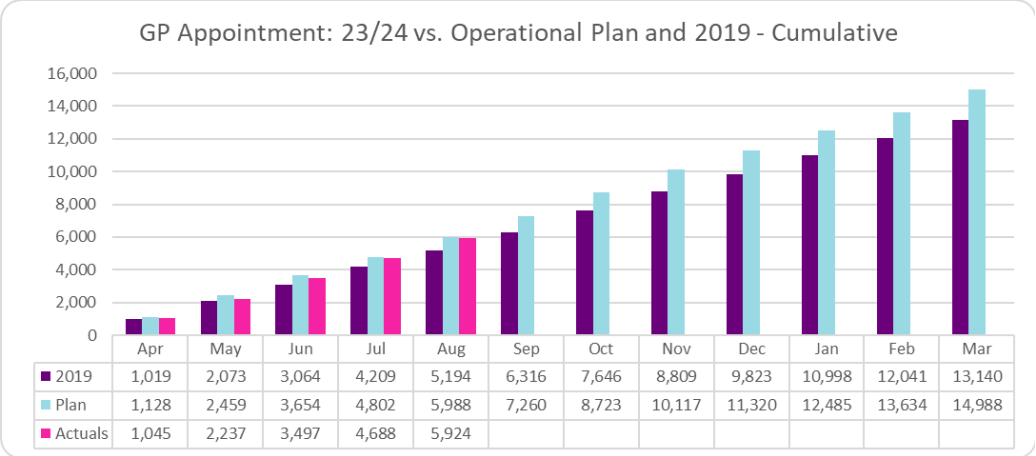
Role Source	Staff Role
NWRS / ARRS Claims Portal	Advanced Dietician Practitioners
	Advanced Occupational Therapist Practitioners
	Advanced Paramedic Practitioners
	Advanced Pharmacist Practitioners
	Advanced Physiotherapist Practitioners
	Advanced Podiatrist Practitioners
	Apprentice Physician Associates
	Care Coordinators
	Dieticians
	First Contact Physiotherapists
	General Practice Assistants
	Health and Wellbeing Coaches
	Mental Health Practitioners
	Nursing associates
	Paramedics
	Pharmacy Technicians
	Physician Associates
	Podiatrists
	Social Prescribing Link Workers
	Therapists - Occupational Therapists
	Trainee Nursing Associates
NWRS Only	Applied Psychologists - Clinical
	Apprentice - Health Care Assistants
	Apprentice - Others
	Apprentice - Pharmacists
	Apprentice - Phlebotomists
	Apprentice - Physiotherapists
	Apprentices
	Clinical Associates in Psychology
	Dispensers
	Health Support Workers
	Healthcare Assistants
	High Intensity Therapists
	Mental Health and Wellbeing Practitioners
	Other Direct Patient Care
	Peer Support Workers
	Phlebotomists
	Physiotherapists
	Psychological Wellbeing Practitioners
	Social Workers
	Therapists - Counsellors
	Therapists - Others
	Trainee Clinical Associates in Psychology
	Trainee High Intensity Therapists
	Trainee Mental Health and Wellbeing Practitioners
	Trainee Psychological Wellbeing Practitioners

Appointments:

2023/24 NHS Operational Plan Targets – NHS Cheshire and Merseyside currently offers 730,000 more appointments than at pre pandemic levels. This equates to an additional 14% compared to the same cumulative position in 2019 (April to August). As part of the Operational Planning ICBs were set a national target of 14.98m GP Appointments. For NHS Cheshire and Merseyside this equates to an additional 1.8m appointments by March 2024 (compared to 2019). Current performance shows 60,000 appointments under target

as at August 2023, however for the last 3 months actual appointments have exceeded plan figures.

Table 3 – Operational Plan Appointments



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2019	1,019	2,073	3,064	4,209	5,194	6,316	7,646	8,809	9,823	10,998	12,041	13,140
Plan	1,128	2,459	3,654	4,802	5,988	7,260	8,723	10,117	11,320	12,485	13,634	14,988
Actuals	1,045	2,237	3,497	4,688	5,924							

Appointments: % of appointments within 2 weeks of booking. The National IIF ask is 85% (Lower Threshold) and 90% (Upper Threshold) of appointments to take place within 2 weeks of booking. NHS Cheshire and Merseyside performance currently sits at 85.5% of appointments taking place within 2 weeks. 216 (of 350) GP Practices are delivering 85% of appointments within 2 weeks of booking.

Table 4 – Appointments within 2 weeks of booking

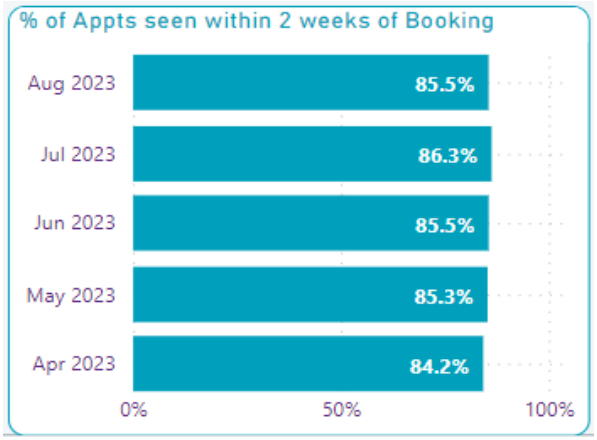


Table 5 - Appointments split by mode – year on year comparison (Jan-Sep)

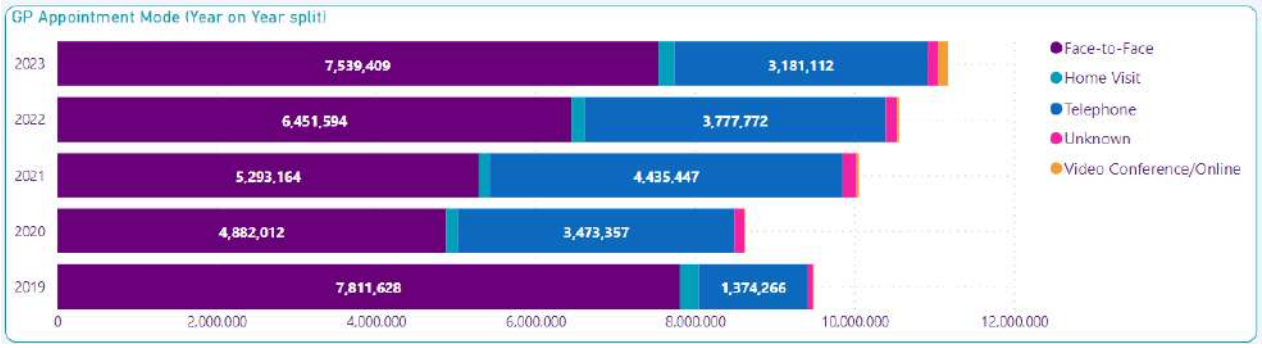
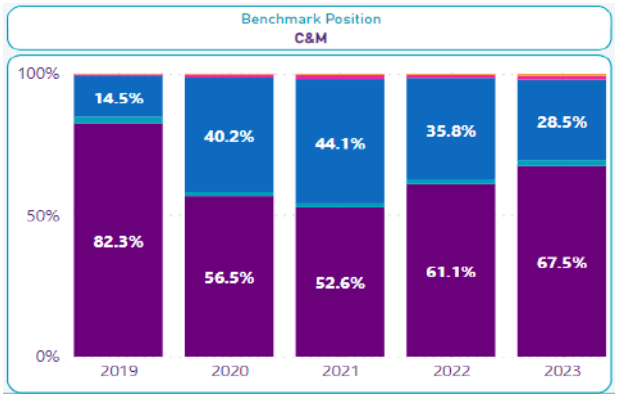
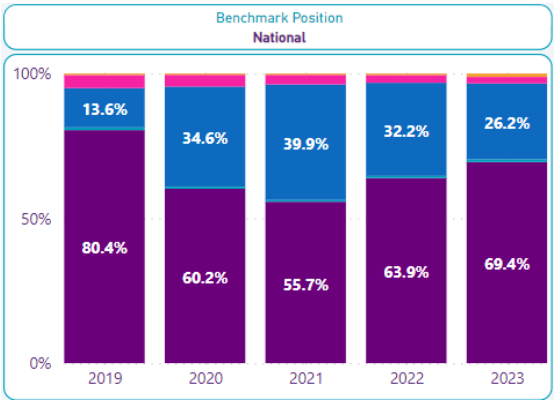


Table 6 - Appointments % split by mode – year on year comparison (Jan-Sep): NHS Cheshire and Merseyside vs. England Average





Increase in new doctors

- There are currently 103 Fellowships across NHS Cheshire and Merseyside and we plan to invest £1.6 million in 23/24 with a target of 140 to be achieved by March 24.
- NHS Cheshire and Merseyside are using the 2031/32 ambition of 6,000 extra GPs adjusted to apply to March 24. This translates to a target of 1,868 extra GPs by Mar 2024.
- We currently have 1,847 FTE GPs and are predicting that by year end we will have 1,836. We therefore forecast that by year end there will be a shortfall of 32 FTE GPs.
- Further work is required to refine this trajectory for 24/25 and beyond.
- In 23/24 NHS England further funded a local recruitment offer to ICBs, for PCNs with MIAA (Mersey Internal Audit), who between April 2023 and September 2023 supported and filled 92 vacancies for PCNs with their candidates.

Retention and return of experienced GPs

- We know more and more GPs are planning to retire earlier NHS Cheshire and Merseyside currently has 611 GPs (head count) over the age of 50.

- This equates to 477 WTE which represents 26% of our overall GP workforce. NHS Cheshire and Merseyside currently has 30 doctors on the National GP retention scheme and we continue to work with regional leads to promote and support this scheme.

- In 23/24 NHS Cheshire and Merseyside will invest a minimum of £659,000 at Place and system level in GP retention initiatives.

- In May 2023 we agreed our GP Retention Plan which was developed with our colleagues at the NHS Cheshire and Merseyside Training Hub, Place colleagues and wider stakeholders.

Table 7 - Breakdown of GP Full Time Equivalent by Age band – latest 4 months

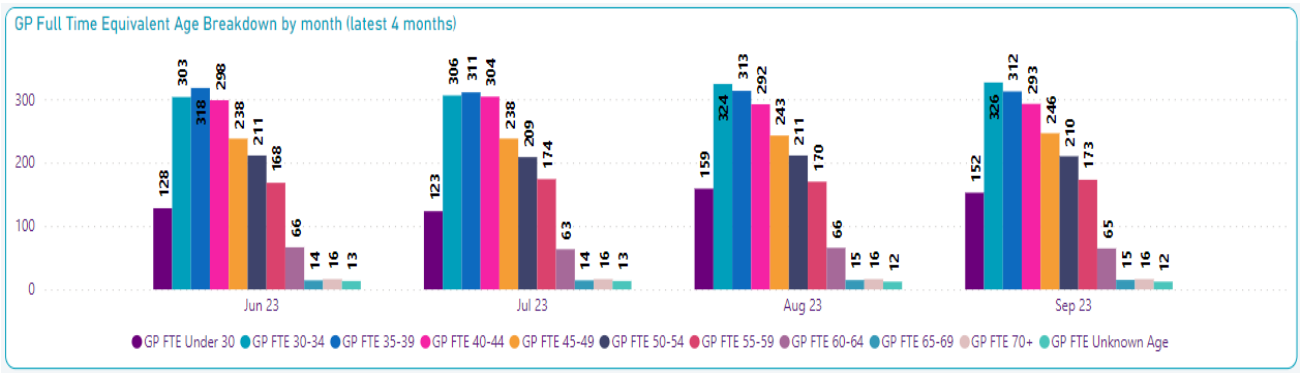
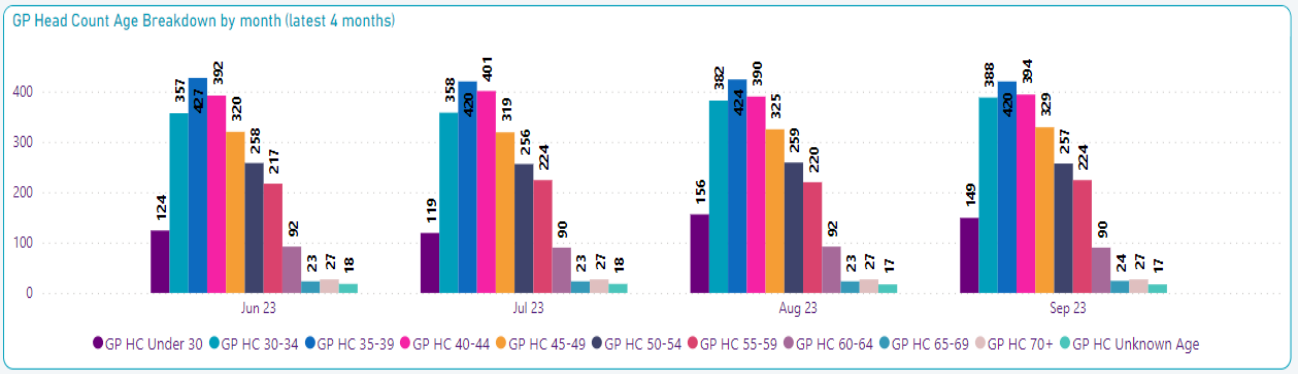


Table 8 – Breakdown of GP head Count by Age Band – Latest 4 Month



- The plan identified the following areas for spend for 2023/24;

  ✓ GP Mentors - £392,000 available (but not committed) for 23/24 for this, with 20 active trained GP Mentors with a target of an additional 5 GP Mentors by March 2024

- ✓ Next Generation GP initiative - one active programme across Cheshire. Discussions underway with several Places regarding additional programmes across NHS Cheshire and Merseyside.
- ✓ GP Locum Peer Support networks
- ✓ Developing Portfolio Careers
- ✓ Career Conversations
- ✓ Face to Face networking
- ✓ GP Equality and Diversity in the workplace
- ✓ CPD and Training
- ✓ 'Your Voice, Your Career' engagement events completed in two places.
- ✓ GP Retention Survey(s) – currently completed in Cheshire East Place with responses from 95 GPs with analysis is underway. The survey will be used to develop local retention initiatives and map GP ambitions and portfolio working to local service delivery. Conversations happening with other Places to consider replicating this approach to help inform local retention approaches.

- £1.6 million investment in fellowships in 23/24 with a target of 140 to be achieved by March 24, current number is 103.

- Using the 2031/32 ambition of 6,000 extra GPs used and adjusted to apply to March 24. This estimated 23/24 national achievement target was then applied to C&M ICB pro rata. This translates to a target of 1,868 extra GPs for Mar 2024. NHS Cheshire and Merseyside have 1,847 (-21) FTE GPs against a Mar 24 target of 1,868 and are predicted to end the year with a figure of 1,836 (-32). We are currently forecast to end the 23/24 FY under this ambition by a shortfall of 32 FTE GPs. Further work is required to refine this trajectory for 24/25 and beyond.

- In 23/24 NHS England further funded a local recruitment offer to NHS Cheshire and Merseyside, for Primary Care Networks (PCNs) with MIAA (Mersey Internal Audit), who between April 2023 and September 2023 supported and filled 92 vacancies for PCNs with their candidates.

Retention and Return of experience GPs

- We know more and more GPs are planning to retire earlier NHS Cheshire and Merseyside currently has 611 GPs (head count) over the age of 50. This equates to 477 Whole Time Equivalents which represent 26% of our overall GP workforce. There are currently 30 doctors on the National GP retention scheme https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/retained-doctors/ and we continue to work with regional leads to promote and support this scheme.

- In 23/24 NHS Cheshire and Merseyside will invest at *least* £659,000 at place and system level in GP retention initiatives. In May 2023 the ICB agreed a GP retention plan developed with our colleagues at the NHS Cheshire and Merseyside Training Hub, place colleagues and wider stakeholder(s) which produced the following areas for spend for 23/24;

- GP Mentors - £392,000 available (but not committed) for 23/24 for this, with 20 active trained GP Mentors with a target of an additional 5 GP Mentors by March 2024
- Next Generation GP initiative - One active programme across Cheshire and discussions underway with several Places regarding additional programmes across NHS Cheshire and Merseyside
- GP Locum peer support networks
- Developing Portfolio Careers
- Career Conversations
- Face to face networking
- GP Equality and Diversity in the workplace
- CPD and Training
- 'Your Voice, Your Career' engagement events completed in two places.
- GP Retention Survey(s) – currently completed in Cheshire East Place with responses from 95 GPs with analysis is underway. The survey will be used to develop local retention initiatives and map GP ambitions and portfolio working to local service delivery. Conversations happening with other Places to consider replicating this approach to help inform local retention approaches.

6.2 Wellbeing

In 23/24 NHS England supported NHS Cheshire and Merseyside with continuation of the Health Assured wellbeing offer for all practice time. 40 staff have taken up this offer so far this year. £75k has been secured from NHS England for further intense support for practices that experience serious violent and aggressive incidents in a practice. The external funding is not recurrent and therefore will be a priority for the ICB to prioritise ongoing investment to support the wellbeing of GPs and all practice staff from 2024/25.

6.3 Primary Care Strategic Estates Plan

The national NHS Property Services Town Planning Team are supporting NHS Cheshire & Merseyside to request Section 106 (S106) healthcare contributions for major planning applications over 200 units and respond to local planning policy consultations.

Cheshire and Merseyside Health and Care Partnership's agreed estate strategy sets out our system commitment for the next five years. We are committed to the NHS, local government and other agencies working together to deliver our Estates Plan and take steps to create stronger, greener, smarter, better, fairer health and care infrastructure together with efficient use of resources and capital to deliver them.

Our focus for delivery will primarily be in eight key areas:

1. **Fit for Purpose** – Our Estate will be fit for purpose. It will accommodate the needs of patients and staff alike and provide the best possible care for those who need it the most.
2. **Maximising Utilisation** – We are committed to maximising the utilisation of clinical space. We will be efficient in our design and operation of services.
3. **Environmentally Sustainable** – Our Estates will be more environmentally sustainable. We are willing to invest in making our buildings more energy efficient to make

this happen. Reduce our carbon footprint and play an active role in tackling climate change.

4. **Value for Money & Social Value** – We will strive to ensure maximum value for money and economic benefit for society. We will continuously look for ways to improve social value and make a positive impact on society.
5. **Services & Buildings in the right place** – We want to ensure that everyone has access to the care they need when they need it. Providing care in the right buildings with the right staff and resources.
6. **Flexibility** – We aim for flexibility to be built into our Estate. We will adapt our buildings and facilities to meet the changing needs of the service and constantly review /make changes where necessary.
7. **Technology** – We will optimise the use of Technology for our Estate, making sure our buildings are "Digitally Ready"
8. **Working in Partnership** – We are committed to working in partnership with Local Authorities and other agencies to allow for more efficient use of resources and create opportunities for better health outcomes.

Since April 2023 a total of £2.7m S106 healthcare contributions have been requested to mitigate the impact of new housing on primary care services for significant developments across Cheshire, Halton, Knowsley, St Helens and Wirral.

Where we are successful in securing S106 funding the team will work directly with place primary care leads and individual practices to deliver improvements to infrastructure.

Progress so far

- The Cheshire and Merseyside programme to develop PCN clinical and estates plans will be completed by the end of November. In additions to the plans for PCNs each Place and NHS Cheshire and Merseyside will have a prioritised list of primary care projects for future investment which will be considered as part of the Integrated Care System Infrastructure Strategy.

- NHS Cheshire and Merseyside has commissioned NHSPS to support Places in responding to planning applications and identifying requests for Section 106 infrastructure funding.

- As part of normal planning processes, NHS Cheshire and Merseyside is working with local stakeholders to take account of areas where housing developments are putting pressure on existing services.

- In addition, we continue to have local discussion at Place Strategic Estates Groups on local pressures and specific cases.

- Regarding existing plans, these are currently coming to completion for primary care and PCNs across all 9 places with the individual knowledge transfer meetings being held with each of the 9 places over the next two weeks and the central ICB meeting

planned for 14 December 2023. This work will give us full list of primary care priorities for C&M including capital and revenue implications.

6.4 Next Steps

A formal response to the NHS Workforce Plan will be developed once the further national guidance is released, which will include combining actions from the GP Retention Plan and also include the plan for nursing and other allied health professionals/direct patient care staff.

By March 2024 to Board, to be confirmed by People Board/Primary Care Workforce Steering Group

- Clear targets and trajectories for workforce from 24/25 onwards, as part of the above plan for appointments and workforce, but for elements where targets are tbc (see Performance Dashboard, Appendix 12, for current gaps)
  By March 2024 to Board

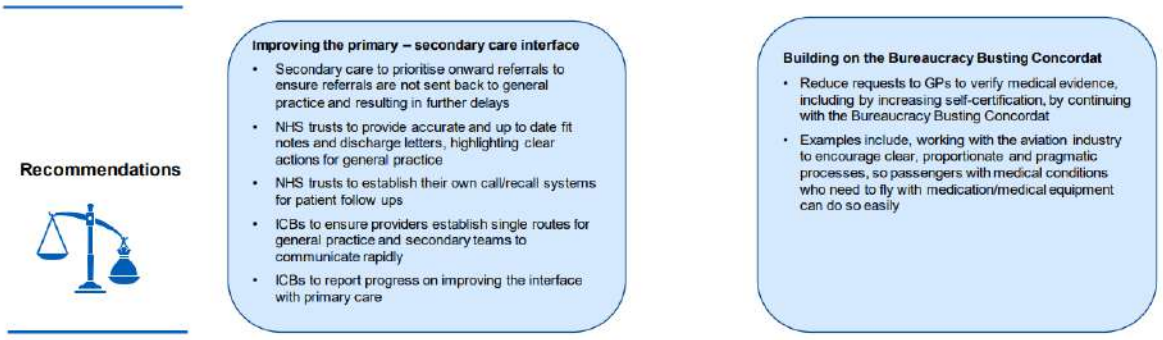
- Understanding and planning for any assumptions made in relation to the additional roles (ARRS scheme) once the national GP contract from 24/25 has been agreed (still under negotiation)
  TBC

- Places with particular challenges in relation to appointments and workforce will be undertaking further place actions as detailed in their place plans to address this - place plans will be updated to reflect progress.
  By March 2024 to Board

- Recognising the huge pressures facing our primary care staff, further work for 24/25 on wellbeing offers, which will be a major theme for the improvement plan.
  Update at March 2024 Board

7. Busting Bureaucracy

7.1 Consensus on the Primary Secondary Care Interface



- We published our Consensus on the Primary and Secondary Care Interface in June 2022. This document was created collaboratively with Primary and Secondary Care across the Integrated Care System footprint.

- The principles within the document include within it the national asks detailed above.

- The Consensus and the Primary Care Access Recovery Plan has been presented to the following Cheshire and Merseyside groups.

    - Trust Chief Executives
    - Trust Medical Directors
    - Trust Chairs
    - Trust Chief Operating Officers

7.2 Primary Secondary Care Interface Groups

- We have established Primary Secondary Care Interface Groups across the Integrated Care System footprint:
    - North Mersey
    - Mid Mersey
    - Wirral
    - Warrington
    - Cheshire West
    - Cheshire East

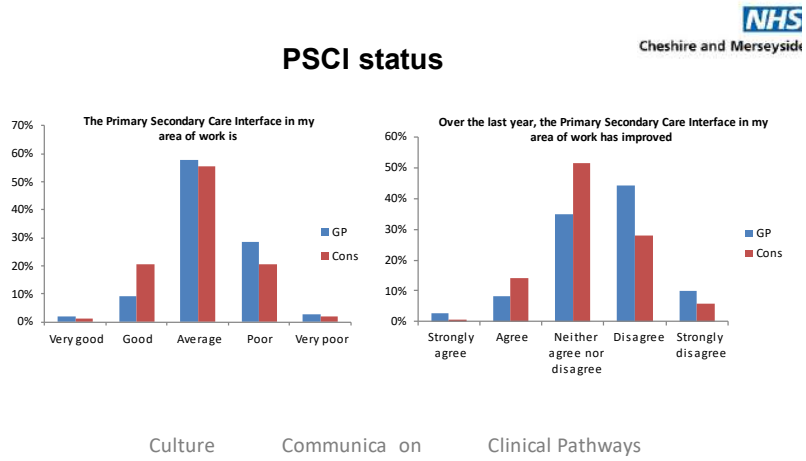
- These groups are working on ‘operationalising’ the consensus document and thus delivering the asks within the Primary Care Access Recovery Plan.

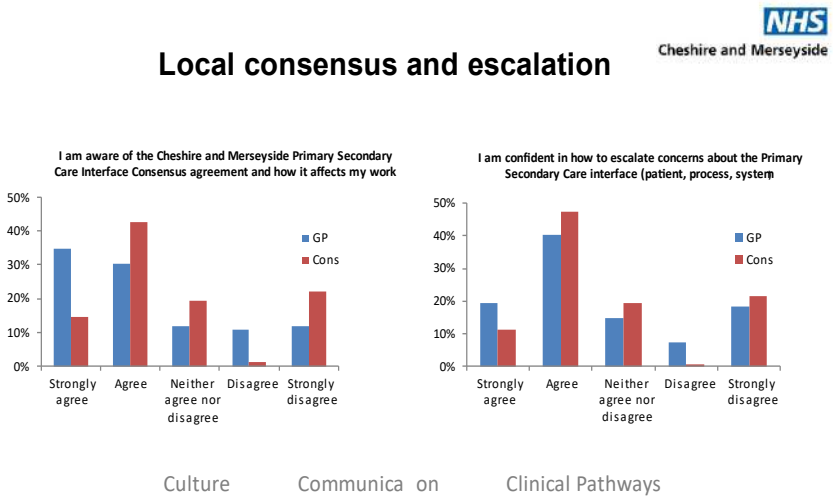
- In particular they are looking to ensure there are clear escalation routes and communication between Primary and Secondary Care.

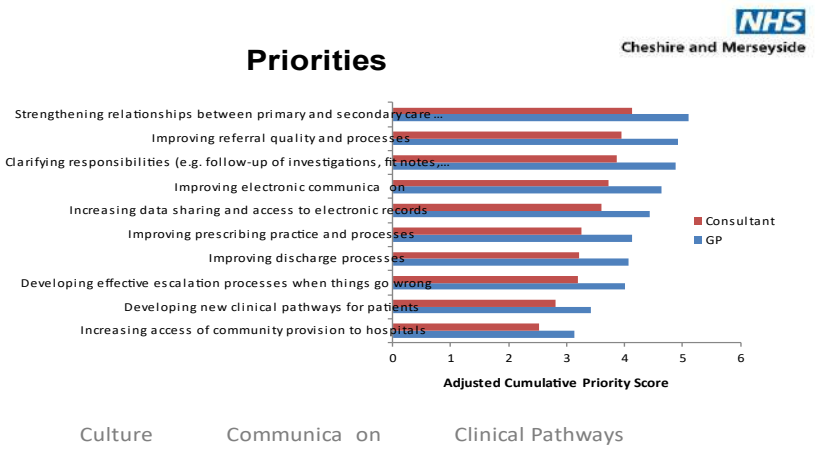
- The groups have representation from both Primary Care clinicians including Local Medical Councils as well as Secondary Care colleagues, typically Medical Directors or Associate Medical Directors.

7.3 Primary Secondary Care Interface Survey

- We have undertaken a survey to assess the current satisfaction with the Primary Secondary Care Interface (PSCI).
- 283 clinicians responded to the survey with a roughly equal split between Primary and Secondary Care responders.
- Key headline results show that GPs are slightly less satisfied with the current situation than consultant colleagues, but that all clinicians have the same priorities.
- The key priority for all clinicians is to improve relationships between Primary and Secondary Care.







- We also have a wealth of qualitative feedback from the survey to analyse and inform ongoing work within our Primary Secondary Care Interface Groups.

7.4 Bureaucracy Busting Concordat

- We continue to wait for further information and national guidance in this area but will look to lead on some local changes with wider system partners such as education and housing to reduce the burden on practices who receive requests for doctors' letters to support a variety of asks from patients.

7.5 Key Challenges

- This workstream requires collaboration across the whole system. There is concern that secondary care may not recognise the need for this work, seeing it as an issue facing Primary Care, rather than a s a true system issue affecting patient pathways.

7.6 Next Steps

- Ongoing work within PSCI Groups.

- A draft Trust Communications Toolkit and a draft Trust Checklist have been produced. These are proposed to be distributed to Trusts shortly for use and completion.

8. Next Steps and Key Milestones

1. **December 2023** Plan to System Primary Care Committee.

2. **To End of March 2024** Programme Board structures remain in place.

3. **Jan 2024 onwards** - Dashboard updated monthly and reported to System Primary Care Committee, Place level plans updated and monitored at place level, with collective discussions at fortnightly primary care leads meeting (inter place and system).

4. **Jan – March 2024** Patient feedback – how do we know our plans are working. Commission additional work pending the GP Patient Survey 2024, at place/system level to understand the impact of these measures – to be discussed further with Health watch colleagues. This will include targeted work with our most challenging communities and will be informed by the working in our Equality/Health Inequality analysis.

5. **Jan-March 2024 -** Gather in more case studies of 'success' / best practice.

6. **March 2024 –** Updating our actions in relation to Equality/Health Inequality analysis including bringing a more bespoke plan to Board to underpin this.

7. **March 2024** Plan returns to Board March 24 with missing targets for 24/25 agreed and in place plus updates in all areas.

8. **March 2024** - Place plans updated for March Board, ongoing assurance at place level through place primary care forums/assurance visits.

