Thursday 26 January 2023
10.45am to 13:45pm
Tower Room, Floral Pavilion Theatre & Conference Centre,
Marine Promenade, New Brighton, Wallasey
CH45 2JS

NHS
Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:45am	**Preliminary Business**			
ICB/01/23/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/01/23/02	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)*	Chair	Verbal	-
ICB/01/23/03	Minutes of the previous meeting: • 28 November 2022.	Chair	Paper Approval	Page 3
ICB/01/23/04	Board Action Log	Chair	Paper For note	Page 18
ICB/01/23/05	Board Decision Log	Chair	Paper For note	Page 20
10.55am	**Standing Items**			
ICB/01/23/06	Report of the Chief Executive	GUR	Paper For note	Page 24
ICB/01/23/07 **11:05am**	Report of the Wirral Place Director	SBA	Paper & Presentation For note	Page 42
ICB/01/23/08 **11:15am**	Resident Story	SBA	Presentation For note	-
11:20am	**ICB Key Update Reports**			
ICB/01/23/09	Executive Director of Nursing & Care Update Report	CDO	Paper For noting	Page 69
ICB/01/23/10 **11:30am**	Cheshire & Merseyside System Month 9 Finance Report	CWI	Paper For noting	Page 76
ICB/01/23/11 **11:40am**	Cheshire & Merseyside ICB Quality and Performance Report	AMI/ CDO	Paper For noting	Page 94
11:50pm	**ICB Business Items**			
ICB/01/23/12	Review of Liverpool Clinical Services	JLE / GUR	Paper For approval	Page 144
ICB/01/23/13 **12:20pm**	Cheshire & Merseyside Integrated Care Partnership Interim Draft Strategy 2023-24	CWA	Paper For noting	Page 210
ICB/01/23/14 **12:35pm**	NHS 2023/24 Priorities and Operational Planning Guidance	CWI	Paper For noting	Page 268
ICB/01/23/15 **12:45pm**	Public and Patient Engagement Strategy & Framework Update	CWA	Paper For endorsement	Page 281

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
12:55pm	**Sub-Committee Reports**			
ICB/01/23/16 **13:05pm**	Report of the Chair of the Cheshire & Merseyside ICB Audit Committee, including amendments to the ICB SORD & SFIs	NLA	Paper For noting & Approval	Page 336
ICB/01/23/17 **13:15pm**	Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee	TFO	Paper For noting	Page 372
ICB/01/23/18 **13:20pm**	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee	TFO	Paper For noting	Page 380
ICB/01/23/19 **13:25pm**	Report of the Chair of the Cheshire & Merseyside ICB System Primary Care Committee	EMO	Paper For noting	Page 388
ICB/01/23/20 **13:30pm**	Report of the Chair of the Cheshire & Merseyside ICB Transformation Committee	CWA	Paper For noting	Page 394
13:35pm	**Other Formal Business**			
ICB/01/23/21	Closing remarks, review of the meeting and communications from it	Chair	Verbal For Agreement	-
13:40pm	**CLOSE OF MEETING**			

Date and time of next meeting:
23 February 2023 ***time*** *tbc* Whiston Town Hall, Old Colliery Road, Whiston, Merseyside, L35 3QX

A full schedule of meetings, locations, and further details on the work of the ICB can be found here: www.cheshireandmerseyside.nhs.uk

Speakers

AMI	Anthony Middleton, Director of Performance and Planning, C&M ICB
CDO	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
CSO	Christine Samosa, Chief People Officer, C&M ICB
CWA	Clare Watson, Assistant Chief Executive, C&M ICB
CWI	Claire Wilson, Executive Director of Finance, C&M ICB
EMO	Erica Morriss, Non-Executive Director, C&M ICB
GUR	Graham Urwin, Chief Executive, C&M ICB
JLE	Jan Ledward, Place Director (Liverpool), C&M ICB
NLA	Neil Large, Non-Executive Director, C&M ICB
SBA	Simon Banks, Place Director (Wirral), C&M ICB
TFO	Tony Foy, Non-Executive Director, C&M ICB

Meeting Quoracy arrangements:
Quorum for meetings of the Board will be a majority of members (eight), including:
- the Chair and Chief Executive *(or their nominated Deputies)*
- at least one Executive Director *(in addition to the Chief Executive)*
- at least one Non-Exective Director
- at least one Partner Member; and
- at least one member who has a clinical qualification or background.

NHS
Cheshire and Merseyside

Integrated Care Board Meeting in Public

Held at
Veep Lounge, Warrington Conference Centre, Halliwell
Jones Stadium, Mike Gregory Way, Warrington, WA2 7NE
Thursday 28 November 2022
10:00am to 12:30pm

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB **(voting member)**
Prof. Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council **(voting member)**
Christine Douglas MBE	CDO	Executive Director of Nursing and Care, Cheshire & Merseyside ICB **(voting member)**
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Adam Irvine	AIR	Partner Member, Chief Executive Officer, Community Pharmacy Cheshire and Wirral (CPCW**) (voting member)**
Cllr Paul Cummins	PCU	Partner Member, Cabinet Member for Adult Social Care, Sefton Council **(voting member)**
Ann Marr OBE	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust **(voting member)**
Graham Urwin	GUR	Chief Executive, Cheshire & Merseyside ICB **(voting member)**
Claire Wilson	CWI	Chief Finance Officer, Cheshire & Merseyside ICB **(voting member)**
Prof. Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care NHS Trust, **(voting member)**
Prof. Rowen Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB **(voting member)**
Neil Large MBE	NLA	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Regular Participant, Associate Medical Director, Cheshire & Merseyside ICB
Anthony Middleton	AMI	Regular Participant, Director of Performance and Improvement, Cheshire & Merseyside ICB
Christine Samosa	CSA	Regular Participant, Director of People, Cheshire & Merseyside ICB
Clare Watson	CWA	Regular Participant, Assistant Chief Executive, Cheshire & Merseyside ICB
John Llewellyn	JLL	Regular Participant, Chief Digital Officer, ICB
Prof. Ian Ashworth	IAS	Director of Public Health for Cheshire West and Chester Council

		(Representing ChaMPs)
Carl Marsh	CMA	Place Director – Warrington
David Wilson	DWI	Chief Officer Halton Healthwatch
Alison Cullen	ACU	Chief Officer Warrington Voluntary Action (Voluntary Sector Representative)
Warren Escadale	WES	Chief Officer Voluntary Sector North West (Voluntary Sector Representative)
Louise Murtagh	LMU	Corporate Governance Support Manager (Minutes)

Apologies		
Name	**Initials**	**Role**
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**

Item	Discussion, Outcomes and Action Points	Action by
	Preliminary Business	
ICB/11/22/01	**Welcome, Introductions and Apologies**	
	The Chair (RJA) introduced himself, outlined the housekeeping rules and thanked Warrington Place for hosting the meeting. RJA welcomed all present to the meeting of the Integrated Care Board (ICB) for NHS Cheshire and Merseyside and members introduced themselves to the audience. Attendees were reminded that this was a meeting held in public and confirmed that questions received would be responded to in writing following the meeting and published on the ICB website. Apologies for absence were Noted.	
ICB/11/22/02	**Declarations of Interest**	
	There were no declarations of interest pertinent to the items being discussed today.	
ICB/11/22/03	**Minutes of the previous meeting – 27 October 2022**	
	The minutes of the meeting held on 27 October 2022 were agreed as a true record of proceedings subject to the following: • SBR questioned the minutes relating to item ICB/10/22/12 Provider Collaborative Update. He asked that the minute be changed to confirm that further discussions between JRA, SBR and GUR would take place but NOT 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. RJA advised that his recollection was that the report had been requested. He confirmed that the recording of the meeting would be reviewed, and confirmation of the agreed action be shared. • JRA advised that Mersey Care was not part of Sefton Council as listed in the attendance table. He confirmed that this entry should read as Mersey Care NHS Trust.	RJA

Item	Discussion, Outcomes and Action Points	Action by
	The Board Approved the Minutes of the 27 October 2022 meeting subject to the above.	
ICB/11/22/04	**Board Action Log**	
	Copies of the action log were provided to the Board prior to the meeting and RJA Noted that there were no outstanding actions requiring further update for this meeting.	
ICB/11/22/05	**Board Decision Log**	
	Copies of decision logs were provided to the Board prior to the meeting and RJA Noted that all decisions had been recorded as appropriate.	
	Standing Items	
ICB/11/22/06	**Report of the Chief Executive (Graham Urwin)**	
	GUR presented the Chief Executive Report to the Committee. There were three items that were brought to the attention of members. 1. Industrial Action The Royal College of Nursing (RCN) had been the first trade union to conclude their ballot and would undertake industrial action on 15 and 20 December. Emergency care would be maintained and the definition of what this referred to locally was being agreed. Other trade unions were undertaking similar ballots. The Board was advised that the ICB was not responsible for setting its employee rates of pay but that the organisation respected and supported employee rights to take industrial action. 2. Adult Social Care Discharge Fund Cheshire and Merseyside ICB population was circa 5% of the national population but had been allocated 6.4% (circa £19.2m) of the national resource under the discharge fund. The report provided a breakdown of allocations give to each C&M Council and Place Directors were working with partners on plans on how best to utilise the additional funding to increase capacity and reduce the number of non-criteria to reside patients that were occupying hospital beds. Ultimately, the decisions would be made through the Better Care Fund in each locality. It was noted that due to the lateness in receiving the funding not all places may be in the position to set up contracts and spend the money prior to the end of the financial year. AMA commented that although work on schemes covered by the fund needed to be arranged quickly it was imperative that they were effective and that the proper governance had been followed. GUR confirmed that Place Directors had been asked to provide outline plans to aid speedy mobilisation. SBR agreed that the £19.2m was welcomed but noted that this would not cover the required shortfall in adult social care. In response, GUR asked that members noted the recurrent nature of this funding. 3. Decisions taken at the Executive Committee (Employee Lease Car/Salary Sacrifice Scheme) GUR confirmed that this was not a subsidy to ICB employees, but a continuation of salary-sacrifice schemes operational under CCG	

Item	Discussion, Outcomes and Action Points	Action by
	arrangements. The Board also commented on three further entries in the report • Publication of the Cheshire and Merseyside Five Year Suicide Prevention Strategy. The work of CHAMPS was endorsed, and comments were received on how well the system had worked to produce the strategy. • Harmonisation of Clinical Commissioning Policies Update. It was good to see the progress being made in harmonising policies and that any future actions would include financial implications. • EPRR Annual Return Update. It was noted that compliance stood at 60%. This rating should not be perceived as poor as the EPRR Team was delivering against each NHS Core Standard for EPRR following the ICB becoming a Category 1 responder from the 1 July 2022. **The Integrated Care Board noted the contents of the report.**	
ICB/11/22/07	**Warrington Together (Carl Marsh)**	
	CMA provided a presentation to the Board, covering demographics for Warrington, the Place vision and priorities, the integration journey, and the delivery framework. Warrington was a large unitary authority and had a population of more than 200,000 people. This number continued to rise and with this came the significant pressure of an ageing population. CMA highlighted the following from his presentation: • Alcohol-related hospital admissions amongst those aged under 18 years were significantly higher than the average for England. However, the long-term trend shows substantial reductions in the rate of admissions • Obesity prevalence was an issue locally with estimates that almost two-thirds (64%) of the Warrington adult population were at an unhealthy weight. This was higher than the average for England. • Life expectancy at 65 for both males and females remained significantly lower than England. • Workforce was the biggest issue that the health and social care sector faced in Warrington. • System working with partners and citizens was paramount to success. • The vision for Warrington was to create a 'place where we work together to create stronger neighbourhoods, healthier people and greater equality across our communities'. • Twelve priorities for Warrington had been agreed pre-pandemic but were still valid. Of these, three were highlighted - Mental Health, Poverty and Living Well (Connected Communities) • The governance and delivery frameworks were shared showing the Health and Wellbeing Board and the Warrington Together Place Partnership Board as central to decision making. • Place development and the integration journey - The Local Government Association had provided vital input into the transformational work. With respect to integration Warrington had self-assessed and Established/Thriving.	

Item	Discussion, Outcomes and Action Points	Action by
	CMA then introduced Rebecca Emery (REM), Clinical Specialist for Paediatric Physiotherapy Team Lead for Warrington Paediatric Occupational Therapy and Physiotherapy Service.	
ICB/11/22/08	**Resident's Story**	
	A local citizen (Elspeth) had volunteered to talk to the Board about her journey as a patient in receipt of services. Unfortunately, she was unable to attend, and REM had agreed to present her story for her. REM started by providing a summary of key entries to Elspeth's medical history following her diagnosis of Spinal Muscular Atrophy, Type 2. Members were then provided with information on how the services were trying to incorporate the voice of the patient in their work. Elspeth and her family had been asked to provide feedback from their own personal experiences as a service user and a service user's family: • Positives for Elspeth were that the staff nice and kind, they worked at the right pace for her, and they understood what works for her • Positives for the parents included that the staff were professional, knowledgeable, and worked with Elspeth as an individual • Negatives for Elspeth were that things change (e.g., sore hips at present), it could be a long time between reviews and the need regular reviews for equipment • Negatives for the parents included the disparity between provision with other Trusts, the frequency of reviews and availability of staff, and funding for services e.g., hydro and equipment. The slides provided examples of how Elspeth had been involved in her care and treatment decisions and how feedback from patient experience influenced service improvement. An example of the type of questions received from Elspeth was, why were all letters relating to her appointments and treatment addressed to her parents? This led to a change in process where letters were sent to both patient and parent when appropriate. SBR presented REM with a personalised Warrington Wolves Rugby Shirt and match tickets to be passed on to Elspeth. **The Integrated Care Board thanked REM and noted the presentation.**	
	ICB Key Update Reports	
ICB/11/22/09	**Executive Director of Nursing & Care Report (Christine Douglas)**	
	CDO report provided assurance from the Executive Director of Nursing & Care to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) on the quality, safety and patient experience of services commissioned and provided across the geographical area of C&M. The report provided the position on the framework for quality governance and assurance, work underway to ensure safety in the urgent and emergency care pathway, and the workforce position for C&M. **Quality Governance and Assurance**	

Item	Discussion, Outcomes and Action Points	Action by
	CDO referred to the 2021 and 2022 National Quality Board (NQB) guidance that suggested key requirements for quality oversight by ICS and principles for systems to adopt to deliver their responsibilities. This included the management of risks to delivering quality and how this was aligned to organisational frameworks. Through the evolution of the C&M System Quality Group (SQG), Quality & Performance Committee, alongside the Place Based Partnerships, oversight and assurance of quality was being managed in accordance with levels of risk and associated escalation. **Maintaining Safety in Urgent and Emergency Care** Maintaining safety in urgent and emergency care, particularly during periods of intense demand, was of paramount importance. A national letter, issued in August 2022 had outlined steps to increase capacity and operational resilience in urgent and emergency care ahead of winter, including reducing ambulance handover delays, reduction of overcrowding in emergency departments, reducing hospital occupancy and timely discharge, all of which were inextricably linked and known to have a detrimental impact to patient safety and experience. Work at both regional and ICS level was taking place to ensure there was a consistent and systematic approach to understanding and acting upon increasing risk at system level, that supported those working at the frontline to take appropriate action to mitigate and control risk at organisational level. This work aligned with the quality governance framework previously described within the paper, whilst recognising and supporting dynamic risk assessment at the front line. **Workforce** Workforce challenges facing the health and social care system were listed and the report described the collective actions being taken. The key drivers of workforce supply and demand, from a national and local perspective were also provided. The five C&M workforce priorities were system wide workforce planning, creating new opportunities, promoting health and wellbeing, maximising, and valuing the skills of our staff, and creating a positive and inclusive culture. The NHS People Plan had been published in July 2020 and set out NHS priorities. C&M produced a local plan based on this. The focus was on the circa 3,000 vacancies in NHS providers and circa 7,000 in the social/ domiciliary arena. These vacancies led to increased use of bank and temporary staff. As a system the emphasis was to ensure that the aspirations for staffing in the NHS did not negatively impact social care provider partners. Plans would be developed collaboratively with ADASS, NHS England and primary care partners. Work on addressing the retention of staff was key as attrition rates were high. Positive actions taken to date included the new post of a C&M Employment Lead, the further post of a Senior Nurse to support Care Nurses, and ring-fenced funding for mentoring. Members moved on to talk about risks and challenges facing all partners in	

Item	Discussion, Outcomes and Action Points	Action by
	the system including attracting and retaining staff, planned and potential industrial action. CDO confirmed that the C&M People Board was operational and that there was a need for robust plans to be developed to support this area of work. Early considerations included potential rostering issues and the introduction or continuation of flexible working arrangements PCU commented that low pay for care staff was one of the biggest issues faced, the additional £19.2m funding through the Adult Social Care Discharge Fund would not cover costs and questioned cross budgetary support options. GUR confirmed that the Better Care Fund was designed to provide a forum for co-funding and co-design solutions. It had not been designed to co-subsidise across organisations. **The Integrated Care Board:** • **Noted the content of the report** • **Requested that a report was presented in January 2023 to describe if and how arrangements had been successful**	
ICB/11/22/10	**Cheshire & Merseyside System Month 7 Finance Report (Claire Wilson)**	
	The report updated the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year. A number of key areas were highlighted: • A year-to-date (YTD) deficit position of £56.8M against a planned deficit of £25m, resulting in a YTD variance of £31.9m. This was in part due to efficiency plans not being met and energy increases • The ICB and NHS Providers continued to plan delivery a £30.3m deficit by financial year end. • Cost Improvement Plan (CIP) YTD performance had improved by £45.9m in month to £182.6m (full year plan is £330.9m). • Financial risks associated with the delivery of the financial position were set out in the paper and CWI confirmed that there were five organisations within the system that were being actively monitored. • Provider Trusts cited key pressures related to underachievement on delivery of CIP programmes as; rising inflation with regard to energy and operational pressures associated with continued provision of escalation bed capacity. • Unmitigated net risk remained consistent with month 5 at £74m Members discussed two Trusts (Liverpool University Hospitals NHS Foundation Trust and Countess of Chester Hospital NHS Foundation Trust) and questioned their ability to meet CIP targets. CWI confirmed that there were regular and thorough conversations with system partners and NHS England to agree a system approach to meeting the deficit across C&M. There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year. In the absence of this presently, members would be sent dashboards that provided the wider financial position and workforce	

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	information. RJA commented that the ICB needed to be an exemplar in terms of its own financial position, and in respect of required recurrent cost improvement. He asked CWI to comment on this. Members were advised that the position was as a result of a gap in finances that was taken on at the start of the year. This would be mitigated by the end of the year. In respect of recurrent CIP, it was an area that the ICB needed to improve for future years. Plans to address this were already being formed. **The Integrated Care Board:** • **Noted the contents of this report in respect of the Month 7 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.**	
ICB/11/22/11	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	
	AMI provided an update on the Cheshire and Merseyside ICB Quality and Performance Report. This included an overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations. A number of key areas were highlighted: • the urgent and emergency care system continued to experience significant pressure in C&M. Although hospital visits were lower than the previous year, occupation was higher. There were significant and rising numbers of patients that no longer met the criteria to reside in hospital. They occupied over 20% of beds and in turn resulted in insufficient beds to admit patients from the Emergency Department (ED). Long waits ED often resulted in poor patient outcomes, poor patient experience, and delayed ambulance handovers. TFO asked if the Board could receive an appraisal next year on the opening up of 205 additional beds over winter to ascertain any impact the action had made. CDO advised that the workforce groups that she was involved with would provide better intelligence and that she would provide this in her routine report. • The significant backlog for both elective and cancer care due to the number of patients built up during the pandemic. Patients waiting over 104 weeks for treatment had grown from 30 in April 2021 to a peak of 1,235 in February 2022. Following focused work, C&M had zero patients waiting over 104 weeks except for legitimate exemptions relating to patient choice. It was also expected that there would be a maximum of a 78 week wait for elective surgery by the end of March 2023. The Elective Recovery Programme was leading on work across C&M to support Trusts with the management of their waiting lists, with a particular focus on supporting LUHFT and Countess of Chester. Long waits for cancer and elective treatment resulting in poor outcomes -	

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	C&M performance against this key operational waiting time standards was below plan. More patients than ever were being seen within 14 days; high demand had seen performance remain below standard at 73.97% against the 14- day urgent referral 93% standard. The Cheshire and Merseyside Cancer Alliance (CMCA) maintained oversight of performance across C&M using a system level Patient Tracking List (PTL), targeted support for the most challenged trusts, who had been provided with additional resources to aid rapid improvement. C&M had seen a rise in cancer referrals that were running at 120% pre-COVID levels. AMA reported that cancer referrals, at the time of the meeting, stood at 130% from pre-pandemic rates. This resulted in not only 30% more referrals but 30% more treatment. As alluded to earlier in the meeting, workforce issues exacerbated the problem. RJA requested that the CMCA be invited to the January 2023 meeting to explain its work programme • Increased demand, acuity and complexity of cases relating to Mental Health (MH) & Learning Disabilities continued to cause system wide pressure and adverse impacts on MH acute care flow. The ICB was not meeting the national ambition to eliminate out of area placements for adults in acute inpatient care as a result. There was an action and capacity plan in place to address this **The Integrated Care Board:** • **Noted the contents of the report and take assurance on the actions contained.** • **Requested that the Cancer Alliance be invited to the January 2023 meeting to explain it work programme**	
	ICB Business Items	
ICB/11/22/12	**Cheshire and Merseyside ICS Digital Strategy (John Llewellyn and Rowan Pritchard-Jones)**	
	JLL and RPJ provided a presentation to the Board to accompany the draft ICB Digital and Data Strategy. RPJ advised members that putting digital into the medical directory was key to delivery of the digital strategy. It resulted in intelligence directly feeding though to the strategy and put the citizen central to any decisions being made. The presentation highlighted the goals, mechanisms for change, strategic principles and critical success factors connected to the strategy. The aim was for C&M to be the most digitally advanced and data driven ICS in England by 2025. Key to success was a comprehensive levelling up programme that provided equity of access for all in areas such as digital skills, digital inclusion, linked databases, and access to specialist expertise. A digital exclusion heatmapping tool had been developed. This helped the organisation to identify where people were most at risk at being left behind digitally. This data would be used to identify where resources such as kit and training, should be	

Item	Discussion, Outcomes and Action Points	Action by
	focussed. Members were advised how investment in technology can improve patient experience and outcomes, reduce hospital beds days and in turn reduce costs. Examples were provided the presentation. PRJ explained that the strategy was in draft form and the next steps were to talk to partners and Place prior to approval by the Board. A collective view on funding and the setting of priorities would need to be agreed. Following this there would be a period of consultation. Members commented on the importance of levelling up whilst leaving no-one behind. It was encouraging to see proposals relating to the up-skilling of citizens and the recycling of devices to get online. It was also important note affordability for all due to the cost-of-living crises and that traditional routes for accessing health care should not be cut off. The four priority areas were welcomed as was the continued commitment to share data across partners to aid with delivery. RJA referred to the significant opportunities this strategy offered and also earlier similar digital strategies. A clear execution plan would be critical to its success. **The Integrated Care Board:** • **Endorsed the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting.**	
ICB/11/22/13	**ICB Equality, Diversity, and Inclusion Update Report (Clare Watson and Chris Samosa)**	
	CWA and CS presented the ICB Equality, Diversity, and Inclusion Update Report paper to the Board for noting. C&M ICB was the organisation with responsibility for paying 'due regard' to the Public Sector Equality Duty (Section 149, Equality Act 2010) and for all mandated regulatory Equality Diversity and Inclusion (EDI) requirements. The Board needed to provide visible leadership to advance equality of opportunity across the ICB and wider system and lead the ICB to become a more inclusive employer. From a workforce perspective it was critical for the organisation to ensure that all staff felt safe and supported. Compliance with the Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and other mandated regulatory requirements were key. For citizens, the ICS had adopted Equality Delivery Systems 2022 (EDS2). This generic system aimed to help local NHS systems and organisations, in discussion with local partners and local populations, to review and improve their performance for people with characteristics protected by the Equality Act 2010. The report further provided a patient facing EDI update, key priorities and actions taken since 1 July 2022. Members were advised that all decisions made by the Board needed to be through an equality lens. Section four of the report showed where the ICS had	

Item	Discussion, Outcomes and Action Points	Action by
	already put this into action. Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this. **The Integrated Care Board noted:** • **noted the work undertaken to date from a workforce and patient perspective.** • **noted the key priorities that need to be progressed before April 2023.** • **noted the current resource constraints to deliver against some deliverables. These had been highlighted and mitigations were being explored by relevant Executive Officers.** • **Requested that IAS present a report to the Board at a future meeting on Core20Plus**	
ICB/11/22/14	**Consensus on the Primary Secondary Care Interface** **(Rowan Pritchard-Jones)**	
	RPJ presented the Consensus on the Primary Secondary Care Interface to the Board for endorsement and approval of actions for implementation. Members were advised that the C&M ICB and HCP had recently published the document that provide a set of principles, that clinicians were encouraged to consider, at the interface between Primary and Secondary Care. The purpose of the consensus was to reduce unnecessary bureaucracy and inappropriate workflow. If followed, these principles would improve patient care by reducing potential delays in arranging or delivering interventions as well as, critically, improving relationships between clinicians. The report listed the organisations involved in its co-design and how it had been further promoted on social media. It had been positively acknowledged by many other systems across the country. AIR agreed that the Consensus document was a welcomed approach and had been discussed at the Primary Care Leadership Forum. There were some areas that would require a significant amount of work from both primary care and secondary care providers. As means of an update to the report AIR confirmed that the smoking cessation service was now operational and receiving referrals. PRJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review. AMA and JRA confirmed that they supported the Consensus paper from a partner collaborative perspective. RPJ confirmed that there were plans in place to continuously review the document through staff surveys and check-ins with parties across C&M. An update report would then be presented to Board over the next 12 months. **The Board:**	

Item	Discussion, Outcomes and Action Points	Action by
	• **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/11/22/15	**Winter Planning 2022-2023 Update (Anthony Middleton)**	
	AMI referred members to the NHS England letter 'PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter' as issued 12 August 2022, followed by further national guidance on 18 October 2022 under the banner 'Going further on our winter resilience plans'. The Winter Planning 2022-2023 report presented to Board updated on the response to the supplementary guidance. AMI confirmed that this work would be coordinated via the Winter Planning Oversight Group and an updated position would be reported to the Board in due course. A key number of areas were highlighted in the report: • Acute and community bed capacity • Provision of Urgent treatment Centres and High Intensity User services • Hour Urgent Crisis Response provision • Implementing 'out of hospital' home-based pathways, including Virtual Wards • Supporting Primary Care • Increasing number and breadth of services profiled on the Directory of Services to facilitate rapid signposting to the most appropriate services • Recruitment and retention • Utilisation of VCS and volunteers • Local communications campaigns • Discharge – increasing capacity on discharge pathways. Meetings had been held with seven of the nine Place Directors to review plans and at the end of quarter 4 there would be a further review of these to ascertain if they had been effective and met their purpose. Comments received following the presentation included a potential gap around the work of local councils and the voluntary sector, for example food banks and support for fuel/energy poverty. A local initiative run by the voluntary sector, but funded through the NHS, at Warrington Hospital around hospital discharges was referred to. They were currently supporting 140 patients to remain at home independently. The Board discussed metrics and how these would be used to assess if services had performed well and if the introduced measures had been effective. Any review would be conducted objectively by an independent person/organisation. RJA welcomed the report and questioned how was best practice shared? AMI confirmed that the System Winter Operational Group met weekly. This is the	

Item	Discussion, Outcomes and Action Points	Action by
	forum where cross system learning would be shared. PRJ provided the example of virtual wards and the effectiveness review that was underway. **The Integrated Care Board:** • **Noted the contents of this report for information.** • **Noted that the Board would receive a further update at its January 2023 Board meeting** • **Requested that Cllr Louise Gittins, as Chair of the Cheshire and Merseyside Health and Care Partnership, receive a report on Place Based Winter Planning.**	
ICB/11/22/16	**Cheshire and Merseyside ICP Board – feedback from the first meeting (Raj Jain)**	
	RJA provided an update report to attendees on feedback from the first Cheshire and Merseyside Integrated Care Partnership (ICP) Board meeting. Members were asked to take the report as read and opened the floor to questions. Members commented on the following: • Happy to see that the establishment of the ICP, or Cheshire and Merseyside Health and Care Partnership, as referred to locally, and that all nine local authorities were represented, and that Cllr Louise Gittins had been appointed Chair • Under the terms of reference (TORS - 4.22 and 6.2) questions were asked around attendees withdrawing during consideration of any item. CWA confirmed that they were meetings held in public. The document also referred to the ICB's constitution, Standing Orders, and Standards of Business Conduct Policy. CWA advised that as a partnership, attendees would be expected to act in accordance with their organisation's code of conduct. The TORS were currently in draft form and could be amended upon receipt of comments such as those received today • The position of joint Co-Vice Chair would from the Voluntary, Community and Faith Sector. **The Integrated Care Board:** • **noted** the establishment of the Cheshire and Merseyside ICP and the discussions and outcomes of its first meeting • **considered** the Partnerships Terms of Reference and provided feedback • **noted** that the Partnership Terms of Reference will need to return to the ICB Board at a future meeting for its approval • **noted** that the ICB Board will receive a summary report of the outcomes of the Health and Care Partnership Committee after each of its meetings and its confirmed minutes.	
12.35pm	**Sub-Committee Reports**	
ICB/11/22/17	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Tony Foy)**	
	TFO provided a verbal report to the Board on what was discussed at the most recent meeting of the C&M ICB Quality and Performance Committee. TFO advised of the common theme from the reports considered by the Committee of improving use of data, intelligence, and a continued focus on risk.	

Item	Discussion, Outcomes and Action Points	Action by
	Main items considered at the meetings included: • An aggregated report from Place Associate Directors of Quality. This was a substantial report monitoring quality and risk in each Place. Examples from each Place were referred to. • The performance report where the committee had focused on the complex situation in urgent and planned care noting significant challenges, including handover delays, 12-hour waits, 4-hour target performance, and capacity challenges. Analysis of the data would continue at the next meeting. • The Patient Safety Incident report was received, evidencing the work of the task and finish group to collate reported SIs across the 9 Places and establishing common themes. Preparations were underway to use the national standard framework using early adopter's feedback. Positive work was noted from Warrington and Halton in engaging with Primary Care and care homes. • A progress report was received on the development of a Learning Disability and Autism Dashboard with social care also to be included in the planning. • Assurance was received regarding the LeDeR programme highlighting the need for a whole system focus on reducing health inequalities for people with a learning disability and autistic people. Workforce development in the service was highlighted as a priority. • A report on the innovative use of CIPHA data. An example of people with respiratory problems who lived in damp housing being given priority on waiting lists was provided. This highlighted how data could be used to target those most in need. **The Integrated Care Board noted the items covered by the Cheshire & Merseyside ICB Quality and Performance Committee at its last meeting.**	
ICB/11/22/18	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee (Clare Watson)**	
	CWA provided the Board Members with an update on key issues for consideration, approval and matters of escalation considered by the C&M ICB Primary Care Committee at its last meeting and as outlined within the report to Board. A number of key areas were highlighted: • Primary Care Operating Model update • Deep dive from Place Directors in relation to access to General Practice, and transformation and development • A primary care finance update report including information on the additional roles recruitment scheme of monies (ARRS) • Community Pharmacy contractual changes. A further deep dive report was due to committee in December 2022. AIR confirmed that there had been 590 community pharmacies when the ICB took over responsibility and this now stood at 582. Working with community pharmacies was key in how to alleviate pressures elsewhere in the system • An update on dentistry and optometry. A full formal report on dentistry would be presented to Board in February 2023 relating to this • The Primary Care Strategy. This would be presented to the Board in March 2023	

Item	Discussion, Outcomes and Action Points	Action by
	The Integrated Care Board noted the contents of the report.	
ICB/11/22/19	**Report of the Chair of the Finance, Investment and Resources Committee (Claire Wilson)**	
	CWI provided the Board Members with an update on key issues for consideration, approval and matters of escalation considered by the C&M ICB Finance, Investment and Resources Committee. A number of key areas were highlighted: • The committee reviewed and updated its workplan • Received the Liverpool University Foundation Hospital Trust external finance review and action plan • Discussed the financial strategy and the ICB's approach. The settlement figure would be provided at the end of December 2022 • CSA provided a work force consultation update • Received financial policies for review. **The Integrated Care Board:** • **Noted the report** • **Approved the revised terms of reference attached to the paper.**	
	Other Formal Business	
ICB/11/22/20	**Responses to questions raised by Members of the Public in relation to items on the agenda**	
	RJA advised the Board and members of the public present that questions that had been received before the meeting would be addressed and the responses would be made available on the website.	
ICB/11/22/21	**Closing remarks from the Chair, review of the meeting and communications from it:** The Chair firstly thanked Warrington colleagues for hosting the meeting and wished Elspeth (patient story item) a speedy recovery. A summary of the meeting would be posted on the ICB website shortly. The Chair thanked members, presenters, and the public for their attendance today.	
1.00pm	**CLOSE OF MEETING**	
Date of Next Meeting:		
26 January 2023		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2022-23

Updated: 19 January 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-22-08	28-Nov-2022	**Minutes of the previous meeting – 27 October 2022**	SBR questioned the minutes relating to item ICB/10/22/12 Provider Collaborative Update. He asked that the minute be changed to confirm that further discussions between JRA, SBR and GUR would take place but NOT 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. RJA advised that his recollection was that the report had been requested. He confirmed that the recording of the meeting would be reviewed and confirmation of the agreed action be shared.	Raj Jain		*Recording reviewed and confirmation that agreement was given to receive a further report to the Board. Agreement that report will only come to Board once there has been prior enggement with Trust and Local Authority colleagues*	ONGOING
ICB-AC-22-09	28-Nov-2022	**Executive Director of Nursing & Care Report**	CDO confirmed that the C&M People Board was operational and that there was a need for robust plans to be developed to support this area of work. Early considerations included potential rostering issues and the introduction or continuation of flexible working arrangements Requested a report to January 2023 to describe if and how arrangements had been successful	Christine Douglas	Jan 2023		NEW
ICB-AC-22-10	28-Nov-2022	**Cheshire & Merseyside System Month 7 Finance Report**	There was a need for a comprehensive provider organisational integrated performance report to be presented to the Board covering all challenges being faced by organisations. This would be provided in the new financial year.	Claire Wilson	April 2023		NEW
ICB-AC-22-11	28-Nov-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		NEW
ICB-AC-22-12	28-Nov-2022	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	RJA requested that the Cheshire and Merseyside Cancer Alliance be invited to the January 2023 meeting to explain its work programme	Matthew Cunningham	Jan 2023	*Due to come to February Board*	ONGOING
ICB-AC-22-13	28-Nov-2022	**ICB Equality, Diversity and Inclusion Update Report**	Members discussed how data collected via WRES, WDES, CORE20, EDS2 and other system would be used and shared with the Board. IAS agreed to bring a further report on Core20Plus to a future Board meeting in relation to this.	Ian Ashworth			NEW
ICB-AC-22-14	28-Nov-2022	**Consensus on the Primary Secondary Care Interface**	PRJ confirmed that discharge medicines services were crucial for patients and a future paper would be required at Board to review. An update report would then be presented to Board over the next 12 months	Rowen Pritchard-Jones		*Added to forward planner*	ONGOING
ICB-AC-22-15	28-Nov-2022	**Winter Planning 2022-2023 Update**	Requested that Cllr Louise Gittins, as Chair of the Cheshire and Merseyside Health and Care Partnership, receive a report on Place Based Winter Planning	Anthony Middleton		*Report to be sent to Cllr Gittens by 20.01.23*	ONGOING
ICB-AC-22-16	28-Nov-2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	An update on dentistry and optometry. A full formal report on dentistry would be presented to Board in February 2023.	Clare Watson	Feb 2023	*Added to forward planner*	ONGOING
ICB-AC-22-17	28-Nov-2022	**Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee**	The Primary Care Strategy. This would be presented to the Board in March 2023	Clare Watson	Mar 2023	*Added to forward planner*	ONGOING

CHESHIRE MERSEYSIDE INTEGRATED CARE BOARD

CLOSED ACTIONS

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-22-01	01-Jul-2022	**ICB Constitution**	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 2) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the Board. 3) The wording of section 7.3 will be reviewed to ensure completeness. 4) The role of the local authority will be strengthened and added to the final version document prior to publication. 5) The principles in section 6.2.1 will be revised and updated subject to the approval of the Board.	Clare Watson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED
ICB-AC-22-02	**01-Jul-22**	**ICB Functions and Decision Map**	The diagram/wording on page 241 will be reviewed to make the link between the ICB and the Health and Wellbeing Boards clearer.	Claire Wilson	**27-Oct-22**	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in October following completion of the review of the Constitution, SORD and SFIs and Decision and Functions Map*	COMPLETED
ICB-AC-22-03	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	28-Nov-2022	*Workforce Update report included within the Director of Nursing and Care Report*	COMPLETED
ICB-AC-22-04	27-Oct-2022	**Executive Director of Nursing and Care Report - Recommendations within the Kirkup Report**	An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Agreed to take the Kirkup recommendations to the Quality Committee for consideration.	Christine Douglas	28-Nov-2022	*Taken action to Quality Committee*	COMPLETED
ICB-AC-22-05	27-Oct-2022	**Continuous Glucose Monitoring Update**	Requested that in 12 months' time the Board be provided with a progress update.	Rowen Pritchard-Jones	01-Oct-2023	*Added to forward planner*	COMPLETED
ICB-AC-22-06	27-Oct-2022	**Provider Collaborative Update**	Agreed that a strategic business case relating to increased delegation be brought to the Board for consideration.	Joe Rafferty	28-Nov-2022	Request to receive Business Case at February Board has been received. Added to forward plan.	COMPLETED
ICB-AC-22-07	27-Oct-2022	**Winter Planning 2022-23**	Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting	Anthony Middleton	28-Nov-2022	Winter Resilience Plan update report included on agenda for November 2022 meeting	COMPLETED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 January 2023

NHS Cheshire and Merseyside

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

Decision Log 2022 - 2023

Updated: 10 January 2023

NHS Cheshire and Merseyside

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-22-08	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	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 January 2023

NHS Cheshire and Merseyside

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-22-19	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	
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.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 January 2023

NHS Cheshire and Merseyside

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-22-34	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.	

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executives Report

26 January 2023

Agenda Item No	**ICB/01/23/06**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

Chief Executives Report (November 2022)

<table>
<tr><td>Executive Summary</td><td colspan="5">This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on:
System Pressures / NHS Urgent Care Update
Discharge funding for step down care - £200 million fund
Harmonisation of Clinical Commissioning Policies Update
Specialised Commissioning Update
Covid-19 Autumn Booster Update
ICB Organograms
North West Ambulance Service – Winter Watch
Decisions undertaken at the Executive Committee.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
note the content of the report
approve the publication of the revised statement on the harmonisation of clinical commissioning policies</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td colspan="2"></td><td>X</td><td></td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td>X</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No</td></tr>
<tr><td>Next Steps</td><td colspan="5">None</td></tr>
<tr><td rowspan="3">Appendices</td><td>Appendix One</td><td colspan="4">Outline of strike action dates in Cheshire and Merseyside</td></tr>
<tr><td>Appendix Two</td><td colspan="4">Clinical Commissioning Polices QIA List and updated legal statement</td></tr>
<tr><td>Appendix Three</td><td colspan="4">NWAS Winter Watch December 2022 Newsletter</td></tr>
</table>

Chief Executives Report (January 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 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. System Pressures / NHS Urgent Care Status

2.1 I am glad to report that there has been some alleviation of pressure across the system in the last week and would like to thank all our partners who have worked tirelessly to achieve this. Our Trusts that went to OPEL 4 have managed to go to OPEL 3 and sustain this. That said, OPEL 3 still represents a significant level of system pressure, and particularly for those trusts that have spent a sustained period of time escalated at OPEL 4, the recovery is ongoing and needs to be supported.

2.2 It is encouraging that ambulance handover delays have further reduced. However, whilst this is encouraging, those delays that are occurring still significantly compromises the ability of the ambulance service to meet its response times. With the improvement in handover times, we have seen improved ambulance response times for the people of Cheshire and Merseyside. Over the weekend of 14th and 15th January 2023 for example, the mean response time for Category 2 calls, which should be responded to within 18 minutes, stood at 20 minutes 48 seconds on the Saturday and 19 minutes 28 seconds on the Sunday. I cannot emphasise enough how important these response times are, and this improvement is encouraging when you consider that the response time exceeded 2 hours most days over the Christmas and New Year period.

2.3 Fewer of our residents are being cared for on hospital corridors. That said, corridor care should not happen at all and is a sign that we are still under great pressure.

2.4 Emergency departments are still full with too many patients spending in excess of 12 hours in department, but thankfully far fewer patients are currently experiencing extreme waits with an overall reduction in the numbers of patients in Emergency Departments waiting for a bed. However, our more challenged Trusts are still dealing with 50 or more patients in their Emergency Departments who are waiting for a bed each day, due to persistently high bed occupancy.

2.5 Whilst we have seen improvements in discharges and flow as a result of system wide efforts, our hospitals are still full with bed occupancy averaging 97% across our hospitals as we started the weekend (14th/15th) . This is despite well over 400 hospital escalation beds open and occupied.

2.6 Long stays are an issue, with 1,493 beds occupied by patients who have been in hospital for 21 or more days as at the 14 January 2023. Many of these longer stays are for patients who no longer meet the criteria to reside. The latest full week of data that we have, covering the 2nd to the 8th of January shows that 1,122 of our hospital beds were occupied by patients no longer meeting the criteria to reside in hospital, this is around 20% of our beds compared to approximately 12% nationally, and an ambition we set for no more than 10%.

2.7 We are immensely grateful for all the efforts that have been made over the past two weeks to deliver this progress, but as we can expect a high level of pressure for the coming months, and we also have the additional factor of ongoing industrial action, we need the continued efforts of system partners to:

- Increase and maintain the run rate of hospital discharges every day
- Make effective and rapid use of the national discharge funding
- Move patients to the first available slot, with a view to then moving then onward to the correct pathway if correct pathway capacity is not readily available.
- Collectively increase our risk-based decisions about who can go home earlier with a lower package than might previously have been assessed.

2.8 The ICB has been working closely with provider organisations to plan for days of industrial action and provide overall system coordination on the day as part of its Category 1 status under the civil contingencies act. The ICB's stategic coordination centre mobilised from the 01 December 2022 to support delivery of the urgent care system through the winter period steps up to an Incident command centre during periods of action and is manned round the clock until formal step down is agreed through the national incident command and control arrangements.

3. Discharge funding for step down care - £200 million fund

3.1 The Government announced[1] on 13th January 2023 the release nationally of £200m funding designed to increase capacity in post-discharge care and support improved discharge performance, patient safety, experience, and outcomes. Through use of this fund, integrated care boards are expected to deliver reductions in the number of patients who do not meet the criteria to reside but continue to do so, as well as improvements in patient flow which in turn help waiting times in emergency departments and handover delay.

[1] https://www.england.nhs.uk/publication/discharge-funding-for-step-down-care-200-million-fund/

3.2 This fund is a short-term intervention to support immediate improvements and reduce pressures across the UEC pathway, in response to increases in numbers of patients with no criteria to reside in acute beds. This fund is separate and in addition to other sources of funding such as the Adult Social Care Discharge Fund. Cheshire and Merseyside has received an allocation of £9.877 million. As with the approach undertaken by the ICB with the Adult Social Care Discharge Fund, the ICB will apportion the funding to Place as per the national NHS allocation formula.

4. Specialised Commissioning Update

4.1 NHS England National Moderation Panel took place in December 2022 and that from a North West perspective, the three North West Pre-Delegation Assessment Frameworks (PDAF) (Cheshire and Merseyside Greater Manchester and South Cumbria and Lancashire) have been received and endorsed.

4.2 A recommendation is going to NHSE Board in February 2023, that we move to joint working arrangements from the 01 April 2023. This conclusion was reached for all seven regions across England.

4.3 The North West were scrutinised on the following areas in particular, which we will reflect on to ensure that they are more front and centre of our revised PDAF submissions, were as follows:

- clinical leadership within Domain 2 and describing in more detail how clinicians will be the front and centre of decision making.
- the governance model in the North West given that we are unique in segmenting the specialised commissioning delegated list into two different distinct planning geographies.

4.4 Cheshire and Merseyside have been given the green light to move to the next step and that this will go to NHS England Board in February 2023. Alongside this, there will be a final list of services that we think are suitable and ready for delegated commissioning.

4.5 Next steps

- the joint working arrangements from the 01 April 2023 need to be approved by the 3 North West ICBs. This legally has to be a Section 65 joint working arrangement, as defined in the 2006 act, as amended. NHS England lawyers are working on this at present.
- establish a Joint Planning Forum and target operating model and for this to be up and running for the beginning of 2024.
- the planning guidance requires ICB's to identify a minimum of three joint priorities with specialised commissioning teams around transformation. Strategic Senior leadership meetings are taking place at NHSE to do further work around this, and we should be in position this time next month about what those priorities might look like from a Cheshire and Merseyside perspective.

- NHSE is required to do complete population-based budgets for 2023/24, working with ICBs. It is anticipated that the allocation formula is published at some point in January.
- Further work to ensure that ICB's are fully sighted on quality issues in relation to specialised services and that there is a common understanding about who is responsible around specialised activity.
- Completion of the revised PDAF (timescales for this are not yet known).

5. Harmonising Clinical Commissioning Policies Update

5.1 As the successor body to the nine former Clinical Commissioning Groups (CCGs) within Cheshire and Merseyside, we have inherited each CCG's commissioning policies which set out what services are available for the CCG's population as a whole and which are based on eligibility criteria.

5.2 Each CCG had a suite of policies with regards to the commissioning of various health care services. Having considered each policy it is evident that a degree of variation existed between the CCGs. Where this is the case, there is a need to develop and implement a single suite of commissioning policies across Cheshire and Merseyside as soon as possible so that the commissioning of these services is consistent and applicable across Cheshire and Merseyside going forwards.

5.3 Where there is no such variation between the CCG policies, NHS Cheshire and Merseyside has nonetheless determined that, in view of the age of the policies, there is still a need for those policies to be reviewed and for a single suite of commissioning policies across Cheshire and Merseyside to be developed.

5.4 Developing a single Cheshire and Merseyside wide suite of commissioning policies is a complex programme of work and requires formal processes to be followed, including a review and consideration of the latest evidence based clinical practice and engagement with patients, the public and other key stakeholders across Cheshire and Merseyside, including with local authorities.

5.5 In our previous statement on this matter published on 01 July 2022 we stated that we planned to be in a position to adopt a single suite of commissioning policies across Cheshire and Merseyside by 01 April 2023. Having now considered each policy in some detail, it has become clear that in view of the work involved in creating a single suite of policies across the NHS Cheshire and Merseyside footprint, we will not meet the intended date of 01 April 2023.

5.6 A paper is scheduled for the forthcoming Quality and Performance Committee, (19 January 2023), to seek approval to harmonise 56 (out of 111 Clinical Policies) (Appendix Two). For these policies, Quality Impact Assessments have been undertaken and there is little or no variation between the previous CCG policies and they are in line with the latest evidence base.

5.7 For the remaining clinical policies and more detailed consideration and work to ensure that the harmonisation of these policies results in an NHS Cheshire and Merseyside single suite of policies which are up to date and reflect the latest evidence base. This work is in progress, and we will engage with patients, the public and other key stakeholders across Cheshire and Merseyside as part of this process.

5.8 We hope to be in a position to adopt a single suite of commissioning policies across Cheshire and Merseyside by early 2024.

5.9 Considering this, we now request the Board approves the revised Legal statement as detailed within Appendix Two, that has been reviewed by Hill Dickinson.

6. Development of ICB Organograms

6.1 The Secretary of State for Health and Social Care has requested that every ICB publishes its structure charts / organograms on its public website and accordingly the details for Cheshire and Merseyside can be found on its website.[2]

6.2 As the Board is aware, in October 2022, a review of structures commenced, and a formal consultation was undertaken for a number of functions, places and teams. Further work is still required to determine the structures for the following teams:

- All Age Continuing Health Care,
- SEND,
- Digital
- the Medicines Optimisation team
- Research and innovation.

6.2 Therefore the published structures will be subject to further revision as we progress this work. It should also be acknowledged that throughout 2023/2024 additional functions and responsibilities will transfer to the ICB from NHS England and Health Education England and structures will need to be amended accordingly to reflect these changes.

7. North West Ambulance Services Activity

7.1 Each month, North West Ambulance Service (NWAS) provides partners with a useful newsletter that is shows a summary of its performance and calls to its Paramedic Emergency Service, NHS 111 service and Patient Transport Service, with comparisons to the previous year. Attached as Appendix Three to this report is the latest newsletter which shows the tremendous effort and challenges faced by our ambulance colleagues.

[2] https://www.cheshireandmerseyside.nhs.uk/media/mu3h3hdw/nhs-cheshire-merseyside-icb-organisational-structure-6-jan-2023.pdf

7.2 Of note in this newsletter is that there were more recorded incidences in December 2022 than the same time last year, but more patients were dealt with at the scene, so conveyance to hospital was lower this year than the same period last year.

8. Autumn 2022 COVID-19 Booster Programme Update

8.1 The Autumn booster offer is now into its 20th week with an uptake for all eligible cohorts in Cheshire and Merseyside, as of 15 January 2023, of 60.9% compared with an uptake in the North West region of 58.6%. Whilst uptake is lower than the last autumn booster and spring booster Cheshire and Merseyside are performing best in NW region and nationally uptake is in a similar position. Between the 05 September and 15 January 2023, the Cheshire and Merseyside programme has delivered 777,497 seasonal boosters and almost 14,000 primary doses as part of the continuing evergreen offer.

8.2 With demand expected to be low in Quarter 4 the network size has been reduced from 117 to 85 sites with ongoing review and community pharmacy as the main delivery model. As well as the standard offer, targeted hyperlocal offers are being used in low uptake areas and Primary Care Networks as well as for citizen groups such as those with severe mental illness and learning disabilities. Access and inequalities funding continues to be used to support local offers and the Living Well Buses with targeted communications to ensure that citizens are aware of the ongoing autumn winter seasonal booster and the evergreen offers.

8.3 Trust frontline Healthcare worker uptake is reported as 47.8 % which is higher than the national and regional percentage (both at 45.9%). However, there are significant variations in the denominator used by the national team and the actual Cheshire and Merseyside performance is nearer to 50.5%. A meeting is shortly to be held with the national team to try to resolve the denominator issues. Whilst Cheshire and Merseyside are performing better than other subregions within the Northwest, uptake remains disappointing and intensive work is ongoing at each Trust to improve the position.

8.4 The success of the Living Well service continues (offered by Cheshire Wirral Partnership) which is a system wide offer, directed by Place to target hard to reach, seldom heard groups to offer the autumn booster and evergreen offer. To date the service has delivered almost 10,000 COVID vaccinations, 2440 Make every Contact Count intervention and approaching 3000 health screenings across almost 250 clinics.

8.5 News on the future strategy for COVID vaccination and movement to business as usual together with funding to continue for the Covid Response Team after 31 March 2023 are still awaited.

9. Decisions taken at the Executive Committee

9.1 Since the last Chief Executive report to the Board in November 2022, the following decisions have been made under the Executives' delegated authority at the Executive Committee. At each meeting of the Executive Team any conflicts of interest stated were noted and recorded within the minutes:

- **Primary Care Rebate scheme.** The Executive Team considered a paper on contractual arrangements with pharmaceutical companies and the NHS where discounts are offered to get primary care to prescribe a particular brand of drug, highlighting that £2.1m of savings were identified last year alone. The Executive Team agreed to progress the development of a policy for Cheshire and Merseyside.
- **Area Prescribing Committees.** The Executive Team considered and approved a paper requesting the development of area prescribing committees.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Chief Executive

Appendix A: Strike Action across Cheshire & Merseyside

18th January

00:01 – 23:59hrs

- Mersey Care NHS FT

08:00 – 20:00hrs

- Countess of Chester Hospital NHS FT
- Mid Cheshire Hospitals NHS FT
- Bridgewater Community Healthcare NHS FT
- Wirral Community Health and Care NHS FT
- Wirral University Teaching Hospital NHS FT
- NHS Cheshire and Merseyside ICB
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Cheshire and Wirral Partnership NHS FT

19th January

08:00 – 20:00hrs

- Countess of Chester Hospital NHS FT
- Mid Cheshire Hospitals NHS FT
- Bridgewater Community Healthcare NHS FT
- Wirral Community Health and Care NHS FT
- Wirral University Teaching Hospital NHS FT
- NHS Cheshire and Merseyside ICB
- St Helens and Knowsley Teaching Hospitals NHS Trust
- Cheshire and Wirral Partnership NHS FT

23rd January

00:00 – 00:00hrs

- North West Ambulance Service

00:01 – 23:59hrs

- North West Ambulance Service

00:01 – 23:59hrs

- North West Ambulance Service

07:00 – 19:00hrs

- Liverpool Heart and Chest NHS FT
- Liverpool University NHS FT

24th January

00:01 – 23:59hrs

- North West Ambulance Service

26th January

Times TBC

- Alder Hey Children's NHS FT
- Liverpool Heart and Chest NHS FT
- Southport and Ormskirk Hospital NHS FT

6th February

08:00 – 20:00hrs

- Countess of Chester Hospital NHS FT
- Liverpool University Hospitals NHS FT
- Mid Cheshire Hospitals NHS FT
- Wirral University Teaching Hospital NHS FT
- St Helens and Knowsley Teaching Hospitals NHS FT
- Liverpool Heart and Chest Hospital NHS FT
- The Clatterbridge Cancer Centre NHS FT
- Liverpool Women's NHS FT
- Alder Hey Children's NHS FT
- The Walton Centre NHS FT
- North West Ambulance Service

7th February

08:00 – 20:00hrs

- Countess of Chester Hospital NHS FT
- Liverpool University Hospitals NHS FT
- Mid Cheshire Hospitals NHS FT
- Wirral University Teaching Hospital NHS FT
- St Helens and Knowsley Teaching Hospitals NHS FT
- Liverpool Heart and Chest Hospital NHS FT
- The Clatterbridge Cancer Centre NHS FT
- Liverpool Women's NHS FT
- Alder Hey Children's NHS FT
- The Walton Centre NHS FT
- North West Ambulance Service

9th February

Times TBC

- Organisations TBC

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Chief Executive

Appendix B: Clinical Commissioning Polices QIA List and revised legal Statement

Appendix Two: Revised Legal Statement for Approval

On 1st July 2022 NHS Cheshire and Merseyside Integrated Care Board (NHS Cheshire and Merseyside) became the new statutory body responsible for ensuring health care services are available to meet the reasonable needs of the people of Cheshire & Merseyside.
NHS Cheshire and Merseyside is required to have clinical commissioning policies that set out what services are available for our population as a whole and which are based on eligibility criteria.
As the successor body to the nine former Clinical Commissioning Groups (CCGs) within Cheshire and Merseyside, we have inherited each CCG's commissioning policies which set out what services are available for the CCG's population as a whole and which are based on eligibility criteria.

Each CCG had a suite of policies with regards to the commissioning of various health care services. Having considered each policy, it is evident that, in respect of the commissioning of some health care services, a degree of variation existed between the CCGs. Where this is the case, it is acknowledged by NHS Cheshire and Merseyside that there is a need to develop and implement a single suite of commissioning policies across Cheshire and Merseyside as soon as possible so that the commissioning of these services is consistent and applicable across Cheshire and Merseyside going forwards.

Where there is no such variation between the CCG policies, NHS Cheshire and Merseyside has nonetheless determined that, in view of the age of the policies, there is still a need for those policies to be reviewed and for a single suite of commissioning policies across Cheshire and Merseyside to be developed.

Developing a single Cheshire and Merseyside wide suite of commissioning policies is a complex programme of work and requires formal processes to be followed, including a review and consideration of the latest evidence based clinical practice and engagement with patients, the public and other key stakeholders across Cheshire and Merseyside, including with local authorities.

In view of the variation between existing policies, and in some cases the age of the existing policies, it is essential that any single suite of commissioning policies for Cheshire and Merseyside reflects and is based on up-to-date clinical practice and research, but also takes into account the current commissioning landscape, the changing needs of the Cheshire and Merseyside population and the duties on NHS Cheshire and Merseyside to ensure that health care services are available to meet the reasonable needs of the population.

In our previous statement on this matter published on 1st July 2022 we stated that we planned to be in a position to adopt a single suite of commissioning policies across Cheshire and Merseyside by 1st April 2023. Having now considered each policy in some detail, it has become clear that in view of the work involved in creating a single suite of policies across the NHS Cheshire and Merseyside footprint, we will not be in a position to carry out this work and adopt those policies by 1 April 2023.

We have identified 64 (of 112) policies where there is little or no variation between the previous CCG policies and, having reviewed those policies, they are in line with the latest evidence base. It is therefore intended that those policies are harmonised into a policy applicable across Cheshire and Merseyside. Following the review and subsequent endorsement of the completed Quality Impact Assessments in relation to those policies and approval of this approach by the Quality and Performance Committee of NHS Cheshire and Merseyside (held on 19th January 2023), we are now in a position to harmonise 56 of those policies, as detailed within Appendix 1a. The Quality Impact Assessments in relation to the remaining 8 of those 64 policies are not yet complete, but we hope to complete those shortly so that those policies can also be harmonised in the same way. The harmonisation process will produce equivalent policies for NHS Cheshire and Merseyside, applicable to the population across the NHS Cheshire and Merseyside area.

The remaining policies, following review, will require more detailed consideration and work to ensure that the harmonisation of these policies results in an NHS Cheshire and Merseyside single suite of policies which are up to date and reflect the latest evidence base. This work is in progress and, as appropriate, NHS Cheshire and Merseyside will engage with patients, the public and other key stakeholders across Cheshire and Merseyside as part of this process.

We very much hope to be in a position to adopt a single suite of commissioning policies across Cheshire and Merseyside by ***early 2024***, and we will publish new policies as soon as these are completed and have been through the relevant engagement and governance processes required.

In the meantime, NHS Cheshire and Merseyside will continue to adopt and operate the CCG policies it has inherited at Place/borough level, which means that there is currently no change in commissioning policy for local people resident in those Places/boroughs from what was in place prior to 1st July 2022.

We will continue to report progress on the development of the new Cheshire and Merseyside wide policies through regular updates via our website and through our local networks within communities.

56 Policies to be harmonised, following completed Quality Impact Assessments and approval by the Quality and Performance Committee (on 19/01/23):

Aesthetics/Cosmetics	• Cosmetic Procedures
Ear Nose & Throat (ENT)	• Rhinophyma Treatment
Endocrinology	• Monogenic Diabetes Testing
Musculo-skeletal (MSK)	• Low Back Pain - Peripheral Nerve Field Stimulation • Low Back Pain - Spinal Injections • Steroid Joint Injections • Tendonopathies Treatments
Obstetrics & Gynaecology	• Dilation and Curettage
Ophthalmology	• Irlens filters for Treatment of Dyslexia
Paediatrics & Child Health	• Positional Plagiocephaly Cranial Banding
Radiology	• Sinus X-ray
Rheumatology	• Joint Pain Injections
Surgery - Breast Surgery	• Breast Reduction • Mastopexy • Nipple Inversion Correction
Surgery - Ear Nose & Throat (ENT)	• Adenoidectomy • Grommets • Snoring Interventions • Tonsillectomy
Surgery - Gastroenterology	• Diastasis of the Recti • Gallstones
Surgery - General Surgery	• Haemorrhoid Surgery
Surgery - Musculo-skeletal (MSK)	• Bunion and Lesser Toe Deformity Surgical Removal • Carpal Tunnel • Dupuytren's Contracture • Epidural Adhesions • Foraminoplasty with Endoscopic Laser • Ganglion Removal • Knee Arthritis Diagnostic Arthroscopy • Knee Arthroscopy • Low Back Pain - Imaging • Low Back Pain - Spinal Fusion • Lumbar Spine Stabilisation Techniques (Non-Rigid) • Morton's Neuroma Surgery

	• Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal • Pectus Deformity Surgical Treatment • Prosthetic Intervertebral Disc Replacement • Temporo- Mandibular Joint Surgical Replacement • Total Knee Arthroplasty • Trigger Finger
Surgery - Obstetrics & Gynaecology	• Hysterectomy for Heavy Bleeding
Surgery - Ophthalmology	• Chalazion or Meibomian Cyst Removal • Macular Degeneration - Intraocular Telescope • Myopia and Hypermetropia Treatments • Xanthelasma Palpebrum Surgical treatment
Surgery - Plastic Surgery	• Body Contouring and other skin excisions • Ear Lobe Surgical Remodelling • Rhytidectomy - Face or Brow Lift • Skin Lesion Removal • Skin Pigment Disorder Treatment • Viral warts surgical/Laser Therapy
Surgery - Urology	• Penile Implant • Sterilisation Reversal (Male)
Surgery - Vascular	• Hyperhydrosis (Extreme Sweating) Surgery • Varicose Veins
Vascular	• Vascular Occlusions Chelation Therapy

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Chief Executive

Appendix C: NWAS Winter Watch December 2022 Newsletter

NHS
North West Ambulance Service
NHS Trust

Winter Watch
Spotlight on December 2022

This is a monthly summary of our performance and calls to our Paramedic Emergency Service, NHS 111 service and Patient Transport Service, with comparisons to the previous year. It is shared to keep you informed of the demand for our services. If you have any questions or comments on the content you can contact us at communications@nwas.nhs.uk.

Paramedic Emergency Service

168,668 emergency contacts (inc all 999 calls, duplicates, events, & 111 ambulance referrals)

▲ 6.6% increase on December 2021

92,945 unique incidents

(average of 2,998 a day)

▲ 0.85% increase on December 2021

3,027 additional operational resources were deployed throughout December 2022 to help manage demand

Hear & treat
16447 patient concerns were resolved over the telephone (17.70% of all incidents)

▲ Compared to 10,051 (10.91%) in December 2021

See & treat
26,971 patients treated at the scene and left there safely (29.02% of all incidents)

▼ Compared to 28,442 (30.86%) in December 2021

See & convey
49,527 patients taken to a destination for further care (53.29% of all incidents)

▼ Compared to 53,660 (58.23%) in Dedember 2021

Cat 1
11,001 (11.84% of all incidents) were categorised as immediately life-threatening

▼ Compared to 14,826 (16.09%) in December 2021

Cat 2
51,157 (55.04% of all incidents) were categorised as emergencies

▲ Compared to 50,892 (55.23%) in December 2021

Cat 3
17,437 (18.76% of all incidents) were categorised as urgent

▲ Compared to 14,334 (15.55%) in December 2021

Cat 4
954 (1.03% of all incidents) were categorised as less urgent

▲ Compared to 297 (0.32%) in December 2021

43,722 attendances at A&E departments

▼ Compared to 54,293 in December 2021

Average hospital handover time 48 minutes 12 seconds

▲ Compared to 27 minutes and 57 seconds in December 2021

NHS 111

156,023 calls answered in December 2022

Compared to 155,692 in December 2021

10,945 (7.66%) of all contacts resulted in ambulance response

Compared to 14,399 (10.26%) in December 2021

37,081 (23.80%) calls answered within 60 seconds

Compared to 56,317 (36.17%) in December 2021

20,422 callers were offered a callback

Compared to 20,027 in December 2021

20,548 (14% of all triaged calls) referred to a clinical advisor

Compared to 20,163 (14%) in December 2021

11,701 (8% of all patients) were advised to attend A&E

Compared to 13,459 (10%) in December 2021

2,683 (3%) patients were given self care advice

Compared to 2,917 (4%) in December 2021

90, 707 (63%) patients were referred to community, primary care or other services

Compared to 82,560 (59%) in December 2021

83.33% of patients surveyed in December 2022 after accessing 111 said they were very satisfied/fairly satisfied' with their experience

A decrease of 1.79% compared to December 2021 (reponse rates have been impacted by postal strikes).

Patient Transport Service

Overall contracted activity: 94,533 journeys

A decrease of 5% (99,236 journeys) on December 2021

45,302 ambulance journeys undertaken

A decrease of 6% (48,111 journeys) on December 2021

9,216 on the day unplanned journeys (discharges)

An decrease of 8% (10,072 journeys) on December 2021

39,532 pre-planned journeys (outpatients)

A decrease of 10% (44,042 journeys) on December 2021

45,141 renal and oncology patients transported

An increase of 0.46% (44,933 journeys) on December 2021

8,254 aborted journeys (on the day cancellation/patient no show)

An increase of 0.48% (8,186 journeys) on December 2021

Integrated Care Board Report

26 January 2023

Place Director Report – Wirral

Agenda Item No	**ICB/01/23/07**
Report author & contact details	Simon Banks, Place Director (Wirral)
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Simon Banks, Place Director (Wirral)

Place Director Report – Wirral

<table>
<tr><td>Executive Summary</td><td colspan="5">Each host Place is required to produce a Place Director's Report for consideration by the Cheshire and Merseyside Integrated Care Board.

The Wirral Place Director report aims to provide an overview of the Wirral Place, its successes, its partnership working and its challenges.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• note the contents of the report and presentation.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td colspan="2"></td><td>x</td><td></td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td></td><td colspan="2">X</td><td>X</td><td>X</td></tr>
<tr><td>Appendices</td><td>Appendix A</td><td colspan="4">Wirral Place Director Presentation</td></tr>
</table>

NHS
Cheshire and Merseyside

Place Director (Wirral) Presentation

26 January 2023

Overview

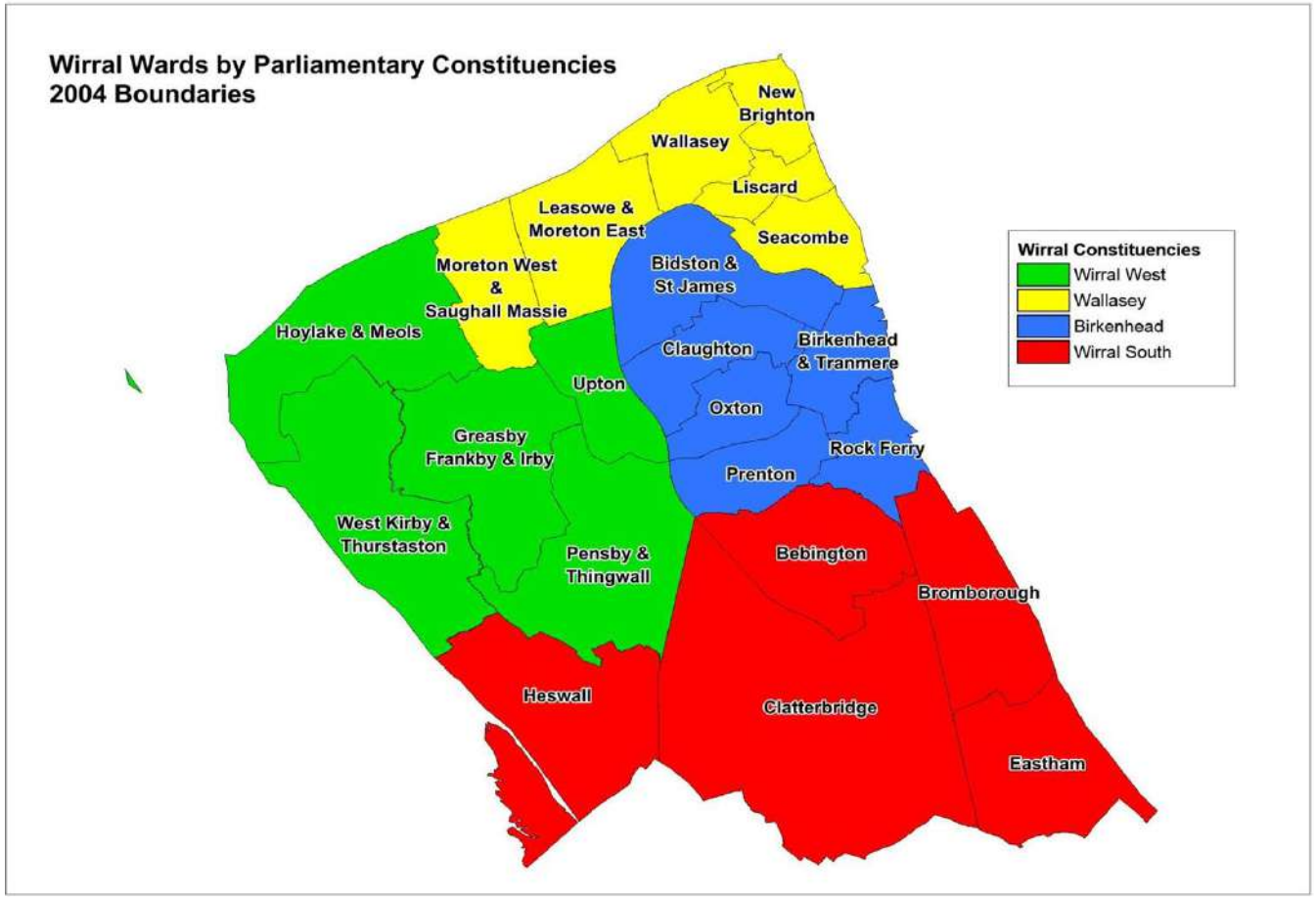
1. Our Wirral Place
2. Our context
3. What guides us
4. How we work together
5. What we working on
6. Frankie's Story

NHS
Cheshire and Merseyside

Our Wirral Place

Our Wirral Place

Resident Population c. 323,000	47 General Practices	5 Primary Care Networks
1 Acute Trust	1 Community Trust	1 Mental Health Trust
Vibrant voluntary, community, faith and social enterprise sector		
1 Local Authority	22 Wards 4 Constituencies	



Our Wirral Place

- Wirral is as diverse as it is distinctive. It is a place of disparities, with some of the most affluent and deprived wards in the UK on opposite sides of the motorway, which runs through the middle of the borough.

- A peninsula some 15 miles long and 7 miles wide, it is bound by the River Dee to the west, River Mersey to the east, and the Irish Sea to the north.

- Named one of the happiest places to live in the UK, it has a current population of 322,796 (48.4% Male/ 51.6% Female), Wirral is one of the largest metropolitan boroughs in England. This population is set to increase by 3% to 334,500 in 2040.

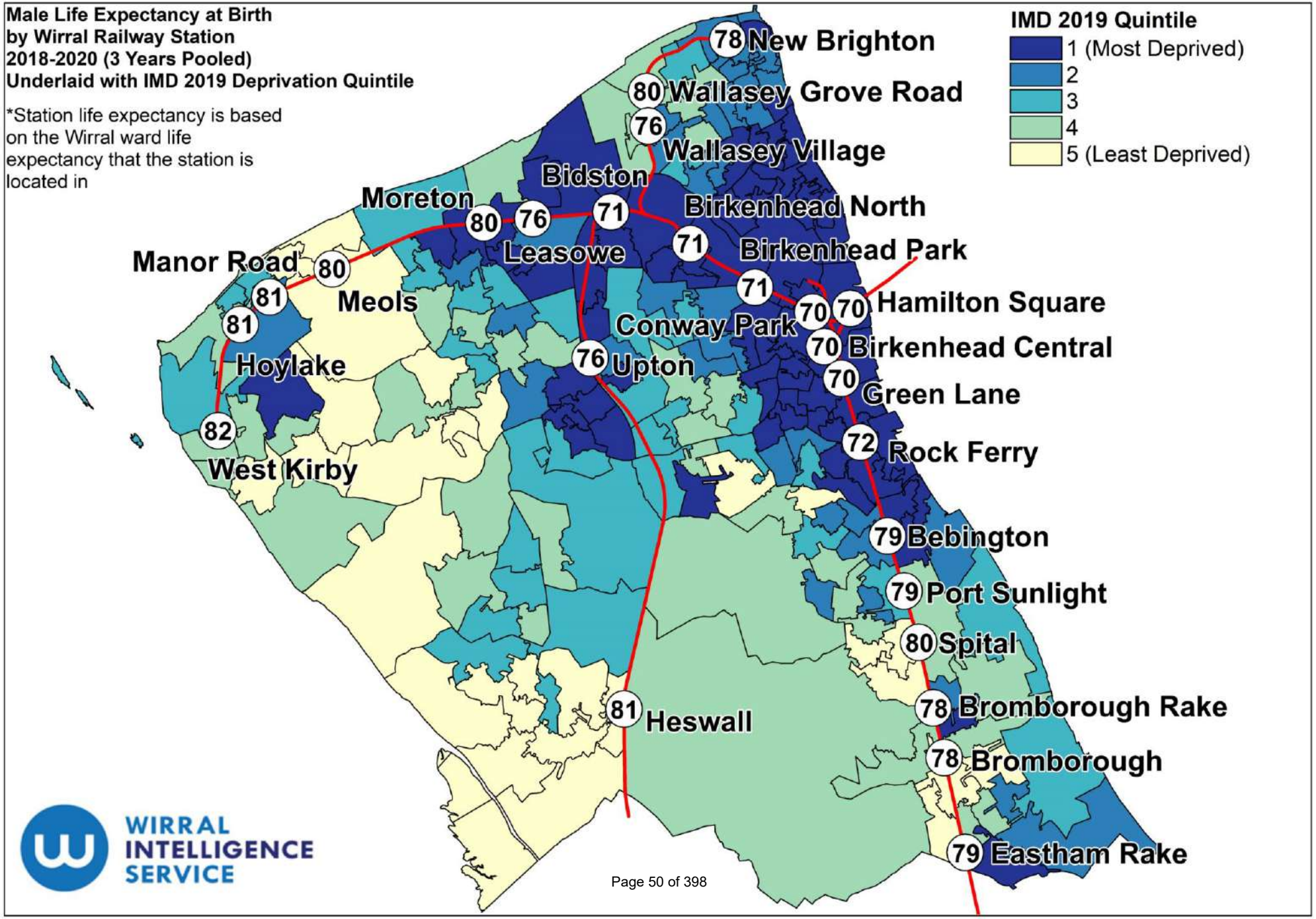
- Wirral has 50 miles of rural walking routes, cycle areas and beaches, 24 miles of coastline and some of the best parks and green spaces in the Country. A rich built, industrial, maritime, social and cultural heritage that is internationally significant whilst also being a very connected and accessible destination.

- A great place to live, work, and to do business.