9. Appendices

A1	Equality and health inequality analysis and report  EHIA PCARP
A2-10	Place Plans x 9 Note – *all place appendices have been removed for the purposes of this paper only but are available on request*  East Cheshire.docx  Halton.docx  Knowsley.docx  Liverpool.docx  System Plan Sefton v4 FINAL.docx  St Helens.docx  Warrington.docx  West Cheshire.docx  Wirral.docx
A11	Communications Overview summary
A12	Place Checklist for Primary Secondary Care Interface Trust Checklist for Primary Secondary Care Interface Primary Secondary Care Interface Communications Toolkit  Place Primary Secondary Care Interf  Trust Primar Secondary Care Interf  PSCI Communications Tool
A13	Access Improvement Dashboard
A14	Investment in Access recovery
A14	Risk Register  Risk Register

Appendix 11 – Communications overview summary (as at October 2023)

Primary Care Recovery Access Plan (PCARP) communications and engagement overview: The table below sets out milestones for the PCARP communications and engagement approach, and shows the different levels where activity will happen. Each milestone will have an individual action plan. As in most cases activity will align with the national approach – for consistency and to increase impact – campaign start dates are dependent on NHSE timescales.

Milestone	National activity	NHS C&M communications and engagement (C&E) team activity	Other activity
Additional roles in primary care campaign (launch planned for 19 October 2023, with activity continuing for a number of months afterwards)	PR activity to generate content and media coverage to increase patients' knowledge and confidence in the primary care triage process, and the wider multi-disciplinary team of clinicians that are available in general practice. Production of new patient/public video for use on websites/social media. Production of a toolkit for GP practices.	Cascade communications toolkit to practices via GP briefing. Produce C&M press release and local case study films, for use in local PR, across NHS C&M channels (website, social media, and newsletters) and by practices. Issue briefing note to key stakeholders, incl. Healthwatch.	Individual GP practices to use toolkit assets on their own communications channels (e.g., websites and social media). Place directors/primary care teams to share briefing and toolkit with any additional local stakeholders/groups as required.
PCARP plan presented to NHS Cheshire and Merseyside ICB (30 Nov 2023)	n/a	C&E team to issue press release providing summary of C&M plans, including what it will mean across different Places. Content will be used in C&M stakeholder bulletins.	Place directors/primary care teams to share with any additional local stakeholders as required.
Access routes to primary care comms, (currently proposed for Q4 2023/24)	Campaign around routes for accessing general practice services, focusing on digital.	As for additional roles in primary care campaign. Targeted social media activity – utilising health inequalities data – using budget from system development fund.	As for additional roles in primary care campaign.
Wider care available campaign (tbc – potentially spring 2024)	Potential campaign to support new community pharmacy common conditions service.	As for additional roles in primary care campaign.	As for additional roles in primary care campaign.

In addition to the milestones highlighted above, both GP and pharmacy access feature in the Cheshire and Merseyside Winter Communications and Engagement Plan, which includes focal points such as Ask Your Pharmacist Week, Self Care Week, World Antimicrobial Awareness Week, and advice for Christmas/Bank Holiday prescriptions and access (system development fund budget will be used to boost social media messaging around the latter over the holiday period). This activity will be co-ordinated centrally by the communications and engagement team, and shared with NHS C&M Place primary care teams and C&M practices through the fortnightly GP briefing. The team is also planning a separate piece of work aimed at supporting PCNs to develop skills and share best practice in patient involvement, which it is hoped will also provide further opportunities around GP access communications.

Appendix 13 – Access Improvement Dashboard

REF	Area	Actual	Target	BY	RAG	Comments
	ICB Access Recovery Plan - Performance Dashboard v22					
	AS AT October 2023					
1. Empowering Patients						
1.1	No. of additional CCS, OC & BP consultations delivered	TBC	TBC	TBC	TBC	Working locally to develop metric data
1.2	No. of pharmacies registered for CCS/PF	TBC	TBC	TBC	TBC	Working locally to develop metric data
1.3	No. of pharmacies registered for BP/OC	TBC	TBC	TBC	TBC	Working locally to develop metric data
1.4	% of 7 self-referral pathways in place across ICBs	TBC	TBC	30.09.23		Have NW position but not C&M as %
1.5	50% increase in self-referrals	3,420	3,685	31.03.24		Numbers as provided by NHSe. C&M ICB BI colleagues working with NHS Digital to produce local monitoring which will allow for indivudal Provider discussions. Worth noting that the C&M ICB target is based on a Provider being classed as a 'Cheshire & Merseyside ICB Provider', rather than a C&M ICB registered patient.
1.6	CPS Referrals	15,209	TBC	TBC	TBC	To date (Sep-23) there have been 15,209 referrals. This equate to 4.87 referrals per 1,000 patients. Worth noting there have been 348 declined referrals
	NHS App					
1.7	Practices/PCN have enabled all four NHS App functions for patients: Records	97.4%	90%	31.07.23		Updated from POMI for Sept 23 - 9 practices have not enabled this function
1.8	Practices/PCN have enabled all four NHS App functions for patients: Appointments	84.0%	90%	Ongoing		Updated from POMI for Sept 23 - 53 practices have not enabled this function
1.9	Practices/PCN have enabled all four NHS App functions for patients: Messages	N/A	N/A	N/A		Not Available
1.10	Practices/PCN have enabled all four NHS App functions for patients: Prescriptions	97.1%	90%			Updated from POMI for Sept 23 - 10 practices have not enabled this function
1.11	Enable patients to have access to the four key NHS App functionalities (records, messages, apps, scripts): % practices enabled to book/cancel appointments	44.1%	TBC	31.03.24		Updated from POMI for Sept 23
1.12	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled to order repeat prescriptions	49.6%	TBC	31.03.24		Updated from POMI for Sept 23

1.13	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled to view care records	20.4%	TBC	31.03.24		Updated from POMI for Sept 23
1.14	Enable practices to have access to the four key NHS App functionalities (records, messages, apps, scripts): % patients enabled for at least one online service	TBC	TBC	31.03.24		Digital team unable to access this to report latest information
2. Modern General Practice Access						
	Transformation Support					
2.1	No. of practices participating in INTERMEDIATE support offer:	30	No national target set for ICB	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.
2.2	No. of practices participating in INTENSIVE support offer:	16	No national target set for ICB	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.
2.3	Total Number of Practices participating in national support offers:	46	63	31.03.25		63 is ICB "fair share" of national available resource.
2.4	No. of practices at Modern General Practice Access Model:					This will be collated based on the national definitions by the next board update.
	Transition and Cover Support (Average of £13.5k for those needing support)					
2.5	Number of Practices identified as receiving Transition cover 23/24	0	No national target	31.03.25		Places working with practices to identify early cohorts for support. No funding drawn down as yet as it is provided on a reimbursement basis.
	Nominations and Allocations to Care Navigator Training					
2.6	How many practices have identified 1 x person for the national training programme?	146	No national target set for ICB	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.

2.7	How many practices have identified 6 x persons for the C&M local training programme ?	220	No national target set for ICB	31.03.25		Practice participation is voluntary; ICB continues to encourage uptake at regular Place Forums.
2.8	How many PCNs have identified digital and transformation leads?	36	No national target set for ICB	31.03.25		PCN participation is voluntary; ICB continues to encourage uptake at regular Place Forums.
	Digital Telephony					
2.9	Number of Practices transitioned to cloud-based telephony	0	36	31.03.24		All practices actively working with National Commercial & Procurement hub. Contracts must be signed by 15th December 2023 - 1 signed currently
2.10	Number of evergreen practices transitioned to cloud-based telephony	0	5	31.03.24		All practices actively working with National Commercial & Procurement hub
3. Building Capacity						
3.1	ARRS - Number of ARRS WTE and which roles	1060	see line 39	31.03.24		Additional WTE roles
3.2	Additional GPs recruited in year (numbers are headcount GPs)	1836	1868	31.3.24		using national ambition 'extra 6000 GPs by 23/24'
3.3	DPC Staff our share of 26,000 national ambition by 31.3.204	1,453	759	31.3.24		figure is number of roles' DPC direct patient care staff
3.4	GP Mentors	20	25	31.3.24		
3.5	Fellowships	140	103	31.3.24		
3.6	UNDERGRAD MED SCHOOL PLACES: NW Baseline – 900 approx. NW increase 100 by 2025, 375 by 2028 and 1000+ by 2031					NHSE to confirm this
3.7	Number of GPs on National Retention Scheme	30				https://www.england.nhs.uk/gp/the-best-place-to-work/retaining-the-current-medical-workforce/retained-doctors/
3.8	Training Practices - increase number	210		24/25		
3.9	Practice Nurse HC total	699	TBC	TBC	TBC	Target TBC
3.10	Vacancies GP					Not currently collected - 24/25 ambition

3.11	Vacancies supported / filled by MIAA offer 23/24	92				
3.12	No. of **additional** appointments	730,000	1.8m	Mar-24		Using planning guidance assumptions (60k under currently)
3.13	Face to face appointments (note Pre pandemic 2019 levels were 921k)	927k				Cumulative – as at September 2023
3.14	Telephone appointments (note pre pandemic 2019 levels were 150k)	336k				Cumulative – as at September 2023
3.15	On line appointments (note pre pandemic 2019 levels were 2k)	34k				Cumulative – as at September 2023
3.16	Deliver on same day appointments - No.of GPs					Target/Data source TBA
3.17	Deliver on appointment within 2 weeks - No. of appointments at lower threshold	85.50%	90%	Mar-24		The National IIF ask is 85% (Lower Threshold) and 90% (Upper Threshold) of appoint-ments to take place within 2 weeks of booking.
3.18	Deliver on appointments within 2 weeks - number of practices delivering on lower threshold	216	430	Mar-24		Out of 350
3.19	Practices with GPAD enabled	100%	100%	Aug-23		NHSE supplied data
3.20	PCNs – GPAD Enabled	48	34	Aug-23		Note - GPAD enabled but full PCN data is still a challenge as different appt book/system so not all available data may be captured at the moment.
3.21	PCNs – GPAD reviewed	48	33	Dec-23		See note above
3.22	**well being** - number of staff who have access offers	40				offer end in March 24
3.23	ADULT NURSE TRG PLACES: NW Baseline – 3350 approx. NW increase 250 by 2025, 1200 by 2028 and 2700					TBC from 24/25
3.24	ADVANCED PRACTITIONERS: ACP Baseline NW – 450 approx. – increases of about 100.					TBC from 24/25
3.25	CLINICAL APPRENTICESHIPS: NW Baseline – About 1 in 10, by 2030 aim 1 in 6					TBC from 24/25
3.26	MED DEGREE APPRENTICESHIPS: At least three providers in the NW interested					TBC from 24/25
3.27	PHARMACIST UNDERGRADS: Working with Jane Brown (NW Pharmacy Dean on numbers).					TBC from 24/25
4. Cutting Bureaucracy						
4.1	Onward referalls C2C	44,677	TBC	01.03.24		Year to date (April – September) there have been 44,677 C2C referrals, using Outpatient First Attends as a proxy. This equates to 6.5% of referral to Acute Sec-ondary Care. This number of C2C refer-rals is an increase on the last 3 years.
4.2	Number of fit notes, discharge letters issued by 2ndc	TBC	TBC	01.03.24		Initial scoping has identified a number of interdependencies related to this

4.3	Call and recall	TBC	TBC	01.03.24		requirement. Further clinical and technical infrastructure insight required to inform next steps. Potential for workshop involving all stakeholders to map current position and future state. Update will be in March 24 ICB Board papers.
4.4	Clear points of contact: ICBs should ensure providers establish single routes for general practice and secondary care teams to communicate rapidly: e.g., single outpatient department email for GP practices or primary care liaison officers in secondary care.	TBC	17 NHS Trusts	30.11.23		Initial scoping has identified a number of interdependencies related to this requirement. Further clinical and technical infrastructure insight required to inform next steps. Potential for workshop involving all stakeholders to map current position and future state.
4.5	Roll out online patients registration service to up to 2,000 Nationally practices by December 2023	31.6%	32%	31.12.23		C&M fair share target is 32%. Good progress been made within the last month - position 22% @ 14/9/23, current position @ 25/10/23 31.6% (112 practices). NHSE national team attending Digital Primary Care Board meeting 8th November to share examples of good practice amongst C&M practices.
4.6	Reduce requests for GPs to provide medical evidence for other government					This is a national task / awaiting further guidance.
4.7	To establish primary-secondary care interface forums and report progress on AoMRC key asks	6	6	TBC		We have a target of 6 PSCI groups and we have 6. They will in due course report on the AoMRC recommendations. Each PSCI group is working on establishing the communications asked for so still amber.
5. OTHER AREAS						
	Communications					
5.1	% of population that understand digital access routes					This may be being collated regionally
5.2	% of population understand community pharmacy					This may be being collated regionally
5.3	% of population confident in MDT and triage					This may be being collated regionally
	Integrated System related					
5.4	Calls to 111 (that could have been managed in primary care)					To be confirmed for 24/25
	Other					
5.5	National GP Patient Survey – overall experience 'good' returns to previous levels	72%	84%	July survey	TBC	For reporting in 24/25 survey

5.6	Friends and Family Test 'Good'	90.1%	90%	Mar-24		Note - some practices not submitting data/being followed up
5.7	Place improvement plan in place and agreed	9	9	20.10.23		Complete

Appendix 14 – Investment in Access and Recovery

SDF and Primary Care Access Recovery Funding	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral	Central - C&M ICB	Total
GP Practice Fellowships										1,667,000	**1,667,000**
Supporting GP Mentors										392,000	**392,000**
GP IT and Resilience	84,609	42,056	29,437	40,994	136,521	63,817	45,755	44,929	80,210		**568,328**
C&M GP Retention	40,166	40,166	36,666	10,041	40,166	40,166	36,666	36,666	40,166		**320,869**
Top Slice for Digital Funding										600,000	**600,000**
Transformation Funding Pool	460,348	190,836	160,161	223,042	742,791	347,221	248,945	244,453	436,420		**3,054,216**
Leadership & Management	280,342	264,149	94,485	135,827	452,343	211,450	151,603	148,866	265,770		**2,004,835**
Total SDF 23/24	**865,466**	**537,207**	**320,749**	**409,904**	**1,371,821**	**662,654**	**482,969**	**474,914**	**822,566**	**2,659,000**	**8,607,248**
Capacity and Access Support Fund (CAP)	1,133,253	1,067,876	394,273	549,069	1,828,551	854,764	612,840	601,788	1,074,348		**8,116,762**
Capacity and Access and Improvement Payment (CAIP)	485,680	457,661	168,974	235,315	783,665	366,327	262,646	257,909	460,435		**3,478,612**

Transition Cover and Transition Support Funding										2,050,000	**2,050,000**
Cloud Based Telephony										1,178,000	**1,178,000**
ARRS Support	9,439,441	9,043,560	3,283,547	4,325,923	14,115,602	6,860,053	5,107,025	5,097,845	8,509,091		**65,782,087**
Pharmacy Offer (£TBC)											**0**
Primary Care Access Rovery Support Funding	**11,058,374**	**10,569,097**	**3,846,794**	**5,110,307**	**16,727,818**	**8,081,144**	**5,982,511**	**5,957,542**	**10,043,874**	**3,228,000**	**80,605,461**
Total Funding	**11,923,840**	**11,106,304**	**4,167,543**	**5,520,211**	**18,099,639**	**8,743,798**	**6,465,480**	**6,432,456**	**10,866,440**	**5,887,000**	**89,212,709**

NHS
Cheshire and Merseyside

Equality and Health Inequality Assessment Report (stage one).

NHS Cheshire & Merseyside ICB - Primary Care Access improvement plans-

Start Date:	13.09.23	
Equality and Inclusion Service Signature and Date:	Andy Woods Andrew lead EDI Manger – Communications and Empowerment Function NHSC&M	
Sign off should be in line with the relevant ICB's Operational Scheme of Delegation (*amend below as appropriate)		
***Place/ ICB Officer Signature and Date:**	Chris Leese Associate Director of primary Care NHSC&M.	
***Finish Date:**	10.11.23	
***Senior Manager Sign Off Signature and Date**	Ian Ashworth Director of Population Health NHSC&M 21.11.23	
***Committee Date:**	NHS Cheshire and Merseyside Board 30.11.2023	

1. Details of service / function:

Guidance Notes: Clearly identify the function & give details of relevant service provision and or commissioning milestones (review, specification change, consultation, procurement) and timescales.

Legal duties

NHS Cheshire and Merseyside (NHSC&M) ICB is subject to legal duties to give due regard or regard to addressing health inequalities and advancing equality of opportunity. These separate duties are the Public Sector Equality Duty (PSED), section 149 (1) of the Equality Act 2010 and the health inequalities duties set out as section 13G of the National Health Service Act 2006 as amended. This Equality and Health Inequalities Impact Assessment (EHIA) explains how NHSC&M has considered and addressed these 'equality duties' in developing the Primary Care improvement Plan.

Background and context- Primary Care Improvement Plan

Following the publication of the Delivery plan for recovering access to primary care (https://www.england.nhs.uk/publication/delivery-plan-for-recovering-accessto-primary-care/) in May 2023, Integrated Care Boards (ICBs) are required to develop system-level access improvement plans. This aligns with their leadership responsibilities and accountability for commissioning general practice services and delivery as well as, from April 2023, community pharmacy, dental and optometry services.

Recovering Access to Primary Care -Key National Ambitions

- National Guidance [1]document provides the direction for recovering access to primary care.
- Aimed at General Practice but with some Community Pharmacy actions due out of ongoing national negotiations.
- Aim to tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice.
- Enabling patients to know how their needs will be met when they contact their practice.
  A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022*.
- ICBs have to ensure their system level plans are submitted to Boards in October/November using the referenced guidance document[2].
- The guidance focuses on four areas to alleviate pressure and support general practice further. These are:

  - Empowering Patients
  - Implementing Modern General Practice Access
  - Building Capacity
  - Cutting bureaucracy

The purpose of the EHIA document is to address the national NHS England guidance, which requires NHS Cheshire & Merseyside ICB (NHSC&M) to look at:

- How the recovery plan supports equality, diversity, and inclusion?
- How does the ICB intend to support practices in areas of deprivation and practices disproportionally affected by health inequalities?

This iteration of EHIA (stage one, November 2023) is part of an ongoing process of ensuring EDI and tackling health inequalities are aligned to the improvement plan and aims to support system wide and local Place commissioners and PCNs to:

- **Consider the issues and barriers to access and poorer outcomes in relation to the four focus areas to alleviate pressure** (access and engagement; structures and processes of care; patient experiences; staff training and development).

[1] https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/
[2] https://www.england.nhs.uk/long-read/primary-care-access-improvement-plans-briefing-note-for-system-level-plans/

- **Define the group(s) experiencing inequity** and discrimination in relation to primary care access and recovery. Understand the characteristics and needs of people in inclusion health groups.

The EHIA will then be shared with Place and PCN leads and used to inform updated plans due in February /March 2024 (in line with governance and plan implementation milestones).

Key mitigation/ actions have been outlined in sections five (differential table) and section seven to support further development of plans around EDI and addressing HI and supporting practices in deprived areas. With a range of initial Stage 1 recommendations described in section ten for considerations.

Current Place submissions can be viewed in Appendix A.

To support how NHSC&M embeds EDI and HI actions and approaches within the improvement plans we are utilising the FAIRSTEPS [3] and EQUALISE [4]studies, which provides an evidence-informed framework to guide the commission, design and delivery of interventions in primary care, to address health inequities involving four steps.

Taking this approach will bring about meaningful and incremental changes that support recovery and access to primary care.

2. <u>What is the legitimate aim of the service change / redesign/ improvement? Primary care recovery and improvement.</u>

a. <u>The region experiences significant Health Inequalities</u>

The Cheshire and Merseyside region is home to more than two and a half million people across nine boroughs. The region has areas of substantial wealth and substantial deprivation. Overall, a third (33%) of Cheshire and Merseyside population live in the most deprived 20% of neighbourhoods in England, with significant negative implications for health. The average Index of Multiple Deprivation score in Cheshire and Merseyside is 28.6 compared to 19.6 in England. The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England, Liverpool the third. Knowsley has the highest proportion of its population living in income deprived households in England (tied with Middlesborough), equating to one in four of all households. Liverpool has the fourth highest proportion, with 24% living in income deprived households. Even within the wealthier areas in the region, there is substantial deprivation and associated poor health – while 31% of neighbourhoods in Cheshire West and Chester are in the top two income deciles, compared to an England average of 20%, 16% of neighbourhoods in Cheshire West and Chester are in the lowest income deciles.
(All Together Fairer[5]).

[3] https://www.qmul.ac.uk/ceg/research/health-inequalities/building-equitable-primary-care/
[4] Building Equitable Primary Care | Cambridge Public Health
[5] All Together Fairer | Champs Public Health Collaborative

b. Equality, diversity and inclusion in Cheshire and Merseyside.

Through an equality and health inequality lens NHSC&M have mapped vulnerable communities across the Liverpool City Region and across Cheshire and Warrington. The analysis can be viewed in the following links.
https://www.ljmu.ac.uk/~/media/phi-reports/pdf/2021-03-vulnerable-groups-profile-liverpool-city-region
https://www.ljmu.ac.uk/-/media/phi-reports/pdf/2021-03-vulnerable-groups-profile-cheshire-and-warrington.pdf

People who share protected characteristics and people from health inclusion groups face significant barriers in relation to accessing primary care services and its imperative that action is taken to mitigate discrimination, advance equality of opportunity and address widening health inequalities.

c. The recovery and improvement plan for primary care are a significant priority nationally and across the sub region.

A step toward delivering the vision set out in the Fuller Report [6]Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022.*

3. Enablers to improve access and outcomes (primary Care improvement Plan)

The Primary Care improvement plans are a key opportunity to improve access, outcomes, and experience for patients across Cheshire and Merseyside.

Primary care already plays an essential role preventing ill health, discrimination and tackling health inequalities. The Fuller stocktake, identified three areas in which primary care is taking a more active role in creating healthy communities and reducing the incidence of ill health: by working with communities and a more effective use of data.

Primary care has an essential role to play in preventing ill health and tackling health inequalities, working in partnership with other system players to prevent ill health and manage long-term conditions. People in the most deprived areas of England develop multiple health conditions 10 years earlier than people in the least deprived areas. The incidence of multiple conditions is rising; without concerted, targeted responses in our

[6] NHS England » Next steps for integrating primary care: Fuller stocktake report

most deprived communities, progress on inequalities in healthy life expectancy will continue to stall.

To support improvements in primary care from an equality, inclusion and health inequality lens NHSC&M have a number of key enablers that can drive improvements in access and outcomes.

a. <u>NHSC&M Clinical and Care Constitution</u>

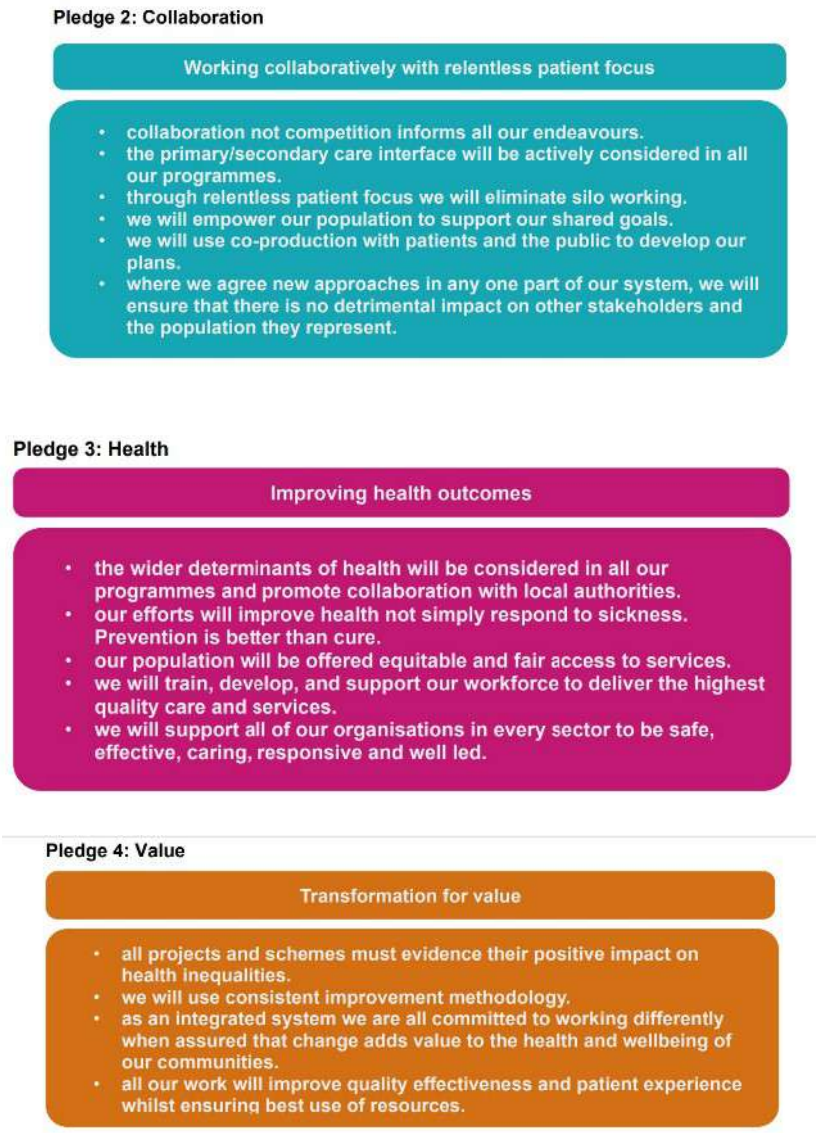
The NHSC&M adoption of the Clinical and Care Constitution made of four pledges (below) which frames agreements between NHSC&M clinicians and decision makers to guide future working including the improvements to primary care with a significant focus on reducing health inequalities.

The Constitution can be summarised as a plan on the slide below and we have identified a number of ways of working and important tools to support these pledges into action.

Pledge 1: Quality

Designing and delivering high quality resilient services through an evidence based approach

- all clinical recommendations will be evidence-based.
- we will make consistent use of intelligence to drive and evidence the impact of action.
- where there are multiple demands, prioritisation will be via a robust clinically led methodology based on the principle of proportionate universalism (Marmot Review 2010, 2020).
- we will routinely contribute to the evidence base via high quality research.



NHSC&M have also started to develop a programme of Deep End General Practices, whereby primary care staff who work in practices in the most socioeconomically deprived areas of Cheshire and Merseyside seek to collaborate and make positive changes to tackle localised health inequalities for their patients and communities. This evolving programme has two core aims;

» To address workforce, education, advocacy, and research related issues in deprived areas in order to improve primary care and address health inequalities.

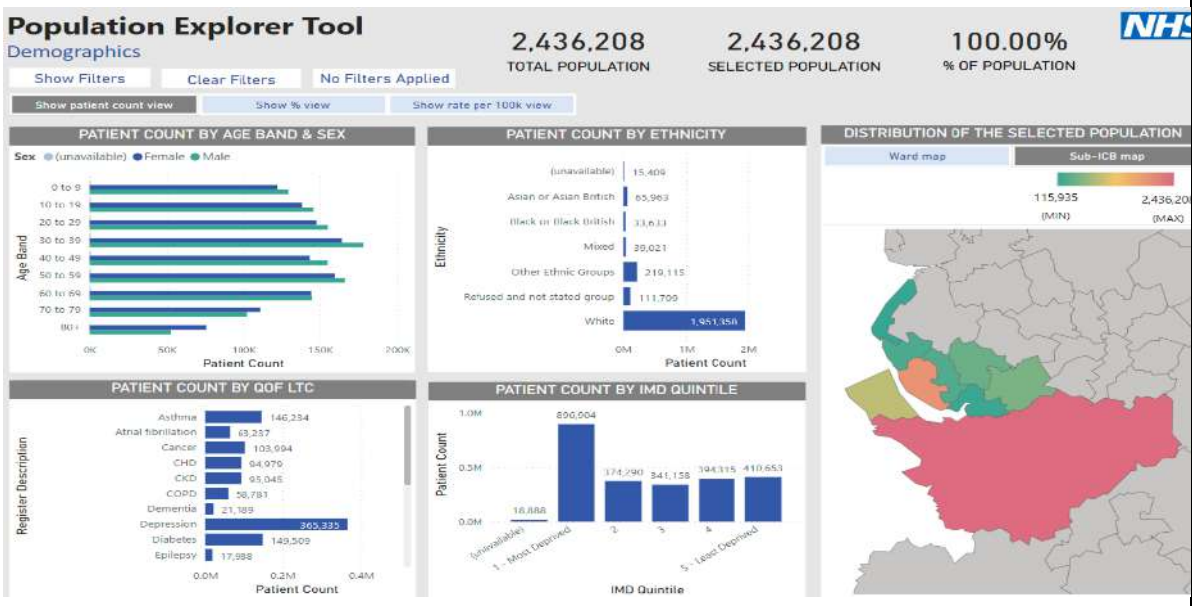
And,

» To promote a strong multidisciplinary focus in primary care and link with existing resources and services in the community.