NHS
Cheshire and Merseyside

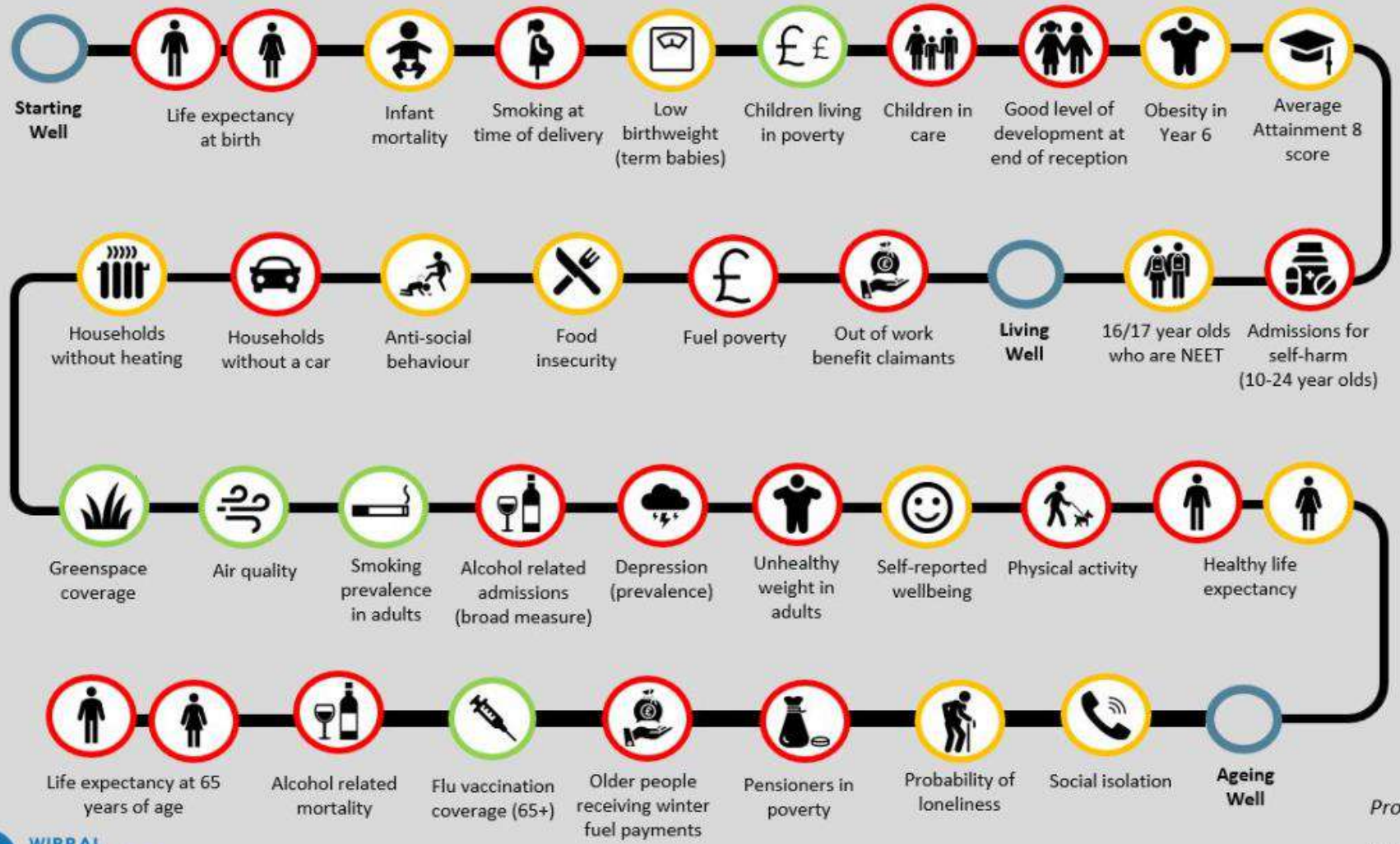
Our context

Source: [State of the Borough - Wirral Intelligence Service]


Male Life Expectancy at Birth
by Wirral Railway Station
2018-2020 (3 Years Pooled)
Underlaid with IMD 2019 Deprivation Quintile
*Station life expectancy is based on the Wirral ward life expectancy that the station is located in
IMD 2019 Quintile
1 (Most Deprived)
2
3
4
5 (Least Deprived)
78 New Brighton
80 Wallasey Grove Road
76 Wallasey Village
Bidston
Moreton
80
76
71 Birkenhead North
Leasowe
71 Birkenhead Park
Manor Road
80
81
Meols
71
70
70 Hamilton Square
81
Conway Park
70 Birkenhead Central
76 Upton
Hoylake
70 Green Lane
82
72 Rock Ferry
West Kirby
79 Bebington
79 Port Sunlight
80 Spital
81 Heswall
78 Bromborough Rake
78 Bromborough
79 Eastham Rake
WIRRAL INTELLIGENCE SERVICE

Wirral life course statistics 2021

A comparison to England



Wirral Facts

Population

*About 324,000 people live in Wirral

Deprivation

35% of the Wirral population live in the top 20% most deprived areas in England

Child Poverty

15% of children aged 0 to 15 live in poverty in Wirral

Key

Statistical significance to England

- Better
- No significant difference
- Worse

Produced by Wirral Intelligence Service

Some icons were made by FlatIcon and are available here: https://www.flaticon.com/

WIRRAL INTELLIGENCE SERVICE

Wirral Health Inequalities Electoral Ward Profiles

Better 95% | Similar | Worse 95%

Quintiles: Best | | | | Worst

Indicator	Bebington	Bidston and St James	Birkenhead and Tranmere	Bromborough	Clatterbridge	Claughton	Eastham	Greasby, Frankby and Irby	Heswall	Hoylake and Meols	Leasowe and Moreton East	Liscard	Moreton West and Saughall Massie	New Brighton	Oxton	Pensby and Thingwall	Prenton	Rock Ferry	Seacombe	Upton	Wallasey	West Kirby and Thurstaston	Wirral	England
Total Population	15,669	16,256	16,926	16,427	13,986	14,201	14,195	13,728	13,126	13,451	[illegible]	[illegible]	13,958	15,162	13,784	13,024	14,786	14,751	15,609	16,924	14,658	12,543		
Population aged 65 years and over	3,375	2,340	1,948	3,021	4,146	3,244	3,392	4,058	4,374	3,602	2,785	3,012	3,402	3,336	3,325	3,775	3,067	2,251	2,066	3,633	3,535	3,602		
Black and Minority Ethnic Population (Census, 2011)	683	836	1,682	659	512	831	410	487	653	723	648	768	476	922	835	460	735	820	846	764	587	764		
IMD Score, 2019	17.1	60.6	61.5	30.8	11.4	37.3	17.9	9.5	6.3	12.2	39.3	39.1	24.8	32.0	21.3	15.3	23.5	54.2	58.0	33.8	15.6	12.6	29.6	21.7
Income deprivation, IMD 2019	9.9	37.7	36.7	16.7	6.5	21.1	9.9	6.0	4.3	7.4	23.5	21.1	14.7	18.0	11.6	9.9	13.6	33.2	33.8	20.8	8.9	7.6	17.4	12.9
Older people in Poverty, English Indices of Deprivation, 2019	10.6	36.3	40.1	17.9	7.4	21.8	12.1	7.4	5.1	8.9	25.6	21.5	18.0	19.7	13.2	13.7	15.7	29.9	31.4	22.3	11.6	9.1	16.6	14.2
Child Poverty, English Indices of Deprivation , 2019	11.7	45.2	41.1	20.0	5.9	24.9	11.5	5.7	4.0	5.6	29.2	25.8	18.2	20.2	11.2	8.3	13.8	41.9	41.5	25.6	9.6	6.4	21.8	17.1
GCSE Achievement	73.9	44.1	37.4	62.2	72.8	54.5	57.2	69.5	79.9	73.0	46.7	48.9	59.3	49.5	64.2	69.3	68.7	53.1	39.2	53.1	61.1	76.9	59.1	56.6
Fuel Poverty, 2020	13.1	23.2	22.4	16.0	9.3	15.8	11.1	8.4	8.0	11.1	16.0	17.7	11.0	15.2	10.8	10.7	13.6	22.1	21.7	13.8	11.7	9.0	14.4	13.2
Emergency hospital admissions in under 5s	173.8	183.1	190.7	176.4	202.2	197.0	174.0	168.6	142.8	171.4	187.5	176.8	199.4	151.9	224.1	139.9	183.0	214.9	211.4	198.0	163.5	123.0	182.9	140.7
Emergency hospital admissions for injuries in under 5 years olds	108.0	163.7	174.0	97.5	112.8	155.2	117.6	122.4	80.5	125.1	140.4	130.4	129.2	131.1	102.8	120.6	120.7	140.5	152.6	120.7	112.4	109.5	130.8	119.3
Emergency hospital admissions for injuries in under 15 years old	82.1	130.0	124.7	82.0	80.8	119.1	87.3	89.8	73.9	92.2	110.3	111.7	89.9	107.4	104.5	99.0	78.4	110.7	105.4	111.5	72.8	81.7	99.9	92.0
Emergency hospital admissions for injuries in 15 to 24 years old	127.0	219.2	326.9	160.8	82.1	196.3	119.6	106.7	102.5	126.1	192.2	165.3	183.5	163.1	171.7	141.0	171.6	259.3	175.7	188.6	122.9	156.0	174.0	127.9
Emergency hospital admissions for intentional self harm	95.7	214.8	302.8	128.4	64.3	210.1	109.3	53.7	85.2	82.7	153.9	162.9	134.8	163.3	126.8	98.0	126.5	227.9	229.2	168.0	68.5	94.0	147.9	100.0
Emergency hospital admissions for all causes, all ages	107.2	176.2	180.7	127.9	101.8	148.4	112.4	94.7	84.9	102.8	150.7	134.2	125.3	122.5	122.5	104.9	120.3	180.2	165.2	137.2	96.2	94.1	125.5	100.0
Emergency hospital admissions for coronary heart disease	109.2	151.3	154.3	105.4	84.3	118.2	111.5	100.2	77.3	82.1	127.0	115.1	127.3	98.9	117.7	101.7	93.8	151.6	164.9	118.4	92.2	85.3	110.0	100.0
Emergency hospital admissions for Myocardial Infarction (heart attack)	66.5	108.3	120.3	79.2	62.7	88.2	75.7	84.7	69.6	70.9	101.7	85.0	85.8	68.3	96.7	71.3	73.5	91.6	126.6	105.0	73.0	67.7	83.3	100.0
Emergency hospital admissions for stroke	89.9	125.4	143.9	94.9	84.9	101.1	85.5	74.1	81.8	79.9	131.4	110.5	79.2	88.0	97.8	90.7	86.4	118.1	152.5	87.4	69.3	84.0	94.6	100.0
Emergency hospital admissions for hip fracture in 65+	79.3	145.2	122.3	107.5	106.8	112.9	79.6	69.0	79.3	101.5	128.7	109.6	89.1	115.6	133.3	74.0	89.9	156.6	119.2	101.8	67.0	78.0	99.0	100.0
Incidence of all cancers	111.4	134.6	113.9	104.8	103.9	104.7	118.3	102.3	101.4	100.1	118.8	101.9	116.1	100.5	103.0	115.5	111.0	130.3	119.4	109.6	100.9	102.1	109.3	100.0
Incidence of breast cancer	109.6	79.6	89.4	97.6	103.0	98.3	114.4	104.2	114.7	129.8	92.0	83.9	106.2	99.0	117.8	133.6	115.6	82.8	84.5	114.5	98.7	114.5	104.8	100.0
Incidence of colorectal cancer	119.9	135.4	100.8	93.9	108.6	104.6	126.1	111.2	114.9	113.7	136.6	89.9	144.8	104.8	98.8	113.4	121.3	104.3	156.5	96.3	103.0	100.0	112.8	100.0
Incidence of lung cancer	97.7	204.0	222.5	121.5	74.7	112.3	109.8	74.1	53.3	69.4	150.1	146.4	126.1	132.0	98.2	90.6	115.2	171.8	180.5	125.0	82.8	78.7	112.8	100.0
Incidence of prostate cancer	108.8	93.6	52.6	89.0	117.5	86.9	107.8	108.8	105.9	101.8	99.3	78.1	74.9	66.0	115.2	119.7	110.3	98.8	69.4	86.6	94.7	101.8	96.3	100.0
Deaths from all cancer, all ages	99.6	157.2	140.6	108.5	103.6	106.9	114.8	93.9	90.2	99.9	128.0	112.8	108.9	115.3	96.5	101.6	95.6	144.4	142.4	110.7	97.0	87.1	108.6	100.0
Deaths from all cancer, under 75 years	91.8	188.4	165.5	113.8	91.4	111.7	122.0	79.4	73.1	94.0	143.8	127.7	105.0	105.2	104.8	95.0	112.3	151.8	160.0	121.8	96.1	82.7	112.5	100.0
Deaths from all causes, all ages	109.6	164.4	166.1	121.7	104.8	140.7	94.0	74.4	85.1	107.1	122.9	131.7	101.2	123.4	92.0	85.9	100.0	164.5	156.1	122.2	81.1	79.9	110.3	100.0
Deaths from all causes, under 75 years	99.7	215.5	233.1	128.0	85.1	121.3	111.4	68.1	71.7	84.0	145.4	140.5	107.8	124.1	96.1	85.6	117.3	185.3	193.7	136.9	86.2	75.6	119.7	100.0
Deaths from causes considered preventable, under 75 years	96.6	266.9	293.2	128.4	68.4	118.5	111.7	65.8	51.0	75.7	159.6	159.6	115.7	124.9	88.4	71.9	113.4	214.6	219.8	151.7	82.8	69.6	124.7	100.0
Deaths from circulatory disease, all ages	92.8	138.5	145.1	117.4	90.6	110.5	86.3	71.6	81.9	85.8	125.2	114.2	99.0	111.1	81.9	79.7	90.9	118.9	154.9	92.4	84.7	74.8	97.8	100.0
Deaths from circulatory disease, under 75 years	86.9	196.9	235.3	123.6	62.3	107.2	101.9	56.8	79.7	54.3	145.3	120.7	89.5	114.3	74.8	74.2	115.0	129.9	222.8	124.3	73.2	64.1	107.2	100.0
Deaths from coronary heart disease, all ages	89.6	155.1	158.4	119.7	80.3	95.6	83.3	71.6	69.7	78.7	120.7	107.7	89.2	101.6	80.2	87.2	91.1	118.9	161.4	83.8	77.9	60.0	93.9	100.0
Deaths from respiratory diseases, all ages	120.1	232.0	203.7	140.6	97.2	156.8	116.3	72.0	78.5	104.5	181.2	164.5	132.2	151.9	96.8	82.6	131.8	211.8	207.9	150.5	88.4	76.2	126.8	100.0
Deaths from stroke, all ages	93.7	104.7	123.7	118.4	105.0	142.1	102.2	78.6	84.1	89.7	147.4	147.0	94.3	161.6	91.8	75.1	112.0	131.4	142.3	100.0	82.2	99.8	107.0	100.0

NHS
Cheshire and Merseyside

What guides us

What guides us - Wirral Plan 2021-2026

Our vision is to create equity for people and place and opportunities for all to secure the best possible future for our residents, communities and businesses. The vision has been developed to build on five thematic priorities that focus on improving outcomes for whole population groups.

Sustainable Environment
Working towards a clean-energy, sustainable borough that leads the way in its response to the climate emergency and is environmentally friendly.

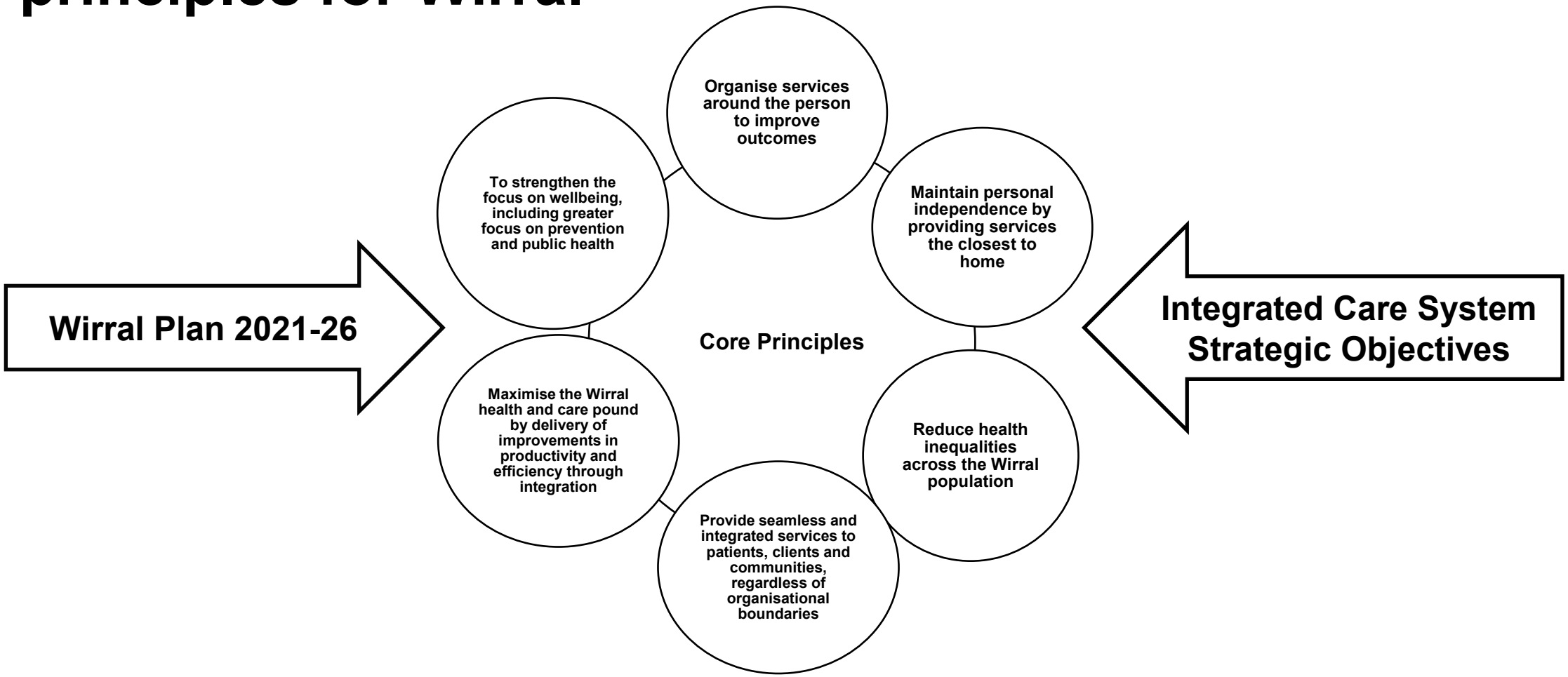
Brighter Futures
Working together for brighter futures for our children, young people and their families by breaking the cycle of poor outcomes for all regardless of their background.

Inclusive Economy
Working for a prosperous, inclusive economy - helping businesses to thrive and creating jobs and opportunities for all.

Safe and Pleasant Communities
Working for safe and pleasant communities where our residents feel safe, and are proud to live and raise their families.

Active and Healthy Lives
Working to provide happy, active and healthy lives for all, with the right care, at the right time to enable residents to live longer and healthier lives.

What guides us – integrated health and care principles for Wirral

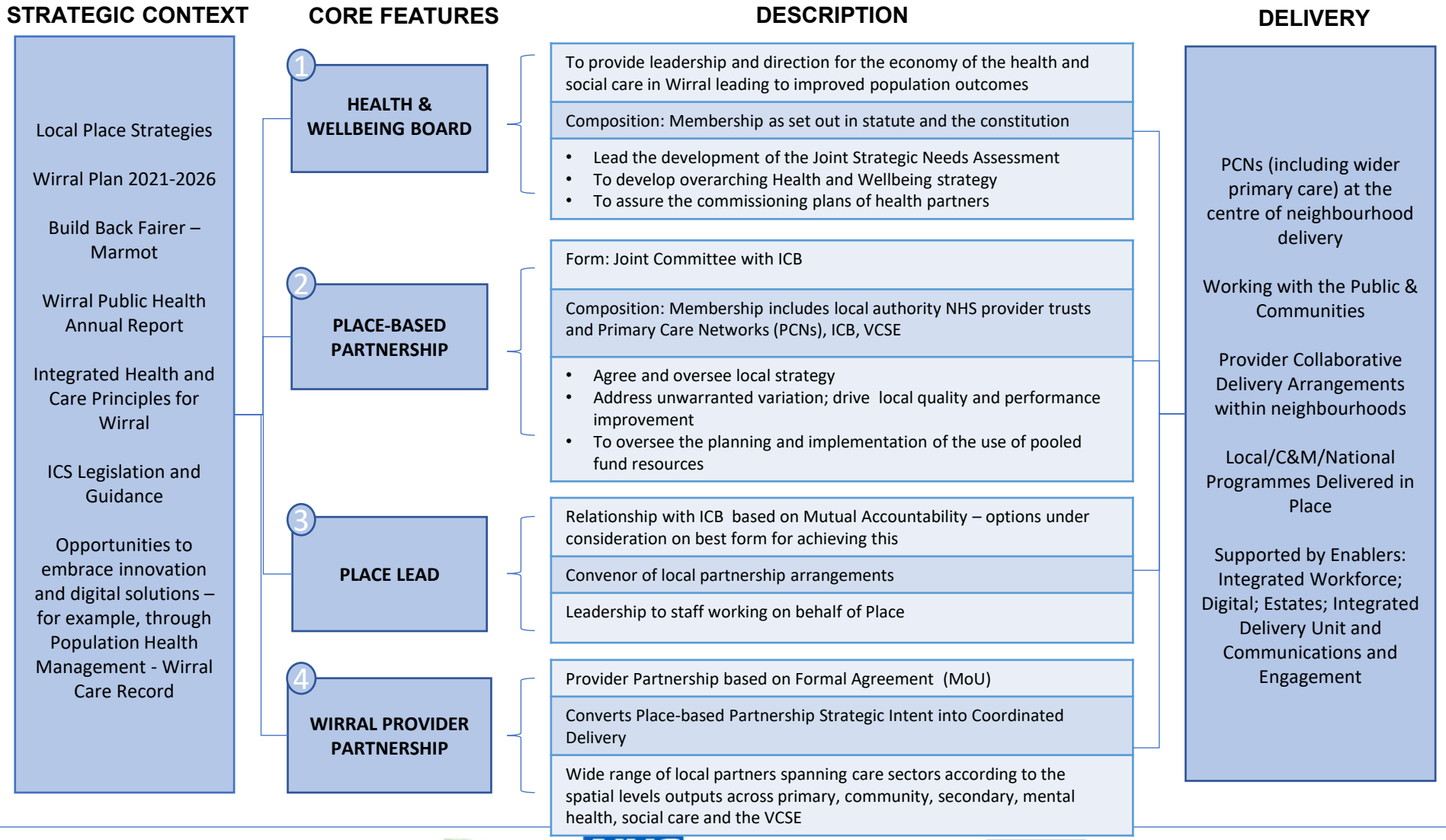


NHS
Cheshire and Merseyside

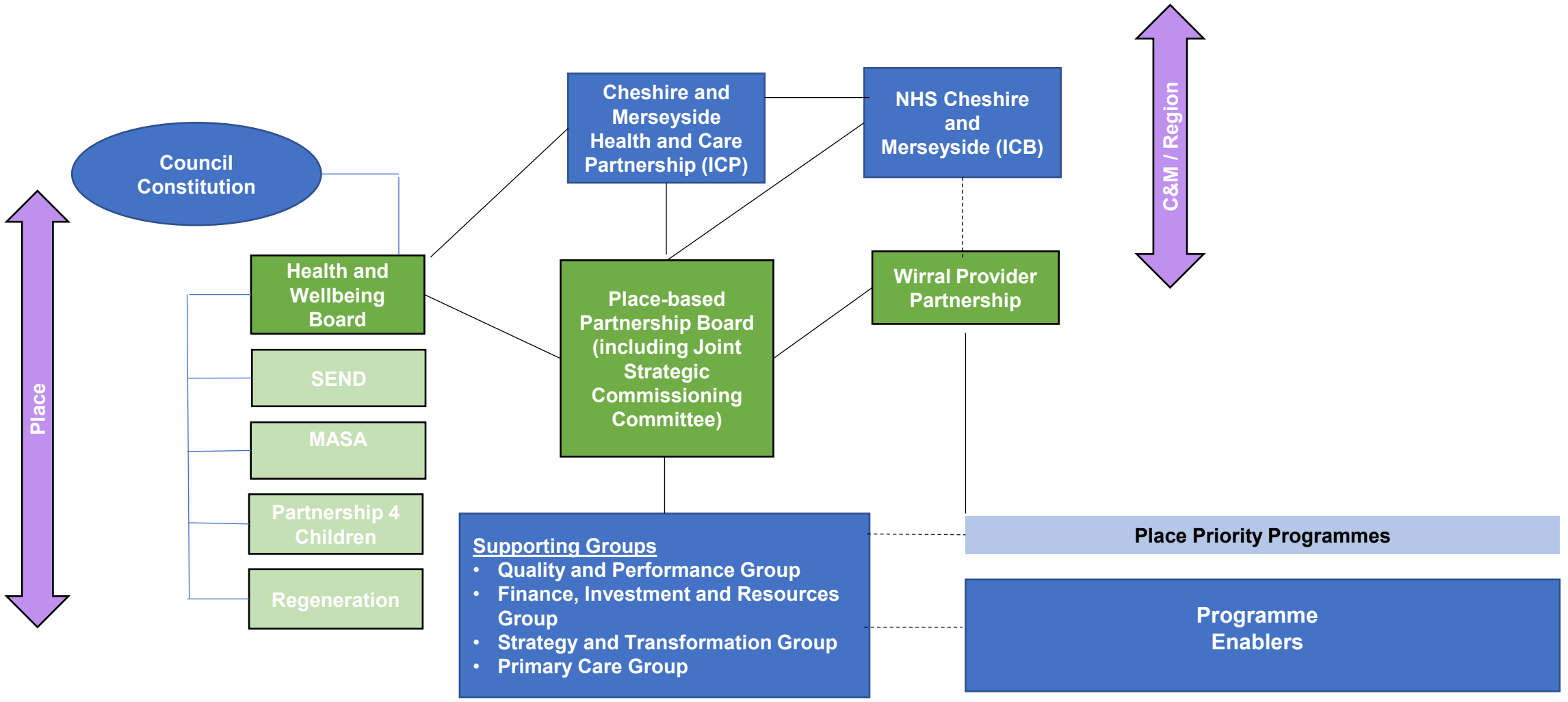
How we work together

NHS Wirral University Teaching Hospital NHS Foundation Trust
Primary Care Partnership WIRRAL
NHS Wirral Community Health and Care NHS Foundation Trust
NHS Cheshire and Wirral Partnership NHS Foundation Trust
NHS Cheshire and Merseyside
WIRRA

How we work together - Wirral Operating Model



How we work together - Governance Map



NHS
Cheshire and Merseyside

What we are working on

We are working together…..

- To deliver NHS Operational Planning Priorities 2022/23 and local Place priorities, aligned to Wirral Plan 2026 and Health and Wellbeing Strategy.
- To enable greater independence for adults and older people in their own homes and local environment.
- For brighter futures for our children, young people, and their families by breaking the cycle of poor outcomes for all regardless of their background.
- To provide happy, active, and healthy lives for all, with the right care, at the right time to enable residents to live long and healthier lives.
- For a prosperous, inclusive economy - helping businesses to thrive and creating jobs and opportunities for all.
- To ensure that primary care is integrated into Place governance and delivery mechanisms in Wirral.
- To mitigate the impact of cost-of-living increases on our population.
- Maximise the use of public sector estate and ensure that this is linked to Wirral Council's Local Plan and regeneration work.

NEW LOCAL

Three NHS paradigms: state, market and community

The NHS	State paradigm	Market paradigm	Community paradigm
Key organisational principle	Standardisation	Efficiency	Prevention
Key problems seeking to solve	Treating illness	Treating illness more efficiently	Preventing illness, alongside treatment when needed
Locus of power	Clinician and Whitehall bureaucrat	Clinician and manager	Clinician and community
View of service user	Deficit-led: primarily a passive patient	Transaction-led: a customer with choice determined by provider	Asset-led: a participant in their own health and wellbeing
View of communities	Not in the purview of services	A source of alternatives through social prescribing	Equal partners with deep insight into effective service response
Implementation method	Top-down, uniform model of provision	Targets, performance management and productivity drives	Devolution, culture change and deep community engagement
Organisational relationships	Separate specialist organisations	Competition between organisations	Collaboration and shared community-led mission across organisations
Funding model	Centrally planned funding model	Activity-based funding model	Place-based funding allocations, joint investment in prevention
Accountability	Whitehall	Whitehall, across an increasing number of arms-length bodies	Local accountability in the context of a national outcomes framework
Approach to engagement	Not widely pursued	Patient feedback sought through closed surveys	Community participation viewed as essential to service design
Attitude to data	Quantitative data informs decision-making at the top	Quantitative data informs performance management within different services	Quantitative data, combined with qualitative community insights, informs prevention shift

Moving the paradigm?

NHS
Cheshire and Merseyside

Frankie's Story

Meet Frankie

I am Frankie and I'm 16 years old. I live with my mum and younger brother in South Wirral. My dad doesn't live with us but he's sometimes around. We have contact but we don't always get on very well.

I sometimes struggle with my mental health, and I have self-harmed and attempted suicide before, but I do feel more positive now. My mum also struggles with low mood and drug and alcohol use.

I have a diagnosis of autism. I have been missing from home a number of times , and this has caused problems between me and my mum.

I've just started at college which I'm enjoying. I've got an Education Health Care Plan and I'm supported by a mentor.

I had a social worker for over two years as there were concerns about my safety and possible exploitation. I was sexually assaulted in a relationship I had.

Frankie’s Story

- January 2019- became known to children's services
- February 2021- Admitted to Wirral Hospital
- March 2021 -referral to children's services
- September 2022- Police Involvement
- November 2022- Stepped down

Frankie’s Story

- January 2019- became known to children's services
- February 2021- Admitted to Wirral Hospital
- March 2021 -referral to children's services
- September 2022- Police Involvement
- November 2022- Stepped down

Areas of Good Practice (1)

Agency	Comments
Children's Services	There has been a positive impact for Frankie during the period of planning. The family have been offered a number of services. CAMHs are working directly with Frankie and this work is bringing about some positive changes. The SW has been able to build a relationship with the family.
Domestic Abuse Hub	Based on partnership working, there is evidence that the Frankie's needs have been recognised.
Compass	Excellent recording, evidence base, impact, and prevention of further Missing and CE risk since the intervention.
Police	Really good partnership working has taken place. Frankie has been protected from future harm. Her wishes and feelings have clearly been taken into consideration. She has been subject of a strategy meeting and heard at MARAC within 3 days of the incidents being reported. Thorough police report provided for the strategy meeting. Although Frankie does not wish to proceed with the rape allegation, further Investigative checks and processes are being undertaken before the case is filed.

Areas of Good Practice (2)

Agency	Comments
Cheshire and Wirral Partnership Trust	Within CAMHS there is clear evidence of good record keeping, plans, risk management and responding to need. It is difficult to measure improvement in the young person due to the complex presentation.
Wirral Community Health and Care Trust	It is difficult to measure if there has been improvement across all outcome areas by the MDT i.e. To support Frankie to reduce risk behaviours and improve mental health outcomes, to support mother to safeguard Frankie and develop their relationship further. To support Frankie and her mother to access services.

Overall Comments

This case is of a good quality.

There is evidence of consistently good and outstanding practice by a range of agencies and services highlighted in the report, and the range of interventions have undoubtedly made Frankie safer and provided her with tools to support her in the long term.

The audit reports have identified the importance of understanding the complexities of the relationships between Frankie and her parents, as these will need to be worked on before stronger relationships can form. However, the recent work led by the social worker, with Frankie's mum has helped her understand what shapes her relationship with Frankie, and this work is showing positive outcomes.

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

The Director of Nursing & Care's Report

Agenda Item No	**ICB/01/23/09**
Report author & contact details	Kerry Lloyd – Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Chris Douglas – Executive Director of Nursing & Care
Responsible Officer to take actions forward	Kerry Lloyd – Deputy Director of Nursing & Care

<table>
<tr><td>Executive Summary</td><td>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 and issues impacting on quality and safety within the Cheshire and Merseyside ICS footprint.

The report will feature updates that include:

• Industrial Action
• System wide operational pressures
• The All Age Continuing Health Care Review (AACHC)
• Special Educational Needs and Disabilities (SEND) – ICS Maturity Matrix
• Management of Serious Incidents (including North-West Ambulance Service)
• Supporting Patient Discharge.</td></tr>
<tr><td>Purpose (x)</td><td><table>
<tr><th>For information / note</th><th>For decision / approval</th><th>For assurance</th><th>For ratification</th><th>For endorsement</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table></td></tr>
<tr><td>Recommendation</td><td>The Board is asked to:
• note the content of the report and request additional information/assurance as appropriate.</td></tr>
<tr><td>Key issues</td><td>In preparation for the planned first wave of industrial action (IA), the ICS established a governance framework that aligned to both national and regional architecture. Within that framework, was the establishment of a clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell has met twice weekly to plan and mitigate the associated risks to patient safety, as a result of the IA. The Cheshire and Merseyside cell presented the learning from the first wave of the IA at both the North West Director of Nursing meeting, and the regional clinical/workforce cell

Current demand for health and care services, combined with resource challenges, has resulted in growing operational service pressures. Such pressures have the potential to impact on quality and safety of the services provided. The quality governance framework for oversight, as previously reported, supports proportionate risk-based escalation of risks and issues, in line with the ICB governance framework:

• Organisational oversight
• Place based oversight
• System based oversight.

The AACHC review across C&M has commenced, with a preliminary update brought to the Executive meeting of the ICB in January 2023, with</td></tr>
</table>

<table>
<tr><td></td><td>an expected completion date of Autumn 2023. The reviewers have developed a full programme plan and are currently in the ‘information gathering and diagnostic phase’. There is ongoing engagement with system partners to better understand feedback from the range of stakeholders involved in delivering and receiving AACHC in each of the nine places across C&M.

The Director of Nursing & Care continues to progress the work to deliver improved outcomes for those children and young people (and their caregivers) with SEND. The ICS must submit a quarterly self-assessment of their maturity in relation to this important agenda. Recognising the need for place-based partnership working, whilst supporting Executive responsibility at ICS level, is an area of ongoing focus, with a specific focus as we move into Quarter 4 2022/23 of the co-production agenda.</td></tr>
<tr><td>Key risks</td><td>That quality of service provision and patient safety is negatively impacted by demand for services.</td></tr>
<tr><td rowspan="3">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td></td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Route to this meeting</td><td colspan="4">Not Applicable</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">No conflict of interest identified</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="4">Not Applicable</td></tr>
<tr><td>Equality, Diversity and Inclusion</td><td colspan="4">The nature and content of the paper does not require an Equalities Health Impact assessment (EHIA) to be undertaken.</td></tr>
<tr><td>Health inequalities</td><td colspan="4">Not Applicable</td></tr>
<tr><td>Next Steps</td><td colspan="4">Reporting will continue via the established governance routes.</td></tr>
<tr><td>Appendices</td><td colspan="4">None</td></tr>
</table>

Director of Nursing and Care Report

1. Executive Summary

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

1.2 The report will feature highlights and updates into areas that include:

- Industrial Action
- System wide operational pressures
- The All Age Continuing Health Care Review (AACHC)
- Special Educational Needs and Disabilities – ICS Maturity Matrix
- Management of Serious Incidents (North-West Ambulance Service)
- Supporting Patient Discharge.

2. Industrial Action

2.1 There have been several periods of IA taking place throughout the month of December 2022 and January 2023, with further dates planned for January 2023. The organisations identified for IA have been concentrated within the C&M system.

2.2 In preparation for the first wave of IA, the ICS established a governance framework that aligned to both national and regional architecture. Within that framework, saw the establishment of a clinical/workforce cell. The cell comprises Nursing, Human Resource and Medical senior leaders. The cell has met twice weekly since late November 2022, to plan and mitigate the associated risks to patient safety as a result of the IA.

2.3 The cell has gathered insight and impact feedback from all affected organisations within C&M and has developed a tracker for oversight of any associated patient harm. Several incidents across the day of action have been identified and further investigatory work is underway to establish the timeline and patient level detail before outcomes can be concluded.

2.4 The C&M cell presented the learning from the first wave of IA at both the North-West Director of Nursing meeting, and the regional clinical/workforce cell.

3. System Wide Operational Pressures

3.1 The C&M ICS has continued to see extended waits for services by patients across the health and care system. The nursing and care team have worked with regional colleagues to develop a suite of documents that support in ensuring that professional standards are maintained during periods of increased pressure. The team has oversight of any patient related harm via organisational/place based reporting and have received information in relation to Serious Incidents from both the North West Ambulance Services and place based quality leads. A regional Standard Operating Procedure (SOP) has been previously approved that describes those incidents requiring regional

3.2 Escalation, and the team can evidence the impact of when this has taken place. These incidents will be investigated in line with the associated governance in place and reported via the ICB Quality & Performance Committee reports.

4. All Age Continuing Health Care Review (AACHC)

4.1 The ICB is accountable, via quasi-judicial and legal processes for the fair and equitable distribution of funding against assessed health needs, as well as being accountable for the quality, safety and financial assurance of continuing care provided. This area of provision has significant, and growing costs, with forecast YE £428.199m (2022/23), which represents 7.26% of the forecast total ICB budget.

4.2 Continuing Care assessment, and commissioning is the responsibility of each of the 9 places. Currently there are broadly 4 different delivery models across Cheshire and Merseyside. In house clinical resource, outsourced to commissioning support, local authority managed and hybrid arrangements.

4.3 The purpose of the review is to deliver a Cheshire and Merseyside model of AACHC that is designed to deliver, equity, consistency, value and quality assurance whilst building upon the strength and best practice that currently exists in each place.

4.4 The review will therefore set out:

- Baseline financial and performance comparator information
- An option appraisal of AACHC delivery models
- A new model of shared assurance and governance
- AACC best practice and any gaps in quality/risks in practice
- Outline implementation plan.

4.5 Given the complexity of the C&M system and differing models for delivery, the review is due for completion by Autumn 2023.

5. Special Educational Needs and Disability (SEND)

5.1 The Children and Families Act (2014) and SEND Code of Practice (2015) informed the SEND reforms of 2014, providing legislative guidance to ensure a holistic approach was taken to identify the education, health and social care needs of children and young people aged 0-25 years with SEND. Local areas were required to develop appropriate provision, within a spirit of inclusion, to meet the identified needs of their SEND children and young people and thereby ensure positive outcomes for this vulnerable population. The reforms enabled a progression from a previous focus upon the educational needs and provision of children with SEN into a holistic model across education, health and social care, in addition to acknowledging the frequent overlap between SEN and long-term disability.

5.2 A SEND Review Green Paper was launched in March 2022 regarding SEND and alternative provision system (APS) in England, with the government aiming to level up opportunities for all children, including those with SEND. Consultation ended on 22.7.22 and an Improvement Plan is expected to be published by the Department for Education by 31.3.23.

5.3 New statutory guidance relating to Area Special Educational Needs and Disabilities (SEND) inspections was published on 29th November 2022 and came into force on 1st January 2023. The guidance comprises of a framework and a handbook:
https://www.gov.uk/government/news/improving-outcomes-for-children-and-young-people-with-send.

5.4 This new framework will place increased focus on the impact that local area partnerships have on the experiences and outcomes of children and young people with SEND. A new on-going cycle of inspections has been introduced, with the aim of strengthening accountability and supporting continuous improvement across SEND systems. The SEND teams in each of the ICS place-based areas are currently preparing for potential inspection announcements through development and completion of a pre-inspection toolkit and attendance at a series of national educational events.

5.5 Statutory guidance regarding the SEND functions required of NHS Integrated Care Boards (ICBs) is still awaited, with no timeframe of publication confirmed. In the interim, SEND functions are embodied in the SEND Code of Practice (2015). The C&M ICB has to undertake a maturity assessment on a quarterly basis against a range of Key Lines of Enquiry (KLOE) that demonstrate development in supporting those with SEND. In January 2023 the KLOEs focused on co-production. The outcome of an amber rating suggested that whilst the C&M ICS has fora for co-production in each of its nine place-based areas, more work needs to focus on a consolidated ICS approach that draws in representation from each of the place-based groups. This work will be a priority for development in Quarter 4 2022/23.

6. Discharge Funding for Step Down Care

6.1 The Nursing and Care team will be supporting in the development of a quality governance framework to support the discharge of those who no longer meet the criteria to reside in the acute hospital setting. The work will involve ensuring there is oversight of patient safety and experience across the patient pathway and that those identified for this programme are receiving the appropriate level of care provision.

7. Recommendations

7.1 The Board is asked to:

- Note the content of the report and request additional information/assurance as appropriate.

8. Officer contact details for more information:

Kerry Lloyd – Deputy Director of Nursing & Care
Kerry.lloyd@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Cheshire and Merseyside System Finance Report – Month 9

Agenda Item No	**ICB/01/23/10**
Report author & contact details	Mark Bakewell – Deputy Director of Finance
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance

Cheshire and Merseyside System Finance Report – Month 9

<table>
<tr><td>Executive Summary</td><td colspan="5">This report updates the Board on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g. Cash Management and Better Payment Practice Code) and utilisation of available ‘Capital’ resources for the financial year.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• Note the contents of this report in respect of the Month 9 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.</td></tr>
<tr><td>Key issues</td><td colspan="5">As at 31st December 2022 (Month 9), the ICS ‘System’ is reporting an aggregate deficit of £71.9m against a planned deficit of £34.9m resulting in an adverse year to date variance of £36.9m.</td></tr>
<tr><td>Key risks</td><td colspan="5">Outlined within the main paper.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td colspan="2"></td><td>X</td><td>X</td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td></td><td colspan="2"></td><td></td><td>X</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">Paper discussed at ICB Finance, Investment and Resources Committee.
Provider position will be presented to Cheshire and Merseyside Acute and Specialist Provider Collaborative in line with agreed reporting timetable</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No specific issues raised</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">Financial performance at both place and provider level will be subject to local public communications and engagement arrangements.</td></tr>
<tr><td>Equality, Diversity, and Inclusion</td><td colspan="5">Efficiency Plans and Investment decisions will need to be subject to organisation level Equality Impact Assessments (EIA). This will be subject to internal audit review in line with locally agreed audit plans.</td></tr>
<tr><td>Health inequalities</td><td colspan="5">Healthcare resource and investment decisions impact on health inequalities and so future place-based allocation decisions will be subject to EIA processes. Strong budget management and control is important to minimise areas of overspend which lead to an unplanned redistribution of resources.</td></tr>
<tr><td>Next Steps</td><td colspan="5">Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency</td></tr>
</table>

	opportunities. Development of financial strategy to support future financial sustainability.
Appendices	Appendices 1-5 gives details of the narrative in the main body of the report.

Cheshire and Merseyside System Finance Report – Month 9

1. Executive Summary

1.1 This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England, and alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year.

1.2 It should be noted that full NHS provider returns for month 9 will only be submitted on 24th of January 2023 and are therefore not available in time to produce this report. Summary financial performance information, or 'key data', is used as the basis of this report but means that some performance information is not available, for example, cash balances and better payment practice code (BPPC),

1.3 Financial performance for the period ending 31 December 2022:

- the system is reporting an aggregate deficit of £71.9m in the year to date against a planned deficit of £34.9m, resulting in an adverse year to date variance of £36.9m.
- this represents a deterioration of £15.7m from the position last reported to the board at month 7.
- cost Improvement Plan performance has improved by £57.5m to £241.1m (full year plan is £330.9m).
- the unmitigated financial risk being reported by organisations has improved by £37m, to £37m, with further work being done across the system to mitigate this in full before the year end.

1.4 The year to date (YTD) position is set out in the table below and comprises a lower-than-plan YTD surplus position of £4.3m for CCGs/ICB (compared to a plan profile value of £14.8m) and a year-to-date deficit in the NHS providers of £76.2m (compared to plan profile of £49.7m).

Sector	2022/23 Annual Plan £m Surplus / (Deficit)	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	YTD Variance £m Surplus / (Deficit)	2022/23 Forecast £m Surplus / (Deficit)	Forecast Variance £m Surplus / (Deficit)
CCG/ICB	19.7	14.8	4.3	(10.4)	19.7	(0.0)
NHS Providers Trusts	(50.0)	(49.7)	(76.2)	(26.5)	(50.0)	(0.0)
Total System	**(30.3)**	**(34.9)**	**(71.9)**	**(36.9)**	**(30.3)**	**(0.0)**

1.5 The system continues to forecast achievement of the annual planned deficit of £30.3m. However, a small number of organisations are informally reporting that delivery of their plan is at risk and so the wider system is working to identify where improvements can be made to offset any potential overspends against plan. It is anticipated that the overall system plan of £30m deficit can still be achieved and discussions with the organisations concerned are ongoing. Further details are set out in in the report.

1.6 **M9 Performance – Capital.** As at 31st December 2022, provider operational capital expenditure remains below year-to-date planned values by £42.1m as set out in sections 32 to 44. All Trusts are forecasting achievement of plan, except for LUHFT, whose underperformance reflects additional allocation recently allocated and Mersey Care, whose underperformance will be subject to a transfer of allocation to Lancashire Care for work on the Whalley site.

1.7 **Key Performance Indicators.** Full key performance indicator data is not available until providers have submitted their month 9 financial returns later in the month.

System Finance Report to 31 December 2022 (Month 9)

Background

1) This report updates the ICB on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, and utilisation of available 'Capital' resources for the financial year.

2) The revised system plan for 2022/23 submitted on 20th June was a combined £30.3m deficit consisted of a £19.7m 'surplus' on the commissioning side (CCG/ ICB) which partly offset an aggregate NHS provider deficit position of £50.0m. The plan position reflected a variety of surplus / deficit positions across each C&M CCG and NHS Provider organisations as can be seen in Appendix 1.

3) It should be noted that ICBs as successor bodies to CCGs are required to plan for 'at least' a break-even position as reflected in the recent Health & Social Care Act, which has been reflected in the distribution / relative risk position within the ICS plan submission.

4) At the end of quarter one and in all financial performance circumstances, CCGs have been deemed to have delivered a breakeven financial performance position through an adjusting resource allocation process for the Q1 period (from the full year ICB allocation) with any residual difference in Q1 performance (both favourable / adverse) being inherited by the ICB during Q2-4.As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

Month 9 (December) Performance

ICB/CCG performance

5) For quarter 1, the CCGs allocations were adjusted to breakeven to match the reported position, this has resulted in the movement of the £6.7m favourable variance to plan from CCGs budgets to the ICB budget to support achievement of the annual plan.

6) The ICB is currently reporting a year-to-date surplus of £4.3m compared to an original planned surplus of £14.7m resulting in an adverse variance to plan of £10.4m as per the table below:

	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	2022/23 YTD Variance £m Surplus / (Deficit)	2022/23 YTD % Variance £m Surplus / (Deficit)
System Revenue Resource Limit	**-2,963,803**			
ICB Net Expenditure				
Acute Services	1,568,051	1,568,213	(162)	(2.7%)
Mental Health Services	282,823	289,701	(6,878)	(2.4%)
Community Health Services	301,054	298,603	2,451	0.8%
Continuing Care Services	148,022	159,879	(11,857)	(8.0%)
Primary Care Services	301,559	306,348	(4,788)	(8.0%)
Other Commissioned Services	8,117	8,186	(69)	(0.9%)
Other Programme Services	30,196	30,145	52	0.2%
Reserves / Contingencies	3,059	1,716	1,343	43.9%
Delegated Primary Care Commissioning including:	275,491	272,768	2,724	1.0%
a) Primary Medical Services	239,142	236,574	2,568	1.1%
b) Pharmacy Services	36,350	36,194	156	0.4%
ICB Running Costs	23,961	23,902	59	0.2%
Total ICB Net Expenditure	**2,942,334**	**2,959,461**	**(17,126)**	**24.1%**
TOTAL ICB Surplus/(Deficit)	**21,468**	**4,342**	**(17,126)**	**(0.6%)**
**** NB - CCG Q1 Adjustment***	***(6,716)***	***-***	***6,716***	***0.5%***
Adjusted Surplus	***14,752***	***4,342***	***(10,410)***	***(0.1%)***

7) This adverse year to date performance is driven by the following issues which are being actively managed to ensure delivery of the plan by the year end.

a. Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity. This risk is being managed collaboratively with Mental Health provider partners and expected

to be mitigated non-recurrently in year though risk share and slippage on other relevant allocations.

b. Primary Care Services - overspend on prescribing partially offset by underspends on GPIT and investments.
c. Community Services – overspend relating to independent sector contracts and community equipment services offset by underspends following a detailed review of place budgets
d. Continuing care - overspend relating to increases to volume and price for continuing care packages and funded nursing care. This is an area of significant focus and review by each place team.
e. Reserves – mitigations secured to offset accepted planning risks.
f. Delegated Pharmacy – additional funding has now been received to offset the pressures previously seen in the year-to-date position.
g. Efficiency savings are built into the year-to-date position and reflects a favourable position of £5.0m but a significant proportion of this is non-recurrently delivered. Development of recurrent savings was a key area of focus within the place review meetings in January 2023.

8) Further work is required to review transactions from predecessor organisations to ensure a consistency of approach to accounting policies e.g., the basis for accruals in areas such as prescribing.

9) The ICB continues to forecast achievement of the annual planned surplus of £19.7m. However, there are several risks that are being actively managed to ensure the plan is delivered. This includes a step change in the focus on the development of recurrent efficiencies.

NHS Provider Performance

10) The table below summarises the combined NHS provider position to the end of October 2022 reflecting a year-to-date cumulative deficit position of £76.2m compared to a year-to-date profile plan figure of £49.7m. Further detail is provided in Appendix 2.

	M9 YTD Plan £m	M9 YTD Actual £m	M9 YTD Variance £m	Annual Plan £m	M9 Forecast ACTUAL £m	M9 Forecast VARIANCE £m	Forecast Movement M7 - M9 £m
Alder Hey Children's NHS Foundation Trust	1.6	1.6	0.0	4.6	6.1	1.5	1.5
Bridgewater Community Healthcare NHS Foundation Trust	(0.1)	0.4	0.5	0.0	0.6	0.6	0.6
Cheshire and Wirral Partnership NHS Foundation Trust	2.0	2.1	0.1	2.9	3.2	0.3	0.3
Countess of Chester Hospital NHS Foundation Trust	(3.6)	(19.3)	(15.6)	(3.1)	(6.3)	(3.2)	(3.2)
East Cheshire NHS Trust	(2.6)	(2.4)	0.2	(2.6)	(2.3)	0.3	0.3
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.7	2.4	0.7	2.3	3.1	0.8	0.8
Liverpool University Hospitals NHS Foundation Trust	(22.2)	(27.7)	(5.5)	(30.0)	(30.0)	(0.0)	(0.0)
Liverpool Women's NHS Foundation Trust	0.7	(1.5)	(2.2)	0.6	0.6	0.0	0.0
Mersey Care NHS Foundation Trust	4.0	4.0	(0.0)	5.7	7.7	2.0	2.0
Mid Cheshire Hospitals NHS Foundation Trust	(8.6)	(10.5)	(1.8)	(10.4)	(10.4)	0.0	0.0
Southport And Ormskirk Hospital NHS Trust	(13.9)	(13.8)	0.0	(14.2)	(14.2)	0.0	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(4.9)	(3.7)	1.2	(4.9)	(3.1)	1.8	1.8
The Clatterbridge Cancer Centre NHS Foundation Trust	1.2	2.3	1.1	1.6	2.0	0.4	0.4
The Walton Centre NHS Foundation Trust	2.0	2.7	0.8	2.9	3.9	1.0	1.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(8.3)	(8.3)	(0.0)	(6.1)	(6.1)	(0.0)	(0.0)
Wirral Community Health and Care NHS Foundation Trust	0.6	0.6	0.0	0.7	0.7	0.0	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.6	(5.4)	(6.0)	0.0	(5.5)	(5.5)	(5.5)
Total Providers	**(49.7)**	**(76.2)**	**(26.5)**	**(50.0)**	**(50.1)**	**(0.1)**	**(0.1)**

11) 5 provider Trusts have reported an adverse year to date deficit position for months 1-9, resulting in an adverse position compared to plan of £31.1m.

12) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£164.3m) and non-pay costs (£34.2m) offset set by favourable movements in Income (£163.3m) and non-operating items (£8.7m) as per the table below.

Surplus / (Deficit)	2022/23 Year-to-date				2022/23 Forecast			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
Income	(4,201.7)	(4,365.0)	163.3	-3.9%	(5,606.7)	(5,819.0)	212.3	(3.8%)
Pay	2,726.5	2,890.8	(164.3)	(6.0%)	3,632.8	3,820.9	(188.1)	(5.2%)
Non Pay	1,451.9	1,486.1	(34.2)	(2.4%)	1,926.7	1,961.9	(35.2)	(1.8%)
Non Operating Items (exc gains on disposal)	73.0	64.3	8.7	11.9%	97.2	86.2	11.0	11.3%
Total Expenditure	4,251.4	(3,944.6)	(166.5)	(3.9%)	5,656.7	5,869.0	(212.3)	(3.8%)
C&M NHS Providers	**49.7**	**(8,309.7)**	**(3.2)**	**(6.4%)**	**50.0**	**50.1**	**(0.1)**	**(0.1%)**

13) A small number of organisations are informally reporting that delivery of their plan is at risk and so the wider system is working to identify where improvements can be made to offset any potential overspends against plan. Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation and operational pressures associated with continued provision of escalation bed capacity.

14) The recent increases in the Bank of England base rate have given rise to increasing inflows from interest receivable. Some providers have able to reflect this as an improvement to the forecast, as can be seen in the position reported by Alder Hey, Bridgewater, East Cheshire, Liverpool Heart and Chest, Mersey Care, St Helens and Knowsley, Clatterbridge and The Walton Centre. This has offset the financial deterioration in forecast of Countess of Chester and Wirral Teaching Hospital.

15) Mid Cheshire and Liverpool Women's have also reported that they are unlikely to meet their financial plan and further discussions are ongoing to identify how the system can work together to offset these risks as they crystallise.

16) National Guidance has been published for those systems and organisations who are reporting deterioration to their forecast. Several investigative and assurance actions are carried out and the development of a recovery plan is a key component of this. The system is required to instigate a specific set of financial controls and delegated limits with any organisation unable to deliver its agreed financial plan; the arrangements for how this will be done for the Trusts now reporting adverse forecast variances are being developed.

17) The following Trusts are currently reporting adverse variances to plan in the year to date. The ICB Executive team are meeting regularly with each trust to discuss the drivers of the positions reported and to seek assurance of the work being done to support delivery of the financial plan whilst delivering safe, high-quality care for our resident population.

- **Countess of Chester NHS Foundation Trust**
  Key drivers to the £15.6m variance to plan are a high level of substantive vacancies resulting in high levels of agency and bank spend, increased energy costs, insourcing capacity and Waiting List Initiative (WLI) costs incurred to deliver elective recovery. CIP performance is marginally behind plan, but being delivered non-recurrently, resulting in a future pressure. There is significant concern over the Trust's ability to deliver its planned forecast outturn.

- **Liverpool University Hospitals NHS Foundation Trust (LUFT)**
  A total of c78 escalation beds open, down from c115 last month. Corridor care remains in place and a significant driver of additional staffing requirements. The adverse position reported to date is also driven by energy and non-pay inflation costs, and premium pay costs being incurred to address sickness, vacancies, and escalation capacity. Efficiencies are currently above the YTD plan, but a large amount has been delivered non-recurrently, creating future financial pressure. Elective activity levels remain below the pre-pandemic levels.

- **Liverpool Women's NHS Foundation Trust**
  The YTD adverse variance is primarily driven by use of agency and premium rate staffing. This is due to higher levels of sickness and national shortages of midwives and consultants.

- **Mid Cheshire NHS Foundation Trust (MCHFT)**
  The Trust is experiencing increased unplanned demand, resulting additional escalation beds and newly opened discharge lounge. Premium costs are being incurred to staff these additional areas, driving the overspends reported against plan. CIP performance is behind plan and elective recovery is also behind pre-pandemic levels.

- **Wirral University Teaching Hospitals NHS Foundation Trust**
  The adverse variance to plan is as a result of 64 open escalation beds, use of corridor care in ED, increased energy costs and the Trust's underperformance in respect of recurrent CIP.

18) The ICS continues to work with providers with a view to making any final changes to forecasts before month 10. To support delivery of the overall system position, a number of mitigations and potential upsides are being explored, including:

    a. Identifying any further benefits from increases in interest receivable
    b. National allocation of capital charges support which is approximately £8m and not yet reflected in the forecast.
    c. Any opportunities from the establishment of a C&M Capital Incentive Scheme are being explored
    d. Additional upsides from contract resolutions with commissioners outside of Cheshire and Merseyside.

Provider Agency Costs

19) ICB Providers set a plan for agency spend of £113.3m, compared to actual spend in 2021/22 of £139.2m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.

20) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 9, agency spend is £116.8m (£32.4m above plan), with all Trusts except for Southport and Ormskirk reporting adverse positions to plan. The forecast spend being reported by Trusts is £150.9m (£37.7m above plan) which equates to 4.1% of total pay.

21) Agency spend pressures are variable across Trusts, with some Trusts being successful reducing their reliance on temporary staffing and are seeing reductions in agency costs year-on-year. Sharing best practice in this area and providing additional focus through the efficiency at scale board should provide opportunities to reduce spend levels.

Efficiencies

ICB Efficiencies

22) The ICB is currently reporting a £5.0m favourable variance to plan YTD mostly because of non-recurrent savings. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m. However, there remains a level of unidentified efficiency as highlighted below.

23) The ICB has established a programme approach to identification, development and tracking of efficiencies and is a key area focus in respect of both this and future financial years and this has been a key area of focus in the recent place review meetings chaired by the ICB CEO.

Provider Efficiencies

24) Provider efficiency schemes are now £0.6m ahead of plan at month 9; efficiencies of £183.5m have been delivered to date compared to a plan of £182.9m. However, only £64.7m of this has been delivered recurrently (£118.8m non-recurrently) and this is a key risk to the underlying financial position of the system. The detail by provider is included in Appendix 4.

Risks & Mitigations

25) The unmitigated financial risk being reported by organisations has improved by £37m, to £37m at month 9, with further work being done across the system to mitigate this in full before the year end.

ICB Risk and Mitigations

26) A risk review has identified potential financial risks of £33.4m for 22/23 with a series of mitigations assessed at a value of £20m leaving a residual unmitigated risk of £13.4m, This is a £6.6m improvement from the previously reported position of £20m net risk. Key remaining risks are included in the table below:

Risk	Gross Risk £m	Residual Risk after Mitigations £m
Drawdown funding not received	-0.7	-0.3
Additional System Efficiencies	-5.7	-2.6
ICB Additional Efficiencies/Operational Pressures	-27.0	-10.5
Total ICB	**-33.4**	**-13.4**

27) The ICB is working alongside system partners to ensure mitigation plans are in place to manage risks including the continued review of ICB expenditure budgets for SDF and HCP programmes to identify areas of slippage.

Provider Risks & Mitigations

28) NHS England collect gross risk data from each provider, together with the mitigations currently being managed. A net risk position is then calculated for each.

29) For Cheshire and Merseyside, £203.5m of gross risk is being reported across providers, with mitigations being pursued for £179.8m of this, leaving a net risk position of £23.7m reported for Countess of Chester (£15m), Liverpool Women's (£3.6m), Wirral Teaching Hospital (£2.1m) and Mid Cheshire (£3m). Non delivery of CIP, energy inflation, and premium pay pressures continue to be flagged as the main risks at month 9.

30) Active discussions with those organisations identifying net risk are ongoing. Cross system discussion amongst CEOs and CFOs is ongoing to explore all opportunities available. These opportunities include national capital charges allocation, Commissioner negotiations and Interest receivable.

31) The consequences for both the system and individual organisation of not delivering its plan have been set out in the forecast variance protocol by NHS England.

Provider Capital

32) The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. Spend in relation to National programmes and other items chargeable to the Capital Direct Expenditure Limit (CDEL) are effectively administered on the

behalf of systems, and therefore under/overspending does not score against System's Capital performance.

33) At month 9, progress of the system's operational capital programme expenditure remains below year-to-date planned values by £42.1m. Detail by provider is set out in Appendix 5.

34) All Trusts are forecasting achievement of plan, except for the following:

a. LUHFT are forecasting an underspend of £12m, following the allocation of Additional PDC to support the New Hospital build. This has brought the ICS forecast in line with the allocation.
b. Mersey Care are reporting at £1.3m underspend, which is related to spend at the Whalley Site, which is now being carried out by Lancashire Care on their behalf. An allocation transfer will take place in Month 10 to bring the position back in line with plan.
c. Alder Hey and CWP are reporting £36k and £100k underspend respectively. We are looking to reallocate this to other providers.

Primary Care Capital

35) C&M ICB has a capital allocation of £4.7m for Primary Care, but also benefits this year from a legal charge redemption of £1.235m.

36) NHSE Primary Care commissioners have engaged with GP practices and premises grant requests totalling £1.826m in 22/23 with a further 23/24 impact of £0.846m have been received and reviewed against the requirements of the Premises Directions. Plans have now been approved by the ICB Primary Care Committee and NHSE.

37) Place digital leads identified and prioritised £4.1m for GP BAU IT. These programmes have been approved by NHSE regional team and the Primary Care Committee.

38) All schemes are being monitored for delivery before year-end. We have been notified of £551k of slippage, which we are looking to reallocate the resource to the pipeline of improvement grants or digital schemes not prioritised in the 22/23 allocation

39) The system has been notified that there may be additional capital monies available for winter resilience. A bid of £2.4m has been put forward for this, although we do not know the quantum of resource available.

Strategic Capital

40) There are a large number of Strategic Capital schemes, administered by NHS England, the main ones being:

a. Mental Health – Urgent and Emergency Care, Dorm Eradication.
b. Elective Targeted Investment Fund.
c. Community Diagnostic Centres.
d. Diagnostics – Levelling up, digitisation, single CT scanner sites.
e. Digital – EPR, frontline digitisation.
f. NHP – New Hospitals Programme.

41) Business cases to bid for these funds have been submitted and most funds allocated for Mental Health, TIF, CDC, NHP and Diagnostics. Digital diagnostics and frontline digitisation are yet to be allocated.

42) The revenue consequences of these investments may pose a risk to providers financial positions should anticipated efficiencies are not delivered.

43) Performance against these schemes does not score against the system allocation, but slippage on these schemes can adversely impact the system allocation in future years.

Recommendations

The Integrated Care Board is asked to:

- Note the contents of this report in respect of the month 9 year to date financial position for both revenue and capital allocations within the 2022/23 financial year.

Officer contact details for more information

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Appendix 1

2022/23 plan submissions by CCG / NHS provider

CCG / ICB	Full Year Plan (Deficit) / Surplus
	£ 000's
NHS HALTON CCG	(3,340)
NHS KNOWSLEY CCG	12,051
NHS SOUTH SEFTON CCG	(4,051)
NHS SOUTHPORT AND FORMBY CCG	(6,336)
NHS ST HELENS CCG	(1,905)
NHS WARRINGTON CCG	(2,302)
NHS WIRRAL CCG	7,499
NHS CHESHIRE CCG	(28,814)
NHS LIVERPOOL CCG	19,755
Total CCG Position	**(7,788)**
NHS LIVERPOOL CCG - as ICB Host	27.112
Total ICB Planned (Deficit/Surplus)	**19,669**

Cheshire & Merseyside Provider Organisation	Full Year Surplus / (Deficit) £'000s
ALDER HEY CHILDREN'S NHS FOUNDATION TRUST	4,630
BRIDGEWATER COMMUNITY HEALTHCARE NHS FOUNDATION TRUST	0
CHESHIRE AND WIRRAL PARTNERSHIP NHS FOUNDATION TRUST	2,856
COUNTESS OF CHESTER HOSPITAL NHS FOUNDATION TRUST	(3,066)
EAST CHESHIRE NHS TRUST	(2,554)
LIVERPOOL HEART AND CHEST HOSPITAL NHS FOUNDATION TRUST	2,328
LIVERPOOL UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	(30,010)
LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	563
MERSEY CARE NHS FOUNDATION TRUST	5,698
MID CHESHIRE HOSPITALS NHS FOUNDATION TRUST	(10,415)
SOUTHPORT AND ORMSKIRK HOSPITAL NHS TRUST	(14,175)
ST HELENS AND KNOWSLEY TEACHING HOSPITALS NHS TRUST	(4,949)
THE CLATTERBRIDGE CANCER CENTRE NHS FOUNDATION TRUST	1,621
THE WALTON CENTRE NHS FOUNDATION TRUST	2,868
WARRINGTON AND HALTON TEACHING HOSPITALS NHS FOUNDATION TRUST	(6,106)
WIRRAL COMMUNITY HEALTH AND CARE NHS FOUNDATION TRUST	684
WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FOUNDATION TRUST	19
TOTAL	**(50,008)**

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 9 (31st December 2022)

	M9 YTD Plan £m	M9 YTD Actual £m	M9 YTD Variance £m	Annual Plan £m	M9 Forecast ACTUAL £m	M9 Forecast VARIANCE £m	Forecast Movement M7 - M9 £m
CCGs/ICB	14.8	4.3	(10.4)	19.7	19.7	(0.0)	(0.0)
	14.8	**4.3**	**(10.4)**	**19.7**	**19.7**	**(0.0)**	
Providers:							
Alder Hey Children's NHS Foundation Trust	1.6	1.6	0.0	4.6	6.1	1.5	1.5
Bridgewater Community Healthcare NHS Foundation Trust	(0.1)	0.4	0.5	0.0	0.6	0.6	0.6
Cheshire and Wirral Partnership NHS Foundation Trust	2.0	2.1	0.1	2.9	3.2	0.3	0.3
Countess of Chester Hospital NHS Foundation Trust	(3.6)	(19.3)	(15.6)	(3.1)	(6.3)	(3.2)	(3.2)
East Cheshire NHS Trust	(2.6)	(2.4)	0.2	(2.6)	(2.3)	0.3	0.3
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.7	2.4	0.7	2.3	3.1	0.8	0.8
Liverpool University Hospitals NHS Foundation Trust	(22.2)	(27.7)	(5.5)	(30.0)	(30.0)	(0.0)	(0.0)
Liverpool Women's NHS Foundation Trust	0.7	(1.5)	(2.2)	0.6	0.6	0.0	0.0
Mersey Care NHS Foundation Trust	4.0	4.0	(0.0)	5.7	7.7	2.0	2.0
Mid Cheshire Hospitals NHS Foundation Trust	(8.6)	(10.5)	(1.8)	(10.4)	(10.4)	0.0	0.0
Southport And Ormskirk Hospital NHS Trust	(13.9)	(13.8)	0.0	(14.2)	(14.2)	0.0	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(4.9)	(3.7)	1.2	(4.9)	(3.1)	1.8	1.8
The Clatterbridge Cancer Centre NHS Foundation Trust	1.2	2.3	1.1	1.6	2.0	0.4	0.4
The Walton Centre NHS Foundation Trust	2.0	2.7	0.8	2.9	3.9	1.0	1.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(8.3)	(8.3)	(0.0)	(6.1)	(6.1)	(0.0)	(0.0)
Wirral Community Health and Care NHS Foundation Trust	0.6	0.6	0.0	0.7	0.7	0.0	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.6	(5.4)	(6.0)	0.0	(5.5)	(5.5)	(5.5)
Total Providers	**(49.7)**	**(76.2)**	**(26.5)**	**(50.0)**	**(50.1)**	**(0.1)**	**(0.1)**
Total System	**(34.9)**	**(71.9)**	**(36.9)**	**(30.3)**	**(30.4)**	**(0.1)**	**(0.1)**

Note: brackets denote deficit/overspend.

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 9 (31st December 2022)

Provider	Month 9 YTD			Month 12 Forecast		
	Plan	Actual	Variance	Plan	Forecast	Variance
Alder Hey Children's NHS Foundation Trust	0	(849)	(849)	0	(1,153)	(1,153)
Bridgewater Community Healthcare NHS Foundation Trust	(3,712)	(4,427)	(715)	(4,952)	(5,758)	(806)
Cheshire And Wirral Partnership NHS Foundation Trust	(2,323)	(5,789)	(3,466)	(3,100)	(7,519)	(4,419)
Countess Of Chester Hospital NHS Foundation Trust	(6,335)	(14,607)	(8,272)	(8,448)	(18,844)	(10,396)
East Cheshire NHS Trust	(5,736)	(8,488)	(2,752)	(7,739)	(10,559)	(2,820)
Liverpool Heart And Chest Hospital NHS Foundation Trust	(513)	(859)	(346)	(682)	(1,072)	(390)
Liverpool University Hospitals NHS Foundation Trust	(9,138)	(11,948)	(2,810)	(12,197)	(15,604)	(3,407)
Liverpool Women's NHS Foundation Trust	(626)	(2,372)	(1,746)	(834)	(2,432)	(1,598)
Mersey Care NHS Foundation Trust	(13,302)	(15,540)	(2,238)	(17,744)	(20,573)	(2,829)
Mid Cheshire Hospitals NHS Foundation Trust	(15,737)	(16,012)	(275)	(20,983)	(20,007)	976
Southport And Ormskirk Hospital NHS Trust	(7,056)	(5,320)	1,736	(9,413)	(7,058)	2,355
St Helens And Knowsley Teaching Hospitals NHS Trust	(7,662)	(8,445)	(783)	(10,228)	(11,260)	(1,032)
The Clatterbridge Cancer Centre NHS Foundation Trust	0	(1,292)	(1,292)	0	(1,617)	(1,617)
The Walton Centre NHS Foundation Trust	0	(161)	(161)	0	(284)	(284)
Warrington And Halton Teaching Hospitals NHS Foundation Trust	(7,545)	(11,186)	(3,641)	(10,241)	(14,771)	(4,530)
Wirral Community Health And Care NHS Foundation Trust	(1,286)	(1,960)	(674)	(1,715)	(2,417)	(702)
Wirral University Teaching Hospital NHS Foundation Trust	(3,384)	(7,529)	(4,145)	(5,031)	(10,038)	(5,007)
Cheshire & Merseyside Total	**(84,355)**	**(116,784)**	**(32,429)**	**(113,307)**	**(150,966)**	**(37,659)**

YTD and forecast is 4.1% of Total Pay.

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 9 (31st December 2022)

	M9 YTD Plan £m	M9 YTD Actual £m	M9 YTD Variance £m	Annual Plan £m	M9 Forecast ACTUAL £m	M9 Forecast VARIANCE £m
CCGs/ICB	51.6	56.6	5.0	68.8	68.8	0.0
	51.6	**56.6**	**5.0**	**68.8**	**68.8**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	10.3	10.6	0.4	14.5	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	3.0	3.0	0.0	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	6.1	5.7	(0.4)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	8.9	8.6	(0.4)	13.4	13.4	0.0
East Cheshire NHS Trust	3.8	4.0	0.2	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	3.7	3.9	0.2	4.9	6.0	1.2
Liverpool University Hospitals NHS Foundation Trust	53.9	58.6	4.8	75.0	75.0	0.0
Liverpool Women's NHS Foundation Trust	4.2	3.9	(0.3)	5.6	5.5	(0.1)
Mersey Care NHS Foundation Trust	17.1	17.1	0.0	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	12.6	12.1	(0.5)	16.8	15.8	(1.0)
Southport And Ormskirk Hospital NHS Trust	5.9	5.9	0.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	16.3	16.3	0.0	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	5.1	4.9	(0.1)	6.8	6.8	0.0
The Walton Centre NHS Foundation Trust	3.5	3.6	0.1	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	9.9	9.1	(0.9)	15.7	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	3.1	2.7	(0.3)	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	15.6	13.5	(2.2)	20.8	20.0	(0.9)
Total Providers	**182.9**	**183.5**	**0.6**	**262.2**	**261.4**	**(0.8)**
Total System	**234.5**	**240.1**	**5.6**	**330.9**	**330.1**	**(0.8)**

Recurrent/Non-recurrent split of Provider CIP delivery

PROVIDERS	Recurrent				Non Recurrent				TOTAL			
	M9 YTD Actual £m	M9 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M9 YTD Actual £m	M9 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M9 YTD Actual £m	M9 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	3.2	(3.5)	7.1	(2.6)	7.4	3.8	7.4	2.6	10.6	0.4	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.1	(0.2)	1.4	(0.5)	1.9	0.2	2.8	0.5	3.0	0.0	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.2	0.4	2.9	0.2	3.6	(0.8)	5.4	(0.2)	5.7	(0.4)	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	3.8	0.2	5.5	(0.0)	4.8	(0.5)	7.9	0.0	8.6	(0.4)	13.4	0.0
East Cheshire NHS Trust	1.2	(1.3)	1.9	(1.6)	2.8	1.5	3.6	1.6	4.0	0.2	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.9	(0.9)	3.5	(0.3)	1.9	1.1	2.5	1.5	3.9	0.2	6.0	1.2
Liverpool University Hospitals NHS Foundation Trust	9.1	(9.6)	13.0	(19.0)	49.6	14.4	62.0	19.0	58.6	4.8	75.0	0.0
Liverpool Women's NHS Foundation Trust	1.3	(1.7)	2.1	(2.1)	2.6	1.4	3.4	2.0	3.9	(0.3)	5.5	(0.1)
Mersey Care NHS Foundation Trust	11.5	(0.2)	15.3	(0.2)	5.6	0.2	7.5	0.2	17.1	0.0	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	3.8	(1.2)	5.2	(1.9)	8.3	0.7	10.6	0.9	12.1	(0.5)	15.8	(1.0)
Southport And Ormskirk Hospital NHS Trust	5.2	(0.7)	7.8	(3.0)	0.7	0.7	3.0	3.0	5.9	0.0	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	10.3	(6.0)	22.1	0.0	6.0	6.0	6.0	0.0	16.3	0.0	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	2.1	(1.2)	2.9	(1.5)	2.8	1.1	3.8	1.5	4.9	(0.1)	6.8	0.0
The Walton Centre NHS Foundation Trust	2.1	(0.8)	3.2	(0.9)	1.5	0.8	1.8	0.9	3.6	0.1	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	0.7	(3.2)	2.0	(4.5)	8.4	2.4	13.7	4.5	9.1	(0.9)	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	1.4	(0.7)	2.3	(0.3)	1.4	0.3	1.8	0.3	2.7	(0.3)	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	3.9	(6.5)	5.8	(8.1)	9.6	4.3	14.2	7.2	13.5	(2.2)	20.0	(0.9)
Total Providers	**64.7**	**(37.1)**	**104.0**	**(46.5)**	**118.8**	**37.7**	**157.4**	**45.7**	**183.5**	**0.6**	**261.4**	**(0.8)**

Appendix 5

Provider Capital: Current Performance and Forecast Outturn as at Month 9 (31st December 2022)

(based on formal reporting to NHSEI)

Excluding IFRS16 Impact

PROVIDER:	M9 YTD PLAN £m	M9 YTD ACTUAL £m	M9 YTD VARIANCE £m	ANNUAL PLAN £m	M9 FORECAST ACTUAL £m	M9 FORECAST VARIANCE £m
Alder Hey Children's NHS Foundation Trust	4.2	4.9	(0.8)	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.8	0.7	1.1	2.1	2.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	2.2	1.8	0.4	2.6	2.5	0.1
Countess of Chester Hospital NHS Foundation Trust	8.0	8.5	(0.4)	19.9	19.9	0.0
East Cheshire NHS Trust	4.6	1.0	3.6	6.1	6.1	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	7.5	6.0	1.5	11.3	11.3	0.0
Liverpool University Hospitals NHS Foundation Trust	44.5	25.0	19.4	62.6	50.6	12.0
Liverpool Women's NHS Foundation Trust	8.3	5.0	3.3	8.8	8.8	0.0
Mersey Care NHS Foundation Trust	7.7	3.6	4.1	11.1	9.8	1.3
Mid Cheshire Hospitals NHS Foundation Trust	20.7	21.5	(0.8)	38.0	38.0	0.0
Southport And Ormskirk Hospital NHS Trust	7.7	5.9	1.8	11.3	11.3	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	3.0	2.3	0.8	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	5.0	2.3	2.7	7.0	7.0	0.0
The Walton Centre NHS Foundation Trust	4.3	1.6	2.7	5.7	5.7	0.0
Warrington and Halton Teaching Hospitals NHS Foundation	7.0	5.5	1.5	12.5	12.5	0.0
Wirral Community Health and Care NHS Foundation Trust	7.7	5.8	2.0	9.4	9.4	0.0
Wirral University Teaching Hospital NHS Foundation Trust	8.7	9.4	(0.7)	11.9	11.9	0.0
Total Charge against System Operational Capital Plan	**152.8**	**110.6**	**42.1**	**233.7**	**220.3**	**13.4**
System Operational Capital Allocation				**222.4**	**220.3**	**2.1**

Note: brackets denote deficit/overspend

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Quality & Performance Report

Agenda Item No	**ICB/01/23/11**
Report author & contact details	Andy Thomas (contact details in body of report)
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Quality & Performance Report
Board Summary

<table>
<tr><td>Executive Summary</td><td colspan="5">The attached presentation provides on overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Committee is asked to:
• note the contents of the report and take assurance on the actions contained.</td></tr>
<tr><td>Key issues</td><td colspan="5">• the urgent and emergency care system continues to experience significant and sometimes severe pressure across the whole of NHS Cheshire & Merseyside.
• significant backlogs for both elective and cancer care.</td></tr>
<tr><td>Key risks</td><td colspan="5">• 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 resulting in poor outcomes.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td></td><td></td><td>X</td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td></td><td>X</td><td></td><td colspan="2"></td></tr>
<tr><td>Route to this meeting</td><td colspan="5">n/a</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">n/a</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">n/a</td></tr>
<tr><td>Equality, Diversity, and Inclusion</td><td colspan="5">n/a</td></tr>
<tr><td>Health inequalities</td><td colspan="5">n/a</td></tr>
<tr><td>Next Steps</td><td colspan="5">n/a- regular report</td></tr>
<tr><td>Appendices</td><td colspan="5"></td></tr>
</table>

Quality & Performance Report
Board Summary

1. Urgent Care

1.1 The urgent and emergency care system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside.

1.2 All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). Trusts across C&M have been consistently reporting at OPEL 3 for an extended period during 2022. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'. All acute Trusts report that they are often close to OPEL 4, the highest level of escalation.

1.3 As winter pressures continued to build over the course of December, a number of Trusts across C&M declared the highest level of escalation, OPEL 4. This means that actions at OPEL 3 have failed to deliver sufficient capacity, that emergency care pathways are significantly compromised, with severe handover delays, ambulances unable to unload their patients, crowded emergency departments due to delays in admitting patients to hospital beds, high bed occupancy, and the system unable to manage effective flow/discharge capacity. During December, the following Trusts have been at OPEL 4 for one or more days on one or more occasions:

- St Helens & Knowsley
- Warrington & Halton
- Southport & Ormskirk
- Liverpool University Hospitals
- Wirral University Teaching Hospital
- Countess of Chester.

1.4 North West Ambulance Service (NWAS) is consistently reporting at Resource Escalation Action Plan (REAP) Level 4, its highest escalation, with C&M recently under the greatest pressure across the NW region, particularly over the festive period.

1.5 Ambulance handover delays over 60 minutes have continued to rise. On some days within the past month over 100 ambulances have been delayed outside Trusts in Cheshire & Merseyside for over an hour, impacting in turn on ambulance response times.

1.6 Category 2 ambulance call response times, which should be responded to within 18 minutes and includes serious presenting conditions including patients who may have had a stroke or are experiencing chest pain, have deteriorated since September, and in December there were severe performance challenges, with the mean wait for a Category 2 call exceeding 2 hours on several days.

1.7 The delays in ambulance handovers at hospitals relate to overcrowding in emergency departments. Overall demand in terms of ED attendances is not exceptionally high. Rather, the overcrowding is caused by there being insufficient bed capacity available within our hospitals to admit all those patients requiring a hospital bed. This leads to patients having to wait for a bed in the emergency department or on an assessment unit, as can be seen from the increasing number of patients experiencing a delay of over 12 hours from the point of a decision to admit.

1.8 The impact on ED of delays from decision to admit is crowding in department and in waiting areas and corridor care, with the numbers of patients waiting more than 12 hours in A&E from a decision to admit increasing steeply over recent months. All our acute Trusts with the exception of Alder Hey and specialist trusts, are having to care for patients on corridors in order to try to release ambulance crews as rapidly as possible.

1.9 The majority of C&M acute Trusts with an Emergency Department are reporting occupancy in a range from 97%-100%, despite the opening of additional escalation beds. The lower occupancy levels reported in the performance tables reflect the inclusion of specialist Trusts.

1.10 Within acute Trusts, there continues to be a significant number of patients no longer meeting the criteria to reside in hospital, who typically occupy over 20% of acute hospital beds. In conjunction with increased admissions due to influenza and the continued underlying level of COVID-19 (7% of hospital beds occupied by patients with COVID-19 at time of this report), this in turn means that there are insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds.

1.11 In terms of mitigations, in the run up to winter, the ICB coordinated the production and assurance of winter plans at Place level, with each Place having a winter plan agreed with system partners. This was further assured through a series of Place Review meetings.

1.12 These winter plans included additional national funding to open an additional 205 beds over the course of the winter. The trajectory called for 161 of these beds to be open by the end of December. In practice 194 of these beds were open as at the end of December, with Trusts accelerating the roll out in response to system pressures. It should be noted that Trusts report that over 400 escalation beds are open across Cheshire & Merseyside.

1.13 The ICB also opened its System Control Centre (SCC) on 01 December in line with national guidance. The SCC operates daily, gathering intelligence and where possible brokering mutual aid across the system. This has been augmented by a dedicated EPRR response to industrial action in December and January with an Incident Coordination Centre stood up alongside the SCC on these days to mitigate.

1.14 All winter plans included plans to discharge as many patients as possible ahead of the festive period and to hold discharge focused events in January, such as MADE or Perfect Week. The mounting pressure ahead of the Christmas weekend limited the ability of Trusts to reduce occupancy sufficiently ahead of the bank holidays, and consequently severe pressure was experienced over the week between Christmas and the New Year, and into the first weeks of January.

1.15 Place Directors are working closely with their respective Local Authorities to facilitate discharge. Given the extraordinary level of pressure, this response has included a focus on:

- Increasing and then maintaining the run rate of hospital discharges every day.
- Moving patients to the first available slot, with a view to then moving then onward to the correct pathway if correct pathway capacity is not readily available.
- Collectively increasing risk based decisions about who can go home earlier with a lower package of care than might previously have been assessed.

1.16 The key risks to delivery remains workforce, encompassing recruitment, retention (better wages available in other sectors), skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, mental health and community care, and social care including domiciliary care

2. Elective Care & Diagnostics

2.1. The Cheshire & Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST) hosts the C&M Elective Recovery programme. The programme is focused on two key areas of performance namely recovery of elective activity to pre-pandemic levels and beyond, and the reduction of the longest waits for treatment.

2.2. The current priority is on eliminating waits in excess of 78 weeks by the end of March 2023. As at the week ending 11 December 2022, 3,259 patients across Cheshire & Merseyside were waiting over 78 weeks.

2.3. Whilst long waits for elective treatment are a recognised issue for all Trusts, the largest numbers of patients how have been waiting over 78 weeks are at Liverpool University Hospitals (LUHFT) with 1,799; St Helens & Knowsley (367); Warrington & Halton (235); and Countess of Chester (166).

2.4. The Elective Recovery Programme is leading on work across C&M to support Trusts with the management of their waiting lists, with a particular focus on supporting LUHFT and Countess of Chester. In order to ensure that no patients are waiting over 78 weeks at the end of March 2023, the system has 11,907 patients to clear by March 2023. Previous reporting indicated 13,592 patients to clear by March 2023. The system is clearing on average 1400 patients per week.

2.5. The providers with the highest number of patients to clear are LUHFT (5379) and Countess of Chester (1513).

2.6. Theatre productivity is a key element of plans, and in Cheshire & Merseyside this continues to be in the upper quartile nationally, however risks exist with the non-elective pressures currently being experienced by the system.

2.7. Current clearance rates are consistent with achievement of the elimination of 78 2week waits, but this is subject to significant risk of disruption due to impact of winter pressures and industrial action.

2.8. Patients waiting for long periods of time deteriorate and may require more interventions. We are working hard to clear the longest waiting patients to reduce this risk.

2.9. It should be noted that overall numbers on referral to treatment pathways for elective care are still increasing, whilst the overall 78 week wait cohort is reducing steadily as a result of the work the team are supporting. There are active schemes of work across all providers to fill the gap between their internal capacity and the demand of 78 weeks. This includes use of the ISP, productivity programmes, Mutual Aid plans and use of elective hubs.

2.10. Specific deep dive profiling work has taken place at LUHFT to support their overall restoration which looks at clock stops per specialty on a weekly basis.

2.11. Clinical pathways development continues across key specialties: Orthopaedics, ENT, and Dermatology

2.12. The Mutual Aid Hub is live in C&M and supporting trusts with their escalation around long waits and complex patients.

2.13. Implementation of Elective Hubs continue to be a mitigating factor providing additional capacity. 5 Hubs being developed – Clatterbridge (Wirral), Broadgreen (LUFT), Northwich (Mid Cheshire), Liverpool Women's and North Mersey (location and focus TBC).

2.14. Approval has been given to fast track the capital business case process for the procurement of an additional LUHFT robot which will support general surgery and urology patients.

2.15. OP performance remains strong, and the % follow ups remains below the England average.

2.16. Numbers of patients on a PIFU pathway is also improving.

2.17. Elective recovery is measured in terms of value-weighted elective activity for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 30 September 2022, taken from SUS puts C&M at 93.1% of 2019/20 spend value compared to 88.4% for the North West, and 94.9% for England.

2.18. Diagnostics: National waiting target remains at <1% waiting over 6 weeks for a diagnostic test and zero 13+ week waiters. A national activity target has been set at 120% of pre-pandemic levels, specifically 2019/20 activity baseline across a range of seven common diagnostic modalities.

2.19. 77% of patients have been waiting 6 weeks or less with 23% of patients waiting 6 weeks or more. The total number of patients waiting has increased to 72,607.

2.20. All of the 7 test modalities monitored within the operational plans have seen an increase in activity in October.

3. Cancer

3.1. A sharp and sustained rise in urgent suspected cancer referrals, capacity constraints experienced during each wave of COVID-19, alongside ongoing diagnostic backlogs and workforce constraints has resulted in the total cancer waiting list increasing considerably since 2019.

3.2. Urgent suspected cancer GP referrals continue on an upward trend. YTD referrals are 127% of pre-pandemic baseline Conversion rates have not significantly changed and the number of new cancers diagnosed has increased. This suggests that, in most cases, the increase in demand (i.e., GP cancer referrals) is genuine and appropriate.

3.3. More patients that ever are being seen within target time, however performance against the 14 day standard remains below target.

3.4. 28 day faster diagnosis performance remains challenged due to high referral volumes.

3.5. Lower GI cancer pathways are under significant pressure in most providers as a combined result of increased referrals and diagnostic capacity constraints. LGI referrals are up 25% on last year, and up 56% on 2019.

3.6. 62 day cancer performance remains below the operating standard. However, C&M is the second best performing Alliance in England.

3.7. The number of patients waiting more that 62 days for a diagnosis or treatment (aka the over 62 day backlog) remains a concern. Whilst the backlog reduced during November, it has risen again during December. Liverpool University Hospitals NHS FT accounts for 41% of C&M's backlog. Nearly half the backlog in LUFT and at Alliance-level is made up of patients on suspected LGI cancer pathways. The over 62 day cancer backlog stands at 1,892 as at 04 December 2022.

3.8. High referral levels have resulted in more cancer patients being diagnosed and treated than in any previous year. Data suggest that the proportion of patients diagnosed with early stage cancers has increased, which is positive.

3.9. However, although a greater number of patients have been seen and treated within target times, high volumes have meant that significant numbers of patients have experienced delays. The impact will continue to be monitored through patient experience surveys and clinical harm reviews. 2,800 additional cancer first appointments are being provided each month compared with 2019 to manage increased demand.

3.10. The Cancer Alliance is supporting improved efficiency and productivity with funding and project resources through the faster diagnosis programme.

3.11. Lower GI pathways continue to be the focus of targeted support, primarily through the Alliance's faecal immunochemical testing (FIT) programme and the Endoscopy Network's improvement programme.

3.12. Capital investments, training & education (in both primary and secondary care) and a pipeline of innovation are all building resilience and supporting recovery.

3.13. The key targets highlighted in the 2023/24 operational planning guidance, namely the 28 day faster diagnosis standard and the reduction of the over 62 day backlog, are both anticipated to be achieved by the end of Q4 2023/24 in line in the national expectation Cancer services are busier than ever, seeing and treating more patients each month than ever before. Further efficiencies are being pursued; however, the sustained rise in demand will also require significant further investment in the workforce.

4. Mental Health & Learning Disabilities

4.1. IAPT recovery and waiting times are continuing to improve, however, the number of people accessing services for the month of September appears to have reduced across all 5 providers. This is being explored further to understand the potential impact on the ability to achieve agreed recovery targets by March 2023.

4.2. Perinatal MH access is increasing as new staff start in post. The recovery plan agreed with NHS England is on track for delivery by March 2023. This forecast will result in the ICB being one year behind the national LTP trajectory.

4.3. Access to Physical Health Checks for people with Severe Mental Illness (SMI) remains below the annual trajectory but historic trends indicate that primary care increase the number of checks undertaken during the last quarter of the year. Links have been strengthened with the Core20Plus5 workstream to explore opportunities for focused action to achieve target.

4.4. The number of out of area placement bed days is reducing, however, elimination by March 2023 is unlikely to be achieved as a result of continued high demand and delayed discharges.

4.5. Winter pressure funding has been used to maintain some of the successful discharge initiatives previously implemented.

4.6. ICB level data has not been published for all MH metrics as a result of errors being found in the NHS Postcode Directory data produced by ONS which NHS Digital use for location derivation.

4.7. Workforce is a continued significant risk in terms of delivery of the Mental Health Long Term Plan ambitions, across a wide range of staffing groups.

4.8. In relation to LD Annual Health Checks, as in previous years most GP practices experience a peak in Q4, rather than a smoother profile being delivered throughout the year. This presents an additional risk to achieving targets and the LD population receiving their LD Annual Health checks, as time for mitigating actions in year is limited.

4.9. Ongoing work continues to improve the accuracy of the LD registers. A new monthly LD AHC dashboard which provides GP Practice level uptake data is circulated to place to support monitoring and targeting of practices, to promote uptake throughout the year.

4.10. LD Annual Health Checks are an enhanced service, which provides limited leverage. Places will be asked to confirm their forecast outturns early in Q4.

4.11. During Q1 and Q2 as per the National directive there has been a focus on targeting those patients who had not received an LD AHC in 12 months+, and were classified as ‘outstanding’, as well as delivering routine checks due.

4.12. Engaging with ‘hard to reach’ patients has been challenging and time consuming, as of September 2022 c28% of those ‘outstanding’ had undertaken their LD AHC, with a further 150 patients ‘declining with capacity’. Separate reporting for the ‘outstanding’ group ceased in September.

4.13. South Sefton GP Federation continue to pilot the utilisation of a small dedicated Primary Care team to facilitate LD AHCs, help to identify barriers and enable reasonable adjustments. This approach continues into Q4 and is yet to be fully evaluated.

4.14. In Q4, we are planning to pilot the use of ‘point of care’ kit blood sampling in Liverpool GP practice(s), introducing a reasonable adjustment with the aim of improving uptake, efficiency, and experience.

5. Primary Care

5.1. The number of GP Practices across Cheshire and Merseyside is 355 looking after a population of 2.7 million people with the GP Practices grouped into 55 Primary Care Networks to deliver certain functions under the relevant national contracts.

5.2. GP practices were asked to focus on ‘recovery and restoration’ of general practice services, returning to pre-pandemic levels and scope of delivery as quickly as possible during 2022-23.

5.3. In relation to access, appointment activity during November 2022 is higher than the same pre-pandemic period.

5.4. The mix of appointments across Cheshire & Merseyside however shows that face to face appointments, are overall slightly lower than pre pandemic but there has been a relative increase in telephone appointments.

5.5. Further work is ongoing in care navigation support for practice and patients in understanding the various forms of consultation available and why a certain type of appointment is used in some circumstances.

5.6. A small number of PCNs Enhanced Access provision is still not at full capacity. Assurance regarding this is being followed up by Place with the relevant PCNs to ensure this is addressed.

6. Summary/Recommendations

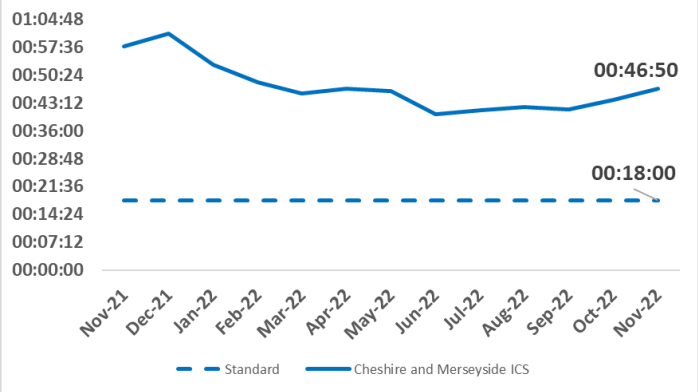
6.1. The Board is asked to note the contents of the report and take assurance on the actions contained.

NHS
Cheshire and Merseyside

Performance Report

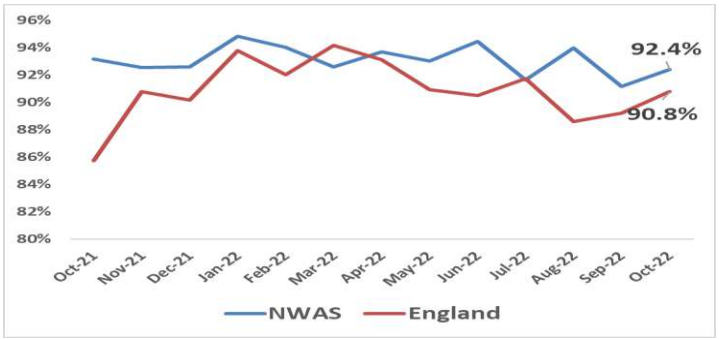
Section II: Urgent Care

Ambulance Response times – Cat 2



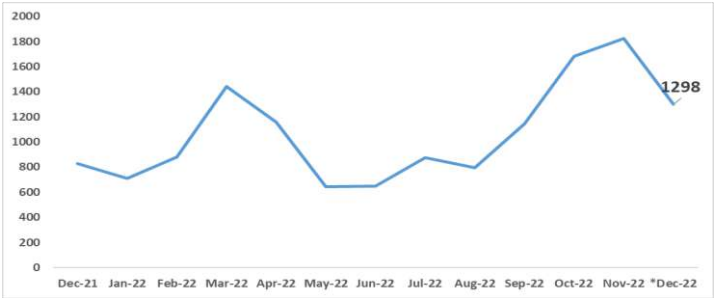
Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	00:41:36	00:44:07	00:46:50
North West	00:38:14	00:58:03	00:44:15
England	00:47:59	01:01:19	00:53:17

Friends & Family score – Ambulance Service



Organisation	Aug-22	Sep-22	Oct-22
NWAS	93.94%	91.14%	92.36%
England	88.57%	89.18%	90.76%

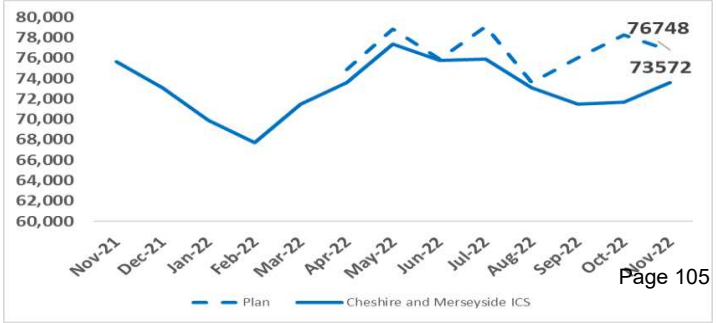
Ambulance Arrival to handover >60 mins

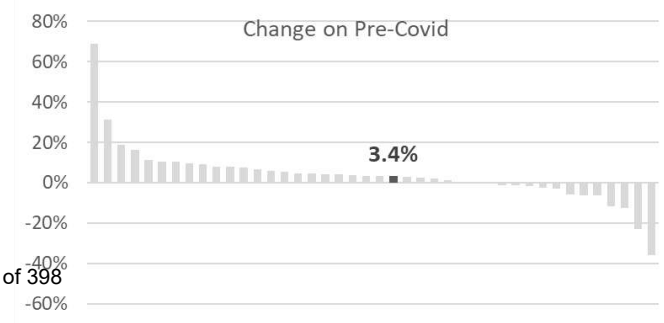


Organisation	Sep-22	Oct-22	Nov-22	*Dec-22
Cheshire & Merseyside	1142	1680	1822	1298
North West	3990	5108	4710	3529

* to 21st December

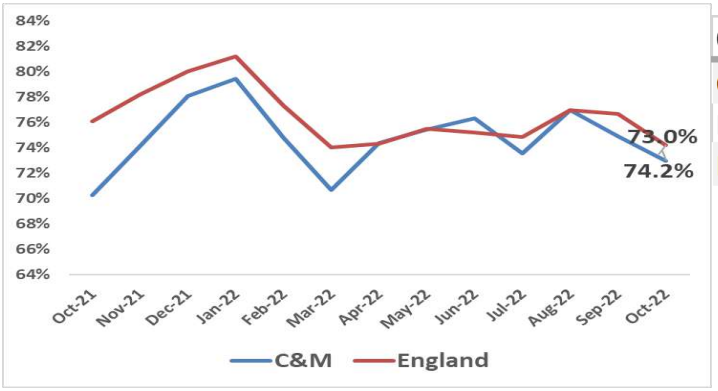
A&E Attendances (Type 1)





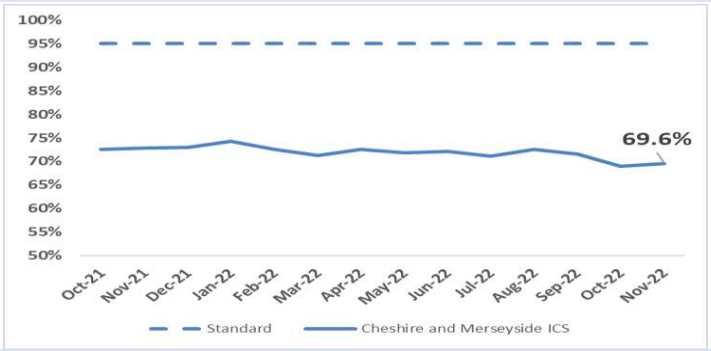
Section II: Urgent Care

Friends & Family score – A&E



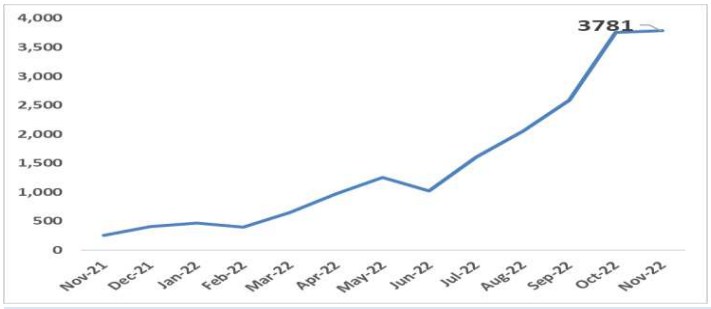
Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	77%	75%	73%
North West	76%	75%	73%
England	77%	77%	74%

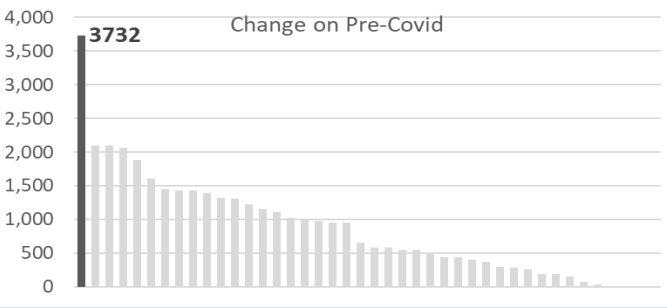
A&E 4 Hour Standard



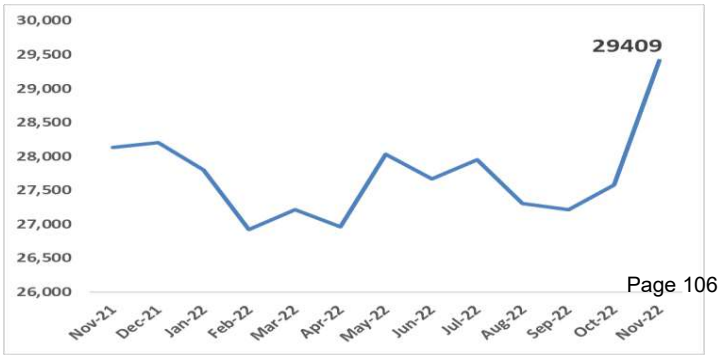
Organisation	Sep-22	Oct-22	Nov-22
Cheshire & Merseyside	71.6%	68.9%	69.6%
North West	71.6%	71.5%	70.6%
England	67.2%	66.4%	65.7%

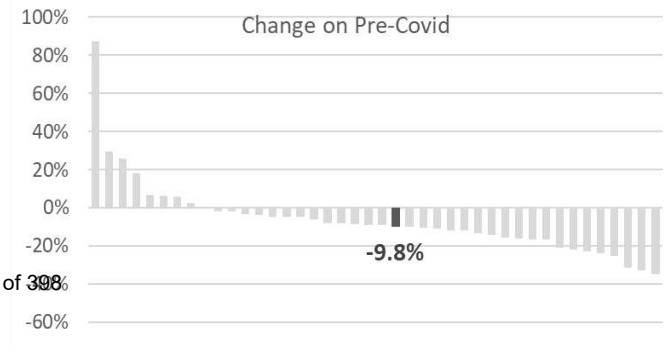
A&E 12 hour delays from decision to admit





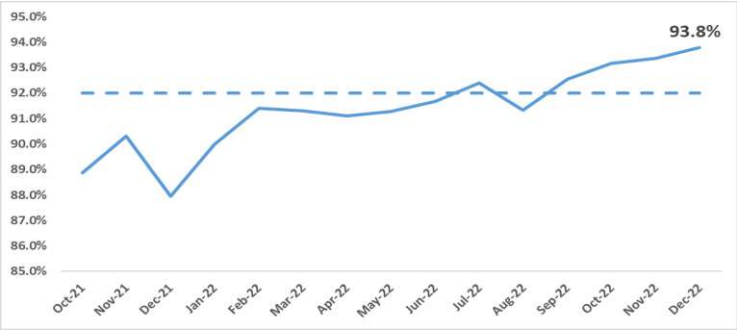
Total Emergency admissions





Section II: Urgent Care

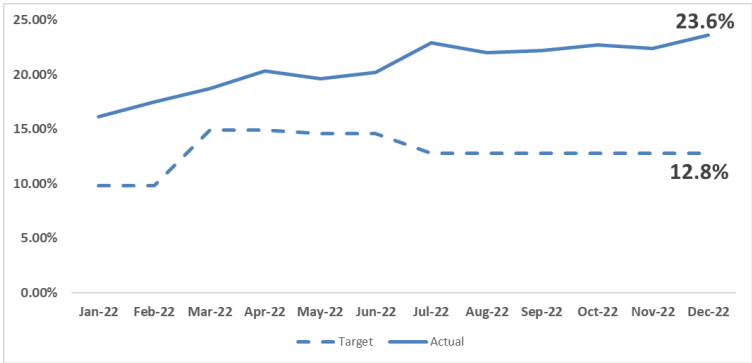
Bed Occupancy General & Acute



Organisation	Sep-22	Oct-22	Nov 22	Dec-22*
Cheshire & Merseyside	92.5%	93.2%	93.4%	93.8%
North West	92.9%	93.5%		
England	93.4%	94.3%		

* - Daily average to 22nd December

No longer meeting criteria to reside (Percentage of G&A bed stock)



Organisation	Oct-22	Nov-22	* Dec -22
Cheshire & Merseyside	22.7%	22.4%	23.6%

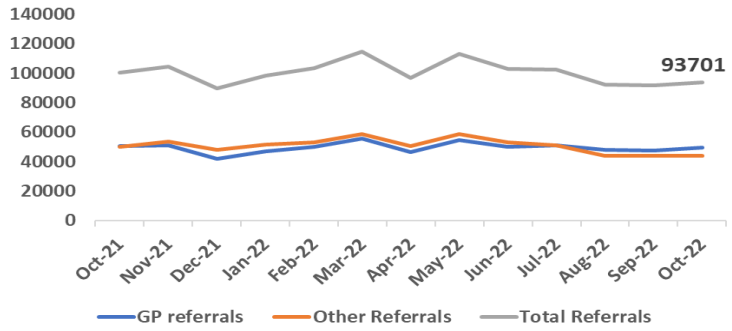
* Week commencing 05/12

Southport and Ormskirk, and Warrington and Halton did not submit data this week. Therefore the latest C&M and NW positions will be underreported by c. 210.

NHS
Cheshire and Merseyside

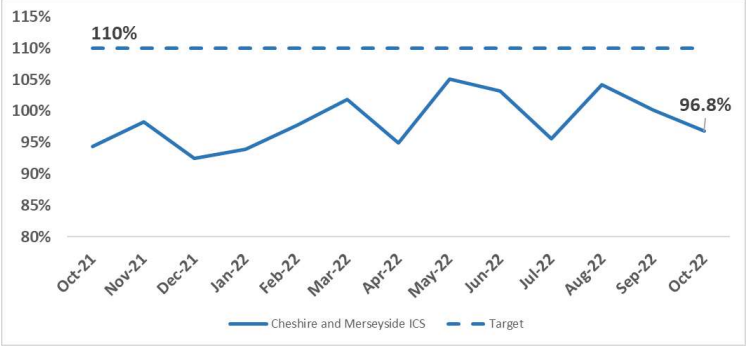
Section II: Planned Care

Referrals



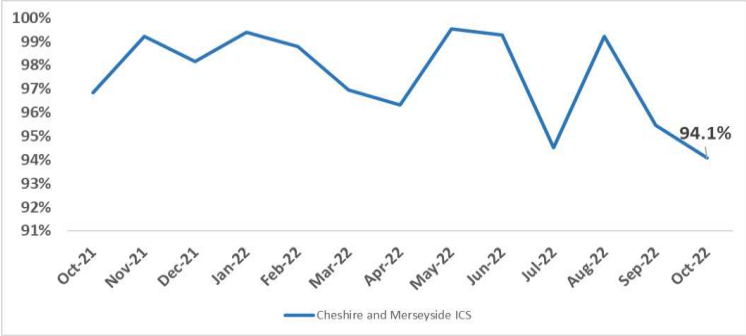
Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	92,025	91,532	93,701
North West	232,540	227,572	238,299
England	1,835,606	1,816,619	1,860,404

Outpatient First % of pre-COVID activity - Oct 22 (comparison with 2019/20)



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	104.1%	100.2%	96.8%
North West	104.1%	100.2%	96.8%
England	101.5%	99.5%	98.5%

Outpatient Follow-up % of pre-COVID activity - Oct 22 (comparison with 2019/20)



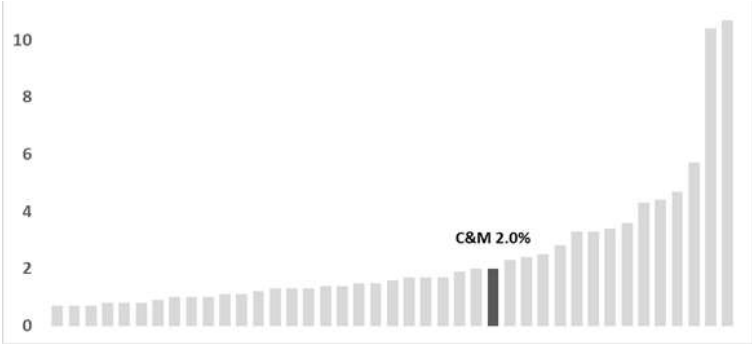
Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	99.2%	95.5%	94.1%
North West	99.2%	95.5%	94.1%
England	101.7%	100.5%	97.6%

Friends & Family score – Outpatient

Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	94%	94%	94%
North West	93%	92%	92%
England	94%	94%	94%

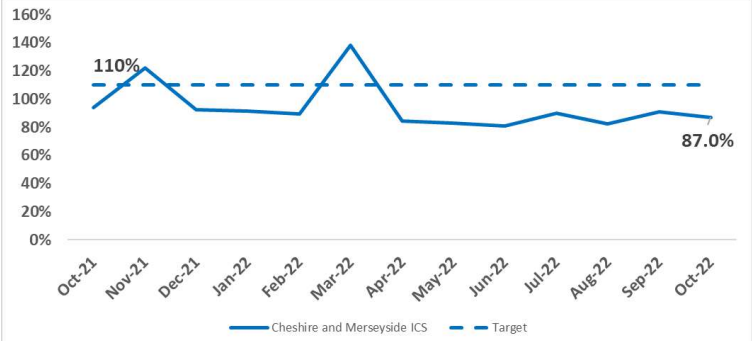
Section II: Planned Care

Patient Initiated Follow-up (PIFU) ICS Benchmark - Oct 22



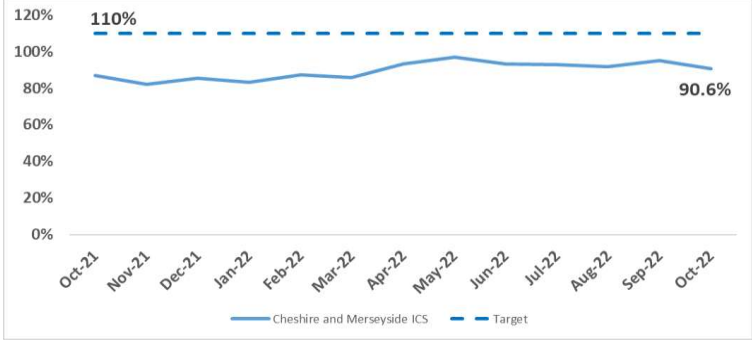
Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	1.4%	1.7%	2.0%
North West	1.2%	1.6%	1.5%
England	1.7%	1.7%	1.9%

Elective inpatient admissions % of pre-COVID activity - Oct 22 (comparison with 2019/20)



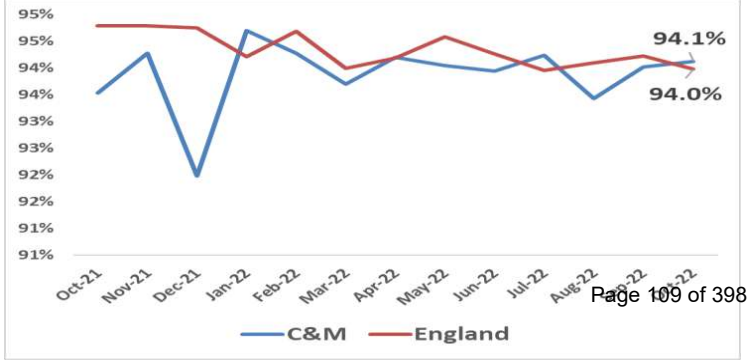
Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	82.3%	90.9%	87.0%
North West	82.3%	90.9%	87.0%
England	81.5%	87.9%	86.9%

Day cases % of pre-COVID activity - Oct 22 (comparison with 2019/20)



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	92.0%	95.3%	90.6%
North West	92.0%	95.3%	90.6%
England	96.5%	98.7%	99.7%

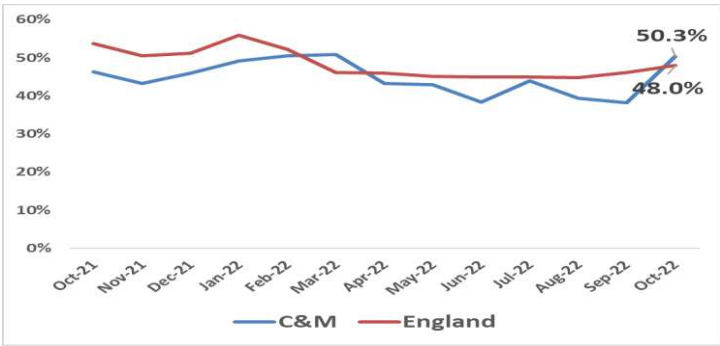
Friends & Family score – Inpatient



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	93.4%	94.0%	94.1%
North West	93.4%	94.0%	93.5%
England	94.1%	94.2%	94.0%

Section II: Planned Care

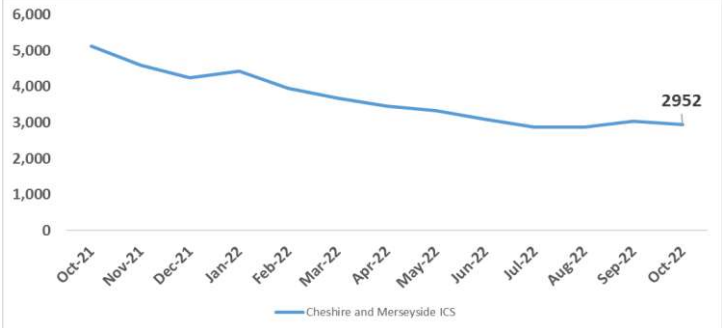
Hip fracture best practice



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	39.3%	38.2%	50.3%
North West	39.3%	38.2%	50.3%
England	44.7%	46.2%	48.0%

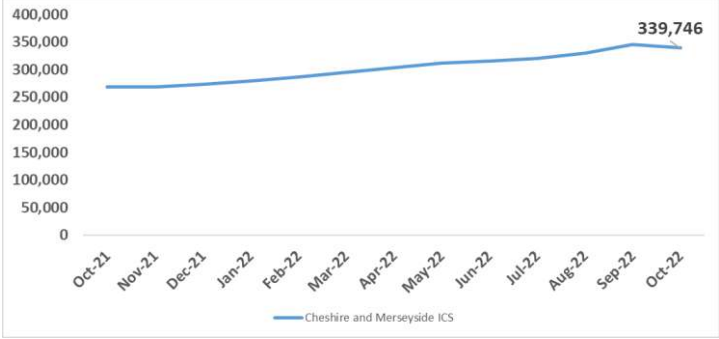
The proportion of patients that have fractured their hip whose care against a basket of indicators covering eight elements of is considered to be best practice

The number of people waiting 78 Weeks or more – Oct 22



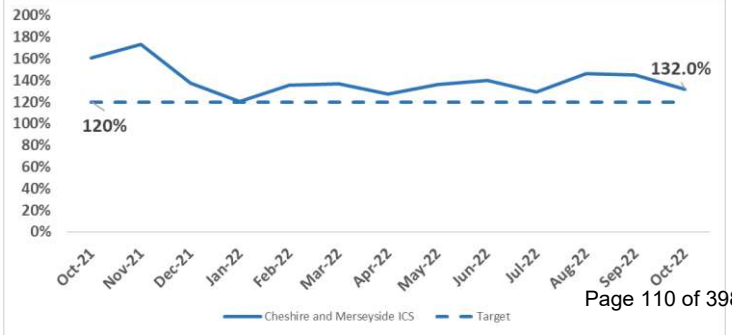
Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	2866	3047	2952
North West	9345	10111	7219
England			

Waiting list (RTT total incompletes) - Oct 22



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	330,528	345,460	339,746
North West	951,384	965,635	804,964
England			

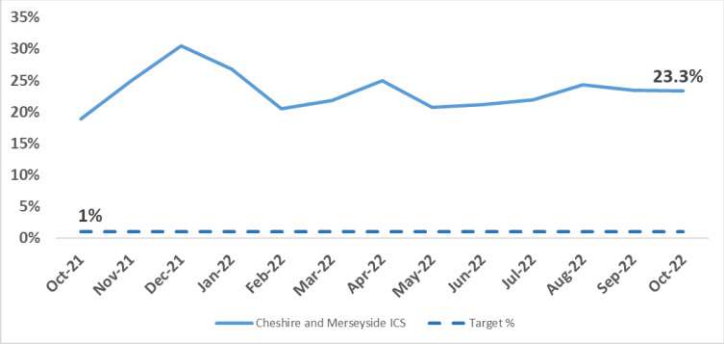
Diagnostic Activity: % of pre-COVID activity – Compared to same month in 2019



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	146.1%	145.0%	132.0%
North West	120.3%	116.4%	100.2%
England			

Section II: Planned Care

Diagnostic 6 week wait – objective no more than 1%

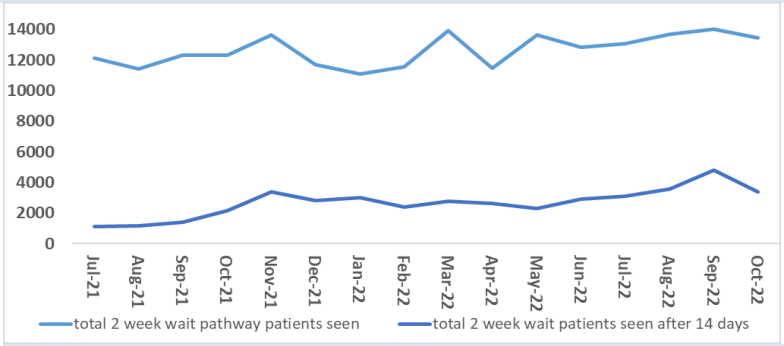


Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	24.4%	23.5%	23.3%
North West	30.6%	31.8%	28.4%
England	33.2%	32.0%	30.7%

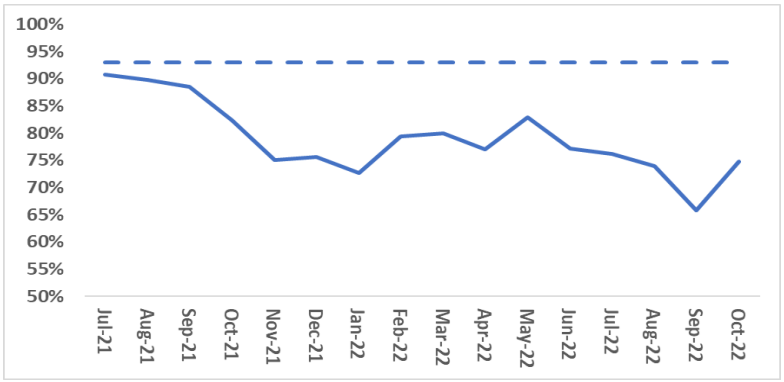
NHS
Cheshire and Merseyside

Section IV: Cancer Care

The number of 2 week wait pathway patients seen * *proxy for referrals*

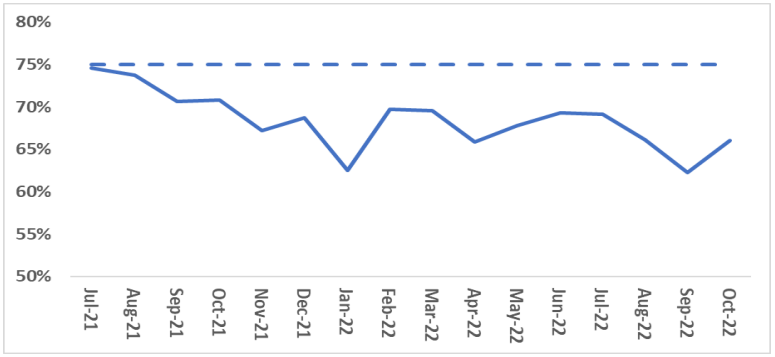


% of patients who waited for less than 14 days to be seen after referral



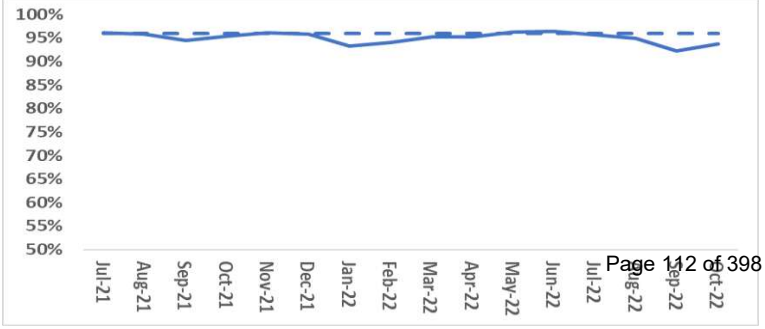
Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	73.97%	65.80%	74.80%
North West	71.07%	68.20%	71.60%
England	75.60%	72.60%	77.80%

% of patients receiving a diagnosis or ruling out of cancer within 28 days of referral



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	66.10%	62.30%	66.00%
North West	65.30%	64.60%	62.60%
England	69.45%	67.20%	68.50%

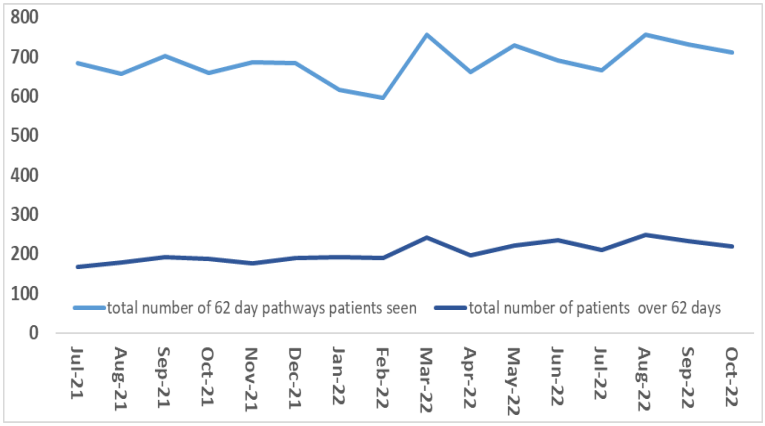
% of patients diagnosed with cancer receiving treatment within 31 days of diagnosis



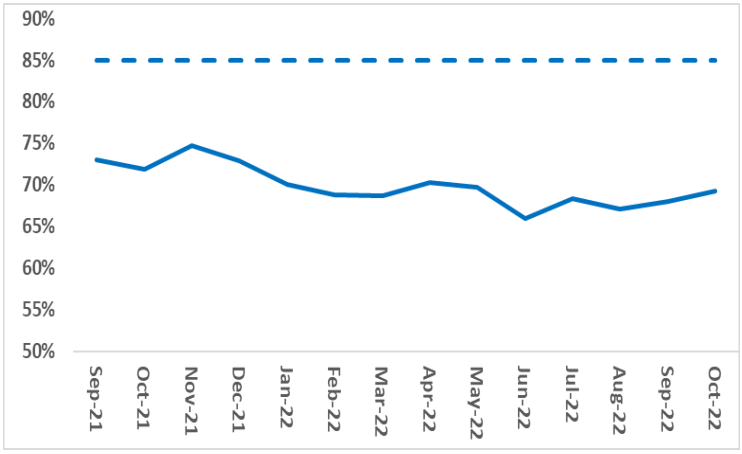
Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	94.87%	92.30%	93.70%
North West	93.10%	91.00%	92.60%
England	92.09%	91.10%	92.00%

Section IV: Cancer Care

Number of patients receiving treatment for cancer treatment by their GP waiting on 62 day pathway

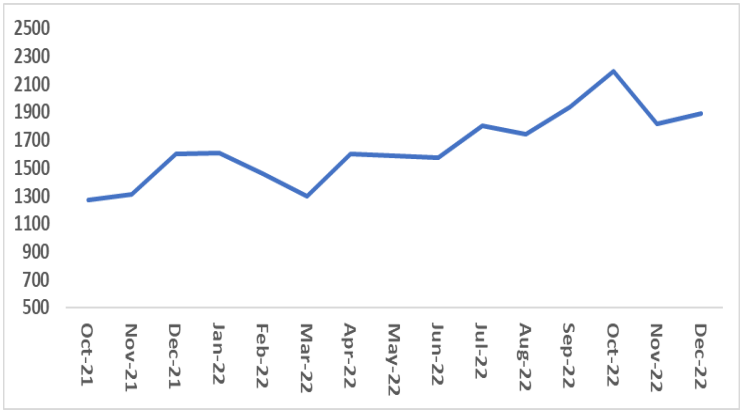


% Patients referred for cancer treatment by their GP waiting less than 62 days for treatment to start



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	67.57%	68.00%	69.20%
North West	60.70%	59.70%	62.30%
England	61.90%	60.50%	60.30%

Over 62 day cancer backlog *as at 4th Dec 22

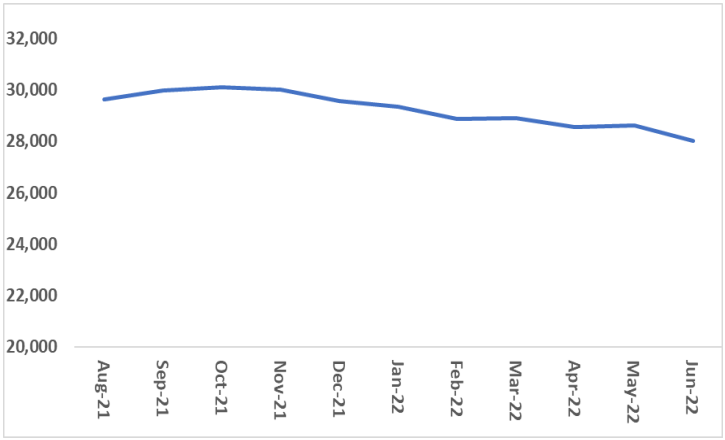


Organisation	Oct-22	Nov-22	Dec-22
Cheshire and Merseyside	2205	1819	1892
North West	5948	5007	4950
England	33207	28409	27463

NHS
Cheshire and Merseyside

Section V: Mental Health

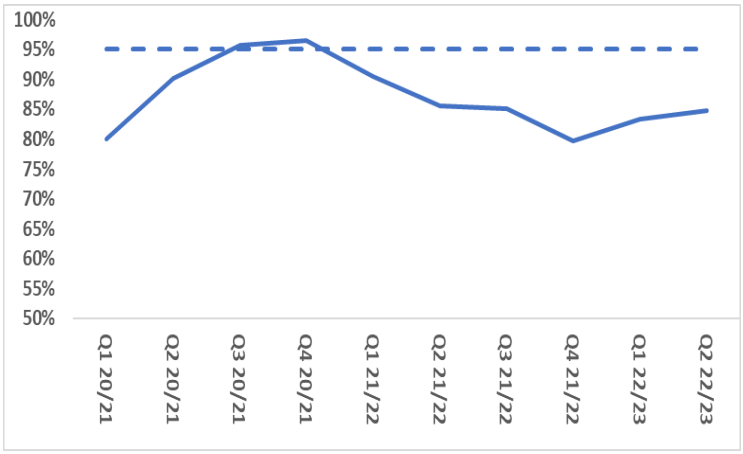
Children and young people (ages 0-17) mental health services access (number with 1+ contact)



No update for this metric

Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	28,560	28,610	28,010
North West	92,591	94,070	93,827
England	677,230	689,380	691,935

% of children and young people with eating disorders seen within 1 week (Urgent): *rolling 12 months

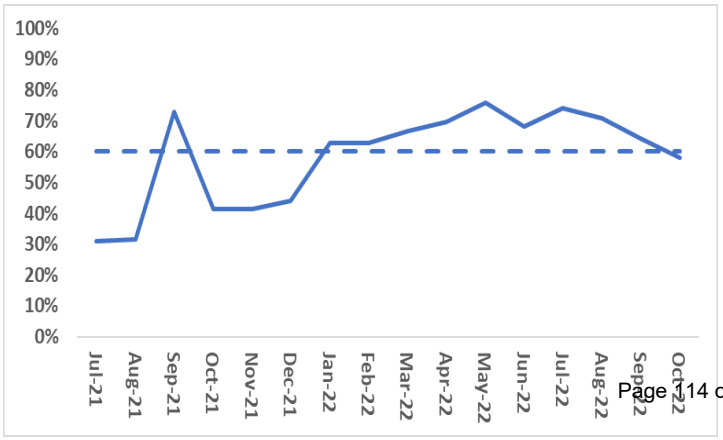


No update for this metric

Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	85%	79.6%	83.3%
North West	85%	90.9%	84.6%
England	59%	61.9%	68.1%
** 12 months to end of quarter*			

no national/regional benchmarking available due to cyber incident affecting submissions

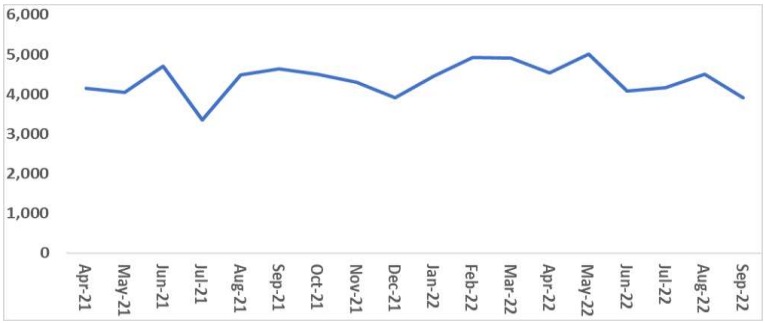
% of open referrals on EIP pathway that waited for treatment within two weeks *rolling 3 months



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	70.83%	64.30%	57.96%
North West	-		
England	69.50%	72.73%	76.92%

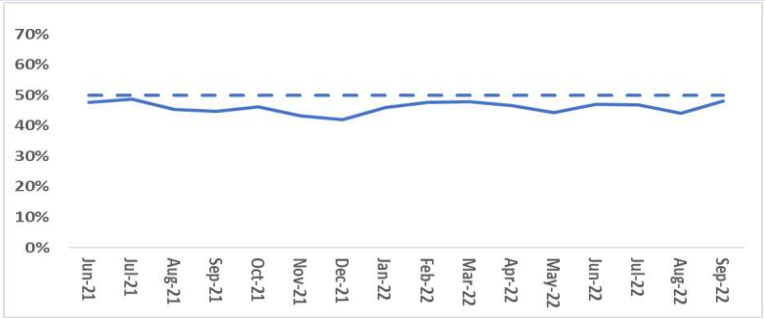
Section V: Mental Health

IAPT access: No of people entering NHS funded treatment



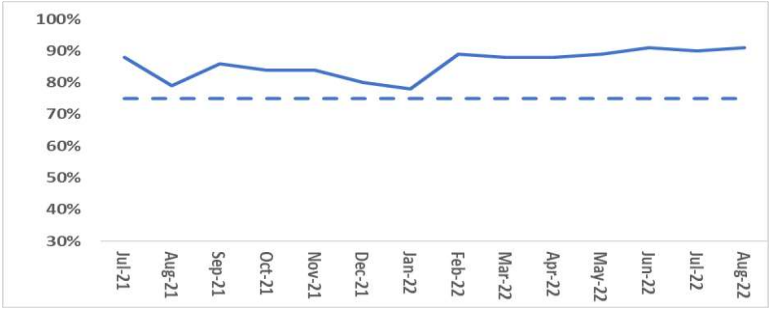
Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	4165	4510	3915
North West	13095	14255	12605
England	96156	101382	95023
source: NHS futures core data pack			

IAPT recovery: % of people that attended at least 2 treatment contacts and are moving to recovery



Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	44.00%	43.30%	48.0%
North West	48.00%	47.00%	49.0%
England	49.90%	49.40%	49.8%

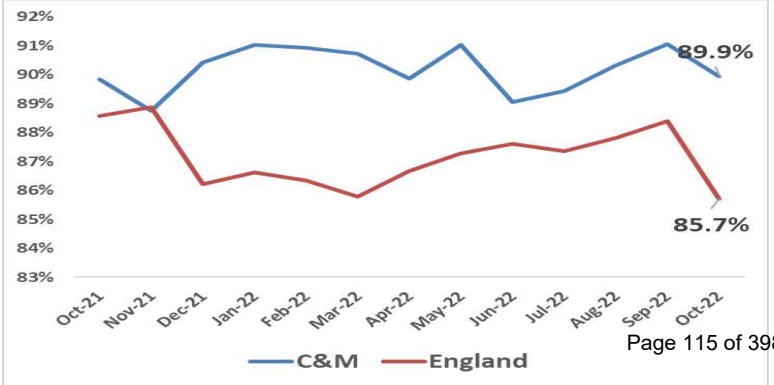
The percentage of people entering IAPT who waited less than 6 weeks for 1st treatment



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	91.00%	90.00%	91.00%
North West	85.00%	85.00%	86.00%
England	88.70%	89.60%	91.20%

*source : NHS futures IAPT dashboard

Friends & Family – Mental Health

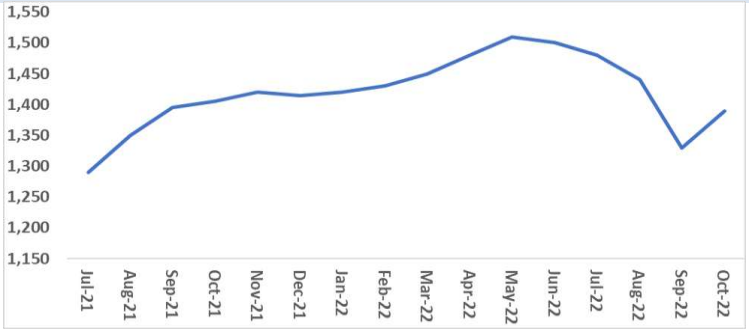


Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	90.3%	91.0%	89.9%
North West	89.1%	89.1%	89.9%
England	87.8%	88.4%	85.7%

NHS
Cheshire and Merseyside

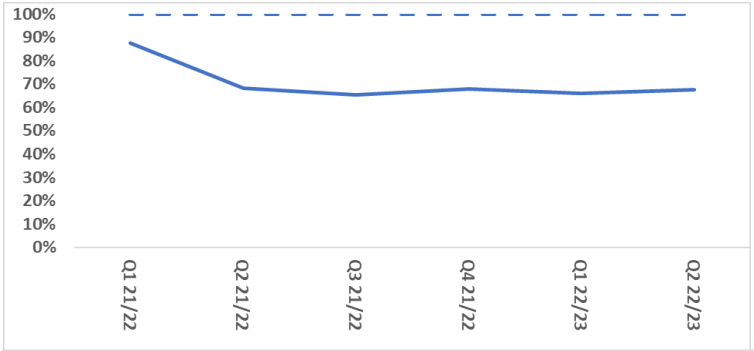
Section V: Mental Health

No of women accessing specialist community perinatal mental health services *rolling 12 months



Organisation	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	1,440	1,330	1,390
North West	5,540	5,405	5,455
England	45,130	44,565	44,860

Physical health checks for people with severe mental illness

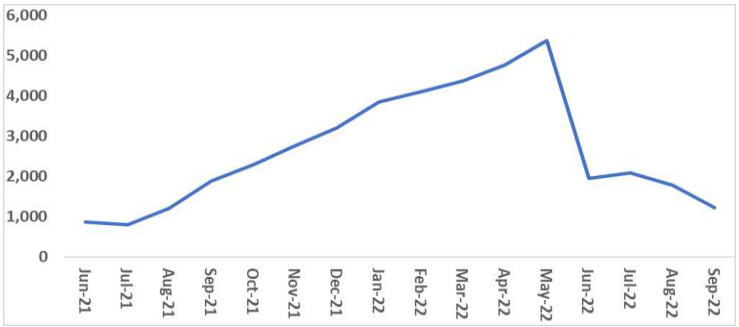


No update for this metric

Organisation	Q4 21/22	Q1 22/23	Q2 22/23
Cheshire and Merseyside	67.9%	65.9%	67.6%
North West	75.7%	73.2%	73.9%
England	75.7%	73.2%	74.5%
source: NHS SOF			

* metric calculation has changed in line with SOF definition – denominator is LTP indicative trajectory (weighted share of national LTP ambition 22/23

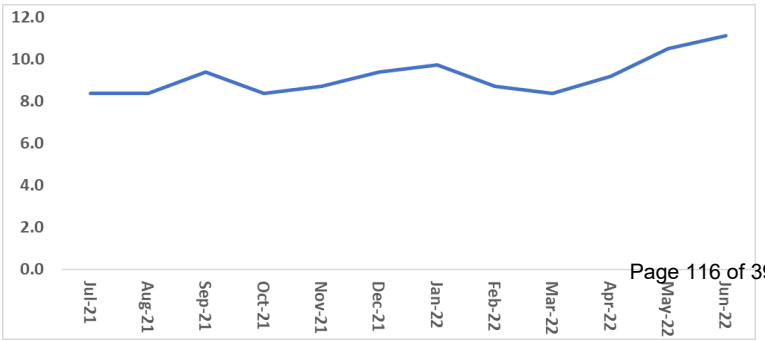
Total number of inappropriate adult acute mental health out of area placements bed days : rolling 3 month periods



Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	2,095	1,790	1,230
North West			
England	52,815	53,450	54,865
source: NHS futures OAP report			

* Data quality issues addressed from June (over-reported in previous periods)

Rate of people discharged per 100,000 from adult acute beds aged 18-64 with a length of stay of 60+ days *rolling Qtr



No update for this metric

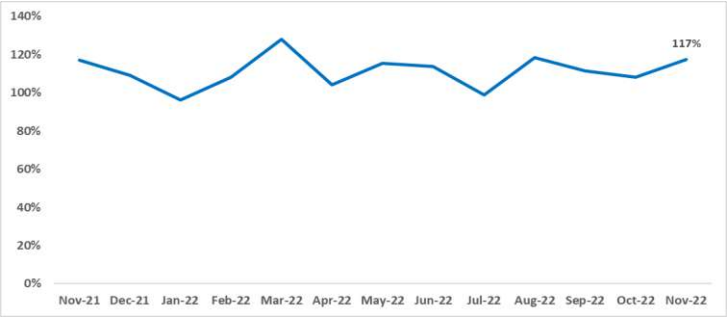
Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	9.20	10.50	11.10
North West	9.00	11.00	11.00
England	8.10	8.70	8.70

Source: MH core data pack NHS futures

NHS
Cheshire and Merseyside

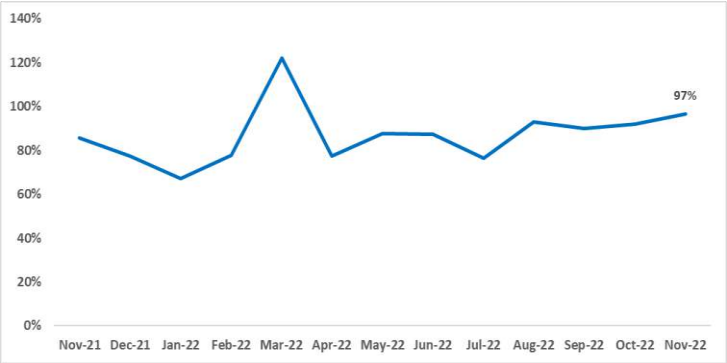
Section VI: Primary Care

Total appointments delivered against pre-covid baseline



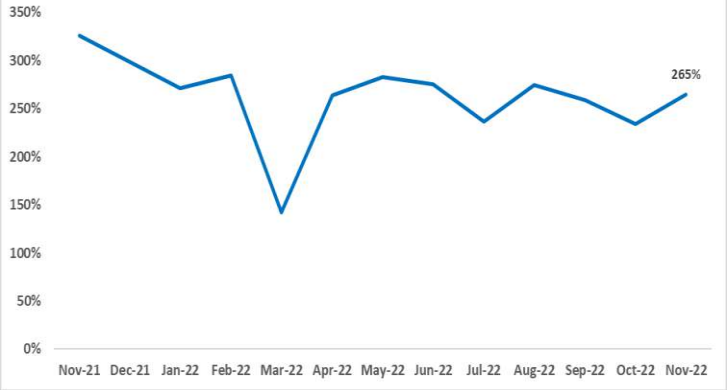
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	111.6%	108.2%	117.4%
North West	113.8%	110.2%	120.0%
England	111.1%	107.9%	118.1%

Face to Face appointments delivered against pre covid baseline



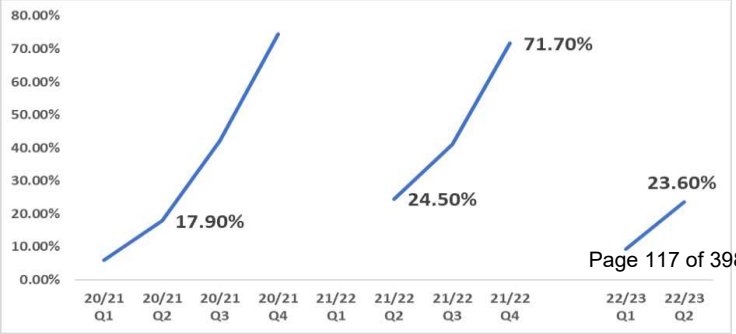
Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	89.8%	91.8%	96.5%
North West	93.3%	94.8%	100.9%
England	92.9%	93.8%	100.3%

Telephone appointments delivered against pre-covid baseline



Organisation	Sep-22	Oct-22	Nov-22
Cheshire and Merseyside	258.4%	233.6%	264.9%
North West	299.9%	266.1%	294.2%
England	241.0%	215.4%	239.5%

Number of people aged 14+with a learning disability on the GP register receiving an annual health check



Organisation	Aug-22	Sep-22	Oct-22
Cheshire & Merseyside	18.7%	23.6%	29.3%
North West	18.7%	24.1%	30.3%
England	20.2%	26.0%	32.1%

NHS
Cheshire and Merseyside

Section VII: Quality Care Dashboard

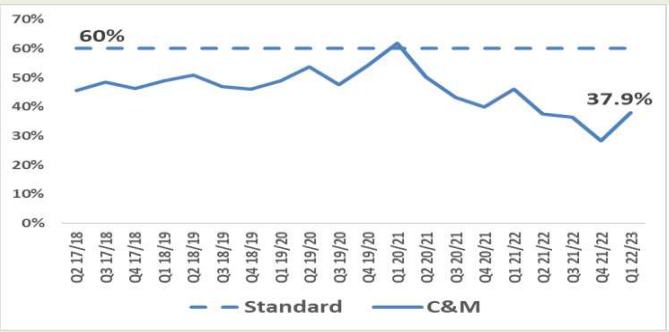
	Latest period	Target	Value
Clinical Effectiveness			
Admitted to stroke Unit < 4 hours	Q1 22/23	60.00%	37.90%
Assessed by stroke consultant within 24 hours	Q1 22/23	90.00%	83.00%
Assessed by stroke nurse within 24 hours	Q1 22/23	90.00%	92.00%
Spent >90% of stay on stroke unit	Q1 22/23	90.00%	71.90%
Stroke Audit Score	Q1 22/23	70	68
Antibacterial items by STAR PU	12 months to Jun 22	0.871	1.006
% Co-amoxiclav, Cephalosporins, Quinolones items	12 months to Jun 22	10.00%	8.10%
Watch Reserve DDD's / 1000 total admissions	12 months to Aug 22	2658	2707
Combined antibiotic prescribing to patients aged 70 year plus, per 1000 patient list size aged 70+	12 months to Jul 22	369	354
Percentage of Children aged 0-4 prescribed antibiotics	Aug-22		3.90%
Cancelled Operations	Q2 22/23	0.65%	1.00%
Treated Within 28 Days of Cancellation	Q2 22/23	99.00%	77.70%
Patient safety			
Summary Hospital Mortality Indicator	Jul-22	100	101.9
C.difficile (All Cases)	Sep-22	-	44.6
C.difficile (Hospital Onset)	Sep-22	13	22.9
E.coli (All Cases)	Sep-22	-	104
E.coli (Hospital Onset)	Sep-22	-	20.6
Klebsiella spp. (All Cases)	Sep-22	-	29
Klebsiella spp. (Hospital Onset)	Sep-22	-	8.5
MRSA (All Cases)	Sep-22	-	1.8
MRSA (Hospital Onset)	Sep-22	-	0.5
MSSA (All Cases)	Sep-22	-	37.6
MSSA (Hospital Onset)	Sep-22	-	11.5
P.aeruginosa (All Cases)	Sep-22	-	7.9
P.aeruginosa (Hospital Onset)	Sep-22	-	2.6
Serious Incidents	12 months to Sept 22		1187
Never Events	12 months to Sept 22		29
Pressure Ulcers meeting SI Criteria	12 months to Sept 22		86
NRLS - proportion incidents reported that are harmful (average of C&M Trusts)	6 months to Aug 22		23.70%
Patient Experience			
Complaints Rate	Q4 21/22	23	17.6
Mixed Sex Accommodation Breaches	Oct-22	0	29

Source: Public View & Regional Quality Group – Northwest

NHS
Cheshire and Merseyside

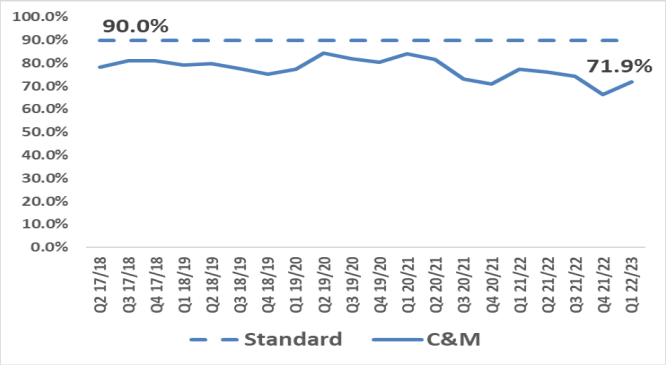
Section VII: Quality Care

Admitted to stroke unit <4 hours



Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire & Merseyside	36.4%	28.2%	37.9%
North West	40.7%	36.3%	40.6%
England	39.6%	38.2%	38.6%

Spent >90% of time on stroke unit

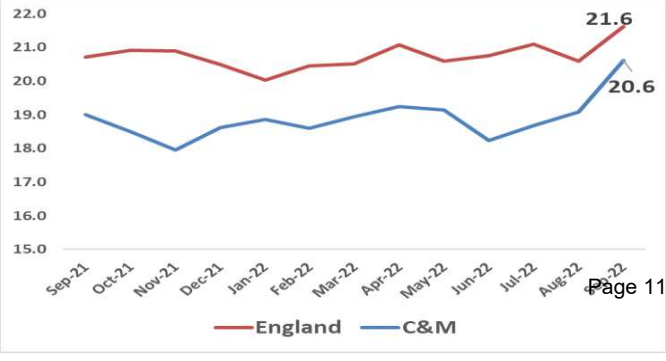


Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire & Merseyside	74.3%	66.3%	71.9%
North West	75.0%	68.2%	75.0%
England	76.8%	73.1%	74.2%

C.Difficile (Hospital Onset)

Organisation	Jul-22	Aug-22	Sep-22
Cheshire & Merseyside	21.4	22.0	22.9
North West	23.9	25.5	26.0
England	19.1	19.0	19.0

E.Coli (Hospital Onset)



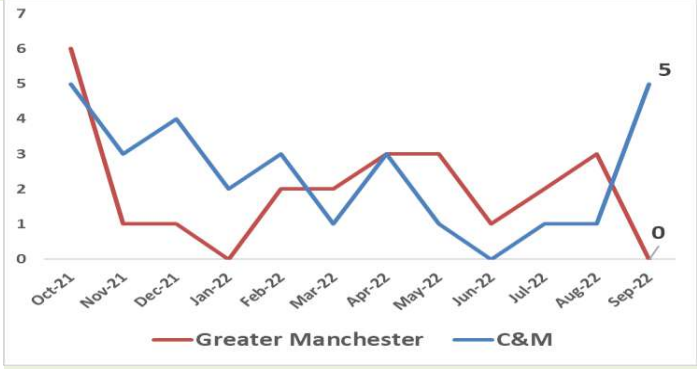
Organisation	Jul-22	Aug-22	Sep-22
Cheshire & Merseyside	18.7	19.1	20.6
North West	22.3	22.7	22.4
England	21.1	20.6	21.6

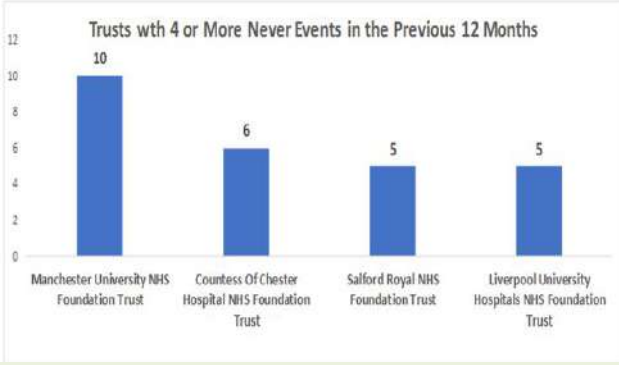
Section VII: Quality Care

SHMI

Organisation	May-22	Jun-22	Jul-22
Cheshire & Merseyside	102.1	101.7	101.9
North West	102.3	101.7	101.9
England	102.0	101.4	101.9

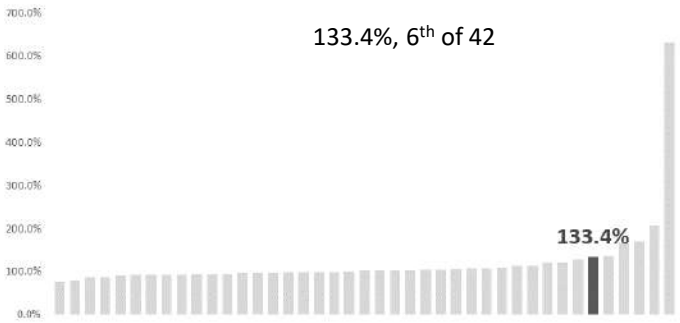
Never Events



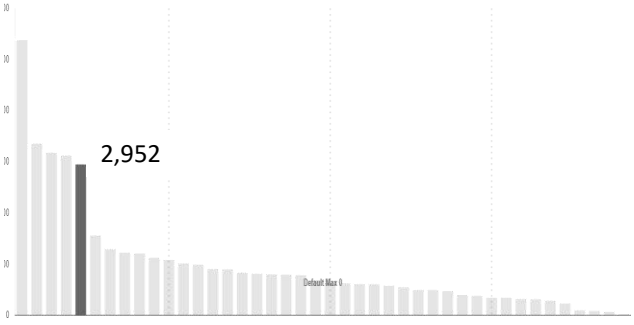


ICB – National Performance Ambition Metrics

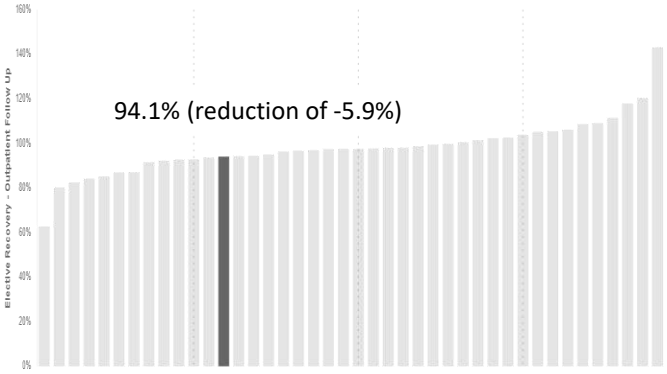
Increase diagnostic activity to 120% pre-pandemic levels



Eliminate 78 week waiters by the end of March 2023

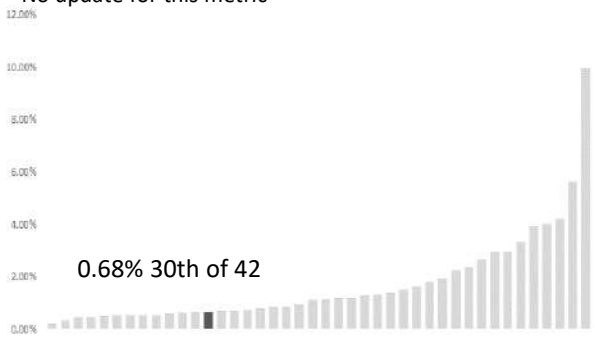


-25% reduction in outpatient follow up attendances



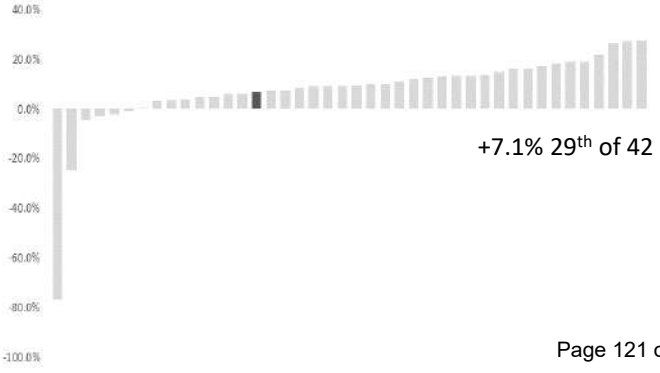
5% of outpatient attendances to convert to PIFU pathways