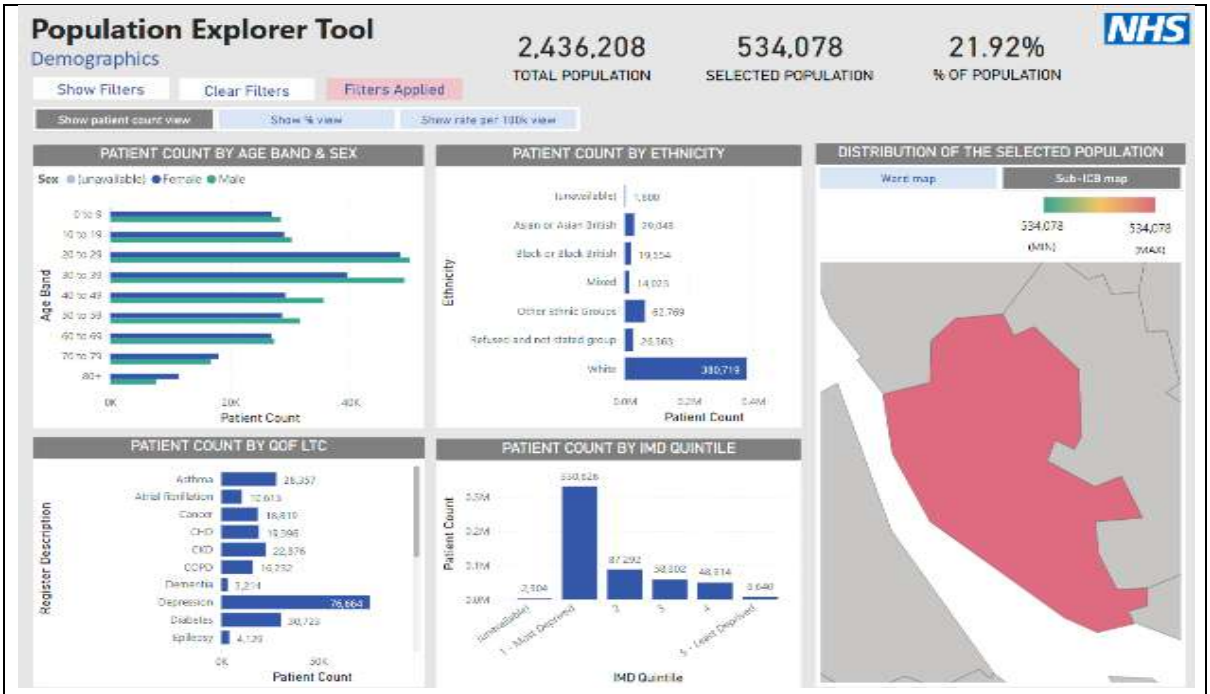
b. <u>Improving quality data and insight to understand need of specific communities and address health inequalities through Combined Intelligence for Population Health Action (CIPHA)</u>

The CIPHA data platform is a powerful tool that can be used to identify where best to focus work to tackle the wider social determinants of health and to reduce health inequalities. The slides below demonstrate how NHSC&M system wide and place commissioners and PCN's can use the tool to identify needs in their specific communities. It is essential that the tool is utilised at a system wide, place and local level to understand the populations being served, understand needs and address health inequalities.

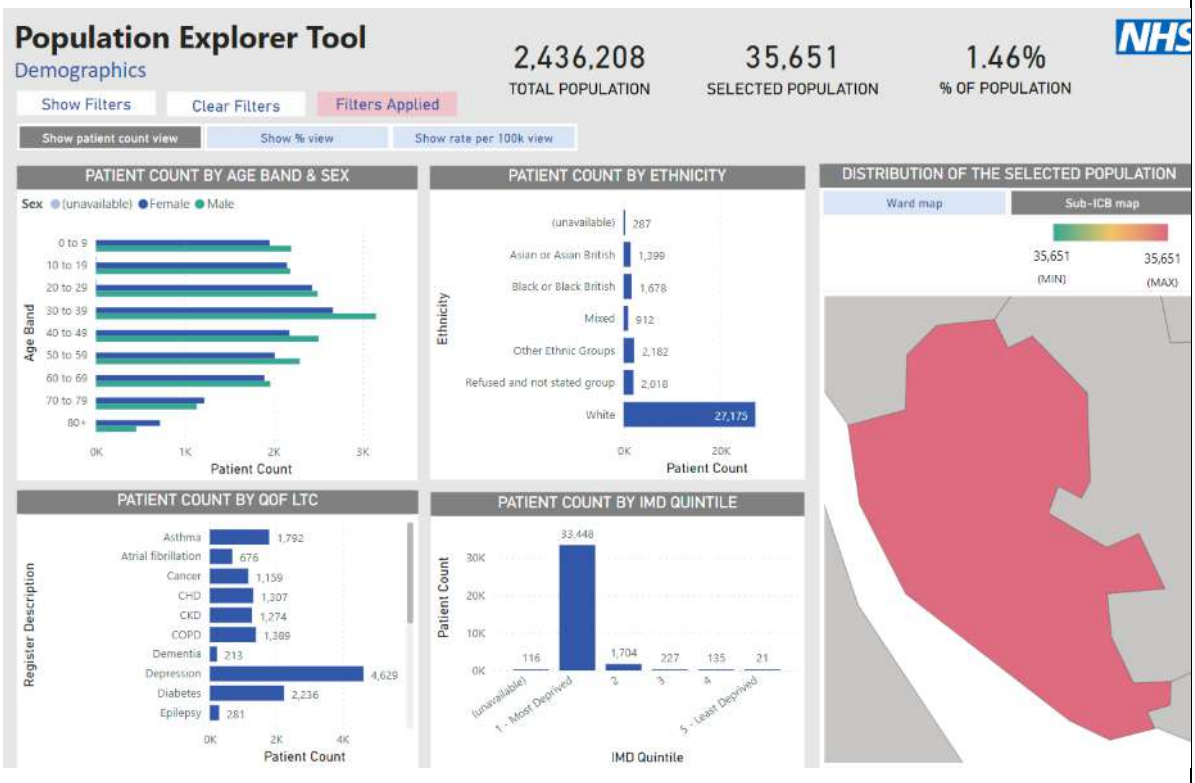
The following slides demonstrate CIPHA usage at system level across Cheshire and Merseyside and provide an example of how local areas can use the available data sources to inform any relevant service improvements to help reduce inequalities within their local communities and vulnerable population groups.



Slides below demonstrate CIPHA usage at Place level, for example Liverpool Place, below.



Slides below demonstrate CIPHA usage at PCN level, for example Anfield & Everton PCN



ICS Population Health

Enables benchmarking of Cheshire & Merseyside ICS, and geographies within, to inform service planning and delivery

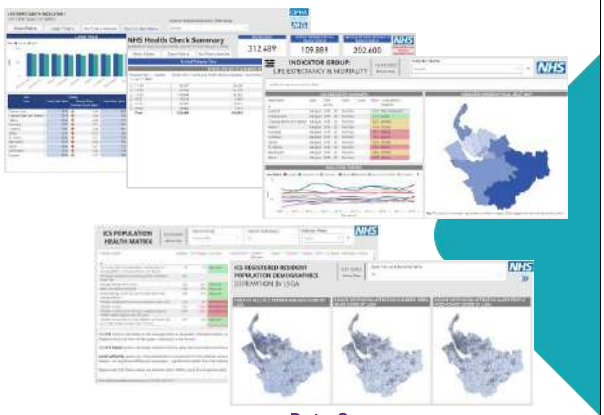
The ICS population health dashboard provides a high -level overview of the health of Cheshire & Merseyside GP -registered patients.

This includes performance relating to starting well, living well, aging well, health protection, marmot indicators and NHS health checks.

The dashboard benchmarks the ICS against National performance against a set of priorities.

Functionality

- Provides **demographic breakdown** of population including deprivation
- Provides **trend and geographic breakdown** of starting well, living well, aging well and health protection indicators
- Also includes **life expectancy and mortality** indicators
- **Benchmark the ICS** and local authorities against national performance for all indicators
- Includes granular breakdown of **NHS Health checks** done across the ICS
- Includes All Together Fairer (**Marmot**) indicators by Local Authority



Data Sources

Primary Care | Fingertips

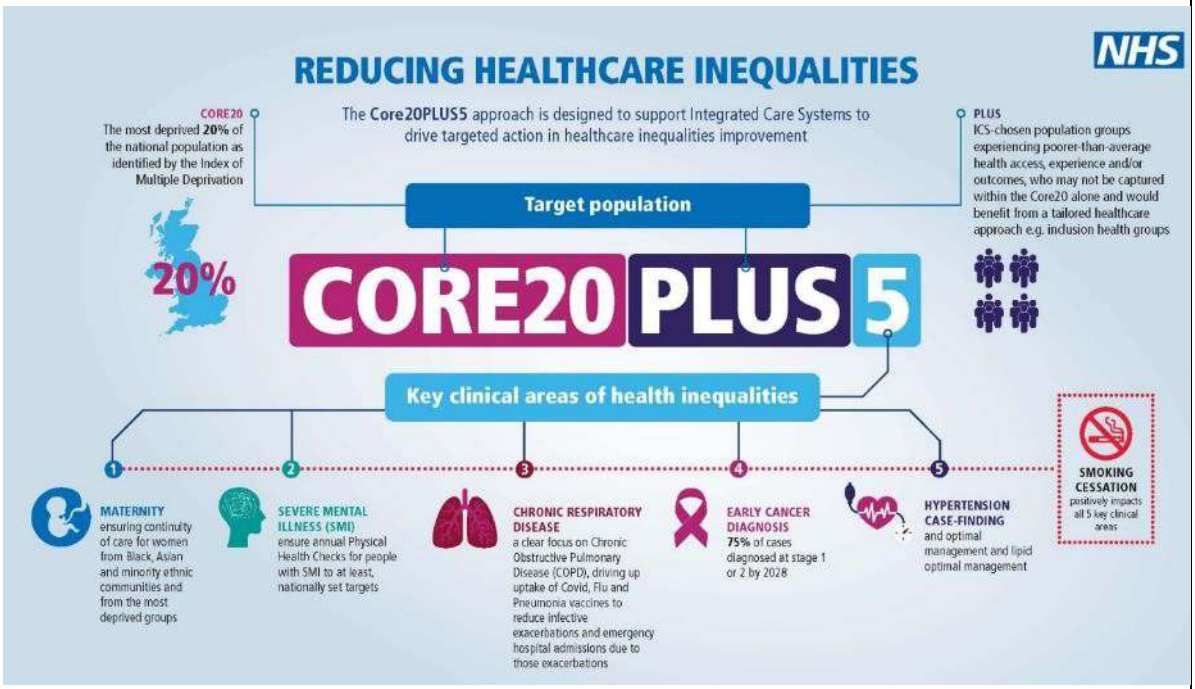
Available ***de-identified*** *for population health*

Link to dashboard here

c. NHSCore20PLUS5[7]

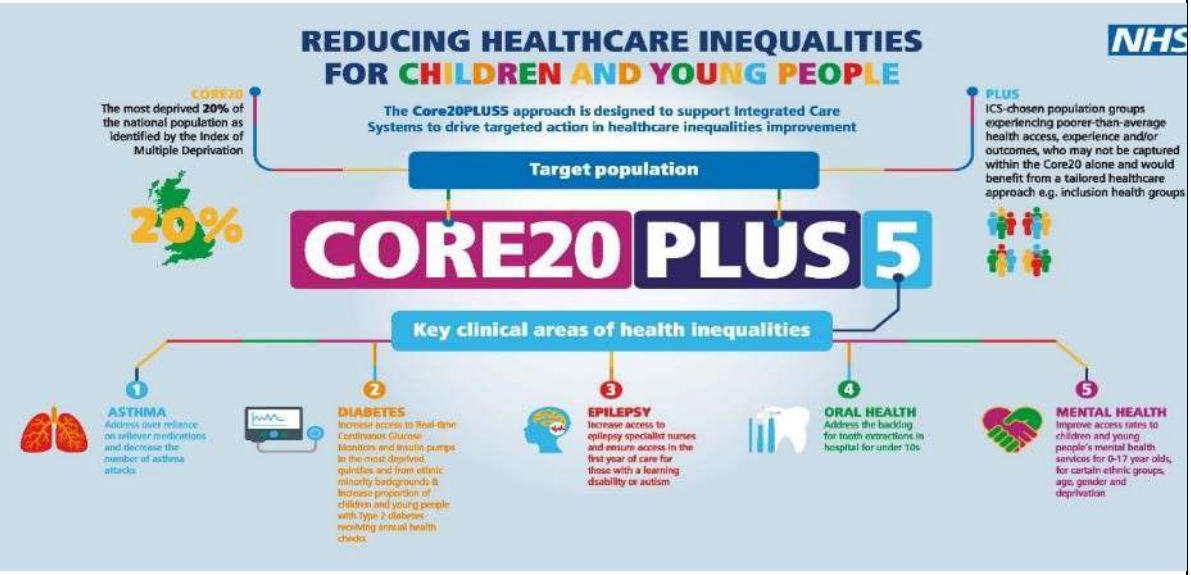
Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

The information below outlines the Core20PLUS5 approach for adults.



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

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people.



d. HEAT tool

Action on health inequalities requires improving the lives of those with the worst health outcomes, fastest. The Health Equity Assessment Tool (HEAT) aims to empower professionals across the health and the wider system landscape to do this. It supports the user to identify practical action in their work programme or service to address health inequalities and consequently improve health outcomes. HEAT is highly pertinent in the context of COVID-19, enabling colleagues in the system to consider which groups have been particularly affected by the pandemic, and mitigate any negative impacts in collaboration with other system partners.

It is essential that the tool is used at a system wide, Place and local level to understand need and develop clear actions to address health inequalities.

The NHSE Healthcare Public Health Team and OHID Northwest have also worked together to produce a HEAT Core20PLUS5 Toolkit. This toolkit contains an adapted version of the HEAT tool for each of the five clinical priority areas. It contains a series of prompts and signposting to relevant data sources. The toolkit is designed to support the identification of health inequities and actions to reduce inequalities.

https://www.gov.uk/government/publications/health-equity-assessment-tool-heat

4. Issues and barriers relevant to the protected characteristics and addressing health inequalities that must be addressed in PC improvement plans.

Guidance note: describe where there are potential disadvantages.

The following areas have been identified as priorities to tackle discrimination and health inequalities in relation to the primary care improvement plan. Each section outlines the concern and highlights the approach NHSC&M are currently undertaking to mitigate disadvantage and negative impact.

a. Digital exclusion/ Inclusion (Age- older people, Disabled people and people with sensory disabilities, sex, socio economic background, geographical- rural areas).

Digital exclusion refers to the lack of access, skills and capabilities needed to engage with devices or digital services that help people participate in society [8]. As more services are delivered online through websites, apps, email and SMS, and online becomes the preferred means of contact, digitally excluded people are in danger of being left behind. Digital inclusion is the approach for overcoming exclusion by addressing the barriers to opportunity, access, knowledge and skills for using technology.

There are commonly held assumptions about who is and isn't able to use and benefit from digitally enabled health and care services. Groups commonly considered digitally excluded or who experience poorer care through lack of digital services include older people, people with disabilities, ethnic minorities, people who are homeless, sex workers, people from Gypsy, Roma and Traveller communities, people living in rural areas, people from low socio-economic background and those with low digital or literacy skills.

Improving digital inclusion means that everyone is equally able to engage with all public services, including health and care services. Well-designed and inclusive digitally enabled services lead to improvements in convenience for staff and users, communication between staff and users, health outcomes, quality and experience of care. If services are not well designed or people are excluded, they are left feeling frustrated, angry and powerless to have the care they seek[9].

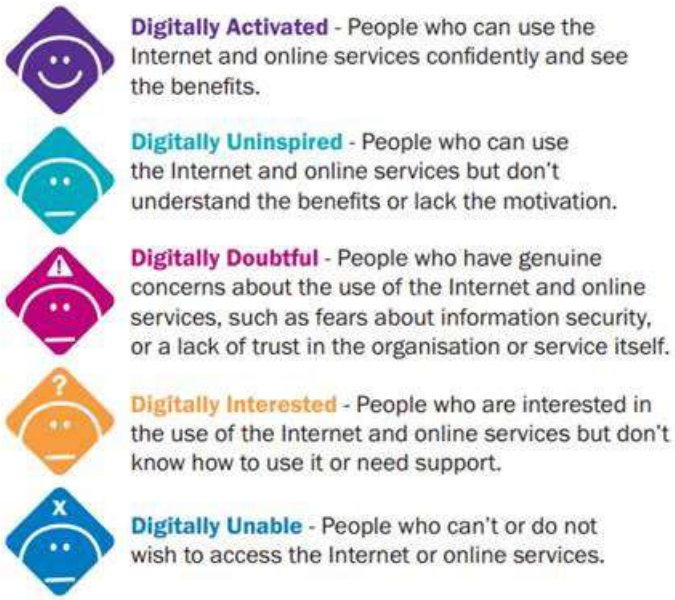
If policy and funding prioritise digital-first services without addressing the barriers to digital inclusion, it's highly likely to result in increasing inequalities by excluding people who are unable to benefit from digital services. This is because they will have reduced access to digital health services, resources and information and there may be no alternative routes.

Current NHSC&M approach to digital inclusion/ exclusion

C&M 'Give it a go' campaign (aiming to increase sentiment towards and adoption of online/digital health and care support)

In 2022, C&M commissioned [10] large scale market research project looking into the barriers to digital inclusion for the population of Cheshire and Merseyside. A key finding of this was that there are people using digital for other aspects of their life but who do not trust or see a benefit of using digital channels to support their health. As part of the NHSC&M Digital Inclusion workstream, a Digital Inclusion Approach and Toolkit was developed for NHSC&M, outlining the following target audiences when looking to increase and support digital adoption:

[8] phw.nhs.wales/publications/publications1/digital-technology-and-health-inequalities-a-scoping-review/
[9] Connection Lost (kingsfund.org.uk)
[10] barriers_digital_inclusion_cheshire_merseyside.pdf (cheshireandmerseyside.nhs.uk)



By supporting the middle three groups of people (Uninspired, Doubtful, Interested), we will free up much needed non digital routes to support for those who are Digitally Unable. Following the recommendations from the research, the ICB commissioned a social media campaign to increase sentiment towards digital NHS support. This comprised images that would highlight the benefits, the trust and the fact that there will always be a non-digital alternative. The Give it a go Landing page had more info if people were ready to 'give it a go'. Findings [11]on impact have will be published in November 2023.

The digital inclusion Heatmapping tool and digital inclusion impact assessment are vital resources that need to be utilised by Primary Care to support the NHSC&M approach[12].

Other useful resources [13]for PCN's and GPs include the top 10 tips for supporting digital inclusion, in which NHSC&M heatmapping tool is a case study in best practice.

b. **Accessible Information and communication** (Disability, low level of literacy)

All NHS primary care providers must meet the Accessible Information Standards (AIS)[14]-. AIS applies to people who use a service and have information or communication needs because of a:

- disability
- impairment
- sensory loss

Five steps of implementation that are required to be followed.

[11] barriers_digital_inclusion_cheshire_merseyside.pdf (cheshireandmerseyside.nhs.uk)
[12] Digital Inclusion in Cheshire and Merseyside - NHS Cheshire and Merseyside
[13] https://www.england.nhs.uk/long-read/supporting-digital-inclusion-in-general-practice-10-top-tips/
[14] NHS England » Accessible Information Standard

1. **Identify**- How does the service assess for disability related information or communication needs? How does the service find out if people have any of these needs? How does the service plan how it will meet those needs?
2. **Record-** How does the service record those identified needs clearly? What systems are in place as part of the assessment and care planning process?
3. **Flag**-How does the service highlight or flag people's information and communication needs in their records? This could be in paper or electronic records. The chosen method must make it possible for all staff to quickly and easily be aware of (and work to meet) those needs.
4. **Share**-Services sometimes need to share details of people's information and communication needs with other health and social care services. This means that other services can also respond to the person's information and communication needs.
5. **Meet**-How does the service make sure it meets people's needs? How does the service make sure that people receive information which they can access and understand? How does the service arrange communication support if people need it?

For example, patients and people using a service should:

- be able to contact (and be contacted by) services in accessible ways, such as via email, text message or Text Relay
- receive information and correspondence in formats they can read and understand. This could be, for example, in audio, braille, easy read or large print.
- be supported by a communication professional at appointments if needed to support conversation. This could be a British Sign Language interpreter.
- get support from health and care staff and organisations to communicate. This could include help to lip-read or use a hearing aid.
- **CQC [15]Monitoring and inspection** During inspections, we will look at these five steps by talking to staff and people using the service. Wherever possible, our inspectors will review the assessment and care plan of at least one person using the service who is affected by AIS. These will be selected as part of our usual inspection evidence-gathering. In addition to inspections, we will also ask you how you are meeting AIS through annual Provider Information Requests/Collections.
- **Primary medical and dental services**- In primary medical and dental services, we will look at how a practice is meeting AIS under R1.4 of person-centred care (healthcare services). In general practice, if the findings - relate to people with a learning disability, AIS may also be part of the population group section under "people whose circumstances make them vulnerable".

The experiences of people with communication needs in general practice are particularly stark – a recent review [16]of the Accessible Information Standard by Sign Health and Healthwatch England, highlighted that only half of this group had an accessible way to contact their GP. The review [17]also found that more than a third of health professionals have never received training about this standard, despite it being a legal requirement for all NHS organisations since 2016. Poor experiences trying to access primary care can

[15] https://www.cqc.org.uk/guidance-providers/meeting-accessible-information-standard
[16] Review of the NHS Accessible Information Standard - SignHealth
[17] https://www.healthwatch.co.uk/news/2022-02-23/accessible-information-standard-our-recommendations

lead to people giving up on engaging with health care, with all the risks that entails. (The Kings Fund- Tackling ableism in Health Care – the role Primary Care).

Website accessibility does not fall under AIS.

GP practices therefore need to ensure their websites are highly accessible and usable for all patients including:

- Compatibility with disabled people and people with impairments software
- Patients reading age by constituencies. In many areas across NHSC&M adult literacy levels average reading age is as low as 7 years of age and primary care services need to ensure these needs are accommodated.
- The embedded Adult Literacy slides gives an additional overview of this challenge GP's need to take account of in their written communications.

Adult Literacy levels.pptx

The NHS England guidance Creating a highly accessible and usable GP website[18] provides user-tested advice; a summary of the requirements for general practices; templates to make changes easy; and guidance on how and where to get specialist advice on testing and improving the usability, accessibility and inclusivity of websites. The GP website benchmarking and improvement tool [19]can help ICSs, PCNs and general practices audit and benchmark the usability of GP websites.

Approach of NHSC&M

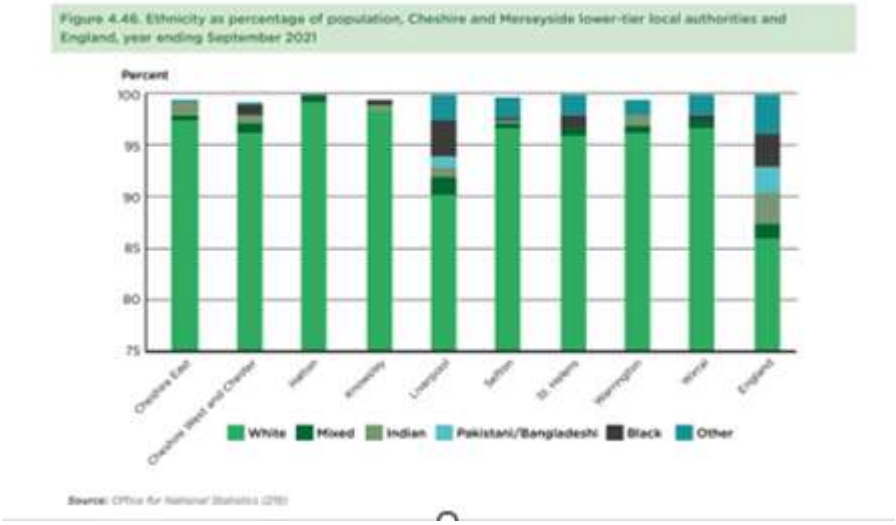
The accessible information standard is currently being reviewed by NHS England in response to the stark findings of the reports outlined above. NHSC&M EDI leads have begun to establish an Accessible Information Group, working closely with NHS and Local Authority colleagues at Sefton Place. The group are currently looking at collating a range of resources to support Primary Care and will begin to develop guidance documents. Once AIS has been the reviewed and launched by NHSE in the new year the group will begin to work with key stakeholders to support more effective implementation.

c. Tackling racism and race discrimination

Ethnic minority groups often experience worse outcomes in the social determinants of health, such as income, quality of employment and housing conditions – this relates to experiences of discrimination and exclusion. Ethnic minority populations are more likely to report being in poor health and have poor experiences using health services than the White British population. The COVID-19 pandemic has revealed the stark inequalities in

[18] Creating a highly accessible and usable GP website
[19] NHS England » GP website benchmarking and improvement tool

health and economic and social inequalities for many of the UK's ethnic minority communities. (All Together Fairer[20]).



Despite years of trying to address issues of racism in the NHS, there has only been a limited amount of success. We have seen many short-lived race equality initiatives designed to improve outcomes but unfortunately, with no long-lasting or significant effect. Strategies are often defeated by deep-rooted cultural norms.

There is no substantial evidence that any singular intervention will make a significant difference.

We understand that this lack of progress is complex and that this is an uncomfortable issue. To address the structural racism, we must all:

- Acknowledge the problem and take this seriously through demonstrable action.
- Improve our understanding of the depth and complexity of the issue.
- Ensure that commitment is followed up with positive and targeted action.
- Be prepared to be held accountable and hold others to account.
- Be prepared to face the consequence of our behaviour is unacceptable and causing harm to others.
- Create equality of opportunity for under-represented groups if in a position of power and privilege.

Centuries of racial discrimination have hard-wired inequality into our institutions and people's ways of thinking. These inequalities have ensured that White people get better chances in life. These issues are complex, and a sustainable strategy should be based on educating, supporting and challenging. (NHSE- Tackling racism and other types of discrimination[21]).

<u>Approach of the NHSC&M</u>

- To demonstrate this commitment to eliminating structures that support discriminatory practices and thereby improve health inequalities, Cheshire and Merseyside ICB has approved the ***implementation of the Northwest BAME***

[20] Cheshire-and-Merseyside-report_interactive-v6.pdf (champspublichealth.com)

[21] NHS England — Midlands » Tackling racism and other types of discrimination

***Assembly's Anti-Racism Framework*[22].** The Framework is a tool designed to support NHS organisations to become intentionally anti racist by tackling structural racism and discrimination through collaboration, reflective practice, and accountability. It recognises that this intention requires committing to undertaking a journey that involves the continuous review of progress and being intentional about actions for change. The NHSC&M Associate Director of EDI will facilitate a Primary Care Group to support the implementation of the framework.

- Another key issue to resolve is the need for comprehensive, good-quality data which is essential for enabling policymakers and health care professionals to identify the specific needs of different ethnic groups, respond with tailored strategies for addressing inequalities, discrimination and track the impact of these strategies.
- Language needs not being met- NHSC&M are currently exploring the development of a bilingual volunteer scheme to support people from racialised communities to access and register at primary care. To support booking appointments and support the development of non-clinical translated documents.

d. Women's and Children's Health and Maternity -The Equity & Equality Action Plan (EEAP)

1. Maternity

The Cheshire and Merseyside Women's Health and Maternity Programme (WHaM) facilitates the Cheshire and Merseyside Local Maternity and Neonatal System. The Equity & Equality Action Plan [23](EEAP) has been developed to improve equity for mothers, birthing people, and their babies and embed race equality for NHS staff in Maternity and Neonatal settings. The EEAP contains the detail to specifically address the following requirements: **Priority 4. Accelerate preventative programmes that engage those at greatest risk of poor health outcomes.**

- a Understand your population & co-produce interventions.
- b Action on maternal mortality, morbidity, and experience
- c Action on perinatal mortality and morbidity
- d Support for maternity and neonatal staff
- e Enablers

The COVID-19 pandemic highlighted the urgency of the need to prevent and manage ill health in groups that experience health inequalities, which was also outlined within the NHS Long Term Plan. To help achieve this, NHS England and NHS Improvement issued guidance as part of their phase 3 response to the Covid-19 pandemic, setting out eight urgent actions for tackling health inequalities. The 2021/22 priorities and operational planning guidance[24]: Implementation guidance asked systems to focus on five priority areas, distilled from the original eight actions:

[22] NHS England — North West » Anti Racist Framework
[23] https://www.improvingme.org.uk/media/1214/eeap-website-edit-2022.pdf

[24] www.england.nhs.uk/publication/implementation-guidance/

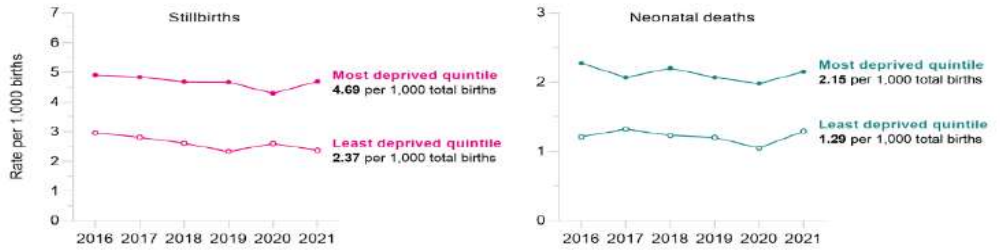
C&M LMNS & WHaM already have many programmes in place to reduce variation by tackling health inequalities which includes the NHS CORE20PLUS5 priority clinical areas. We have listened to women, birthing people, their families, carers (including unpaid) maternity, and neonatal staff with the aim to use the feedback and information to plan co-produced activity to design interventions which transform and:

- Improve equity and reduce health inequalities for mothers and babies from Black, Asian, Minority Ethnicity, Socially Deprived and Protected Characteristic Groups.
- Support the embedding of race equality for Maternity & Neonatal staff across C&M LMNS.