No update for this metric

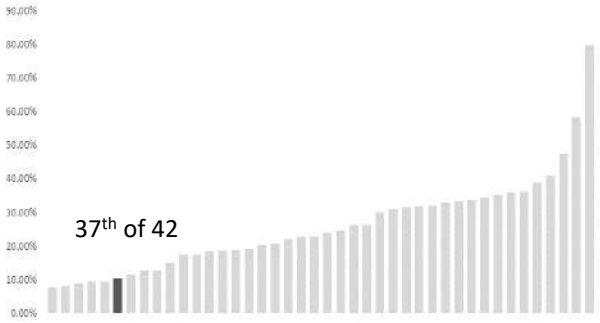


10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



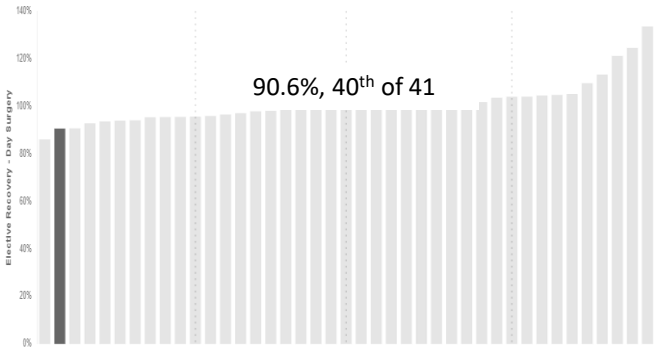
Advice & Guidance



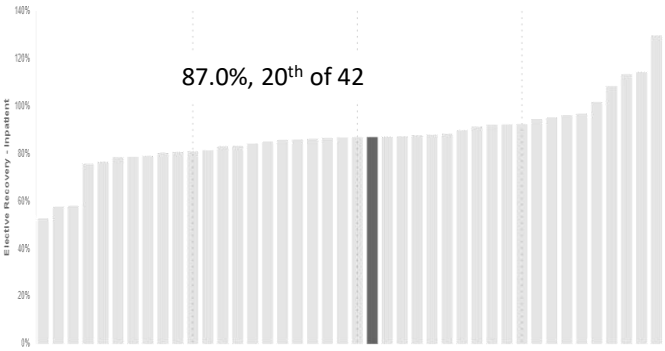
ICB – National Performance Ambition Metrics

Increase day cases, ordinary admissions, OPFA and OP with procedures (excluding OPFU) by 10% on 2019/20 levels

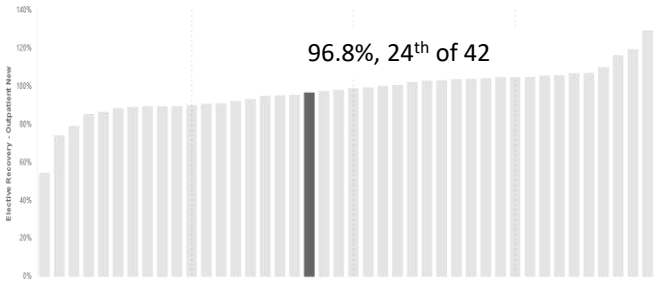
Day case



Ordinary admissions



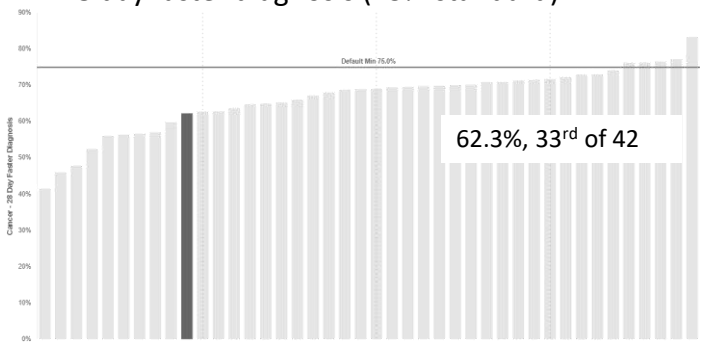
Outpatient new



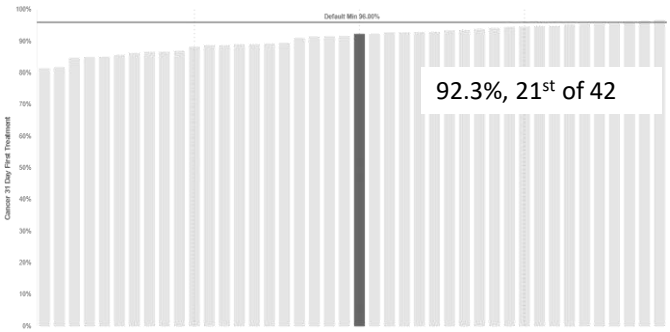
ICB – National Performance Ambition Metrics

Improvements to cancer treatments against cancer standards (62 days urgent ref to 1st treatment, 28 faster diagnosis & 31 day decision to treat to 1st treatment)

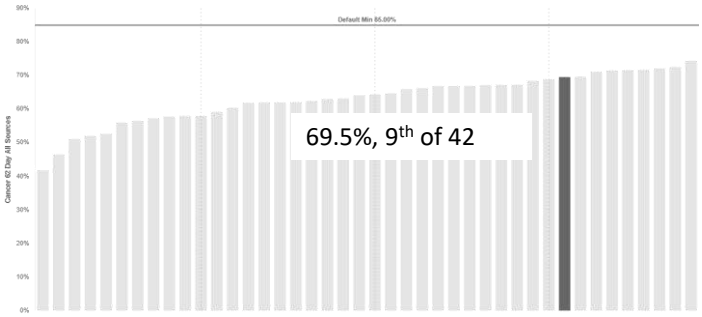
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)

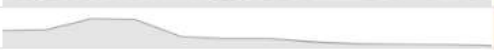


NHS
Cheshire and Merseyside

Appendix 2 – Provider Summaries

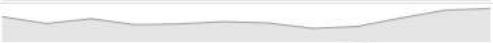
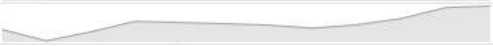
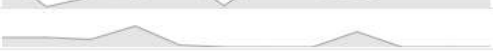
NHS
Cheshire and Merseyside

Warrington & Halton Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**63.8%**		
A&E Attendances All	Nov 22	-	10,512		
Breast Feeding Initiation	Sep 22	70.0%	**67.6%**		
C.difficile (Hospital Onset)	Sep 22	13.00	**21.7**		
Cancelled Operations	Q2 22/23	0.65%	0.4%		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**72.9%**		
Cancer 2 Week Wait	Oct 22	93.00%	**89.2%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	97.9%		
Cancer 31 Day First Treatment	Oct 22	96.00%	98.3%		
Cancer 62 Day Classic	Oct 22	85.00%	**64.9%**		
Day Surgery Activity	Oct 22	-	2,255		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**24.1%**		
E.coli (All Cases)	Sep 22	-	112.7		
Elective Inpatient Activity	Oct 22	-	230		
Mixed Sex Accommodation Breaches	Oct 22	0	**3**		
MRSA (All Cases)	Sep 22	-	3.2		
MSSA (All Cases)	Sep 22	-	37.0		
Outpatient Follow Up Activity	Oct 22	-	28,385		
Outpatient New Activity	Oct 22	-	7,330		
Outpatient Total Activity	Oct 22	-	35,715		
RTT 104 Week Breach	Oct 22	0	**4**		
RTT 52 Week Breach	Oct 22	0	**1,583**		
RTT 78 Week Breach	Oct 22	0	**215**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**61.7%**		
RTT Total Incompletes	Oct 22	-	28,533		
Sickness Absence Rate	Jul 22	4.00%	**7.4%**		
Staff Recommend Care	Q3 21/22	80.00%	**63.7%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	97.4		

NHS
Cheshire and Merseyside

Wirral University Teaching Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**63.9%**		
A&E Attendances All	Nov 22	-	11,207		
Breast Feeding Initiation	Sep 22	70.0%	**59.6%**		
C.difficile (Hospital Onset)	Sep 22	13.00	**45.5**		
Cancelled Operations	Q2 22/23	0.65%	**0.9%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	75.2%		
Cancer 2 Week Wait	Oct 22	93.00%	**88.3%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	-		
Cancer 31 Day First Treatment	Oct 22	96.00%	97.3%		
Cancer 62 Day Classic	Oct 22	85.00%	**73.1%**		
Day Surgery Activity	Oct 22	-	3,705		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**13.2%**		
E.coli (All Cases)	Sep 22	-	97.6		
Elective Inpatient Activity	Oct 22	-	515		
Mixed Sex Accommodation Breaches	Oct 22	0	**3**		
MRSA (All Cases)	Sep 22	-	1.6		
MSSA (All Cases)	Sep 22	-	34.4		
Outpatient Follow Up Activity	Oct 22	-	32,375		
Outpatient New Activity	Oct 22	-	12,350		
Outpatient Total Activity	Oct 22	-	44,725		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**1,279**		
RTT 78 Week Breach	Oct 22	0	**55**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**61.8%**		
RTT Total Incompletes	Oct 22	-	37,157		
Sickness Absence Rate	Jul 22	4.00%	**7.0%**		
Staff Recommend Care	Q3 21/22	80.00%	**67.8%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	**104.4**		

NHS
Cheshire and Merseyside

St Helens & Knowsley Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**60.7%**		
A&E Attendances All	Nov 22	-	14,634		
Breast Feeding Initiation	Sep 22	70.0%	**45.8%**		
C.difficile (Hospital Onset)	Sep 22	13.00	**13.4**		
Cancelled Operations	Q2 22/23	0.65%	**1.1%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**66.3%**		
Cancer 2 Week Wait	Oct 22	93.00%	**64.8%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	93.0%		
Cancer 31 Day First Treatment	Oct 22	96.00%	97.4%		
Cancer 62 Day Classic	Oct 22	85.00%	**82.6%**		
Day Surgery Activity	Oct 22	-	4,080		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**23.2%**		
E.coli (All Cases)	Sep 22	-	99.3		
Elective Inpatient Activity	Oct 22	-	425		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	1.5		
MSSA (All Cases)	Sep 22	-	38.6		
Outpatient Follow Up Activity	Oct 22	-	28,320		
Outpatient New Activity	Oct 22	-	14,505		
Outpatient Total Activity	Oct 22	-	42,825		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**2,408**		
RTT 78 Week Breach	Oct 22	0	**395**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**67.3%**		
RTT Total Incompletes	Oct 22	-	44,394		
Sickness Absence Rate	Jul 22	4.00%	**4.2%**		
Staff Recommend Care	Q3 21/22	80.00%	**79.4%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	**104.3**		

NHS
Cheshire and Merseyside

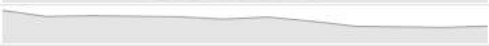
Mid Cheshire Hospitals Summary

The trust have reported no patients waiting over 104 weeks for the second month. Despite more activity in most diagnostic modalities in 2022 compared to pre-pandemic, the backlog has increased slightly. Performance against the majority of Cancer targets for the trust remain above England and Cheshire & Merseyside averages.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**57.8%**		
A&E Attendances All	Nov 22	-	9,518		
Breast Feeding Initiation	Sep 22	70.0%	70.6%		
C.difficile (Hospital Onset)	Sep 22	13.00	**15.9**		
Cancelled Operations	Q2 22/23	0.65%	**1.8%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**69.2%**		
Cancer 2 Week Wait	Oct 22	93.00%	**91.0%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	**83.7%**		
Cancer 31 Day First Treatment	Oct 22	96.00%	**89.8%**		
Cancer 62 Day Classic	Oct 22	85.00%	**74.7%**		
Day Surgery Activity	Oct 22	-	2,120		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**28.1%**		
E.coli (All Cases)	Sep 22	-	96.3		
Elective Inpatient Activity	Oct 22	-	240		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	2.0		
MSSA (All Cases)	Sep 22	-	31.8		
Outpatient Follow Up Activity	Oct 22	-	17,370		
Outpatient New Activity	Oct 22	-	8,370		
Outpatient Total Activity	Oct 22	-	25,740		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**1,635**		
RTT 78 Week Breach	Oct 22	0	**145**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**57.1%**		
RTT Total Incompletes	Oct 22	-	36,738		
Sickness Absence Rate	Jul 22	4.00%	**5.9%**		
Staff Recommend Care	Q3 21/22	80.00%	**71.9%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	94.7		

NHS
Cheshire and Merseyside

Liverpool University Hospitals Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**66.5%**		
A&E Attendances All	Nov 22	-	26,837		
C.difficile (Hospital Onset)	Sep 22	13.00	**24.2**		
Cancelled Operations	Q2 22/23	0.65%	**0.8%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**59.7%**		
Cancer 2 Week Wait	Oct 22	93.00%	**54.5%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	**44.0%**		
Cancer 31 Day First Treatment	Oct 22	96.00%	**90.7%**		
Cancer 62 Day Classic	Oct 22	85.00%	**53.6%**		
Day Surgery Activity	Oct 22	-	5,330		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**16.7%**		
E.coli (All Cases)	Sep 22	-	113.7		
Elective Inpatient Activity	Oct 22	-	1,065		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	1.9		
MSSA (All Cases)	Sep 22	-	37.3		
Outpatient Follow Up Activity	Oct 22	-	50,665		
Outpatient New Activity	Oct 22	-	28,170		
Outpatient Total Activity	Oct 22	-	78,835		
RTT 104 Week Breach	Oct 22	0	**13**		
RTT 52 Week Breach	Oct 22	0	**10,382**		
RTT 78 Week Breach	Oct 22	0	**1,739**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**49.0%**		
RTT Total Incompletes	Oct 22	-	87,097		
Sickness Absence Rate	Jul 22	4.00%	**7.2%**		
Staff Recommend Care	Q3 21/22	80.00%	**60.3%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	**102.2**		

NHS
Cheshire and Merseyside

East Cheshire Hospitals Summary

Significant progress continues with the utilisation of Independent Sector capacity, specifically within Gastroenterology, ENT, General Surgery and T&O specialities and some theatre lists are being converted to support long waiting patients. The cancer 62 day performance has seen a continuation of challenged performance. This is multi-factorial with the main impacts being the challenges of complex diagnostic pathways, delays in radiology as well as the reporting of histology.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**52.6%**		
A&E Attendances All	Nov 22	-	4,238		
C.difficile (Hospital Onset)	Sep 22	13.00	10.7		
Cancelled Operations	Q2 22/23	0.65%	**2.2%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**64.9%**		
Cancer 2 Week Wait	Oct 22	93.00%	**80.8%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	**58.6%**		
Cancer 31 Day First Treatment	Oct 22	96.00%	**48.1%**		
Cancer 62 Day Classic	Oct 22	85.00%	**32.8%**		
Day Surgery Activity	Oct 22	-	875		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**20.8%**		
E.coli (All Cases)	Sep 22	-	103.0		
Elective Inpatient Activity	Oct 22	-	100		
Mixed Sex Accommodation Breaches	Oct 22	0	**12**		
MRSA (All Cases)	Sep 22	-	1.8		
MSSA (All Cases)	Sep 22	-	50.6		
Outpatient Follow Up Activity	Oct 22	-	5,420		
Outpatient New Activity	Oct 22	-	4,185		
Outpatient Total Activity	Oct 22	-	9,605		
RTT 104 Week Breach	Oct 22	0	**1**		
RTT 52 Week Breach	Oct 22	0	**237**		
RTT 78 Week Breach	Oct 22	0	**31**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**68.9%**		
RTT Total Incompletes	Oct 22	-	10,313		
Sickness Absence Rate	Jul 22	4.00%	**7.3%**		
Staff Recommend Care	Q3 21/22	80.00%	**64.6%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	**116.9**		

NHS
Cheshire and Merseyside

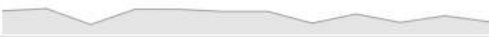
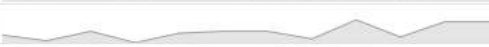
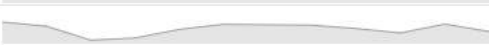
Countess of Chester Hospital Summary

The trust upgraded from an out-dated electronic patient record (EPR) system to a new EPR system in 2021. Data issues have impacted on availability of data and the trust's ability to manage waiting lists effectively, leading to poor performance across the majority of areas.
Issue: Data, once migrated from the old system, was not visible on the new system, leading to ongoing use of manual records.
Action: Detailed validation of patient records across every service and all points of delivery (POD), eg Out Patients, Inpatients etc. commenced in November 2021 and is expected to be completed by December 2022.
Mitigation: As at September 2022 validation of Diagnostic data is almost complete and good progress has been made on validating RTT, particularly Open Pathways. In addition there is notable improvements to TCI data and Outpatient Follow Ups (FUPs). The trust are also working with NHS digital to ensure data from the new system is loading accurately onto the "Spine".
For cancer the trust have implemented a process/pathway review, leadership restructure and overhaul of operational reporting governance.

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**55.1%**		
A&E Attendances All	Nov 22	-	7,067		
Breast Feeding Initiation	Sep 22	70.0%	**66.7%**		
C.difficile (Hospital Onset)	Sep 22	13.00	**36.3**		
Cancelled Operations	Q2 22/23	0.65%	**0.7%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**62.3%**		
Cancer 2 Week Wait	Oct 22	93.00%	**70.1%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	**-**		
Cancer 31 Day First Treatment	Oct 22	96.00%	97.8%		
Cancer 62 Day Classic	Oct 22	85.00%	**79.5%**		
Day Surgery Activity	Oct 22	-	2,015		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**24.2%**		
E.coli (All Cases)	Sep 22	-	128.4		
Elective Inpatient Activity	Oct 22	-	265		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	1.4		
MSSA (All Cases)	Sep 22	-	49.6		
Outpatient Follow Up Activity	Oct 22	-	15,725		
Outpatient New Activity	Oct 22	-	7,085		
Outpatient Total Activity	Oct 22	-	22,810		
RTT 104 Week Breach	Oct 22	0	**4**		
RTT 52 Week Breach	Oct 22	0	**4,368**		
RTT 78 Week Breach	Oct 22	0	**210**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**44.1%**		
RTT Total Incompletes	Oct 22	-	39,810		
Sickness Absence Rate	Jul 22	4.00%	**5.7%**		
Staff Recommend Care	Q3 21/22	80.00%	**57.1%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	98.9		

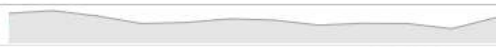
NHS
Cheshire and Merseyside

Southport & Ormskirk Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**74.2%**		
A&E Attendances All	Nov 22	-	10,727		
Breast Feeding Initiation	Sep 22	70.0%	**62.2%**		
C.difficile (Hospital Onset)	Sep 22	13.00	**25.6**		
Cancelled Operations	Q2 22/23	0.65%	**1.0%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**63.3%**		
Cancer 2 Week Wait	Oct 22	93.00%	**78.4%**		
Cancer 2 Week Wait Breast Symptomatic	Oct 22	93.0%	-		
Cancer 31 Day First Treatment	Oct 22	96.00%	**87.2%**		
Cancer 62 Day Classic	Oct 22	85.00%	**65.6%**		
Day Surgery Activity	Oct 22	-	1,745		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**25.2%**		
E.coli (All Cases)	Sep 22	-	153.4		
Elective Inpatient Activity	Oct 22	-	215		
Mixed Sex Accommodation Breaches	Oct 22	0	**11**		
MRSA (All Cases)	Sep 22	-	1.5		
MSSA (All Cases)	Sep 22	-	46.5		
Outpatient Follow Up Activity	Oct 22	-	14,820		
Outpatient New Activity	Oct 22	-	5,720		
Outpatient Total Activity	Oct 22	-	20,540		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**218**		
RTT 78 Week Breach	Oct 22	0	**15**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**67.5%**		
RTT Total Incompletes	Oct 22	-	15,493		
Sickness Absence Rate	Jul 22	4.00%	**7.9%**		
Staff Recommend Care	Q3 21/22	80.00%	**52.8%**		
Summary Hospital Mortality Indicator	Jul 22	100.00	**100.9**		

NHS
Cheshire and Merseyside

Liverpool Women's Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**93.5%**		
A&E Attendances All	Nov 22	-	1,252		
Breast Feeding Initiation	Sep 22	70.0%	**67.5%**		
C.difficile (Hospital Onset)	Sep 22	13.00	0.0		
Cancelled Operations	Q2 22/23	0.65%	0.2%		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**52.9%**		
Cancer 2 Week Wait	Oct 22	93.00%	**91.8%**		
Cancer 31 Day First Treatment	Oct 22	96.00%	**81.3%**		
Cancer 62 Day Classic	Oct 22	85.00%	**23.8%**		
Day Surgery Activity	Oct 22	-	415		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**38.2%**		
E.coli (All Cases)	Sep 22	-	46.6		
Elective Inpatient Activity	Oct 22	-	145		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	0.0		
MSSA (All Cases)	Sep 22	-	3.6		
Outpatient Follow Up Activity	Oct 22	-	7,745		
Outpatient New Activity	Oct 22	-	4,350		
Outpatient Total Activity	Oct 22	-	12,095		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**2,548**		
RTT 78 Week Breach	Oct 22	0	**62**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**44.8%**		
RTT Total Incompletes	Oct 22	-	17,716		
Sickness Absence Rate	Jul 22	4.00%	**8.2%**		
Staff Recommend Care	Q3 21/22	80.00%	**69.1%**		

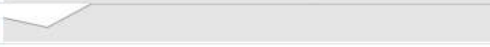
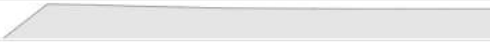
NHS
Cheshire and Merseyside

Liverpool Heart & Chest Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
C.difficile (Hospital Onset)	Sep 22	13.00	2.0		
Cancelled Operations	Q2 22/23	0.65%	**2.3%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**33.3%**		
Cancer 2 Week Wait	Oct 22	93.00%	100%		
Cancer 31 Day First Treatment	Oct 22	96.00%	100%		
Cancer 62 Day Classic	Oct 22	85.00%	100%		
Day Surgery Activity	Oct 22	-	350		
Diagnostics - 6 Week Standard	Oct 22	1.00%	0.4%		
E.coli (All Cases)	Sep 22	-	14.1		
Elective Inpatient Activity	Oct 22	-	375		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	0.0		
MSSA (All Cases)	Sep 22	-	22.2		
Outpatient Follow Up Activity	Oct 22	-	4,050		
Outpatient New Activity	Oct 22	-	2,430		
Outpatient Total Activity	Oct 22	-	6,480		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**56**		
RTT 78 Week Breach	Oct 22	0	**14**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**78.9%**		
RTT Total Incompletes	Oct 22	-	4,956		
Sickness Absence Rate	Jul 22	4.00%	**6.7%**		
Staff Recommend Care	Q3 21/22	80.00%	91.6%		

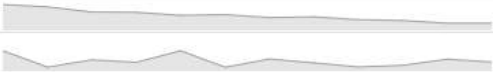
NHS
Cheshire and Merseyside

Alder Hey Hospital Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**64.6%**		
A&E Attendances All	Nov 22	-	6,609		
C.difficile (Hospital Onset)	Sep 22	13.00	0.0		
Cancelled Operations	Q2 22/23	0.65%	**1.3%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	100%		
Cancer 2 Week Wait	Oct 22	93.00%	100%		
Cancer 31 Day First Treatment	Oct 22	96.00%	100%		
Cancer 62 Day Classic	Oct 22	85.00%	-		
Day Surgery Activity	Oct 22	-	1,745		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**35.9%**		
E.coli (All Cases)	Sep 22	-	45.0		
Elective Inpatient Activity	Oct 22	-	340		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	1.6		
MSSA (All Cases)	Sep 22	-	31.0		
Outpatient Follow Up Activity	Oct 22	-	16,035		
Outpatient New Activity	Oct 22	-	6,335		
Outpatient Total Activity	Oct 22	-	22,370		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**378**		
RTT 78 Week Breach	Oct 22	0	**3**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**54.5%**		
RTT Total Incompletes	Oct 22	-	23,576		
Sickness Absence Rate	Jul 22	4.00%	**7.4%**		
Staff Recommend Care	Q3 21/22	80.00%	89.5%		

NHS
Cheshire and Merseyside

The Walton Centre Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
C.difficile (Hospital Onset)	Sep 22	13.00	**14.0**		
Cancelled Operations	Q2 22/23	0.65%	**0.9%**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	92.9%		
Cancer 2 Week Wait	Oct 22	93.00%	100%		
Cancer 31 Day First Treatment	Oct 22	96.00%	100%		
Cancer 62 Day Classic	Oct 22	85.00%	**0.0%**		
Day Surgery Activity	Oct 22	-	765		
Diagnostics - 6 Week Standard	Oct 22	1.00%	0.1%		
E.coli (All Cases)	Sep 22	-	30.2		
Elective Inpatient Activity	Oct 22	-	240		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	0.0		
MSSA (All Cases)	Sep 22	-	18.6		
Outpatient Follow Up Activity	Oct 22	-	6,955		
Outpatient New Activity	Oct 22	-	3,325		
Outpatient Total Activity	Oct 22	-	10,280		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**154**		
RTT 78 Week Breach	Oct 22	0	**4**		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**79.8%**		
RTT Total Incompletes	Oct 22	-	12,380		
Sickness Absence Rate	Jul 22	4.00%	**6.3%**		
Staff Recommend Care	Q3 21/22	80.00%	88.7%		

NHS
Cheshire and Merseyside

The Clatterbridge Cancer Centre Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
C.difficile (Hospital Onset)	Sep 22	13.00	**48.4**		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	100%		
Cancer 2 Week Wait	Oct 22	93.00%	100%		
Cancer 31 Day First Treatment	Oct 22	96.00%	99.6%		
Cancer 62 Day Classic	Oct 22	85.00%	**76.1%**		
Day Surgery Activity	Oct 22	-	355		
Diagnostics - 6 Week Standard	Oct 22	1.00%	0.0%		
E.coli (All Cases)	Sep 22	-	134.1		
Elective Inpatient Activity	Oct 22	-	95		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
MRSA (All Cases)	Sep 22	-	3.7		
MSSA (All Cases)	Sep 22	-	59.6		
Outpatient Follow Up Activity	Oct 22	-	39,600		
Outpatient New Activity	Oct 22	-	1,340		
Outpatient Total Activity	Oct 22	-	40,940		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	0		
RTT 78 Week Breach	Oct 22	0	0		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	97.2%		
RTT Total Incompletes	Oct 22	-	931		
Sickness Absence Rate	Jul 22	4.00%	**5.6%**		
Staff Recommend Care	Q3 21/22	80.00%	85.5%		

NHS
Cheshire and Merseyside

Cheshire & Wirral Partnership Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
Day Surgery Activity	Oct 22	-	-		
EIP Open Referrals Waiting < 2 Weeks	Oct 22	75.00%	**2.6%**		
Elective Inpatient Activity	Oct 22	-	-		
IAPT Face to Face	Sep 22	-	10%		
IAPT Incomplete Waiting under 18 weeks	Sep 22	95.0%	**78.7%**		
IAPT Incomplete Waiting under 6 weeks	Sep 22	75.0%	**64.7%**		
IAPT Recovery Rate	Sep 22	50.0%	53.5%		
IAPT Referrals	Sep 22	-	920		
MH AWOL Episodes	Sep 22	-	-		
MH Under 18 Bed Days on Adult Ward	Sep 22	-	-		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
Outpatient Follow Up Activity	Oct 22	-	-		
Outpatient New Activity	Oct 22	-	-		
Outpatient Total Activity	Oct 22	-	-		
Sickness Absence Rate	Jul 22	4.00%	**7.3%**		
Staff Recommend Care	Q3 21/22	80.00%	**69.5%**		

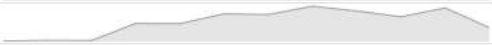
NHS
Cheshire and Merseyside

Mersey Care Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	96.5%		
A&E Attendances All	Nov 22	-	12,929		
Day Surgery Activity	Oct 22	-	-		
EIP Open Referrals Waiting < 2 Weeks	Oct 22	75.00%	**46.2%**		
Elective Inpatient Activity	Oct 22	-	-		
IAPT Face to Face	Sep 22	-	13%		
IAPT Incomplete Waiting under 18 weeks	Sep 22	95.0%	99.0%		
IAPT Incomplete Waiting under 6 weeks	Sep 22	75.0%	97.0%		
IAPT Recovery Rate	Sep 22	50.0%	**49.8%**		
IAPT Referrals	Sep 22	-	2,565		
Mixed Sex Accommodation Breaches	Oct 22	0	0		
Outpatient Follow Up Activity	Oct 22	-	-		
Outpatient New Activity	Oct 22	-	-		
Outpatient Total Activity	Oct 22	-	-		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	0		
RTT 78 Week Breach	Oct 22	0	0		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	97.9%		
RTT Total Incompletes	Oct 22	-	47		
Sickness Absence Rate	Jul 22	4.00%	**8.7%**		
Staff Recommend Care	Q3 21/22	80.00%	**67.0%**		

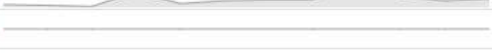
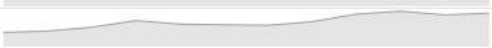
NHS
Cheshire and Merseyside

Wirral Community Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	98.8%		
A&E Attendances All	Nov 22	-	3,739		
Cancer 31 Day First Treatment	Oct 22	96.00%	-		
Cancer 62 Day Classic	Oct 22	85.00%	-		
Diagnostics - 6 Week Standard	Oct 22	1.00%	67.0%		
RTT 104 Week Breach	Oct 22	0	2		
RTT 52 Week Breach	Oct 22	0	6		
RTT 78 Week Breach	Oct 22	0	4		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	86.3%		
RTT Total Incompletes	Oct 22	-	139		
Sickness Absence Rate	Jul 22	4.00%	8.5%		
Staff Recommend Care	Q3 21/22	80.00%	72.8%		

NHS
Cheshire and Merseyside

Bridgewater Community Healthcare Summary

Key Performance Indicator	Period	Target		SPC	Last 12 Months
A&E - 4 Hour Standard	Nov 22	95.00%	**87.3%**		
A&E Attendances All	Nov 22	-	3,690		
Cancer - 28 Day Faster Diagnosis	Oct 22	75.0%	**72.9%**		
Cancer 2 Week Wait	Oct 22	93.00%	**92.4%**		
Cancer 31 Day First Treatment	Oct 22	96.00%	100%		
Cancer 62 Day Classic	Oct 22	85.00%	92.0%		
Day Surgery Activity	Oct 22	-	0		
Diagnostics - 6 Week Standard	Oct 22	1.00%	**1.3%**		
Elective Inpatient Activity	Oct 22	-	0		
IAPT Incomplete Waiting under 18 weeks	Sep 22	95.0%	-		
IAPT Incomplete Waiting under 6 weeks	Sep 22	75.0%	-		
IAPT Recovery Rate	Sep 22	50.0%	-		
IAPT Referrals	Sep 22	-	-		
Mixed Sex Accommodation Breaches	Oct 22	0	-		
Outpatient Follow Up Activity	Oct 22	-	7,260		
Outpatient New Activity	Oct 22	-	1,895		
Outpatient Total Activity	Oct 22	-	9,155		
RTT 104 Week Breach	Oct 22	0	0		
RTT 52 Week Breach	Oct 22	0	**9**		
RTT 78 Week Breach	Oct 22	0	0		
RTT Incomplete 18 Week Standard	Oct 22	92.00%	**39.7%**		
RTT Total Incompletes	Oct 22	-	2,773		
Sickness Absence Rate	Jul 22	4.00%	**7.2%**		
Staff Recommend Care	Q3 21/22	80.00%	**77.7%**		

NHS
Cheshire and Merseyside

C&M Place Summary:

Dec 22 System Oversight Framework publication

			SubICB								
NHS OF Metric Name Full	Aggregation Source	Period	NHS CHESHIRE (SUB ICB LOCATION) (27D)	NHS HALTON (SUB ICB LOCATION) (01F)	NHS KNOWSLEY (SUB ICB LOCATION) (01J)	NHS LIVERPOOL (SUB ICB LOCATION) (99A)	NHS SOUTH SEFTON (SUB ICB LOCATION) (01T)	NHS SOUTHPORT AND FORMBY (SUB ICB LOCATION) (01V)	NHS ST HELENS (SUB ICB LOCATION) (01X)	NHS WARRINGTON (SUB ICB LOCATION) (02E)	NHS WIRRAL (SUB IC LOCATION) (12F)
S009a: Total patients waiting more than 52 weeks to start consultant led treatment	SubICB	2022 09	8,452	926	1,884	6,763	3,020	679	973	1,552	1,553
S009b: Total patients waiting more than 78 weeks to start consultant led treatment	SubICB	2022 09	849	126	250	823	440	71	137	238	113
S009c: Total patients waiting more than 104 weeks to start consultant led treatment	SubICB	2022 09	46	1	1	20	10	5	1	10	3
S010a: Total patients treated for cancer compared with the same point in 2019/20	SubICB	2022 09		174%	78%	96.3%	130.9%	165.6%	106.3%	96.4%	123.4%
S012a: Proportion of patients meeting the faster cancer diagnosis standard	SubICB	2022 09	63.8%	70%	56%	43.8%	54.6%	62.8%	69.4%	71.5%	71.6%
S013a: Diagnostic activity levels: Imaging	SubICB	2022 09	110.1%	102.8%	99.1%	106.6%	97.1%	103%	100.2%	99.7%	108.7%
S013b: Diagnostic activity levels: Physiological measurement	SubICB	2022 09	67.5%	82.7%	101.1%	98%	67.7%	117.3%	95.6%	67.5%	63.1%
S013c: Diagnostic activity levels: Endoscopy	SubICB	2022 09	77.6%	125.4%	115.8%	104.4%	80.8%	75.9%	103.2%	115.4%	82.2%
S013d: Diagnostic activity levels: Total	SubICB	2022 09	103.2%	102.5%	100.3%	105.5%	92.5%	102.4%	99.9%	97.4%	100.1%
S031a: Rate of personalised care interventions	SubICB	22-23 Q2	57.5 per 1,000	21.03 per 1,000	52.99 per 1,000	87.44 per 1,000	40.44 per 1,000	26.15 per 1,000	43.76 per 1,000	68.05 per 1,000	63.44 per 1,000
S032a: Personal health budgets	SubICB	22-23 Q1	0.61 per 1,000	1.57 per 1,000	0.97 per 1,000	0.41 per 1,000	0.54 per 1,000	0.71 per 1,000	12.85 per 1,000	1.02 per 1,000	0.45 per 1,000
S040a: Methicillin resistant Staphylococcus aureus (MRSA) bacteraemia infection rate	SubICB	2022 09	12	2	0	11	1	1	1	4	4
S041a: Clostridium difficile infection rate	SubICB	2022 09	122.3%	129.4%	112.2%	102.9%	120.3%	91.7%	70%	150%	143.2%
S042a: E. coli bloodstream infection rate	SubICB	2022 09	108.6%	96.8%	134.5%	121.9%	112%	117.8%	103.4%	111.7%	125%
S044a: Antimicrobial resistance: total prescribing of antibiotics in primary care	SubICB	Sep 2021 - Aug 2022	89.3%	110.5%	109.1%	106.1%	114.8%	96.1%	112.7%	91.2%	109%
S044b: Antimicrobial resistance: proportion of broad-spectrum antibiotic prescribing in primary care	SubICB	Sep 2021 - Aug 2022	7.55%	6.68%	7.38%	8.23%	9.02%	9.37%	6.08%	6.46%	10.7%
S046a: Population vaccination coverage: MMR for two doses (5 year olds)	SubICB	21-22 Q4	92.1%	88.7%	78.7%	77.8%	79.2%	91.2%	89.3%	94.9%	89.9%
S047a: Proportion of people over 65 receiving a seasonal flu vaccinatio	SubICB	2022 02	86.5%	81.6%	76.1%	77.3%	79.6%	85.8%	82.1%	81.9%	84%
S050a: Cervical screening coverage : % females aged 25 - 64 attending screening within the target period	SubICB	21-22 Q4	75.5%	71.6%	72%	64.4%	69.5%	73.3%	72.5%	74.3%	72.8%
S053a: % of atrial fibrillation patients with a record of a CHA2DS2-VASc score of 2 or more who are treated with anticoagulation drug therapy	SubICB	2021-22	88.4%	90.7%	91.6%	89%	88.9%	89.5%	90.7%	90.9%	90.6%
S053b: % of hypertension patients who are treated to target as per NICE guidance	SubICB	2021-22	60.7%	57.1%	53.6%	57.3%	52.3%	62.8%	58.1%	58%	57.7%
S053c: % of patients identified as having 20% or greater 10-year risk of developing CVD are treated with statins	SubICB	2022 03	56.2%	58.6%	60.1%	59.9%	58.4%	51.1%	57.5%	54.5%	58.9%
S055a: Number GP referrals to NHS Digital weight management services per 100k population	SubICB	22-23 Q2	114.2 per 100,000	86.2 per 100,000	76.3 per 100,000	124.3 per 100,000	40.9 per 100,000	133 per 100,000	69.3 per 100,000	62.9 per 100,000	24.9 per 100,000
S086a: Inappropriate adult acute mental health placement out of area placement bed days	SubICB	Jun 2022 - Aug 2022	1,120	40	0	35	0	0	0	0	595
S105a: Proportion of patients discharged from hospital to their usual place of residence	SubICB	2022 09	89.8%	95.8%	95.1%	94.7%	95.6%	91.1%	94.6%	95.3%	94.2%
S115a: Proportion of diabetes patients that have received all eight diabetes care processes	SubICB	21-22 Q4	42.9%	28.5%	31.8%	42.9%	32.4%	47.2%	26.9%	27.3%	30.9%

Rank Banding
- Highest performing quartile
- Interquartile range
- Lowest performing quartile

NHS
Cheshire and Merseyside

ICB – Provider SOF Segments

NHS Provider Segmentation: as of 7th October 20222

Trust	Segmentation Score
Cheshire and Wirral Partnership NHS Foundation Trust	1
Liverpool Heart and Chest Hospital NHS Foundation Trust	1
The Walton Centre NHS Foundation Trust	1
Alder Hey Children's NHS Foundation Trust	2
Bridgewater Community Healthcare NHS Foundation Trust	2
Clatterbridge Cancer Centre NHS Foundation Trust	2
Mersey Care NHS Foundation Trust	2
Mid-Cheshire Hospital NHS Foundation Trust	2
North West Ambulance Service NHS Trust	2
Southport and Ormskirk Hospital NHS Trust	2
St Helens and Knowsley Teaching Hospitals NHS Trust	2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	2
Wirral Community Health and Care NHS Foundation Trust	2
Countess of Chester NHS Foundation Trust	3
East Cheshire NHS Trust	3
Liverpool Women's Hospital NHS Foundation Trust	3
Wirral University Teaching Hospital NHS Foundation Trust	3
Liverpool University Hospitals NHS Foundation Trust	4

Key

Segment 1	Consistently high performing across the five national oversight themes and playing an active leadership role in supporting and driving key local place-based and overall ICS priorities
Segment 2	Plans that have the support of system partners in place to address areas of challenge.Targeted support may be required to address specific identified issues
Segment 3	Significant support needs against one or more of the five national oversight themes and in actual or suspected breach of the licence (or equivalent for NHS trusts)
Segment 4	In actual or suspected breach of the licence (or equivalent) with very serious, complex issues manifesting as critical quality and/or finance concerns that require intensive support

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Liverpool Clinical Services Review

Agenda Item No	**ICB/01/23/12**
Report author & contact details	Carole Hill, Associate Director, Strategy, Integration and Partnerships, Liverpool Place
Report approved by (sponsoring Director)	Jan Ledward, Liverpool Place Director
Responsible Officer to take actions forward	Jan Ledward

Liverpool Clinical Services Review

Executive Summary	The purpose of this paper is to publish the report from the Liverpool Clinical Services Review, which includes a set of recommendations for the Cheshire and Merseyside ICB to consider. 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.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
		X			
Recommendation	**The Board is asked to:** • **approve**, in full, the recommendations set out in the report. • **note** the implementation plan and associated timescales.				
Key issues	The objective of the review is to identify ways in which to improve outcomes and ensure clinical and financial sustainability of acute and specialist services delivered by NHS providers in Liverpool.				
Key risks	The report from the clinical services review sets out: • the population health challenges and inequalities experienced by people in Liverpool region to be addressed. • the fragmentation and variability of acute services in the Liverpool city region.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X		X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Route to this meeting	The Clinical Services Review has been overseen by the One Liverpool Partnership Board				
Management of Conflicts of Interest	N/A				
Patient and Public Engagement	The recommendations from the Clinical Services Review do not represent formal proposals at this stage. The next phase of implementation will require co-production, patient, and public engagement,				
Next Steps	Next steps are detailed in the body of the paper.				
Appendices	**Appendix One**	Liverpool Clinical Services Review Report			
	Appendix Two	Summary of Recommendations			
	Appendix Three	High Level Implementation Plan			
	Appendix Four	High Level Communications Plan			

Liverpool Clinical Services Review

1. Executive Summary

1.1 The purpose of this paper is to publish the report from the Liverpool Clinical Services Review, which includes a set of recommendations for the Cheshire and Merseyside ICB to consider.

1.2 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 and beyond.

1.3 The review is set within the context of the One Liverpool Strategy and involves the whole Liverpool system, including primary, community and mental health.

1.4 Liverpool is exceptional in the number of acute and specialist provider trusts in the city, many of which provide outstanding care but are challenged due to fragmentation of services, variation in quality, financial positions, experiences of care, workforce capacity and sustainability.

2. Introduction

2.1 Cheshire and Merseyside Integrated Care System (C&M ICS) were asked by NHS England to commission an independent review that identified and provided recommendations to realise opportunities for greater collaboration between acute and specialised trusts to optimise the model for acute care in Liverpool and beyond.

2.2 The review was also to consider alignment and interdependencies with One Liverpool, the city's health and wellbeing strategy and the wider Cheshire and Merseyside system.

2.3 The focus of the review was primarily the six acute and specialist trusts in the city: Alder Hey Children's NHS Foundation Trust; Clatterbridge Cancer Centre NHS Foundation Trust; Liverpool Women's Hospital NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Liverpool University Hospitals NHS Foundation Trust; and The Walton Centre NHS Foundation Trust. Other partners core to the Liverpool system, also involved in the review, include general practice, Mersey Care NHS Foundation Trust and Liverpool City Council.

2.4 The deliverables for the review were:

- To make a clear and compelling case for greater collaboration
- Identify priorities for collaboration and the reasons why
- Develop a blueprint for the collaborative opportunities to be implemented.
- To articulate the conditions for success, setting out the supporting arrangements to be put in place
- To produce an implementation roadmap to deliver the blueprint.

3. Overview of Recommendations

3.1 Through the review process, twelve opportunities emerged, which are detailed in the full report, which is at Appendix One.

3.2 Some of these opportunities are already being implemented through the delivery of the One Liverpool strategy and through ICS-wide programmes led by Cheshire and Merseyside Acute and Specialist Trusts (CMAST), Community and Mental Health Collaborative and the Cancer Alliance.

3.3 An extract of all the recommendations associated with the priorities identified are at Appendix Two.

3.4 In pursuing delivery of the 12 priorities, it is recommended that a detailed programme of work should be produced, building on existing programmes where appropriate and ensure the creation of other mechanisms to ensure delivery e.g., Joint Committees between a number of providers, to take forward these opportunities.

3.5 The consensus of the One Liverpool Partnership Board is that there are three critical priorities to take forward immediately to address the challenges with greatest risk and opportunity within the Liverpool system:

- Solving the clinical sustainability challenges affecting women's health in Liverpool.
- Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at the Aintree, Broadgreen and Royal Liverpool Hospital sites.
- Significant opportunities to achieve economies of scale in corporate services.

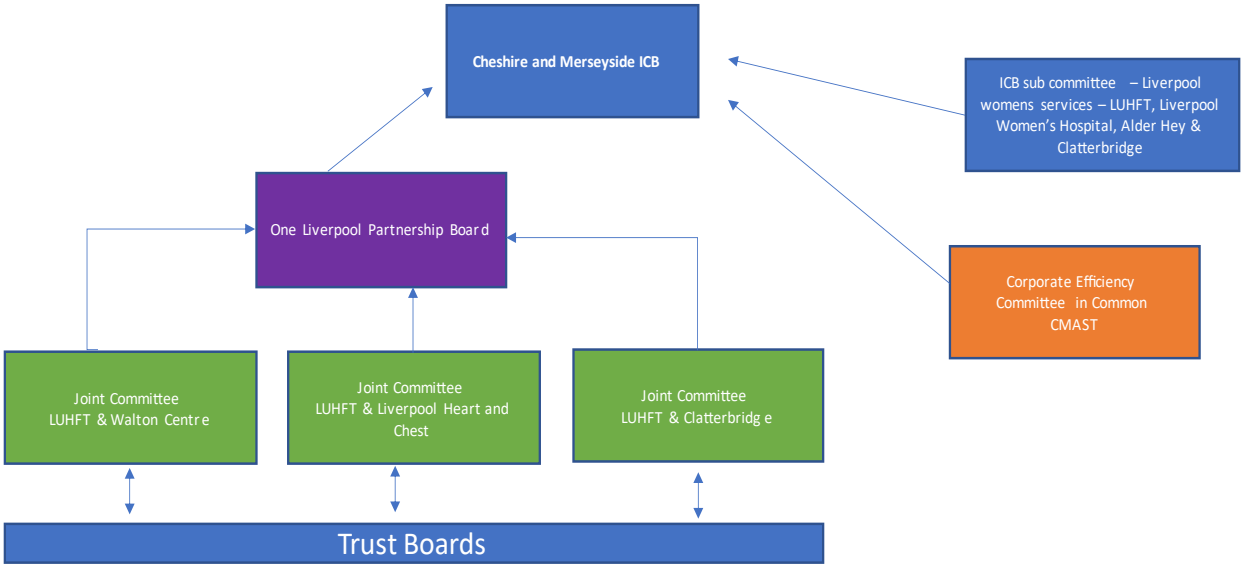
4. Governance and Reporting

4.1 The legislative changes within the Health and Care Act (2022) allow NHS foundation trusts to jointly exercise their functions with other NHS trusts and foundation trusts to form joint committees that could exercise functions and jointly take decisions that have been delegated by their individual organisations, in line with their schemes of delegation. Recent NHS guidance also sets out clear expectations for collaboration by NHS trusts and the governance characteristics that trusts can adopt to support this.[1]

4.2 The governance arrangements for the Liverpool Clinical Services Review are represented in the Diagram One.

[1] https://www.england.nhs.uk/wp-content/uploads/2022/10/B2075-guidance-on-good-governance-and-collaboration-october-22-1.pdf

Diagram One: Liverpool Clinical Services Review Governance diagram



4.3 The recommendations from the Clinical Services review include proposals for Liverpool acute and specialist trusts to form joint committees to expedite the recommendations from the review.

4.4 Monthly reporting from the Joint Committees into the One Liverpool Partnership Board will provide assurance on delivery of the recommendations. The One Liverpool Partnership Board will, in turn, report quarterly to the ICB.

4.5 The ICB subcommittee for women's services will report monthly into the ICB.

4.6 A risk register will be required for each joint committee and the One Liverpool Partnership Board. Unmitigated risks will be escalated to the ICB as part of the quarterly reporting, or sooner if the risk posed is significant and requires immediate action and/or decisions.

4.7 The ICB reserves the right to intervene where:

- Progress is deemed to be stalled or timescales are not being met.
- Decisions are not within the scope of agreed terms of reference.
- Where one of more partners cannot agree.

4.8 A set of principles have been proposed for partners to observe, within scope of the Liverpool Clinical Services Review. Once these are agreed they will be shared.

5. Implementation

5.1 A high-level implementation plan for the first phase of taking forward the recommendations from the Clinical Services Review is at Appendix Three.

5.2 The implementation plan sets out shorter-term actions to establish governance, leadership, and resourcing arrangements for implementation of the recommendations. Detailed plans will be developed and reported as implementation workstreams proceed.

6. Engagement and Communications

6.1 It is important to recognise that the Clinical Services Review goes no further than making recommendations for NHS and wider partners to take forward collaboratively. These recommendations do not represent formal proposals at this stage.

6.2 The next phase of proposal development for the two critical priorities will incorporate co-production and patient and public engagement, in line with NHS England guidance[2] setting out engagement best-practice principles and legal requirements for Integrated Care Boards and other NHS organisations, as well as the Cheshire and Merseyside ICS Public Engagement Framework.[3]

6.3 Specific engagement and communications plans will be incorporated into the implementation of each workstream.

6.4 A high-level communications plan to support the initial implementation phase is at Appendix Four.

7. Recommendations

7.1 **The Board is asked to:**

- approve, in full, the recommendations set out in the report.
- note the implementation plan and associated timescales.

8. Officer contact details for more information

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[2] NHS England issued Working with People and Communities: statutory guidance, for ICBs and other NHS organisations.
[3] https://www.cheshireandmerseyside.nhs.uk/media/jz1ip34u/cm-public-engagement-framework-draft-101022.pdf

NHS Cheshire and Merseyside Integrated Care Board Meeting

Liverpool Clinical Services Review

Appendix One: An independent review of acute and specialist provider collaboration in Liverpool

NHS
Cheshire and Merseyside

Liverpool Clinical Services Review

An independent review of acute and specialist provider collaboration in Liverpool

Final version
18 January 2023

Contents

Purpose of the document

This document outlines the outputs of the Liverpool Clinical Services Review, commissioned by the Cheshire and Merseyside Integrated Care Board (ICB), and delivered by CF. The Cheshire and Merseyside Integrated Care System (ICS) was asked by NHS England (NHSE) to commission an independent review of the acute care model with a view to identifying opportunities that will improve hospital-based clinical services in terms of their quality, efficiency, and effectiveness.

The focus of the review and consequently this document is primarily on the six acute and specialist trusts: Alder Hey Children's NHS Foundation Trust; Clatterbridge Cancer Centre NHS Foundation Trust; Liverpool Women's Hospital NHS Foundation Trust; Liverpool Heart and Chest Hospital NHS Foundation Trust; Liverpool University Hospitals NHS Foundation Trust; and The Walton Centre NHS Foundation Trust. The Trusts operate as part of the Liverpool place-based partnership, led by the One Liverpool Partnership Board. Other partners core to One Liverpool include general practice, Mersey Care NHS Foundation Trust, and Liverpool City Council.

The review took was conducted over a 16-week period from August to December 2022, broadly following an Appreciative Inquiry (Ai) approach before deep-diving into priority areas. The outputs of this engagement are summarised in this document, which covers the case for greater acute and specialist provider collaboration, the priorities for action, the conditions needed for success, and the recommendations of the review.

Executive summary

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review that identified and detailed how to realise collaborative opportunities for the acute and specialist trusts to optimise the acute care model for Liverpool.

The new Health and Care Act 2022 includes a set of legislative changes to enable health and care to work more closely together. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives.

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Liverpool is a place-based partnership in the Cheshire and Merseyside ICS, and major city in England. A significant proportion of the people of Liverpool live in deprivation, with 58.4% of households classified as being deprived to some degree, and/or with poor health and wellbeing. This contributes to the people of Liverpool living on average two and a half years less than people in the rest of England. Progress on closing this gap has stagnated in recent years and the gap between the most affluent and most deprived groups has widened. Much of the morbidity and early mortality is avoidable. Despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate.

Organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In this context, the independent review was commissioned to complement this strategy and accelerate provider collaboration in recognition of the opportunity to optimise the acute care model and deliver financial sustainable services.

The review engaged over 300 people through individual interviews, group discussions with each of the acute and specialist provider executive and hospital management teams, a GP engagement session with PCN clinical leads, and over 150 senior staff from across Liverpool who contributed via a staff survey.

Through this engagement, twelve opportunities emerged that, together, form the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute and specialist providers themselves, and collectively with Mersey Care, PCNs, and the local authority, but also the academic institutions in Liverpool and other stakeholders. The twelve collaboration opportunities are:

1. **Improving physical and mental health by strengthening ways of working with PCNs and neighbourhood teams and providing more anticipatory care, especially for people with long term conditions and complex lives** – Liverpool has a higher burden of long-term conditions, in particular cardiovascular disease, and chronic obstructive pulmonary disease, and multimorbidity than the

national average. The current consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation. There is a significant improvement opportunity by proactive, anticipatory management of conditions to improve health, avoid acute exacerbations and the need for hospital-based services.

2. **Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation** – People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England. Once employed, however people living in Liverpool have better weekly earnings than in other areas. With NHS organisations being one of the major employers, their role within this opportunity is evident in providing wider economic benefits in terms of job offerings. Colleagues clearly described the opportunity to collaborate on shared apprenticeship and school leaver programmes for the local community. There is an imperative opportunity to support local people to gain and remain in employment, taking collective action to address local deprivation.
3. **Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites** – There are challenges with both timely access and poor outcomes in the urgent and emergency care pathways. Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas which means that when people need specialist care, they frequently require transfer to another site and their care becomes fragmented. For some specialties and conditions, this results in long lengths of stay in the emergency department and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients. There can even be significant delays in care when this is delivered between different providers occupying the same hospital site. There is an opportunity to embrace collaboration, and in doing so share best practice, drive up collective quality and performance standards and standardise pathways to ensure optimum emergency care delivery across the city.
4. **Levelling-up performance on cancer and cardiovascular disease to address health inequalities** – Cancer is the city's largest cause of premature deaths. There has been a large increase in referrals and consequently the number of people on the cancer patient tracking list from the pre-pandemic baseline. Additionally, the review found stark inequalities in cancer diagnosis. Patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be an ethnic minority than white, and we know these late-stage diagnoses are likely to have a significant impact on survival rates. Similarly for cardiovascular disease, which is largely preventable through a healthy lifestyle and the early detection and control of risk conditions, there are significant gaps in diagnosis and treatment across Liverpool. There is an opportunity to address late diagnosis of cancer and cardiovascular disease, and inequalities in access which requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs.
5. **Providing timely access to high-quality elective care by making efficient use of existing estates and assets** – Elective waiting lists have grown across Liverpool by a third every year since 2019 and this has been further exacerbated by the impact of the pandemic. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS Foundation Trust has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. All organisations in the city have theatre capacity that could be used more effectively as a shared asset to provide timely access to high quality elective care.
6. **Solving clinical sustainability challenges affecting women's health in Liverpool** – Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was the clinical sustainability of services for women and the clinical risk in the current model of care. Specifically, seven

of twelve co-dependencies for maternal medicine centres and therefore for consultant-led obstetric services are not currently met at the Crown Street site. This results in fragmentation of services for women and babies, with some requiring ambulance transfer to other providers to receive the care they need. This, given the clinical circumstances necessitating the transfer, carries an inherent risk, and also result in mothers and babies being separated. There is an imperative opportunity and shared will amongst the acute and specialist providers to respond to the current case for change, developing a future care model to ensure the best possible care for women and babies across Liverpool.

7. **Combining expertise in clinical support services to provide consistent services across the city** – Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories; and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was opportunity for further collaboration to combine expertise in clinical support services in order to address workforce challenges and make efficient use of resources. Examples of this include diagnostic imaging and the ability to address the workforce challenges, pharmacy and the sustainability of its workforce, and further consolidation of pathology services including resetting existing partnerships to maxmise value.
8. **Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials** – Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure to develop world-leading services for the city – primarily by delivering data-enabled clinical trials and establishing a hub to act as a single point of planning and operations for delivering clinical trials.
9. **Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff** – Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed in 2021/22, many of whom live in Liverpool, and £1.29bn was spent on workforce costs in 2021/22. According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff. Colleagues also consistently described how competition between Trusts magnifies this challenge and the benefits that collaborative working could have in addressing these issues. Opportunities included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment, working together to create a strong employer brand to improve recruitment and retention rates and reduce recruitment costs.
10. **Achieving economies of scale in corporate services** – Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than other Trusts. Collaborative working between the trusts would encourage a uniform approach to services and to the delivery of corporate services, freeing up resources by doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all. This opportunity could be rapidly realised in transactional areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support.
11. **Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability** – There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool and despite some organisations using the same software company, the systems do not deploy functionality that allows

for interoperability. There is an opportunity to increase the overall level of interoperability between information and data systems to support the more effective delivery of care across organisational boundaries.

12. **Making best use of resources to secure financial sustainability for all organisations in Liverpool** – Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year. The Cheshire and Merseyside ICS is set to see its allocation reduced by circa £350 million over the coming years and this sets the context for needing to stabilise the current position and prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined in the case for collaboration have either a direct or indirect financial benefit that organisations can realise.

Several of these opportunities are already being taken forward as part of implementing the One Liverpool strategy via the programme of work led by Liverpool Health Partners, and through ICS-wide programmes led by Cheshire and Merseyside Acute and Specialist Trusts (CMAST) and the Cancer Alliance. In these areas, the ongoing work can be supplemented by the findings and opportunities identified in this review.

The One Liverpool Partnership Board agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration: 1) Solving clinical sustainability challenges affecting women's health in Liverpool and 2) Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites.

In pursuing these opportunities, we recommend that:

1. The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For five of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:
    a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care FT,
    b. Levelling-up performance on cancer to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance,
    c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
    d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
    e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

2. For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in

the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

3. A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:
   a. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
   b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

4. The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:
   a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals NHS FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
   b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
   c. A non-executive director of the ICB to be identified to chair the sub-committee.
   d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
   e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
   f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.

g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

5. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:
   a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
   b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
   c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
   d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
   e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
      i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
      ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
      iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
   f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

6. To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, The Walton Centre NHS FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required, and
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

7. To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

8. A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

Introduction and context

Like ICSs all over the country, NHS Cheshire and Merseyside became a statutory organisation on 1 July 2022 and is now responsible for the health and care of over two and half million people across nine places. Places are coterminous with local authority boundaries in Cheshire East, Cheshire West, Halton, Knowsley, Liverpool, Sefton, St Helens, Warrington, and Wirral. The ICS includes 18 NHS trusts, 355 GP practices in 50 PCNs and 590 community pharmacies that provide services for people in Cheshire and Merseyside, and in some cases beyond.

The geography has areas of substantial wealth and others of substantial deprivation. 33% of the population live in the most deprived 20% of neighbourhoods in England. The Index of Multiple Deprivation shows that Knowsley is the second most deprived borough in England and Liverpool the third. Knowsley also has the highest proportion in England of its population living in income deprived households (tied with Middlesborough), equating to one in four of all 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, 16% of neighbourhoods are in the lowest income deciles.

The vision for the ICS is for "everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live longer". Its mission is to do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest. In support of this vision and mission, the ICS has four strategic objectives, which are to:

- Improve population health and healthcare
- Tackle unequal outcomes and access
- Enhancing productivity and value for money
- Support broader social and economic development

Within Cheshire and Merseyside, place-based partnerships – led by Place Directors – have freedom to design and deliver services according to local need. This includes understanding and working with communities, joining up and co-ordinating services around the needs of people, addressing social and economic factors that influence health and wellbeing, and supporting quality and sustainability of local services.

Liverpool and its population

Liverpool is a major city in England and one of the Core Cities, along with Belfast, Birmingham, Bristol, Cardiff, Glasgow, Leeds, Manchester, Newcastle, Nottingham, and Sheffield. It is the 8th largest city by population size and is home to 565,000 people, including 119,000 children and young people, 332,000 working age adults, and 50,000 people over the age of 70. Liverpool has relatively less ethnically diverse communities compared to the other Core Cities, with 86% of population identifying as White British.

This population of Liverpool is expected to grow by 10% to 2043, which is 2% greater than the growth expected nationally. The group expected to see the largest growth, by 60%, is the 80+ group, which is slightly lower than the 70% growth seen nationally for this age group.

Liverpool has the greatest extent of deprivation in England as measured by the Index of Multiple Deprivation (IMD), with two in three people living in deprivation, and eight in every hundred people living in the most deprived one percent of the country. With respect to income, Liverpool is the 4th most deprived local authority, and the 5th most deprived with respect to employment and living environment.

The pertinence of this is characterised by the growing body of evidence showing that population health is determined to a great extent by social, environmental, economic, political, and cultural factors (the social determinants of health as set out in Figure 1). As a result, health follows a social gradient; a higher social position, whether measured by education, income, or occupational status, is associated with better health and longevity. The accumulation of positive and negative effects of social, economic, and environmental conditions on health and wellbeing throughout life contributes to inequalities in health.[1]

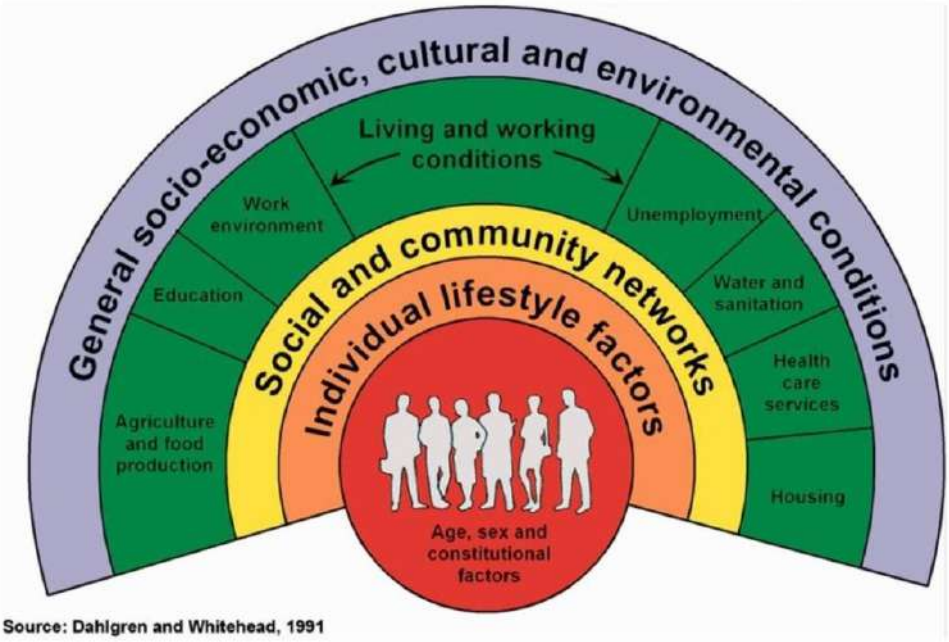


Figure 1: Dahlgren-Whitehead rainbow model of social determinants of health

In that context, the negative impact of deprivation affects people in Liverpool even before they are born. Babies are born to mothers in poorer health, who are twice as likely to smoke during early pregnancy and less likely to take folic acid supplements. Services in Liverpool have responded to this heightened risk by providing earlier access to maternity to more mothers than other places in England. The number of mothers who are smoking falls from 21.5% in early pregnancy to 11.3% at the time of delivery (compared to 17.1% and 12.4% respectively for the rest of England). However, this does not fully mitigate the impact of a poorer start in life for children. Babies are more likely to be low birth weight (7.3% compared to 6.9% nationally) and more likely to die as neonates (3.0 deaths per 1,000 live births compared to 2.8 nationally). This continues to affect children and young people in Liverpool throughout their life course. They are more likely to be overweight or obese at reception (26.8% compared to 23.0% nationally) with the gap increasing further by year 6 (41.2% compared to 35.2% nationally). They are more likely to live in dysfunctional families and have lower educational attainment than elsewhere in the country with only 44% of pupils achieving >Grade 5 in English and Maths at GCSE compared to 51.9% nationally.

As adults, lifestyle factors that contribute to improved health and wellbeing such as physical activity rates and healthy eating are all lower in Liverpool compared to the rest of the country. For example, 27% of

[1] Public Health England and the UCL Institute of Health Equity; Psychosocial pathways and health outcomes: Informing action on health inequalities (2017); (accessed on 20/09/2022) https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/647709/Psychosocial_pathways_and_health_equity.pdf

adults are physically inactive compared to 22% in England. The environment people live in is also particularly challenging. In Liverpool, there are greater levels of air pollution, and households are more likely to suffer fuel poverty and live in overcrowded conditions. Children and adults also live in a city with the highest rates of violent crime in England; three times as many hospital admissions are due to violence than the England average.

More people also engage in health-harming behaviours. Adults are more likely to smoke and drink over 14 units of alcohol per week. Consequently, Liverpool has one of the highest rates of alcohol related hospital admissions in England with higher proportion of dependent drinkers not in treatment than the rest of England. People are also more likely to misuse and abuse drugs with two and half times as many deaths from drug misuse in Liverpool compared to the national average.

All these factors together, contribute to men and women in Liverpool living on average two and a half years fewer than the people in the rest of England, with the progress to close the gap stagnating in recent years. This gap is wider still between the most affluent and most deprived people living in Liverpool with men and women in Everton spending 18 and 17 fewer years of their lives respectively in good health compared to men and women living in Church.

Much of this morbidity and mortality is avoidable and despite significant improvement over the last 20 years, the rate of avoidable mortality in Liverpool has remained consistently 50% above the national rate. This represents an additional 740 people dying every year in Liverpool with the leading causes of these deaths being cancer, cardiovascular disease, and respiratory disease.

The cost-of-living crisis is also expected to have a negative impact on physical and mental health, with more than half of British people[2] already reporting a negative health effect from increased food, heating, and transport costs. In the short term, there will be an increased demand for health and care services and in recognition of this, the Combined Authority has earmarked £5 million to provide voluntary and community sector support[3]. In the longer term, the situation will likely exacerbate the existing health inequalities, making them starker still.

This context provides an opportunity for organisations in Liverpool to work together to improve outcomes, health and wellbeing for people living and working in Liverpool.

Collectively the six acute and specialist organisations in Liverpool provide local acute hospital services to the people of Liverpool and the surrounding areas including Sefton and Knowsley. Liverpool based providers also support service provision at neighbouring District General Hospitals such as Southport and Ormskirk Hospital NHS Trust. All organisations in Liverpool also provide specialist tertiary services for the wider Cheshire & Merseyside ICS, the North West of England, Isle of Man and North Wales, and train future staff for a significantly wider footprint. Several organisations, namely Alder Hey Children's NHS FT, Liverpool Heart and Chest Hospital NHS FT, the Hewitt Fertility Centre and fetal medicine services at the

[2] BMJ; Rising cost of living is damaging people's health, says royal college, 2022. https://www.bmj.com/content/377/bmj.o1231?ijkey=8666283869e9198ad1ceb17bf009f6ab08e86913&keytype2=tf_ipsecsha

[3] Liverpool City Combined Authority, 2022. https://www.liverpoolcityregion-ca.gov.uk/4-7m-cost-of-living-support-prioritised-as-liverpool-city-regions-44m-shared-prosperity-fund-plans-revealed/

Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT, have a national and international reputation that attracts quaternary referrals.

In this context, organisations in Liverpool have collectively developed a 5-year strategy, One Liverpool, which runs from 2019 to 2024. Its aim is to deliver better population health and wellbeing in Liverpool, and it represents a whole system approach to delivering change that engaged Liverpool City Council, the local NHS and other key public and voluntary sector partners in its development. The One Liverpool Strategy is part of the Liverpool City Plan and focuses on the positive and transformative actions that the health and care system will take together and with the people of Liverpool to improve population health and reduce health inequalities. In support of that, it has four objectives: 1. Targeted action on inequalities, at scale and with pace; 2. Empowerment and support for wellbeing; 3. Radical upgrade in prevention and early intervention; and 4. Integrated and sustainable health and care services. The strategy commits to being all age, all ethnicity, physical and mental health, aimed at empowering residents, improving equity and outcome focused.

Provider collaboration as a strategic enabler

The new Health and Care Act 2022 has a set of legislative changes to enable health and care to work more closely together. The intention is that there is a duty to collaborate, promoting joint working across healthcare, public health, and social care. The duty will apply to both NHS organisations and local authorities with a focus on reducing competition, removing the legislation that hinders collaboration and joint decision-making. Provider collaboratives are a key component of delivering system working, being one way in which providers work together to plan, deliver, and transform services. National guidance has mandated that all trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022.

By working effectively at scale, providers can properly address unwarranted variation and inequality in access, experience, and outcomes across wider populations, improve resilience in smaller trusts, and ensure that specialisation and consolidation occur where this will provide better outcomes and value. Meeting these challenges is essential to delivering recovery from the pandemic and can only be achieved by providers working together with a shared purpose. The experiences of existing provider collaboration and the successful ways that providers have worked together to respond to the pandemic have demonstrated the specific types of benefits of scale that can be delivered including[4]:

- Reductions in unwarranted variation in outcomes and access to services,
- Reductions in health inequalities,
- Greater resilience across systems, including mutual aid, better management of system-wide capacity and alleviation of immediate workforce pressures,
- Better recruitment, retention, development of staff and leadership talent, enabling providers to collectively support national and local people plans,
- Consolidation of low-volume or specialised services, and
- Efficiencies and economies of scale.

In identifying, promoting, and championing the benefits of collaboration, NHS England have encouraged providers to build on local successes through provider collaborative structures and now, also require

[4] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf

all providers to be part of a collaborative. This policy imperative is seen as a mechanism to ensure providers support the delivery of the triple aim through:

- Aligning priorities,
- Supporting establishment of the Integrated Care System (ICS) with the capacity to support population-based decision-making, and
- Directing resources to improve service provision.

In Cheshire and Merseyside, there are two provider collaboratives: Cheshire and Merseyside Acute and Specialist Trust (CMAST) and Mental Health, Community and Learning Disability Collaborative (MHLDSC). The acute and specialist providers are part of CMAST, which in addition to the triple aim priorities, has identified a number of complementary functions that the collaborative can and should perform:

- Prioritising key programmes for delivery on behalf of the system, and
- Creating an environment of innovation, challenge, and support in order to deliver improved performance and quality of service provision.

Following the success of a number of CMAST initiatives and the establishment of the NHS Cheshire and Merseyside ICB, CMAST's ways of working have been formalised through a Joint Working Agreement, which has passed through each of the Trust Boards. The acute and specialist trusts have identified that a preferred model for their closer collaboration and joint working is to establish a governance structure that, so far as possible within the legislation, enables "group" and common decision-making structures. Each organisation has agreed to establish a committee that has functions delegated to it from its respective Trust which shall work in common with the other CMAST Committees in Common, but which will each take its decisions independently on behalf of its own Board. The CMAST Committees in Common will act collectively through the CMAST Leadership Board.

Through this Joint Working agreement, CMAST will pursue several immediate and short-term programmes of work to ensure the coordination of an effective provider response to current system and NHS priorities including ongoing pandemic response, NHS service restoration and elective recovery, support, and mutual aid, sharing best practice, increasing standardisation, and reducing variation.

The health and care landscape of Liverpool, particularly the acute sector, is unusual with six separate acute NHS organisations serving the local population. The complexity of the landscape is exacerbated by the range of specialist hospitals and services, and the varied financial positions and spectrum of care quality ratings across providers. Consequently, there is greater provider and system fragmentation within the Liverpool boundary. In the context of national policy on provider collaboration, there is a greater opportunity for working together differently and hence the review has focused on opportunities where the benefits to staff, patients and the wider healthcare system can be realised.

Stakeholders spoke extensively about the foundations for closer collaboration that have been set in Liverpool, particularly as a result of managing the Covid-19 pandemic response. During that time, a sense of shared purpose helped to accelerate collaboration and draw on the collective strengths of all partner organisations. A range of clinical examples of previous and current collaboration were cited including the work of the Liverpool Neonatal Partnership, mutual aid during the pandemic between organisations such as the use of paediatric ITU capacity at Alder Hey Children's NHS FT for adults, and stroke services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. Additionally there were some limited examples of risk sharing between organisations, specifically for spinal services between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT, and haemo-oncology services between Liverpool University Hospitals NHS FT and The Clatterbridge Cancer Centre NHS FT. Beyond clinical collaboration,

colleagues described opportunities that had been realised in the establishment of CIPHA as a population health management platform across Cheshire and Merseyside, and sharing of new internationally recruited nurses between Liverpool Heart and Chest Hospital NHS FT, The Walton Centre NHS FT, and Liverpool University Hospitals NHS FT.

The engagement that has taken place to date has clearly highlighted an enthusiasm for collaboration, and to build on the existing strengths within the organisations and the ongoing mutual aid arrangements that exists between organisations.

Purpose and scope of the review

CF was commissioned in August 2022 by the Cheshire and Merseyside Integrated Care Board (ICB), NHS Cheshire and Merseyside, with day-to-day oversight from the One Liverpool Partnership Board, to undertake an independent review of the acute care model with a view to identifying opportunities that will improve clinical hospital-based services in terms of clinical quality, efficiency, and effectiveness. The original terms of reference for the review can be found in Annex 1.

The organisations primarily in scope of the review were the six NHS Trusts that are part of the Liverpool Place: Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, Liverpool Women's Hospital NHS FT, and The Walton Centre NHS FT.

Other partners core to One Liverpool include general practice, Mersey Care FT, and Liverpool City Council. The North West Ambulance Service (NWAS), the University of Liverpool and Liverpool John Moores University are also key partners to the six acute and specialist providers.

At the outset of the work, colleagues requested a reset of the scope of work. In particular, colleagues felt that the starting point for the review needed to articulate the significant collaborative efforts that were already underway. The revised objectives of the review were to identify and detail how to realise opportunities that optimise the acute care model for Liverpool including co-designing seamless pathways of care for those using services, which provide high quality and safe care, improving equity and integration in terms of access and outcomes, making best use of resources to create long term financial and clinical sustainability and maximising the wider potential of Liverpool City Region.

This revised scope was then socialised through a set of meetings and agreed by One Liverpool Partnership Board on 2 August.

The deliverables agreed were:

- A case for collaboration that sets out the context for, and drivers of, deeper collaboration, the priorities that have been chosen for collaboration and reasons why,
- A blueprint for collaborative opportunities that sets out detail on how to realise the collaboration opportunities chosen and identified areas of challenge and requirements to overcome,
- An articulation of the conditions for success which describe the supporting arrangements that will need to be in place to achieve the domains of collaboration outlined in the case for collaboration, and
- An implementation roadmap which sets out the steps needed to deliver the blueprint and support conditions for success.

Approach to the review

The approach to the review was one of Appreciative Inquiry (Ai), which is an established method to facilitate change that seeks to build on what is already working well. Collaboration opportunities were identified through exploring where strengths can be harnessed, where challenges are shared and where individual challenges need to be addressed collaboratively.

The review was conducted in full recognition of the NHS Long Term Plan, the One Liverpool Strategy, and the strategies of the six organisations. In support of that, over 50 documents were reviewed and considered as part of the review.

The terms of reference highlighted the need to engage with a range of stakeholders, including those beyond the primary scope of the review. The discovery phase of the work engaged almost 300 people with 70 individual interviews, group discussions with each of the acute and specialist provider executive teams and hospital management groups that engaged over 50 people, a GP engagement session with eight PCN clinical leads, and over 150 senior staff from across Liverpool contributing via a staff survey.

The engagement was supplemented by extensive data analysis to sense check and evidence the hypotheses and views expressed in the interviews, discussions, and survey outputs.

The outputs of the discovery work were reflected back, tested, and refined in a series of joint sessions – a small group discussion, a system-wide workshop and as part of a One Liverpool Partnership Board discussion in September 2022. The opportunities that have been identified vary in their detail, reflecting the constraints of the process.

The full interview list can be found at Annex 2 and covers both those people engaged through one-to-one and group discussions. The survey was anonymous. Participants in the workshops and boards meetings, which engaged in the overall findings reflected in this report are also listed in Annex 3.

Representatives from each organisation agreed the next phase of the work should move on to address the most critical issues facing the system, which are the longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. They also wanted to push recommendations to a tangible level of detail on a subset of opportunities, as opposed to a broad-brush approach on many. Consequently, a gateway review including prioritisation took place as part of a One Liverpool Partnership Board discussion.

For the prioritised opportunities, a series of task and finish groups, involving clinical colleagues from all organisations, was held to work through the detail of the opportunity, with a system workshop to check and challenge the outputs. Participants in each task and finish group are listed in Annex 4 and for the workshop in Annex 3.

The roadmap for pursuing the opportunities was explored in a smaller roundtable discussion and confirmed at the One Liverpool Partnership Board discussion in November 2022. Participants of both meetings are listed in Annex 3.

The rest of this document sets out the case for greater acute and specialist provider collaboration, the priorities for action, and the conditions needed for success, and includes the recommendations of the review.

The case for greater acute and specialist provider collaboration

Twelve collaboration opportunities have emerged through the engagement and collectively these make up the strategic agenda for collaboration between the acute and specialist providers. These opportunities are additive to pre-existing priorities and will in some cases require wider partnerships to deliver on them. They outline a holistic and systematic requirement for collaboration between the acute providers themselves, and collectively with Mersey Care, PCNs, and the local authority, in particular, but also the academic institutions in Liverpool and other stakeholders.

Improving physical and mental health by providing more anticipatory care, especially for people with long term conditions and complex lives, through strengthened relationships with primary care

Liverpool has a higher burden of long-term conditions and multimorbidity than the national average. The consequence of this is an increased use of hospital-based services, which reactively manage deterioration and acute exacerbation as opposed to the proactive anticipatory management that could avoid use of hospital-based services. Liverpool also has one of the highest rates of unplanned admissions for chronic ambulatory sensitive conditions, with an additional 365 people a year admitted to hospital compared to the rest of the country. Much of this activity is from relatively small groups of the population - people with Complex Lives and long-term conditions.

Around 45% of the population have one or more long-term condition (LTC). People with LTCs account for 60% of all A&E attendances, 85% of all hospital admissions, 92% of mental health contacts and 91% of all community contacts. The long-term conditions that affect people living in Liverpool at a higher rate to the rest of England are chronic obstructive pulmonary disease (COPD), coronary heart disease (CHD), obesity, and depression. In Liverpool, there are 80,000 people with high blood pressure, 17,800 people with coronary heart disease and 17,400 with chronic obstructive pulmonary disease. The prevalence of these conditions is similar to the national average although many of these conditions will be co-existing, increasing the burden of disease. Throughout the engagement colleagues reflected on the younger presentation and extent of multi-morbidity in Liverpool.

In Liverpool people with complex lives represent 1% of the population but account for over £43 million spent every year on health and care services, or around 5% of the total locally commissioned expenditure on acute and community and services. They are people who have either:

- One or more physical condition, and one or more mental health condition, and one or more of either homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse,
- Or regardless of physical or mental health, three or more from - homelessness, substance and/or alcohol abuse, history of offending, high intensity use of A&E, history of being looked after, or domestic abuse.

People with Complex Lives are twice as likely to use acute hospital services than others and more than ten times as likely to use mental health services. As well as being more likely to access services, the average use of services is also significantly higher for those with Complex Lives, with 2.5 emergency department attendances per year compared to 0.3 for the rest of Liverpool, and 8 mental health contacts per year compared to 0.4.

Colleagues spoke passionately about the significant opportunities for collaboration to provide holistic, preventative, and anticipatory care for people in Liverpool and expressed a strong desire to work in

partnership with primary care to deliver this care. Many of the foundational elements needed, such as an integrated dataset, are already in place in Liverpool through CIPHA and so collaborative effort on population health management could have significant impact. Work to set up multi-disciplinary neighbourhood teams and provide integrated care must begin now for benefits to be realised in the future.

In pursuit of this opportunity, the acute and specialist providers in Liverpool should continue work collaboratively with system partners to support the development of effective place-based partnerships as part of the One Liverpool programme of work to deliver holistic, anticipatory care through multi-disciplinary neighbourhood teams that take targeted action at PCN-level. The CORE20plus5 approach should also be embedded into the One Liverpool strategy and delivery methodology to ensure that prevention and addressing health inequalities are core to the programme of work.

For long term conditions, an anticipatory model of care should be developed and implemented that encompasses case finding, care planning, structured education and self-management, and access to specialist opinion involving a health and social care multi-disciplinary team at a PCN level. For people with complex lives, the anticipatory model should be supplemented by care planning and navigation / co-ordination, rapid response, reablement and a healthy living environment. The One Liverpool Programme already has programmes of work related to both segments and these opportunities should be taken forward by the relevant Segment delivery groups.

Making place-based partnerships a priority ensures that the needs of local populations, at place and neighbourhood level, are being recognised by leveraging collective expertise, insight, and relationships. The objectives of a place-based partnership centre on improving the quality, co-ordination and accessibility of health and care services and this needs to be a focus in order fully to respond to the case for collaboration.

Creating socially inclusive training and employment opportunities for the Liverpool City Region, leveraging anchor institution status to address local deprivation

The position of NHS organisations as major employers and anchor institutions in the Liverpool City Region emphasises the role of a hospital beyond the direct patient care benefits that they deliver. Having a hospital within the community generates wider economic benefits as a result of the jobs it offers. It is also a focal point which can help partnerships between healthcare organisations and communities responding to the wider social determinants of health.

People living in Liverpool are more disengaged from the labour market with long-term unemployment rates twice that of the rest of England (3.9 people per 1,000 working age people in Liverpool vs. 1.9 in England). One in ten people receive Employment and Support Allowances compared to one in twenty in the rest of the country. This is even starker for those with long term health or mental health conditions with more relatively disengagement in the labour market than in the rest of the country.

One consequence of this lack of employment is that Liverpool has the greatest extent of deprivation in the country: two thirds of people in Liverpool are in the most deprived 30% of people nationally, and 8% are in the most deprived 1%. Income deprivation affects four in ten children in Liverpool, the fourth highest rate in the country after Middlesbrough, Knowsley, and Hartlepool. The lack of money (or low income) has been shown to have the strongest impact on children's cognitive, social-behavioural, educational attainment and

health outcomes, independent of other factors[5]. The consequence is increased risk of social and economic disadvantage in early adulthood, which includes lower earnings, higher risk of unemployment or spending time in prison (men) and becoming a lone parent (women)[6,7].Once employed, however people living in Liverpool have better weekly earnings (£480) than in other Core Cities (£465).

There is an imperative to support local people to gain and remain in employment, taking collective action to address local deprivation. Specifically, stakeholders described energy around creating socially inclusive training and employment opportunities through apprenticeship and preceptorship programmes for the Liverpool City Region. While many organisations offer a small number of such programmes already, the collective efforts of the acute and specialist providers in Liverpool could scale and significantly extend the reach of the ongoing work. Many other systems are already working collaboratively on socially inclusive employment to address local workforce challenges, by pooling and making use of unused apprenticeship levies and jointly procure training programmes for apprentices that could be replicated in Liverpool.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

Urgent and emergency pathways in Liverpool are one of the greatest points of pressure for the city, frequently cited by stakeholders as the most significant issue after the sustainability of women's health services in Liverpool. There are challenges with both timely access and poor outcomes, and performance has worsened since the onset of the covid pandemic. In most places access is falling short of national standards, especially with respect to emergency department waits.

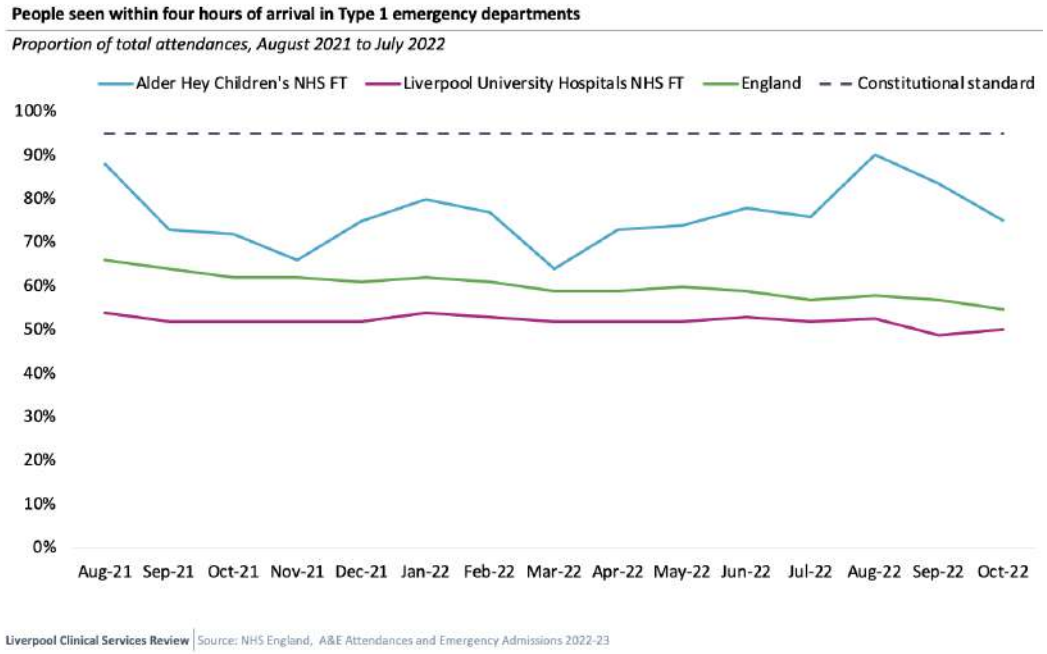


Figure 2: Four hour performance by organisation

[5] Cooper K and Stewart K. Does money affect children's outcomes? An update. London: Centre for Analysis of Social Exclusion; 2017. http://sticerd.lse.ac.uk/dps/case/cp/casepaper203.pdf (accessed 24/10/2022)
[6] Gregg P, Harkness S and Machin S. Child poverty and its consequences. York: Joseph Rowntree Foundation; 1999. www.jrf.org.uk/report/child-poverty-and-its-consequences (accessed 24/10/2022)
[7] Gregg P, MacMillan L and Vittori C. Nonlinear estimation of lifetime intergenerational economic mobility and the role of education. Department of Quantitative Social Science working paper no. 15-03. London: Institute of Education; 2015. http://repec.ioe.ac.uk/REPEc/pdf/qsswp1503.pdf (accessed 24/10/2022)

Liverpool University Hospitals NHS FT sees 52% of people within four hours of arrival at an emergency department. This is 43% below the constitutional standard, and 9% below the national average as set out in Figure 2.

Emergency inpatient services across Liverpool are more commonly provided from only one of the city's five acute sites compared to other areas, with some notable exceptions, which are non-interventional cardiology, respiratory and haematology services. This means that when people need specialist care, they frequently require transfer to another site and their care may become fragmented in some places. For some specialties and conditions, this results in long lengths of stay in the emergency department (Figure 3) and inpatient lengths of stay that are double the national average. This is associated with increased mortality and poorer outcomes for patients.

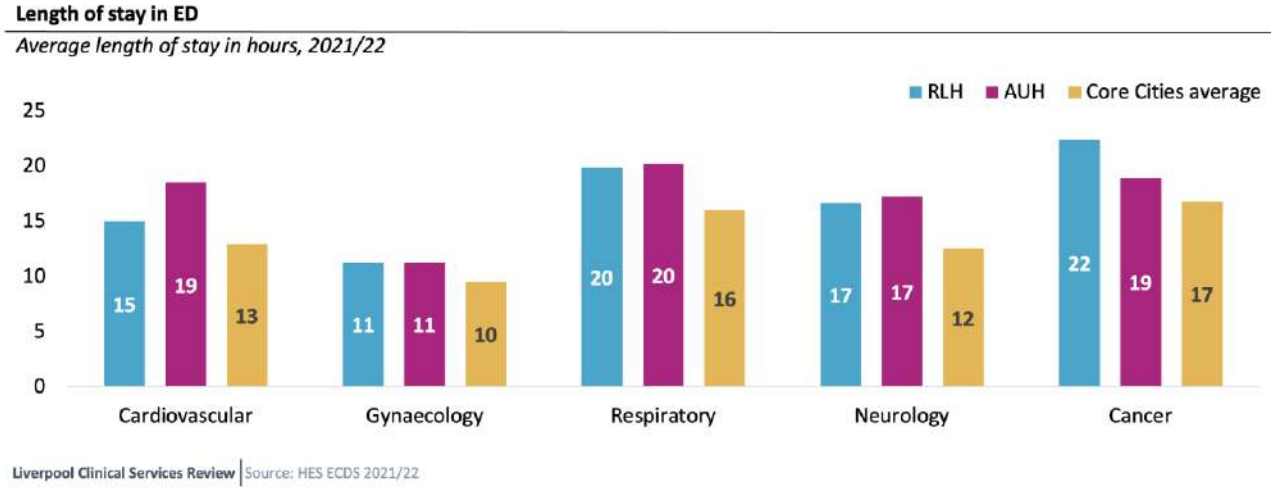


Figure 3: average length of stay in the emergency department by speciality

A specific example of this is care for non-ST elevation myocardial infarctions (NSTEMI). Liverpool has the fifth highest rate of death attributed to heart disease in England, whilst NHS Cheshire and Merseyside ICB is ranked 40 of 42 for access to invasive investigation for NSTEMI within 72 hours of hospital admission. When we consider length of stay for those with a NSTEMI, patients admitted to Aintree University Hospital or Royal Liverpool Hospital who are subsequently transferred to Liverpool Heart and Chest Hospital NHS FT have on average a combined length of stay that is double the length of stay of those who are admitted directly.

NSTEMI is an example of fragmented care and through the engagement it was clear that there were several other groups of people that were not having their emergency needs met through the existing pathways including women, people with head injuries and people with mental health needs.

Opportunities exist across a spectrum of collaboration. This includes sharing best practice, data and information, standardising quality, and performance standards, creating rotational posts and shared roles between organisations, standardising pathways, and ensuring robust protocols and procedures are in place, networking services and consolidating services. Stakeholders agreed it was important to consider this opportunity in more detail to understand where greater collaboration could have the most impact.

Levelling-up performance on cancer and cardiovascular disease to address health inequalities

Cancer is the city's largest cause of premature deaths with 605 deaths under the age of 75 in 2020, representing around a third of all premature deaths in Liverpool.

The impact of the pandemic on cancer care has been significant. The number of people referred for a cancer assessment has grown by 134% over the last 2 years and the number of people on the cancer waiting list has increased by 220% as shown in Figure 4. The 62-day backlog has increased by 241% compared to the pre-Covid baseline, with progress to work off the backlog worsening in recent months with progress to clear the 104-day cancer backlog also having stagnated recently.

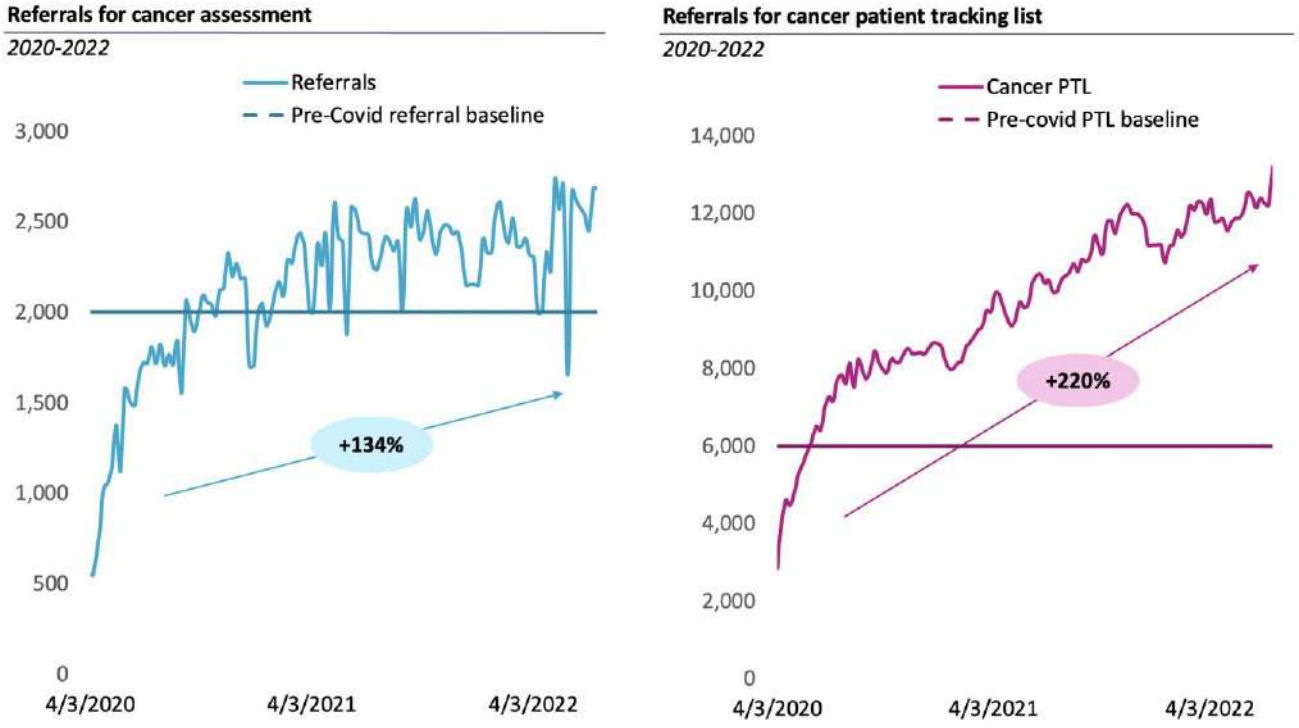


Figure 4: cancer assessment and patient tracking list referrals for Cheshire and Merseyside

This is a significant increase from the pre-pandemic baseline and collaboration between organisations needs to ensure that capacity is directed effectively between planned care backlog clearing efforts. The Cheshire and Merseyside Cancer Alliance is responsible for taking forward cancer recovery efforts including reducing waiting times for diagnosis and treatment, improving awareness of the symptoms of cancer, providing personalised care, and focusing on prevention to stop cancer from developing in the first place.

Every week, three people are diagnosed with cancer in the Emergency Department at the Royal Liverpool Hospital, and this cohort of patients also exposes some clear inequalities - patients diagnosed with cancer in the Emergency Department last year were between 2 and 6 times more likely to be from an ethnic minority than white. We know that cancers diagnosed in ED are likely to be in later stages of disease progression and there is likely to be an impact on survival rates as a consequence. Action to address late diagnosis of cancer and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Cancer Alliance and could be rolled out to other places in the Cheshire and Merseyside ICS.

Similarly, there are opportunities in cardiovascular disease, which is the second biggest cause of premature mortality in Liverpool, with around 400 deaths a year of people aged 75 and under from all cardiovascular causes. Liverpool has the fifth highest rate of death attributed to heart disease in England and the ninth highest from acute myocardial infarction for men. Cardiovascular disease is considered to be largely

preventable through a healthy lifestyle and the early detection and control of risk conditions; atrial fibrillation (AF), high blood pressure (hypertension, BP) and high cholesterol (the 'ABC' of CVD prevention). While significant progress has been made in diagnosis atrial fibrillation, gaps in hypertension and high cholesterol diagnosis and early treatment exist with only 58.5% of the expected people with high blood pressure diagnosed and of those diagnosed only 57% being treated in accordance with NICE guidelines. Cardiovascular disease and its early diagnosis are associated with deeply embedded inequalities in Liverpool and is the most significant contributor to the gap in life expectancy between the most and least deprived in Liverpool, accounting for 21% of the difference in 2021.

As with cancer care, action to address late diagnosis of cardiovascular disease and inequalities in access requires a place-based approach involving primary care and local government, working at PCN level to implement culturally sensitive targeted interventions, taking account of local needs. This approach should be endorsed by the Liverpool Cardiology Partnership and could be rolled out to other places in the Cheshire and Merseyside ICS.

Providing timely access to high-quality elective care by making efficient use of existing estates and assets

Elective waiting lists have grown across Liverpool by a third every year since 2019 as shown in Figure 5. This rate is expected to increase even further as the post-COVID recovery or 'bounceback' in referrals continues to be seen. While all trusts in Liverpool have seen an increase in the number of people waiting for treatment, Liverpool University Hospitals NHS FT has faced very challenging circumstances with both a significant elective 18 week and 104+ week backlog across multiple specialities. As of July 2022, 49% of patients were seen within 18 weeks with 9,869 waiting more than 52 weeks for treatment at Liverpool University Hospitals NHS FT, and 62 people waiting more than 104+ weeks as of June 2022. Waits of this nature mean that patients are living with painful conditions for longer, and recent research[8] has shown that those who wait more than 6 months for elective surgery will have a 50% increased chance of worse outcomes – a far shorter period than the 52 weeks many patients have waited already.

[8] Cisternas, Alvaro F.a; Ramachandran, Roshnia,*; Yaksh, Tony L.b; Nahama, Alexisa Unintended consequences of COVID-19 safety measures on patients with chronic knee pain forced to defer joint replacement surgery, PAIN Reports: November/December 2020

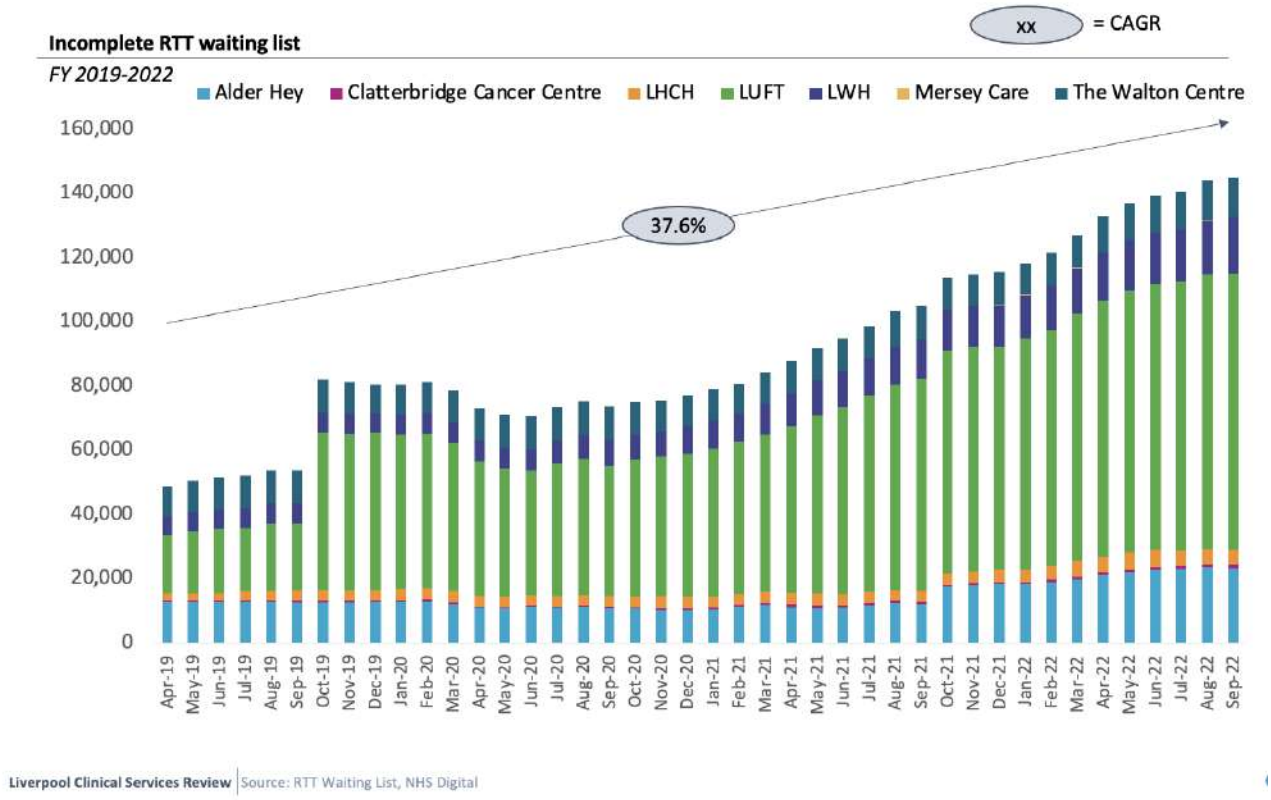


Figure 5: incomplete referral to treatment waiting list

Working through the elective backlog will be long-term challenge, given the continued 'bounceback' and the size of the current waiting list. The service changes set out by Liverpool University Hospitals NHS FT following its formation seek to create a split between elective and emergency activity, concentrating the former at Broadgreen. Implementation of this new configuration will not be immediate and, beyond this there is also an opportunity in the short to medium term to think about how to make efficient use of existing estates and assets across the city.

Following the pandemic, the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST) mobilised a programme of work focusing on elective recovery efforts. The programme seeks to recover activity levels to pre-Covid levels and exceed them, reduce the waiting list and treatment backlogs, and transform pathways to deliver resilient pathways in the longer term.

Within Liverpool, all organisations in the city have physical theatre capacity that could be used between organisations more effectively to provide timely access to high quality elective care. An example of this in practice during the pandemic was the provision of ophthalmic surgery at the Crown Street site. Collaboration at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity.

Providing an increase to the level of elective capacity, where patients have a far lower risk of their procedure being cancelled or postponed due to emergency pressures, provides greater resilience in the system. This benefit is conferred when it is needed most, during periods of particularly high demand, such as winter, when elective performance typically suffers. In addition to the patient benefit, the ability to provide protected elective services offers more effective and attractive training opportunities and a potential opportunity to consider repatriation of activity from outside of Liverpool. There are also central

incentives for ICSs to recover elective activity to above pre-pandemic levels and collaborative efforts within and even beyond acute and specialist providers in Liverpool would support collectively achieving the funding available through the Elective Recovery Fund.

Solving clinical sustainability challenges affecting women's health in Liverpool

Overwhelmingly, the most important challenge stakeholders identified as needing to be addressed was clinical sustainability of services for women in Liverpool and the associated clinical risk. The Liverpool Women's Hospital NHS FT is a maternal medicine centre, has a world-leading reproductive medicine unit, and provides tertiary services across its full portfolio of specialities. The Liverpool Women's Hospital NHS FT main hospital site at Crown Street is isolated from other adult services in Liverpool meaning it is less able to manage acutely ill or rapidly deteriorating patients, women with complex surgical needs and significant medical co-morbidities. There is a lack of specialist expertise on site to render assistance, intensive care facilities and critical care outreach services, 24-hour laboratory services to support diagnosis, monitoring and intervention, therapies and recovery support, a blood transfusion laboratory suitable for the management of major haemorrhage, and imaging facilities to support timely diagnosis. Specifically, seven of twelve co-dependencies for maternal medicine centres (and therefore for consultant-led obstetric services) are not currently met at the Crown Street site. Additionally of the 1,132 standards for service delivery, currently 118 are not met by the Liverpool Women's Hospital NHS FT, and 75 of these are not met as a consequence of being on an isolated site.

Services should be co-located in the same hospital
Adult critical care
General and obstetric anaesthetics
Neonatology: L3
Emergency general surgery
Acute medicine
Acute stroke
General cardiology
Interventional radiology
X-ray
Obstetric ultrasound
Urgent access to CT scan
Emergency haematology and biochemistry

Services do not meet recommendations

Service provision inconsistent

Services meet recommendations

Figure 6: co-dependencies met for maternal medicine centre and consultant-led obstetric unit

Similarly, other adult acute sites in Liverpool do not have co-located women's services and are therefore less able to meet women's medical needs, including women who are pregnant, when they present at the emergency department or who are inpatients at other sites.

A number of groups are particularly impacted by the configuration of services across sites:

- Women with complex conditions who need specialist care while pregnant as their birth is classed as 'high-risk'
- Pregnant women needing intensive care while giving birth
- Babies requiring complex surgery after birth followed by specialist neonatal care

- Women needing intensive care while undergoing surgery for a gynaecological issue
- Women with complex conditions who need acute medical or surgical input
- Women admitted to LWH with acute medical or surgical problems needing general or specialist opinion
- Women with complex gynaecological issues requiring surgery and those with gynaecological cancers requiring surgery

The consequence of this is that women and babies are transferred by ambulance between sites to receive the care they need. LWH has the one of highest rate of transfers in the country for mothers and their babies with 11 transfers for every 1,000 discharges.

LWH is the only specialist obstetric and gynaecology service provider in the country in such an isolated position. This has created a significant gender inequality in access to services and suboptimal quality of care for women and their families, as well as increased risks for clinical and care staff to manage, both at the Crown Street site and other acute sites across Liverpool. The current risks have a multitude of impacts including difficulties in recruitment and retention, particularly for gynaecologists and anaesthetists, and an inability to meet national care standards. They are also driving increased clinical negligence costs for LWH with maternity CNST costs per £100m the highest in the country by a significant margin, over and above what those costs that are driven by the case mix and highly specialised service provision at the Liverpool Women's Hospital NHS FT.

While many risks have been mitigated or worked around, stakeholders spoke extensively about their concerns for the safety of women and babies whose condition deteriorates while within the hospital and the subsequent risk of being transferred across the city.

Combining expertise in clinical support services to provide consistent services across the city

Stakeholders have spoken enthusiastically about the collaboration that already takes place for delivering clinical support services, both within the city, such as Liverpool Clinical Laboratories, and as part of the ICS, such as Cheshire and Merseyside Radiology Imaging Network (CAMRIN). There was widespread recognition that there was still scope for further collaboration to combine expertise in clinical support services. The imaging and pathology networks sit within the overarching CMAST Diagnostic Programme, which brings together all diagnostic networks, including endoscopy, Community Diagnostic Centres, physiological testing, primary care diagnostics and digital in diagnostics. This dedicated programme of work is focused on diagnostics with focus on driving forward and facilitating collaboration, improving productivity, reducing waiting and reporting times, and ensuring only clinically appropriate tests are carried out.

Diagnostic imaging
Diagnostic tests, both imaging and reporting, have seen increased waiting times in 2022 compared to 2021 for six week waits, which reached a peak of 45% of the waiting list, and 13 week waits, which reached a peak of 25% of the waiting list.

Trusts within Cheshire and Merseyside have been working collaboratively since they joined together to procure their Radiology Information System (RIS) and Picture Archiving Communication Software (PACS) in 2012. This approach was ground-breaking and the first of its type in England and it is now seen as the gold standard for imaging networks. Since 2016, 12 Trusts across the ICS have come together to work on a large-scale change programme to improve services for patients and staff. Opportunities continue to exist to unify

systems as well push innovative practice further in this space including implementing the use of AI at scale in radiology.

One of the biggest challenges facing the service is the scale of the workforce challenge and while work is ongoing at the ICS level, stakeholders identified opportunities for further collaboration, specific to the acute and specialist Trusts in Liverpool. Joint radiology training posts and appointments between the organisations in Liverpool were thought to be valuable to support recruitment and retention of staff.

As with elective backlogs, collaboration to address 6- and 13-week backlogs for diagnostic imaging services at the Liverpool footprint should be pursued alongside CMAST efforts on the basis that the any negative impact to access to care is minimal between these providers, and currently represents an underutilisation of system capacity. These opportunities should be taken forward specifically by the Imaging workstream and the Imaging Network Management Group which forms part of the CMAST Diagnostic Programme.

Pathology

There is significant work underway to develop the Cheshire and Merseyside Pathology Network and consolidate pathology services across the footprint. The direction of travel has been consolidation of pathology services to concentrate expertise and deliver targeted investment to strengthen a regional pathology network. Following the formation of Liverpool University Hospitals NHS FT, Liverpool Clinical Laboratories (LCL) developed as a successful partnership between three organisations: Liverpool Heart and Chest Hospital NHS FT, Liverpool University Hospitals NHS FT, and Liverpool Women's Hospital NHS FT. LCL employs over 500 staff and processes the sixth highest volume of laboratory tests in England.

Stakeholders expressed that there was an opportunity for other organisations to take part in LCL and support its ambition to become a centre of excellence for clinical diagnostic and investigation services. To realise this opportunity, ways of working between existing organisations in the collaboration as well as any new partners need to be reset and worked through.

This opportunity should be taken forward specifically by the Pathology workstream and the Pathology Network Management Group of the CMAST Diagnostic Programme.

Pharmacy

Currently acute and specialist organisations in Liverpool collectively spend £11.4 million on pharmacy services for the city. Some organisations provide their services separately to one another, including having duplicated services on the same site. Colleagues described the pharmacy workforce as being particularly fragile due to increasing workloads and a lack of funding and opportunity for training opportunities for pharmacists.

The Transfers of Care Around Medicines initiative between Cheshire and Merseyside trusts and community pharmacies has saved £11 million over three years and an estimated 6,008 bed days[9] through medication reviews after discharge in the community. This collaboration is believed to be the fastest and widest roll-out of any such initiative in England, demonstrating the scope for further collaboration in this space.

[9] https://www.pharmacynetworknews.com/health-nhs/cheshire-and-merseyside-pharmacies-help-save-nhs-11-million

For future collaboration, stakeholders identified opportunities similar to those for radiology, with joint appointments as an opportunity to address the sustainability and resilience of the pharmacy workforce. This would enable better training opportunities for pharmacy staff with a broader range of experience and specialisms, which would in turn support recruitment and retention.

Colleagues also thought there would be benefit in pursuing a partnership model similar to the LCL to provide a single pharmacy function across Liverpool, recognising that collaboration on pharmacy services for the Aintree and Broadgreen sites already exists. Leveraging the scale of this service would enable pharmacists to spend more time on clinical services, and less time on infrastructure or back-office services[10]. This in-turn would allow pharmacist to drive medicines optimisation on wards in hospitals, thereby securing better outcomes for patients and better value for money.

Developing world-leading services in Liverpool by realising the collaborative potential in innovation, research, and clinical trials

Over the years, the research and education infrastructure of Liverpool has had healthy investment, with significant resources available across the city region. Stakeholders almost universally reflected that there were opportunities to leverage this infrastructure. There are two NIHR funded Clinical Research Facilities (CRF) in the city, one at the Royal Liverpool Hospital and the other at Alder Hey Hospital. These are two of 28 research facilities across the UK funded by the NIHR, and Alder Hey's CRF is one of two exclusively for paediatric patients in the country. Funding for these facilities has been granted until 2027. Organisations in Liverpool are estimated to have a combined income of c.£104 million annual for research and development in 2021/22, of which £31.6 million is Trust based and £73 million is allocated to academic institutions.

The acute and specialist trusts in Liverpool work in partnership to deliver the Liverpool CRF with 26 beds at the Liverpool University Hospitals NHS FT, units at the Clatterbridge Cancer Centre NHS FT, and at the Liverpool Heart and Chest Hospital NHS FT. The CRF at the Royal Hospital sites has more than doubled in size from 12 beds to 26 beds as part of the move to the new hospital. The CRF was instrumental in responding to the COVID-19 pandemic, working in partnership with academics at the University of Liverpool and Liverpool School of Tropical Medicine to test and develop vaccines and medicines to combat the virus.

As well as the CRF, organisations in Liverpool are involved in wider research collaboration. Examples include:

- Liverpool has an Experimental Cancer Medicine Centre (ECMC), which is a collaboration between the University of Liverpool (Liverpool Clinical Trials Centre and Good Clinical Practice Laboratory Facility) and The Clatterbridge Cancer Centre NHS FT
- The Clatterbridge Cancer Centre NHS FT is also part of a Biomedical Research Centre (BRC) with The Royal Marsden NHS FT, The Institute of Cancer Research (ICR), and City, University of London, which is the only BRC specifically focused on cancer

[10] Department of Health and Social Care, 2015. Operational productivity and performance in English NHS acute hospitals: Unwarranted variations. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/499229/Operational_productivity_A.pdf

- The Liverpool Centre for Cardiovascular Science (LCCS) has also been formed as a strategic research platform between University of Liverpool, Liverpool Heart and Chest Hospital Trust, Liverpool John Moores University and Liverpool Health Partners
- The Liverpool Neuroscience Biobank at The Walton Centre (LNBW) was established to promote multidisciplinary basic and translational neuro-oncology and neurology research working in Liverpool and within the Brain Tumour North West Collaboration.

Despite the investment in clinical research, clinical trial participation per 100,000 of the population in Liverpool is lower than Core City peers. Clinical research brings significant benefits to the patient population and studies have shown that Trusts with the best emergency mortality outcomes were those that were most active in clinical research[11]. A systematic review by the Health Services and Delivery Research programme, suggested that engagement with clinical research by individuals and healthcare organisations increased the likelihood of a positive healthcare performance.

The NIHR-INCLUDE commission, which sought to address the lack of representation in health and care research, identified the socio-economically disadvantaged, unemployed, and those on low income as under-represented groups in research[12,13]. Liverpool presents an opportunity to enhance research for such under-represented groups. People living in the city have some of the most challenging social issues in the UK, which means there also is a chance for research to make an impact on health where it is needed most.

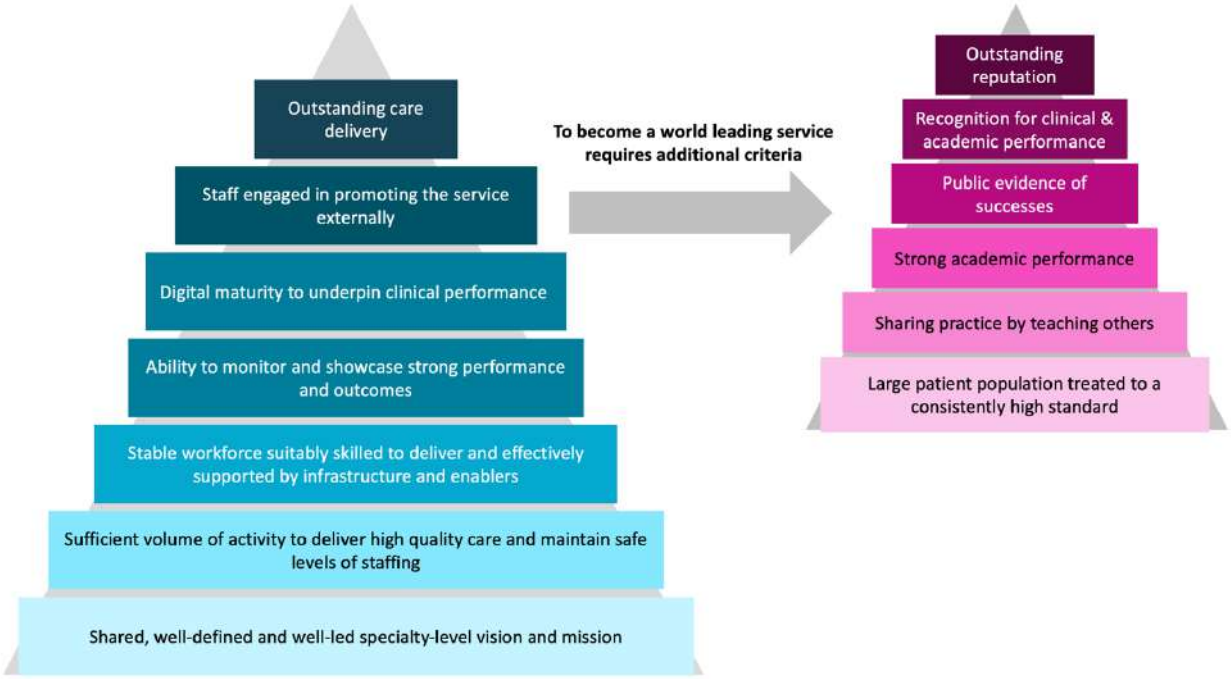


Figure 7: world-leading services framework

[11] Research Activity and the Association with Mortality, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4342017/
[12] NIHR (2020) Improving inclusion of under-served groups in clinical research: Guidance from the NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/improving-inclusion-of-under-served-groups-in-clinical-research-guidance-from-include-project/25435 (date accessed: 21/10/2022)
[13] NIHR (2020) Ensuring that COVID-19 Research is Inclusive: Guidance from the NIHR CRN NIHR-INCLUDE project. UK: NIHR. Available at: www.nihr.ac.uk/documents/ensuring-that-covid-19-research-is-inclusive-guidance-from-the-nihr-crn-include-project/25441 (date accessed: 21/10/2022)

In addition, being able to harness the research and innovation potential across the Trusts is vital in fulfilling the criteria to becoming world leading services. The 'Outstanding' reputation that many of the acute and specialist Trusts have for service delivery from the CQC can be built upon to deliver world-leading services. A strong academic strategy will support delivery of the world leading services by attracting research funding and investment, talent, and driving quality as set out in Figure 7.

The research and innovation agenda for the city should be pursued through a refreshed scope of the Liverpool Health Partners (LHP), working with all existing partners and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. The refreshed scope of the LHP should consider:

- Delivering data-enabled clinical trials from end-to-end by using routine data rapidly to identify potential trial recruitment pools, recruiting participants through a single point of entry, and tracking them through a trial using data collected from routine sources and telemedicine
- Establishing a hub to act as a single point of planning and operations for organisations interested in running a clinical trial in Liverpool, supported by spokes that support recruiting participants and facilitating ongoing monitoring

Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff

Health and social care is the largest employer in the Liverpool City Region, employing 117,000 people. Across the six organisations, around 25,000 people were employed and £1.29bn was spent on workforce costs in 2021/22. As a result, the workforce agenda between the acute and specialist trusts is significant and has far reaching consequences into the community.

According to senior staff, the biggest challenge to ongoing service delivery is recruitment and retention of staff (Figure 8). This reflection is supported by data and is seen to manifest in several ways:

- The turnover rate for medical staff is relatively high, ranging between 20% to 35% across the Trusts, with four of the six organisations having a rate above the national median of 30%.
- Staff motivation shows room for improvement with staff reporting on or below average motivation scores in five out of six organisations.
- Satisfaction with training programmes is also variable across Liverpool with overall satisfaction lower than the national average at four out of six organisations.
- Use of bank and agency staff is high, and competition for capacity in the same staff groups leads to often escalating rates paid out to staff and subsequently disproportionate spend on agency and bank rates.

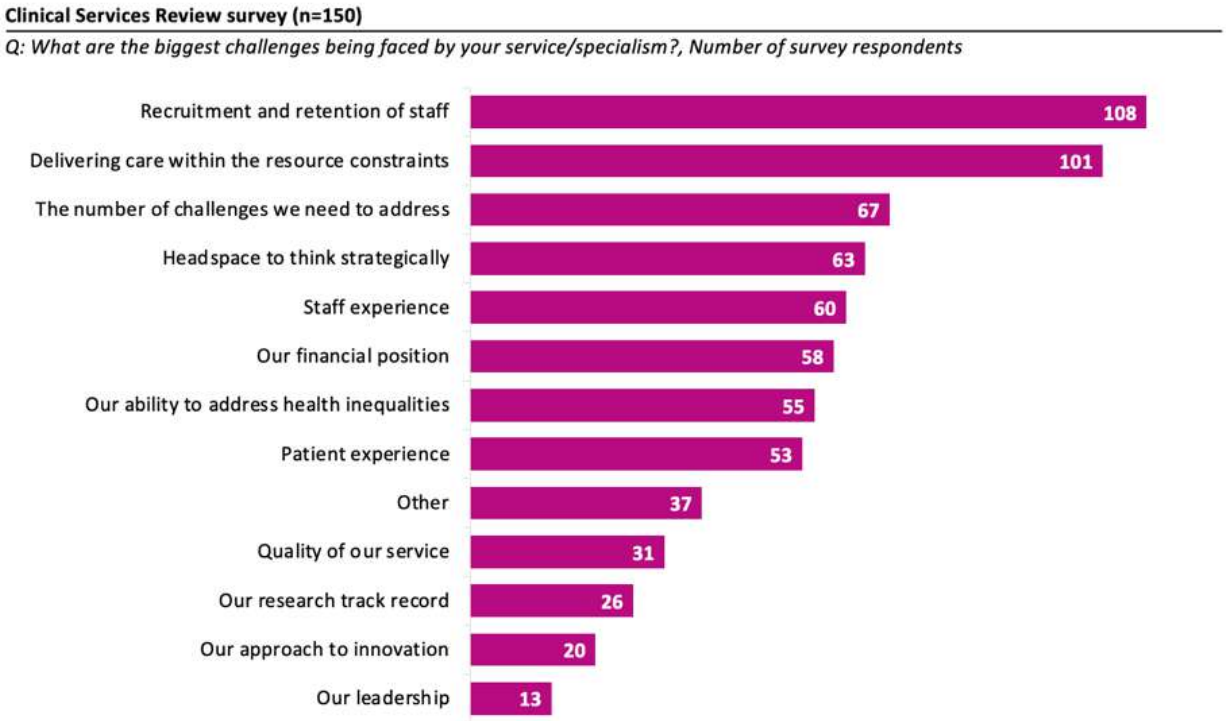


Figure 8: Liverpool Clinical Services Review survey - biggest challenges faced by your service responses

Colleagues also consistently described how competition between Trusts magnifies this challenge in particular in relation to staff groups that are common to all organisations, such as theatre staff.

To address these issues, stakeholders described a host of different opportunities in this space to work collaboratively to attract and retain talent at all levels. These included an integrated training and development offer, implementing staff passports, standardising policies, collective workforce planning, and joint recruitment. Working together to create a strong employer brand could improve recruitment and retention rates, reduce recruitment costs, and increase pride amongst staff.

A consistent theme in the opportunities described was the opportunity to integrate training, education, and development for staff. The collective scale and the diversity of work within the organisations allow for a greater range of programmes, and more varied training opportunities to be offered to all staff. Colleagues also described how each organisation had its own leadership development training and that a joint programme in this space could support colleagues to lead for collaboration. Colleagues also felt that implementing staff passporting mechanisms would not only improve often lengthy mandatory and staff training requirements, allowing faster recruitment, but would enable the movement of staff seamlessly between sites and support filling gaps in staffing at other organisations.

Working together could allow all organisations to set a single set of policies and prices for temporary staffing, allowing for a more consistent level of spend between them particularly given financial constraints. Work to set up a collaborative bank also has the potential to release significant savings, as well as bring greater flexibility of working for staff.

Through CMAST, there is an existing Workforce Programme focused on addressing system workforce pressures and leading on workforce development that should support the implementation of this

opportunity. In the longer term, recognising the inherent challenge for the health and social care workforce as a whole, organisations in Liverpool should work together to standardise workforce models and proactively identify roles that will be particularly difficult to recruit for. This should be done in conjunction with the implementation of new proactive models of care that provide preventative and anticipatory care.

Achieving economies of scale in corporate services

Another area where stakeholders were able to clearly articulate the potential for closer working was corporate services and leveraging the expertise across organisations and economies of scale in doing so. Across all organisations in Liverpool, £132.4 million is spent on corporate services (2021/22) and the majority of trusts spent more on corporate services per £100 million income than trusts in the Core Cities as shown in Figure 9. In 2020/21[14], all organisations in Liverpool spent more on finance and HR corporate functions for every £100 million of income earned than the national lower quartile.

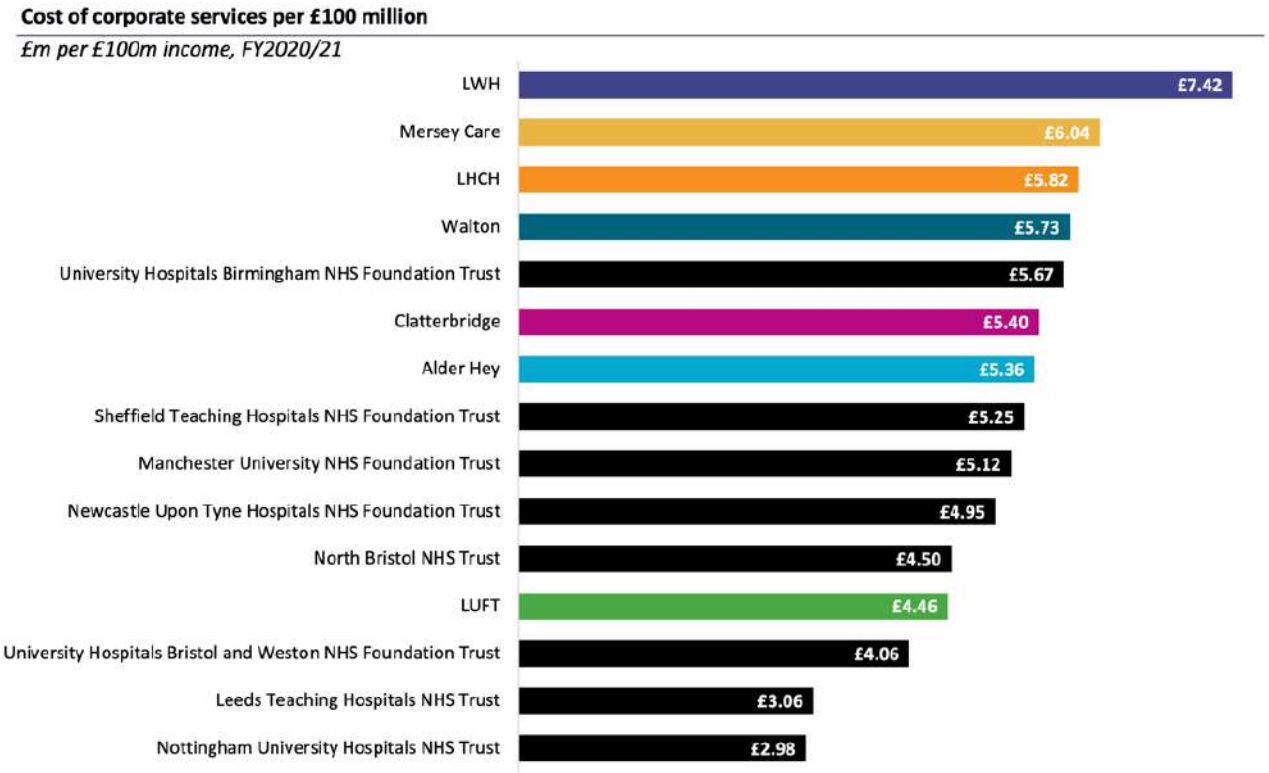


Figure 9: cost of corporate service per £100 million income by organisation

Post-covid there is more collaboration than ever, with a joint procurement function having been set up between The Walton Centre NHS FT, Clatterbridge Cancer Centre NHS FT, Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. There are also opportunities to build on, including the joint digital service that has been established between Alder Hey Children's NHS FT and Liverpool Heart and Chest Hospital NHS FT. Scaling these collaborative efforts further and applying them to other corporate services including HR, Finance, Estates and Facilities and IM&T has been recognised as a point of focus in addressing the financial challenges faced by the system. Specifically, collaborative working between the trusts would encourage a uniform approach to the delivery of corporate services, freeing up resource by

[14] Note: these figures pre-date the collaboration on procurement and the Clatterbridge Cancer Centre currently hosts the Cheshire and Merseyside Cancer Alliance along with other ICS function which inflates their position.

doing a greater number of tasks once between the organisations. As well as reducing cost and duplication, maximising this opportunity allows expertise across the city to be shared and leveraged for the benefit of all.

The case for collaborating on transactional services that could be more efficiently done once for all organisations is made clearly through payroll, in recognition of the work already undertaken on behalf of the system by St Helens and Knowsley Teaching Hospitals NHS Trust. This could be expanded to other areas where services are process and system based including HR services such as recruitment checks, finance administration and IT support, and should be addressed at pace.

With respect to facilities such as catering, colleagues also felt there would be significant benefit, both operational and financial, in joint procurement of services to leverage the scale of multiple organisations in the negotiation of contracts. Taking this further still, stakeholders saw an additional opportunity to support local economic growth by jointly procuring these services with local organisations, or potentially even bringing the services in-house with a host organisation to lead this.

In working these opportunities through, the different models for collaboration and consolidation of corporate services should be considered from retaining in-house functions and hosting to fully outsourcing services to external providers.

An existing programme of work pursuing this opportunity is being led by the Cheshire and Merseyside Acute and Specialist Provider Collaborative, through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme. The specific opportunities outlined in this opportunity should also be considered as part of realising the opportunity to deliver the emergency pathway (opportunity 3).

Building on and integrating digital investments to unlock innovative approaches to delivering care and achieving commitments to environmental sustainability

The Long-Term Plan is explicit about the need for digitally enabled care to become mainstream, and stakeholders across Liverpool are enthusiastic about the potential benefits of drawing on a greater range of digital solutions to support patient care.

There has been significant investment in digital systems across the city with some organisations achieving international recognition for their efforts, but there is more work to do in order to bring all organisations up to the same standard. More than ten EPR and PAS systems are in use across organisations in Liverpool which limits interoperability, and even where organisations are using the same software company, functions to support interoperability have not been deployed or are not made use of. Currently only Alder Hey Children's NHS FT and the Clatterbridge Cancer Centre NHS FT have invested in HL7 Fast Healthcare Interoperability Resource application programming interfaces.

While there is longstanding agreement that a place-based or system-based approach should be taken for EPR procurement in line the with national process that has been set up, re-procurement of services is still a way into the future for some organisations. Stakeholders spoke extensively about the opportunity to ensure that current procurement efforts are aligned to collective future ambitions and are future proofed for interoperability.

Alongside EPR systems, colleagues also describing the host of other software used such as Sunquest ICE for pathology services that are currently not deployed across all organisations. A specific example cited was at the Broadgreen site where pathology information such as blood test results are not visible between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT.

Digital solutions can also be put in place to support more anticipatory care closer to the home. Mersey Care NHS FT hosts the largest telehealth service in Europe and the service currently supports around 2,000 patients a day with long-term conditions such as COPD, diabetes, and heart failure across its catchment, with significant success in terms of outcomes for patients and reducing hospital visits. The benefits of using the service were particularly apparent for many stakeholders during the pandemic. However, colleagues also described these services as being underutilised in Liverpool and saw opportunity for clinical teams to work together to make better use of existing services and to expand their scope to meet the needs of local people.

A longer-term commitment for the city has been to implement a shared care record. The Share2Care record has been developed as Cheshire and Merseyside's Local Health and Care Record, providing a repository for key documentation through E-xchange. However as of December 2020, some organisations in Liverpool do not publish or view data using this platform including the Liverpool Women's Hospital NHS FT, some sites of the Liverpool University Hospitals NHS FT, Mersey Care NHS FT, and primary care. This should be resolved and pursued at a system level, docking into the ICB Digital Programme to ensure that there is consistency across the ICS.

Making best use of resources to secure financial sustainability for all organisations in Liverpool

Currently, NHS organisations in Liverpool are in financial deficit with an aggregated reported deficit position of £12.3 million at YTD (August 2022/23), which is expected to deteriorate further over the rest of the financial year.

The Cheshire & Merseyside ICS allocation per head to NHS organisations remains higher than all other core cities with the overall allocation due to decrease by c.£300 million over the coming years. Alongside this the new Specialised Commissioning allocation will mean that Cheshire and Merseyside will be allocated £50 million less income from specialised commissioning. Local government in Liverpool and across Cheshire and Merseyside has also seen one of the largest decreases in real terms spending power since 2010 with a decrease of £700 per head of the population.

This sets the context for needing to stabilise the current position before it deteriorates further and start to prepare for the future challenge ahead. Throughout the review, colleagues have reflected on the financial pressures and sustainability challenges faced in Liverpool and how opportunities to collaborate could seek to address these challenges. Each of the opportunities outlined have either a direct or indirect financial benefit that organisations can realise:

i. Colleagues spoke extensively about reducing cost through supporting more proactive anticipatory models of care, and reducing the number of high-cost interventions required in hospital
ii. Reducing duplication of effort and excess lengths of stays associated with fragmentation of emergency pathways
iii. All trusts have an opportunity to increase theatre utilisation and elective productivity, which would allow for more treatment to be delivered at a lower cost

iv. Increasing the elective throughput will help to prevent conditions from worsening and requiring more expensive care in the long-term
v. Increasing elective throughput will also help to keep profitable procedures within the NHS, rather than allowing them to go to the private sector
vi. Improving cancer and cardiovascular care to promote earlier diagnostics, will allow for earlier interventions, which are generally less expensive
vii. Reducing the number of transfers needs for women and babies across Liverpool to access services by resolving co-dependencies
viii. Reducing the level of spend on bank and agency staff by supporting staff recruitment, retention and health and wellbeing
ix. Improving the research offer will allow for greater income to be received from clinical trials and attract investment from life science companies. It will also contribute to improving the reputation of the organisations, which can also attract further investment for the city
x. Improving digital investment in care models will support more proactive and less expensive models of care
xi. Doing a host of corporate activities once between organisations will free up resource to be directed and invested elsewhere

In responding to the case for collaboration, we recommend:

The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For four of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:

a. Improving physical and mental health by providing more anticipatory care (opportunity 1) requires working through the One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care NHS FT,
b. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) requires working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative and consequently the work should be undertaken in the view of the Collaborative and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

Priorities for action

Several opportunities are already being taken forward by programmes of work as part of implementing One Liverpool, the Liverpool Health Partners, and as ICS-wide programmes of work through CMAST and the Cancer Alliance. In these areas there is ongoing work, which can be supplemented by the findings and opportunities identified in this review.

To take the prioritised programmes of work forward, we recommend:

A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stocktake of existing workstreams, specifically:

a. Address inequalities in cancer diagnosis (opportunity 4) through the Early Detection workstream and Health Inequalities and Patient Engagement Programme, of the Cheshire and Merseyside Cancer Alliance, and
b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long Term Conditions Segments, of the One Liverpool Programme.

As transformational change becomes business as usual, priorities should be reassessed and agreed.

Colleagues agreed that the review should move on to address the most critical issues facing the system, which are longstanding clinical risks for women's health, current financial sustainability, and operational pressures for emergency care. Two priorities were aligned upon as a core focus for collaboration in the coming period:

1. Solving clinical sustainability challenges affecting women's health in Liverpool
2. Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

The collective financial challenge faced by Liverpool was considered to be underpinning and should be threaded through all collaboration opportunities. This was explicitly considered as part of realising the two opportunities prioritised and the opportunity benefit is articulated throughout this document.

Solving clinical sustainability challenges affecting women's health in Liverpool

In exploring this opportunity, it was recognised that extensive work has been ongoing for a number of years to set out the case for change and develop a set of recommendations for service change, including work to prepare for a public consultation. Between 2015 and 2017, an extensive programme of work was undertaken, led by the Liverpool Clinical Commissioning Group, supported by the Liverpool Women's Hospital NHS FT, and involving significant engagement from system partners on a pre-consultation business case to explore options for the future of health services for women and babies in the city.

The challenges prompting this work remain and have been reviewed by external independent bodies including the Northern England Clinical Senate. These independent views have universally recognised that services would become unsustainable and potentially unacceptable within the next 5 years, and consequently there is a system imperative to resolve this issue.

The current work, led by the Liverpool Women's Hospital NHS FT and supported by system-wide stakeholders and the Liverpool Place colleagues, as part of the Future Generations programme, has been focused on formalising existing joint working arrangements with Liverpool University Hospitals NHS FT and implementing further mitigating actions through a Partnership Board. These actions have included redevelopment of the existing neonatal unit, investment to increase 24/7 consultant cover and planning for a 24/7 on-site transfusion laboratory at Crown Street by April 2023.

The future programme of work to realise the women's health opportunity will need to follow the latest national guidance on service change and should be pursued as an ICB-led service change programme. In parallel to this, recognising the timescale of any service change programme, the ongoing work to continue to mitigate and address risks must be continued and strengthen through the existing Partnership Board arrangements. To deliver this, an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks. In so doing, there should be a recognition of the costs associated with these measures, driven by the unique nature of the service model, and financial support for this should be worked through with the ICB.

The service change work should begin by reconfirming and strengthening the current case for change. In responding to the challenges set out by the case for change, opportunities and best practice care models should be developed that set out how care could be delivered in the future. To deliver the future care model, service change will likely be required, by which we mean what services can be accessed and where. In following this process, extensive clinical engagement will be needed, as well as engagement from finance, estates, and information colleagues. Any potential service change implications would require the ICB to undertake an options appraisal process.

Service change and the requirement to consult is complex with no clear definitions in law. 'Substantial' changes to NHS service provision (how, where or when) mandate consultation with relevant Local Authorities who then determine the need for public consultation or not. Early engagement is key.

If an options appraisal process is recommended to consider the proposed service changes, it would need to follow best practice and requirements on service reconfiguration. As part of this process any interdependencies with other services will be considered as well as the potential impact of proposed service changes on population groups with protected characteristics. The outputs of the options appraisal process would be described in a pre-consultation business case (PCBC) which would set out the benefits and limitations of the options compared to the status quo. We would recommend that the Strategic Outline Case, which will describe the high-level business case for the changes and estimated capital and revenue requirements, is also drafted alongside the PCBC.

The ICB may then need formally to consult the public on any proposed service changes. Any decision to consult would require formal approval of the ICB Board, who would consider in public the PCBC. Before consultation on each preferred option, the financial proposal should be assessed for capital and revenue impact and only implementable and sustainable options (in service, economic and financial terms) should be offered for public consultation. Capital funding requirements of > £15 million mandate confirmation of affordability before consultation is launched.

Public consultation allows the public to comment on the options proposed and in support of this, a consultation document is produced. Input from the public information can be captured through holding events or through asking for responses online, for instance via a survey. Concurrently, an Outline Business Case (OBC) should be drafted to set out the preliminary information on the proposed options. Feedback from the public consultation, alongside internal views on the preliminary outline business case should be used to refine the options proposals and provide basis for any extra analysis to be performed. These alterations should be incorporated into A Decision-Making Business Case (DMBC) to refine and detail the preferred option and include detailed financial and implementation planning. To complete the process, a Full Business Case (FBC) should be produced to explain in detail the planned solution and how it matches service requirements and constraints, through the latest evidence and analysis. It should also show that the most economically advantageous offer is being proposed and is affordable.

There are a number of benefits that could be realised from service change and are important for people, staff, and the wider healthcare system. Optimal clinical co-location of services would result in improved patient safety, outcomes, and experience, through enhanced provision of clinical necessary services. It would support staff satisfaction, recruitment, and retention, ensuring that the organisation is an attractive and fulfilling place to work and that there are opportunities to upskill staff in multi-disciplinary teams (MDTs) though managing complex cases, providing access to an experienced workforce and development opportunities through close working with other specialities. Furthermore, co-location would expand the development of world-leading services for women and babies in Liverpool building on the existing research portfolio and strengthening the resilience of the workforce.

As well as resolving critical clinical and workforce issues through service change, there are several quantifiable opportunity benefits that may be possible to realise should there be a change in how services are provided. These include:

- Reducing maternity clinical negligence costs (CNST) at Liverpool Women's Hospital NHS FT which are significantly higher than peers at £2.3 million per 1,000 births. With the assumption that service provision would be enhanced and reduce risk, clinical negligence costs could reduce over a period time with the recurrent benefit equivalent to between £4.9 million to reach the peer median and £6.1 million to reach the upper quartile.
- Reducing soft facilities management costs at Crown Street depending on the resulting service provision there. Based on the assumption that 24/7 care may no longer be provided at the site, there would be an opportunity benefit of around £1.6 million
- Reducing the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT for women who need critical or specialist care, would have an opportunity benefit equivalent to £155,000 (through 229 transfers in 2019/20) which would not be cash-releasing
- Reducing the length of stay for people staying in hospital who subsequently need transfer has opportunity benefit based on 2019/20 activity equivalent to £65,825, although due to the occupancy rates at Liverpool University Hospitals NHS FT, we would not expect that this benefit would be cash-releasing.

Further benefits could also be realised by a change to service model as the current model of care has required significant investment to be made in workforce for example for additional rotas and capital for additional diagnostic capacity such as a CT scanner. Some of these investments could be unwound and efficiencies gained if the service model were to change in the long-term. In the short-term this investment

needs to continue to continue delivery of safe and effective services, and ongoing financial support should be worked through with the ICB.

To take forward this priority opportunity, we recommend that:
The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

a. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
b. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
c. A non-executive of the ICB to be identified to chair the sub-committee.
d. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
e. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
f. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.
g. A reset work programme be created and agreed by January.
h. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen, and Royal Liverpool sites

For emergency pathways, each hospital site in Liverpool should deliver optimal care and efficiency, uninhibited by organisational boundaries. The task and finish process for this opportunity recognised that for urgent and emergency care, there are a number of co-dependencies for services that are not met by current service delivery in Liverpool.

The core emergency department offer at the Royal Liverpool and Aintree sites does not benefit from on-site access to gynaecology and interventional cardiology services, necessitating interhospital transfer for some patients. More critically, the Major Trauma Centre at the Aintree site does not have on-site access to gynaecology, neonatology, obstetrics, thoracic or cardiac surgery. Although it also does not have access to acute paediatric services, this is mitigated by Alder Hey Children's Hospital NHS FT being the Major Trauma Centre for children and young people aged under 16 and providing access to specialist paediatric services on site, meeting all co-dependency requirements. For children aged between 16 and 18, colleagues

discussed the option of considering them as part of the scope of this opportunity, however this group represented small volumes and therefore effort was prioritised to addressing other groups first.

Two groups of users emerged: those for whom critical co-dependent services are not available on the site they are receiving care, and those for whom collective expertise and existing co-adjacencies could be further leveraged. For each, colleagues described an ambition for emergency pathways that enable people seeking urgent and emergency care to avoid unnecessary transfers between sites and organisations, minimising delays and providing timely access. This would also reduce repetition for people accessing services and duplication of effort for staff, by providing the right information at the right time for people, their carers and staff and making use of digital innovation and technology as far as possible. Colleagues aspired to deliver a pathway that facilitates joint ways of working within and between organisations and allows for proactive planning for onward care, thinking holistically about the person at every stage including presentation.

Guided by this ambition existing pathways for groups where needs are currently sub-optimally met were mapped and redesigned across eight pathways. Common themes between the redesigned pathways were identified and articulated into three additional pathway elements for how care should be delivered in the future. They are fast-tracking, passporting, and in-reach. Each element has specific benefits which are set out below.

Fast-tracking
When people with an emergency need require care, they either present directly or are conveyed by ambulance to either the Royal Liverpool or Aintree emergency departments, where they are assessed and often admitted to receive initial care before clinical teams determine they require specialist treatment and care at a different site. This results in long wait times both in the emergency department and as an inpatient awaiting transfer.

Fast-tracking allows for people to be directly conveyed or rapidly directed to the best place of care for their primary condition either through a rapid transfer protocol or access to specialist opinion using a digital platform to determine whether direct conveyance to hospital is appropriate. Fast tracking protocols already exist for a number of pathways, for example major trauma and stroke protocols directly to Aintree site, and STEMI direct conveyance to Liverpool Heart and Chest Hospital NHS FT.

Implementing fast-tracking will ensure that people receive streamlined and appropriate specialist care in a timely fashion, meeting their needs more effectively and reducing the need for transfers when they are critically unwell. Direct conveyance to the most appropriate setting will improve morbidity and potentially mortality.

Colleagues agreed that this opportunity should be initially implemented for cardiology services including acute coronary syndromes and arrythmias, and for neurology services specifically moderate head injuries.

This pathway change will reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 577 cardiology, 118 cardiac and thoracic surgery, and 348 neurology attendances could have been avoided, equivalent to a potential saving of £175,000. As a consequence, spells at Liverpool University Hospitals NHS FT would also be avoided as patients attend the specialist centre directly. If this model was implemented in 2021/22, 411 cardiology spells, 110 cardiac and

thoracic surgery spells and 211 neurology spells would have been avoided with an opportunity benefit of £1.77 million.

There will also be a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and specialist trusts. For 2021/22, the numbers of transfer avoided would have been 577 cardiology and 118 cardiac and thoracic surgery transfers between Liverpool University Hospitals NHS FT and Liverpool Heart and Chest Hospital NHS FT and 91 neurology transfers between Liverpool University Hospitals NHS FT and The Walton Centre NHS FT. The potential opportunity benefit is £204,000.

Passporting

Some groups of people with an emergency need have access to a specialist advice service which can sign-post them to the correct service. For example, people with cancer have access to an oncology helpline. In some instances, people can be directly admitted to the Clatterbridge Cancer Centre Clinical Decisions Unit for assessment and treatment of their condition, however existing conveyancing protocols mean those attending by ambulance can currently only be taken to emergency departments at the Royal Liverpool or Aintree sites.

Passporting allows people with a known condition to bypass A&E and reach the most appropriate place for their primary need. In practice, this means having an agreed written care plan that can be easily located and accessed by any health care professional (for example by keeping it in the fridge) and implemented should an emergency need related to the known condition arise. This passport gives them 'priority' or direct access into the service they require. Passporting could result in a variety of alternative outcomes:

- People and their families or carers would have clear signposting should an emergency need arise
- Paramedics can directly convey to the appropriate service, notifying the relevant on-call team ahead of time
- Paramedics can access specialist advice from the relevant on-call team if there is uncertainty about the best conveyance destination
- Where direct access to services would not be appropriate, the passporting mechanism could alert the relevant team that the person is being taken to A&E so that relevant information can be shared, and ongoing specialist support provided

Implementing passporting will improve experience of care, safety, and outcomes by providing appropriate specialist care for people in the right place by specialist multidisciplinary teams who can comprehensively meet their needs. These teams will be guided by an individualised care plan and will only carry out relevant tests and diagnostics.

Colleagues agreed that the first areas to implement passporting would be for people with cancer and for people readmitted within 14 days of a stay in hospital. This pathway change has the potential to reduce emergency department attendances to Liverpool University Hospitals NHS FT. If this model was in place in 2021/22, 143 cancer attendances could have been avoided and 134 spells for cancer, equivalent to an opportunity benefit of £529,000. This would have been accompanied by a reduction in the number of interhospital transfers needed between Liverpool University Hospitals NHS FT and Clatterbridge Cancer Centre NHS FT and reduced length of stay. In 2021/22, the numbers of transfers avoided could have been up to 48, resulting in an additional opportunity benefit of £12,000, with the reduction in beds equivalent to 1.7 beds across the year and an opportunity benefit of £193,000.

In-reach

When someone with an acute need also has co-morbidities, they often require expert advice to optimise the management of their co-morbidities along with their acute presentation. Consultants can currently make consultant-to-consultant referrals for advice, however there are often delays in providing this and at times it will not come until post-discharge. Advice can be sought from colleagues informally but there is no established mechanism for this.

In-reach provides multi-disciplinary team input for people with a known condition who attend the hospital and need specialist advice for their known condition (which is not their primary need). In-reach means specialist advice can be easily and quickly obtained by other teams. This can happen through a variety of means which can reach any site if needed:

- through an "advice and guidance" service: a digitally enabled service manned by a dedicated specialist in which requests can be logged and responded to within a defined time period, via telephone or message depending on what is most appropriate.
- virtual consultation: based on the advice and guidance service, virtual consultations can be set up if recommended. This mechanism should leverage existing digital capabilities and models used for virtual appointments but in an acute inpatient setting.
- in person consultation: based on contact through the advice and guidance service, the dedicated specialist can easily move between sites to provide in person consultations where necessary.

In-reach improves the experience and care that people receive by ensuring this is holistic and that co-morbidities are proactively managed in the context of an unrelated acute presentation. This can contribute to a reduced length of stay as there is timelier access to specialist opinion and people, their carers and staff will have greater confidence in management and treatment plans. In-reach also creates an environment for further learning opportunities and cross-fertilisation of expertise and knowledge across professions and specialities. Models for in-reach already exist for some specialist services across the city for example cancer services.

This pathway change has the potential to reduce overall length of stay as people with multiple co-morbidities in Liverpool have a significantly higher length of stay than the national average. Those with fewer co-morbidities had a similar length of stay to the national average indicating where people have multiple co-morbidities, there would be a benefit from in-reach. If the in-reach model had been in place in 2021/22, 4,603 bed days or 12.6 beds could potentially have been saved, which is equivalent to an opportunity benefit of £1.3 million.

Colleagues agreed that in-reach should be implemented for all people with comorbidities across all sites beginning with those with diabetes to test the concept, and then rapidly rolled out for other conditions. This pathway should be implemented in all areas where sufficient demand exists across organisations to realise a cumulative benefit of the service.

To deliver these, an operating model for each site should be developed to include implementing processes to create joint teams across sites, ensuring clear clinical pathways and accountability, and optimising site-based working. This includes:

- Ring-fencing capacity for additional fast-tracking and passporting services,
- Sharing physical capacity, for example ITU beds, to enable elective activity to continue without being displaced by emergency pressures,
- Sharing diagnostic capacity such as x-ray machines and scanners to provide timely access,

- Making best use of staff experience and expertise, for example creating joint appointments to provide specialist input across sites, and
- Consolidating teams that could be shared, for example through having a single medical emergency team for each site and a shared discharge support team
- Clinical support services sharing physical capacity and workforce, for example a shared pharmacy service for the site with a single overnight rota for pharmacy.

Colleagues identified several priority pathways where these three pathway elements could be applied, with a view to maximising the impact of the opportunity:

- All sites should implement passporting for people with cancer and people readmitted within 14 days of a stay in hospital and in-reach for people with comorbidities, for this purpose defined as people with an HRG complication or comorbidities score (CC) of 10 and above.
- At Broadgreen site, focus should initially be on rapid implementation of fast-tracking for cardiology services including acute coronary syndromes and arrythmias; strengthening the STEMI pathway as well as setting up a pathway for direct conveyance of NSTEMI and pacing.
- At the Aintree site, colleagues should initially focus on fast tracking for moderate head injuries, as well as reviewing the effectiveness of the stroke pathway which has recently been implemented.
- At the Royal site, effort should be directed at developing passporting for people with cancer who could be seen directly at the CCC.

Implementing joint clinical working will also bring synergies in operations on each site and there are examples of inefficient use of resources that represent opportunities for non-clinical integration. As organisations collaborate to implement new clinical pathways, they should also embrace this broader agenda. These include:

- Digital: resolving interoperability of systems to ensure information can be shared and diagnostics such as pathology and radiology do not need to be duplicated,
- Corporate services: in support of joint operations on sites, shared HR, finance, strategy, and estates functions that work across organisations on sites, and
- Facilities management: where there is duplication of services on sites for both hard and soft facilities management services, for example catering, portering and security services.

The site-based operating models will have financial benefits over and above those set out for the clinical pathways in particular where services can be consolidated across sites to provide shared teams. The opportunities relevant to each site need to be systematically and holistically worked through to determine the full scale and scope of the site-based model.

We recommend that:

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review: 1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:

a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
    i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
    ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
    iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

This opportunity and the resulting recommendations form one part of the urgent and emergency care pathway and should be seen as additive to the other system initiatives such as efforts to reduce attendances and redirect demand to primary and community settings. Colleagues reflected on the urgent emergency pressures currently faced by the system and felt there were two particular areas of focus: community urgent and emergency care, and flow and discharge pathways. Prior to the pandemic, the North Mersey review of urgent care provision concluded there was a need for an integrated UTC model to be developed to support delivery of same day and urgent care needs of local people and connect seamlessly with other parts of the emergency pathway. There is a need to reset and reinvigorate this work in order to address urgent and emergency demand that continues to put pressure on organisations. At the

other end of the emergency pathway, colleagues also felt that there was a need to work together on improving flow and discharge along with community and social care to reduce the number of people in hospital who did not need have the criteria to reside. During the review period, colleagues also reflected on the need for a review of community and mental health services and capacity, reflecting on the long waits in the emergency department and in hospital for in-reach and onward care.

All organisations involved in the urgent and emergency pathway need a forum in which they can review system effectiveness with a shared data view and to make decisions about improving quality and safety of the emergency pathway as well as optimising the use of overall resources. Committees in Common create a mechanism for doing this by allowing two or more organisations to meet in the same place at the same time to discuss the same topics yet remain distinct and take their own decisions. The benefit of this arrangement is that it allows each organisation to retain control but is supportive of collaboration. It also reduces administrative burden and is an efficient decision-making process.

We recommend that:
To provide overall Liverpool system oversight and review of performance on delivering high quality emergency care with aligned incentives and funding, two committees-in-common should be established involving relevant executives and non-executives from Alder Hey Children's NHS FT, Clatterbridge Cancer Centre NHS FT, Liverpool Heart and Chest Hospital FT, Liverpool University Hospitals FT, Liverpool Women's Hospital NHS FT, The Walton Centre FT, Mersey Care FT, and General Practice Liverpool. These committees-in-common should meet quarterly and cover:

a. Quality – reviewing the effectiveness and quality of emergency care using shared data and analysis and determining further improvements required;
b. Finance – reviewing overall financial effectiveness and establish effective incentive and risk sharing mechanisms.

Conclusion and next steps

In conclusion, this report sets the direction and short-term priorities for further collaboration between the acute and specialist trusts in Liverpool. In describing these benefits, stakeholders also caveated these opportunities by highlighting several conditions that would need to be in place for them to be realised. The case for collaboration provides a basis for long term strategic efforts between acute and specialist providers in Liverpool and creates the shared vision and goal needed for collaboration.

Several elements were thought to be foundational including developing governance for collaborative decisions, sharing information, and having an interoperable digital environment, having an underpinning financial framework, and communicating and engaging clearly.

Developing the governance arrangements to support collaborative decisions making will be required for enduring collaboration. This will include outlining clear ways of working, which align the decision-making structures of organisations. Both the proposed joint committees and committees in common work in support of this condition. In aligning the operating models in the collaboration, the relationship between the collaboration and the wider provider collaboratives within the ICS need to be clarified.