The EEAP specifically focuses on the C&M LMNS Equity & Equality Analysis (EEA) findings and the "All Together Fairer" Working as one to build a fairer, healthier Cheshire and Merseyside #AllTogetherFairerCM Strategy.

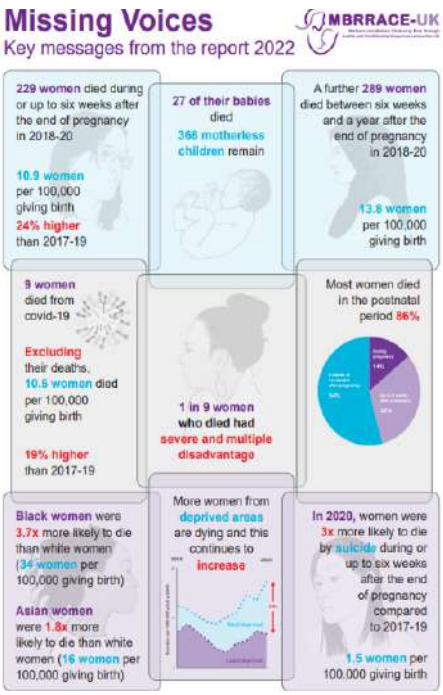
ⓘ There was a widening of inequalities in stillbirth rates by deprivation between 2020 and 2021.

Figure 4: Stillbirth and neonatal mortality rates by mothers' socio-economic deprivation quintile of residence: United Kingdom, for births in 2016 to 2021



ⓘ There was wide variation in stillbirth and neonatal mortality rates, even when deaths due to congenital anomalies were excluded.

Figure 2: Stabilised & adjusted stillbirth, neonatal and extended perinatal mortality rates for Trusts and Health Boards by comparator group: United Kingdom and Crown Dependencies, for births in 2021



2. Women's Health Strategy

The Cheshire and Merseyside Women's Health and Maternity Programme has facilitated the Cheshire and Merseyside Women's Health Strategy, in response to the government's first Women's Health Strategy for England [25]– August 2022.

While women in the UK on average live longer than men, women spend a significantly greater proportion of their lives in ill health and disability when compared with men. And while women make up 51% of the population, historically the health and care system has been designed by men for men.

This 'male as default' approach has been seen in:

- research and clinical trials
- education and training for healthcare professionals
- the design of healthcare policies and services

Currently, Gynaecology services have the longest waiting times in across C&M. There are currently 4 Special Interest Groups (SIG) set up to tackle some of the greatest needs within C&M.

- Menopause
- Cytology
- Endometriosis
- Paediatric and adolescent Gynaecology

- Life expectancy for women living in most deprived areas across C&M is **9.5 years less** than those living in the least deprived
- Females with a Learning Disability (LD) life expectancy is **18 years** less than those without LD
- **8.1%** of the C&M population are from Black, Asian, or Minority Ethnic backgrounds, with a **5th** recording **English as their second language**
- **44%** of the population in the Liverpool City Region live in the top **20%** most deprived areas in England
- **Liverpool City** has the highest numbers of **asylum seeking and refugee families** in the Northwest Region
- **26%** children (0-15 years) live in **poverty** as compared to the England average of **15.6%**
- **25%** of the female population claim employment allowance and identify as having a core disability

[25] Women's Health Strategy for England - GOV.UK (www.gov.uk)

e. **<u>Supporting Primary Care in areas of high deprivation</u>**
(Inverse care described in slide below).

GP practices in more deprived areas of England are relatively underfunded, under-doctored, and perform less well on a range of quality indicators compared with practices in wealthier areas.

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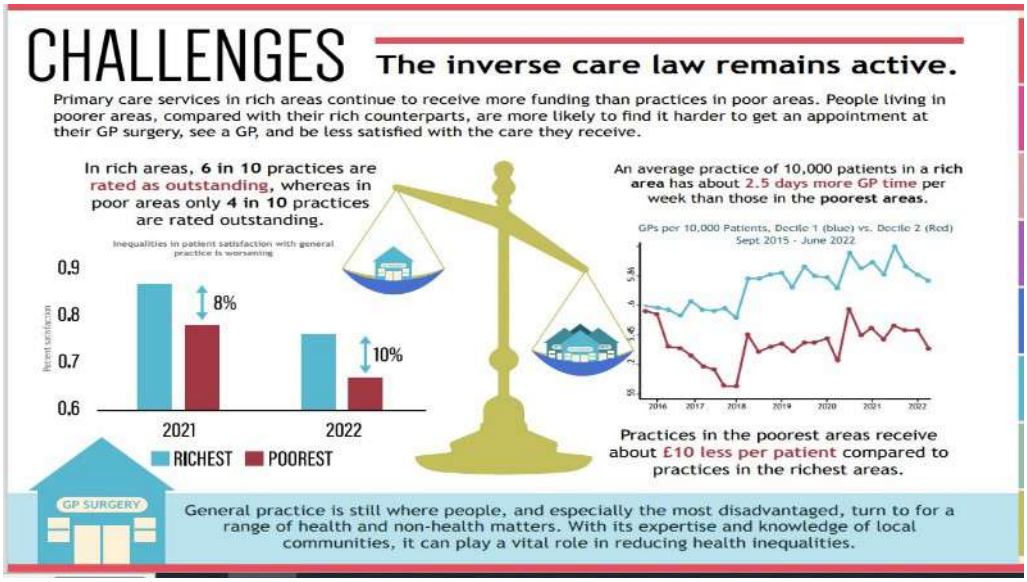


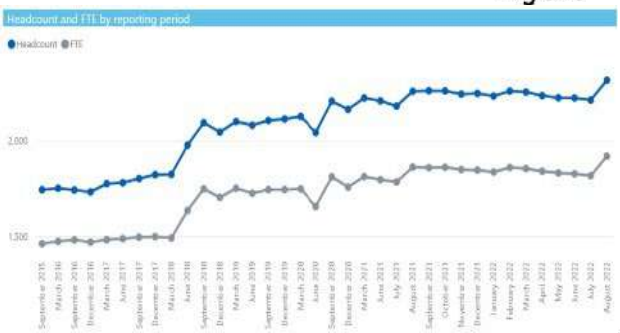
Cheshire and Merseyside General Practice Workforce Doctors

NHS England

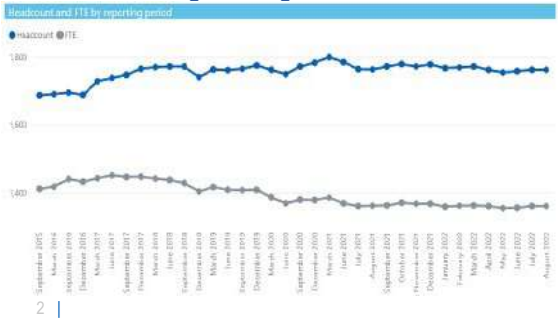
Overall headcount increase may plateau as trainee allocation achieved.
Limited growth seen when excluding training grades.
Wirral has the highest GP/100k patients in C&M
Knowsley has the lowest GP/100k patients in C&M

	Fellowship				Mentors
ICB Name	GPs year 1	GP year 2	Nurses year 1	Nurse year 2	Trained Mentors
NHS Cheshire And Merseyside ICB	32	9	3	0	19

All GP

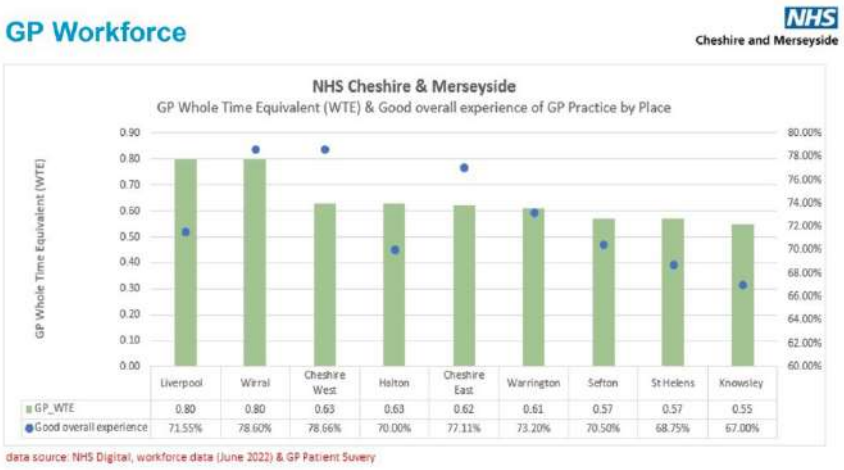


All GP Excluding Training Grades



All GPs (including GPs in Training Grades) FTE		Comparison to Baseline (Mar-19)				Comparison to Target (6k/Weighted Registered Population)			
Cheshire & Merseyside	Latest Mth Aug-22	Mar-19 Baseline	Latest Mth vs Mar-19 baseline	Trend from Mar-19 baseline	% Difference	Target* 2023/24	Variation from target against Aug-22	Movement towards target	% Difference
NHS Cheshire and Merseyside ICB - 27D Cheshire	535	480	55	↑	11.5%	557	-22	↓	-4.0%
NHS Cheshire and Merseyside ICB - 03F Halton	91	81	10	↑	12.0%	94	-4	↓	-3.8%
NHS Cheshire and Merseyside ICB - 01J Knowsley	103	82	21	↑	25.3%	99	4	↑	4.2%
NHS Cheshire and Merseyside ICB - 99A Liverpool	448	420	28	↑	6.6%	475	-27	↓	-5.6%
NHS Cheshire and Merseyside ICB - 01T South Sefton	98	100	-1	↓	-2.0%	116	-18	↓	-15.2%
NHS Cheshire and Merseyside ICB - 00V Southport and Formby	76	82	-6	↓	-7.1%	95	-18	↓	-19.4%
NHS Cheshire and Merseyside ICB - 01R St Helens	127	120	6	↑	5.3%	140	-13	↓	-9.6%
NHS Cheshire and Merseyside ICB - 02E Warrington	158	155	3	↑	1.8%	257	-19	↓	-12.0%
NHS Cheshire and Merseyside ICB - 12F Wirral	303	255	49	↑	19.1%	288	15	↑	5.3%
Cheshire & Merseyside	1,919	1,755	164	↑	9.3%	2,021	-102	↓	-5.0%
England	37,085	34,736	2,349	↑	6.8%	40,736	-3,651	↓	-9.0%

[26] (Nuffield Trust (2021) Digital and remote primary care: the inverse care law with a 21st century twist? Available from: https://www.nuffieldtrust.org.uk/news-item/digital-and-remote-primary-care-theinverse-care-law-with-a-21st-century-twist)



GP practices serving more populations in areas of high deprivation receive around 7% less funding per patient than those serving more affluent populations, NHSC&M will work with PCNs to make GP access equitable and specifically target areas where general practice is either under the greatest pressure and of poorest quality.

General practice should be funded using proportionate universalism whereby all universal services are adequately resourced and additional funding is provided to areas where the degree of need is higher. (Fuller report[27])

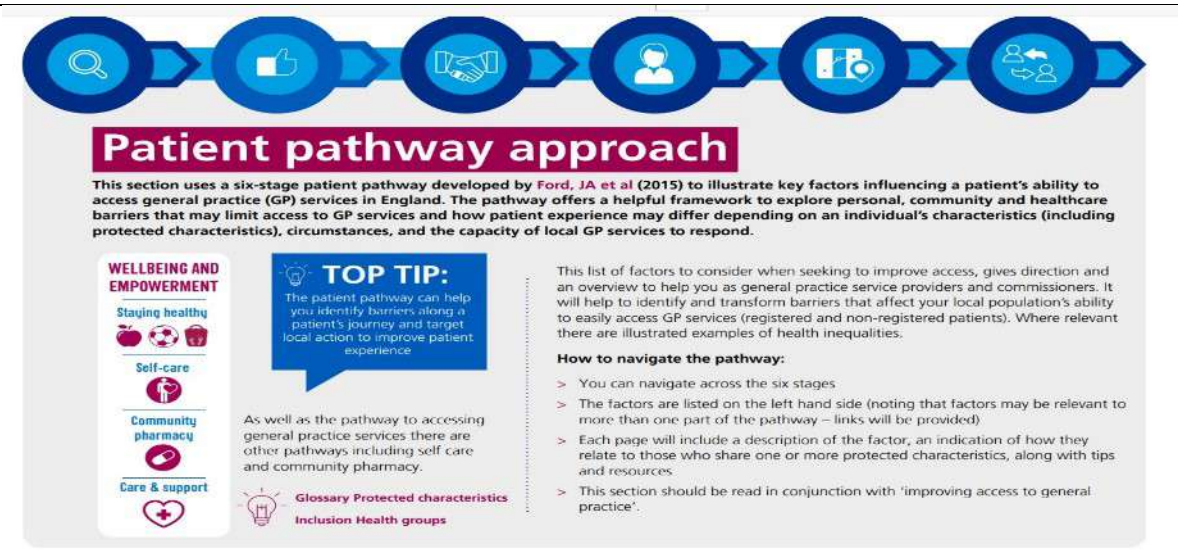
NHSC&M Considerations

- NHS C&M must maintain a system wide view of GP services and work with PCN's to make access equitable where there is the greatest need, pressure, and poorest quality.
- NHSC&M must maintain a system wide/ helicopter view on the cumulative impact of GP closures (including branch closures) in areas in the greatest priority need.
- NHSC&M to consider resource allocation in the areas of greatest priority need.

f. Barriers faced by patients at different points of the access pathway to primary care [28](Improving access for all: NHSE reducing inequalities in access to general practice services)

It is important that this document is used by commissioners and GP practices to understand the difficulties and disadvantages at play.

[27] NHS England » Next steps for integrating primary care: Fuller stocktake report
[28] https://www.england.nhs.uk/wp-content/uploads/2017/07/inequalities-resource-sep-2018.pdf)



Access across patient pathways from identifying a health need, making the decision to seek help, obtaining an appointment, interacting with primary care staff and clinicians have been identified in the differential table below, across all protected characteristics.

One key element of the pathway is Clinical care and decision making (see Clinical and care constitution above in section three).

GPs need to be aware of how their interactions contribute to, or have the potential to reduce, health inequalities. This could be facilitated through having a working knowledge of national and local demographics. If a GP is not aware about the health risk associated with particular groups, then health needs may not be identified. For example, cancer is diagnosed at a later stage in people from lower socio-economic groups, and screening participation is lower for colorectal, cervical and breast cancer. General practitioners and primary care health professionals are well placed to engage their patients. For example, mechanisms could exist to ensure that 'failure to attend' screening letters were discussed with patients, rather than simply being filed in the notes.

5. **<u>Differential table -</u> Define the group(s) experiencing inequity** and discrimination in relation to primary care access and recovery. Understand the characteristics and needs of people in inclusion health groups.

Protected Characteristic	Issue/ barrier	Mitigation
Age	Difficulty in obtaining an appointment due to: • old age and care and support needs • working arrangements • confidence and perceptions of young people	Plans to tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice must consider these issues and provide mitigations to access.

	• dependence on parents and carers for children. • Poverty – without good access to data & calls Older people are more likely to experience digital exclusion. Access for working age population. Healthwatch England found that many young adults conveyed a lack of confidence about accessing services, feeling that GPs did not listen fully or always believe what they had to say.	Access to face to face appointments and non-digital alternatives. Utilise the NHSC&M resources to support digital inclusion. Access to a range of appointment times including enhanced provision. Targeted cultural competency training, delivered by organisations who have experienced discrimination. Develop a repository of online training tools and resources.
Disability (you may need to discern types)	Getting a GP appointment is often a challenge at the moment, but for many disabled people, access to their GP has long been a problem. In the Kings Fund recent project exploring disabled people's experiences of involvement in health and care design, people told us about their experiences accessing health and care, as well as of involvement in service design. Some participants described the significant difference a GP could make those who made someone feel listened to and validated, compared with GPs who dismissed concerns or spoke to a person's personal assistants rather than directly to them. Information and communication need not being met. Professional perceptions – lack of knowledge about requirements of	Effective implementation of the Accessible information Standard. Targeted cultural competency training, accessed or delivered by organisations who have experienced discrimination. Develop a repository of online training tools and resources for reception staff and clinicians. Recommendations from the NHSC&M Accessible information working group. Development and resource a How to make information accessible guide from Primary Care. Consideration for future incentivised scheme / resource allocation to improve AIS and reasonable

	making reasonable adjustments. For example, longer appointment times. Appointment times that meet the needs of autistic people and avoid waiting rooms. Lack of knowledge around the needs of disabled people and people with impairments. Diagnostic overshadowing and its impact on clinical decision making. Digital exclusion Poorer experience of access and outcomes	adjustment compliance, once the national review has taken place. Involvement of disabled organisations to support PCNs and practices to improve access and outcomes. Targeted cultural competency training, accessed or delivered by organisations who have experienced discrimination. Access to face to face appointments. and non-digital alternatives. Utilise the NHSC&M resources to support digital inclusion. Commissioning an Autism register at GP level.
Gender reassignment	• Poor and varied experiences and outcomes of accessing GP services. • Patient safety issues- due to lack of understanding of the complexities of supporting trans patents. • Patient safety – disproportionate levels of suicide • Patient safety – significantly poorer mental ill health • Patient safety – sourcing hormone medication from third parties. • Direct and indirect discrimination resulting in significantly poor access, poor outcomes, significant health inequalities and significant variation of acre across GP services. • Lack of culturally competent services.	Transformation Directors to consider plans to implement the Sefton Place GPwI service incrementally over a two-to-three-year period. See EIS attached.  2022-2023 EIA Template NHS C&M 1 Or develop an alternative approach urgently.

	• Not access appropriate screening and health checks, resulting in poor outcomes	
Marriage and Civil Partnership	N/A	
Pregnancy and maternity	Babies born in the most deprived areas are at an 80% higher risk of stillbirth and neonatal death compared to those living in the least deprived areas. Women living in these areas are almost three times more likely to die themselves. Significantly poorer outcomes health inequalities for mothers and babies from Black, Asian, Minority Ethnicity, Socially Deprived and Protected Characteristic Groups <u>Intersectional</u> Ethnic disparities in maternal care <u>Race</u> The 2021 MBRRACE report also highlighted 'the stark disparity in maternal mortality rates between women from Black and Asian aggregated ethnic groups and White women – more than four times higher for Black women, two times higher for mixed ethnicity women and almost twice as high for Asian women. Apart from a slight drop in the maternal mortality rate for Black women, this bleak picture has not changed in over a decade.' (Page 1 MBRRACE-UK Foreword - Saving Lives, Improving Mothers' Care 2021).	Consideration of perinatal social prescriber service in Kirkby PCN Liverpool John Moore's University Public Health institute evaluation available on request. Develop a repository of training and resources with Women's and maternity EDI lead. Involvement of people lived experience Via Improving me WHaM Board. Consideration of perinatal social prescriber service in Kirkby PCN to rolled out across other areas in high priority need.
Race	Structural racism which impacts on people's experience, access and outcomes on physical and mental ill health. (Race is a social determinant	NHSC&M Primary care lead and EDI team to work with PCN's on implementation of the anti-racist framework/ approach.

	of health All together fairer CHAMPs) • Poorer health outcomes • Experience Poor access to services. • Lack of culturally competent services. • Biases in clinical decision making (for example pain) and responding to diversity. https://www.kingsfund.org.uk/publications/health-people-ethnic-minority-groups-england Racism in medicine | The BMJ Difficulty obtaining an appointment. Lack of good quality ethnicity data Digital exclusion Language needs not being met to register/ access primary care services.	NHSC&M Primary Care leads to work with PCNs to work closely and involve, racialised communities CDW group to support improved access and culturally competence. Explore future resource allocation to support people from racialised communities and their interactions with primary Care. Supporting primary care to embed themselves within communities and deliver population health priorities. For example, hypertension in racialised communities. Develop a repository or training and resources. **Training** programme /promotion page https://champspublichealth.com/race-equality-training-will-help-make-cheshire-and-merseyside-a-fairer-healthier-place-to-live/ Liverpool city Region staff can access race equality training. https://www.doctorsoftheworld.org.uk/safesurgeries/ Improve NHSC&M CIPHA ethnicity data (review Greater Manchester ICB approach). Access race equality foundation research on collecting ethnicity data. https://raceequalityfoundation.org.uk/press-release/report-on-improving-the-recording-of-ethnicity-in-health-published/Conduct an ethnicity data cleanse on CIPHA Access to face to face appointments and non-digital alternatives.

	Varied community support organisations across each Place.	Effective usage and monitoring of the T&I framework. By Place. Consider resource to support funding the development of the Cheshire and Merseyside bilingual community volunteer scheme.
Religion and belief	Compliance with medical treatment can be affected by health beliefs of an individual or a group. In addition, the ways in which ill health is defined can negatively influence help-seeking behaviour. Health behaviour is any activity undertaken, or not undertaken, by a person for the purposes of preventing disease or detecting it at a symptomatic stage. All cultural groups hold concepts related to health and illness. Although people might share the same ethnicity an individual's socioeconomic, educational, geographic, religious among other factors will shape cultural beliefs.	Targeted cultural competency training, accessed or delivered by organisations who have experienced discrimination. Targeted health literacy and health promotion campaigns
Sex	Digital exclusion Men self-electing not access primary care services. Nearly twice as many men as women visit their GP less than once a year. Women who experience domestic violence Sex workers Woman's health Biases in clinical decision making and responding to diversity.	Access to face to face appointments and non-digital alternatives. Mechanisms could exist to ensure that 'failure to attend' appointments /screening are actioned rather than simply being filed in the notes. Targeted cultural competency training, accessed or delivered by organisations who have experienced discrimination. Involvement of people lived with experience Via Improving me WHaM Board EDI lead.

Sexual orientation	Lack of cultural competency and understanding	Promote and monitor uptake of Navajo charter mark. PCNs to work with local LGB groups.
Whilst currently out of scope of Equality legislation it is also important to consider issues relating to socioeconomic status to ensure that any change proposal does not widen health inequalities. Socioeconomic status includes factors such as social exclusion and deprivation, including those associated with geographical distinctions (e.g. the North/South divide, urban versus rural). *Examples of groups to consider include:* *refugees and asylum seekers, migrant, unaccompanied child asylum seekers, looked-after children, homeless people, prisoners and young offenders, veterans*		
General Practice and Primary Care Networks General Practice has an essential role to play in addressing inclusion health, working in partnership with other system partners to prevent ill health and manage long-term conditions amongst socially excluded groups. Primary care networks (PCNs) are the building blocks of integrated neighbourhood teams, and one of the main delivery partners of local place-based partnerships. As part of the Tackling Neighbourhood Health Inequalities Designated Enhanced Service (DES) specification (part of the GP contract), many PCNs have a nominated health inequalities lead, facilitating the join-up and sharing of learning and practice with provider trust and ICB SROs for health inequalities. The Fuller Stocktake highlighted the critical role of primary care in both prevention and tackling health inequalities. Integrated neighbourhood teams can support this work by providing capacity to identify and reach out to communities who find it difficult to engage with health services, building on the learning from community outreach models of care that helped to increase uptake of the Covid-19 vaccination. https://www.england.nhs.uk/long-read/a-national-framework-for-nhs-action-on-inclusion-health/#appendix-a-selected-statistics-on-the-health-of-inclusion-health-groups		
Health inclusion groups Looked after and accommodated Homeless people or those who experience homelessness: people. • Those involved in the criminal justice system: offenders in	Experience higher levels of health inequalities. And poorer access to primary care services Under supply of services, were there is greatest priority need. Difficulty obtaining an appointment. Homeless people, and carers from refugee or new migrant communities are likely to have difficulty understanding health and social care systems and also may lack social networks. Individuals often have multiple and complex needs with a range of	**Committing Places and PCNs to action to inclusion Health principles** **Inclusion health principles** 1. Commit to action on inclusion health 2. Understand the characteristics and needs of people in inclusion health groups 3. Develop the workforce for inclusion health 4. Deliver integrated and accessible services for inclusion health 5. Demonstrate impact and improvement through action on inclusion health.

prison/on probation, ex-offenders. • People with addictions and substance misuse problems. People who have low incomes. People who have poor literacy. People living in deprived areas. Asylum seekers and refugees \Gypsy /Travellers	clinical and social challenges. The incidence of mental health problems amongst socially excluded people is very high. The homeless population has a greater number of missing and decayed teeth and fewer filled teeth with almost a third (32%) reporting dental pain The average age of death for patients experiencing homelessness and rough sleeping is 43 years for women and 45 years for men. Due to lack of knowledge of general practice services, ex-offenders on release from prison are part of the large proportion of people using the NHS's urgent healthcare services. Asylum seekers are 10-20 times more likely to suffer from PSTD compared with the general population due to war, violence and living in fear People in the criminal justice system experience rates of mental ill health three times higher compared to the general population Professional perceptions – lack of knowledge about requirements when registering patients. For example, those who are homeless or new migrants / asylum seekers. The rate of suicides in boys aged 15-17 who have been sentenced and remanded in custody are 18 times higher than the rate of suicides in boys in the general population. Over a quarter of children with parents who experience homelessness and rough sleeping feel depressed (26%) or socially isolated (28%) because of living in temporary accommodation.	Update stage 2 EHIA in partnership with clinical Place leads and GPs leading on health inequalities. Proactively improve data and insights on the needs of people in inclusion health in through CIPHER. Use data to inform updated improvement plans at NHSC&M level and PCN level. **Training for staff on inclusion health covers:** • What inclusion health is and how to address health inequalities? • How to develop and deliver culturally appropriate, compassionate, trauma - informed care. • Digital inclusion and health literacy • Understanding people's entitlement to services and feeling confident to support and refer individuals appropriately, • Understanding where to access information to support people from inclusion health groups, • How to use Personalised Care to enable people to have greater choice and control over their care and support, address wider determinants of health. • How the 'Making every contact count' (MECC) approach, can be adapted for inclusion health groups to encourage conversations about health at scale. Targeted cultural competency training, accessed or delivered by organisations who have experienced discrimination.

	Roma, Gypsy, and Traveller communities experience high infant mortality rates with 18% of women having experienced the death of a child. Language needs not being met to register/ access primary care services. Language needs not being met.	Develop a repository of online training tools and resources. Consider resource to support funding the development of the Cheshire and Merseyside bilingual community volunteer scheme.

6. Does this service go to the heart of enabling a protected characteristic to access health and wellbeing services?
Yes
7. Consultation
Guidance note: How have the groups and individuals been consulted with? What level of engagement took place? (If you have a consultation plan insert link or cut/paste highlights)
The stage one Equality and Health Inequality Assessment (EHIA) provides a clear steer on the communities and patients that need to be involved in co-designing approaches to improve access from health inclusion groups and people who share protected characteristics. Place leads and PCN's to develop Stakeholder analysis/ matrix. NHSC&M Communication & Empowerment function have developed the Cheshire and Merseyside's Primary Care Patient voice project that will begin by working with PCN leads across Cheshire and Merseyside to understand how they already engage patients via their constituent GP practices – and the wider community, where relevant – and where there might be opportunities to further develop this. We want to develop the skills and confidence of primary care teams to increase engagement and maximise the way the insights gathered are utilised. This will include raising awareness of the principles set out in the Working with People and Communities guidance. The project will be community-led, so that solutions are geared towards those who will be using them – PCNs. After carrying out our initial research, we will organise events which bring together PCN representatives, as well as members of the public already involved with practice participation. Ultimately, we will draw together the insights that emerge from this to produce a toolkit for PCNs. We aim to make sharing best practice around patient voice amongst PCNs second nature, and we envisage using a digital platform to share information on an ongoing basis. We want to empower PCNs to fully harness the benefits of patient involvement – learning from those who are already doing so – and ensure that arrangements enable input from a range of different voices. As a Marmot community, we want to use our learning to ensure that PCNs are fully engaged in this work and create opportunities to consider the role that patient voice can play in addressing health inequalities.

Racialised Community Development Steering Group.
Includes a range of organisations who support racialised communities across all Places in Cheshire and Merseyside will meet commissioners and PCN staff April 2024 to sense check plans and support implementing mitigations and improve access and experiences.

Jan – March 2024 Patient feedback – how do we know it's working – Commission additional work pending the GP Patient Survey 2024, at place/system level to understand the impact of these measures – to be discussed further with Health watch colleagues.

AIS group -Disability and impairments– post April 2024.

Engage with GP health inequality leads across NHSC&M

Places have a GP who takes a lead on inequalities. At C&M level associate MD for system improvement and quality and she does a lot on inequalities. For primary Care the associate MD.

8. Have you identified any key gaps in service or potential risks that need to be mitigated
Lack of resources to support improvements.

9. Is there evidence that the Public Sector Equality Duties (PSED) will be met (give details) Section 149: Public Sector Equality Duty (review all objectives and relevant sub sections)
PSED Objective 1: Eliminate discrimination, victimisation, harassment and any unlawful conduct that is prohibited under this act: (check specifically sections 19, 20 and 29)
A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022* The improvement plan aims to: • tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice. • Enabling patients to know how their needs will be met when they contact their practice. From EDI perspective this ambition represents a significant move to address an indirect discriminatory practice of a 'first come first served' basis (in trying to make an appointment on the day), which has been essentially pitting all patients in competition against each other on an unlevel playing field, in which people with disabilities and impairments, older people and people of working age and people with language needs experience significant disadvantages. The EHIA has highlighted a number of key issues and barriers that must be embedded into system wide, place and PCN plans moving forward.
PSED Objective 2: Advance Equality of opportunity. (check Objective 2 subsection 3 below and consider section 4)

A step toward delivering the vision set out in the Fuller Report Next Steps for Integrating Primary Care *"There are real signs of growing discontent with primary care – both from the public who use it and the professionals who work within it." Fuller Stocktake Report - May 2022*

The improvement plan aims to:

- tackle 'the 8AM rush' to ensure patients can receive same day support and guidance from their local practice.
- Enabling patients to know how their needs will be met when they contact their practice.

From EDI perspective this ambition represents a significant move to advance equality of opportunity and provide a more equitable approach in relation to access.

The EHIA has highlighted a number of key issues and barriers that must be embedded into system wide, place and PCN plans moving forward.

PSED Objective 2: Section 3. sub-section a) remove or minimise disadvantages suffered by people who share a relevant protected characteristic that are connected to that characteristic.

PSED Objective 2: Section 3. sub-section b) take steps to meet the needs of people who share a relevant protected characteristic that are different from the needs of people who do not share it

As above

PSED Objective 2: Section 3. sub-section c) encourage people who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such people is disproportionately low.

As above

PSED Objective 3: Foster good relations between persons who share a relevant protected characteristic and persons who do not share it. (Consider whether this is engaged. If engaged, consider how the project tackles prejudice and promotes understanding -between the protected characteristics)

Not engaged

Health Inequalities: Have regard to the need to reduce inequalities between patients in access to health services and the outcomes achieved (s.14T);

To be completed for stage two iteration.

10. Recommendation to Board

Guidance Note: will PSED be met?

The key purpose of the stage one EHIA report is to identify the issues and barriers to access and poorer outcomes and define the group(s) experiencing inequity and discrimination, within the context of primary care recovery and improvement.

This document will inform the second iteration of NHSC&M system wide / Place and PCN plans for February /March 2024, specifically around:

- How the recovery plan supports equality, diversity, and inclusion?
- How does the ICB intend to support practices in areas of deprivation and practices disproportionally affected by health inequalities?

Stage 1 EIA/HIA Recommendations:

1. To enable and support tackling discrimination and health inequality in relation to primary care NHSC&M has approved the Clinical and Care Constitution. The pledges within this need to be embedded into practise.
2. To enable and support tackling discrimination and health inequality in relation to primary care NHSC&M and PCN's must utilise CIPHA data to gain quality insight and support targeted interventions.
3. To enable and support tackling discrimination and health inequality in relation to primary care NHSC&M and PCN's must utilise HEAT tool to identify key priorities.
4. To work with GP health inequality leads and Place clinical leads on the stage 2 EHIA.
5. Workforce and cultural issues will be considered in the next iteration of the EHIA. To support workforce EDI and health inequality issues.
6. NHS C&M must maintain a system wide view of GP services and work with PCN's to make access equitable where there is the greatest need, pressure and poorest quality.
7. NHSC&M must maintain a system wide/ helicopter view on the cumulative impact of GP closures (including branch closures) in areas in the greatest priority need.
8. NHSC&M Primary care programme board to work in synergy with all relevant programme board across the system to highlight key areas that would improve primary care access. For example, to have an agenda item across programme boards to identify key access issues.
9. NHSC&M to consider resource allocation in the areas of greatest priority need.
10. Ensure CIPHA ethnicity data is reviewed, based on the activity in Greater Manchester.
11. Consider resource allocation for the following:

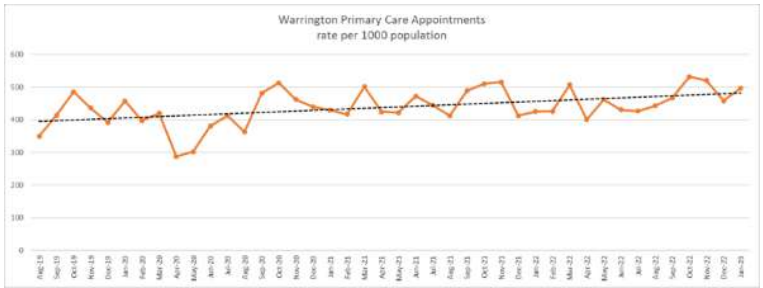
- Development of the bilingual volunteer scheme to support Primary Care
- Development of how to guide on developing accessible information in primary care.
- Develop a plan to improve AIS compliance in Primary care in preparation of the reviewed standard and CQC inspection.
- Consideration of rolling out perinatal prescribing service in Kirkby PCN to other areas of priority need.

Appendix A Place PC Improvement Plans submissions- first iteration.

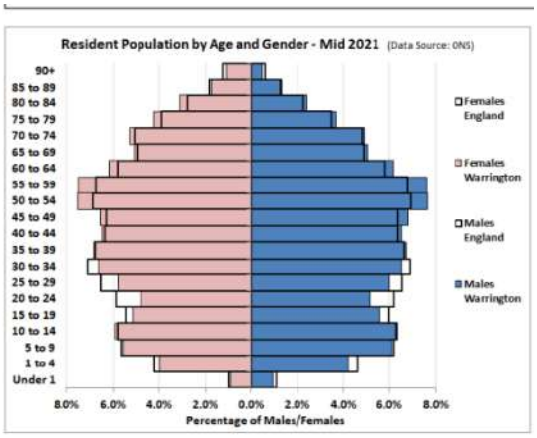
Place	• **How does the plan support equality, diversity, and inclusion?** • **How does it support practices in areas of deprivation and practices disproportionally affected by health inequalities?**
Cheshire East	Within Cheshire East there are areas of affluence but also areas of high deprivation, rural poverty and an aging population. 22% of the population are aged 65 or over and a further 27% aged 45 – 64 years. The Town of Crewe presents it's own unique challenges. Crewe is an area of high deprivation, high unemployment and greatest health inequalities as clearly highlighted the Cheshire East Tartan rug and the dark red column on the left hand side of the diagram below. Cheshire East has undertaken an analysis over the past 3 years against key indicators to understand where there may be access challenges or inequalities and it is clear that patients in areas of higher poverty and deprivation do record a lower level of satisfaction with accessing services. And residents who live Crewe are more likely to access A&E rather than a GP practice. Cheshire East Place recognizes this to be a fact and is engaged in conversation with Partners about how resources are distributed based on need, although this is at a very early stage. We have been able to utilize some funding last year to increase access to general practice though the Better Care Fund and winter pressures funding. An example of this being our Asylum Seeker and Refugee support programme to manage registrations and health checks of residents in hotels in Crewe and if funding is available there are plans drawn up to look at expanding access for high intensity users with a focus on children and young people. We are also at the beginning of a conversation around dentistry provision in Crewe and in the process of mapping provision and services as in ability to access dental services impacts both primary and secondary care locally. The Crewe Care Community Clinical Lead and Clinical Lead for Eaglebridge Health Centre sit on the improving equalities commission with Local Authority and Public Health and we are actively involved in the JSNA work that focuses in our health inequalities and areas of need.
Cheshire West	**Health inequalities:** Cheshire West has a number of PCNs that serve populations with significant deprivation for example Ellesmere Port, Chester South and Winsford. The Support Level Framework conversations have been prioritised for those areas with high levels of deprivation and those disproportionally affected by health inequalities. One of the benefits of PCNs is their ability to focus on the needs of their populations and use the ARRS funding to recruit staff roles that will be able to best meet these needs. The PCNs in Cheshire West have embraced this opportunity and have maximised the opportunities presented by the PCN DES to support the needs of their populations. The PCNs have also worked with the voluntary sector to think more broadly about how to meet the needs of their population to best effect.
Halton	5.1 How the place approach tackles HI / access. Halton is a deprived borough (with a few areas which are less deprived, relative to England as a whole (27th most deprived of 326) and over one quarter of its population live in areas classified in the 10% most deprived in England. Therefore, the place plan is a universal approach. Residents of more deprived areas are more likely to be in worse health, spend more of their lives in poor health, require greater access to healthcare and other services; however, they often do not have their greater needs met.

	Halton historically has a less diverse population; however, this is changing due to the increase of Asylum Seekers housed in the Daresbury IAC and dispersed accommodation. Awareness of the above continues to be considered at a Practice, PCN and ICB Place perspective. For example: 1. Runcorn PCN have aligned x2 ARRS Care Navigators to support the Daresbury IAC 2. Former CCG Social Prescribing Link Worker service model has been reviewed, improved and aligned to PCNs, maximising the additional support provided in practice to support patients in accessing support to address their social needs. 3. Former CCG First Contact Practitioner service has been reviewed and aligned to PCNs, with Runcorn PCN providing additional FCPs to support the high demand in the population. 4. Halton is a lead site for the NHSE led Community Connectors Pilot programme which aims to recruit and support local people, to become 'Connectors', who then act as a conduit to communication with their community, and to gather local intelligence on accessing services which can be used to inform change. The Connector Project has successfully recruited 10 Connectors to date. The Connectors are representative of geographical neighbourhoods such as Murdishaw and Ditton, but also of 'PLUS' communities such as Veterans, Care-leavers, LD Community and others. VCA are the designated VCFSE partner for the project and have developed good relationships with the target populations. Recent work has included: - Encouraging 30 veterans to discuss health, both physical and mental, this resulted in 30 blood pressure checks and additional support offered from the HIT Men's Suicide Prevention Officer. - Holding workshops in Murdishaw to understand "what it's like to live in Murdishaw and what is good health" - These conversations are currently being written up by VCA partners. - Audio interview with a Murdishaw Connector who provides great insight into some of the drivers of ill health and the things that can create health. - Discussions with Halton Housing about combining their Destination Upton project with our Connector work. Discussions with a group of residents from Ditton in regard to becoming Connectors and opening their own community room.
Knowsley	Residents of more deprived areas are more likely to be in worse health, spend more of their lives in poor health, require greater access to healthcare and other services; however, they often do not have their greater needs met. As set out in section 1 Knowsley as a borough is faced with a significant degree of deprivation but also has significant variation in relative levels of deprivation within localities. The Knowsley place partnership identified during 2022 that the Northwood in Kirkby, an area which experiences the worst health outcomes of any ward within Knowsley across a range of key indicators, should be the focus of a dedicated project to better understand the challenges faced in accessing services and being supported to make healthy lifestyle changes. Significant community led engagement has taken place to identify priorities and plans that will support sustainable improvements for the local population by ensuring that these plans are built from a community perspective. The intention is that learning from this process will inform and advise the rollout of a similar approach to locality based provision across Knowsley Primary Care access has been part of this process and the Knowsley ICB team have successfully appointed a dedicated GP clinical lead to focus on healthcare inequalities across the borough. To launch awareness of this area of work amongst peers the initial HE workplan will be shared with all GP practices at the Knowsley protected time event being held on Thursday 26th October.

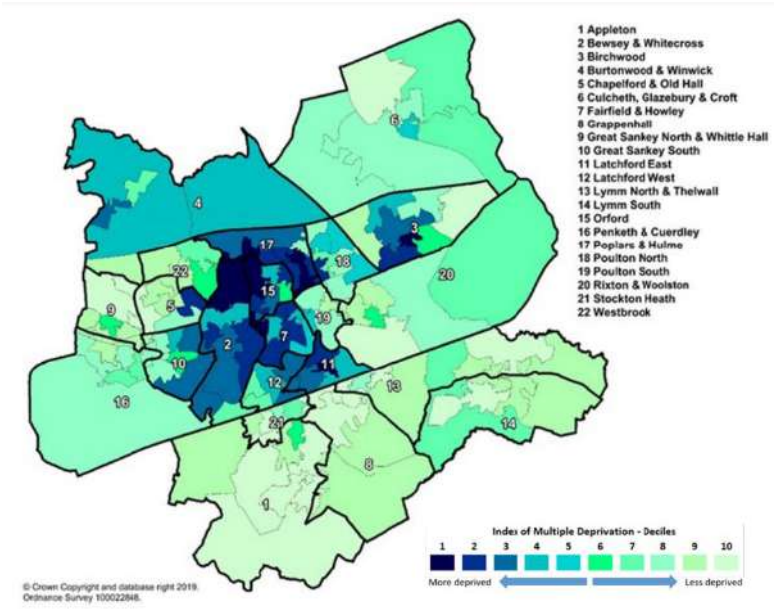
Liverpool	Liverpool is a vibrant city with a growing population and is a great place to live, work and socialise. Like all cities, Liverpool faces many challenges. A joint strategic needs assessment (JSNA) carried out in April 2023 highlighted the key health and wellbeing issues affecting our residents and has informed the priorities and the development of the delivery plans for Liverpool Place. In 2022, more than 4,700 people died in Liverpool and from these 1,914 people died young, equating to 4 out of 10 residents dying under the age of 75. Over 1,000 of these were considered preventable deaths. The main causes of premature mortality were cancer (32.6%), cardiovascular disease (21%), respiratory disease (11.9%), external causes (9.4%) and digestive diseases (8.7%). Growth in life expectancy has stagnated – it is now 80 years for female and 76 years for male, with a 12-year gap in life expectancy between deprived and least deprived wards in Liverpool. The greatest contributors to our gap in life expectancy in Liverpool are cardiovascular disease (CVD), cancer, and respiratory disease. From an NHS perspective, inequity in morbidity and multimorbidity is driving demand, with a 15-year difference in onset of multimorbidity between the most and least deprived. On average, men will spend 23% of their life in poor health and women 28% in poor health. Inequalities in the wider determinants, risks and behaviours are strongly associated with poorer outcomes. The principal risk factors associated with the main causes of death and ill health are smoking, high blood pressure, diet, obesity and alcohol. Liverpool has higher than national rates of these common, but modifiable, risk factors. The One Liverpool Integrated Business Plan 2023/24 embedded within this template sets out the wider plan and remit around the Population Health Segment workstreams, which are supported by the health inequalities leads via the Prevention and Health Inequalities Group (PHIG), which guides and targets work plans to greatest benefit of those in disadvantaged populations and with greatest need. Through this group subject matter experts provide leadership, advice and assurance for delivery of key preventative population level commissioned services and work with the Primary Care Networks (PCN) to target actions to reduce health inequalities in specific communities based on need. Each PCN has an Health Inequalities Lead. PCNs are starting to utilise the HEAT toolkit to document their plans and bring to the PHIG for review and input. In addition, there are a number of communities of practice established, particularly the PCN Tackling Health Inequalities forum between Liverpool Place and Liverpool PCNs, which supports PCNs in delivery of the PCN DES requirements. Additional funding, such as SDF, is being allocated on weighted population fair share allocations supporting health inequalities approaches. PCNs are being supported to access a range of other additional funding opportunities and commissioned offers for their communities, such as Health Equity Liverpool Project, commissioned by Public Health and delivered in partnership with Liverpool School of Tropical Medicine. This project is working with some of the PCNs to use local data, insight and develop resources to improve MMR uptake within specific local BAME communities until November 23 and applies a co-produced action research model to better understand communities with low uptake of screening and immunisation and implement rapid change. There is work ongoing in relation to SDF and new approaches around ADHD and to help address health inequalities.
Sefton	5.1 How the place approach tackles HI / access. • Health inequalities lead identified for each PCN. • S&F PCN working on complex lives. • SS PCN working on ACEs programme. • LD and SMI health checks to improve access.

	• Vaccination programmes Social Prescribers work with CVS/community group – support for most deprived areas
St. Helens	5.1 How the place approach tackles HI / access St Helens Place have 10 Clinical Leads who are reviewing data for each PCN to determine priorities and areas with the highest need. We have set up a Health Inequalities Commission, this has won a national MJ award and has wide representation from LA, Youth services, health, public health, YMCA, VCA and primary care. The role of the commission is to ensure that inequalities are driving our health and social care decisions and examples of schemes that have been developed are a COPD Winter Warmth scheme and food pantries in areas of highest need. All PCNs have Frailty teams who are supporting Enhanced Health in Care Home requirements under the DES and proactively visiting frail and Housebound patients. As part of the Development of Care Communities, we are looking at CIPHA data for enhanced case finding of the most vulnerable people/known to multiple services and high deprivation areas. Two priority groups have been identified: 18-30's, living in most deprived area, history of living in a care home and have Mental Health conditions and GP Frequent flyers known to multiple services. St Helens Place is working with the LA to provide technology enabled care which allows patients to be monitored remotely in their own home to prevent falls and deterioration of medical conditions. The LA will be leading a project to support our residents with Telehealth products that will proactively monitor various key indicators to predict the likelihood of a deterioration in condition or fall. It will be monitored by Contact Cares. The Digital Inclusion team will link to family hubs, consider a presence to support vulnerable families in utilising digital technology eg to register births and will Identify groups where there is inequity in digital access and outreach to those groups (community groups, asylum seekers, deprived communities etc). Cheshire and Wirral Partnership have a bus which supports St Helens one day a week with a focus on hard-to-reach areas where vaccination rates are low. This includes Covid, Flu vaccinations and Health checks.
Warrington	Challenges: • General Practice on average look after 9% more patients than in 2019. • Across Cheshire and Merseyside General Practice are carrying out 14% more appointments than in 2019. • The national GP appointments dataset shows that appointments across Warrington in have significantly increased in comparison to 2019/20  • 2022/23 saw over 1,189,184 appointments in general practice, averaging 99,098 per month. • The 4 winter months of 2022/2023 over 100k appointments were provided during each month (Oct/Nov/Jan/March). • Primary Care workforce is over stretched due to increasing patient demand and complexity availability, this affects how our patients can access Primary Care and may negatively impact patient safety.

- The workforce mix in Warrington shows relatively that Nursing staff are under-represented - as at July 2023 there were 238 FTE General Practice Nurses per 100,000 population vs a Cheshire and Merseyside average of 273.9 FTE General Practice Nurses per 100,000 population.
- The GP patient survey responses for Warrington demonstrate that despite the overall satisfaction improving year on year, access to Primary Care is the main priority to our patients, including waiting times in GP practices and accessing GP appointments.
- Locally, our patients tell us that they want greater coordination of their care and to only have to tell their story once, they also want access to a wider range of services within their GP practice.
- Our refreshed health and wellbeing strategy identifies that the key issues facing Warrington residents include, ongoing recovery from the pandemic, the impact of 'cost-of-living' pressures and the growing risk that poverty presents.
- The chart below shows that Warrington has an older population than England, this is also the same for all age bands over 40. However, the population of under 40s is lower than the national average.



- Future projections (based on 2018 mid-year estimates) show that Warrington's population is estimated to increase over the next 25 years by about an extra 8,860 people (+4%); an extra 4,460 males and 4,400 females.
- The map shows the spread of deprivation across Warrington. Areas shaded the darkest shades of blue, together make up Quintile 1, the most deprived quintile (darkest blue areas are the most extremely deprived). Quintile 1 areas tend to be in inner Warrington and the least deprived (quintile 5), shaded pale green, in outer Warrington.



	• The data point to a number of health inequalities in Warrington when compared to Cheshire and Merseyside: • Warrington has the highest prevalence of smoking at 15 years of age • Warrington has the highest rate of depression (151.1 per 1000) • Warrington has the highest rate of co-morbidities (84.3 per 1000) • Warrington has the highest rate of Osteoporosis (97.3 per 1000) • Warrington has the 2nd highest rate of complex long term conditions (95.5 per 1000) In Warrington all practices have access to Aristotle which is a Population Health Management (PHM) tool which can be used to risk stratify their patients, this is incentivised by a local LES
Wirral	Wirral Place has numerous challenges. Wirral is one of the 20% most deprived boroughs in England with areas of affluence alongside areas of high deprivation. Life expectancy for both men and women is lower than the England average, with variation upon where people live. Wirral also has an increased older population when compared to the national average. Mental health amongst adults is consistently higher than the national average. Similarly for children, Wirral is a significant outlier for indicators relating to mental health, self-harm, alcohol and substance misuse. 5.1 How the place approach tackles HI / access Practices supported to have accessible websites in place. Care navigation to support patients seeing the most suited practice MDT member and releasing capacity to see those based on clinical need and who may need longer appointment times. Neighbourhoods are in the pilot stage and are about to launch in 2 of the most deprived neighbourhoods in Wirral. The aim of which is to harness what exists in the community already and what means most to them which health will inevitably be a key factor.

Meeting of the Integrated Care Board of NHS Cheshire and Merseyside

30 November 2023

Joint Forward Plan/NHS Delivery Plan development and Reporting for 2024/2025

Agenda Item No: ICB/11/23/20

Responsible Director: Clare Watson Assistant Chief Executive

Joint Forward Plan/NHS Delivery Plan development and Reporting for 2024/2025

1. Purpose of the Report

1.1 This paper provides an update on the 23/24 Joint Forward Plan (JFP) and the current reporting arrangements for each of the core plan elements. It also outlines the proposed development of the 24/25 plan including the alignment of the Health and Care Partnership (HCP) Strategy with the All Together Fairer report, "Health equity and the social determinants of health in Cheshire and Merseyside".

2. Executive Summary

2.1 The initial JFP was developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount of content and detail in our plans. A summary Annual Delivery Plan (see Appendix 1) was developed that provided detail on the work taking place to progress the core JFP themes and outlining the priority programmes, enabler functions and system development work.

2.2 The JFP and the associated Annual Delivery Plan were approved by the Board in June 2023. This plan included details on the reporting routes for the core themes and enablers. In reporting on progress against the JFP, consideration needed to be given to how we avoid multiple reporting routes and duplication of effort. The approach taken has been that the existing sub-committees are supported to ensure that their current reporting adequately describes progress against the relevant sections of the JFP Annual Delivery Plan related to that sub-committee.

2.3 Whilst progress in delivering the 2023-24 delivery plan is being reported as generally positive, to ensure the Board has sight of progress going forward Board sub-committees will highlight key areas of progress in future sub-committee reports and key metrics have been included in the Integrated Performance Report.

2.4 Learning from the production of this first JFP and the associated Annual Delivery Plan, it is intended to align future iterations more closely with the final Health and Care Partnership (HCP) Strategy, when produced later this year. This approach has been identified following consistent feedback from Health and Wellbeing Boards and the Health and Care Partnership membership in relation to the plans appearing "NHS centric". The intention is to align the HCP Strategy with the All Together Fairer Report and to make the JFP more reflective of the plans of the whole health and care system.

2.5 Within this single overarching system JFP document NHS-specific plans would be outlined as one of the component sections. This approach would be implemented for the 2024-29 JFP which is to be published in March 2024.

2.6 Learning from 2023-24 we will ensure that we ensure all plans contain sufficient detail, including the identification of a set of clear metrics and delivery milestones. This will ensure that plans provide sufficient pace, stretch and are detailed and robust enough to provide the necessary challenge, providing the board with a clear, timely and accurate position on progress through the sub-committee governance.

3. Ask of the Integrated Care Board and Recommendations

3.1 The Board is asked to note:

3.2 the approach being taken in relation to the approach to monitoring delivery of the 2023-28 Joint Forward Plan and the current reporting routes through the Board sub-committees.

3.3 the proposed approach around the reframing and alignment of the HCP Strategy with “All Together Fairer” and the development of a refreshed JFP which will include an associated NHS Delivery Plan alongside our wider HCP and Place partnership plans.

4. Reasons for Recommendations

4.1 The 2023-28 JFP was developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount, and breadth, of content and detail in our plans. A summary Annual Delivery Plan was developed that provided detail on the work taking place to progress the core JFP themes and outlining the main outcomes from each of the priority programmes, enabler functions and system development work.

4.2 The JFP and the associated Annual Delivery Plan were approved by the Board in June 2023. This plan included details on the reporting routes for the core themes and enablers. In reporting on progress against the JFP, consideration needed to be given to how we avoid multiple reporting routes and duplication of effort. The proposal was that the existing sub-committees are supported to ensure that their current reporting adequately describes progress against the JFP Annual Delivery Plan.

4.3 Much of the current reporting against the milestones in the delivery plan presents a positive picture in relation to progress however, feedback and wider understanding indicate that future plans can be improved by ensuring all plans include clear metrics. This will ensure that plans provide sufficient stretch, pace and are detailed and robust enough to provide the necessary challenge. Details on the current reporting routes can be seen in Appendix 2.

4.4 Health and Wellbeing Boards and the Health and Care Partnership membership have fedback that both the HCP Strategy and JFP content is too centred on NHS activities and in response to this feedback the intention is to align the HCP Strategy with the All Together Fairer Report and to make the JFP more reflective of the plans of the whole health and care system.

4.5 Within this single overarching system JFP document NHS-specific plans would be outlined as one of the component sections alongside the delivery plan for the wider HCP priorities and our 9 Place partnership plans. This approach would be implemented for 2024-29 with the JFP to be published in March 2024.

4.6 Building further on the approach from this year the JFP and NHS Annual Delivery Plan will take a consistent approach for capturing delivery against plans with our existing sub-committees being responsible for ensuring plans identify a set of clear metrics. This will ensure that plans provide sufficient pace, stretch and are detailed and robust enough to provide the necessary challenge, providing the board with a clear, timely and accurate position on progress, including through our Integrated Performance Report and the revised ICB sub-committee reporting templates.

4.7 It is worthy to note that in support of this report the Board reporting template and sub-committee templates have been updated to ask report authors to provide greater visibility to the Board in relation to progress in delivering the Annual Delivery Plan.

5. Background

5.1 On 23rd December 2022 NHS England issued guidance to the NHS in relation to Operational Planning for 2023-24 and the production of Five-Year Joint Forward Plans (JFP). The two documents are relatively concise at 20 and 23 pages in length with a reduced number of national objectives included.

5.2 The JFP is a nationally mandated document which will combine the Cheshire and Merseyside delivery plans to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

5.3 Whilst the JFP covers a five-year timeframe, the document focuses more on the early part of this time period and includes the key actions identified in our plans for the year 2023-2024 which forms our Annual Delivery Plan (see Appendix 1)

6. Joint Forward Plan 2023-28 core themes and current reporting routes

6.1 The national requirements of a JFP include confirming how the statutory duties of an ICB are to be delivered, but additionally the JFP outlines how we will work together as partners it also includes content on the following:

- workforce (plans align with operational and financial plans)
- performance (trajectories/milestones aligned to NHS operational planning requirements and NHS Long Term Plan)
- digital/data (steps to increase digital maturity and reduce digital inequality in an integrated health and care system)
- estates (plans for improved health and care infrastructure aligned with financial and capital plan)
- procurement/supply chain (plans to deliver more efficient procurement and best value; can describe governance and supporting technology & infrastructure)
- population health management (prevention and personalised care models through data, address inequalities and model future demand and service/financial impacts to support redesign and integrated models
- system development (How the system will operate e.g., governance, emphasising the importance of Place partnerships, provider collaboratives, clinical and care professional leadership, system OD)
- supporting wider social and economic development (approach to social, environmental and economic factors impacting health and wellbeing e.g., Anchor Institute plans within communities).

6.2 The JFP also includes:

- a summary and link to a copy of each “Place Plan” reflecting the priorities agreed within each Place and aligned to the Place Health and Wellbeing Strategy. These plans are monitored by each of the respective Place Partnership arrangements.
- plans in relation to a wider range of local programmes that are described in the interim draft Cheshire and Merseyside Health and Care Partnership Strategy e.g., existing C&M transformational programmes such as elective recovery, disease / condition specific programmes or priorities e.g., diabetes, cardiovascular disease, mental health, or carers.
- key ICB organisational programmes, for example the NHS England delegation of Specialised Services to the ICB
- links to partner strategic documents/sections on NHS provider and local authority websites.

6.3 One of the challenges in developing the JFP and the annual delivery plan has been whether stretching and detailed measures are in place to adequately assess progress against delivery of the proposed outcomes. A number of the programmes and specifically the enablers have identified actions that are more process driven, the downside of this being that there are no established measurable indicators to adequately assess the direction of travel. Whereas other programme areas have been able to identify specific measures (the majority of which subsequently feature in highlight reports and associated dashboards).

6.4 Some metrics are only captured and reported on an annual basis which makes it difficult to assess progress on a quarterly basis. One specific example are the 22 Marmot indicators which are only available to be reported annually. Work is underway to try and establish a set of interim proxy measures, but this is proving difficult due to the availability, robustness and validity of the data sources.

6.5 As outlined, the current schemes in the JFP Annual Delivery Plan have an established governance and reporting route (See Appendix Two). Most report via groups reporting through our sub-committees for example the Digital Transformation and Clinical Improvement Assurance Board with the main reporting routes to ICB Board being: -

- Quality and Performance Committee
- Transformation Committee
- Population Health Board (To Transformation Committee)
- Provider Collaboratives (To Transformation Committee for Transformation funded programmes)
- Finance Investment and Resources Committee
- System Primary Care Committee
- Health Care Partnership
- Peoples Board.

6.6 These sub-committees are monitoring the delivery plan outlined in Appendix 1 with material exceptions to the expected plan delivery being reported through the revised Board sub-committee template or highlighted where appropriate through the Integrated Performance Report.

7. Joint Forward Plan 2024-29 and Alignment of the HCP strategy with All together Fairer

7.1 Feedback from across the system indicates that there is strong ownership and a sense of engagement in the All Together Fairer (ATF) report, its recommendations and implementation plans. The impact the HCP can have in positively addressing inequality and social determinants should be the primary focus of our plans.

7.2 Whilst feedback in relation to the interim HCP Strategy and subsequently the Joint Forward Plan has been very positive, it has, however, highlighted an NHS bias to the content in both documents. This is in part due to the direction provided in national guidance and the fact that a number of the legacy programmes across Cheshire and Merseyside focused on health service-related areas.