Sharing of information and performance data was considered to be an important enabling factor in decision making and in providing clarity to issues that require collaboration. To ensure the smooth movement of

patients between sites and organisations, shared clinical information and a digital environment for staff, which supports movement between organisations.

Colleagues also described the uncertainty around how the financial flows will settle with the ICS, and how risk is managed within that can get in the way of clinical decision making that would support collaboration. In order to address this, creating effective incentives and risk sharing mechanisms for finance were thought to be important.

Critically, in recognition of the considerable scope of these opportunities, colleagues described needing strong clinical and non-clinical leadership to take forward the work, reflecting the significant mindset shifts that are needed. Stable leadership provides staff with clear direction and draws professionals together around a shared vision for the future, which is central to co-ordinating transformation across several sites and functions. Leadership oversight should be proportionate to the scope of the initiative that is being delivered.

Protecting time and creating dedicated capacity for collaboration will create the headroom needed to transform services and the way that organisations and people work together, ensuring that operationally pressures do not hinder progress. To make best use of this capacity, it was agreed that prioritising efforts and phasing delivery of the work was needed to make the biggest impact, rather than trying to collaborate on many things simultaneously. For some of the more significant opportunities that have been outlined, this will require a substantial commitment.

Overwhelming colleagues talked about the need for trusted relationships between partners as the basis for collaboration. Relationships have been improving over time; COVID helped to accelerate progress However, colleagues also highlighted that they would need to continue building trusted relationships, putting collaboration ahead of organisational sovereignty.

The collaborative opportunities that have been identified are considerable in scale and scope. Stakeholders have often been able to describe with enthusiasm the potential benefits of deeper collaboration.
There has been significant energy to engage in the process so far with a collective willingness and motivation to act on the findings of the review. To build on this momentum, action to implement the recommendations of the review needs to be taken swiftly and without delay, and should be resourced commensurate to their scope.

We recommend that:
To progress at pace Boards of relevant organisations should receive proposed terms of reference, including delegations, accountability, and escalation arrangements, for the governance groups set out in the recommendations 4, 5 and 6 in their January meetings. A proposal for how the programme(s) of work is resourced should also be included to ensure the appropriate team and leadership needed to deliver.

A communications and engagement plan should also be developed and agreed by all organisations. The aim should be to communicate the findings of the review and its recommendations and engage staff, patients, and the public on the next steps. Engagement on the future programme of work as well as open communications in respect to progressing the recommendations should be embedded into how this is taken forward.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Liverpool Clinical Services Review

Appendix Two: Summary of Recommendations

Appendix Two Summary of Recommendation

Collaboration

In responding to the case for collaboration, the following partnership configurations are recommended for each opportunity identified in the review:

The twelve opportunities in the case for collaboration should be adopted by the six acute and specialist providers in Liverpool as their strategic agenda for working together. For four of the opportunities, wider partnerships are required, which should be forged to ensure progress, specifically:

a. Improving physical and mental health by providing more anticipatory care (opportunity 1) - One Liverpool Partnership with General Practice, Liverpool City Council and Mersey Care NHS FT,
b. Levelling-up performance on cancer and cardiovascular disease to address health inequalities (opportunity 4) - working through a place-based partnership endorsed by the Cheshire and Merseyside Cancer Alliance and the Liverpool Cardiology Partnership respectively,
c. Work with all existing partners of the Liverpool Health Partners to pursue the research and innovation agenda (opportunity 8) and additionally include Liverpool City Council and Applied Research Collaboration North West Coast. This effort could be expanded to include interested providers across Cheshire and Merseyside ICB,
d. The longer-term digital agenda (opportunity 11), which requires working through the Cheshire and Merseyside ICB as part of the Digital Programme,
e. To solve clinical sustainability challenges affecting women's health (opportunity 6), work with the Cheshire and Merseyside ICB (see recommendation 4).

For the further five opportunities there is a synergy with the agenda of the Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST), Community and mental health Collaborative and consequently the work should be undertaken in the view of the Collaboratives and in line with its governance. The starting point for realising the opportunities identified in this review should be the six organisations in Liverpool. Only once tangible progress is made within this scope should it be broadened to a wider geography. This includes:

a. Address elective care waits and backlog (opportunity 5) through the Elective Recovery and Transformation Programme,
b. Combine expertise in clinical support services (opportunity 7), in part through the Diagnostics Programme,
c. Attracting and retaining talent across Liverpool, providing a more joined-up offer for staff (opportunity 9) through the Workforce Programme,
d. Realise economies of scale in corporate services (opportunity 10) through the Efficiency at Scale workstream of the Finance, Efficiency & Value Programme, and
e. Making best use of resources to secure financial sustainability for all organisations in Liverpool (opportunity 12) through the Finance, Efficiency & Value Programme.

Interdependent Programmes

To take the prioritised programmes of work forward, it is recommended that:

A rolling programme should be established, building on relevant pre-existing programmes, to take forward the opportunities for implementation. Overall, it will take a number of years to realise the potential benefits from this effort. The work should start by leveraging efforts already underway. Pre-existing programmes should incorporate the findings of the review into their ongoing work by undertaking a stock take of existing workstreams, specifically:

a. Address inequalities in cancer diagnosis (opportunity 4) through the Early Detection workstream and Health Inequalities and Patient Engagement Programme, of the Cheshire and Merseyside Cancer Alliance, and
b. Provide anticipatory care to improve physical and mental health (opportunity 1) through the Complex Lives and Long-Term Conditions Segments, of the One Liverpool Programme.

As transformational change becomes business as usual, priorities should be reassessed and agreed.

Women's Health

In the work to solve clinical sustainability challenges affecting women's health in Liverpool, it is recommended that:

The current programme of work, the Future Generations Programme, led by Liverpool Women's Hospital NHS FT should be reset as a system priority. The opportunity to solve clinical sustainability challenges for women's health should be taken forward as an ICB-led service change programme, in line with best practice requirements for service reconfiguration. To support this, we recommend:

1. A sub-committee of the ICB to be established to oversee the programme of work, including at minimum representation from Liverpool Women's Hospital NHS FT, Liverpool University Hospitals FT, Clatterbridge Cancer Centre NHS FT and Alder Hey Children's NHS FT. These organisations will need to identify dedicated clinical and managerial leadership to engage deeply in the programme with partners, with external stakeholders, with patients and the public and within their own organisations with staff.
2. A director of the ICB be identified as the joint-SRO of the programme and lead the work.
3. A non-executive director of the ICB to be identified to Chair the sub-committee
4. A clinical joint-SRO to be identified who can work on the programme for a dedicated period every week and chair the clinical working group. This individual should be experienced in service change with experience in a relevant clinical area, and independent of any of the organisations in Cheshire and Merseyside.
5. The finance director of the ICB to chair the finance, analytics and estates working group which will develop and review the economic and financial modelling, including capital requirements.
6. A dedicated team to be identified to support the programme, with the expertise needed to meet the different requirements of the programme such as clinical evidence and research, communications and engagement, finance, analysis and estates and capital development. This team should be hosted by the ICB reporting to the lead ICB director.
7. A reset work programme be created and agreed by January.
8. An operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT should be developed to optimise partnership working and short-term mitigation of risks, led by the existing Partnership Board.

Improving Outcomes and Access to Emergency Care

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies at Aintree, Broadgreen and Royal Liverpool sites.

It is recommended that:

Improving outcomes and access to emergency care, making optimal use of existing co-adjacencies should also be immediately prioritised for delivery. A programme of work should be established which implements the three new pathway elements proposed by this review:

1. fast-tracking, 2. passporting, and 3. in-reach. The overall aim of this work should be to ensure each hospital site in Liverpool delivers optimal care and efficiency, uninhibited by organisational boundaries. This should include creating integrated clinical teams on each site with joint ways of working. In taking this forward, we recommend:

a. Clinicians should be at the forefront of the development of this approach and leads should be identified from each organisation and each site, to oversee the work and facilitate broad engagement with staff.
b. There should be early engagement with General Practice, Mersey Care FT, and the North West Ambulance Service NHS Trust to incorporate pre- and post-hospital elements of the pathway.
c. An operating model for each site should be developed, ensuring highest quality clinical pathways, clear accountability, and optimised site-based working. This should be underpinned by demand and capacity analysis.
d. Building on the financial analysis undertaken as part of this review, a target financial model should be developed and agreed linked to 5c. This should reset financial flows and ensure overall efficiencies are realised including in respect to reduced length of stay and reduced interhospital ambulance transfers.
e. Three joint committees should be established with delegated authority from the relevant trusts for site-based operations. These arrangements should oversee the design and delivery of the new operating models as well as business-as-usual operations, which will likely give rise to further improvement opportunities. The three committees should include at least one non-executive director and executive director from each organisation as well as a site-based leadership team. The committees should comprise of:
i. Liverpool University Hospitals FT and Liverpool Heart and Chest Hospital FT for the Broadgreen site
ii. Liverpool University Hospitals FT and The Walton Centre FT for the Aintree site
iii. Liverpool University Hospitals FT and Clatterbridge Cancer Centre NHS FT for the Royal Liverpool site
f. To progress the work, a dedicated team supporting all three joint committees should be established that provides capacity to systematically work through the operating model on each site, undertaking design work and modelling for the pathway and service transformation. This team should be led by a dedicated senior individual working across organisational boundaries on behalf of all organisations.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Liverpool Clinical Services Review

Appendix Three: High Level Implementation Plan

Appendix Three High Level Implementation Plan

Action	Lead	Deadline
1. Women's Health		
Establish a sub-committee of the ICB to oversee the programme to develop service change proposals for the future configuration of services: • Agree terms of reference and membership • Agree that Raj Jain chairs the sub committee • Ask CMAST to identify a representative from the other DGHs who provide maternity services to be a member of the sub-committee	SRO, supported by ICB Governance lead	31/01/23
Agree that Christine Douglas is the Executive SRO for the programme	ICB CEO	31/01/23
Appoint an independent Clinical SRO	ICB Medical Director	28/02/23
Review existing governance in place – align or stand down if appropriate	SRO	31/01/23
Establish working groups for finance/estates/capital, engagement, clinical research/evidence.	SRO	24/02/23
Identify resources with the right skill mix and experience to support the programme, hosted by the ICB	SRO	24/02/23
Develop an operating model between the Liverpool University Hospitals NHS FT and Liverpool Women's Hospital NHS FT to optimise partnership working	LUHFT & LWH	31/03/23
Define the work programme and timescales for delivery	SRO	28/02/23
Establish monthly reporting to the ICB, aligned to the ICB Board cycle	SRO	28/02/23
2. Improving Outcomes and Access to Emergency Care		
Establish three joint committees with delegated authority from the relevant trusts to enable streamlined governance for site-based proposals: • Agree terms of reference • Identify membership of each Joint Committee (minimum 1 trust executive and 1 non-executive) • Date of first meetings – early February 23	Trust Chairs	10/02/23
Identify SROs for each site-based programme	Trust CEOs	31/01/23
All relevant Trust Boards to consider and approve recommendations from the Liverpool Clinical Services Review, including approval to establish joint committees with delegated authority within this agreed scope.	Trust CEOs	31/01/23

Recommendations to include principles for collaboration, for approval by Trust Boards		
Establish a Programme Management Office to support delivery of programmes, led by a dedicated senior manager, working on behalf of all organisations	Trust CEOs	28/02/23
Establish engagement and involvement mechanisms with other partners providing dependent services across the whole patient pathway, including General Practice, Community, and mental health, NWAS	AD for Delivery, Liverpool provider Collaborative	28/02/23
PMO to establish monthly reporting to the OLPB and quarterly reporting to the ICB and relevant Trust Boards	PMO Lead	28/02/23
Develop a target financial model to reset financial flows and ensure overall efficiencies are realised	ICB Director of Finance	
Establish clinical leadership and engagement mechanisms across each site, to ensure clinical effective clinical input into the development of proposals.	Trust Medical Directors	28/02/23
3. Corporate Back Office		
Engage with Cheshire and Merseyside Acute and Specialist Trusts (CMAST) to align recommendations from the Clinical Services Review with Cheshire and Mersey-wide priorities to realise economies of scale in corporate services.	Chair CMAST	28/02/23
Accountability		
Identify and map governance arrangements for each component of delivery of the recommendations from the Liverpool Clinical Services review and overarching accountability for delivery of the whole programme.	Liverpool Place Director	31/01/23

NHS Cheshire and Merseyside Integrated Care Board Meeting

Liverpool Clinical Services Review

Appendix Four: High Level Communications Plan

Appendix Four High Level Communications Plan

The recommendations from the Liverpool Clinical Services Review will lead to the establishment of significant programmes which will be supported on an ongoing basis by patient, public and stakeholder communications, engagement, and involvement.

If any programme develops proposals which represent a service change, providers and the ICB are subject to comply with statutory requirements and NHS guidance in engaging with patients and public in the development of proposals.

The communications plan, below, sets out high level actions based on what is known about implementation of these recommendations. Detailed plans will be developed as programmes progress and proposals are developed.

Action		Lead	Date
Resources	Identify resources within the ICB communications and engagement function and within Trusts to support the overarching programme and each workstream Ensure resource includes skills in delivering engagement and public consultation	AD for Communications and Empowerment, ICB	28/02/23
Launch	Develop a proactive plan to communicate the recommendations from the review, subject to ICB. Products to include public-facing core narrative about the purpose and deliverables of the Clinical Services Review in establishment phase Incorporate progress and updates in the One Liverpool Partnership Board, Trust and ICB communications.	ICB communications team for overarching co-ordination and women's services. Provider communications teams to collaborate based on site-based configurations	20/01/23

Action		Lead	Date
	Utilise case studies, patient stories and data to communicate delivery. Communicate collaborative nature of programmes. **Channels:** ICB, One Liverpool Partnership Board, Trust websites Stakeholder and public bulletins Proactive Media Social media Promote options for involvement and engagement		
Staff Communications	Provider communications teams to incorporate communications about the purpose and programme deliverables through existing internal communications channels.	Provider communications teams to work collaboratively to ensure consistency of approach and messaging Liverpool Place/ICB communications team to support trusts to establish trust - led communications	Commence from 26/01/23 and ongoing
Trust Boards within scope of review	Collaborate with Trust governance leads to incorporate updates and patient stories into Trust board cycles Launch stakeholder briefing to be shared with each trust board	Provider communications teams	26/01/23
Trust engagement forums	Identify existing engagement forums and how they could be engaged and involved in each workstream and proposal development. Identify gaps and promotion of engagement options to broaden involvement	Trust communications and engagement teams working collaboratively	28/02/23

Action		Lead	Date
General practice, community, and social care partners – North Mersey	Establish ongoing communications through regular stakeholder updates for use in partner communications, including LA, PCNs, LMCs and Mersey Care	ICB communications lead, liaising with three North Mersey Place teams	19/01/23 onwards
MPs	Stakeholder briefing and face to face updates offered on a regular basis - Knowsley, Liverpool and Sefton constituencies	ICB communications team	18/01/23 and continuous following launch
Local authorities	Stakeholder briefing for Cabinet members for social care and onward cascade to senior team and councillors. Discuss requirements for Scrutiny Committees with each Chair of the three North Mersey LAs	ICB communications team	18/01/23
Media	Develop a media plan for launch on ongoing communications. Establish ongoing plan for proactive media as each workstream progresses, informed by key milestones	ICB Communications team	19/01/23
Healthwatch Knowsley, Liverpool and Sefton	Stakeholder briefing for launch Engage with each Healthwatch about ongoing engagement and involvement in the programmes	ICB communications team	19/01/23

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Cheshire and Merseyside Health and Care Partnership Draft Interim Strategy

Agenda Item No	**ICB/01/23/13**
Report author & contact details	Neil Evans, Associate Director of Strategy and Collaboration (neilevans@nhs.net or 07833685764)
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Neil Evans Associate Director of Strategy and Collaboration

Cheshire and Merseyside Health and Care Partnership Draft Interim Strategy

Executive Summary					
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X				
Recommendation	**The Board is asked to:** • **Note t**he contents of the draft interim strategy • Note the proposed next steps agreed by the Health and Care Partnership at the meeting of 17th January; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan.				
Key issues	The Integrated Care System will struggle to provide the capacity and resource to deliver the wide range of areas included in the draft interim strategy. To mitigate this the strategy is being prioritised to allow for more detailed delivery plans to be developed targeted at those areas with the greatest impact on population health and reducing inequalities.				
Key risks	Financial resources to implement the strategy in a constrained financial environment. The maturity of the HCP membership and relationships will take time to develop in order to maximise the full benefits of system working. The capacity to implement the breadth of priorities identified in the strategy could lead to a more limited scale of improvement in the health of our population				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
	X	X	X	X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
	X	X	X	X	
Route to this meeting	The Strategy has been considered at the Health and Care Partnership Meeting on 17th January. A number of next steps were agreed, which are described in this report.				
Management of Conflicts of Interest	None identified				
Patient and Public Engagement	Healthwatch intelligence has informed the interim strategy content. However, engagement on the interim strategy document itself has not directly taken place. As the Joint Forward Plan content is developed there will be engagement with the public to reflect the Health and Care Partnership and Health and Wellbeing Board Strategies and Operational Plan priorities.				

	The engagement is planned to take place through existing Place based engagement mechanisms.
Equality, Diversity, and Inclusion	The document has been developed based on existing plans and strategies, some of which have had the impacts assessed. However, as the interim strategy is relatively high-level the lack of sufficient detail available on plans has meant it is not possible to undertake some of the assessments. As the detailed plans behind the strategy are further developed then the impacts will be fully assessed and considered.
Health inequalities	Addressing health inequalities have been identified as a key strategic objective, with the All Together Fairer recommendations adopted. Health inequalities are a golden thread running through the draft interim strategy
Next Steps	A number of next steps were agreed at the Cheshire and Merseyside Health and Care Partnership Meeting of 17th January 2023: • undertake a further period of engagement to enable the full breadth of HCP member partners to add their perspective and expertise to the strategy and identifying the highest priority areas within it. • undertake engagement with our citizens on the priorities and plans, alongside our Place Health and Wellbeing Boards to maintain a single joined up conversation about our plans. It is envisaged that we will utilise existing and established forums across Cheshire and Merseyside to gain further feedback from citizens, the findings of which will be reported back to the HCP. The ICB, and partners, will publish the document on websites to support this process. • develop a prioritisation framework which will support the refinement process. The work developing this draft framework is being overseen by our Population Health Board. • use the information collected through the population health intelligence to inform a workshop with the HCP in March 2023 to identify the greatest priority work areas within our draft interim strategy and the intention is to ensure the breadth of the HCP membership is included in these sessions in order that all organisations can consider the priorities from a system perspective as well as considering how they may be incorporated into their own organisational plans. This will include the commitments identified in the strategy as “We Will” statements. • include relevant additional national planning requirements for those areas relevant to the HCP strategy including the national financial and operational planning guidance to the NHS, and the initial guidance from DHSC indicated updated national guidance on ICP (HCP) strategies would be issued “by June 2023” to the final strategy.

	• consider the draft interim strategy priorities, alongside our nine Health and Wellbeing Board priorities and the national universal NHS operational planning priorities for 2023-24 when producing the ICB Five Year Joint Forward Plan. • develop a financial strategy that complements this work will happen during 2023 in reflection of the budgetary projections.	
Appendices	**Appendix One**	Cheshire and Merseyside Health and Care Partnership Draft Interim Strategy

Glossary of Terms	Explanation or clarification of abbreviations used in this paper
Champs	The Champs Public Health Collaborative
CIPHA	Combined Intelligence in Population Health Action
DHSC	Department of Health and Social Care
ICB	Integrated Care Board
ICP/HCP	Integrated Care Partnership in Cheshire and Merseyside we refer to the ICP as a Health and Care Partnership (HCP)
ICS	Integrated Care System
JFP	Five Year Joint Forward Plan
LTP	NHS Long Term Plan
NHS	National Health Service

Cheshire and Merseyside Health and Care Partnership Draft Interim Strategy

1. Executive Summary

1.1 On 17th January 2023, the Cheshire and Merseyside Health and Care Partnership considered the draft interim strategy, which has been developed across the HCP during the final quarter of 2022.

1.2 The interim strategy was developed following guidance from the Department of Health and Social Care (DHSC) requiring development and publication of a strategy by December 2022. This date was driven by the requirement to inform the development of an Integrated Care Board (ICB) Five Year Joint Forward Plans by April 2023. Following feedback as to the challenges meeting this date the DHSC clarified the December 2022 publication date was not mandatory and can be considered as guidance.

1.3 The approach taken by Cheshire and Merseyside has been to build from existing strategic priorities and plans, with a specific focus on prioritising reducing health inequalities and prevention of ill health.

1.4 As the HCP is not yet a formal joint committee, and following discussions with Local Authority legal representatives, it was recommended and accepted that the HCP strategy remains as a draft interim document which we work to refine and improve in parallel to formalising the HCP governance with an updated final strategy document presented for approval, to the HCP, in the summer of 2023.

1.5 A draft of the interim strategy was shared with a range of stakeholders on 01 December 2022 and the strategy updated to reflect this feedback. The document presented was noted with the following next steps agreed at the HCP meeting on 17th January 2022:

- the draft interim strategy document would be published on the NHS Cheshire and Merseyside ICB website alongside those of wider partners at their own organisational discretion. This would allow wider access and engagement on the draft strategy with our public during 2023

- engagement would take place with our communities and HCP members/partners in refining the content, in partnership with Place Health and Wellbeing Boards

- work would continue to prioritise the areas contained in the draft interim strategy by reviewing population health intelligence and then reviewing, and agreeing, the priorities at a workshop in the March 2023 HCP meeting

- that NHS Cheshire and Merseyside ICB consider the prioritised areas identified within this draft interim strategy when developing the ICB Five Year Joint Forward Plan, by June 2023 (draft by March 2023) and all HCP members use the interim draft strategy to inform their own organisational plans

- the HCP would develop an annual plan which details work programmes which deliver these shared priorities and have clear and measurable outcomes. The work programmes will recognise the response to our immediate service pressures as well as our longer-term objectives as members of the HCP

- development of a system financial strategy that supports delivery of the final approved HCP Strategy, recognising that this would most likely extend beyond the end of March

- when the NHS planning process would be completed as part of the NHS operational planning process

- work between Partners would continue with the intention to establish the HCP as a Statutory Joint Committee from July 2023.

2. Introduction / Background

2.1 The Department of Health and Social Care (DHSC) issued statutory guidance[1] for the production of an HCP Strategy, which should be published by the HCP by December 2022. Noting that following a number of queries nationally it was recently clarified that December timeline was a recommendation rather than a requirement.

2.2 The draft interim HCP strategy has been designed to describe the areas of work being undertaken collectively at a Cheshire and Merseyside level and complement our nine Place based Health and Wellbeing Strategies.

2.3 Both the HCP Strategy and nine Health and Wellbeing Strategies are required to be considered, alongside 2023 NHS Planning Guidance, by NHS Cheshire and Merseyside ICB in developing the Five Year Joint Forward Plan by April 2023. This purpose was the driver for having an HCP Strategy available by December. These ICB plans are required to be updated annually, so in support of this regular refreshes of the HCP strategic priorities will be required.

2.4 In developing the draft interim strategy there was a list of areas which DHSC said should be included, and have been considered in developing the HCP strategy:
- personalised care
- addressing disparities in health and social care
- population health and prevention
- health protection

[1] Guidance on the preparation of integrated care strategies

- babies, children, young people and their families, and healthy ageing
- workforce
- research and innovation
- health-related services
- and data and information sharing.

2.5 The local approach has been designed following discussions with a range of stakeholders including HCP founder members meeting in September, Directors of Public Health, Health and Wellbeing Board feedback, ICB Executive and Board discussions, Healthwatch and ICS Population Health Board. The approach taken has been to build from our existing Cheshire and Merseyside strategic plans, and associated documents, pulling the work together into a single strategy.

2.6 This approach has meant the document is relatively lengthy and covers a huge breadth of activity, and the relative maturity and detail of plans is variable.

2.7 The key focus of the draft interim HCP strategy is to reduce health inequalities, and to support this the Cheshire and Merseyside All Together Fairer recommendations and Beacon Indicators are embedded as Strategic Objectives as well as a focus in Section 6 of the draft interim strategy, as well as being a golden thread running through the document.

2.8 Through discussions with our nine Healthwatch organisations we identified a number of challenges being experienced by our communities (Section 4), and which were being reported to them. The document provides information in response to these areas (primarily Sections 6 and 8).

2.9 The content has been further developed through engagement with a range of stakeholders including, Champs Public Health Collaborative, Directors of Public Health, Population Health Board, Health and Wellbeing Boards and subject matter experts related to specific areas such as Healthwatch, ICS programme leads, CVFSE representatives.

2.10 A draft of the document was shared with HCP and ICB Board Members, Health and Wellbeing Boards and a wider range of stakeholders and content contributors, e.g., Population Health Board members, on 1 December 2022 with a large volume of feedback received and incorporated into the latest version of the strategy, appended to this report. The most material revisions made to the document where in relation to:

- Flow and structure of the document; including addition of a section which describes the reason for developing the strategy and key next steps (Section 3)
- Specifically reference prevention in our mission and strategic objectives (Section 5)

- the recently published principles for Health and Wellbeing Boards and Integrated Care Systems when working together[2] (Section 2)
- Integration of the Core20PLUS5 for Children and Young People into our section on Children and Young People (Section 7)
- Focus on reflecting our duties in relation to Equality, Diversity, and Inclusion.

2.11 The Cheshire and Merseyside Joint Health Scrutiny Committee have also received a copy of the report and provided feedback. The feedback received will be used to support development of the plans within individual programmes of work.

3. Recommendations

3.1 The Board is asked to:

- **Note t**he contents of the draft interim strategy
- **Note t**he proposed next steps agreed by the Health and Care Partnership at the meeting of 17th January; including the ICB using the priorities within the draft interim strategy to inform development of the ICB Five Year Joint Forward Plan.

4. Next Steps

4.1 In developing the interim strategy document it was recognised that is to be an interim strategy and that further work was required to refine the content and to identify the priority areas within it over the coming months.

4.2 As such, a further period of engagement has been agreed by the HCP, providing additional time and opportunity to enable the full breadth of HCP member partners to add their perspective and expertise to the strategy and identifying the highest priority areas within it.

4.3 This extended engagement period will also allow us to undertake engagement with our citizens on the priorities and plans, alongside our Place Health and Wellbeing Boards to maintain a single joined up conversation about our plans. It is envisaged that we will utilise existing and established forums across Cheshire and Merseyside to gain further feedback from citizens, the findings of which will be reported back to the HCP.

4.4 Work has commenced to develop a prioritisation framework which will support the refinement process. The core team members include Public Health (Champs/Director of Public Health), ICB, Place leadership, Business Intelligence (Cheshire and Merseyside, CIPHA – Combined Intelligence for Population Health Action, System P and regional Office of Health improvement and Disparities-OHID), a Finance representative and a representative of our communities. The work developing this draft framework is being overseen by our Population Health Board.

[2] health-and-wellbeing-boards-guidance

4.5 The information collected through the population health intelligence will be used to inform a workshop with the HCP in March 2023 to identify the greatest priority work areas within our draft interim strategy and the intention is to ensure the breadth of the HCP membership is included in these sessions in order that all organisations can consider the priorities from a system perspective as well as considering how they may be incorporated into their own organisational plans. This will include the commitments identified in the strategy as “We Will” statements.

4.6 We will also include relevant additional national planning requirements for those areas relevant to the HCP strategy including the national financial and operational planning guidance to the NHS, and the initial guidance from DHSC indicated updated national guidance on ICP (HCP) strategies would be issued “by June 2023”.

4.7 In developing the ICB Five Year Joint Forward Plan the draft interim strategy priorities will be considered, alongside our nine Health and Wellbeing Board priorities and the national universal NHS operational planning priorities for 2023-24

4.8 Developing a financial strategy that complements this work will happen during 2023 in reflection of the budgetary projections.

5. Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neilevans@nhs.net or 07833685764)

NHS Cheshire and Merseyside Integrated Care Board Meeting

Cheshire and Merseyside Health and Care Partnership Interim Strategy

Appendix A: Cheshire and Merseyside Health and Care Partnership draft Interim Strategy

Cheshire and Merseyside Health and Care Partnership (ICP) Interim Strategy

2023-2028

Table of Contents

Section 1 - Foreword

For too long health and care organisations across Cheshire and Merseyside have struggled to bridge the gap between health and social care, ill-health prevention and treatment – despite much well-meaning effort.

The development of Cheshire and Merseyside Health and Care Partnership – our statutory Integrated Care Partnership – provides a once-in-a-lifetime opportunity to combine our efforts and collective resources to make tangible improvements across our communities.

Consisting of representatives from across our communities, the NHS, local authorities, voluntary sector, housing, police, education and fire and rescue, and local businesses our Partnership Board provides a multi-agency forum to assess the health, public health and social care needs of people across Cheshire and Merseyside – and develop a combined strategy to address them.

Joining up health and care is nothing new – we have been working towards this for years and will continue to build on this excellent work by supporting innovation and learning from examples of best practice across Cheshire and Merseyside and beyond.

Tackling health inequalities is our shared key aim. As a 'Marmot Community', we are truly committed to improving the health and wellbeing of our population and in doing so focussing on reducing inequalities.

We are already well-placed to not only understand what the key issues are across Cheshire and Merseyside – but how to measure our collective progress in tackling them.

Published in May 2022, the landmark report All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside features 22 Beacon Indicators to help measure our progress against the key themes.

This strategy sets out how we will work together to address the key challenges facing people across Cheshire and Merseyside. Over the coming year we will work to develop this strategy, and the detailed plans sitting behind it, and as part of this ensure the voice of our communities is at the heart of everything we do.

Cllr Louise Gittins
Chair

Raj Jain
Vice Chair

XXX
Vice Chair (TBC)

Section 2 - About the Health and Care Partnership

Our health is affected by many things outside of our genetic make-up – such as housing, unemployment, socio-economic disadvantage, financial stress, experiences in childhood, domestic abuse, poverty and lifestyle choices. This can only truly be addressed via a partnership between our communities, the NHS, local government, the voluntary sector and others.

For years health services, such as GP practices and hospitals, and care services were run by separate organisations with different objectives. Now, building on ever-closer collaboration, not least in response to the Coronavirus (COVID-19) pandemic, the health service and local authorities have come together with system partners to form Cheshire and Merseyside Health and Care Partnership – our Integrated Care Partnership.

The Health and Care Partnership is currently moving towards operating as a statutory committee consisting of health and care partners from across the region and provides a forum for NHS leaders, local authorities and other key organisations to come together, as equal partners, and take collective action.

A vital role of the partnership is to assess the health, public health and social care needs of Cheshire and Merseyside and to produce a strategy to address them – thereby helping to improve people's health and care outcomes and experiences and ensuring we reduce variation across our communities. In making our decisions on where to invest our resources we will prioritise based on evidence.

By working in partnership, health and care organisations across Cheshire and Merseyside will be better supported to combine our assets to improve efficiency and reduce duplication. By working across Cheshire and Merseyside we can ensure that we learn from each other and adopt what's working well to collectively improve.

The core membership of Cheshire and Merseyside Health and Care Partnership includes:

- NHS Cheshire and Merseyside Integrated Care Board
- Local authority partners
- Ambulance Service
- Police
- Fire and Rescue Service
- Voluntary, community and faith sector
- Local Enterprise Partnership
- Primary care
- Provider collaboratives
- Social care provider
- Adult social care
- Children's services
- Public health
- Carers
- Housing
- Healthwatch
- Education.

Working together as Partners

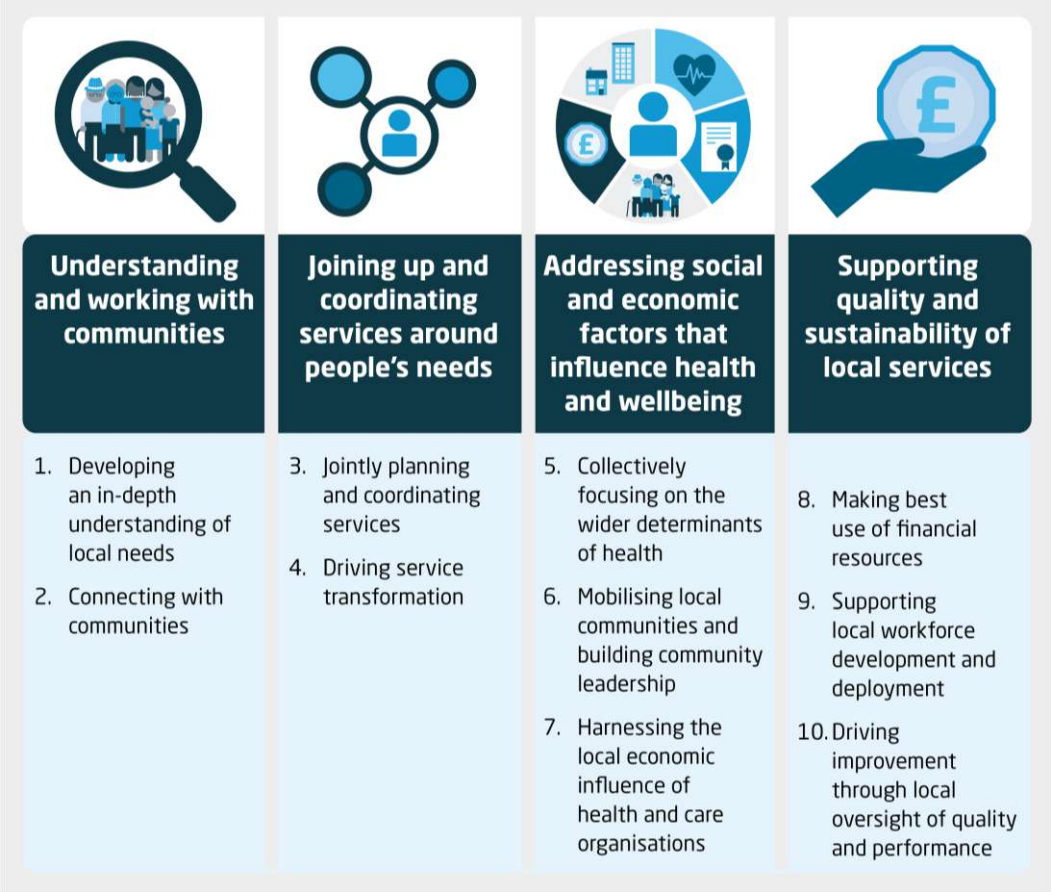
As a Partnership we will apply a set of principles to our relationships, including:

- building from the bottom up
- following the principles of subsidiarity
- having clear governance, with clarity at all times on which statutory duties are being discharged
- ensuring that leadership is inclusive and collaborative
- avoiding duplication of existing governance mechanisms
- being led by a focus on population health and health inequalities.

This strategy builds on local joint strategic needs assessments and health and wellbeing strategies and will be further developed with the involvement of local communities and independent health and care consumer champion Healthwatch. We will ensure that the voice of our population will be central to our planning and decision making. Whilst the document doesn't aim to describe all the work happening across our nine Places in Cheshire and Merseyside it is intended to describe many of the key areas of work being undertaken collectively and which complement existing Health and Wellbeing Board Strategies and Place Plans - hence the inclusion of summaries of Cheshire and Merseyside's nine Place Plans in Section 10.

Much of the work outlined in this document will be delivered in localised Place-based partnerships. The infographic below - courtesy of the King's Fund - sets out the key functions of Place-based partnerships:

Figure 1 Key functions of place-based partnerships



Charles A, Ewbank L, Naylor C, Walsh N, Murray R (2021). Developing place-based partnerships: the foundation of effective integrated care systems. London: The King's Fund. Available at: www.kingsfund.org.uk/publications/place-based-partnerships-integrated-care-systems

Working with people and communities

Across Cheshire and Merseyside, partners are committed to involving people and communities to harness the knowledge and lived experience of those who use and depend on the local health and care system and provide an opportunity to improve outcomes and develop better, more effective services, removing barriers to accessing services where they exist.

Healthwatch, the community, voluntary and faith sector, local authorities, NHS organisations and other partners already have well-established ways of engaging with people and communities, and we need to build on these strengths and assets, and recognising the vital role played in both creating and delivering solutions to local challenges.

If we are to help reduce inequalities and close the gap on the disparities in access to, experience of and outcomes for health and care, we must collaborate, cocreate and

coproduce solutions to the design, development and delivery of local services.

Developed by NHS England, the Local Government Association, Healthwatch England and the National Association for Voluntary and Community Action, the 10 key principles that will guide how we work with people and communities in Cheshire and Merseyside are:

10 key principles	
1. Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS.	**2.** Start engagement early when developing plans and feed back to people and communities how their engagement has influenced activities and decisions.
3. Understand your community's needs, experience and aspirations for health and care, using engagement to find out if change is having the desired effect.	**4.** Build relationships with excluded groups, especially those affected by inequalities.
5. Work with Healthwatch and the voluntary, community and social enterprise (VCSE) sector as key partners.	**6.** Provide clear and accessible public information about vision, plans and progress, to build understanding and trust.
7. Use community development approaches that empower people and communities , making connections to social action.	**8.** Use co-production, insight and engagement to achieve accountable health and care services.
9. Co-produce and redesign services and tackle system priorities in partnership with people and communities.	**10.** Learn from what works and build on the assets of all ICS partners – networks, relationships, activity in local places.

These principles have recently been the subject of national public consultation and published in statutory guidance.

Now Cheshire and Merseyside Health and Care Partnership has been established on a new statutory footing, partners have been asked to endorse and collectively 'sign up' to these principles - as a first step in co-producing a coherent and connected approach to public involvement in Cheshire and Merseyside.

We recognise the incredible contribution made by our communities, with hundreds of thousands of people providing unpaid care to support others, and who freely give their time and skills through volunteering and contributing to developing their local community.

The Voluntary Community, Faith and Social Enterprise Sector

Across Cheshire & Merseyside there are over 15,000 voluntary, community, faith and social enterprise (VCFSE) organisations, ranging from national charities and social enterprises employing a large workforce to informal grassroots and volunteer-led groups supporting people in their local community.

We recognise the key role which the VCFSE sector plays in contributing to the delivery of a population-based model of care in Cheshire and Merseyside, focused on the needs and wishes of individuals. VCFSE help us by working closely with us to shape local services that support both health and wellbeing for local people and deliver choice and person-centred care. Through this document you will see examples of this.

VCFSE are important members of our HCP Board, including holding a Board Vice Chair role, and we will continue to build trusting relationships with VCFSE leadership and providers building our understanding of VCFSE capacity, potential barriers and enablers and opportunities for co-designing population health-based solutions which are embedded in communities.

Building on community assets we will work with VCFSE to identify and explore known and emergent gaps in provision, recognising and harnessing the reach of VCFSE to voices seldom heard and to provide us with the rich insight of VCFSE as a cornerstone of our communities.

In line with our commitment to achieve value for money we see growing investment in VCFSE as an important way of delivering our priorities described in this document. We will support VCFSE to maximise opportunities for non-financial support that builds sector resilience and organisational sustainability including enabling access to VCFSE workforce development at scale.

The HCP will support overarching principles when working with VCFSE:

- Embedding VCFSE as key partners in our processes of planning, service delivery and re-design, co-designing outcomes to maximise the knowledge, data and expertise contained within the sector to deliver evidence-based solutions
- Commitment to supporting VCFSE sector investment, both financially and organisationally and with shared plans, enabling VCFSE to have the capacity to engage as equal partners
- Build on existing infrastructure and VCFSE assets through Place Based sector partnership Infrastructure, VS6 (Liverpool City Region) and CWIP (Cheshire and Warrington).

Section 3 – About this document and our approach to developing this strategy

This document describes our current strategic priorities endorsed as an interim draft strategy by the Cheshire and Merseyside Health and Care Partnership. Whilst many of the partner organisations within our HCP have worked collectively for some years we are now evolving in recognition of the Health and Care Act 2022.

During 2023 we will move the Health and Care Partnership onto a more formal footing by forming a Statutory Joint Committee, and at this point look to formally approve a final version of this strategy.

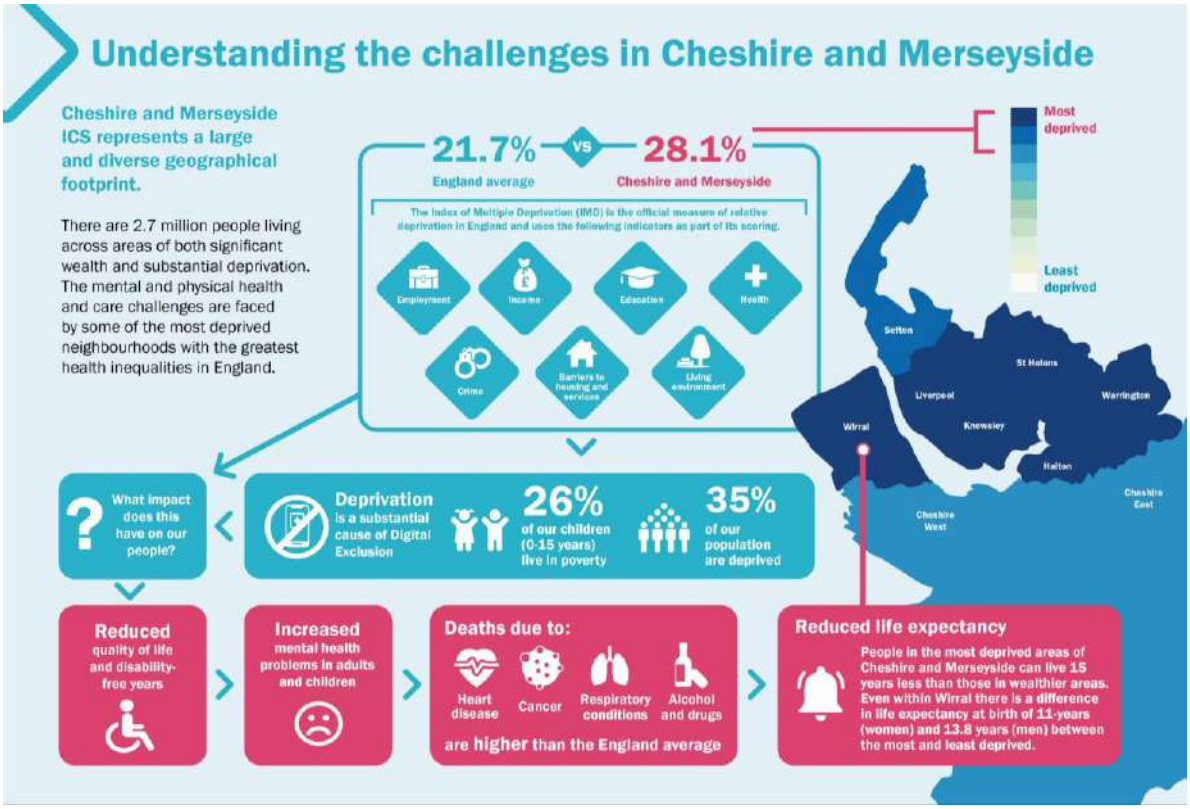
We have developed this interim draft strategy as the start of our journey and it describes the shared areas of focus, we have already been working together on over recent years, as well as reflecting some of the current challenges we face. We recognise that as we develop, in the coming months and years, we will wish to develop and refine the content of our strategy in terms of working with our communities to reassess our priorities and as our relationships as partners mature to identify increasingly integrated innovative solutions to deliver our key shared objectives.

During 2023 we will focus on a number of key activities to further develop this strategy;

- Connect more effectively with our communities to ensure our Place and HCP plans accurately continue to reflect a shared view of our priorities
- Developing a Prioritisation Framework that helps us to ensure our annual plans will deliver the greatest benefit to our population
- Co-producing detailed work programmes which deliver these shared priorities and have clear and measurable outcomes. The work programmes will recognise the response to our immediate service pressures as well as our longer-term objectives
- Agreeing how we measure and report on these outcomes in order that we have trajectories that allow us to assure ourselves as to the progress we are making as an HCP and effectively communicate progress to our population
- Producing a summary version of our strategy, and annual plan, for our citizens, which provides a clear and concise description of our strategic priorities
- Formalising the arrangements of the HCP as a Statutory Joint Committee to oversee finalising this strategy and the associated delivery
- Develop a system financial strategy that supports delivery of this HCP strategy.

Section 4 – Our population profile and challenges

There are long standing social, economic and health inequalities across Cheshire and Merseyside, with levels of deprivation and health outcomes in many communities worse than the national average. There are pockets of deprivation across every one of the nine Places across Cheshire and Merseyside. It is well documented, through evidence-based research, that social deprivation has a direct impact on long-term health outcomes:



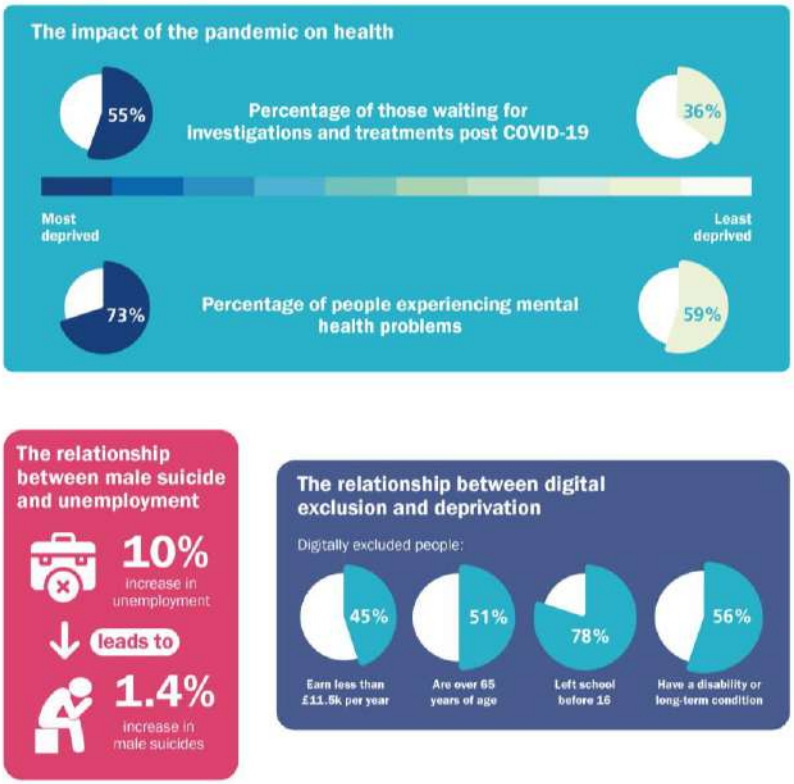
- Life expectancy for women living in most deprived areas across Cheshire and Merseyside is 9.5 years lower than those living in the least deprived
- For women with a learning disability, life expectancy is 18 years lower than those without
- Of the 7% population from ethnic minority population groups, 1/5 experience disproportionate access to services based on language barriers
- Liverpool has comparatively high numbers of asylum seeking and refugee families and who are disproportionately impacted by poverty
- The number of Looked After Children is 47% higher than the England average
- The geography of Cheshire and Merseyside is diverse with a mix of urban but also rural areas which present different challenges in relation to social isolation, limited public transport, increased fuel poverty and loneliness.

Deprivation has a direct impact on mental health and socioeconomically disadvantaged children and adolescents are two to three times more likely to develop mental health problems. One in four people experiencing a mental health problem is in significant debt, and people with mental health problems are three times more likely to be in financial difficulty.[1]

The pandemic has damaged the health of the nation over and above the immediate impact of COVID-19 itself and the numbers awaiting investigations and treatments has increased significantly.

Digital exclusion is another facet of deprivation and socioeconomic inequalities. If the ICS is to drive digital and data enabled improvement to health outcomes, then it is essential to ensure digital skills and access to technologies is in reach for those most in need.

In this complex backdrop digital and data are key enablers to supporting aligned provision and ensure that the public experience maximum benefit from addressing the many factors that impact physical and mental health, wellbeing and independence.



In responding to these challenges, we are faced with increasing need and demand for services both resulting from the impacts of COVID-19, cost of living crisis and an ageing population at the same time as budgetary and workforce pressures. The challenge of sustaining health and care services in parallel to delivering our strategic intent to reduce inequalities and prevent ill health is a real challenge and we recognise the need to innovate and do things differently is key to responding to this.

Listening to you - the Healthwatch perspective

The COVID-19 pandemic combined with cost-of-living pressures have exacerbated inequity in access to health and care services across Cheshire and Merseyside.

Many people struggle to get GP appointments, find it difficult to get through on the phone and – when they do – often complain about the difficulty accessing an appointment. While the introduction of telephone and online consultations during the COVID-19 response was entirely appropriate, they do not work for all – for example people with hearing loss, non-English speakers, people without access to online options, and people who may struggle to communicate without face-to-face contact.

There is inconsistency in arrangements from practice-to-practice. More work is required to raise awareness and understanding of the different roles in general practice – and what they can and can't help people with.

Even greater issues around access are noted in NHS dentistry, with a huge number of people unable to register with an NHS dentist and access appointments.

Those living in areas of deprivation or with more difficult lives are more likely to suffer as a result because people who are either not registered with a dentist or who have missed a legacy appointment find it harder to get dental care. Find there are no appointments left and some are faced with the only availability being to look out of their local area, an option which is not viable for many due to the related time and cost implications. For some, there is also a danger that long waits for treatment mean slower diagnosis of serious conditions, such as throat cancers.

More people have been waiting for elective/planned care and this can have a serious impact on people's mental health and pain management, with a lack of communication often leading to an impact on other health and care services.

Accessing social care is often difficult too, with many care packages offered during the COVID-19 response now being reassessed, and the impact of the significant problems with recruiting and retaining social care workforce.

The impact of COVID-19 and repeated lockdowns on people's mental health was profound – both for those with existing mental health conditions and those without. There are pockets of excellent work across Cheshire and Merseyside to help support people, but do not address the variation and inconsistency that exists, with more isolated communities typically less well-served. Waiting lists for diagnosis and access to mental health support remain long.

The impact of Covid-19 on our children and young people has been highlighted with factors such as missed schooling, delays accessing services and the consequent impact on mental health and future life opportunities.

Cost of living pressures are impacting people's ability to travel to care appointments, while there is anecdotal evidence of people being forced to choose which medications to proceed with on their prescriptions. There are also hidden costs for people who either receive care or care for themselves at home – for example, the cost of charging medical equipment or calling their local GP practice or hospital.

Person-centred hospital discharge processes are not consistently embedded. Too many patients stay on wards for too long, not just because of the lack of packages of care outside of hospital but because of inconsistent discharge processes. Every person who arrives on the ward should know when they are due to leave and what the criteria for discharge is. Lack of communication with patients and their families can lead to an over-reliance on services and a deterioration in people's physical and mental health.

It is concerning when access to urgent care support is not easy, whether through primary care, social care, ambulances, accident and emergency departments or the various other services.

As a result of health and care integration, opportunities to learn from good and less good practice and from patient feedback must be seized and shared – for example patient complaints, concerns, and compliments.

We are committed to working with our public, VCFSE, Healthwatch and system partners recognising that the knowledge of how services are, and should, work is best understood in local communities.

Section 5 - Our Vision, Mission and Objectives

Our Strategic Objectives

Tackling Health Inequalities in outcomes, experiences and access (our eight Marmot principles)

We will:

- 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
- Create fair employment and good work for all
- 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
- Tackle racism, discrimination and their outcomes
- Pursue environmental sustainability and health equity together.

We have also developed a set of "Beacon Indicators" to support measurement of our progress. We are developing improvement trajectories to measure progress in our delivery plans.

Improve population health and healthcare

We will:

Focus on prevention of ill health and improved quality of life by:

- Delivering the Core20plus5 clinical priorities for adults and children and young people
- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity, respiratory illness and smoking as well as harm from alcohol
- Improve early diagnosis, treatment and outcome rates for cancer
- Reduce maternal, neonatal and infant mortality rates
- Improve satisfaction levels with access to primary care services
- Improve waiting times for elective and emergency care services
- Improve diagnosis and support for people with dementia
- Provide high quality, accessible safe services
- Provide integrated, accessible, high quality mental health and wellbeing services for all people requiring support.

Enhancing productivity and value for money

We will:

- Develop a financial strategy focused on investment on reducing inequality and prioritise making greater resources available for prevention and well-being services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole system plans to address workforce shortages and maximise collaborative workforce opportunities
- Develop a whole system estates strategy
- Develop a thriving approach to research and innovation across our Health and Care Partnership.

Helping to support broader social and economic development

We will:

- Embed, and expand, our commitment to social value in all partner organisations
- Develop as key Anchor Institutions in Cheshire and Merseyside, offering fair employment opportunities for local people
- Promote our involvement in regional initiatives to support communities in Cheshire and Merseyside
- Implement programmes in schools to support mental wellbeing of young people and inspire a career in health and social care
- Work with Local Enterprise Partnerships to connect partners with business and enterprise.

During 2023 a comprehensive set of measurable indicators and improvement trajectories will be developed to enable us to demonstrate progress against our priorities.

Section 6 – All Together Fairer - Tackling health inequality, improving outcomes, experiences and access to services

In 2019, health and care leaders across Cheshire and Merseyside outlined their collective commitment to tackling health inequalities by agreeing to become a "Marmot Community". Following unavoidable delays due to the COVID-19 pandemic, nine Place-based workshops were held across Cheshire and Merseyside in November and December 2021, attended by a wide-range of health, care and voluntary sector leaders.

Health inequalities are avoidable and unfair differences in health status between groups of people or communities. The All Together Fairer programme deliberately and specifically focuses on social determinants of health as our health is largely shaped by the social, economic and environmental conditions in which we are born, grow, live and work in.

Shifting to a social determinants of health approach means acting on the drivers of ill-health as well as treating it. The prevention agenda must focus on improving living and working conditions and reducing poverty, as well as promoting healthy behaviours. It is almost impossible to live healthily when in poverty.

Social determinants of health are encompassed by the eight Marmot principles, which Cheshire and Merseyside Health and Care Partnership has adopted in full.

Local authorities and the NHS cannot take on the required actions to reduce health inequalities alone, however. Partnership working with the voluntary, community, faith and social enterprise sector and other public services and businesses to influence wider conditions is required. In addition to the eight Marmot principles, Cheshire and Merseyside

A learning framework including social and cultural factors, capability and skills development will be used to drive social value-based approaches to health improvement. Capability will be developed to support delivery of the ambitions in 'Place-based All Together Fairer' programmes, linked with other local government activity and complement Cheshire and Merseyside-wide work.

There is already a strong theme of working the programme through local Health and Wellbeing Boards and into wider local government strategy.

Health and Care Partnership has taken on board the following system-wide recommendations for action:

We will:

1. Increase and make equitable funding for social determinants of health and prevention
2. Strengthen partnership for health equity
3. Create stronger leadership and workforce for health equity
4. Co-create interventions and actions with communities
5. Strengthen the role of business and the economic sector in reducing health inequalities
6. Extend social value and anchor organisations across the NHS, public service and local authorities
7. Develop social determinants of health in all policies.

And:

- Use our agreed set of local Marmot "Beacon Indicators", developed in partnership with hundreds of local stakeholders, to help Cheshire and Merseyside Health and Care Partnership to monitor delivery or our actions on the social determinants of health.
- Take action required across **all** the areas to help reduce health inequalities.

Prevention pledge

The NHS Prevention Pledge – aims to improve the health of our population and is already adopted by a number of NHS Trusts across Cheshire and Merseyside – is aimed at embedding ill-health prevention within core service delivery and Trust environments. It comprises **14 core commitments** on cross-cutting prevention themes including:

- Reduction of preventable risk factors e.g., healthier catering offer, smokefree sites
- Workforce development, staff health and wellbeing
- Increasing social value and working towards Anchor Institution principles
- Working with partners at Place to build community capacity e.g., social prescribing
- Addressing health inequalities and strengthening diversity and inclusion.

The Prevention Pledge takes a system-wide approach to promoting wellbeing and tackling health inequalities. Working in tandem with the Cheshire and Merseyside Marmot Community Programme, the Prevention Pledge supports NHS Trusts to address findings from the Public Health England 'Disparities Review' published in 2020 and NHS England's Core20PLUS5 initiative.

Many of the Pledge commitments align with the themes set out in the review including the impact of obesity, diabetes, cardiovascular disease, COVID-19, mental wellbeing, increased alcohol consumption, poor diet, increased deconditioning and the impact on unemployment and inequalities.

We will:

- Work to ensure all NHS Trusts across Cheshire and Merseyside have adopted the NHS Prevention Pledge in full
- Ensure prevention and reduction of health inequalities features as a key priority across all Cheshire and Merseyside NHS Trust corporate strategies
- Expand the Pledge to providers across our wider system.

Responding to cost-of-living pressures

There is strong evidence that living in cold homes exacerbates a wide range of physical and mental health conditions, with prevalence expected to increase throughout winter 2022-23.

Data from 2020 shows that a higher percentage of homes in Cheshire and Merseyside are estimated to have experienced fuel poverty than in England as a whole.

Worrying about having enough money to pay bills or buy food can lead to stress, anxiety and depression. Being unable to afford sufficient food leaves people malnourished. Being unable to keep a home warm leaves people at risk of developing respiratory diseases at a time of year when respiratory admissions to hospital typically surge. As respiratory admissions rise, A&E performance typically declines, leading to reduced flow through hospital and ambulance teams less able to reach acutely ill patients at home.

Taking action:

Each Place, alongside NHS Providers, has carried out an assessment to benchmark current activity on tackling fuel poverty against National Institute for Health and Care Excellence (NICE) guidance.

Examples of good practice at Place-level in responding to fuel poverty include:

- Adding “vulnerability to cold” to assessments prior to discharge from health or social care settings to home
- Supporting eligible people to access fuel grants and benefits
- Triangulation of data to help identify those most at risk
- Promotion of optimised care for people with Chronic Obstructive Pulmonary Disease (COPD)
- Inclusion of cold home risk assessment in Fire and Rescue Service “safe and well” checks.

We will:

- Take action to help address the impact of cost-of-living pressures; sharing good practice across our Places
- Work to reduce deprivation and income inequality
- Work to improve housing quality and energy efficiency
- Address health needs via NHS interventions.

Section 7 - Improve population health and healthcare

We are committed to improving the health of our population with our key focus of reducing inequalities and increasingly prevention of ill health and poor outcomes described earlier.

The Cheshire and Merseyside system is diverse, and this section of our strategy describes some of the collective programmes we are working on. There is a wide range of other priorities which aren't described here but are equally important to us, including long term conditions, life limiting illnesses and a range of other vital services which our population relies upon, and which work takes place at either a regional or Place based level.

Our approach to population health builds on the existing successful joint working and progress made with our Population Health Board coordinating this activity and linking our programmes together, under the leadership of our Directors of Public Health and Champs Public Health Collaborative.

Core 20 Plus 5:

Core20PLUS5 is a national approach to inform action to reduce healthcare inequalities. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focus clinical areas requiring accelerated improvement.

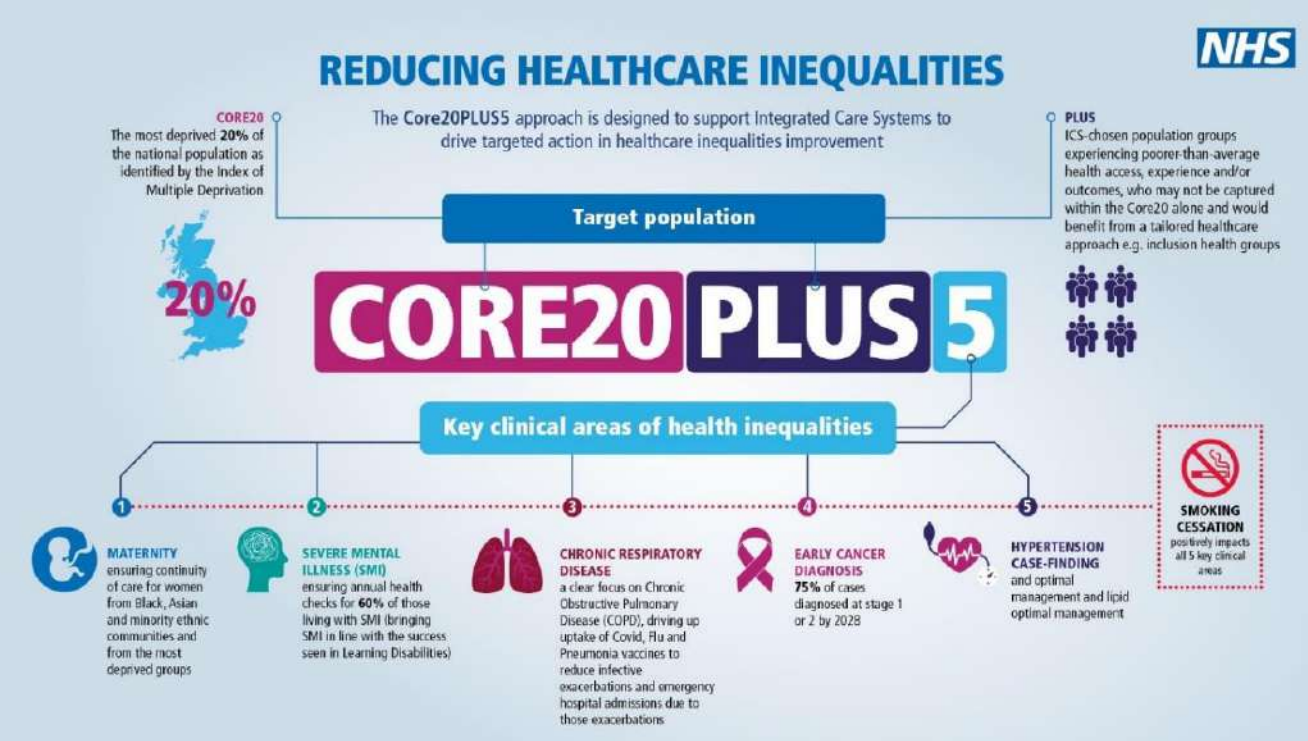
Core20

The most deprived 20% of the national population. For Cheshire and Merseyside this is more than 900,000 of our 2.7m population.

PLUS

PLUS population groups are groups who may be excluded in society, often referred to as "groups". In Cheshire and Merseyside, we do this in our Places where the variations in our population make up can be best reflected.

Inclusion health groups include: people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and wider socially excluded groups.



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There are five clinical areas of focus which require accelerated improvement.

Maternity

We will ensure continuity of care is the default model of care for all women most at risk in pregnancy including those from ethnic minority population groups and from the most deprived groups.

Severe mental illness

We will ensure annual health checks for 60% of those living with severe mental illness. This sits as part of our wider Mental Health programme of work described later.

Chronic respiratory disease

The Cheshire and Merseyside Respiratory Network – which consists of clinicians, commissioners and patient representatives – has agreed a number of key priorities.

We will:

- Implement four key pathways to improve the speed and accuracy of diagnosis and quality of care in relation to breathlessness, obstructive sleep apnoea, asthma and chronic obstructive pulmonary disease (COPD)
- Continue to support greener prescribing of asthma inhalers and expand smoking cessation services – including the CURE programme - to all NHS Trusts across Cheshire and Merseyside
- Intensify efforts to reduce maternal smoking

- Improve access to pulmonary rehabilitation including the short-term reduction in waiting times and developing and implement a Cheshire and Merseyside-wide pulmonary rehabilitation programme which offers services closer to home, harnesses new ways of working and adopts a population health approach
- Drive up uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

Early cancer diagnosis

The Cheshire and Merseyside Cancer Alliance – accountable to NHS England – leads on cancer on behalf of the Integrated Care System. It is an NHS organisation that brings together healthcare professionals, providers, commissioners, patients, cancer research institutions and voluntary sector partners to improve cancer outcomes.

The Cancer Alliance supports innovation and strategic commissioning to ensure the long-term sustainability of modern and effective cancer services and has six core workstreams:

- Prevention and early detection
- Primary care
- Faster diagnosis
- Personalised care
- Workforce
- Health inequalities and patient experience.

Further details here.

We will:

- Work collaboratively across Cheshire and Merseyside to build on best practice and implement new initiatives to prevent cancer and reduce inequalities
- Support Primary Care with the implementation of the early cancer diagnosis agenda, including initiatives to increase cancer screening
- Reduce waiting times for diagnosis and treatment
- Work with healthcare professionals to provide improved, personalised, and faster treatments and care
- Invest in the skills and education of cancer professionals and support workers
- Reduce unwarranted variation in care, access, experience, and outcomes
- Reduce health inequalities for vulnerable communities, who have been affected by cancer.

The Cancer Alliance's Health Inequalities and Patient Experience Team has been nominated for a number of high-profile awards, for our targeted work to reduce inequalities. As an example of this we undertook a successful campaign to increase awareness of the heightened risk of prostate cancer in Black men, compared to the rest of the population.

Cardiovascular disease (CVD)

Cheshire and Merseyside's cardiovascular disease (CVD) programme seeks to support our communities to have the best possible cardiovascular health.

The programme is supporting recovery from the impact of the COVID-19 pandemic on key CVD risk factors and, as a minimum, will achieve the national ambitions for their detection and management by 2029 – with year-on-year progress being made towards that goal.

In the short-term, a CVD, stroke and respiratory dashboard will be further developed to enable greater understanding of CVD inequalities across Cheshire and Merseyside to support targeted interventions – particularly among underserved communities.

A range of approaches in different health and community settings will make every contact count and improve the systematic and targeted detection, diagnosis, management and control of conditions, while flagship digital innovations and programmes will facilitate widespread adoption of new delivery models and quality improvement work e.g. BP@home, Digital First in Primary Care, Virtual Wards and apps.

Happy Hearts

Visit the happy hearts website for more information.

By 2024 we will:

- Have diagnosed and optimally treated 25% of those with familial hypercholesterolaemia.

By 2029 we will:

- Have detected at least 85% of those with Atrial Fibrillation & anticoagulated 90% of those at high risk of stroke
- Have diagnosed at least 80% of those with high blood pressure & be treating 80% of them to target
- Have provided at least 75% of the people aged 40 to 74 with a validated CVD risk assessment and cholesterol reading and 45% of those at highest risk of CVD will be treated with statins
- Have reduced the numbers of strokes and heart attacks.

Smoking

In addition to the "5" clinical focus areas we recognise that smoking impacts across all the five, and our population more generally.

We will:

- Focus on reducing smoking prevalence through not only existing Place-based community smoking cessation activities but we will prioritise implementation of the NHS tobacco dependency treatment pathways in maternity, mental health and acute inpatient services
- Aim to reduce smoking prevalence rates from 12.5% to 5% by 2030.

Children and Young People

As a partnership we have an established Cheshire and Merseyside's children and young people's transformation programme (Beyond). This works collegiately with the Cheshire and Merseyside Directors of Children's Services (DCS) Forum to ensure there is an agreed set of priorities and objectives.

With its multi-agency focus on prevention and early intervention, Beyond supports our key strategic objective to give every child the best start in life, with programme priorities explicitly designed to tackle local challenges in innovative ways.

The voices of children and young people and their families / carers are key to delivery and links are establishing with Place participation partners to inform ongoing design and delivery of our approach through co-production.

We are planning to create a joint three-year strategy and a Children and Young People Partnership Board for Cheshire and Merseyside which is accountable to NHS Cheshire and Merseyside and brings together the work of the Beyond Transformation Programme, the Directors of Children's Services Forum and the range of work across the whole system which contributes to better outcomes for children and young people.

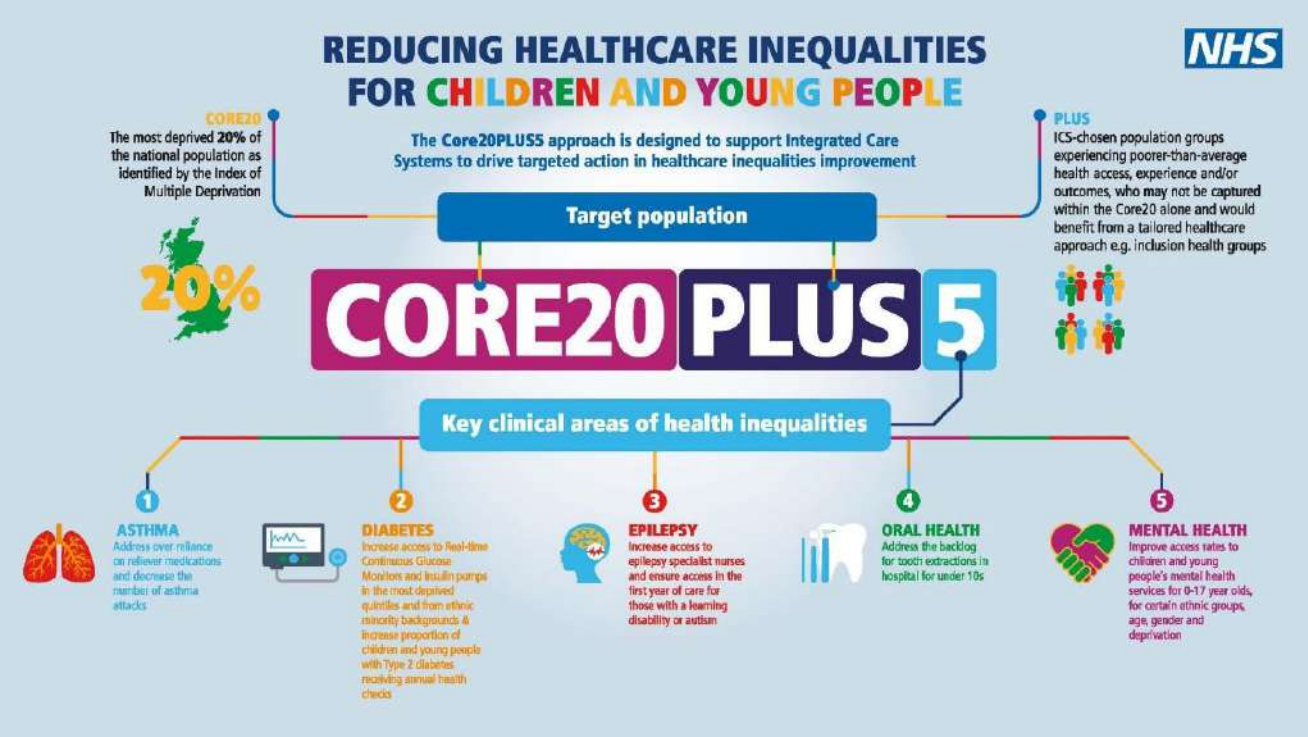
All priorities are linked to the crosscutting Starting Well themes, **CORE 20+5 for CYP** and Marmot indicators to ensure a population health approach aimed at tackling the wider determinants of health inequalities.

We will:

- Listen to children, young people and their families to co-create solutions that work for them
- Establish a single line of sight of the outcomes for CYP, driving improvements in health and social care to address the impact of health inequalities
- Deliver programmes of work in line with CORE 20+5 for CYP
- Work in partnership between Social Care, Health and the Third Sector. support preventative work, spreading examples of good practice
- Implement targeted interventions around alternatives to hospital care, reducing variation in diabetes and epilepsy care and early intervention around healthy weight and obesity
- Implement the recommendations of the Asthma Bundle
- Deliver the ambition of the national Family Hubs and Start for Life programme (2022-2025), including strengthening the work of Children's Centres

- Establish multi-agency “gateway” meetings in all nine Places to support children in crisis
- Develop a model of best practice for safe places for CYP who need alternatives to hospital care due to emotional well-being or social needs
- Implement a health and care workforce strategy and plan for Cheshire and Merseyside that supports integration and collaboration.

The national approach to Core20PLUS5 has identified a range of priorities to improve the health of children and young people and which we will deliver through our Beyond Programme.



We will:

- Address over-reliance on reliever medications and decrease the number of asthma attacks
- Increase access to real-time glucose monitors and insulin pumps in the most deprived quintiles and from ethnic minority backgrounds and increase proportion of CYP with type 2 diabetes receiving annual health checks
- Increase access to epilepsy specialist nurses and ensure access in the first year of care for those with a learning disability or autism
- Address the dental backlog by increasing the number of tooth extractions, in hospital, for children aged 10 years and under
- Improve access rates to CYP mental health services for 0–17-year-olds, certain ethnic groups, age, gender and deprivation.

PLUS

In delivering our objectives we have a focus on ensuring we prioritise our PLUS population groups. With specific consideration being taken for the inclusion of young carers, looked after children/care leavers and those in contact with the justice system.

Maternity Neonatology and Women's Health

The recently published Women's Health Strategy for England has highlighted the significant inequalities that women face in accessing and receiving health care compared to men. We are committed to addressing the issues outlined in this report and reducing gender and intersectional gender health inequality.

This includes working closely with our communities to co-design solutions and overcome barriers to accessing services such as language barriers, poor experience of care and the impacts of poverty and exclusion.

In addition to the collective work happening across Cheshire and Merseyside our Places work on a range of complementary priorities; e.g. increasing rates of breast feeding.

We will:

- Develop a co-produced women's health strategy for Cheshire and Merseyside
- Accelerate preventative programmes to reduce the risks to women, birthing people, and their babies from ethnic minority population groups, socially deprived, under-represented and protected characteristic groups

- Continue to co-produce interventions and services with all women and birthing people across Cheshire and Merseyside and implement recommendations from the National Maternity Transformation Programme to improve the safety and outcomes for maternity and Neonatal services
- Continue to prioritise the restoration of gynaecological services, surgery and screening, post-pandemic
- Deliver actions identified in the national women's health strategy and continue to deliver key priority and preventative

programmes in response to population need

- Support maternity providers to deliver the priorities outlined in national reviews of services and strategies, e.g. Ockenden and East Kent, and the new single delivery plan to improve the safety and care of maternity and neonatal services, and digital strategy
- Further develop community hubs for maternity and women's health across Cheshire and Merseyside.

Learning Disability and Autism

On average people with a learning disability and / or autism die 22-26 years earlier than the general population. This makes it crucial that, as a Health Care Partnership, we tackle the long waits people can experience accessing a diagnosis and treatment for their learning disability or autism and take specific action to tackle health inequalities in access to physical health care.

We have established processes to ensure we codesign improvements to services, working with service users, experts by experience and self-advocates.

We will:

- Ensure people receive services in appropriate environments by reducing the number of people in specialist in-patient services to no more than 70 adults and 11 people under 18 per million of the population by March 2024
- Reduce unnecessary emergency admissions to hospital and support increased discharges through ongoing development of community services and collaborative working by March 2025
- Reduce the gap in life expectancy for people with a learning disability and / or autism compared to the general population by at least 20% by 2028
- Increase the percentage of people with a learning disability and/or autism or who receive an annual health-check and a health care plan to at least 85% by 2028
- Implement the new learning from death reviews (LeDeR) policy to review the deaths of people with a learning disability and identify learning, opportunities to improve and promote good practice
- Work with partners to redesign pathways to reduce waiting times for autism assessment and diagnosis
- Continue to develop services to support schools, children and young people in crisis and their families, children and young people with autism, eating disorders and issues relating to transgender
- Develop a digital single point of access for emotional health and wellbeing. In support of the Transforming Care programme – for children and young people with learning disabilities and / or autism – ensure key workers are in place across Cheshire and Merseyside and that young people aged 14+ have access to annual health checks and personalised care short breaks.

Mental Wellbeing

The Government's Prevention Concordat for Better Mental Health is underpinned by a prevention-focused approach to improving people's mental health and helping to achieve a fairer and more equitable society.

In Cheshire and Merseyside our CHAMPS public health collaborative is leading delivering on the Consensus statement by addressing the following factors:

1. **Protective factors** – maternal and infant mental health, early years support, family and parenting support, connecting with others and forming good relationships, good education, stable, secure, good quality and affordable housing, good quality work, a healthy standard of living, accessible safe and green outdoor space, arts and cultural activities, community cohesion.
2. **Risk factors** – poverty, socio-economic inequalities, child neglect and abuse, unemployment, poor quality work, debt, drug and alcohol misuse, homelessness, loneliness, violence, discrimination of any kind.