7.3 Following a discussion at the June Health and Care Partnership there was an ask that a proposal as to how best to achieve this be developed through the current team coordinating delivery of All Together Fairer and the HCP Strategy. We have taken on board that feedback and now provide an All Together Fairer thematic focus at each HCP meeting. Thematic sessions have so far covered

our joint approaches for working together for Environmental Sustainability in July, a focused workshop on Health, Care and Housing in September and Addressing the Gaps for Children and Young People in November 2023. The January meeting will focus on a stock take of progress against the ATF report and development of the revised HCP Strategy.

7.4 With this context the preferred direction indicated from discussions with our HCP and Health and Wellbeing Boards it is an intention to align our HCP strategic plan more closely with the All Together Fairer report, providing a focus on the wider social determinants of health. This will provide an opportunity to take elements of both the All Together Fairer report and the interim HCP Strategy and reframe these around how we can make the greatest impact as a Partnership on the wider social determinants.

7.5 The proposal is that we can achieve this by: -

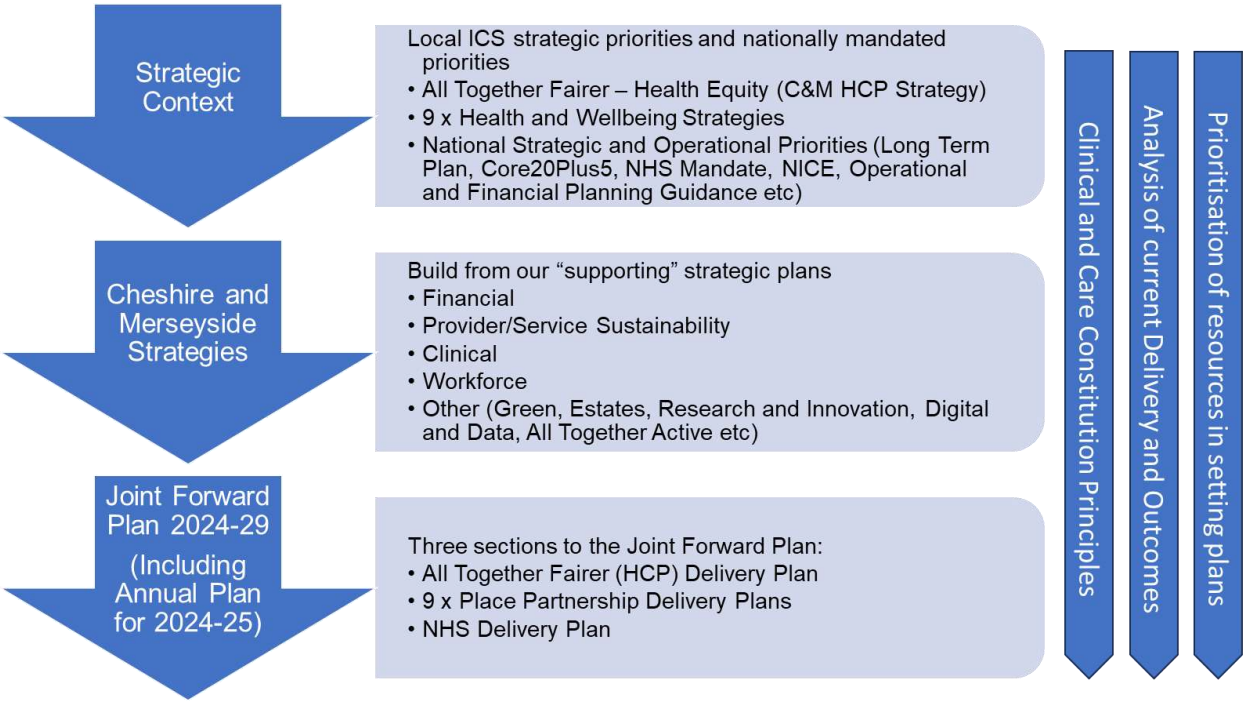
- refocussing the HCP Strategy to be a refreshed set of All Together Fairer priorities focussing on health equity and the wider determinants of health.
- developing an associated Delivery Plan which delivers the revised All Together Fairer/HCP Strategy. This will be part of the System Joint Forward Plan and consolidate existing plans and focus on delivery and implementation.

7.6 A paper outlining the proposed realignment of the HCP with ATF was shared with the HCP Chair and Vice Chairs who supported the direction of travel and a task and finish group has been established to lead wider engagement on development of the final HCP Strategy which will inform the content in the 2024-29 JFP.

7.7 This Joint Forward Plan would be made up of: -

- Cheshire and Merseyside HCP/All Together Fairer delivery plan. This would be developed from consolidating the existing plans, refreshed to recognise progress made and to reflect current context and priorities. This would become the work programme for the HCP.
- Place plans x9 (which reflect the existing Place plans focused on delivery of the respective Health and Wellbeing Strategy).
- NHS Delivery plan. This would enable the Integrated Care Board and NHS Partners to describe the key work plans to deliver both local strategic plans and priorities and incorporate those additional areas mandated in the national planning guidance – this would largely reflect the nature of the 2023-28 published Joint Forward Plan document content.

Figure 1 – Development of the 2024-25 Joint Forward Plan



7.8 In developing the Joint Forward Plan content there will be wide engagement with ICB Board members and partners, including Place Partnerships, Provider Collaborative members, Primary Care, Adult & Childrens Social Care, Sub Regional Leadership Forums alongside ensuring the voice of our communities is heard and reflected in the plans.

7.9 Learning from our previous experience of developing and monitoring the 2023-28 JFP helps inform our future JFP/NHS Delivery Plan reporting structure. It is clear we are on a journey and we have an opportunity to build on the current reporting to ensure that our plans become consistently more detailed, with refined processes to enhance robust and challenging monitoring processes and consistency of reporting/monitoring. through our Board sub-committees.

7.10 The creation of a high-level health and care single system document and the development of a system Joint Forward Plan and NHS Annual Delivery Plan provides us with the opportunity to make sure that the constituent plans are consistent and provide the necessary stretch and detail to assess impact with the added potential to support programmes/enablers to plan better enabling the creation of a clearer set of outcomes and measures.

7.11 To support reporting against the proposed NHS Delivery Plan (NDP) additional work has taken place to develop an Integrated Performance Report which will provide the Board with a high-level summary of progress against selected key metrics. We can ensure that our headline metrics are available throughout the year to allow more timely tracking of the impact of plans.

7.12 The ICB sub-committee reporting templates have been revised to ensure that they adequately reflect progress on the JFP/NDP. The intention would be to continue to refine this approach.

7.13 To support this and provide consistency, we have developed a Cheshire & Merseyside Commissioning Intentions (Joint Forward Plan and Operational Delivery Plan content for 2024-25) planning template to capture this level of detail in plans. This will be accompanied by a simplified prioritisation matrix to help ensure we focus on those areas which will have the greatest benefits.

7.14 Having a consistent approach to planning across the system will help us by:

- Proactively identifying and communicating the totality and alignment of all our plans both internally and externally
- Prioritising plans and assigning financial resources across our system more effectively.
- Provide cross ICB/S visibility of plans reducing duplication in plans and assigning our combined workforce more efficiently.
- Aligning resources to support public engagement and co-production contained within plans.

8. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: **Tackling Health Inequalities in access, outcomes and experience**

Objective Two: **Improving Population Health and Healthcare**

Objective Three: **Enhancing Productivity and Value for Money**

Objective Four: **Helping to support broader social and economic**

8.1 All of the above are core elements in the with the Joint Forward Plan – alignment with the Health and Care Partnership (HCP) Strategy with the All Together Fairer report, “Health equity and the social determinants of health in Cheshire and Merseyside” will further consolidate work in delivering the ICB core objectives.

8.2 The HCP Strategy and JFP will be fully aligned to the 8 Marmot principals.

9. Link to achieving the objectives of the Annual Delivery Plan

9.1 As outlined this paper focuses on the current Joint Forward Plan and the associated Annual Delivery plan.

10. Link to meeting CQC ICS Themes and Quality Statements

10.1 All key themes and quality statements are included in the current Joint Forward Plan and the associated Annual Delivery plan. The development of a refreshed Health Care Partnership Strategy and the alignment with the All Together Fairer report “Health equity and the social determinants of health in Cheshire and Merseyside” will further consolidate work around these core themes.

11. Risks

11.1 That current plans do not provide sufficient detail or stretch in their timelines to fully assess progress, or it may be that the reporting regime is not robust enough to provide the necessary stretch or challenge.

11.2 The volume of work to develop plans in a limited timescale has meant that our plans and associated monitoring processes require further refinement as a number are based on process outcomes rather than specific measurable indicators. The programme management office resource to support this ongoing development need is limited.

11.3 A number of the enabling programme plans e.g., our Finance Strategy, Communications and Engagement, Innovation and Research, are still being completed and may impact on the ability to deliver some of the plans contained in the JFP. In some instances, the reporting routes are still being worked through to ensure they are robust and provide adequate assurance.

11.4 The actions in the Annual Delivery plan have been aligned with the Board Assurance Framework BAF (see Appendix1).

12. Finance

12.1 Financial impacts of the Annual Delivery Plan were included in this year’s finance plans and the development and delivery of a Cheshire and Merseyside a system wide financial strategy as detailed in the Annual Delivery Plan. This includes the delivery of the Finance Efficiency and Value Programme plans.

12.2 Financial planning for 2024/25 will be an integral part of the process for developing the 2024-29 JFP and included as a core element in prioritisation matrix currently in development to prioritise our plans.

13. Communication and Engagement

13.1 Much of the content of the JFP has been developed through existing programmes, which have established mechanisms for engagement in developing the plans.

13.2 A public survey was undertaken in March/April 2023 to look at the content of the draft Interim Cheshire and Merseyside HCP Strategy, with the results assessed as part of developing the JFP. We have subsequently closed the loop on this and fed back via a 'you said we did' approach. The guidance indicates that where JFP's are built on existing plans and strategies there is not a requirement to formally consult.

13.3 Work is underway to develop future engagement through our Place structures. In addition, we will look to conduct a further public survey in development of the refreshed HCP and JFP. In addition to this, the intention would be to facilitate a series of development workshops.

14. Equality, Diversity and Inclusion

14.1 This report describes the JFP planning process communicated with guidance from NHS England. As detailed plans are produced, individual Equality Impact Assessments EIA's will be produced to assess the impact of the plans.

15. Climate Change / Sustainability

15.1 Climate change and sustainability are core elements in the Joint Forward Plan and the Annual Delivery plan (the detail can be seen in Appendix1) they are also core themes in the Health Care Partnership Strategy and the All Together Fairer report "Health equity and the social determinants of health in Cheshire and Merseyside".

16. Next Steps and Responsible Person to take forward

16.1 Agreement of a revised system-wide approach with partners across our Health and Care Partnership for the development of the 2024-29 JFP to be published in March 2024. This would include creating a Cheshire and Merseyside HCP sub-group to develop and deliver the next JFP.

16.2 Creation of a structured work plan to include: -

- Development of a briefing document to share with HWB members.
- Support a series of development workshops to engage with system partners and socialise the approach.
- Consolidate feedback and facilitate a workshop to help develop more detailed strategy content at January HCP to provide and agree outline scope.
- Community engagement to further codesign content in the document.
- Develop Delivery Plans, titled our Joint Forward Plan by March 24 which reflect the priorities of the HCP, Place x 9 and NHS ICB plan content.

16.3 In monitoring progress in delivering the JFP and annual delivery plan agree a consistent approach across our sub-committees to capturing delivery of plans, and progress in impacting the agreed metrics through our existing sub-committees.

17. Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neil.evans@cheshireandmerseyside.nhs.net

Stephen Woods, Head of Strategy
(stephen.woods@cheshireandmerseyside.nhs.net

18. Appendices

Appendix One: - Cheshire and Merseyside Joint Forward Plan Annual Delivery Plan

Appendix Two: - Current JFP reporting routes.

JFP core Theme	Current reporting Route	Exec lead/s	Leads
How we work as partners for the benefit of our population	Transformation Committee Quality and Performance Committee Health Care Partnership	Clare Watson Clare Watson/Chris Samosa/Chris Douglas Clare Watson	Maria Austin / Jonathan Taylor Taira Shaffi / Thomasina Afful / Andrew Woods Dave Sweeney /Kerry Lloyd
Population Health	Transformation Committee (Population Health Board) HCP (All Together Fairer Board)	Clare Watson Professor Ian Ashworth	Mel Roche
Children & Young People (CYP)	CYP Committee (Beyond Programme Board) Currently via DTACIB	Chris Douglas	Liz Crabtree
Women's Health & Maternity	Transformation Committee (Programme Board via DTACIB)	Chris Douglas	Cath McClennan
Diabetes	Transformation Committee (Diabetes Strategic Oversight Group DTACIB)	Fiona Lemmens	Paul Mackenzie
Diagnostics	Q&P Committee (CMAST)	CMAST (Ann Marr)	Julie Massey / Tracey Cole

JFP core Theme	Current reporting Route	Exec lead/s	Leads
Personalised Care	Quality and Performance Committee	Clare Watson	Dave Sweeney
Primary Care	System Primary Care Committee	Clare Watson	Chris Leese / Jon Griffiths
Cardiovascular	Transformation Committee (Cardiac Network Board via DTACIB)	Fiona Lemmens	James Boyes / Jon Develing
Community Health Services	MHLDC Quality and Performance	MHLDC (Joe Rafferty)	Tony Mayer
Elective Recovery	CMAST - Quality and Performance Committee	CMAST (Ann Marr)	Jenny Briggs
Neurosciences	Transformation Committee via DTACIB)	Fiona Lemmens	Andy Nicolson
Respiratory	Transformation Committee (Respiratory Network via DTACIB)	Fiona Lemmens	Sarah Sibley / Tracie MacKenzie
Stroke	Transformation Committee (Integrated Stroke Delivery Network (ISDN) Board via DTACIB)	Fiona Lemmens	Trish O'Keefe
Urgent and Emergency Care	Quality and Performance Committee	Anthony Middleton	Andy Thomas
Mental Health	MHLDC Q&P Committee Transformation Committee (via DTACIB) HCP (NO MORE Suicide Partnership)	MHLDC (Joe Rafferty) Fiona Lemmens Clare Watson Prof Ian Ashworth Ruth du Plessis SRO for MHW, SP, SB for C&M Public Health collaborative	Clare James
Learning disability & autism	Quality and Performance Committee	Chris Douglas (Simon Banks)	Pauline McGrath
Attention Deficit Hyperactivity Disorder	Place Transformation Group	TBC	Stephen Williams / Laura Marsh
End of Life Care	Transformation Committee (Palliative and End of Life Care Programme Board via DTACTC	Fiona Lemmens	Kathy Collins
Workforce priorities	People Board	Chris Samosa	Emma Hood
System Development	Executive Team DTACIB Q&P Committee	Graham Urwin Fiona Lemmens Chris Douglas	Natalie Robinson Kerry Lloyd

JFP core Theme	Current reporting Route	Exec lead/s	Leads
	Transformation Committee	CMAST/ MHLDC Clare Watson Place Directors/Clare Watson/ Claire Wilson Rowan Pritchard Jones John Llewelyn	Linda Buckley / Tony Mayer / Ben Vinter Dave Sweeney Natalie Robinson Natalie Robinson Rowan Pritchard-Jones Adam Drury
Effective use of resources (including All Age Continuing Healthcare)	Finance Investment and Resources Committee Executive Team	Claire Wilson CMAST/Claire Wilson Chris Douglas Clare Watson	Frankie Morris Natalia Armes Andy Davies /
Place Plans	Place partnerships and Health and Wellbeing Boards	Place Directors	AD's Transformation and Partnerships
Note: Reporting routes outlined in the Annual Delivery Plan were signed off by the Board in June 2023			

Meeting of the Board of NHS Cheshire and Merseyside

Date: **30 November 2023**

Cheshire and Merseyside Winter Plan Update

Agenda Item No: ICB/11/23/21

Responsible Director: Anthony Middleton, Director of Performance & Planning

Cheshire and Merseyside Winter Plan Update

1. Purpose of the Report

1.1 This report provides an update on the delivery of the Cheshire & Merseyside Winter plan, which was originally presented to the Board on 28 September 2023.

2. Executive Summary

2.1 The urgent and emergency care system is under increasing pressure and performance has deteriorated during September and October.

2.2 As per the report to Board in September, C&M prepared a Winter Plan in response to national guidance, the final version of which was submitted to NHS England on 27 September 2023, and subsequently signed off by NHS England at NW regional level.

2.3 In the meantime, the ICB has been taking forward actions to address its roles and responsibilities to facilitate partnership working and implementation of winter capacity as set out in the guidance across a range of themes including:

- Delivery of additional bed capacity
- Development of the System Co-ordination Centre (SCC)
- Quality and Infection prevention and control (IPC)
- Actions to support discharge and flow, including on care transfer hubs, intermediate care, virtual wards, Urgent Community Response (UCR), support to care homes and winter preparedness in Primary Care.

2.4 Virtual Wards are a key element of delivery and a more detailed update on capacity and utilisation is provided below.

2.5 On 08 November a national letter was issued, PRN00942 Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take. The ICB and Cheshire & Merseyside NHS providers have reaffirmed their commitments in respect of bed capacity (both acute and virtual ward capacity), along with headline UEC performance and delivery of elective and cancer care.

2.6 The ICB has prioritised the focus on three main aims of the winter plans during December:

- NCTR and overall acute hospital occupancy - Place
- Delivery of G&A bed capacity plan – Hospitals
- Delivery of ambulance hours as per winter plan - NWAS

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- note the contents of the report for information.

4. Background (Operational Context)

4.1 As reported in more detail in the Integrated Performance Report, the urgent and emergency care system is under increasing pressure and performance has deteriorated during September and October as a result. This reflects the national trend, with Cheshire & Merseyside performance close to the median for ICBs across England for the headline measure of 4 hour A&E performance. See table 1:

Table 1:

Metric	Aug-23	Sep-23	Oct-23	Local Trajectory	National Target	Region value	National value	Latest Rank
4-hour A&E waiting time	73.2%	71.0%	69.7%	72.3%	**76%** by Year end	69.0%	70.2%	22/42
Ambulance Cat 2 mean	00:35:13	00:39:13	00:39:41	00:33:00	**00:30:00**	00:27:19	00:31:30	-
NCTR	19.2%	20.6%	20.0%	12.8%	**5.0%**	16.6%	14.3%	40/42
Adult G&A bed occupancy	95.0%	96.0%	96.5%	94.4%	**92.0%**	90.8%	93.7%	27/42

5. Winter Plan Update

5.1 The C&M Winter Plan was submitted to NHS England on 27 September 2023, and subsequently signed off by NHS England at NW regional level.

5.2 The plan set out a range of actions spanning:

- Acute demand and capacity plans, coordinated between Place and Providers
- Community and mental health priorities
- Primary care winter plans in line with the aims of the national Primary Care Recovery Plan
- Social care. The local authority response to the DHSC and NHS winter planning guidance was coordinated via Directors of Adult Social Services, who have an integrated work programme with a programme lead jointly funded between the ICB and Councils
- Voluntary, community and social enterprise partners. Liaison and engagement with VCSE partners is led at Place partnership level with the aim to ensure the potential for support is maximised

5.3 At the point of submission, a number of areas within the winter plan required further review or development. These included:

- Acute Respiratory Infection hubs – understanding of C&M offer
- Increasing 2 Hour urgent care response (UCR) activity
- Increasing utilisation of virtual ward capacity
- Mental health discharge and flow
- Plans for use of targeted social care monies
- Implementation of Operational Pressures Escalation Levels (OPEL) Framework
- Potential for accelerating elective activity to get ahead of winter demand

5.4 The plans were subject to an assurance process by NHS England and were confirmed as signed off by NHS England NW Region on 06 October 2023.

5.5 Plans were scrutinised at Place level via the ICBs cycle of quarterly review meetings.

5.6 On 08 November a national letter was issued, PRN00942 *Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take.* As part of the response to this new guidance, ICBs and providers have been asked to reaffirm their commitments in respect of bed capacity (both acute and virtual ward capacity), along with headline UEC performance and delivery of elective and cancer care.

5.7 The guidance emphasises the need to prioritise urgent and emergency care within the context of wider financial challenges, and focuses in on the importance of 4 hour A&E performance and average Category 2 ambulance response times. **In the submission on 22 November 2023, all C&M providers reaffirmed their winter plans in relation to urgent and emergency care performance were unchanged.**

5.8 In the meantime the ICB has been taking forward actions to address its roles and responsibilities as set out in the guidance and the areas identified above as requiring further discussion or development. This includes:

- **Facilitating partnership working** – ensuring that all system partners are pulling in the same direction to deliver a resilient system, and appropriately manage risk to ensure that it is balanced across the entire system.
- **Delivery of additional bed capacity** in line with agreed 2023/24 ICB Operating Plan – including additional capacity identified via the winter planning exercise.
- **Maintaining 24/7 oversight of system pressures through the System Co-ordination Centre (SCC).** ICB will maintain system oversight through the System Coordination Centre (SCC) this winter. The ICB is implementing the revised national SCC specification to ensure appropriate structures, systems and process are in place to maintain operational oversight and delivery, and is on track to deliver this by 6th December 2023. The SCC is tracking progress towards compliance with the revised Operating Pressures Escalation Levels (OPEL) Framework in a consistent manner across all acute sites as the key clinical safety indicator of system pressure, this will be live through a new real-time reporting tool from 6th December 2023.

- **Mental health discharge and flow:** Further to a pilot in Cheshire & Merseyside, an Adult Mental Health Escalation (AMHE) Framework for North West mental health trusts has been established, operational from 02 October 2023, operating via SCC and NHS England at regional level.
- **Infection prevention and control (IPC):** IPC Colleagues have been pro-actively engaged and contributed to the development of the winter plan through attendance at the weekly winter group and via local place-based governance structures/meetings. Across C&M, Place IPC forums established, membership includes ICB Quality Leads, Public Health and Infection Prevention & Control Teams in the Acute hospitals and Community settings.
- **VCSE Liaison:** Leading, via Place, liaison and engagement with the voluntary, community and social enterprise partners to ensure that they are fully engaged in winter planning and their support maximised.
- **Care transfer hubs:** Care transfer hubs have been identified as a priority area of focus, with the support of ECIST to develop and implement more consistent processes and standards. This will be overseen by the UEC Recovery & Improvement Group.
- **Intermediate care demand and capacity:** Place based reviews of gaps in intermediate care capacity have been undertaken and reported as part of ongoing Better Care Fund work, and mitigations have been developed where shortfalls are predicted.
- **Virtual wards:** Delivering virtual ward capacity and maximising virtual ward use. A detailed update is provided in section 6 below.
- **Urgent Community Response (UCR):** C&M has seen a steady and sustained increase of referrals into UCR services over the last 12 months. Building on this, the Mental Health, Learning Disability and Community (MHLDC) Collaborative has initiated a C&M wide UCR improvement project which aims to extend this increase by ensuring that areas of good practice are identified and spread across the system.
- **Advanced clinical support to care homes:** The PCN DES ensures alignment with all Care Homes, providing a proactive care model with weekly care home visits, MDTs and structure medication reviews. Places have commissioned reactive and proactive support through: End of Life Care Partnership, mental health services, care home / quality matrons, additional social work support, Enhanced Care Home Support Service and Community Trust in reach.
- **Maximising use of the Directory of Services** (DoS), led at Place.
- **Acute respiratory infection (ARI) hubs:** ARI virtual ward pathways are in place across C&M, to include COVID, Community acquired pneumonia, COPD, Bronchiectasis, URTIs, and lower RTI and other viruses. Separately, there was a partial implementation of Primary Care led ARI hubs across C&M during the winter of 2022/23. Utilisation was variable, and the majority of Place level primary care ARI hubs were stood down at the end of last winter, with the exception of the Sefton ARI hub.
- **Primary Care Recovery Plan:** All places have established primary care operational plans for 23 /24 with proactive elements such as the development of integrated community teams adopting a preventative or proactive care response with physical health, mental health or social care needs

6. Virtual Wards

6.1 C&M continues to mobilise virtual wards working with a network of clinical leaders and operational managers at each site. Each virtual ward works to support flow out of acute hospitals through both admission avoidance or early supported activity with delivery of community response services and telehealth remote monitoring provided at scale via Mersey Care NHS Foundation Trust.

6.2 The virtual ward programme and operational response is closely connected to other community services, particularly 2hr UCR services, and is part of the overall EUC recovery plan.

6.3 Virtual wards are both step up and step down and are accessible form a range of services including care homes, ambulance trusts, primary care, and urgent community response.

6.4 Referral points have been centralised in line with single points of access to 2hr UCR services with a “no wrong front door” approach – if the patient is suitable for a virtual ward they will be onboarded or if not will be cared for by an alternative suitable community service without re-referral.

6.5 Common clinically agreed pathways are in place across all sites for use in ARI, with frailty virtual wards in all sites by December 2023.

6.6 Elements of the service providing efficiency are being deployed and an at scale pharmacy team to support local services is under recruitment.

6.7 The services developed and delivered have been recognised for quality and have won several awards including HSJ awards for safety for the virtual ward heart failure service.

6.8 Live pilots in Cancer, Palliative care, Paediatrics, and Heart Failure continue to operate to establish the value further extension of virtual ward use in these specialisms may bring.

6.9 Whilst utilisation has been steadily increasing, the aim for 80% by the end of September has not been achieved when looking at the average across C&M with significant variation by site, some consistently achieving high utilisation and others showing variance. 6-week average occupancy is running at 57.4% as at 13 November 2023. Table 2 below outlines performance year to date:

Table 2:

	Plan Capacity	Plan Occupancy	Plan % Utilisation	Actual Capacity	Actual Occupancy	Actual % Utilisation
Apr-23	330	215	65%	290	164	57%
May-23	335	218	65%	316	159	50%
Jun-23	345	224	65%	338	171	51%
Jul-23	373	242	65%	320	157	49%
Aug-23	398	259	65%	358	247	69%
Sep-23	435	283	65%	380	233	61%
Oct-23	465	372	65%	393	224	57%
Nov-23	502	402	65%			
Dec-23	535	428	80%			
Jan-24	555	444	80%			
Feb-24	575	460	80%			
Mar-24	590	472	80%			

6.10 Each site is now actively reporting and reviewing utilisation with local plans developed with partners to increase to the required level. Interventions range from opening new approved pathways to communication and engagement activity with potential referrers.

6.11 Training to enable safe management on virtual wards has been delivered to all teams, including specialist training all community respiratory teams to allow them to deliver the 6 ARI pathways and personalised care training – ensuring the needs of patients are paramount to care provided.

6.12 Communication and engagement remain a key focus to drive up awareness and utilisation.

6.13 Reporting on activity and impact has been developed at a patient level, with further insight and analysis enabling the service to understand demand and target interventions for potential increased activity as well as identify sources of referral and impact on patient care.

Implications and Comments

7. Link to delivering on the ICB Strategic Objectives and the Cheshire and Merseyside Priorities

Objective One: Tackling Health Inequalities in access, outcomes and experience

7.1 The winter planning process was coordinated in response to national guidance which set out system roles and responsibilities with regards to ensuring access to a range of service offers along the UEC pathway. The plans included specific commitments on A&E performance along with acute, community and virtual ward bed capacity.

Objective Two: Improving Population Health and Healthcare

7.2 Winter plans have been prepared in response to the two key national UEC recovery ambitions, for 2023/24 which are:

- 76% of A&E patients being admitted, transferred, or discharged within four hours by March 2024
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24.

Objective Three: Enhancing Productivity and Value for Money

7.3 Plans have been drawn up in line within the context of national operational and financial planning frameworks, utilising the funding settlement outlined below in section 10.

Objective Four: Helping to support broader social and economic development

7.4 The winter plan does not directly address this objective.

8. Link to achieving the objectives of the Annual Delivery Plan

8.1 The winter plan links to the Urgent and Emergency Care objective within the Annual Delivery Plan, namely delivery of the Urgent and Emergency Care recovery plan to support A&E waiting times, improve bed occupancy rates, support work around NCTR, UCR and LOS, development of Virtual Wards and improve ambulance response times.

9. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

9.1 The winter plan has a clear read across to quality and safety priorities. C&M focused on winter preparedness at its September 2023 System Quality Group, 'Preparing for Winter – Reducing Harm & Improving Patient Experience'.

9.2 The event was supported by CMAST, Health Watch and ECIST partners and aligned to the 10 high impact interventions. This resulted in the agreement of quality metrics and a subsequent CNO round table event took place in November which will feed through into the November SQG.

9.3 C&M monthly Director of Nursing meetings and the C&M Deputy Director of Nursing forum consider 'Winter & Safety' as a standard agenda item.

Theme Two: Integration

9.4 The report to Board in September set out how the winter planning process spans system partners across health and social care and VCSFE sectors. The national guidance set out specific responsibilities for the following:

- Integrated care boards
- Acute and specialist NHS trusts
- Primary care
- Children and young people (CYP) services
- Community trusts and integrated care providers
- Ambulance trusts
- Mental health
- Local authorities and social care

9.5 The ICB has an overarching responsibility to facilitate partnership working through coordination of winter planning and maintaining oversight of system pressures through the System Coordination Centre

Theme Three: Leadership

9.6 Specifically within the context of winter planning, the ICB has responsibility for ensuring the system winter operating plan incorporates all the relevant high impact interventions and actions for the entire health and social care economy, and facilitating integration (see above).

9.7 In addition, the ICB is responsible for leading the delivery of UEC high impact interventions 5-10, working in partnership with local authorities to manage the delivery of:

- Care transfer hubs
- Intermediate care demand and capacity
- Virtual wards
- Urgent Community Response (UCR)
- Advanced clinical support to care homes
- Maximising use of the Directory of Services (DoS)
- Acute respiratory infection (ARI) hubs
- Primary Care Recovery Plan

10. Risks

10.1 System risks that were identified as part of the winter planning process across Cheshire & Merseyside places and providers spanned industrial action, wider workforce pressures, UEC demand, and issues either with the mobilisation of capacity/flow initiatives, or initiatives not having desired impact.

10.2 This ties in with Board Assurance Framework Risk P5, which is that lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary

care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience.

11. Finance

11.1 As previously reported to Board, during the 2023/24 operational planning round the ICB received the following funds, which have been distributed across the system:

- Discharge Fund £18.1m
- Capacity Monies £13.7m
- UEC monies £34.9m
- Virtual Wards £24.7m

11.2 In addition, the adult social care winter letter set out how £600m of national funding held back from initial allocations would be utilised. £570m has been allocated to the MSIF workforce fund, a grant for local authorities to boost adult social care capacity and support the social care workforce, including on pay.

11.3 The remaining £30 million is being made available to local authorities on a targeted basis. All nine C&M Local Authorities submitted proposals which predominantly related to additional staffing to create capacity for discharge assessment, social care, reablement, and therapies as well as additional bed capacity in residential care or intermediate care.

11.4 On 08 November a national letter was issued, PRN00942 *Addressing the significant financial challenges created by industrial action in 2023/24, and immediate actions to take.*

11.5 This sets out the financial context for the remainder of 2023/24. Within this, alongside achieving financial balance, the headline priorities are to protect patient safety and prioritise emergency performance and capacity, while protecting urgent care, high priority elective and cancer care.

12. Communication and Engagement

12.1 The ICB plans were produced in collaboration with C&M NHS providers, with place linking in with place based partnerships.

12.2 The winter plan has not been subject to wider engagement owing to the rapid timescales for production between the issuing of the winter plan guidance and templates and the submission date.

13. Equality, Diversity and Inclusion

13.1 An Equality Impact assessment (EIA) has yet to be completed in relation to the winter plan.

14. Climate Change / Sustainability

14.1 This report does not address any of the ambitions of the ICB regarding the delivery of its Green Plan / Net Zero obligations

15. Next Steps and Responsible Person to take forward

15.1 A key principle as winter pressures are building is to ensure a focus on delivery of actions which have already been agreed and which we know will be most impactful from December through to March 2024.

15.2 In terms of supporting headline A&E 4 hour performance and the Category 2 ambulance response time, the key is to focus on the key actions around bringing agreed capacity online and improving flow. This can best be summarised as:

- NCTR and overall acute hospital occupancy - Place
- Delivery of G&A bed capacity plan – Hospitals
- Delivery of ambulance hours as per winter plan - NWAS

16. Officer contact details for more information

- Andy Thomas, Associate Director of Planning

Meeting of the Board of NHS Cheshire and Merseyside

30 November 2023

Consent Items

Agenda Item No: ICB/11/23/23

- Quality and Performance Committee Confirmed Minutes (October 2023)
- System Primary Care Committee Minutes (September 2023)
- Finance investment and Our Resources Committee (September 2023)

Quality and Performance Committee

Mtg Rm1, No.1 Lakeside, 920 Centre Park Square, Warrington, England, WA1 1QY.
12 October 2023
10.00am to 13.00pm

Minutes

Chair: Tony Foy

Committee Members		
Tony Foy	TF	Non-Executive Director (Chair)
Christine Douglas	CD	Executive Director of Nursing and Care
Clare Watson	CW	Assistant Chief Executive
Paul Cummins	PC	Partner member for local government and ICB
Anthony Middleton	AM	Director of Performance and Planning
David Aspin	DA	Interim Supporting Manager at Healthwatch
Sarah Thwaites	ST	Healthwatch Liverpool
Hilary Garratt	HG	Non-Executive Director
Rowan Pritchard Jones	RPJ	Medical Director
Naomi Rankin	NR	Primary Care Partner Member
In attendance		
Kerry Lloyd	KL	Deputy Director of Nursing and Care – C&M ICB
Susanne Lynch	SL	Chief Pharmacist, ICB
Mark Bakewell	MB	Interim Place Director, Liverpool Place
Devender Roberts	DevR	LMNS Clinical Lead – C&M
Denise Roberts	DenR	Associate Director of Quality & Safety – Warrington and Halton
Paula Wedd	PW	Associate Director of Quality & Safety – Cheshire East
Jane Lunt	JL	Associate Director of Quality & Safety – Liverpool Place
Lisa Ellis	LE	Associate Director of Quality & Safety – St Helens
Via Teams		
Mark Lammas	ML	Senior Quality Manager, C&M ICB Knowsley Place
Apologies noted		
Alison Lee	AL	Place Director, Knowsley

Notetaker: Christine Dougherty

Item	Discussion, Outcomes and Action Points	Action by
PRELIMINARY BUSINESS		
QP/23/10/01	**Welcome, Introductions and Apologies**	
	Welcome & Introductions. The Chair Tony Foy (TF) welcomed all to meeting and attendees made their introductions.	

Item	Discussion, Outcomes and Action Points	Action by
	Apologies received were noted in the table and the meeting was declared quorate.	
QP/23/10/02	**Declarations of Interest**	
	There were no declarations of interest made by Members that would materially or adversely impact on matters requiring discussion and decision.	
QP/23/10/03	**Minutes of the last meeting:**	
	Members reviewed the minutes of the meeting held on 14 September 2023. PC raised a point of accuracy. The minutes state "PC – expressed concerns re advocacy organisations and low numbers." PC stated that this note is not accurate. PC stated that he very much supports the role of advocacy organisations in the process. CD to follow up with Zoe Rubotham to listen to the recording and clarify the note. **Except for the point above, the Quality and Performance Committee approved the minutes of its meeting of 14 September 2023.**	
QP/23/10/04	**Action Log**	
	The Committee received the action log for review. The report was taken as read and members noted the completed actions. Further updates were provided to the following actions: **Action 61** - Was agreed for closure at the last meeting as KF gave a full update. **Action 65** - RPJ updated that he believes the Orthopaedic Network are providing good quality care. The issue is that there are higher rates of falls than there should be. Links into a clinical strategy and a population health approach. Close this action as it is a different problem that needs to be solved. **Agreed Action:** ➢ New action is to start to develop and bring the Clinical Strategy to Q&P Committee. RPJ will look collectively and do something thematically as a system. ➢ RPJ and AM to bring data back to committee early in the new year. SL will link with RPJ about a problem in polypharmacy. **Action 67 –** Close as at Executive level now. **Action 72** – Close as full report of where providers are up to in maternity pack today.	RPJ RPJ/AM SL

Item	Discussion, Outcomes and Action Points	Action by
	Action 81 – Close Patient safety report due as quarterly on the workplan. RPJ will take through the Medical Director route as large volume of never events are surgically related. **Action 69** – Leder forms part of the standard workplan for the committee. Close. **Action 70** – Close as work plan has been updated. **Action 71** – Close as on the agenda. **Action 73** – Close. New action for TF to have a conversation with Chair of Finance about IAPs contracts. **Action 74** – Close. **Action 75** – Close. **Action 76** – will be included in next month's Place reports.	
QP/23/10/05	**Decision Log**	
	The Quality and Performance Committee approved the decision log. - Not discussed.	
QP/23/10/06	**Committee Forward planner**	
	Forward items for next meeting - Deep dive into safeguarding from the System Oversight Board. - Children in Care Report – annual report. - Quarterly patient safety report. - Cheshire and Wirral place-based focus. - Quarterly IPC figures to be included in place-based reports. - NHS England screening presentation. - Patient experience and involvement briefing report.	
QP/23/10/07	**Matters raised in advance to the Chair and lead officer not featured on the agenda**	
	Terms of Reference for All Age Continuing Care – TF asked the Committee to look at and approve the Terms of Reference. Any comments to KL.	
QP/23/10/08	**Maternity LMNS**	
	DevR presented the Cheshire and Merseyside LMNS Exception Report. This report provides a monthly update from the LMNS on Maternity and Neonatal services in Cheshire and Merseyside. Key risk remains with	

Item	Discussion, Outcomes and Action Points	Action by
	Triage as highlighted in previous reports, staffing and CQC planned inspections for all Maternity Providers. DevR highlighted the update on Serious Incidents and Diverts on page 5 of the report. The LMNS have been notified of 2 maternal deaths at LWH in September 2023. These deaths are under formal review. DevR stated that by November all PSIRF policies will be signed off. DR reported that there are some concerns at regional chief midwives' level about the level of oversight in the new framework. There will be a Northwest piece to look at maternal deaths to date with a view to creating an integrated framework. The report provides a comprehensive summary of current CQC status in our Trusts. Liverpool Women's Hospital received a warning notice for triage. Have since had another inspection and met all requirements. KL reported that a Place and LMNS group has met to look at maternity reporting and will join together as an integrated group once a month to determine what intelligence forms the maternity report to committee. DevR outlined the process for health and safety investigations. **Agreed Action:** ➢ DevR to bring a paper with a schematic flowchart to committee to show what happens when an incident occurs and the associated governance.	DevR
QP/23/10/09	**System Oversight Board (SOB) Monthly Exception Report – Special Educational Needs & Disability (SEND) Focused Paper**	
	LE presented the SOB Monthly Exception Report – Improving outcomes for Children and Young People with Special Educational Needs and Disabilities (SEND). Baseline Report – October 2023. This report contains the SEND context, prevalence data, local performance information, assurance, and updates to provide the Quality & Performance Committee with information about SEND from a national, regional and ICB perspective and to provide assurance that Cheshire and Merseyside ICB are meeting their statutory duties in relation to SEND. The baseline picture across Cheshire and Merseyside is one of variation as could be anticipated within a newly forming SEND workforce structure, with reporting and establishment of consistent processes at Place in development. Wait times on the neurodevelopmental pathway are rising due to the number of children on the pathway. There is a need to work more closely with transformation colleagues to look at what we do around the pathway. SL reported a current national shortage of ADHD medication. Providers are looking at how to work together and a briefing paper will be brought to committee next month outlining medicine supply issues.	**SL**

Item	Discussion, Outcomes and Action Points	Action by
	Action: SL to bring briefing paper to November Committee outlining medicine shortage/supply issues and mitigation in place MB commented there are financial and workforce constraints. There is a need to look at different models and get a greater understanding of these waiting lists. RPJ commented that the approach towards the educational needs is different for children in households living with complex lives. RPJ added that targeted support to the highest risk households will make the biggest difference. **Agreed Action:** ➢ RPJ to request information on where the cohort of children with SEND sits within the ICB Public Health intelligence matrix and will bring back to committee.	RPJ **RPJ**
QP/23/10/10	**Feedback report from Sept 2023 System Quality Group (SQG)**	
	KL brought a report from the September 2023 meeting of the System Quality Group. The September 2023 meeting focused on winter preparedness – reducing harm and improving patient experience. The SQG had presentations from the Lead Provider Collaboratives and Health Watch that focused on the lived experience of those experiencing long waits for treatment and the impact on health outcomes. KL stated that there were key areas they wanted to target but they didn't have right people in the room. There were no Place Director Leads. KL is considering inviting UEC Leads to the meeting in November. TF commented that the SQG are excellent sessions but there is a need to move towards something more structured. There is a statutory duty around quality and to be effective need the right people attending.	
QP/23/10/11	**Learning from deaths** **• Rapid Quality Review Update – East Cheshire Trust**	
	RPJ provided a verbal update as papers were not submitted in time for circulation and would be circulated post committee. The notes from the Rapid Quality Review Update – East Cheshire Trust will be circulated after the meeting along with the Risk Summary. RPJ asked the committee to agree the level of risk that will sit within the ICB risk register linked to higher than expected mortality at East Cheshire Trust. East Cheshire have a Standardised Hospital Mortality Indicator (SHMI) of 117. The situation has been ongoing for approximately 9 months. RPJ stated that the East Cheshire SHMI is above the expected range which could be an indicator of sub optimal care of patients resulting in avoidable harm.	

Item	Discussion, Outcomes and Action Points	Action by
	It was found there was a set of issues around potentially patients deteriorating who possibly shouldn't and timelines of escalation when deterioration of patients occurs, patterns around hydration, acute kidney injury, pressure ulcers. SHMI includes deaths both in hospital and 30 days after discharge. The Trust are now focusing an improvement plan on hydration, escalation up to ITU, as well as prevention of deterioration and response to deterioration. There are 40 out of hospital deaths which will be reviewed within the next 2 to 3 weeks to understand whether those deaths were expected as patients nearing end of life but possibly not coded correctly. East Cheshire have limited palliative care provision and may be failing to get palliative care code because they do not have enough consultants. Awaiting more feedback on this. RPJ stated he felt it is the responsibility of this committee to agree what the reporting of that risk should be. The Trust have been holding the risk as 15 based on the rating the likelihood as being possible (3). The consequence is rated as catastrophic (5). RPJ has assessed the risk as 20 based on a likelihood rating of likely (4) and consequence rating of catastrophic (5). RPJ stated this is his considered view. RPJ stated that the risk rating at ICB and the Trust should align. There was discussion around the risk rating. There was concern expressed that the Trust are not considering the gravity of the issue in the same way as ICB colleagues. AM stated that this is not a 'spike', and the fact that it has existed for several years at this rate and is the only outlying rate in the entire system suggests it is "likely". It was reported that the Trust are concerned about the misalignment. RPJ stated that the Trust is rewriting the action plan to reflect the intelligence he has brought forward. It was the unanimous view of the committee that this risk is rated as 20 (4 x 5). **Agreed Action:** ➢ RPJ and CD to meet with Ged Murphy, John Hunter, and the Director of Nursing and go through the data packs with them and endeavour for consensus on levels of risk.	RPJ/CD
QP/23/10/12	**Rapid Quality Review –Cheshire & Wirral Partnership Trust**	

Item	Discussion, Outcomes and Action Points	Action by
	PW presented the Rapid Quality Review for Cheshire & Wirral Partnership Trust. The Rapid Quality Review meeting has convened on three occasions: January, June, and September 2023. The Rapid Quality Review process has focussed on the following areas: • Safety Culture & Incident Reporting • CAMHS - specifically ASD and ADHD pathways delays • Adults and older people MH Inpatients with a focus on: o Length of Stay o Clinically Ready for Discharge o Out of Area Placements • Fragile Services • Extended Waits – Governance and Oversight There are links in the paper to detailed action plans. At the September Rapid Quality Review meeting the Trust provided a presentation of progress made to date and areas that need sustained focus. The paper contains detail of the agreed outcomes. The recommendations include asking Committee members to note the methodology adopted to support the review process and the closure of the Rapid Quality Review Process. The committee agreed to this course of action.	
QP/23/10/13	**Liverpool University Hospital Trust – System Improvement Board Update**	
	KL and JL gave an update on the Liverpool University Hospital Trust System Improvement Board. Liverpool University Hospital Foundation Trust are in national oversight framework rating 4 and have been subject to a System Improvement Board. There are 6 exit criteria that the Trust had to fulfil to move from NOF 4 to NOF 3. There was a System Improvement Board in September where the Trust provisionally demonstrated that they met the criteria to move from NOF 4 to NOF 3. A meeting with NHS England tomorrow will confirm they have met the criteria for NOF 3. It has been agreed to construct and convene a system oversight group. A full paper will go to the Executive Group meeting this afternoon. A meeting with the Trust is planned for November to agree the criteria to move from NOF 3 to NOF 2. JL added that the CQC and Local Authority partner provider organisations have been involved as part of the exit criteria was recognising that whilst LUHFT could manage and change the internal issues there were some other things they needed wider help to do.	

Item	Discussion, Outcomes and Action Points	Action by
	Agreed Actions: ➢ KL to share slides constructed for NHS England plus the draft Terms of Reference for the System Oversight Group. ➢ KL to bring a paper back to Committee which will then be taken to Board as Board needs to be sighted on a new general approach.	KL KL
QP/23/10/14	**Rapid Quality Review Update – Choking Thematic Review**	
	LE and ML presented a paper on the Rapid Quality Review Update – Choking Thematic Review. The paper informs of the Rapid Quality Review process undertaken, an analysis of Serious Incidents of choking reported between 2015 – July 2023, some case studies from Learning Disabilities Mortality Reviews (LeDeR) referenced to Choking, Coronial Case Studies regarding Choking and a thematic review of both choking incidents and Serious Incidents of choking reported by Mersey Care NHS Foundation Trust. Several lessons learned have been identified from each Serious Incident related to choking. Alongside this, the report highlights a series of next steps discussed within the Rapid Quality Review to further share learning across C&M, including the role of the C&M ICB Central Patient Safety Team to identify future themes and trends as serious incidents are reported. There was discussion about advice to carers. LE commented that Influence and stretch is not always getting to where it needs to - family members, homes, education. TF stated there is a role for the ICB to lead on disseminating this. SL stated she is happy to support in relation to supporting carers with patients who need to take medication. Action: TF stated it is important this goes to Board level and that a paper is brought back to committee once available outlining actions taken to learn and improve by LE.	**LE**
QP/23/10/15	**Quality Performance Dashboard/Performance Report**	
	AM presented the Quality & Performance Report. The performance report for September 2023 provides on overview of key metrics drawn from the 2023/24 Operational plans, specifically Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance along with key exceptions. Key risks: - Impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience.	

Item	Discussion, Outcomes and Action Points	Action by
	- Long waits for cancer and elective treatment could result in poor outcomes. Moved to a new report format and away from a narrative. RPJ queried the national ranking 4/22 on page 3 of the report. AM to check this figure is correct. RPJ reported that there is funding for an antimicrobial resistance piece. RPJ will write formally to the team at Liverpool University to see how that resource gets used to do something genuinely transformative. HG asked if some of the funding could be used to invest in leadership for the people making decisions about beds being open or closed. HG commented that the report is light on community data. HG added that indicators for Continuing Health Care and Non-criteria to Reside would be helpful plus the triangulation with workforce. NR suggested taking out the primary care section and changing it to dental. CW commented that there are several Primary Care sections on different pages. CW added that they should come through System Primary Care Committee for sign off. AM noted the need for clearer intonation where things are only available at Provider level or Place level. AM suggested a more extended data set for QPC than the Board. AM stated they can get 5 BCF indicators for inclusion. AM stated that Workforce will be included from next month. TF stated that risks on the BAF are critical to report to the Board.	
QP/23/10/16	**Place Q&P Groups** **• Primary Care** **• Contractual Quality Assurance and Oversight** **• Host Commissioner** **• CQC Inspection Reports**	
	KL presented the C&M Place Quality & Performance Groups Aggregated & Place Specific Key Issues Report. This month's report has a Mid Mersey focus – St Helens, Warrington, and Halton. KL stated that the report details how maternity services have been re-established again in East Cheshire Trust. The report also details 4 anaesthetic related safety incidents at the Trust which are currently under investigation. Countess of Chester Hospital are triggering across a number of areas including a backlog review of covid related deaths, plus an issue around electronic discharge letter.	

Item	Discussion, Outcomes and Action Points	Action by
	DenR highlighted key points including a paediatric audiology incident in Warrington Hospital. There has been a review of all the children, with findings to date indicating one incident of low harm. Warrington Hospital Trust has performance issues relating to sepsis. There is a focus on monitoring alongside what is the patent experience. Looking at what can be done with a new model. This s felt to be an improving picture which will continue to be monitored at place. LE highlighted work being done with Mersey and West Lancashire Teaching Hospital due to merger of services from Southport & Ormskirk site, with an additional level of oversight. There have been a number of KLOEs that have been developed, shared and overseen with the Trust and monthly meetings are in place. KL stated that the annual report for looked after children in coming to committee next month. There were concerns raised about the fragility of services within the place report relating to Bridgewater Trust. DenR suggested these are being managed through place based work. CW stated that it is important to pull through the quality and safety issues into planning discussion for next year so Planning for next year – fragile services may need to pick up and pull through. Bridgewater may be a particular focus.	
FOR NOTING		
QP/23/10/17	**TOR Programme Board** **• AACC workstreams slides**	
	RPJ stated that authors might consider revising the order putting quality first. RPJ stated that as is it does not reflect the way we think or behave. **Decision:** ➢ KL to take back with in principle approval.	**KL**
SUMMARY / PREP FOR BOARD		
	Issues to take to the Board in the Committee's Report - Rapid Policy Review – Cheshire and Wirral. - Update on East Cheshire Mortality - Agree on new reporting format.	
AOB / CLOSE OF MEETING		
Date, time, and location of Next Meeting: 16th November 10:00 – 13:00 **Mtg Rm 1, No.1 Lakeside, 920 Centre Park Square, Warrington, England, WA1 1QY**		

Minutes RATIFIED by Q&P Committee 16/11/2023

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICB
System Primary Care Committee – Part B (Public)

F2F, Lakeside, Warrington

Friday 08 September 2023 from 14:40-16:00

Confirmed Minutes

ATTENDANCE - Membership		
Name	**Initials**	**Role**
Erica Morriss	EMo	Chair, Non-Executive Director
Prof Rowan Pritchard-Jones	RPJ	Medical Director, C&M ICB
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Tom Knight	TKn	Head of Primary Care, C&M ICB
Dr Rob Barnett	RBa	Secretary, Liverpool LMC
Mark Woodger	MWo	LDC representative
Adam Irvine	AIr	Primary Care Partner Member
Christine Douglas	CDo	Director of Nursing and Care, C&M ICB
Louise Barry	LBa	Chief Executive, Healthwatch Cheshire
Fionnuala Stott	FSt	LOC representative
Tony Leo	TLe	Place Director, C&M ICB
Dr Jon Griffiths	JGr	GP & Associate Medical Director
Chris Leese	CLe	Associate Director of Primary Care
In Attendance		
John Adams	JAd	Head of Primary Care Finance, C&M ICB
Lorraine Weekes-Bailey	LWB	Senior Primary Care Accountant, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, C&M ICB
Sally Thorpe	STh	Executive Assistant, Minute taker, C&M ICB
Hilary Southern	HSo	Risk Manager (meeting in part)

Apologies		
Name	**Initials**	**Role**
Matthew Harvey	MHa	LPC representative
Dr Daniel Harle	DHa	LMC representative
Tony Foy	TFo	Non Executive Director, C&M ICB
Matthew Cunningham	MCu	Associate Director of Corporate Affairs & Governance
Claire Wilson	CWi	Director of Finance
Delyth Curtis	DCu	Interim Chief Executive, CWAC
Luci Devenport	LDe	Senior Primary Care Manager Dental

Item	Discussion, Outcomes and Action Points	Action by
SPCC 23/09/B01	**Welcome, Introductions and Apologies**	
	EMo welcomed everyone to the meeting, and apologies were noted. Members of the Public were welcomed to the meeting, and the Committee introduced themselves.	
SPCC 23/09/B02	**Declarations of Interest**	
	Standing DoI were noted. In addition to this; Adam Irvine noted his conflict of interest as the CEO of LPC	
SPCC 23/09/B03	**Minutes of the last meeting (Part B) 22nd June 2023**	
	The minutes of the last meeting were noted to be a true and accurate reflection of the meeting.	
SPCC 23/09/B04	**Action Log of last meeting (Part B) 22nd June 2023**	
	PCC/06/23/P03 (mins of last meeting) - **actioned** PCC/06/23/P05 (questions from public) - **actioned** PCC/06/23/P06 (System pressures) – carry forward to October meeting - **ongoing** PCC/06/23/P09 (dental improvement plan) - **actioned**	
SPCC 23/09/B05	**Questions from the public**	
	None received.	
SPCC 23/09/B06	**Risk Register**	
	Hilary Southern presented this report stating it was the first time the Committee had seen this format, and that going forwards this will be a standard report to the Public element of SPCC. It was noted that there are five risks in the report which sought approval from the Committee to reduce three (2PC, 4PC and 5PC) and to close two risks (4PC and 5PC). This rationale was highlighted on pages 15 and 16 of the papers pack. It was outlined that two risks are still scoring high, one at a score of 16 (Primary Care workforce) and one at a score of 12 (relating to an identified dental provider contract management risk), these risk scores remain unchanged this month. Section 4.3 was highlighted for information as the Committee had requested a view of all place level primary care related risks for the September report, but that usually it is just risks held at place level and only those scoring 15 or more. It was noted that there is ongoing work to review the risk collectively as an ICB and that Places are now tasked with reviewing their risks, there is a training process so they are all now approaching this in the same manner.	

	Questions from the Committee. EMo, asked how TLe (on behalf of the Places) felt about the Place risks? In response, it was outlined that they have had a session with Dawn Boyer and all risks have been looked at again, also in consideration to the PDAF, and strategic aspects and the specific operational risk by function. It was outlined that there will be more things to come and that this was about looking at the strategic risks and how this is managed. CWa outlined that there had been an ask from the Risk Committee in terms of taking a standard approach and to maintain consistency. It was reported that there are nuances that would need to be considered, for example that it is easier to recruit GPs in some areas than in others, and that it would be good to get a sense of the variance and difference across the Places. HSo agreed stated that this is the output of the work being done and that there is a consistency piece of work being done across Places. RPJ enquired regarding page 19 of the papers pack, that Appendix B showed as grey for many of the Places asking if that was because they had not risk? In response HSo outlined that this was not because they don't have a risk, or that there is not necessarily an issue, but that this work is still ongoing, there is a deadline of 6th October so there will be an update in the next report. EMo stated that due to transformational speed and the impact of quality on the area we would want to see this coming up from Place. It was asked whether it was possible to get behind some of the headlines and recognised that work is ongoing in terms of looking at the role of the Risk Committee to question where we can share the levels and how to take a consistent approach. CWa outlined that there were a number of practices come to the end of their contract life and would need reprocuring, suggestion that this was a contractual technical type of risk. It was highlighted that APMS contracts are time limited the procurement team have reviewed and reset them so they are now on a much better legal footing so there is now no immediate risk, but it is recognised there may be some 'unwarranted variation' rather than 'risk'. In relation to the recommendation for 4PC, Community Pharmacy IT provision, it was noted that this was now resolved and reprocured, and outlined that there is now no issue, therefore the recommendation to close. Supporting this, AIr stated that he felt assured that this could be closed and was safe to do so. However, in relation to 5PC, serving notice on Community Pharmacy Services stock by Provider, AIr stated that he did not feel convinced it was quite there yet and that there may be considerations at the Health & Wellbeing Boards as to whether this was an ICB or an ICS risk. There is a Pharmacy needs assessment but it is the Local Authority that assess the need. Comfortable for the ICB to close down risk but not so sure the ICS can close.	

	CWa added that currently we do not have an HCP risk register. AIr confirmed that this was being looked at Local Authority level, and that Jackie Jasper is on board. In light of this, CWa confirmed that this risk could also be closed. But was keen to note that as an SPCC Committee there are a number of risks that ought to be seen here. Adding that as a committee we need to start to think what risks may be seen following the discussions in Part A/B. RBa stated that he was surprised there is no risk regarding GP IT; EMIS in particular. Noted that there is good escalation, and that with both operational groups and working groups we all need to see how they are 'working up'. TLe added that we also need to be really clear between the definitions as to what is a 'risk' rather than an 'issue'. <u>Recommendations</u> - to approve reduction in risk scores for Risks 2PC, 4PC & 5PC – **approved** *But to explore if the scores are going down because there are fewer APMS contracts, or if it is due to the dispersal of lists and level of quality and care?* - to approve closure of risks 4PC and 5PC – **approved** - to note the current position – **noted**	
SPCC 23/09/B07	**System Pressures**	
	JGr gave a verbal on current pressures in General Practice, stating that there is always seasonal variation on what is seen in GP practices, for example Practices will, and have, seen an immediate uptake once schools go back in terms of respiratory conditions. ARI (Acute respiratory infection) Hubs are a major part of the winter planning asks – it is worth noting that currently there is no additional funding on top of transformation funding already released, specifically for these and no national policy asks through primary care, to stand these up. Existing national transformation monies are also the only current pot for winter type pressures. EMIS is an issue, noting that there had experienced a complete shut-down recently, which meant that nationally GPs had little or no access to the system for a whole morning, therefore even a relatively simple patients review was impossible to do. Incidents of aggression and on staff is a cause for concern, and we are aware that in some areas these do cause major issues, questioned what we may be able to do at a system level to support – we are pursuing this with our place colleagues. It was noted that one LMC are putting in additional support, calls regarding alerts and alarms. RBa added that with the accelerated vaccination programme for covid being brought forward, whilst not all PCNs are taking part there is lots of encouragement for Practices to take part and this will add pressure over the next 6-8 weeks.	

	Dental update: MWo stated that as they have no access to the patient summary record there are issues regarding medication reviews, i.e. having to ask patients what medications they are on, or it puts a delay in if having to contact the GP practice, this causes problems if patients have deteriorating health. EMo questioned what was the plan around this? In response MWo noted that this was about getting dental connected into the system, LBa agreed but that this was a national problem and would seem common sense. There is an awareness of some sensitivity in local areas regarding the dental resource put in at Place, now would like to see what was on the workplan as discussed at the last meeting, this is where the clinical lead at Place is really important, for example what happens in Cheshire is very different to that in Halton. RPJ stated that the shared system connectivity should be put onto the risk register and be recognised, also drug interaction, and that that secondly we should take this to the IT team, questioned to scope this out and to look at what is being done elsewhere but agree it should be done systematically. **ACTION : Noted that this will be scheduled for further discussion at a future meeting. RPJ will speak to digital teams regarding this.** AIr stated that there could be learning taken from when pharmacy starting using a shared system and that there needs to be a mandate. JGr agreed that this ought to be agreed nationally and at a higher level as there is a risk that you could end up with a local agreement, which gets complicated. RPJ added that this was also about direct patient care and that it shouldn't raise issues for IG, this deserves to be scoped and brought back. Pharmacy update: AIr outlined that pharmacy remains under pressure, noting that some have applied to reduce their operational hours from 100 hours a week down to 72, Lloyds have now withdrawn Sainsbury's, this is a decrease from around 70 to 24 in Cheshire & Merseyside. He added that there is a first national contract reduction of 12%. Secondly the expectation that the CCGs created from the dispensing contract, now sees local commissioning from local pharmacies, this has caused less national pharmacies than ever before. C&M now has 579 pharmacies, and this is having an effect on the market. Stock issues are a real problem, and there has been national news interest. Anecdotally there is a loss of £1000k alone on one drug, and there is the impact of firstly not being able to obtain the drug and secondly the cost of getting it. Noted that Lancashire have previously run a 'be kind to your pharmacy' campaign, it was questioned maybe this was worth looking at and to run the same. CWa added that given the high profile case recently, maybe we should also look to undertake a 'be kind to your GP / GP practice' Campaign based on the Cheshire one. This would compliment the national respect campaign.	