We will:

- Using population health intelligence, research and engagement to better understand local needs, performance and identify gaps
- Work collaboratively to ensure all parts of the system are working effectively to deliver on mental health inequalities, linking work areas to the population health board and mental health oversight group
- Take action on prevention / promotion of positive mental health to help reduce mental health inequalities
- Use innovation through commissioning community-based schemes e.g. arts, culture and creative health interventions
- Define performance indicators and outcome measures and report on progress quarterly
- Follow the leadership of the lead Director of Public Health for Suicide Prevention and Mental Health and governance by the Mental Health Oversight Group and the Population Health Board.

Mental health

We have established a Mental Health Programme, with oversight of the implementation of the NHS Long Term Plan ambitions for mental health and drives delivery of whole system all age mental health transformation.

The programme leads on priorities deemed best undertaken 'at scale' – as agreed by commissioners, public health representatives, North West Ambulance Service, Police, local authorities and voluntary sector representatives.

We will:

- Continue to roll out school / college-based Mental Health Support Teams
- Work with the ambulance service, Police, hospitals and local authorities to address delays in Mental Health Act assessment processes
- Continue to recruit Mental Health Practitioner roles for primary care
- Implement a First Response Incident Support Service to enable an appropriate health response to mental health crisis
- Continue to increase the range of alternative crisis services to A&E and hospital admission

- Develop a specialist Perinatal Mother and Baby Unit
- Establish places of safety outside of emergency departments in all of Cheshire and Merseyside's nine Places
- Reduce care variation by standardising care pathways through strong Place-based partnerships
- Use artificial intelligence and modelling to support better anticipatory care models in mental health services, risk management in inpatient services and earlier intervention in community-based services.

Suicide Prevention

Our aspiration is for Cheshire and Merseyside to be a region where all suicides are prevented, where people do not consider suicide as a solution to the difficulties they face and where people have hope for the future. Our mission is to build individual and community resilience to help improve lives and prevent people falling into crisis by tackling the risk factors for suicide.

The focus for the system's suicide prevention, suicide bereavement and mental wellbeing work programmes are aligned to the key priorities within the new No More Suicide Strategy:

a. **Leadership and Governance.** Ensuring an effective partnership and collaborative approach taking account of lived experience

b. **Prevention.** Focusing on awareness, skills, and knowledge, supporting suicide prevention in other strategies and work programmes, and through communication and engagement

c. **Intervention.** Focusing on training and safety planning across the organisations working to improve self-harm support and pathways, improving access to mental health support, and ensuring implementation of safe care

d. **Postvention.** Focusing on bereavement services, including postvention support and working with the media

e. **Data, Intelligence, Evidence, Research.** Focusing on better data capture. Evidence on interventions that work and supporting research where there are known gaps.

We will:

- Develop a system action plan to follow the new Suicide Prevention strategy
- Increase awareness of suicide risks, promote suicide prevention messaging and promote suicide bereavement support services
- Build capability and capacity of the wider workforce within the suicide prevention network
- Work with Mental Health Trusts to implement safer care standards across Cheshire and Merseyside
- Ensure data and research on suicide prevention and suicide bereavement is fed into all areas of suicide prevention and bereavement work
- Maintain and strengthen the Real Time Surveillance systems in Cheshire and Merseyside
- Implement a commissioned 'postvention' service offering resources and support to people bereaved and affected by suicide
- Create more peer-to-peer support groups.

Dementia

In parts of Cheshire and Merseyside the rates of dementia are higher than the national average, reflecting the age profiles in our communities, and improving dementia care is important for our population across our nine Places.

We will:

- Consistently, across our Places, exceed the national standard of 66% of expected dementia diagnosis rates
- Offer personalised care through the use of innovative digital technology and our integrated community multidisciplinary teams support to help more people live independently for longer
- Provide support to carers.

Reduction of harm from alcohol

Our strategic aim across Cheshire and Merseyside is to deliver preventative and treatment interventions that reduce alcohol harm and drug dependency through proactive co-production and delivery. This complements a range of local activity being delivered in our Places.

We will:

- Support prevention, detection and early intervention – for example through expansion of projects with the Police and homeless charities
- Work with the Cheshire and Merseyside Pathology Network to develop an intelligent liver function test (iLFT) programme which all GPs across Cheshire and Merseyside are able to access
- Ensure that, by 2028, people transitioning from hospital to community on an alcohol pathway will wait no more than seven days to be seen - improving the care people receive and reducing the risk of readmission including expansion of alcohol care teams.

Addressing Overweight and Obesity

Overweight and obesity is a significant problem across Cheshire and Merseyside affecting populations across the life-course. National Childhood Measurement Programme data for Year 6 overweight and obesity figures in C&M shows that five of the nine local authorities perform worse than the England average. Over 60% of the adult population within C&M are overweight or obese, with 59% of GP practices in the sub-region having an obesity prevalence higher than the national average.

We are supporting local authorities to address overweight and obesity through the Food Active programme, and delivering a new system-wide Strategic Overweight and Obesity Programme with the aim of addressing the social, environmental, economic and legislative factors that influence healthy weight, with a specific focus on areas of higher deprivation.

All Together Active – Physical Activity

We want a Cheshire and Merseyside in which far fewer people suffer health inequalities resulting from physical inactivity by encouraging and supporting people to move more, removing barriers to participation in physical activity and increasing opportunities to be physically active and get involved in sport.

We will:

- Support each of Cheshire and Merseyside's nine Places to further develop opportunities to use physical activity as a way of improving population health
- Work to embed movement, physical activity and sport across the Cheshire and Merseyside health and care system
- Have empowered 150,000 inactive people to become more active by 2026, while delivering measurable reductions in health inequalities.

www.champspublichealth.com/all-together-active

Case studies and good practice can and will be found in the ATA Resource Hub.

ALL TOGETHER ACTIVE
Working as one to build a more active, fairer and healthier Cheshire and Merseyside

Carers

Scoping work across Cheshire and Merseyside in July 2022 estimated that there are around 60,000 adult carers registered with commissioned carer support organisations, while more than 3,500 young carers are registered with local commissioned young carer services. [1]

A new strategic system-wide Carers Partnership Group for Cheshire and Merseyside has been established with representation from local authorities, voluntary sector organisations, NHS England, providers and carers with lived experience. Supported by the NHS England national / regional carers team, it reports into the Health and Care Partnership Board. Our mission is to work in partnership with carers and carer support organisations to develop and implement a Carers Strategic Framework for Cheshire and Merseyside. Our vision is for all carers in Cheshire and Merseyside to have the support they need and recognition they deserve.

In line with the NHS Long Term Plan, we will:

- Identify and support carers, particularly those from vulnerable communities
- Adopt carers passports / introduce best practice quality markers in primary and secondary care
- Share caring status with healthcare professionals wherever they present via electronic health record

[1] Carers on the Frontline – A strategic framework for carers in Cheshire & Merseyside

- Ensure carers understand the out-of-hours options available to them via 'contingency planning' conversations and have appropriate back-up support in place for when they need it. Electronic health records will enable professionals to know when and how to call those plans into action when they are needed
- Implement young carer "top tips" for general practice to include preventative health approaches, social prescribing and timely referral to local support services.

End of Life Care

We are committed to ensuring that when a person reaches the end of their life that they will be supported to die well, with peace and dignity, in the place where they would like to die, supported by the people important to them. End of life care will be personalised to the person who needs it and wants it, available regardless of where they live in Cheshire and Merseyside, or what their illness is and whether an adult or a child.

We will raise public awareness of death and dying so the people of Cheshire & Merseyside are confident enough, and willing to support each other in times of crisis and loss so that at the end of their life people are:

- Treated with compassion and respect
- Helped to remain as independent as possible with a sense of control throughout the course of their illness, supported by skilled, knowledgeable, health and care professionals
- Supported by staff trained to help them to think and plan ahead, if they want to, so they are able to discuss their wishes and preferences of care
- Assured that the needs of their family and those identified as important to them are respected and met, as far as possible during their illness and after their death
- Reviewing and developing services to support end of life care for children and young people in line with the national service specification.

Personalised care

- Personalising health and care is the practice of enabling people to have choice and control over the way their care is planned and delivered, based on what matters to them and their individual strengths, needs and preferences.

Our key guiding principle will be 'what matters to me', enabling service users to have greater control. We will work with our communities to embed personalised care approaches (Shared Decision Making, Personalised Care and Support Planning, Supported Self-Management, Personal Health Budgets, Choice, Community based support) in all our programmes of work and pathways developed across our partnership.

We Will:

- Use MECC (making every contact count) to embed conversations about health and healthy behaviours into day-today conversations and signpost people to support if needed
- Using social prescribing to ensure people have access to available options to support their self-management such as peer support, health coaching, and support groups in the wider community
- Expanding the knowledge, skills, and confidence of those providing services by training in personalised care approaches such as health coaching, personalised care and support planning, and motivational interviewing
- Extend the offer, support, and use of Personal Budgets for locally agreed priorities such as Children and Young People short breaks.

Adult Social Care

The pressures being seen in adult social care have been increased since the Covid 19 Pandemic adult social care is experiencing significant pressure from:

- Increased referrals for support and increasing levels of need from our population
- Challenges supporting people who need to be discharged from Hospital
- Challenges in sustaining capacity in both the residential and nursing home sector and for home care provision including recruiting and retaining sufficient workforce and maintaining independent sector provider sustainability
- We are seeing a growth in our older population, who in turn are the main users of services leading to increased demand
- The financial and consequent physical and mental health and wellbeing issues being faced as a result of the cost-of-living challenges.

As partners we are committed to innovating to ensure people have access to the services, they need including ensuring we maximise access to technology and support, whilst also delivering a wider prevention offer that enables people to live as long as possible independently with good health and wellbeing.

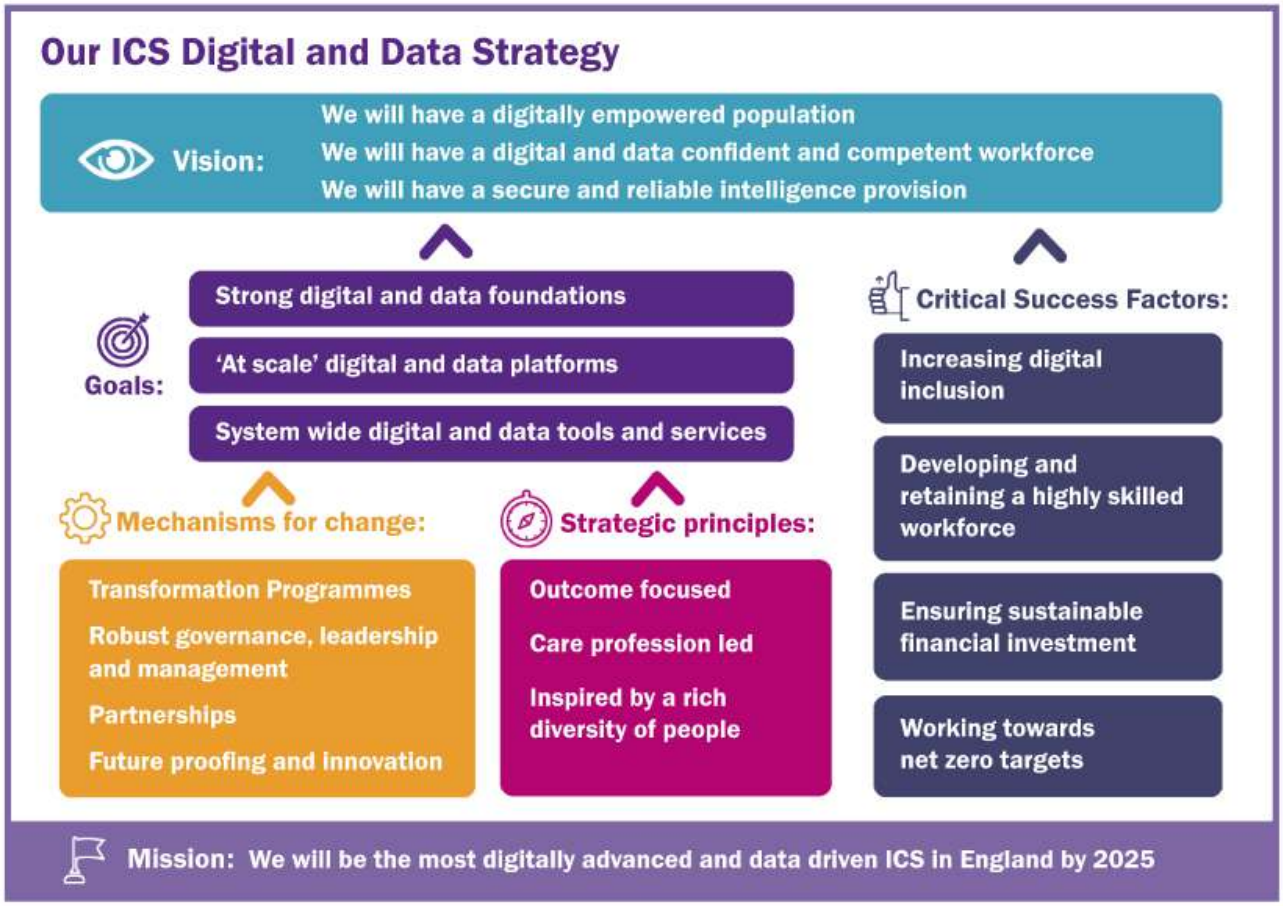
We will:

- Improve access to Home Care and Extra Care Housing, in order to reduce the number of people needing to rely on Residential and Nursing Homes
- We will work with the care market and increase capacity and sustainability
- We will reduce the time spent in hospital by people awaiting access to social care
- We will expand the adult social care workforce by making it an attractive place to work and aligned with our social values and wider workforce plans described elsewhere in this document
- We will build on shared solutions across organisations and communities to maximise expand access to digital and technology that supports our residents.

Digital and Data

Cheshire and Merseyside have ambitious, and highly innovative, plans to be a system where we use data and digital to turn intelligence into action. Our digital and data strategy is the key driver for investment in key IT systems and underpinning IT infrastructure to support health and care delivery.

The data generated supports health and care professionals to better target care and, therefore, better meet the health and care needs of the population. There has been rapid adoption of digital tools such as team collaboration software, video consultations, remote monitoring and the adoption of digital diagnostics, which has changed the way health and care staff work. We have recently updated our digital strategy.



We will:

- Build strong digital and data foundations, including a levelling up of digital infrastructure
- Deliver 'at scale' digital platforms such as shared care records, patient empowerment portals, person-held records, remote care and digital diagnostics
- Develop system-wide population health and business intelligence services.

We are already seeing the benefits of our approach into infrastructure, such as Combined Intelligence in Population Health Action (CIPHA) which supports a range of innovative programmes in Cheshire and Merseyside. System P is a whole system approach to addressing multiagency, multisector challenges that negatively impact population health and will deliver transformational change in service provision through collaborative working. It aims to take a predictive, preventative and precise approach to population, patient, and person health outcomes, supported by joined up data and intelligence.

Research and innovation

Cheshire and Merseyside Integrated Care System has as an ambitious vision for research in our region. Our population is recognised to have been poorly served by research opportunities in the past. That, when coupled with significant health need, highlights the need to work differently. As we have moved to an Integrated *Care* System, we are now creating an Integrated *Research* System as well.

Steps towards this include the ICS's contribution to the North West Region development of a Secure Data Environment (SDE) for research and clinical trials, using funding from NHS England.

We are working closer between our academic institutions, HCP partners (including population health), research partners (including National Institute for Health and Care Research, National Cancer Research Institute and Academic Health Science Network) and industry.

Our ICS is investing in the clinical leadership to realise this ambition with Director and Deputy Director of Research (reporting to the Medical Director) to work closely with our stakeholders to develop the best performing research network in the country.

Furthermore, in our initial months as an ICS, we have already won competitive grant funding securing £100k to work on winter fuel poverty and interventions, as well as a community research development programme as lead in collaboration with Lancashire and South Cumbria ICS. Such awards recognise the significant ambition and high-quality research partnerships that our system will further develop on behalf of our patients.

Mersey Care NHS Foundation Trust and the University of Liverpool are leading the development of a Mental Health Research for Innovation Centre (M-RIC) funded through the Office of Life Sciences as part of the UK Governments 'Health Missions' that aims to bring translational research to those areas currently least well served by research awards yet with the greatest need.

Alongside this, work by the CHAMPS public health collaborative is already underway to strengthen research capacity and capability between the nine local authorities in Cheshire and Merseyside and regional academic partners.

This is an emerging and developing programme of work with a network of research champions and academic partners. It is strongly recommended that partners across Cheshire and Merseyside adopt evidence-based approaches informed by best practice and research in relation to our shared goal to tackle health inequalities.

We will:

- Establish a Cheshire and Merseyside Research Development Hub
- Create a network of research champions across our system
- Deliver annual learning events to showcase latest research and to enable the sharing of skills, toolkits and research to support in-house evaluation of projects
- Contribute to the development of a North West Secure Data Environment (SDE) for research.

Health Protection

Cheshire and Merseyside ICS works closely as partners, including Local Authorities, ICB, UK Health Security Agency (UKHSA), Office of Health Improvement and Disparities (OHID) NHS England and across the local NHS Providers and other stakeholders in each of our nine Places.

Key relationships are with Directors of Public Health who have a statutory duty, as directed by the Secretary of State for Health, to ensure there are robust health protection arrangements in place in our local areas. Directors of Public Health are supported by Consultants in Public Health who often have a lead responsibility for health protection amongst other areas of public health.

As Category 1 emergency responders the ICS partners are members of our two Local Resilience Forums (Cheshire Resilience Forum and Merseyside Resilience Forum). We are also a key member of the Local Health Resilience Partnership through which we ensure there are robust arrangements in place to protect the health of the population and to give assurances to Directors of Public Health. Through effective planning we are ready for any future health protection risks, and we do this across local and sub-regional footprints, in order to prevent health protection risks where possible, but are ready to deal with consequence management when necessary to save lives and reduce harm.

We ensure that we learn and improve together, collaborating where it makes sense do things together.

Using the assets and strengths we have available, we will:

- Critically assure the effectiveness of our approach and clarify any catch-up activity that is required, including from our experiences responding to COVID-19
- Develop a view of common health protection risks and shared mitigation plans, and ensure we have robust clinical pathways in place to deal with issues such as tuberculosis (TB), dispensing of antivirals

- Implement scenario planning activities to maximise our system readiness and ensure that contingency arrangements are known and understood and deliverable, including supporting UKHSA in response to outbreaks and threats if required, and supporting NHS preventative work – especially in respect of transfer of screening and immunisation commissioning
- Continue to develop health protection data, intelligence, surveillance and analytics as part of our early warning system to provide timely communication and access to accurate data to enable effective health protection advice and action
- Further develop our workforce training and development plans including Continued Professional Development
- Undertake a review of local Health Protection arrangements, on behalf of the nine Directors of Public Health, to develop a thematic analysis and identify opportunities to strengthen clinical pathways for TB prevention, management and treatment; dispensing antivirals; deploying resources in workplaces, schools and other settings in the event of an outbreak of infectious notifiable diseases including measles, TB and other infections. This builds on the successful pathway that has been developed for offering vaccination support to prevent the spread of monkeypox
- To work with UKHSA and local authority commissioned community infection prevention and community infection control teams to better utilise this resource in order to prevent as well as manage infections within care homes and other settings
- Contribute to local Health Protection Boards to strengthen our networked arrangements between local authorities, primary care, the NHS and UKHSA to ensure good understanding of roles and responsibilities, especially in respect to planned changes to screening and immunisations and the role of primary care in delivery.

Doing things differently.

We understand that knowing how to access the right services isn't easy and that it is our role to find ways to work our communities to improve this. We have lots of examples of things we've done, and will continue to do so, but to illustrate a very small number of these:

Our approach to:

- Bringing COVID-19 Vaccinations and a physical health check programme to our communities through our "living well bus"
- Providing a community eyecare service for homeless communities
- Improving Maternal Mental Health with VCSE small grants
- The use and impact of arts, culture and creative health interventions as a powerful tool in public health approaches which is backed up by a strong evidence base, we have a range of examples here are a couple;
  - Liv Care
  - Theatre Porto.

Section 8 - Enhancing quality, productivity and value for money

As was described in section 2 we know that sometimes the experiences and outcomes our population experience could be improved. This section outlines some of our work to ensure we continuously improve.

Quality assurance and improvement

Strengthening collaboration and partnership-working across health and social care provides a significant opportunity to improve the quality of health and care across Cheshire and Merseyside.

The Integrated Care System supports and aligns with the key requirements of quality oversight, as set out by the National Quality Board (NQB) in its 2021 'Shared Commitment to Quality' guidance.

We will:

- Ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
- Continually improve the quality of services, in a way that makes a real difference to the people using them
- Work with all of care providers and statutory partnerships in achieving the highest regulatory standards
- Develop and agree a single understanding of quality across the partnership, working together to deliver shared quality improvement priorities, based upon the needs of our population - as well as having collective ownership and management of quality challenges
- Further develop and strengthen our approach to reciprocal and meaningful engagement with service users, working together in an open way with clear accountabilities for quality decisions
- Develop and agree quality assurance and improvement actions across partners through the evolution of the Cheshire and Merseyside System Quality Group (SQG), Quality and Performance Committee and Place-based partnerships, ensuring we are responsive to the lived experience of our diverse population
- Work with our Health and Care Scrutiny Committees to ensure local oversight and assurance around the actions the Partnership is taking to deliver our plans.

Access to Dentistry

A number of factors have led to challenges accessing NHS Dentistry, including a backlog of care needs following the COVID-19 pandemic, workforce recruitment and retention issues and a national NHS dental contract structured more towards treatment than prevention.

On July 19th, 2022, an initial package of reforms to the NHS Dental Contract were announced. Changes include:

- Revised terms to incentivise more effectively treating patient's needs, including supporting higher needs patients
- A focus on adherence to appropriate personalised appointment intervals
- Taking steps to maximise access from existing NHS resources, including through funding practices to deliver more activity in year, where affordable
- Improve information about service availability for patients.

Additional investment has been committed within Cheshire and Merseyside, through to March 2024 to focus on prioritising three key cohorts of patients:

- Urgent Dental Care
- Care Required following an Urgent Treatment
- Routine care where the patient is part of a nationally recognised priority group.

We will:

- Invest in an Advice Triage Helpline service
- Continue to work with partners to develop an oral health strategy to implement sustainable improvements in access to dentistry; including with Health Education England and Cheshire and Merseyside Local Professional Network.

Access to General Practice

In line with national standard operating procedures, face-to-face access to General Practice was limited during the early stages of the pandemic with a move to telephone and online consultations.

Whilst in 2022 the total number of patient appointments is now higher than in 2019, the proportion of in-person appointments remains lower. Variation in appointment availability is being analysed to support local improvement planning and sharing of good practice to improve access where patients need it.

We will:

- Support our Primary Care Networks in addressing the workforce challenges they are experiencing. As part of the national Additional Roles Scheme our Primary Care Networks will continue to grow their broader clinical teams, whilst also working as part of local care community teams to reduce duplication. A number of key programmes to help retain and recruit to General Practice workforce are underway
- Support Primary Care Networks to develop in line with the Fuller Stocktake in relation to the future development for primary care within integrated systems.

All of our Places have developed plans, based on key priorities in reducing inequalities, for their local populations - with sharing of good practice to expand schemes that are shown to work.

Common service plans already developed include acute visiting services, use of additional roles, switching of routine capacity to different parts of the day/week, integration with existing services to maximise capacity and access for patients e.g., tele-dermatology, spirometry clinics, ear irrigation, chronic disease reviews and ensuring we maximise the skills and capacity available in other key services such as our community pharmacies and optometrists.

Community Pharmacy

Community Pharmacy has demonstrated its ability to provide improved access to services for our population.

We will:

- Develop new commissioning models that will expand the range of services and capacity available in Community Pharmacy, in order to improve access to a clinical care and improved health outcomes taking pressure of other parts of the system to improve wider, and more local, access to services
- Enable our population to have access to services directly by integrating systems between providers and sectors and encourage providers to make maximum use of national services
- Integrate Community Pharmacy fully into our local workforce and digital programmes to ensure services are integrated into our local models and pathways with a commitment to support community pharmacy contribute to local structures.

Elective Care Recovery Programme

The COVID-19 impact led to closed wards and beds, and staff diversions to service intensive care departments and urgent care wards during peak times. This unprecedented pressure, and inability to ring fence staff and beds, led to cancellations and cessation of elective services, particularly among “non-urgent” patient groups.

The Cheshire and Merseyside elective waiting lists grew from having no patients waiting more than 52 weeks before the pandemic, to more than 2,200 patients waiting more than 104 weeks by January 2022.

The Elective Recovery and Transformation Programme:

The Elective Recovery and Transformation Programme (ERTP) was established in January 2021 by the Cheshire and Merseyside Acute and Specialist Trusts (CMAST) Provider Collaborative.

The ERTP programme has been working with Trusts to support recovery of activity levels back to pre-COVID levels and reduce in the waiting list backlog as well as a range of transformation schemes to improve outcomes and reduce health inequalities.

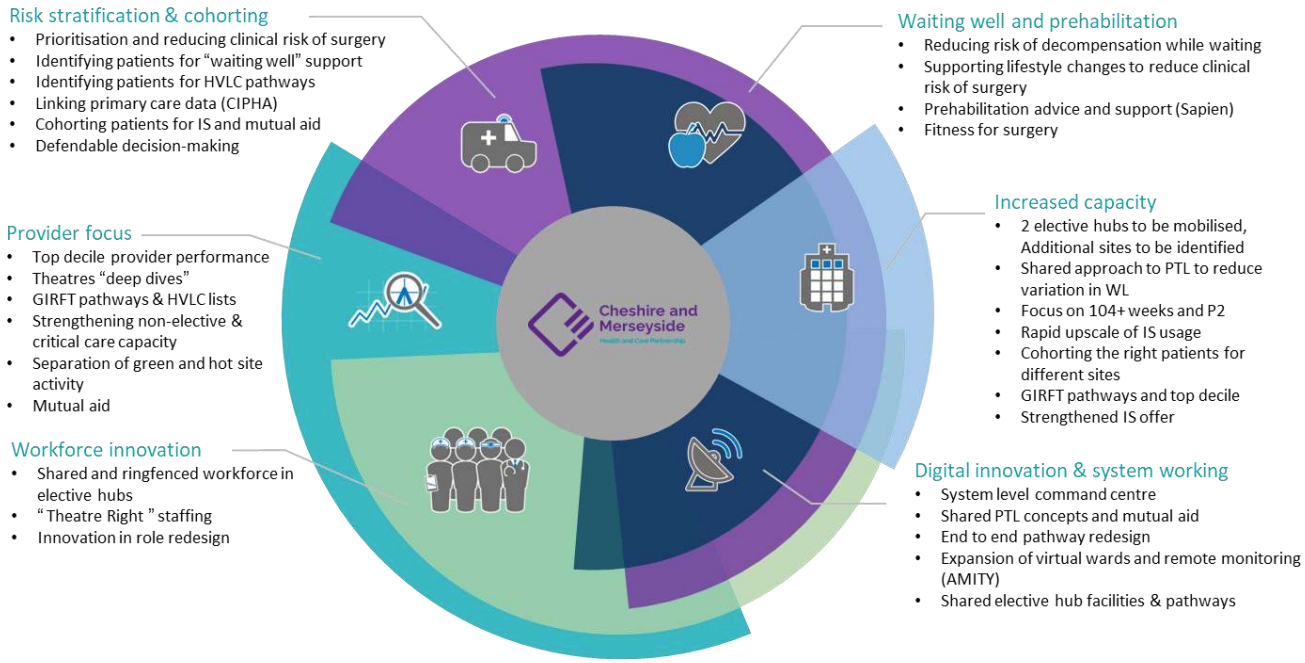
The three immediate system-wide priorities are waiting list management, use of system resources and reducing variation.

We will:

- Complete potential for harm reviews of those who have been waiting a long period and waiting well initiatives
- Eliminate waits of 104+ weeks whilst reducing waits of 78 weeks and 52 weeks through 2023 and 2024
- Establish more elective hubs, separating elective and emergency care to ringfence elective surgery, moving towards a system-level waiting list and maximise use of independent sector capacity
- Aim for top decile performance across all Trusts by implementing Getting it Right First Time and best practice pathways, individual Trust-level efficiency plans and sharing good practice.

To support these aims the following programmes have been developed:

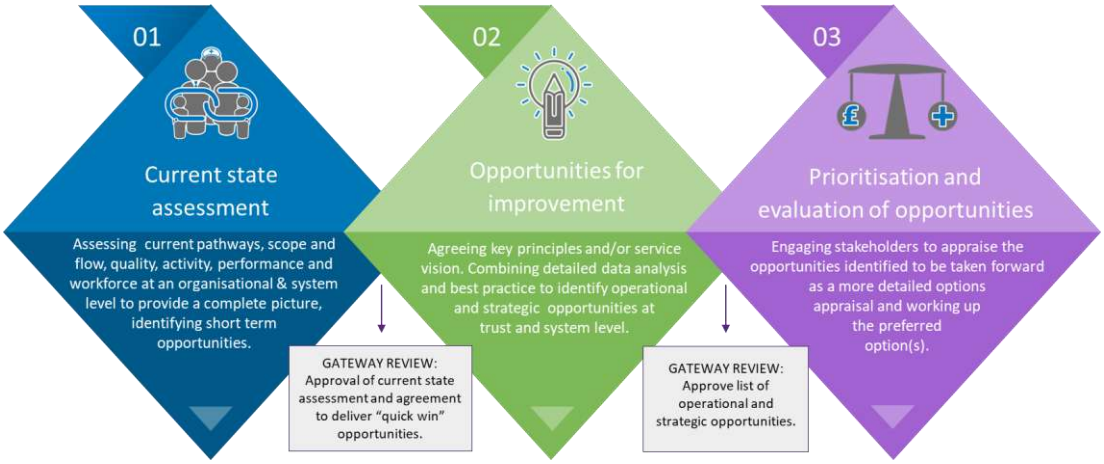
ERTP Programme Workstreams



The Clinical Pathways Programme

The Clinical Pathways Programme (CPP) is focused on transformation of clinical pathways for the long term, improving resilience in smaller NHS Trusts and ensuring that specialisation and consolidation occur where this will provide better outcomes and value.

Cheshire and Merseyside Clinical Pathways Programme Approach



A range of criteria have been used to agree priority specialities for the CPP reviews, including the current waiting list positions, ability to recover activity levels, and services that were considered "fragile" (i.e. where services had closed / limited access).

Access to NHS Diagnostic Tests

More than 80% of patient pathways include a test and so this programme of work is vital to support delivery of almost every other aspect of work in Cheshire and Merseyside.

We will:

- Achieve the six-week waiting time target for routine NHS diagnostic tests by March 2025 (with no over 13 weeks during 2023)
- Deliver 120% of pre-pandemic levels of diagnostic activity by March 2023
- Reduce clinically inappropriate demand
- Use innovation, new technology and digital solutions
- Implement standardised test bundles for key symptomatic pathways so that patients receive the same high quality and timely diagnostics regardless of their location.

Ensuring we have the right services to avoid the need for avoidable hospital admissions

We know that we have higher rates of hospital admissions than our peers. Much of the focus of responding to the causes of this happens within our Place based plans (see Section 10), for example we know that in many of our Places we have high rates of admissions following a fall, and helping our residents prevent falls is a priority for that Place.

As an ICS we are focussed on ensuring that the right personalised services are there to support our population when they need increased support. Our Mental Health, Learning Disability and Community Services Provider Collaborative is working with partners to consistently implement these models, and build the capacity and capability across our system. We have three key areas of work we are focussing on:

Urgent Community Response provides rapid access (within 2 hours) to patients in their own home who, with clinical intervention, can be treated without the requirement of a hospital admission or attendance at A&E, for example following a fall. Whilst the service has been established across all areas of Cheshire and Merseyside, we are developing the model to achieve consistency of referral sources, availability of workforce, communication and engagement with stakeholders and approach to service delivery.

As part of this programme, we will:

- Review how we currently work and share the different ways of working across Cheshire and Merseyside, allowing us to learn from each other and develop plans to apply best practice
- Develop a dynamic business intelligence model that will allow us to track capacity and demand for intermediate care. This will support further development of service delivery, either at place, a collaboration of places, or indeed across Cheshire and Merseyside
- Develop shared workforce development plans.

Workforce

In Cheshire and Merseyside, we work to ensure health and care careers are attractive and encourage people from all backgrounds to consider working in health and care. We aim to retain the highly skilled and committed staff we already have, by enabling flexible and new ways of working, having supportive employment models and ensuring that we have the right skills, competencies and equipment to enable staff to work to their potential.

All staff across the health and care system are important to us and we recognise that we are also supported by a huge number of unpaid volunteers and carers. Our plans will help to ensure that they too are appropriately developed and trained.

To achieve the Health and Care Partnership's priorities we need to change the way we work. We will have new teams, new roles, and we will need to work across multiple organisations and places.

Many staff will work, and want to work, in communities - where they live, and we can offer careers to support this. This strategy does not replace the need for individual organisations to have in place their own strategies and plans but rather focuses on those areas that we can and should do better by working collectively together.

We will:

- Create the conditions for staff to work in the health and care system to end our reliance on agencies
- Up-skill and re-skill staff to work in an integrated system with different competencies / new roles
- Promote staff health and wellbeing and optimise the time staff are in work
- Embed new culturally competent ways of working
- Enable multiple models of employment and engagement
- Develop leadership and talent management
- Work as system partners to develop a social care academy to show the equal priority with clinical training.
- Deliver our public sector equality duty (2010 Act) to be an employer of choice for all staff, investing in positive action to attract, recruit, develop and retain staff from unrepresented groups

Specialised NHS Services

From 2024 NHS Cheshire and Merseyside – an Integrated Care Board (ICB) – will take responsibility (currently with NHS England) for commissioning a range of specialised services. This change will more effectively enable us to integrate the national / regional priorities within our wider Cheshire and Merseyside plans

Our approach is not being developed in isolation and we will work closely with colleagues from across neighbouring ICBs whilst integrating pathways with our local partners and building on our priorities to reduce inequalities and improve population health.

Finance

Cheshire and Merseyside Health and Care partners have combined budgets of £4.4bn meaning we are a significant part of the local economy, in terms of employment and procurement of services.

Whilst all HCP partners are facing significant financial pressures; driven by the levels of funding allocated to us and income raised, alongside the increasing needs of our population, taking an integrated approach presents us with the best way to respond to this challenge and to deliver the priorities described in this document. By working together to spend the limited resources available in the most efficient and effective way we can gain the best value and outcomes for our population.

This will be delivered through integration of budgets and plans at a Place level (see section 10), as well as working on the shared objectives and plans described through this document.

Cheshire and Merseyside ICS will develop its system-wide financial strategy in the first half of 2023, and this will both underpin and support our ambitious system plans alongside long-term financial sustainability.

We will:

Include in our financial strategy:

- An allocation strategy to determine how we will best use our resources to support reduction in inequalities, prevention of ill health and improve population health outcomes
- Financial mechanisms to support health and care integration and a system wide financial regime and funding flow including how we use pooling of budgets across partners and sectors
- Identify key productivity and efficiency opportunities maximised through effective incentives
- System-wide estates and capital requirements and plans
- Supports transformation which will deliver efficiency through integrated working at both a Cheshire and Merseyside and Place level across health and care partners as well as focus on structural instability in services.

Section 9 - Helping to support broader social and economic development

Social Value and Anchor Institutions

The term anchor institutions refers to large organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. .As partners we are a significant part of our local economy, including in terms of as employers, purchasers from the local supply chain as well as being embedded in our communities.

As one of a group of Social Value Accelerator Sites across the UK, we're dedicated to exploring and learning more about how social value can practically and effectively be embedded at scale across Cheshire and Merseyside, within the NHS, Local Authorities and Voluntary, Community, Faith and Social Enterprise sector (VCFSE) and business organisations.

We have co-produced "The Social Value Award" with all sectors which also encourages organisations from the Voluntary Community Faith and Social Enterprise as well as business sectors to embed social value.

Our definition of Social Value is: The good that we can achieve within our communities, related to environmental, economic and social factors;

- Our approach to building capabilities, strengths and assets and enabling people to live a 'valued and dignified life'
- An enabler for the growth of 'Social Innovation' and helps to reduce avoidable inequalities – linked to the Marmot Principles (see Section 5)
- A requirement of 'Anchor Organisations' to use our purchasing power to build capabilities, strengths and assets within our communities, ensuring that Cheshire and Merseyside is a great place to live and work.

We will:

- Work together across sectors to achieve social value outcomes, foster innovation and reduce avoidable inequalities
- Protect health and social care services for future generations
- Give a voice to local communities
- Embed social value across the entire commissioning cycle including procurement
- Make every penny count, growing local wealth, health and our environment
- Create opportunities for social innovation
- Facilitate shared learning, encouraging innovation and best practice in exploring social value.

As an Anchor System we will:

- Sign up to the fair employment charter for Liverpool City Region and Cheshire and Warrington and commit to the real living wage and creating equality within our local job sector
- Pledge to employ and purchase locally, in the first instance
- Pledge to work closely with partners and, where possible, ensure our buildings are viewed as local, community assets
- Measure and evidence the progress made as a result of becoming an Anchor Institution
- Expand the roll-out of the Prevention Pledge
- Develop an Anchor Network Progression Framework to help organisations self-assess / progress ambitions.

Our Green Plan

Climate change poses a threat to our health as well as our planet. The environment is changing, that change is accelerating, and this has direct and immediate consequences for our patients, the public and our partners.

Across our organisations, we are committed to achieving net zero by 2040 (or earlier). All our NHS and local authority partners have well established plans too.

We are:

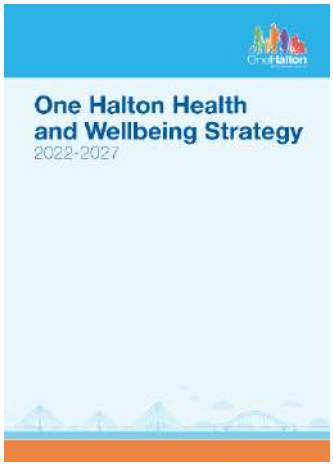
- Transforming the way we use technology to provide health and care
- Decarbonising estates and enhancing sustainable food in hospitals
- Reducing the environmental impact of products we use, including medicines
- Phasing out single use plastics and improving the way both staff and patients travel when accessing health services.

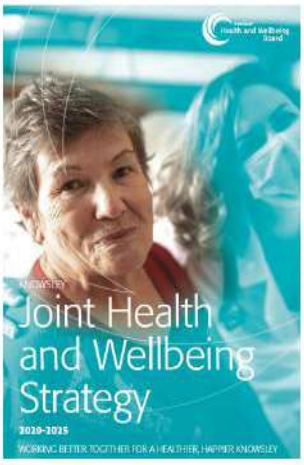
In order to achieve our commitments, we are working with partners in new and innovative ways, including local councils, the NHS Innovation Agency and Liverpool John Moores University.

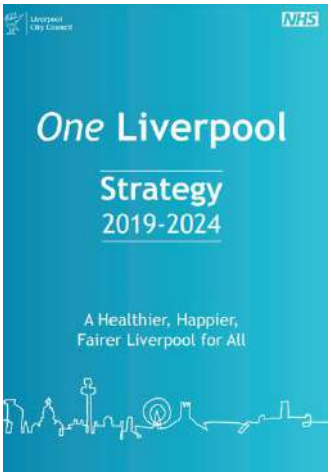
Examples of improvements already achieved include:

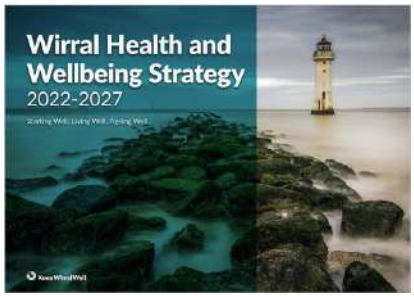
- The installation of more than 300 solar panels at Wirral Community Health and Care NHS FT, St Catherine's site Phasing out the use of the anaesthetic gas desflurane - most NHS Trusts across Cheshire and Merseyside have now phased it out completely
- Reducing the use of nitrous oxide by the equivalent of 443 tonnes of CO_2 – the same as charging more than 50 million smartphones!
- Introducing more cycle to work schemes
- Liverpool Health and Chest Hospital NHS Foundation Trust has introduced reusable theatre gowns, saving more than 23 tonnes of carbon dioxide emissions each year and £22,000 **which was reinvested into patient care**.

Section 10 - Health and Wellbeing Board Strategies and Place Plans (links to docs to be provided)









Section 11 - Glossary

A Glossary of terms is available here.

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

NHS Planning and Operational Guidance 2023-24

Agenda Item No	**ICB/01/23/14**
Report author & contact details	Neil Evans, Associate Director of Strategy and Collaboration (neilevans@nhs.net or 07833685764)
Report approved by (sponsoring Director)	Clare Wilson, Director of Finance
Responsible Officer to take actions forward	Neil Evans Associate Director of Strategy and Collaboration Andy Thomas Associate Director of Planning

NHS Planning and Operational Guidance 2023-24

<table>
<tr><td>Executive Summary</td><td colspan="5">This paper provides an overview of the national NHS Planning Guidance, and requirements of the ICB, for 2023-24.

The guidance requires the ICB, and partners providers, to develop operational plans in relation to finance, activity, performance, and workforce as well as a narrative on service recovery.

There is an additional requirement for development of a Five Year Joint Forward Plan which combines the Cheshire and Merseyside delivery plans in relation to:

• Our Health and Care Partnership Interim Strategy
• Our nine Health and Wellbeing Strategies
• NHS Universal Commitments contained in the national NHS England Planning Guidance.

The operational plans need to be finalised by the end of March, with an interim submission on 23rd of February

A return to a more traditional contracting approach with NHS providers, including “Payments by Results” for elective care, creates an additional requirement to the process, having been suspended during the Covid pandemic

The Joint Forward Plan needs to be in draft form by the end of March and then published by the end of June, following consultation with Health and Wellbeing Boards

A Planning Oversight Group has been formed to oversee development of the plans, including membership from corporate and place ICB teams and our provider collaboratives.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to NOTE:
• 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 our 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.
• note that the submission date for the draft operational plan prevents it from being approved by the board before submission on 23rd February.</td></tr>
</table>

<table>
<tr><td></td><td>It will be reviewed by the ICB Executive Team and Provider Collaboratives before submission and will be presented for review and ratification at the February Board meeting which takes place on the day of submission.
• That the final submissions will be presented to the Board for approval in March 2023.</td></tr>
<tr><td>Key issues</td><td>The condensed timeframe available to develop plans, including the development of strategic priorities in parallel to operational plans creates a challenge in terms of the completeness of plans and capacity to support the work required.</td></tr>
<tr><td>Key risks</td><td>The volume of work to develop plans in a limited timescale may mean our plans require further refinement in Quarter 1 2023-24

The financial plans are being developed with a revised national contracting framework and requires a return to activity-based contract agreements; this could create additional financial pressures to our plans.</td></tr>
<tr><td>Impact (x)
(further detail to be provided in body of paper)</td><td>
<table>
<tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td></tr>
</table>
</td></tr>
<tr><td>Route to this meeting</td><td>This is a description of national guidance and the work that is taking place in Cheshire and Merseyside to develop our approach to responding to this guidance and has not been considered at other committees in advance of this paper.

A Planning Oversight Group has been formed which is developing the approach to planning in Cheshire and Merseyside and includes colleagues from corporate and place ICB teams as well as from our provider collaboratives. This group will oversee development of plan content.</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>None identified at this stage.</td></tr>
<tr><td>Patient and Public Engagement</td><td>Not yet, however as the Joint Forward Plan content is developed there will be engagement with the public to reflect the Health and Care Partnership and Health and Wellbeing Board Strategies and Operational Plan priorities.

The engagement is planned to take place through existing Place based engagement mechanisms.</td></tr>
<tr><td>Equality, Diversity, and Inclusion</td><td>This report describes the planning process communicated in guidance from NHS England. As detailed plans are produced EIA will be produced to assess the impact of the plans.</td></tr>
<tr><td>Health inequalities</td><td>The national planning guidance does include the importance of reducing health inequalities, as do local Health and Wellbeing and Health and Care Partnership Strategies as primary objectives.</td></tr>
</table>

Next Steps	The ICB Planning Oversight Group members are working to develop the core content required within: ○ Operational Plans which must be agreed, and submitted to NHS England by the end of March 2023, with a draft submission on 23 February. This draft will be approved with the Executive Team with the final submissions presented to the Board in March 2023 ○ The Joint Forward Plan must be in draft form by the end of March 2023, with publication of final agreed plans by the end of June 2023, following consultation with Health and Wellbeing Boards. The draft submission will be presented to the ICB Board in March 2023 ○ Agreement of an engagement approach with partners across our Health and Care Partnership and Places, including Health and Wellbeing Boards.	
Appendices	**Appendix One**	National NHS Operational Planning priorities 2023-24

Glossary of Terms	Explanation or clarification of abbreviations used in this paper
DHSC	Department of Health and Social Care
ICB	Integrated Care Board
ICP/HCP	Integrated Care Partnership in Cheshire and Merseyside we refer to the ICP as a Health and Care Partnership (HCP)
ICS	Integrated Care System
JFP	Five Year Joint Forward Plan
LTP	NHS Long Term Plan
NHS	National Health Service

NHS Planning and Operational Guidance 2023-24

1. Executive Summary

1.1 This paper provides an overview of the national NHS Planning Guidance, and requirements of the ICB, for 2023-24.

1.2 The guidance requires the ICB, and partners providers, to develop operational plans in relation to finance, activity, performance, and workforce as well as a narrative on service recovery.

1.3 There is an additional requirement for development of a Five Year Joint Forward Plan which combines the Cheshire and Merseyside delivery plans in relation to:

- Our Health and Care Partnership Interim Strategy
- Our nine Health and Wellbeing Strategies
- NHS Universal Commitments contained in the national NHS England Planning Guidance.

1.4 The operational plans need to be finalised by the end of March, with an interim submission on 23rd of February

1.5 A return to a more traditional contracting approach with NHS providers, including "Payments by Results" for elective care creates an additional requirement to the process, having been suspended during the Covid pandemic

1.6 The Joint Forward Plan needs to be in draft form by the end of March and published by the end of June, following consultation with Health and Wellbeing Boards

1.7 A Planning Oversight Group has been formed to oversee development of the plans, including membership from corporate and place ICB teams and our provider collaboratives.

2. Introduction / Background

2.1 On 23rd December 2022 NHS England issued guidance to the NHS in relation to Operational Planning for 2023-24[1] and the production of Five Year Joint Forward Plans. The two documents are relatively concise at 20 and 23 pages in length with a reduced number of national objectives included.

2.2 Some supporting "technical guidance" in relation to operational planning for finance, workforce, activity, and performance levels has been received during January however there are still some key pieces of guidance to be released which will inform plans. These include national recovery, or delivery plans, in relation to Urgent and Emergency Care, Primary Care and Maternity Services.

2.3 The Five Year Joint Forward Plan is a nationally mandated document which will combine the Cheshire and Merseyside delivery plans in relation to:
- Our Health and Care Partnership Interim Strategy
- Our nine Health and Wellbeing Strategies
- NHS Universal Commitments contained in the national NHS England Planning Guidance.

3. Summary of the NHS guidance for 2023-24

3.1 The Operational Planning Guidance asks systems to focus on the following areas for 2023/24 [1]:
- Prioritise recovering core services and productivity
- Return to delivering the key ambitions in the NHS Long Term Plan (LTP)
- Continue transforming the NHS for the future.

3.2 The headline ambitions contained within the recovering core services section of the guidance relates to improving patient safety, outcomes, and experience by:
- improving ambulance response and A&E waiting times
- reducing elective long waits and cancer backlogs, and improving performance against the core diagnostic standard
- making it easier for people to access primary care services, particularly general practice.

3.3 The guidance includes 31 national objectives for 2023-24. These are included in appendix 1 and go into more detail in relation to the following 12 areas which are identified as national priorities:

3.4 The recovering core services section covers in more detail the national priorities in the areas of:
- Urgent and emergency care
- Community health services
- Primary care
- Elective care
- Cancer
- Diagnostics
- Maternity and neonatal services
- Use of resources

3.5 Delivering the Long-Term Plan and Transforming the NHS section focuses on:
- Mental health
- People with learning disability and autistic people
- Prevention and health inequalities
- Workforce

3.6 In support of the areas identified above the guidance highlights the importance of also focussing on:

- Levelling up digital infrastructure and driving greater connectivity, including development of the NHS App to help patients to identify their needs and get the right care in the right setting
- System working through development of Integrated Care Boards (ICB) and Integrated Care Partnerships (ICP).

4. Summary of the Financial Guidance

4.1 The national average funding allocation includes increases by 3.28% in 2023/24 and 2.14% in 2024/25 (this is 3.13% and 1.77% respectively for Cheshire and Merseyside given our convergence towards target allocation)

- This assumes efficiency of c3% nationally. However, C&M has been given additional efficiency requirement of 0.71% (£37m in 23/24) as part of its trajectory towards distance form target and therefore our system efficiency requirement will be higher. Further convergence adjustments apply of 1.34% in 24/25 financial year
- Includes continuation of £300m discharge fund (allocated to ICBs on a fair share basis)
- Challenging elective recovery targets will be set.

4.2 There are significant changes with the reintroduction of a full contracting approach with NHS providers for 2023-24 including reintroduction of some elements of an activity-based payment scheme, that had been suspended during the Covid Pandemic

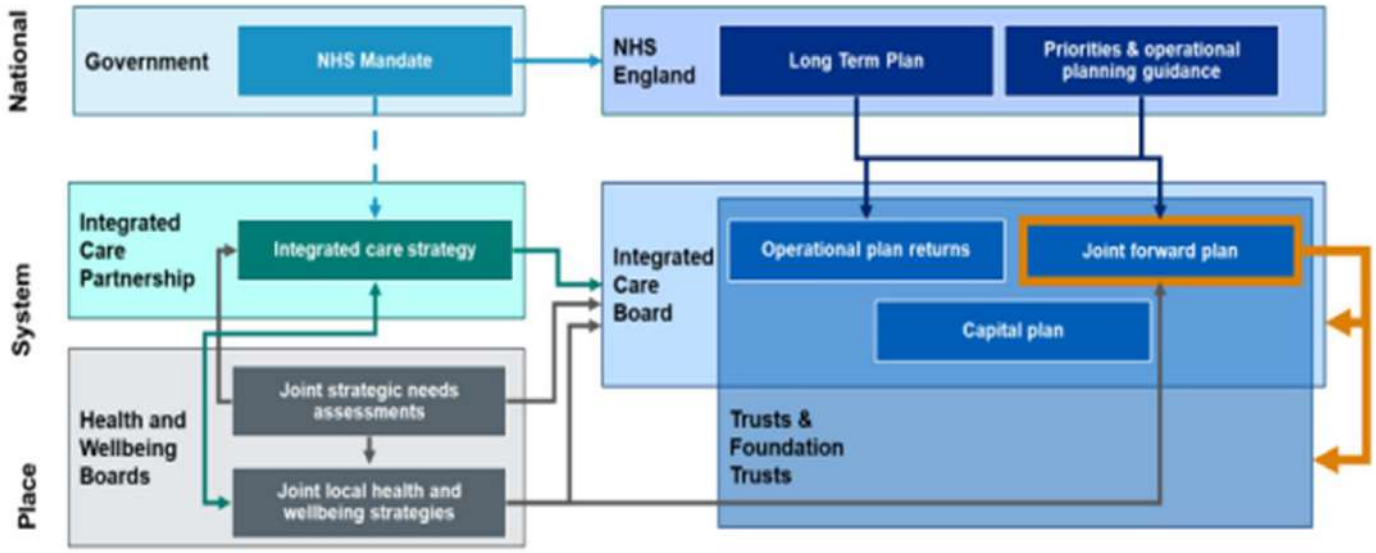
- Return to having agreed contracts in place between commissioners and providers
- 2023-5 NHS Payment Scheme (NHS PS) is currently out for consultation
- Aligned Payment and Incentives (API) will be the core funds flow mechanism
- Payment by Results reintroduced for all elective activity (incl. OP/unbundled diagnostic)
- Fixed payment retained for urgent care and non-elective activity.

4.3 Work is taking place with colleagues from across the system to agree the principles and approaches which will support this national approach. This includes a whole system workshop of Finance Directors on 20th January.

5. How the various Plans and strategies fit together

5.1 There is a requirement for ICBs and their partner NHS trusts to prepare five-year Joint Forward Plans (JFP) [e] before the start of each financial year. The guidance encourages systems to use the JFP as a shared delivery plan for the integrated care strategy (developed by the HCP) and the joint local health and wellbeing strategies (JLHWS) along with the NHS universal priorities. The statutory responsibility for producing the JFP lies with the ICB and its partner NHS provider trusts.

Diagram One



5.2 Operational Plans should be agreed by the end of March 2023, when they are submitted to NHS England. In recognition of the condensed timeframes, and the developing status of Integrated Care Systems the timings for 2023-24 are that a draft JFP should be produced by the end of March with final JFP published by the end of June 2023.

5.3 There is flexibility in the content of JFP but the guidance *"encourages systems to use the JFP to develop a shared delivery plan for the integrated care strategy (developed by the ICP) and the JLHWS (developed by local authorities and their partner ICBs, which may be through HWBs) that is supported by the whole system, including local authorities and voluntary, community and social enterprise partners"*

5.4 In developing the JFP the guidance identifies engaging with the following partners as being essential:

- ICP/HCP (ensuring this also provides the perspective of social care providers)
- primary care providers
- local authorities and each relevant HWB
- other ICBs in respect of providers whose operating boundary spans multiple ICSs NHS collaboratives, networks, and alliances
- the voluntary, community and social enterprise sector
- people and communities that will be affected by specific parts of the proposed plan, or who are likely to have a significant interest in any of its objectives including considering underserved of excluded groups.

5.5 Where plans are built on existing plans and strategies there is not a requirement to formally consult. However, normal legislative requirements remaining if there is a significant planned change to services.

5.6 JFP must be reviewed and updated annually.

5.7 At the Health and Care Partnership (HCP) meeting of 17 January a number of next steps were agreed in relation to the interim strategy, including prioritising the contents to develop a final strategy and inform annual delivery plans, which would be included within the JFP. This work is already underway, with a review of existing population health data and other sources of intelligence to identify those areas of our strategy with the greatest opportunity for improvement when compared with other parts of the country. A workshop of HCP members is planned for 7th March to agree these priorities.

5.8 The ICB and our NHS provider partners must consult with Health and Wellbeing Boards (HWB) as to whether the JFP is considered to reflect their local priorities and include in the final document the opinion received from the HWB. Whilst engagement with HWBs will commence now, the review of the JFP is nationally suggested as taking place between April and June.

6. How the various Plans and strategies fit together

6.1 Building from the approach over recent NHS planning cycles a Planning Oversight Group has been formed and is chaired by the ICB Executive Director of Finance and includes a range of subject matter experts in relation to both themes within the planning guidance and the production of the planning documents themselves.

6.2 The Oversight Group includes representation from Place Teams and our two Provider Collaboratives; recognising:

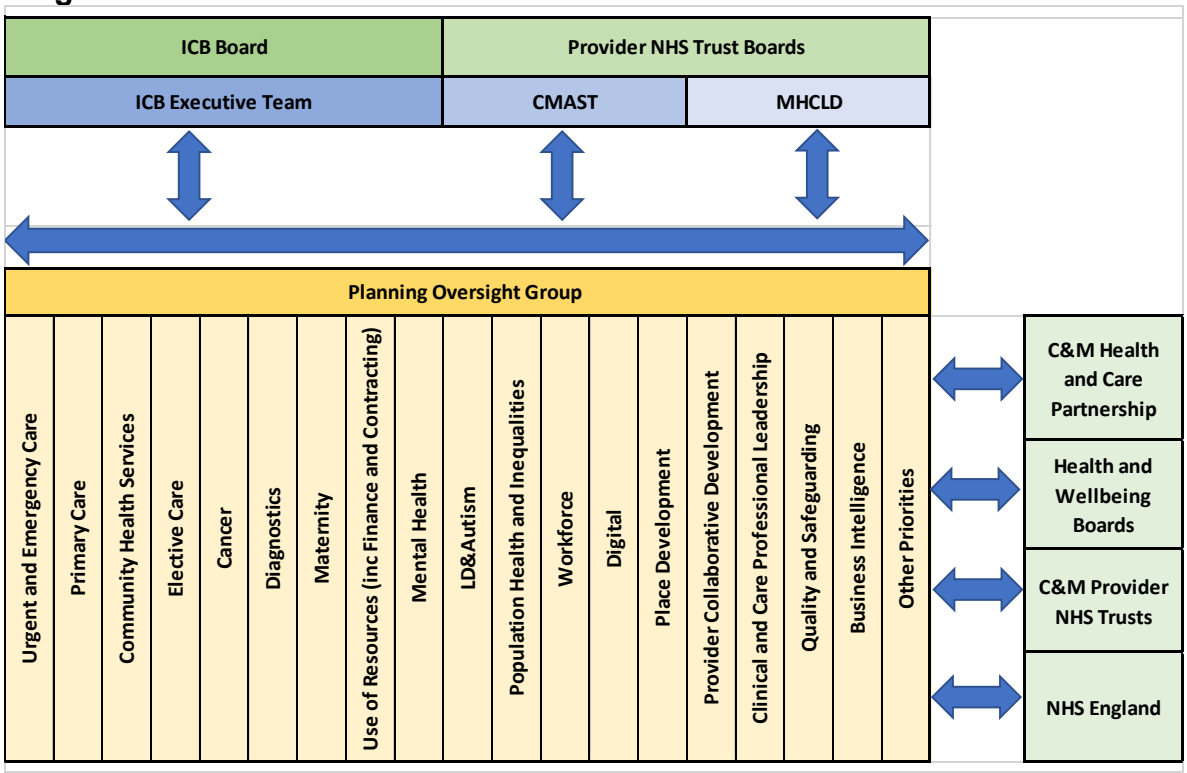
- The need to engage with wider ICS partners (as referenced above), including Health and Wellbeing Boards and constituent stakeholders including local authorities and primary care on plans. With a key consideration the specific requirement to consult Health and Wellbeing Boards on our Joint Forward Plan further supporting a Place led engagement process

- That the Operational Plan submissions, Joint Forward Plan and Capital Plan are a shared statutory responsibility of the ICB, and our NHS Provider partners; and the Collaboratives can support the development and governance associated with approving plans

- A number of the planning themes are being led from either Place or provider collaborative teams.

6.3 Diagram Two illustrates the workstreams and shows the proposed route to approval of final plans at the ICB Board and provider boards

Diagram Two



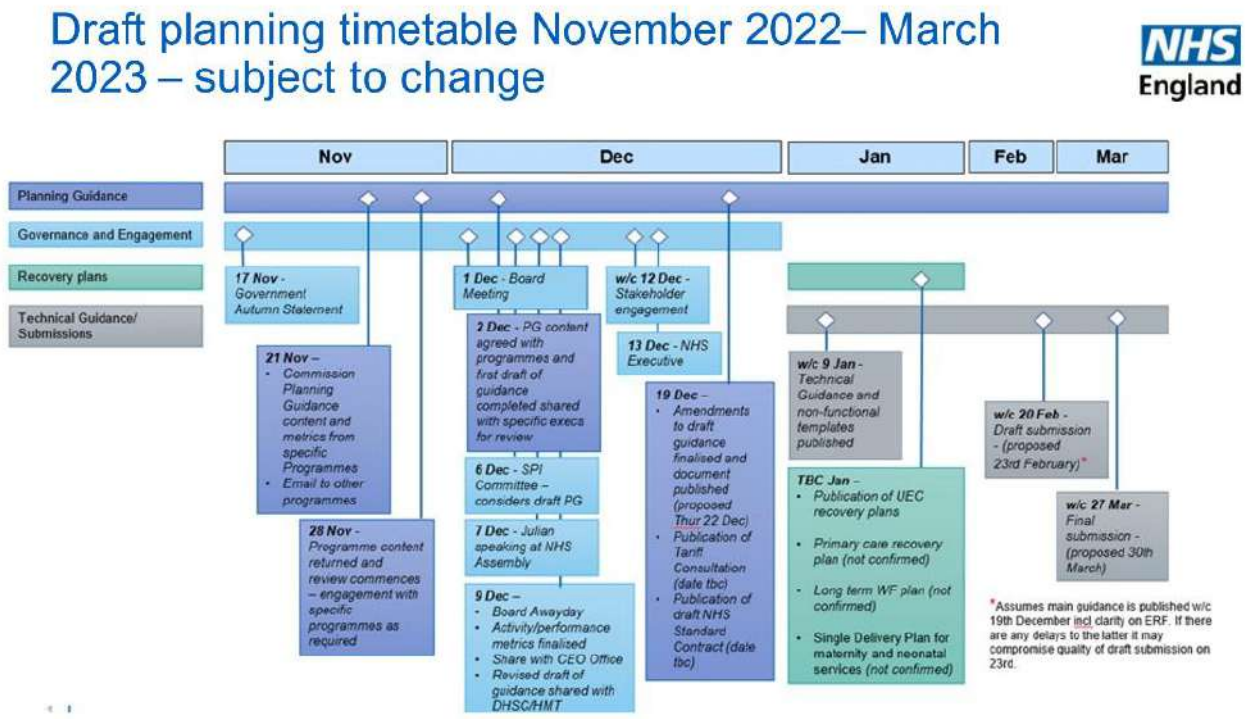
[1] PRN00021-23-24-priorities-and-operational-planning-guidance-december-2022.pdf (england.nhs.uk)

2 NHS England » Guidance on developing the joint forward plan

7. Timetable

7.1 Diagram Three sets out the draft national timetable for the planning process which sets out a schedule of guidance publication and submission dates. Draft operational plans will need to be submitted by 23 February 2023 with final submissions expected to be by 30th March.

Diagram Three



8. Next Steps

8.1 The ICB Planning Oversight Group members are working to develop the core content required within:

- Operational Plans (Including, activity, performance, finance, and capital) must be agreed and submitted to NHS England by the 30 of March 2023, with a draft submission on 23 February. Board approval timeframes will be as follows:
  - The draft plan will be reviewed by the ICB Executive Team and Provider Collaboratives before submission on the 23 February and will be presented for ratification at the Board in its meeting on the same day.
  - The final submissions will be presented to the Board for approval in March 2023.

- The Joint Forward Plan must be in draft form by the end of March 2023, with publication of final agreed plans by the end of June 2023, following consultation with Health and Wellbeing Boards. The draft submission will be presented to the ICB Board in March 2023

- An engagement approach with partners across our Health and Care Partnership and Places, including Health and Wellbeing Boards is being developed.

9. Recommendations

9.1 The Board is asked to **Note**:

- 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 our 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.
- Note that the submission date for the **draft operational plan** prevents it from being approved by the board before submission on 23rd February. It will be reviewed by the ICB Executive Team and Provider Collaboratives before submission and will be presented for review and ratification at the February Board meeting which takes place on the day of submission.
- The **final submissions** will be presented to the Board for approval in March 2023.

Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neilevans@nhs.net or 07833685764)

Appendix 1

National NHS objectives 2023/24

	Area	Objective
Recovering our core services and improving productivity	Urgent and emergency care*	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
		Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
		Reduce adult general and acute (G&A) bed occupancy to 92% or below
	Community health services	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
		Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	Primary care*	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
		Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
		Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
		Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	Elective care	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
		Deliver the system- specific activity target (agreed through the operational planning process)
	Cancer	Continue to reduce the number of patients waiting over 62 days
		Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
		Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	Diagnostics	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
		Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	Maternity*	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
		Increase fill rates against funded establishment for maternity staff
	Use of resources	Deliver a balanced net system financial position for 2023/24
	Workforce	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	Mental health	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
		Increase the number of adults and older adults accessing IAPT treatment
		Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
		Work towards eliminating inappropriate adult acute out of area placements
		Recover the dementia diagnosis rate to 66.7%
		Improve access to perinatal mental health services
	People with a learning disability and autistic people	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
		Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	Prevention and health inequalities	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
		Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
		Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published;*

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Public engagement and involvement update

Agenda Item No	**ICB/01/23/15**
Report author & contact details	Helen Johnson, Head of Communications & Engagement – Liverpool Place, Cheshire & Merseyside ICB
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive, Cheshire & Merseyside ICB
Responsible Officer to take actions forward	Maria Austin, Associate Director Communications and Empowerment, Cheshire & Merseyside ICB

Public Engagement and Involvement Update

<table>
<tr><td>Executive Summary</td><td colspan="5">At the first meeting of Cheshire and Merseyside ICB, on 1 July 2022, the board received a draft public engagement framework. The framework was part of national readiness to operate requirements for ICBs, and was drafted according to a nationally prescribed content guide. Local Healthwatch and VCFSE (Voluntary, Community, Faith and Social Enterprise) leaders were involved in a group overseeing framework development, and were also commissioned to co-produce the document.

This report outlines the progress made to develop the framework in the six months since that first board meeting, including the discussions that have taken place with stakeholders to gather further feedback.

It also sets out the next steps for translating the framework into an overall communications and engagement strategy for NHS Cheshire and Merseyside, which will in turn inform individual Place plans and activity.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• note the update and provide any feedback on the next steps
• endorse further engagement around the framework to inform the production of a communications and engagement strategy for the ICB.
• endorse the regular reporting on involvement and engagement through the Quality and Performance Committee.</td></tr>
<tr><td>Key issues</td><td colspan="5">N/A</td></tr>
<tr><td>Key risks</td><td colspan="5">ICBs have legal duties to make arrangements to involve the public in their decision-making about NHS services. This is set out in NHS England's Working in partnership with people and communities: Statutory guidance (https://www.england.nhs.uk/publication/working-in-partnership-with-people-and-communities-statutory-guidance/)

The main duties on NHS bodies to make arrangements to involve the public are set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022 – for ICBs, this is described in section 14Z45.

In addition to legal requirements, a failure to meet these duties would also mean losing the benefits that come from harnessing the knowledge and experience of those who use and depend on the local health and care system. Effective involvement gives us an opportunity to improve outcomes and develop better, more effective services. Similarly, by building strong relationships with partners to help us develop and deliver meaningful</td></tr>
</table>

<table>
<tr><td></td><td colspan="4">engagement approaches, we increase our reach, reduce duplication, and improve our impact.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td></td><td></td><td></td><td></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td></td></tr>
<tr><td>Route to this meeting</td><td colspan="4">N/A</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="4">N/A</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="4">N/A</td></tr>
<tr><td>Equality, Diversity, and Inclusion</td><td colspan="4">While an equality impact assessment has not been prepared to accompany the framework, it is important that our engagement and involvement and EDI approaches are closely aligned. Reflecting this, NHS Cheshire and Merseyside’s communications and empowerment function includes individuals with a focus on EDI, so that these roles sit under a single team. This will provide an important basis to consider how best to reach our population and ensure that we hear the voices of all our communities.</td></tr>
<tr><td>Health inequalities</td><td colspan="4">One of the key priorities of our Public Engagement Framework is to build relationships with excluded groups – especially those who are affected by inequalities – so that we can understand and meet their needs and aspirations for wellbeing, health, and care.

Our work will build on the CORE20PLUS5 approach – a national framework that helps define the population groups in each system experiencing health inequalities. Hearing their experiences and understanding the barriers these groups face in accessing care and treatment is an important part of addressing
unequal access to services.</td></tr>
<tr><td>Next Steps</td><td colspan="4">Following consideration of this paper by the board, it is planned that engagement with stakeholders around the framework will continue. This will include scoping out how we will deliver the activity needed to support the ten principles for engaging with people and communities.

It is envisaged that this work will inform the development of a comprehensive communications and engagement strategy for NHS Cheshire and Merseyside. A first draft of this strategy will be presented to the ICB’s Quality and Performance Committee in summer 2023, subject to the board agreeing this route.</td></tr>
<tr><td>Appendices</td><td>Appendix One</td><td colspan="3">Cheshire and Merseyside Public Engagement Framework 2022/23: Our strategy for involving people and communities in Cheshire and Merseyside</td></tr>
</table>

Public Engagement and Involvement update

1. Executive Summary

1.1 As a statutory body, NHS Cheshire and Merseyside has a legal duty to involve the public and is required to have a strategy for working with people and communities.

1.2 A draft framework, reflecting national guidance and developed in partnership with local Healthwatch organisations and the VCFSE sector, was presented at the inaugural meeting of the ICB in July 2022.

1.3 The latest version of the framework is attached as appendix 1.

1.4 Since then, further work has taken place to engage with stakeholders about the framework, including Place partnerships. It is intended that this work will continue over the coming months, to inform the development of a comprehensive communications and engagement strategy for the ICB, which will be published in draft form in summer 2023.

2. Introduction / Background

2.1 A draft engagement strategy was one of the national readiness to operate requirements, as set out in ICS (integrated care system) implementation guidance for working with people and communities.

2.2 Work to develop an engagement framework for Cheshire and Merseyside was launched at the C&M Partnership Assembly meeting on 14 December 2021, and subsequently presented at the ICS Development Advisory Group meeting of 31 March 2021.

2.3 Strategy development was then taken forward by a task and finish group, mobilised on 1 April 2022 as part of the ICS Transition Programme, including an engagement representative from each CCG (now Place) – tasked with linking with local multi-agency forums in Place.

2.4 Cheshire and Merseyside's local Healthwatch and VCFSE leaders were members of the task and finish group (as subject matter experts) and were also commissioned to co-produce the framework and run a series of workshops in each of the nine C&M Places.

2.5 As part of this commissioned activity, local Healthwatch and VCFSE produced feedback reports. These were used to shape the further development of the framework and provide key insight and intelligence to inform the development and connectivity of effective public involvement at Place, that informs and influences ICS partners.

2.5 During the initial design and drafting phase (pre-July 1, 2022), the following Place forums – which include both networks for communications/involvement/patient experience professionals, and patient/public engagement and involvement groups – were invited to take part in discussions about development of the strategy:

- Cheshire Communications and Engagement Group
- Liverpool Health and Care Communications and Engagement Network
- Knowsley Communications and Engagement network
- Wirral Communications Collaborative
- Sefton Engagement and Patient Experience Group and Health Information and Communications Group
- Warrington Communications and Engagement Network
- St Helens Stakeholder Forum.

3. Developing our engagement and involvement approach – progress to date

3.1 **Public Engagement Framework.** The framework was presented and adopted as a work-in-progress draft at the first ICB meeting on 1 July 2022, at which a clear commitment was made to ongoing engagement with ICS partners and Place Partnerships to develop our approach to working with people and communities. Since, then the framework has been worked up into an initial designed format, and updated in line with:

- Feedback from ICB Board members
- Feedback from the engagement activity reports commissioned from Local Healthwatch and VCFSE partners
- Feedback from NHS England's National Participation Team (via the national ICB moderation process). This noted that the framework showed both action and commitment, referencing the focus on co-production work with Healthwatch and the VCFSE sector.
- The publication (following national public consultation) of Statutory Guidance for Working with People and Communities.

3.2 **Citizens' Panel.** In October 2022, the ICB launched the NHS Cheshire and Merseyside Citizens' Panel. The Citizens' Panel will help us to develop our approach to working with people and communities and strengthen our ability to demonstrate the impact that people's views, experiences, and insights have on our work. It will be an important part of our wider communications and engagement approach, providing the opportunity to engage with people from all sections of the community, and not simply those already engaged with health, social care and voluntary sector groups.

3.3 A range of methods have been used to recruit to the Citizens' Panel since its launch, including social media promotion and face-to-face events in different locations across Cheshire and Merseyside.

3.4 So far, more than 600 people have been recruited – from this wider pool, a smaller number will be selected with the aim of creating a sample which is demographically representative of Cheshire and Merseyside. Each member of the panel is recruited to represent their own views only, and not the views (or their perception of the views) of the wider population.

3.5 **Ongoing framework engagement.** NHS Merseyside's communications and engagement team is in the process of attending Place Partnership Boards – or Health and Wellbeing Boards where this has been requested by Place Directors – to share the latest draft of the engagement framework. Place Partnerships are key to developing effective public involvement mechanisms for local people, that in turn, can inform the work of Integrated Care System (ICS) partners, so it's important that they have an opportunity to discuss the framework and provide comments.

3.6 During discussions so far, there has been positive feedback about the approach to Healthwatch and VCFSE involvement in framework development, and we will look at ways to continue to this in the activity and plans we put in place over the coming months.

3.7 Healthwatch representatives previously engaged in the framework task and finish group during spring 2022 met at the end of the year for ahead of the framework being presented to Place Partnerships/Health and Wellbeing Board.

3.8 The intention is to reconvene this group, including voluntary sector representatives, as our reference group to support our ongoing engagement.

3.9 **Areas of focus.** As we continue discussions around the draft engagement framework, and begin scoping out specific pieces of work, our focus will include a number of key areas, namely:

3.10 **Governance and public voice.** The first of the ten principles for working with people and communities – set out in national guidance and reflected in our local engagement framework – is: *Build the voices of people and communities into governance structures so that people are part of decision-making processes*. As we begin to translate the guidance into tangible actions, we need to consider how this will look at both system and Place level.

3.11 We will scope out wider opportunities for public input, both in decision-making and at project/programme level. This work will build on the draft Cheshire and Merseyside public involvement policy, as well as existing legacy CCG patient voice and volunteering arrangements in Place.

3.12 **Communications and engagement delivery.** The ICB's communications and engagement function is currently being restructured in line with the wider organisational change process. While a number of staff have been working as a central team since the establishment of the ICB, structures at present largely reflect legacy CCG arrangements. The transition to a new structure aligned to the new Target Operating Model will be finalised in the coming weeks and will then provide a firm basis for putting in place cohesive and connected plans for delivering activity at both corporate and Place level.

3.13 However, Place communications and engagement is not just the responsibility of those staff employed by the ICB as a statutory body – this activity will be delivered as a local partnership, allowing each Place to realise a much greater reach and impact than can be achieved by individual organisations. Therefore, a key priority in early 2023 will be working with Place Directors to support the further development and embedding of clear local arrangements for building this collective approach.

3.14 **Networks and groups.** It is important that our approach to involvement utilises the many groups and organisations which already exist across Cheshire and Merseyside – finding ways to link-up and develop what is already working where possible. We want to take a 'bottom up' approach, finding ways to engage at all levels – from patient participation groups (PPGs) in GP practices, to system-wide networks.

3.15 A range of public/patient voice and engagement mechanisms are already in place, some as a legacy of clinical commissioning group structures, and others formed more recently around the needs of Place.

3.16 While local involvement networks should meet the specific requirements of each Place, and therefore might take a different form in different areas, we will undertake a mapping exercise to ensure that collectively they provide coverage across Cheshire and Merseyside.

3.17 This will include looking at membership and links to Place governance and is connected to the public voice work referenced above. We will also explore opportunities to bring together these groups so that they can form a 'network of networks' for Cheshire and Merseyside when this is required.

3.18 In addition to looking at provision around general or Place-based networks, we want to work with partners to reach specific communities and parts of our population, such as children and young people. It is envisaged that this will involve commissioning groups and organisations to deliver engagement, harnessing their skills and experience, and the relationships and communications routes that they already have in place.

3.19 **Insight gathering and capture.** As we build our strategy for involving local people and gathering their views, we must ensure that systems and processes are in place that allow these insights to be fully harnessed by the whole system. Without this, we risk missing opportunities to share findings more widely, therefore reducing their impact, and leading to potential duplication of effort. As a foundation for this work, we will ensure that the outputs of Cheshire and Merseyside's legacy CCG engagement and involvement activity are brought together in a single location, before looking at how we can expand this to include the work of wider partners, including Healthwatch. We will promote this resource to ICB staff and partners, and encourage them to both utilise and contribute to it.

3.20 **Content and themes.** While channels and mechanisms will provide a framework for our communications and engagement approach, it will be the content that underpins this that will provide substance for our work. We already maintain an ongoing pipeline of upcoming programme work that are likely to need communications and engagement support, and we will be looking to refine these requirements over the coming months. Implementation of the ICB's new communications and engagement structure will also provide an opportunity for fresh discussions with Places around specific needs in each area.