	ACTION : CWa too raise with the Comms team. In relation to the reduction of community pharmacies in the C&M footprint, it was questioned whether the actual number was not the concern, but more about <u>where</u> they are? In response to this, AIr accepted that this was a fair challenge, stating that he was not convinced that the ones closing were the ones that they wanted to close. CWa added that this was about understanding the population health picture lens vs the commercial supply lens. RBa added that locally they had seen a number of consolidations of pharmacies and when this is looked at on a wider geographical view the closures were hardly noticed, however delving deeper and looking at the detail, patients are now having to cross busy roads and/or travel further and this will be disadvantageous to some communities. It was noted that the ICB had recently refused a consolidation in the interest of the population. It was questioned whether there was an access recovery piece that could be done across the North West, in that there are more pharmacies and that they are really accessible, this could be considered for our more deprived areas and we need to keep them in mind. Questioned whether we could use a range of healthcare practitioners and could we commission pharmacies or others to practice something in a different way. Discussion as to whether Practices or PCNs or Local Authority could commission more from their pharmacies? In response to the reduction of the pharmacy hours, RPJ questioned if this was a reduction in capacity? He expressed concern that as we head into winter there will be more pressure into GP and more worryingly into A&E. AIr confirmed that the reduction was not core hours and that the weekends and evenings are protected in legislation. It was noted that it would be useful to see the impact of these suggestions, TKo stated that he had specific details if anyone wanted further information. TKo outlined that he had been reviewing the implications and that at the moment it is minimal but the assurance to come back would be appreciated. AIr added that Pharmacies are businesses and if General Practice puts on a late clinic, then the pharmacies would respond. <u>Optometry update:</u> FSc outlined concern regarding the primary care/ secondary care interface and capacity, outlining there are some problems with this interface. Noting that there are some concerns regarding patient safety where referrals are then owned when rejected by secondary care. Outlined that early October, was hoping to receive some workforce funding and the use of some primary care skills to assist with this. This also ties into optometry practices in that these are also very accessible and there is a skilled workforce across the C&M footprint who can be used across other functions.	

	Numbers in contracts have not really changed and is considered 'stable'. One issue to note is that there is no urgent eye care service in Liverpool but there is across the rest of the patch. Outlined there are no IT issues other than that already mentioned. Verbal updates were noted from colleagues.	
SPCC 23/09/B08	**Contracting and Commissioning Update**	
	CLe outlined the report which provides the Committee with information and assurance in respect of the key national policy and related to local actions in respect of the four primary care contractor groups that now fall under the remit of the SPCC. RBa stated that the Covid 19 vaccination process was on a national enhanced service so it was a contract and now being done as a joint response with the flu campaign. Some issues are being worked through, and that for a GP there is a clause around same day disposition. In terms of optometry, the team have talked this week and the issues of processing of applications by national shared business service, is ever increasing, now looking to put something on the risk register. Reputationally this also impacts on the ICB TKo outlined that the October SPCC will see more detail on dental improvement along with the expansion of the urgent care pathway and the well heard public phase of 'can't get a routine appointment for dentist', this has been escalated to Execs. In progress is the development of a flashcard on performances on practices along with a number of other targets. Place Directors have indicated that they would be keen to see this developed, and it might help towards some of the discussions as to how we work with and support better on dental issues at Place. Outlined the detail on the dental operational group, who meet every 6 weeks and there is a breadth of standing items discussion. In terms of Winter planning, this forms part of the annual cycle of planning and the team are completing this at present, medicine supplies and independent prescriber announced. RBa questioned the access to urgent dental and for this to be more accessible, MWo stated that this was an ad hoc approach, and there is the need to have robust pathways for colleagues in primary medical care, to be able to refer, and to consider the more vulnerable patients. There are lots of important patients that are seen, but that it seems to be who has complained to the right person that gets a better response, rather than the system being joined up to resolve the issues. The pace of change is very slow and the resource is very small, a plea was given to support the resource issues. In relation to emergency dental service, which provides a service for those who are in serious pain, as well as to others who are not registered with a dentist, accessibility can cause issues as they're coming to see GP's.	

	TKo asked the committee if it would be beneficial to invite Roger Hollins and Dr Yvonne Dailey to the SPCC meeting in October. It was agreed this would be very useful. **ACTION : invite to Roger Hollins and Dr Yvonne Dailey for October SPCC for the Dental Improvement Plan discussions.** **ACTION : Paper to next SPCC – Dental Improvement plan update and progress** In relation to community pharmacy, SLy raised the pathfinder programme, and to highlight that they would be reaching out to Places requesting for site hosts and asking how this could potentially work. Funding allocation is secured. <u>Recommendations</u> - To note the updates for each of the four primary care contractor groups – **noted** - To note and be assured of actions to support any particular issues raised in respect of C&M specific contractors - **noted**	
SPCC 23/09/B09	**Transformation – Access Recovery and Improvement Plan**	
	CWa outlined that there is a regular fortnightly meeting and provide assurance that this was happening, it was noted there is still a lot to do. TKo is the Senior Responsible Officer (SRO) for the Empowering Patients pillar, and he outlined that they regularly meet as a programme board, colleagues are represented from Place, as well as IT. The programme is looking at the NHS app around its functionality and increased support for patients' self-directed care and that a baseline questionnaire available. It was outlined that this also gives an idea of where we want to get to within the ICB. Additionally, this pillar also includes all changes on community pharmacy. TLe was noted to be the SRO for the Implementing Modern General Practice Access pillar, and this is around digital enhances, to support the move from analogue to digital telephony. There is baseline work being undertaken, noting that the key component is the access element. All Places signed off their access plans at the end of August, now this is being drawn together into the template. Care navigation, getting the individual to the right care, a universal offer of support to general practice for each practice if needed from a national framework, there are a number of practices that have taken this up at various levels. This is an ongoing phase so is not time limited. RPJ questioned the table on page 48 of the pack, which showed the % take up of share in red, it was outlined that this is regionally monitored and we have been given a share of a national offer, it is then up to us to take up. Noted that this might not be answerable today, but there is something about organising in practices those not ready to take up the offer. There is an intensive share of practices and this shows a fair share as opposed to what is needed.	

	It was questioned whether this was ring-fenced at all, and whether there was any discretion, TLe outlined not in practices as they themselves chose whether to be intensive, intermediate or universal. Noted that this is one national offer, not funding, for the whole of England. It was outlined that it may be prudent to wait for the evaluation in order to better understand the programme, what the offer is and how would it benefit the practices. RBa stated that the practices need breathing space to be able to go on this, and it is probably those struggling with capacity to do so that need to access this most. It needs to be seen more as medium to long term rather than a quick fix. LBa outlined that this was about timings, and questioned how would patients know that the plan was working, but also from a Healthwatch perspective, when will we expect to hear this is changing? Noting that we may not know the answer to this, but we do need to understand when we can expect to feel and see the changes. JGr outlined that whilst this is going on, demand is continuing to go up, Practices are offering far more now than before the pandemic but that the perspective is that it is worse now. Noted that as the backlog increases in secondary care, then primary care will also see this. In terms of access, it was noted that this must deliver, and it was questioned what was the impact? Is it helping the system at large? Is it helping with capacity? The investment into Primary Care is to deal with the impact on other areas of the system, we all really need to make sure that the plans that are signed off really have the desired effect. RPJ agreed with the valid points about the challenge and asked whether there were milestones and timelines? In response TLe stated that there is a plan of measures as to how this should take place, will see that in the next iteration along with timelines of what to achieve and by when. CWa added that there is a meeting, Primary Care Access Recovery Plan (PCARP) who meet every fortnight, and that there is a data set that can be shared with a future SPCC meeting and with Board thereafter. CLe is noted to be the SRO for the Building Capacity pillar, which covers workforce and estates, wellbeing and associated funding streams. It was noted that the Associate Director of Estates is bringing an update on primary care estates to the next System Primary Care Committee, which will include the estates element of this pillar. In terms of delivery we have to take an improvement plan by November, but recognised that not everything will be agreed by then, but there will be a progress update at February or March board. Emo asked when this committee would receive this plan, and given the timings it would need to come in December, with an update at the next Committee. National guidance has been released and can be seen in the document presented to Committee today.	

	JGr is noted to be the SRO for the pillar focussing on 'cut bureaucracy and reduce the workload across the interface between primary and secondary care', and 0utlined that that was about complete care, having appropriate discharge summaries, appropriate fit notes, and becoming comprehensive in terms of prescriptions when patients are in hospital, getting it done there correctly rather than having to go back to the GP after discharge. There are systems in place to give the results of investigations and the need for good communications so that consultants have a place to go back to GPs and vice versa with queries or checks. This is in the hands of consultants and our hospital colleagues. Noted that hospitals do not necessarily see this as a high priority but that one change would be to demonstrate why this is good, to use A&E attendances for example, having a really strong and robust communications kit for hospitals, to get a conference between primary care and secondary care to get the traction needed. JGr outlined that it is in our gift to cut bureaucracy, suggestion that in primary care, every practice should have a second contact phoneline to the 'back office' (i.e., not the public facing number) so that secondary care can call into a practice with specific enquiries. Not all practices are doing this but it would assist to make good referrals, asking each other what do you want from this consultation? Checking medication control, optimise the long term care of a patient at the point of being in the surgery rather than at a pre-op appointment for example. This is not about taking over other roles, but about supporting at general practice level. **ACTION : PCARP data set to come to a future SPCC, then schedule to Board**	
SPCC 23/09/B10	GP Patient Survey - Summary	
	CLe outlined the report, which comes out every year, noted that the response rate is usually quite low. The report summarises the 2023 survey and to look out for some of the key measures and metrics, requested that this be viewed in context with the access recovery plan detail. LBa offered to overlay this around the experiences of different practices across Cheshire East. CLe thanked her for this, adding that he would also like to see this across all Places. CWa noted that the results were 'ok' but looking at it on a Place level, there are some real differences. It was asked whether, through TLe, Places were really looking at this and what were they doing with it? TLe outlined that the sample size for the survey was quite small, but recognised it was a temperature check, he added that there is an issue, and that it is on the scrutiny board and is consistently raised. It was noted that this was a trend more than a snapshot and about clinical access across MDT, but still have a huge problem. It was felt that things were not 'ok', but rather getting worse, it is an national problem and we are above that national average. Noted that now was the time to do a communication piece, to have a strong plan over the next several months as to what is going on in general practice, people do not necessarily understand the offer of general practice, that there are other healthcare professionals available, not just about GPs or	

	nurses, we need to be able to manage expectations and to really sell the positive aspects. CLe did wish to highlight that some practices in some Places get outstanding results year after year, and this is in the detail if you delve down. EMo gave thanks for the detailed discussion but felt that this is such a big and important piece of work that it perhaps needs a longer/ more detailed discussion. Further question in terms of what is the response to this? Cle outlined that the findings of the survey should be coming through into the access improvement plan, through place reports. Therefore the discussion should be around access, including and taking account of the findings of the GP Patient Survey. It was agreed to reiterate this to Place Leads to ensure it was clear in the improvement plans. <u>Recommendations</u> - Note the summary of the GP Patient Survey for 2023 - **noted**	
SPCC 23/09/B11	**Primary Care Strategic Summary**	
	JGr presented this report but highlighted that the recommendations should also have included that Board had asked for SPCC to give final sign off. It was outlined that there has been significant engagement, and just the final two chapters needed for optometry and dental. Although this is noted as a potential risk due to no resource for project management and JGr is the only person assigned on the final work for this. Seeking approval from the Committee so it can be published. Next steps would be for the comms teams to upload onto the website. RBa asked that this was not a glossy document that would just sit on a shelf, but more that it became a real living and working document. CWa agreed with the risk adding that there is a real risk regarding the lack of capacity in the teams. MWo offered support via the LDCs in terms of assistance for enabling practitioners and it is within their mandate to do so. He also added his support in terms of the funding for the event and for all to be invited. TKo offered support to assist with the completion of the dental chapter. Optometry support was offered by FSc. Thanks were given to all offers of support as this was very much appreciated. <u>Recommendations</u> - To note the first two chapters of the Framework – **noted** - To note the engagement that has taken place – **noted** - To note the ongoing work to develop the final two chapters – **noted** - To note the development of a workplan based on the Framework – **noted** - To note the request to the communications team for final publication – **noted**	

	- Additional recommendation : to approve the Primary Care Strategic Framework document ready for final publication - **approved**	
	Closing remarks, review of the meeting and communications from it	
	Nothing further to note.	
Date of Next Meeting: F2F, 19th October Warrington, Lakeside		

End of Meeting

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICB
Finance, Investment and Resource Committee

Virtual meeting via MS Teams

Tuesday 19th September 2023 from 10:35 am to 12:15 pm

Confirmed Minutes

ATTENDANCE		
Name	**Initials**	**Role**
Main Committee Members		
Erica Morriss	EMo	Non-Executive Director, C&M ICB – *FIRC Committee Chair*
Neil Large	NLe	Non-Executive Director, C&M ICB
Clare Watson	CWa	Assistant Chief Executive, C&M ICB
Susanne Lynch	SLy	Chief Pharmacist, Sefton Place, C&M ICB
Christine Douglas	CDo	Director of Nursing and Care, C&M ICB
Christine Samosa	CSa	Chief People Officer, C&M ICB
Rob Collins	RCo	Executive Director of Finance, Merseycare NHS FT
Frankie Morris	FMo	Associate Director of Provider Assurance, Capital and Financial Strategy, C&M ICB
Claire Wilson	CWi	Director of Finance
Val Attwood	VAt	Associate Director of Contracting and Procurement (Health)
In Attendance		
Nigel Gloudon	NGl	Associate Director of Finance and Performance - Halton Place
Simon Howden	SHo	Countess of Chester Hospital
Andrew Whittingham	AWh	Head of Finance (Continuing Care), C&N ICB
Kathryn Bromley	KBo	Portfolio Manager, C&M ICB
Dawn Boyer	DBo	Head of Corporate Affairs & Governance
Cheryl Meaden	CMe	Minute taker

Apologies		
Name	**Initials**	**Role**
Tony Foy	TFo	Non-Executive Director
Laura Marsh		Interim Place Director (Cheshire West, C&M ICB)
Jane Tomkinson	JTo	CEO of Liverpool Heart and Chest Hospital Acting CEO of Countess of Chester Hospital
Mark Wilkinson	MWi	Place Director, Cheshire East, C&M ICB
Anthony Middleton	AMi	Director of Performance and Improvement C&M ICB
Rebecca Tunstall	RTu	Associate Director of Financial Planning C&M ICB
Nesta Hawker	NHa	Associate Director for Transformation and Partnership – Wirral
Martin McDowell	MMc	Associate Director of Finance ICB Wirral

Alex Mitchell	AMi	Associate Director of Finance – Cheshire West
Natalia Armes	NAr	Associate Director Transformation
Grace Price Jones	GPJ	Clinical Network Project Manager C&M ICB
Adam Irvine	AIr	Primary Care Partner, C&M ICB

Item	Discussion, Outcomes and Action Points	Action by
FIRC(B) 19/09/23/01	**Welcome, Introductions and Apologies**	
	EMo chaired the meeting and requested introductions. Apologies were noted above.	
FIRC(B) 19/09/23/02	**Declarations of Interest**	
	Rob Collins declared interest in Capital paper.	
FIRC(B) 19/09/23/03	**Matters raised with advance notice not on the agenda**	
	Nothing had been raised in advance of the meeting.	
FIRC(B) 19/09/23/04 **FIRC(B) 19/09/23/05**	**Minutes and Action Log of last meeting : 15/06/2023**	
	Minutes for 25th July were reviewed. RC declaration of interest wrong, should only be within private papers only (Part A) Action discussed and updated as below: - FIRC(B) 05/23/10 – Month 12 Finance Position Update – Month 12 draft had been brought here, subject to audit. Will bring back following final audits. FIRC (B) 23/03/09 CW – Closed. ICB no longer required to sign memorandum of understanding, and no financial impact. FIRC(B) 07/23/04 – Closed. Emo noted that minutes were not well completed and need closer attention. FIRC(B) 07/23/07 – Long Covid – Nha/GPrJo – Ongoing. FIRC(B) 07/23/09 – Risk Report – closed. CWi noted need to develop allocation strategy as organization. Will send to Board by December 2023.	
FIRC(B) 19/09/23/06	**Work Plan**	
	The Workplan as previously agreed discussed and needs to be updated as meetings now bi-monthly. **Action FM– prepare updated workplan for next FIRC consideration.**	

Procurement		
FIRC(B) 19/09/23/07	**Clinical Policy Harmonisation**	
Kathryn Bromley/Nigel Gloudon	KBr gave update on paper, as presented before at committee, key item is output BI review on next set of policies. No financial impact as most policies similar to what already out in market. Had to do review of latest evidence, but not changed significantly, and no suggestion of change in activity, nor finance required to support. New cohort of policies (4) currently being worked on. Other policies also due for review, which may have a larger impact. Agreed that for any policies without financial impact could proceed with engagement material, and if committee still happy with this approach. If the next 4 found to have no financial impact are committee happy to proceed with engagement material on these also. Any with financial impacts will do deep dive. Due to general election, and period of purdah, if waited to all policies reviewed, would cause issues, and may need to re-engage if local authorities. Would have impact of living with unharmonized policies for longer period. Emo asked if committee had any questions. Recommendation on page 23 of papers. ClWa discussed March for some local elections, and unclear when General election would be and period of purdah. Need to understand level of materiality, and which of clinical policies are public engagement and those for public consultation. First is public engagement, and finance is secondary piece. KBo said none of these policies for public consultation, engagement, some of policies in phase 1 were a communication exercise. Number believe that fit in with second exercise, fit in with this communication, but in legal engagement review on this. Gluten Free and Assisted conception still ongoing, not finished work on these, and these would require engagement. Emo asked if CWa happy that going through due diligence exercise, working with Maria's team and also getting advice from Hill Dickinson. Potentially looking at 8-week engagement as minimal change for any that require it. Being driven by NICE guidance and help manage expectation around these policies. CWa feels does not know enough about this, happy to take discussion offline, but would delay until next meeting. EMo asked if comfortable with the ask, on the provision that further consultation with take place with CWa on the public consultation. NGl - £25k arbitrary threshold is very low, and most of these are not going anywhere near this threshold, Places working off NICE guidelines already. Emo in terms of recommendation happy with this, on basis of further meeting outside this committee with ClWa as previously discussed. Discussed 12-month review, and recommendations, NGl said would need to look at what caused increased costs, whether do all, or cohort of those more impacted. NGl to take action to review in years' time.	

	Action 1 - Note from Clare Watson on consultation prior to next meeting 2 - NGI to return to FIRC in 12 months with confirmation of cost against plan for clinical harmonisation policies agreed. Recommendation from Committee on this basis.	
FIRC(B)19/09/23/08	**People Committee**	
Chris Douglas	No meetings since last meeting, and previous minutes approved in July FIRC. **Impact of change of FIRC Committee dates acknowledged.** **CSU work on redundancy and stranded costs will come to next meeting.**	
Resources		
FIRC(B) 19/09/23/09	**Risk Report**	
Dawn Boyer	Risk Reports in pack. Two most significant risk P7 and F2, both remain rated as extreme. New finance risk regarding capital allocation F7 rated High. F 4 reduced from high score of 12 to 8, still high but now within target score. Changes appear to be working effectively. Risk summaries attached (p54) Work Risk 3 – apprenticeship levy, risk no longer applies so closed. Note current position, look to add any further risks, and provide level of assurances to board. Suggesting workforce risks delegated to People Committee, as get strong set of assurance and data. Emo said normally get view across the impacts on each individual Place, DB said still working with Places to get their Risk registers, and is aware that there are both Finance and Workplace risks, and aware that there are some scored 15 or above that need to come here. NeL discussed Place and delegation to Place where we are with this delegation, and how progressing with financial strategies at place. CWi said allocated ICB resource to Place and budget holder is Place Director, increased limits on Standing orders to allow for more autonomy and Inter relationship with local authorities. Places and their own financial authority, still work to do on this. Some Places that will regularly in teams and finance community have open transparent communications regarding that geography, and finance directors meet regularly. In other Places they can be further behind, ie Liverpool has lots of conversations, but still do not have holistic view across all partners. Have new DoF in Liverpool and need to do work on this area with them. Discussed Places in Cheshire, and if want combined view of all Cheshire, and different levels of maturity in all places. Need to define what footprints want and follow up on those areas not made significant progress. NLa, discussed ICB and place positions deteriorating, for prescribing if rates should go upwards. Does Place risk needs to be reviewed also as finance going in wrong direction?	

	CWi to take action to review risk with prescribing, as biggest risk. Will work with SLy and embed risk. RCo said Merseycare sit in 6 places and some are more progressive than others, and it is timing and maturity, level of challenge, need to understand and get baseline pieces of work right. With level of Risk is it based on timing, or where we are now. Need to look at risk of where want to be in time rather than where are now. **Action Dawn –next FIRC Risk Register to include detail from Place and update on maturity of Place.**	
Finance		
FIRC(B) 19/09/23/10	**Month 4 Finance Report**	
Rebecca Tunstall/ Frankie Morris	**A) Month 4 Finance Report** CWil discussed 2 reports in pack, month 4 detailed and high level of Month 5, to give more detail as now bimonthly meetings. Big issues on prescribing and continuing healthcare. Month 4 position deficit in year of £103M YTD, variance of £38M, increased in that vein for month 5. Month 5 papers describes key variables impacting finance position, industrial actions, Mental health packages of care, and prescribing and continuing healthcare. Position heavily backloaded, graph showing trajectory for aim of £51M deficit for end of year. CWi said challenging position, many variables hard to pin down and out of our control. Size of our ICB affecting size of variants. CWi discussed strikes and the financial impact, and expecting further relaxation based on these. Hopefully can draw down further elective recovery from national team. Also expecting some further funding to support impact of industrial action, and the winter pressures. Government announced £200M but not yet said how will be allocated. Many variables still unclear and hoping as firmed up hoping some respite from relaxation of regime. Non delivery CIP, CWi done comparisons with other systems, and feels are in better position that many others. Information in pack on how current CIP performing, and reported in providers delivered 2.4%, was only at 2.5% in 2016. Covid also had a major impact. CWi believe is good news story on how providers delivering on CIP basis. LUFT recognition nationally costs of new hospital not influenceable by organisation, and given allowable deficit, recent conversations have said will further support first year of operation of new hospital, would be one off non recurrent paper. Hopefully, with some non-recurrent savings, costs of new hospital would be covered. This would then give planned break-even position, but is still a work in progress, but will continue to bring cash into our position. 6-7 providers in deficit, being given plans and meetings with CEO and CWi planned with them at end of month. Will go through control checks and	

spend. 3 Places also part of this scrutiny. A summary of this with come to this meeting as part of CWi report to this committee.

NLa said helpful, and asked Sho how manage their biggest variance to plan, and if will get back to plan. Sho, said some areas doing well, but struggling with urgent care, and believe is nationwide issue. Mental Health patients, taking up space, and the flow through the hospital, and if cannot get this going has major impact on urgent care. Strike funding and how system will cover strikes, and this is difficult message to get through, as non-elective activity. Have manged to shut a ward as was in RACC area. Weekly recovery meetings, weekly vacancy panels, pay being challenge, infrastructure aging, and inflationary impacts. NLa asked about working with others to help resolve issues, SHo said everyone working together, but all in same boat, and facing same challenges. Doing as much as can and working together. CWi said SHo articulated very well and echoed across patch. Criteria for right to reside, always a challenge, and co-ordinated plans for winter. Winter plans key piece and being presented to Board next week. CWi said looks at other systems in terms of their positions and feels our provider positions are holding up better than others across the country. Big concerns over areas cannot influence, ie prescribing.

B) **Deep Dive into Prescribing and Continuing Healthcare (Presentation)**

Presentation Shared on screen.

Discussed prescribing budgets. SLy outlined what included in prescribing budgets. Working with finance colleagues as feeling pressures with providers and places on high-cost drugs. On whole looking at GP's and primary care.

CWil discussed uplifts we are receiving for Growth and Inflation. Flagged inflation as risk to NHSE, and that we could not afford it. Now have clear evidence from BSA, that inflation nationally is at 9.4%. CWi discussed high level analysis of prescribing plan. 9.4% is nearly £50M unfunded cost pressure. Assuming 4% CIP is delivered.

SLy discussed the comparison across national average in growth in costs, and C&M's growth is being managed better than other ICB's in country. Looked at our data and that from across country. NCSO drugs (concession prices), never seen such drug shortages as have at present, the costs of these affecting us significantly. Discussed how these drugs will come off concession lists, and go back in high prices, which causes price pressures, but come of national radar list. SLy discussed National Medicines Optimisation Opp0ortunities. 16 identified. Not all affect Primary care we are looking at, some are just secondary care, and saving elsewhere in system. Will provide a further breakdown to the Execs. 24,000 individual patient reviews undertaken, so is massive piece of work. CWi discussed sent information up to NHSE, met with regional teams, and other ICB's to gain further insights. Continuing to lobby hard to have these issues recognised.

CHC – Awi gave outline of what Continuing healthcare is and those that are eligible based on national frameworks. Children have their own framework. For those not funded, a funded nursing care is awarded.

	Mental health, learning disability and Acquired Brain Injury Awi gave outline of this on how funded, and how can have significant impacts on budget. CWil discussed Price/Activity Variances. Activity has gone up by estimated 11% of which 3% funded in ICB allocations. Also, inflation driving prices up by 8.5%, and still ongoing discussion regarding impact. CWil discussed social care market sustainability grant, and the funding awarded to local authorities, for footprint to give fair cost of care. Uplift this year this has been between 10-20%, and this is influencing when we are buying joint care packages. We cannot afford to just match, so have done piece of work to understand rates across our footprints, and types of care, and in what circumstances do we meet local authority uplift, and where we hold firm. Each PLACE has taken different viewpoints, as each market is so different, and has different requirements. In some authorities having to match the rise, and in other justifications for lower uplifts. Awi outline packages of continuing care. Complex piece of work collating 9 Places with different data. Feb-Mar 2023 had slight dip, and since April/May has been rapid increase to approx. 9000 where we are today. Amount of budget have has had major impact, on overspends. Keenest felt in Cheshire east, Cheshire west and Wirral. When new budgets started, they already started in a deficit, and has continued to deteriorate. Mental Health, continuing to increase over time, to 3006 where we are today, expectations of care are higher than they previously were. National benchmarking collected every quarter, does not include joint funded or children, but can show per 50000 head of population, and across England, most of our PLACES are above England's average. We can only apply framework directly and have a high number of patients with CHC. Cheshire East and Cheshire West have the highest pressures in our area. Covid has impact on the prices that providers now pay. Drivers on cost, hospital discharge programme, no criteria to reside and they tend to have higher needs, and care homes risk adverse leading to hight 121's which are more difficult to remove without assessments, and providers are already charging new rates, and so seeing the impact on our position. CWi said in some areas, the way teams work on CHC activity and assessments, is done differently in each of the PLACES. Landscape in each is so different, making consolidation a challenge, but opportunity to do review, and Andy Davis is leading this for the organisation. RCo discussed how take the intelligence and understand where can influence things, and how often they get reviewed and how can feed into conversations with providers. CWi and RCo, will pick up offline. Information on 4/5 Months Finance Report and Deep Dive on Prescribing and CHC noted by all Comm.	
FIRC(B) 19/09/23/11	**Month 5 Finance Report - Preview**	
Rebecca Tunstall/ Frankie Morris	Covered above.	

Planning		
FIRC(B) 19/09/23/12	**Capital Allocation**	
Frankie Morris	FMo gave update on paper. 2 proposals for approval. Rob Collins left meeting and had already confirmed DOI. 1 - Support for East Cheshire and Mid Cheshire reprofiling of Digital Clinical System support, 2 - Allocation of 7.8M to Alder Hey, Mersey Care and LH&C for recognition of additional services they are delivering. FMo outlined the areas for the funding. Committee agreed recommendations for approval.	
FIRC(B) 19/09/23/13	**Section 75 Approvals – Halton Place**	
Nigel Gloudon	NGl left meeting prior to this section. **Action - bring forward to next meeting.**	
FIRC(B) 19/09/23/14	**Financial Strategy Update**	
Claire Wilson	Time restricted session, slides to be circulated post Comm. **Action CWi – circulation to all.**	
	Closing remarks, review of the meeting and communications from it	
	Emo gave thanks to all and reminded all that next meeting in November.	
Date of Next Meeting: **Tuesday 14th November 2023** **09:00-12:00** **Meeting Room 1, Lakeside, Warrington**		

End of Meeting