4. Recommendations

4.1 The board is asked to:

- **note** the update and provide any feedback on the next steps
- **endorse** further engagement around the framework to inform the production of a communications and engagement strategy for the ICB.
- **endorse** the regular reporting on involvement and engagement through the Quality and Performance Committee.

5. Next Steps

- Engagement with stakeholders around the engagement framework will continue. This will include scoping out how we will deliver the activity needed to support the ten principles for engaging with people and communities.
- It is envisaged that this work will inform the development of a comprehensive communications and engagement strategy for NHS Cheshire and Merseyside. A first draft of this strategy will be presented to the ICB's Quality and Performance Committee in summer 2023, subject to the board agreeing this route.

6. Officer contact details for more information

Maria Austin, Associate Director Communications and Empowerment, 07917 738659
mariaaustin@nhs.net

NHS Cheshire and Merseyside Integrated Care Board Meeting

Public engagement and involvement update

Appendix A: Cheshire and Merseyside Public Engagement Framework 2022/23

NHS
Cheshire and Merseyside

Cheshire and Merseyside Public Engagement Framework 2022/23

Our strategy for involving people and communities in Cheshire and Merseyside

Contents

Foreword

NHS Cheshire and Merseyside is committed to involving people and communities to identify what will help to improve their health and wellbeing, and to work together to shape services.

We are therefore pleased to present our draft Public Engagement Framework as the first step in delivering on that commitment. We will be using the framework to look at locally-available resources to help people improve their health and care, use their skills, and tell us what they want and need.

We are proud that this framework has been co-produced with Healthwatch and local voluntary community, faith and social enterprise (VCFSE) sector partners.

We want to continue that relationship and engage with the public and our partners to seek their views on this framework and help further shape our approach at Cheshire and Merseyside at a system-level across our nine Places, and in our neighbourhoods.

Healthwatch, the VCFSE sector, our councils, hospitals and other partners already have well-established ways of engaging together with people and communities and we need to build on these strengths and assets. We want our approach to be one of evolution, not revolution.

If we are to help reduce inequalities and continuously improve health and care outcomes for all, we must communicate with, and listen to the views and experiences of people and communities in relation to their health and wellbeing.

The publication of this Public Engagement Framework should act as a springboard for our work to develop new engagement mechanisms for NHS Cheshire and Merseyside. Looking ahead, it will be integrated with strategies for communications, equality, diversity, and inclusion, and will be underpinned by detailed action plans at Cheshire and Merseyside system-level, at Place and in our neighbourhoods.

Raj Jain
Chair

Graham Urwin
Chief Executive

1. Context and introduction

1.1 Purpose

The purpose of our Public Engagement Framework is to describe NHS Cheshire and Merseyside's ambition to empower people and communities. It also outlines how our engagement will help us to further tackle the inequalities in our area.

The draft framework has been co-produced with local Healthwatch and voluntary, community, faith and social enterprise (VCFSE) sector organisations across Cheshire and Merseyside.

Public engagement will be undertaken to further design our approach, specific engagement mechanisms, and an action plan, following the national consultation and publication of statutory guidance in July 2022.

We will undertake an Equality Impact Assessment on our framework to ensure that we are paying due regard to the Public Sector Equality Duty, that our processes are fair, and do not present barriers to involvement or disadvantage any protected group. Our impact assessment will also cover health inequalities.

This framework sets out how NHS Cheshire and Merseyside, as a statutory organisation, will involve people and communities. Whilst the framework and the subsequent action plan will be underpinned by partnership working, at system-level and in Place, it is not intended to be prescriptive or a mandate for how involvement is undertaken locally.

1.2 Language

In this framework, we talk about 'involving' and 'empowering' people and communities. We use these phrases to cover a variety of approaches such as engagement, participation, co-production, and consultation. These terms often overlap and mean different things to different people and sometimes have a technical or legal definition too.

By 'people', we mean everyone of all ages, their representatives, relatives, and unpaid carers. This is inclusive of whether they use or access health and care services and support. 'Communities' are groups of people that are interconnected, by where they live, how they identify or their shared interests.

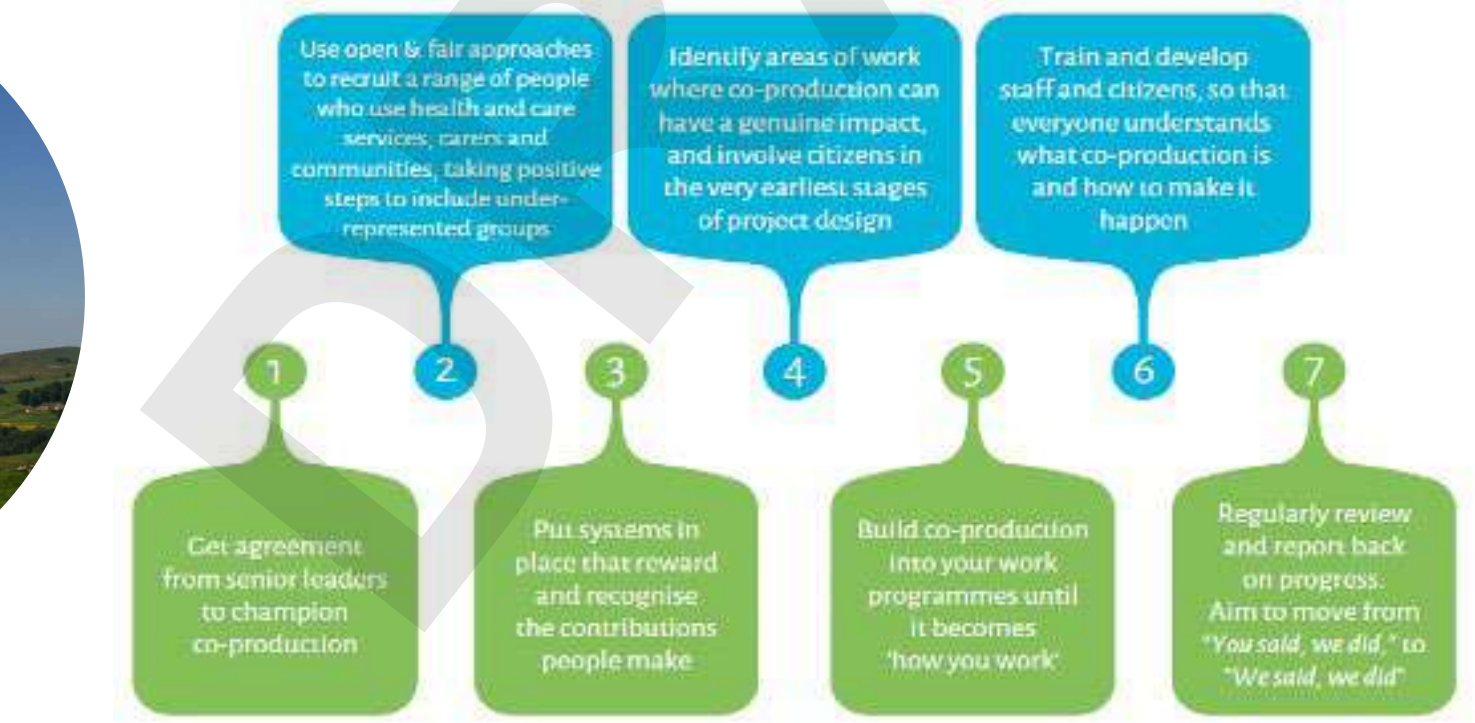
'Community-centred approaches' recognise that many of the factors that create health and wellbeing are at a community level, including social connections, having a voice in local decisions, and addressing health inequalities.

By 'empowering', we mean that people and communities are able to use and share their knowledge, skills and experience to improve access and outcomes.

'Co-production' is a way to involve people by sharing power with them. **The Coalition for Personalised Care** defines co-production as:

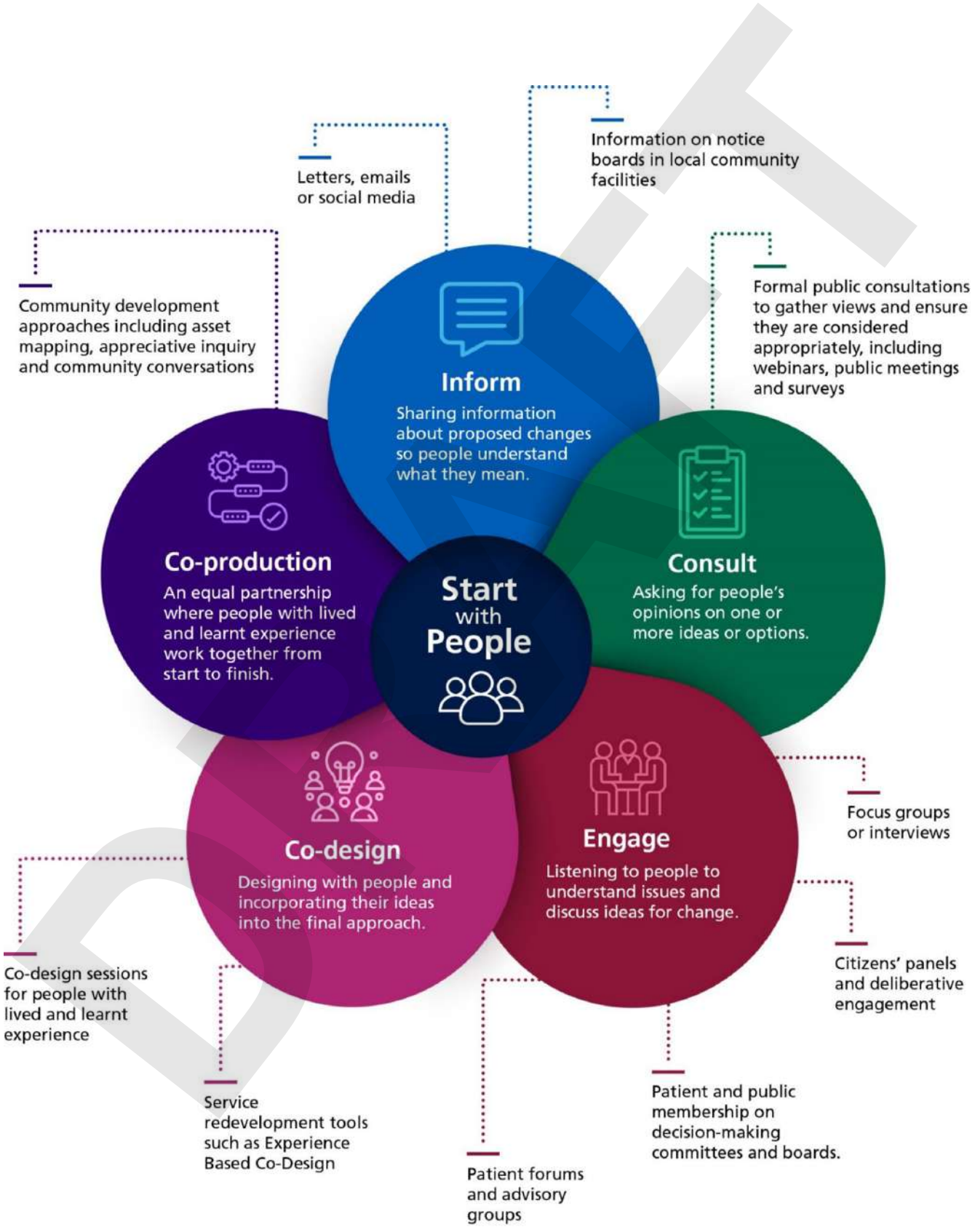
'a way of working that involves people who use health and care services, carers and communities in equal partnership; and which engages groups of people at the earliest stages of service design, development and evaluation.'

The guiding principle is that people with 'specific lived experience' are often best placed to advise on what support and services will make a positive difference to their lives. When done well, co-production helps to ensure discussions are honest, reflective, and that they maintain a person-centred perspective.



1.3 Different ways of working

The diagram sets out different ways of working with people and communities:



1.4 Our Integrated Care System (ICS)

Cheshire and Merseyside ICS embodies a new way of working which brings together all the health and care organisations in our area, so they can work more collaboratively and empower the people and communities who live and work here.

Our health and care organisations have already been successfully working in this integrated way, particularly through the COVID-19 pandemic –an Integrated Care System (ICS) is the next step in recognising this success.

Our ICS is responsible for looking after and delivering all the health and care services in the area we cover. We are made up of an Integrated Care Board and an Integrated Care Partnership, working together.

What is our Integrated Care Board (ICB)?

NHS Cheshire and Merseyside ICB holds responsibility for planning NHS services, including those previously planned by NHS clinical commissioning groups (CCGs). As well as our Chair and Chief Executive, membership of the board includes 'partner' members drawn from local authorities, NHS trusts and general practice.

The ICB will ensure that services are in place to deliver the Integrated Care Strategy developed by the Integrated Care Partnership (ICP). NHS Cheshire and Merseyside ICB was created as a statutory organisation on 1 July 2022.

What is our Integrated Care Partnership (ICP)?

Cheshire and Merseyside Health and Care Partnership (the ICP) is a statutory committee made up of partners from across the local area, including Healthwatch, VCFSE sector organisations and independent healthcare providers, as well as representatives from the ICB.

One of the key roles of the partnership is to assess the health, public health and social care needs of people living and working in Cheshire and Merseyside and to produce a strategy to address them. This, in turn, will direct the ICB's planning of health services and local authorities' planning of social care services.

The ICP will work in partnership with Cheshire and Merseyside Public Health Collaborative (Champs) and the nine Directors of Public Health to develop strategies that improve public health, reduce health inequalities and ensure the health and care system across Cheshire and Merseyside is sustainable.

The ICP have a responsibility to improve the health and wellbeing of our population. We will do this by:

- coordinating plans to make sure our services continue to meet everyone's needs
- joining up services to provide better care, closer to home
- ensuring all our partners across Cheshire and Merseyside focus on addressing the causes of poor health, as well as improving diagnosis and treatment.

Members of the ICB and ICP will listen to, and represent the views of the people and communities we serve. This framework marks the start of a conversation about how we connect with our population and the different needs within it.

Local Healthwatch and VCFSE sector organisations are our key partners. They have used their expertise in representing and advocating for people and communities to co-produce this framework.

We will continue to work together to develop the best arrangements for people to share their views and get involved in decisions that affect their wellbeing, health, and care.

Provider Collaboratives

There are two Provider Collaboratives for Cheshire and Merseyside:

- The Cheshire and Merseyside Acute and Specialist Trusts (CMAST)
- Mental Health, Community, Learning Disability Collaborative (MHLDSC).

Both have agreed specific objectives with the ICB that will help deliver Cheshire and Merseyside's strategic priorities. The two Provider Collaboratives are also committed to working together to support the delivery of benefits of scale and mutual aid across multiple Places or systems.

Place-Based Partnerships

Our Integrated Care Board will arrange for some of its functions to be delivered, and decisions about NHS funding to be made in the region's nine Places – through wider Place-Based Partnerships.

The ICB will remain accountable for NHS resources deployed Place-level. The ICB is represented by designated Place Directors within local Place-Based Partnerships.

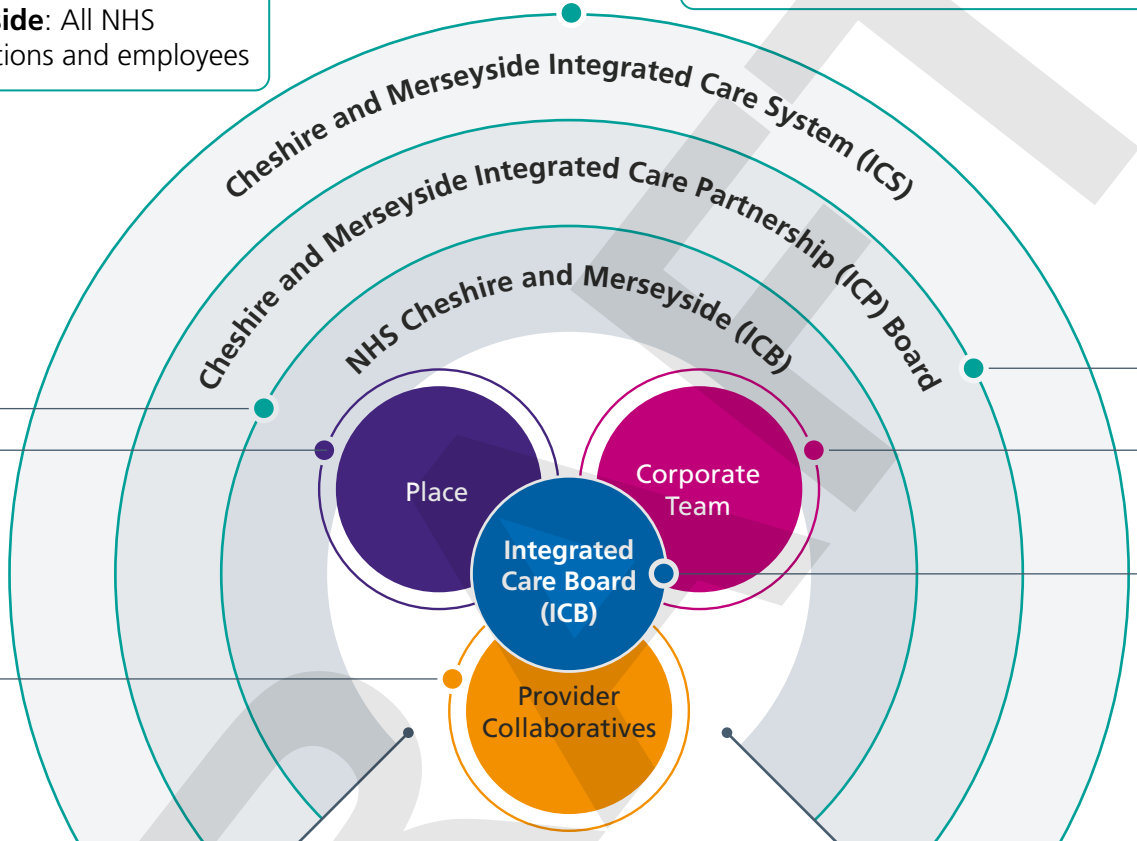
Health and Wellbeing Boards (HWBs) will continue to develop the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, which both the ICP and ICB will give due regard.

Our new integrated care structure

ICS: The **entire** health and care system for Cheshire and Merseyside

NHS NHS Cheshire and Merseyside: All NHS organisations and employees

ICP: The **Board** that brings together **Local Authorities** with the **local NHS** and **Voluntary Sector** to produce an Integrated Care Strategy to meet the health and wellbeing needs of the population



ICS PURPOSE

- Improve outcomes
- Enhance productivity and value for money
- Tackle inequalities
- Support broader social and economic development

9 Places across C&M
Partnerships of NHS, Local Authority and voluntary sector organisations

Providers working together
Two Provider Collaboratives
Primary Care Forum

The Statutory NHS Board
Oversees the NHS budget in Cheshire and Merseyside

The ICB Executive Team that supports the ICB

1.5 About our population

Cheshire and Merseyside is home to **2.7 million people across our nine 'Places'**. Halton is the smallest Place in Cheshire and Merseyside, with a population of 129,000 – compared with Liverpool which has a population of approximately 500,000.

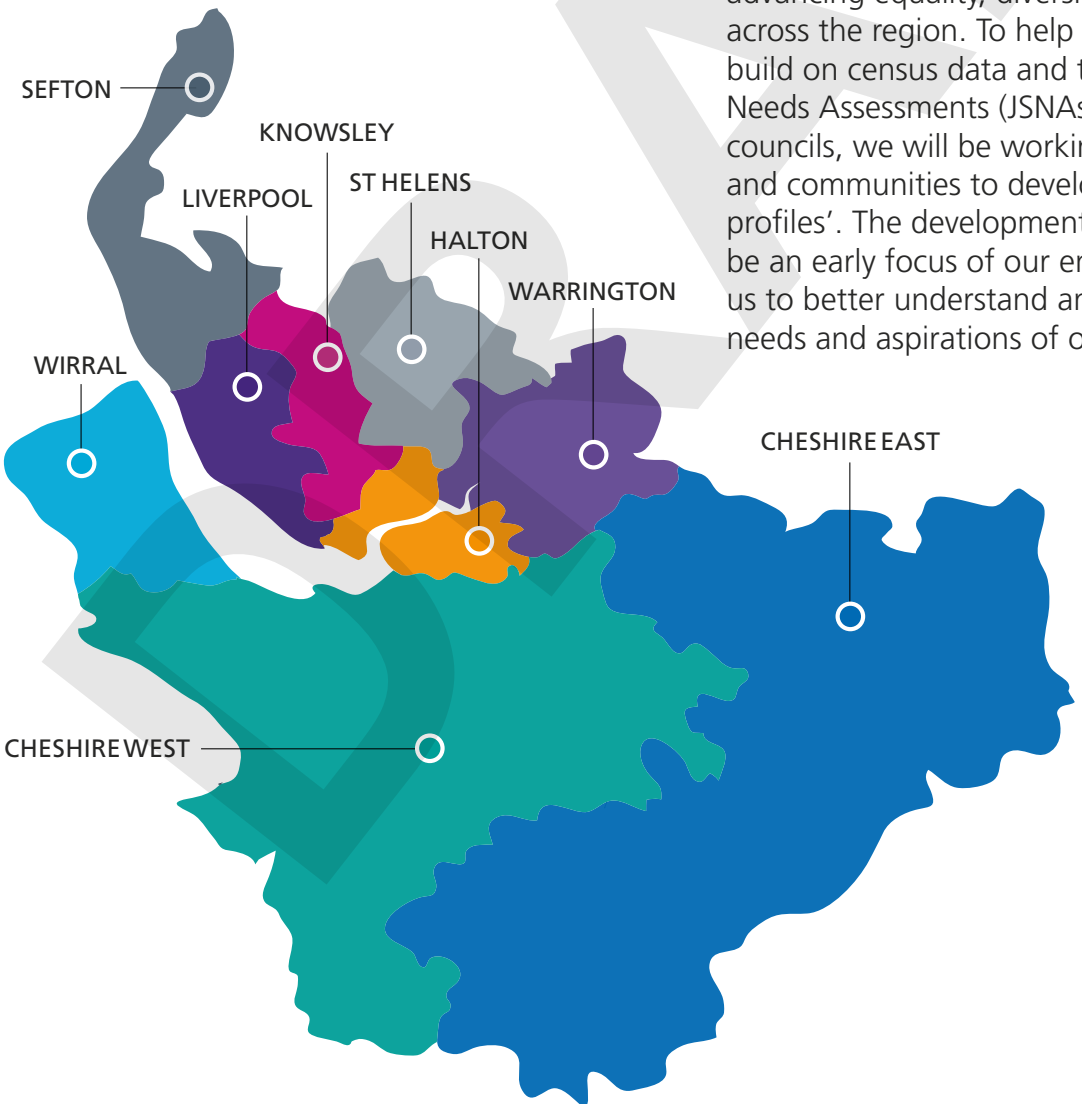
Compared to the England average, the region currently has higher rates of premature cancer, cardiovascular disease (CVD) and respiratory deaths.

One third of our population live in the most deprived 20% of neighbourhoods in England. One in four people in Liverpool and Knowsley live in poverty. 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.

Whilst levels of deprivation are not as high in Cheshire, there are stark pockets of deprivation and health outcomes for some long-term conditions, while alcohol misuse and self-harm are worse than the England average.

Demand for health and care services across the region is high and growing. With demand outstripping available resources, we must work together to place emphasis on prevention and the promotion of positive health and wellbeing

All system partners are fully committed to advancing equality, diversity and inclusion across the region. To help us do that and build on census data and the Joint Strategic Needs Assessments (JSNAs) produced by our councils, we will be working with people and communities to develop detailed 'Place profiles'. The development of these profiles will be an early focus of our engagement and help us to better understand and respond to the needs and aspirations of our population.



2. Key principles

2.1 The 10 principles

There are 10 key principles that will guide how we work with people and communities in Cheshire and Merseyside. These principles have been developed through national consultation, but we want to make sure they resonate with local people as part of a wider conversation about our Public Engagement Framework.

Alongside our partners from local Healthwatch and VCFSE sector organisations, we will continue to test these principles with people and communities in Cheshire and Merseyside and adapt them for local use – based on the feedback we receive.

As Cheshire and Merseyside is a very large and complex system, there can be no 'one size fits all' approach within our system, Places and neighbourhoods. These principles will help our health and care organisations develop ways of working with people and communities – depending on local circumstances and population health needs. They should be applied throughout Cheshire and Merseyside, whether activity takes place within neighbourhoods, in Places, or at system-level.

It is important to reflect that whilst the principles are shown and described separately, they are interlinked and all together will encourage collaboration.


10
principles for working with people and communities
01
Centre decision-making and governance around the voices of people and communities.
02
Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions.
03
Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working.
04
Build relationships based on trust, especially with marginalised groups and those affected by health inequalities.
05
Work with Healthwatch and the voluntary, community and social enterprise sector.
06
Provide clear and accessible public information.
07
Use community-centred approaches that empower people and communities, making connections to what works already.
08
Have a range of ways for people and communities to take part in health and care services
09
Tackle system priorities and service reconfiguration in partnership with people and communities.
10
Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places.

2.2 Turning the principles into action

Our Public Engagement Framework will be used in our work with system partners to develop plans in 2022/23 that turn the principles into action.

1. Centre decision-making and governance around the voices of people and communities

- Build the voices of people and communities into governance structures so that people are part of the decision-making processes
- Recognise the collective responsibility at board level for upholding legal duties, bringing in lay perspectives but avoiding creating isolated, independent voices
- Make sure that boards and communities are assured that appropriate involvement with relevant groups has taken place (including those facing the worst health inequalities); and that this has an impact on decisions
- Ensure that effective involvement is taking place at the appropriate level, including system, Place and neighbourhood, and that there is a consistency and coordination of approaches
- Support people with the skills, knowledge and confidence to contribute effectively to decision-making and governance
- Make sure that senior leaders set an example for inclusive and collaborative ways of working.

2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions

- Take time to plan and budget for participation; recognising that engagement and co-production needs time and resources
- Start involving people as early as possible so that it informs options for change and subsequent decision-making
- Involve people and communities on a continual basis, embed relationships, rather than taking a stop-start approach when decisions are required. As a result, there will be much greater, ongoing awareness of the issues, barriers, assets and opportunities
- Be clear about the opportunity to influence decisions, what taking part in decision-making can achieve, and what is out of scope
- Vary the voices, record and celebrate people's contributions and give feedback on the results of involvement – including changes, decisions made and what has not changed and why
- Keep people informed of changes that take place sometime after their involvement and maintain two-way dialogue so people are kept updated and can continue to contribute
- Take time to understand what works and what could be improved
- Value and appreciate people's contributions.

3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if changes are working

- Use data about the experiences and aspirations of people who use (and do not use) health services, care and support and have clear approaches to using this information and insight to inform decision-making and quality governance
- Work with what is already known by partner organisations, from national and local data sources, and from previous engagement activities including those related to the wider determinants of health
- Share data with communities and seek their insight about what lies behind the trends and findings. Their narrative can help inform about the solutions to the problems that the data identifies
- Understand what other engagement might be taking place on a related topic and take partnership approaches where possible, benefiting from combined assets and avoiding 'consultation fatigue' amongst communities by working together in an ongoing dialogue that is not limited by organisational boundaries
- Build on existing networks, forums and community activities to reach out to people rather than expecting them to come to us. Be curious and eager to listen; don't assume we know what people will say or what matters to them.

4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities

- Proactively seek participation from people who experience health inequalities and poor health outcomes – connecting with trusted community leaders, organisations and networks to support this
- Consider how to include people who do not use services, whether because they do not meet their needs or are inaccessible, and reach out to build trust and conversations about what really matters to them
- Recognise and engage with our partners who have trusted relationships with our population – like community health staff and the Fire Service
- Work with people and communities from the outset, taking time to build trust, listen and understand what their priorities are being realistic about what is in scope and where they can set the agenda for change
- Tailor our approach to engagement to include people in accessible and inclusive ways so we include those who have not taken part before
- Recognise that some communities will not feel comfortable discussing their issues and needs in wider meetings, so may need separate, targeted activities. They may need additional support to take part including reimbursements for their time
- When reporting on engagement activity, explain the needs and solutions for different communities rather than simply aggregating all data and feedback together.

5. Work with Healthwatch and the voluntary, community, faith and social enterprise sector as key partners

- Continue to strengthen our partnership with Healthwatch and the VCFSE sector to bring their knowledge and reach into local communities. Work with them to facilitate involvement from different groups and develop engagement activities
- Recognise the added value that VCFSE can bring by coordinating and engaging with networks and communities that are seldom-heard
- Understand the various types of VCFSE sector organisations in our area, their different features and how we can connect with them
- Value the qualitative work of VCFSE and Healthwatch, and the stories they tell from direct engagement with communities and give equal value to this alongside quantitative data
- Give due consideration to who is commissioned to support engagement activity
- When we commission other organisations to work with communities, ensure that our decision-makers remain personally involved and hear directly what people have to say
- Consider how we use, support and reward volunteers across the system.

6. Provide clear and accessible public information

- Develop information about plans that is easy to understand, recognising that everyone has different needs and testing information where possible
- Where Easy Read documents are required, they should be prepared at the same time as other materials
- Providers of NHS care must meet their requirements under the **Accessible Information Standard** for the information and communication needs of people in their own care.
- These principles should also be applied to public information so that is clear and easy to understand
- Be open and transparent in the way we work, being clear about where decisions are made and the evidence base that informs them, along with resource limitations and other relevant constraints
- Where information must be kept confidential, explain why
- Make sure we describe how communities' priorities can influence decision-making, how people's views are considered, and that we regularly feedback to those who shared their views and others about the impact this has made
- Provide feedback in an inclusive and accessible way that suits how people want or can receive it
- Be aware of using public sector terminology, which is alien to many people and communities
- Make sure information on opportunities to get involved is clear and accessible and encourage a wide range of people to take part
- Ensure that there is information that 'closes the loop', and they are kept informed on how engagement has influenced change.

7. Use community-centred approaches that involve people and communities, building on what works already

- Support and develop existing community assets, such as activities and venues which already bring people together such as faith communities, schools, community centres, employers and local businesses, public spaces and community-centred services like link workers, community champions and peer support volunteers
- Build trust and meaningful relationships in a way that makes people feel comfortable sharing ideas about opportunities, solutions and barriers
- Work with communities to design, deliver and evaluate solutions that are built around existing community infrastructure
- Recognise existing volunteering and social action that supports health and wellbeing and create the sustainable conditions for them to grow
- Share best practice from across the system to support local approaches.

8. Have a range of ways for people and communities to take part in health and care services

- Choose a method of working with people and communities that is appropriate to specific circumstances, ensuring it is relevant, fair and proportionate
- Use methods that are suitable to the situation and blended methods where appropriate
- Design engagement activities to take place at a time and in a way that encourages participation, and consider the support people may need to take part, such as reimbursements for their time
- Recognise that people are busy and have other priorities such as work and caring responsibilities and ensure that there are different ways to get involved with varying levels of commitment
- Include approaches such as co-production, where professionals share power and have an equal partnership with people to plan, design and evaluate together
- Where decisions are genuinely co-produced, then people with specific lived experience work as equal partners alongside health and care professionals (those with learnt experience), and jointly agree issues and develop solutions
- Recognise the time and resource that co-production takes and plan accordingly
- We will ensure that engagement reaches beyond the hours of 9am to 5pm, Monday to Friday. We will also ensure there is a fair mix of face-to-face and online formats.

9. Tackle system priorities and service reconfiguration in partnership with people and communities

- People who use health and care services have knowledge and experience that can be used to improve services with cost-effective and sustainable ideas
- Embracing these ideas can lead to changes that better meet the needs of the local population
- Communities often have longer memories than our staff who may change roles and move therefore understanding the changes experienced by local communities helps to learn and build trust with people
- When people better understand the need for change, and have been involved in developing the options, they are more likely to advocate the positive outcomes and involve others in the process.

10. Learn from what works and build on the assets of all health and care partners – networks, relationships and activity in local places

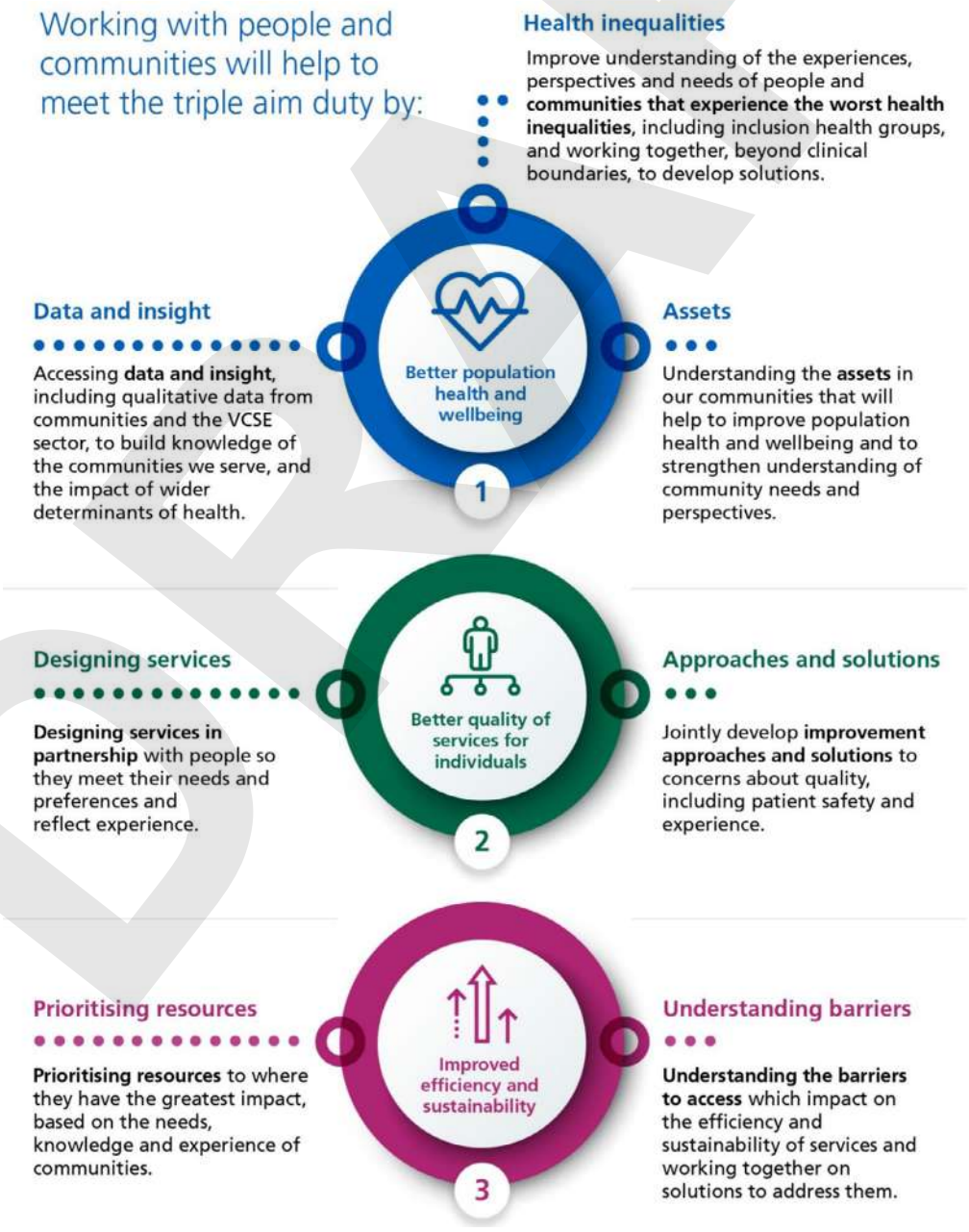
- Collaborate with partners across our system to build on their skills, knowledge, connections and networks
- Reduce duplication by understanding what is already known and what has already been asked, before designing the approach to engagement
- Learn from approaches taken elsewhere in the country and how they can be adapted and applied locally
- Plan together across Places so that partnership work with people and communities is coordinated, making the most of partners' skills, experiences and networks
- It is also important to learn lessons from what hasn't worked and learn from complaints, concerns and incidents.

3. The triple aim duty

NHS England, ICBs, NHS trusts and NHS foundation trusts are subject to the new 'triple aim' duty in the Health and Care Act 2022 (sections 13NA, 14Z43, 26A and 63A respectively). This requires these bodies to have regard to 'all likely effects' of their decisions in relation to three areas:

1. Health and wellbeing and its effects in relation to health inequalities
2. Quality of health services for all individuals, including the effects of inequalities in relation to the benefits obtained from those services
3. The sustainable use of NHS resources.

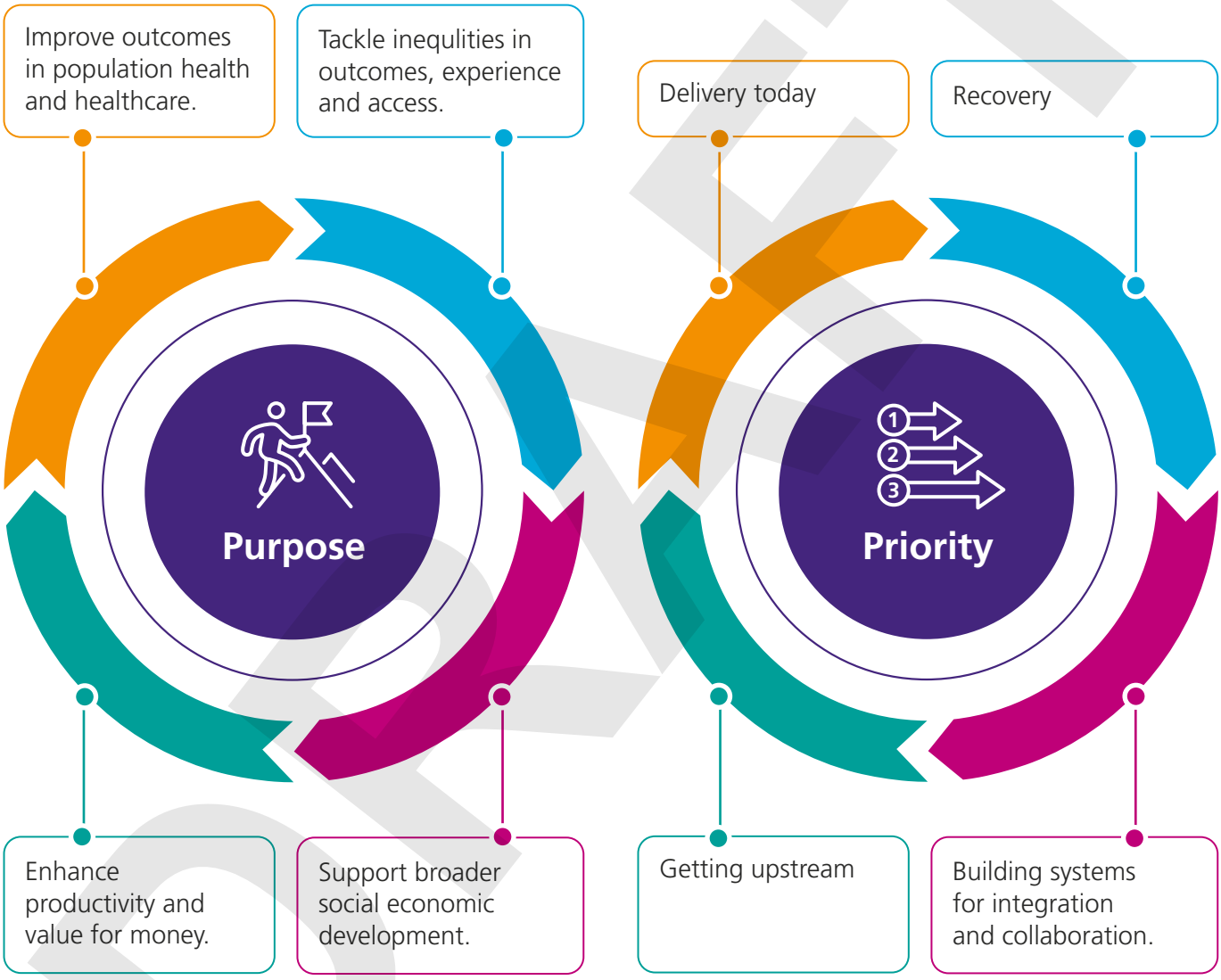
Effective working with people and communities is essential to deliver the triple aim, as shown in the diagram below:



4. Priorities for 2022/23

4.1 System priorities

All ICSs have four core purposes. In Cheshire and Merseyside, we have also set out our shorter-term priorities:



Improve population health and healthcare

- Reduce deaths from cardiovascular disease, suicide and domestic abuse
- Reduce levels of obesity
- Reduce harm from alcohol
- Provide high-quality, safe services
- Provide support to all those experiencing 'long COVID'
- Provide integrated, high-quality, mental health and wellbeing services for all people requiring support from low levels of intervention to crisis management and inpatient care
- Underpin improvements in health and healthcare with Research and Innovation by supporting collaboration between Cheshire and Merseyside academic partners, and making them a key part of our Health and Care Partnership (ICP).

Tackling unequal outcomes and access

- Reduce the life expectancy gap in the most deprived communities, in children and those with mental health conditions and help people live extra years in good health
- Improve early diagnosis, treatment and outcome rates for cancer
- Improve waiting times for children and adult mental health services
- Target those with chronic diseases so they access services – especially those in our most deprived areas
- Reduce the impact of poor health and deprivation on educational achievement.

Enhancing productivity and value for money

- Prioritise making resources available to prevention and wellbeing services
- Plan, design and deliver services at scale (where appropriate) to drive better quality, improved effectiveness and efficiency
- Maximise opportunities to reduce costs by procuring and collaborating on corporate functions at scale
- Develop whole system plans to address workforce shortages and maximise collaborative workforce opportunities
- Secure value for money
- Develop a whole system Estates Strategy.

Support broader social and economic development

- Embed a commitment to social value in all our partner organisations
- Establish the 'Anchor Institution' in Cheshire and Merseyside, offering significant employment opportunities for local people
- ICS will be involved in regional initiatives to develop economy and support communities in Cheshire and Merseyside
- Develop a programme in schools to support mental wellbeing of young people
- Develop a programme in schools to help inspire careers in health and social care
- Work with local economic partnerships (LEPs) to connect ICS partners with business and enterprise.

4.2 Our programmes

There are several system-wide programmes that will help us to meet our priorities. The involvement of people and communities in our programmes is essential to help us improve wellbeing, provide better services and design smoother care pathways.

Programme	Summary
Ageing Well	Urgent community response, enhanced health in care homes and helping people with complex needs to stay healthy.
Beyond Programme (children and young people)	Healthy weight, emotional wellbeing, respiratory health, and care for people with a learning disability and autism.
Cardiac Board	Initiatives focussed on prevention and early intervention, population health and creating stable services.
Diagnostics	Includes all diagnostic tests including, pathology, imaging, endoscopy, screening programmes, cardio and respiratory, neurophysiology and more.
Digital	Tackling digital exclusion, driving integration of care records and population health management, systems to support transformation – including remote monitoring, digital primary care and digital social care, cyber security and service recovery plans to improve treatment times.
Elective Recovery	Reducing waiting lists, restoring services to pre-COVID levels, and embedding sustainable services.
Medicines and Pharmacy	Reducing unwanted variation and creating equitable service provision across Cheshire and Merseyside.
Mental Health	Community mental health, crisis care, psychological therapies, maternal and perinatal mental health, support for our workforce.
Neuroscience	Building on new clinical pathways and increasing the range of services to improve population health.
Population Health	Improving population health and healthcare, tackling health inequalities, and improving outcomes and access to services.
Women's Health and Maternity	Transforming and improving support for women's health, improving wellbeing, life chances and outcomes for women and babies.
Diabetes	Improving treatment targets, multi-disciplinary footcare teams in all Places, specialist nursing and flash glucose monitoring.
Palliative and End of Life Care	For adults, children and young people to live well, before dying in peace and with dignity in the place they would like to die – supported by the people important to them.
Respiratory	Quality assured diagnostic spirometry, pulmonary rehabilitation and psychological support to manage respiratory disease.
Stroke	Reducing the number of strokes in Cheshire and Merseyside by focusing on prevention, reducing health inequalities, improving access and enabling community rehabilitation.

Case studies – Involvement in the Digital Programme

The Cheshire and Merseyside Health and Care Partnership's Digital Programme is working on updating its **Digital Strategy 2018-23**, with a Digital and Data Strategy that better supports recent policy context (as set out in **What Good Looks Like** and **Data Saves Lives)**, and the massive acceleration of digital transformation accelerated by COVID-19.

As part of this piece of work, several engagement exercises are being undertaken with members of the public and health and care professionals living and working in Cheshire and Merseyside. These will help to ensure that the strategy helps to digitally empower the diverse population we serve to take control of their own health and wellbeing. The Digital Programme also enables our health and care workforce to deliver safer, more effective, and efficient care to their patients.

To help illustrate the breadth and depth of this engagement work, the following two case studies have been included to highlight exercises we've started, and how they'll shape our work moving forward.

Digital Inclusion Heatmap and Insight Project

The COVID-19 pandemic has exacerbated inequalities within society – including the digital divide. This was at a time when having full access to computers and the internet could not be more important in allowing people to access online health and care services.

Furthermore, digitally-excluded people (such as older people, financially disadvantaged people and disabled people) – who may be unable to get online due to factors such as access, confidence, motivation, and skills – are some of the heaviest users of health and care services.

To enable better targeting of interventions to support digitally-excluded people across Cheshire and Merseyside, our Digital Inclusion programme has commissioned the development of a 'Digital Inclusion Heatmap for Cheshire and Merseyside'.

Heatmap is a tool that uses data sets supplied by primary care, social care and local authority partners to provide an up-to-date snapshot (that can be updated over time) of digital inclusion initiatives and resources available across the nine local authority areas or 'Places' in Cheshire and Merseyside.

A focused piece of insight is being undertaken to gather attitudes of digitally-excluded people and the barriers and issues that they face when it comes to accessing health and care online – with a specific focus on the NHS App.

Multiple methods are being used, including focus groups, in-depth surveys, community outreach, and engagement with local businesses, to ensure the views of a wide range of people both living and working in Cheshire and Merseyside are captured.

It is hoped that Heatmap and insight work will provide us with a broader understanding of the barriers faced by digitally-excluded people in our area across a variety of settings, when trying to access digital equipment, data, and skills.

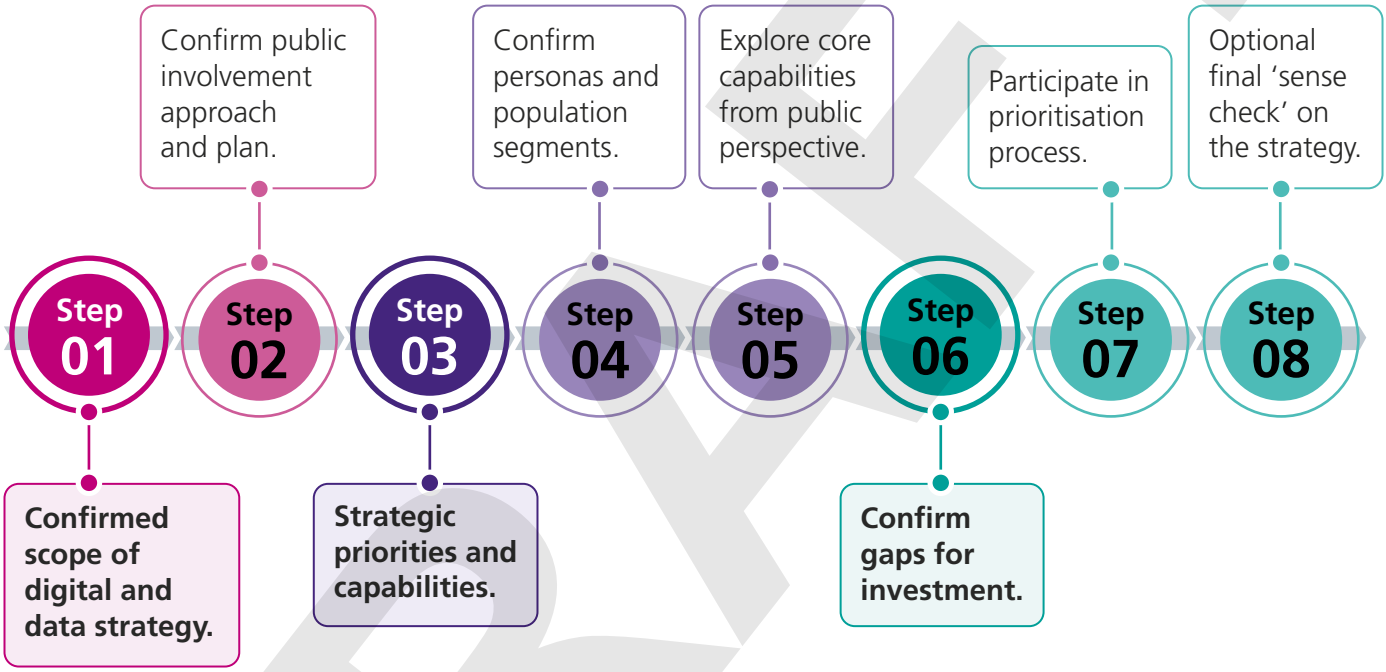
Our aim is to ensure that everyone who is unable to access and engage digitally in Cheshire and Merseyside has the opportunity (as far as possible) to do so or are provided with an alternative solution. This avoids people being left behind as we move towards a 'digital first' culture.

Public Involvement Panels

In order to create a person-centred digital programme we are co-producing our strategy. We have identified several 'touchpoints' where public involvement is helping to test our proposals for digital architecture and systems that span Cheshire and Merseyside.

These touchpoints are shown below as solid circles in the strategy development timeline:

ICS Digital and data strategy development phases and public involvement milestones



The deliberative method we are using incudes 'online group work involving Public Advisers from the National Institute for Health and Care Research (NIHR) and Applied Research Collaboration (ARC) Northwest Coast. Advisers are drawn from across Cheshire and Merseyside to represent diverse communities from our area. They have received training and support from the ARC to participate in this activity.

For children and young people, we are partnering with Youth Federation to involve young people in online events. We have also run an online session with Alder Hey Hospital's Children and Young People's Forum.

These initial events focussed on testing population segments or 'personas', which we created for the purposes of the strategy. Our next events will focus on the core capabilities to be commissioned by ICS digital to ensure these meet the aspirations of the personas.

5. Advancing equality

5.1 Health inequalities

Health inequalities are the unjust and avoidable differences in people's health across the population and between specific population groups. Tackling the causes and consequences of health inequalities is a central priority for the Cheshire and Merseyside ICS. This is also helping to ensure we met the new triple aim duty.

One of the key priorities of our Public Engagement Framework is to build relationships with excluded groups – especially those who are affected by inequalities – so that we can understand and meet their needs and aspirations for wellbeing, health, and care.

Our work will build on the **CORE20PLUS5** approach – a national framework that helps define the population groups in each system experiencing health inequalities. Hearing their experiences and understanding the barriers these groups face in accessing care and treatment is an important part of addressing unequal access to services.

Citizens' Panel

A Citizens' Panel is a large, demographically-representative group of citizens regularly used to assess public preferences and opinions. It aims to be a consultative body of citizens and is typically used by statutory agencies to identify local priorities and to consult members of the public (some of whom may use services) on specific issues.

NHS Cheshire and Merseyside's Citizens' Panel is at an early stage of development and will be 'testing' various approaches to elicit citizens' feedback with the aim of recruiting a sample of up to 1,000 people living and working in the region.

Reducing health inequalities within the nine Places of Cheshire and Merseyside is a key objective. Therefore, it is important that the Citizens' Panel is a diverse cohort focusing on people and communities most affected by heath inequalities in our cities, towns and villages.

Panellists recruited will be representative of the population of Cheshire and Merseyside and, alongside self-selecting engagement partners from existing forums, will be consulted on system health and care issues. Panellists will also inform decision-making and help to shape engagement approaches.

It's essential that we embed the citizens' voice in the commissioning cycle. This is key to strengthening our ability to demonstrate the impact that people's experiences, insights and aspirations have on our work.

There are already some excellent examples of Healthwatch and local authority partners gathering insights from people and communities in Cheshire and Merseyside.

We want to join-up and build on this work at system level, with a particular emphasis on the people and communities who are most affected by heath inequalities in our cities, towns and villages.

We will work with Healthwatch, the VCFSE sector and local authority partners to support the development our Citizens' Panel, which will seek to better understand the barriers faced by ethnic communities and people affected by poverty, unemployment and housing issues, in order to capture a holistic picture of inequalities and work with people and communities on joined-up solutions.

The social determinants of health (such as local neighbourhoods, access to greenspace, opportunities for being more active and access to healthy food) as well as physical and mental wellbeing are key. As a listening organisation, we want to develop an ongoing discussion with panellists about:

- health and care services
- health and wellbeing issues and their ideas to resolve them
- aspirations for better services and care pathways.

The response to COVID-19 has seen people in Cheshire and Merseyside support family, friends and neighbours including those self-isolating and encouraging vaccine take-up. The learning from this should be transferred to help us meet other challenges that health and care services face by listening to people and working with them to decide what will work best locally.

Health inequalities can be reduced by identifying solutions that are developed in partnership with people using community-centred approaches. Understanding the experiences and perspectives of those who face barriers to care and support, and have different outcomes, will help to develop opportunities for improvement and investment. By building trust and mutual understanding of the full range of our marginalised communities we will start to address unequal access to services and health outcomes.

5.2 Equality, Diversity and Inclusion

It is important that we listen, respond to, and make every effort to involve individuals from all protected characteristic groups for example young people, older people, and lesbian, gay, bisexual, transgender, and questioning (LGBTQ) groups. In Cheshire and Merseyside, we celebrate the diversity of our communities.

It is also important that we listen to other underserved groups such as people with specific health conditions, people experiencing homelessness, refugees and asylum seekers, or people living in deprivation and/or rural communities to make sure we reach a diverse range of people to give them the opportunity to share their views.

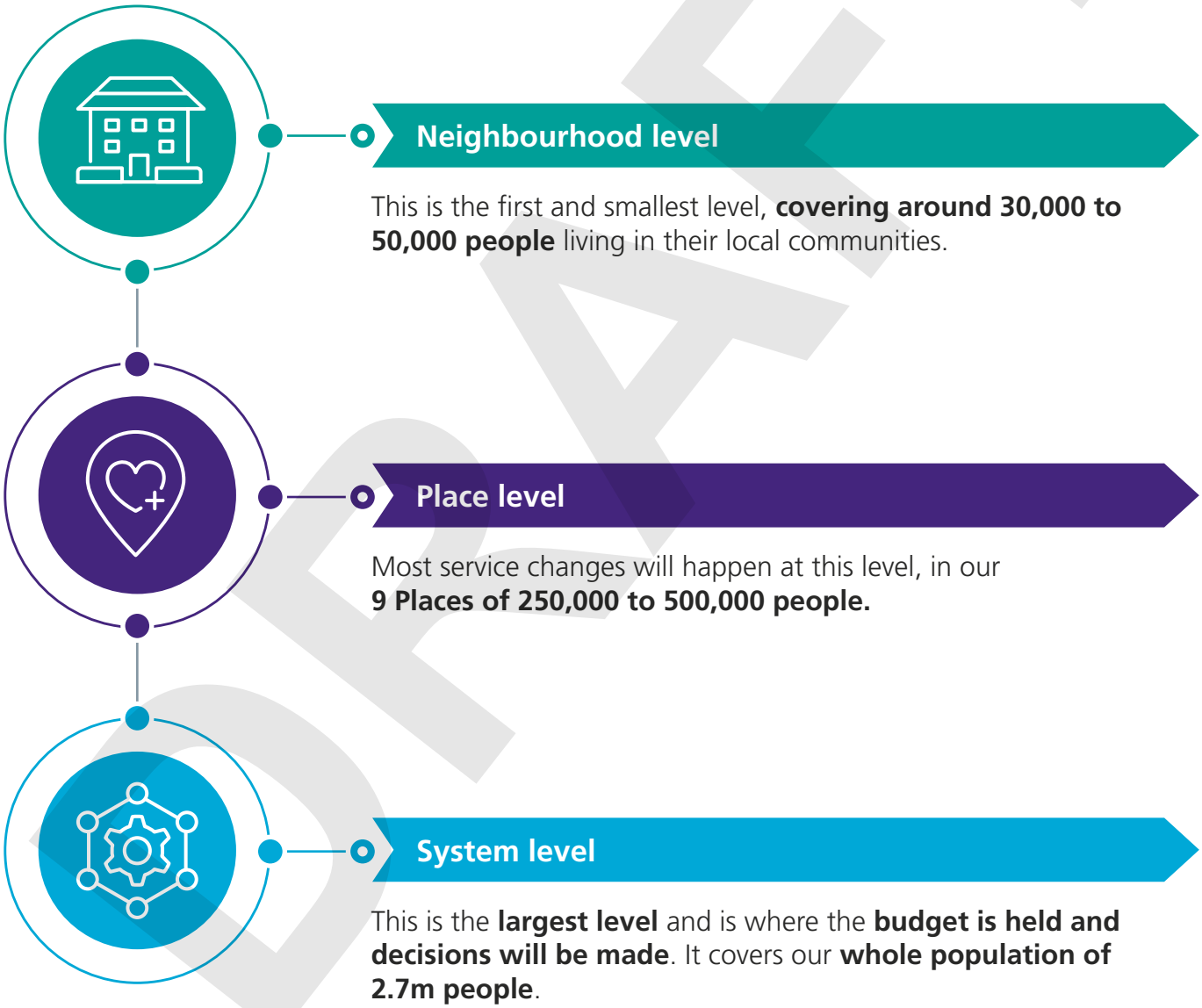
We will use Equality Impact Assessments to help us understand which groups may need to be specifically targeted for a programme of work. We will be informed by Public Health and their needs assessments and evidence on health inequalities.

Healthwatch has developed a checklist for assessing the quality of Equality Impact Assessments which can be used to provide the checks and balances to hold the system to account.

6. Involving people and communities

6.1 Levels of engagement

Our Cheshire and Merseyside Public Engagement Framework will support us to work with people and communities at different levels:



Neighbourhood level

This is the first and smallest level, **covering around 30,000 to 50,000 people** living in their local communities.

Place level

Most service changes will happen at this level, in our **9 Places of 250,000 to 500,000 people.**

System level

This is the **largest level** and is where the **budget is held and decisions will be made**. It covers our **whole population of 2.7m people**.

Neighbourhood

At neighbourhood level, our GPs, opticians, dentists and community pharmacists are working together to deliver 'primary care', which is care that takes place outside of a hospital setting. They work together in your local area to form a Primary Care Network (PCN). All doctors and primary care professionals are part of one of these networks so they can work with people and communities to shape and improve local services.

Nine Places

Our Places are the areas covered by our nine local authorities and include several neighbourhoods. This is where most health and care services are delivered, including hospital care.

There are Place-based partnerships, where local hospitals, care providers, local councils, doctors, Healthwatch and the VCFSE sector are coming together to discuss key health and care issues with local people and communities.

Cheshire and Merseyside 'System'

Our Cheshire and Merseyside Integrated Care System, which is responsible for running health and care services, is made up of two key bodies:

Integrated Care Partnership (ICP)

This links in with all the wider partners - including Healthwatch the VCFSE sector, employment and health - at Place level. Through discussion with people and communities, the partnership will use the information about the local population to create a strategy for helping everyone who lives and works in the system area to live healthily.

Integrated Care Board (ICB)

The ICB oversees the NHS budget and makes sure the services are in place to ensure the strategy becomes a reality on a reality on the ground.

6.2 Using the framework

This framework is not a finished product. It reflects a moment in time, providing our early blueprint for working with people and communities. The longer-term strategy and delivery plan for Cheshire and Merseyside must be co-produced with residents, partners, staff and stakeholders.

Developing our Public Engagement Framework will require us to test approaches, learn and evolve over time. We must challenge ourselves, be flexible and collaborate with people and communities to meet longer-term goals.

Core priorities include developing a culture of co-production and embedding the residents' voice in the way we plan, develop and deliver services.

People and communities have the experience, skills and insight to transform how health and care are designed and delivered. The ambition is for the Cheshire and Merseyside ICS to build positive and enduring relationships with communities to improve services, support and outcomes for people.

This means:

- listening more and broadcasting less
- being flexible and responsive
- ongoing involvement and engagement of people and communities that is iterative and not only done in isolation, when proposing to change services
- focussing on what matters to communities, including people from marginalised groups and those who experience the worst health inequalities
- supporting approaches around existing networks, community groups and other Places where people come together
- developing plans and strategies that are fully informed by people and communities
- providing clear feedback about how people's views will lead to improvement, impact and change
- Involving communities to develop their own solutions to improving the health of all.

Working in this way will enable better decisions with people about service changes, and improve operational effectiveness, Care Quality Commission (CQC) inspection outcomes, safety, quality, experience and performance.

It is vital – whether working at a system-level, in one of our Places or local neighbourhoods – that engagement is carefully planned and designed to ensure that partners, people and communities get the best out of our work together.

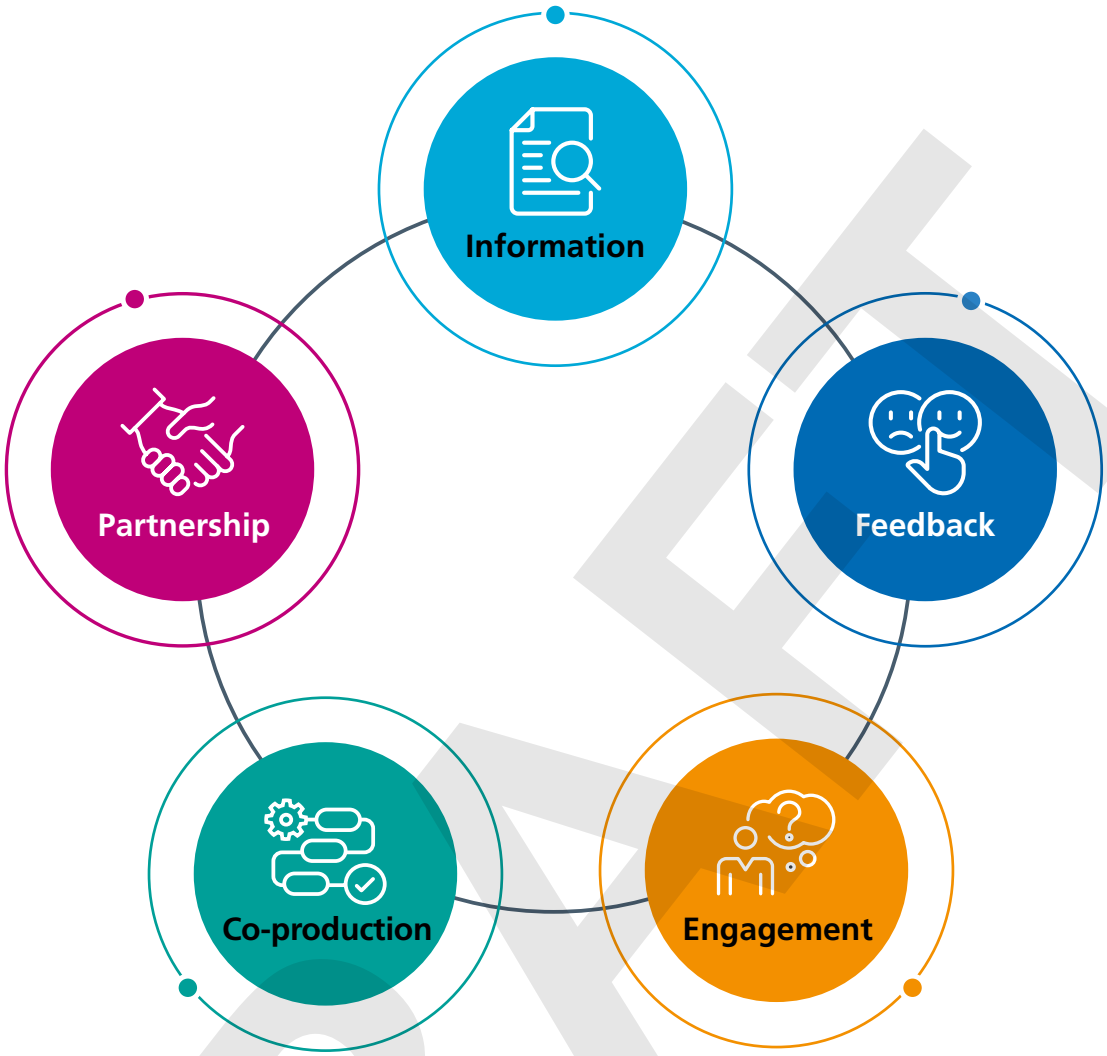
6.3 People's voice

We recognise how important it is for us to be open and transparent about how the feedback we receive informs our planning and decision making. The diagram below simply illustrates the feedback loop that we will use to keep people informed.

To plan, develop and deliver wellbeing, health and care services and support that the people of Cheshire and Merseyside need, we will constantly evaluate feedback from a wide range of sources. We will use the feedback we gather, alongside the quantitative data we collect, to develop a repository of intelligence that we will use to identify actionable insights and ensure people's voice is at the centre of our decision-making.

During the year, we will bring that information together to produce 'Insight and Intelligence' reports at system and in Place. These can be used by our teams to shape programme plans and service change activity.

We will publish these reports to show what we have captured, and we'll also publish details of how feedback has been used and the impact it has had.



6.4 Our approach

1. Reach out to people and ask them how they want to be involved
2. Promote equality and inclusion and encourage and respect different beliefs and opinions
3. Proactively seek the involvement of people who are underserved and who experience health inequalities and poorer health outcomes
4. Value people's specific lived experience and use all the strengths and talents that people bring to the table
5. Provide clear and easy-to-understand information and recognise that everyone has different needs
6. Take time to plan with and involve people as early as possible
7. Be open, honest, and transparent in the way we work – explain decisions, be clear about resource limitations and constraints
8. Where information must be kept confidential, explain why
9. Invest in partnerships, engage in ongoing dialogue and provide information, support, and training to enable leadership from those with specific lived experience
10. Review people's experiences and learn from them to continuously improve how people are involved
11. Recognise, record, and celebrate people's contributions and give feedback on the results of involvement and engagement.

7. Collaboration and partnership working

This is about building relationships with organisations and local communities in a way that treats partners equitably, and that recognises the contribution that can be made to improving the health and care system.

Working collaboratively and in partnership gives us a far greater opportunity to ensure that our services meet people's needs, and that experiences and outcomes can be improved. People and communities have the knowledge, skills, experience and connections to support and improve health and wellbeing.

We want to identify and deliver 'shared outcomes' that meet the needs of communities. This is particularly relevant in the context of population health management and reducing health inequalities. Our health and wellbeing can be affected by many things – housing, unemployment, financial stress, domestic abuse, poverty and lifestyle choices.

Within our partnership Healthwatch, the VCFSE sector, and our local authorities bring vital strengths in working with people and communities – and vast experience of working with people to design and deliver services that meet local needs and build community assets.

In Cheshire and Merseyside, we have very well-established partnerships at a local level, and have had for many years. Our partners work together to improve the health and wellbeing of local people and communities through policies and plans for housing, early years, growth, skills and employment.

Our Integrated Care System puts us in an even better position to respond to these challenges in Cheshire and Merseyside, alongside our local authorities, Healthwatch and the VCFSE sector.

In co-producing our Public Engagement Framework, we have identified a set of principles that will enable us to strengthen our partnership with Healthwatch and the VCFSE sector.

7.1 Working with Healthwatch

What will good look like?

The strength and value of the independent, statutory role of Healthwatch is recognised as fundamental to the planning and delivery of health, care and wellbeing services throughout Cheshire and Merseyside.

'What good will look like' includes:

- Building strong relationships with the local Healthwatch network to help ensure services are shaped around the needs of people and communities
- Partners respecting, valuing and supporting the core duty of Healthwatch to engage with people and communities across all health and care services and the whole 'life-course'
- Acknowledging and benefitting from the unique position Healthwatch holds both outside and inside the wider system, as a voice for people and communities – including those not regularly heard and as a constructive, critical friend with statutory powers

- Working in partnership with Healthwatch to ensure people and communities are able to share their experiences and be involved in service design, planning and delivery, knowing their input is respected, heard and responded to
- Ensuring the statutory functions, activities and duties of Healthwatch are maximised to plan, design and deliver quality services
- Insight and intelligence from Healthwatch reports, and 'Enter and View' programmes of work, regularly being used and referred to for quality planning and assurance of services
- Early inclusion of Healthwatch in designing, planning and delivering engagement activities, ensuring resources and mechanisms are in place to deliver
- Recognising the co-location of local Healthwatch groups within each of the Cheshire and Merseyside Places – their commitment to working collaboratively, and the ability to carry out their role at neighbourhood, Place, system and national-level.

7.2 Working with the VCFSE sector

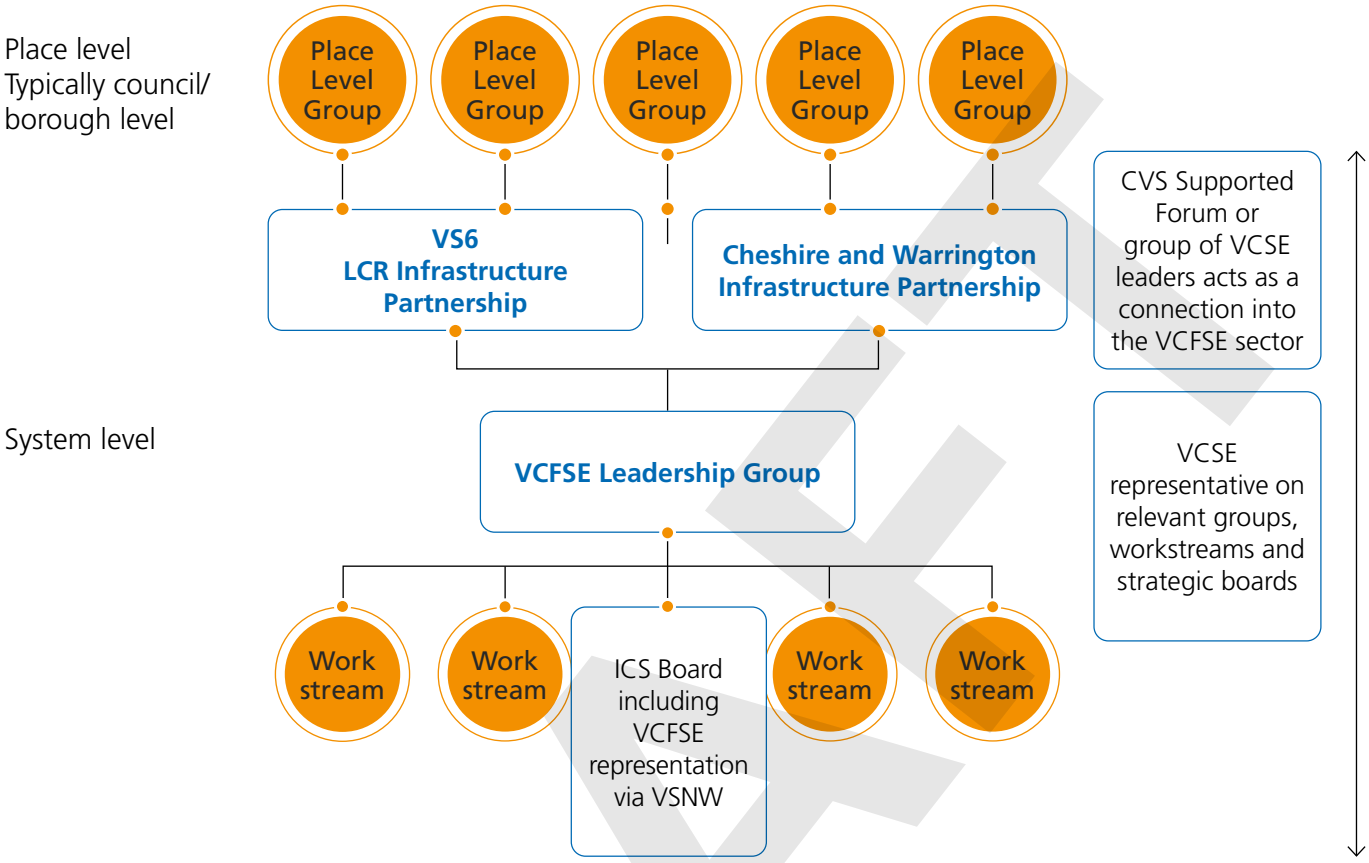
The VCFSE sector has always provided a wide range of support to health, care and wellbeing services including helping community voices to be heard. Working with the Cheshire and Merseyside VCFSE infrastructure provides access to a network of over 15,000 VCFSE organisations, ensuring a stronger collective voice across our diverse communities.

'What good will look like' includes:

- Recognising that the VCFSE sector has a rich source of insight and data, that reflects local community need which is used to inform planning and delivery
- Increased opportunities for community engagement, designed and led by the VCFSE sector, delivering meaningful engagement to provide up-stream solutions with opportunities to co-design, to help influence and shape service provision
- Ensuring leaders and advocates across the VCFSE sector are fully engaged on decision-making programmes and project boards
- Increasing engagement though the extensive VCFSE reach within our diverse and seldom-heard communities to share views and experiences to shape and influence service redesign and encourage co-production
- Using resources and investment to ensure the VCFSE has the capacity to engage as an equal partner across local and regional systems.
- Utilising local infrastructure and established relationships across the Cheshire and Merseyside strategic ecosystem of boards, forums and groups, ensuring credibility and assurance when representing the views of the sector.

VCFSE infrastructure organisations are recognised and used as a key channel for two-way communications with NHS Cheshire and Merseyside, providing a consistent approach to engagement.

Local model for strategic VCFSE engagement:



7.3 The benefits

Accountability and transparency

Our organisations should be able to explain to people how decisions are made in relation to any proposal and how their views have been taken on board. Transparent decision-making with people and communities involved in governance will help make our ICS accountable to communities.

Participating for health

Being involved can reduce isolation, increase confidence and improve motivation towards well-being. Individuals' involvement in their own care can lead to involvement at a service level and to more formal volunteering roles and employment in the health and care sectors. It is well recognised that doing something for others and having a meaningful role in your local community supports wellbeing. Getting involved, being part of a community and being in control is good for our health.

Better decision-making

We view the world through our own lens, and that brings its own judgements and biases. Business cases and decision-making are improved when insight from local people is used alongside financial and clinical information to inform the case for change. People's insight can add practical weight and context to statistical data, and fill gaps through local intelligence and knowledge.

Improved quality

Partnership approaches mean that services can be designed and delivered more appropriately, because they are personalised to meet the needs and preferences of local people. Without insight from people who use (or may not use) services, it is impossible to raise the overall quality of services. It also improves safety, by ensuring people have a voice to raise problems which can be addressed early and consistently.

Value for money

Services that are designed with people and therefore effectively meet their needs are a better use of public sector resources. They improve health outcomes and reduce the need for further, additional care or treatment because a service did not meet people's needs the first time.

Meeting legal duties

Failure to meet the relevant legal duties risks legal challenge, with the substantial costs and delays that entails as well as damage to relationships, trust and confidence between organisations, people and communities.

7.4 Culture and leadership

Our communities and staff will look to system leaders to role model a culture of partnership. This will help to demonstrate that their views are taken seriously, and that power is shared so they can play a genuine part in decision-making. Leadership can be a joint endeavour, with leaders from our system and from within communities working together.

Collaborative and inclusive leadership means seeing involvement as everybody's business (not just a handful of people with a relevant job title) and is fundamental to meeting shared objectives. It means making sure that professionals and communities can work, learn, and improve together.

Senior leaders must:

- promote involvement and co-production through culture and behaviour
- identify areas of work where co-production can have a genuine impact and involve people at the earliest stages
- invest in training and development so that people with specific lived experience and people working in the system know what co-production is and how to make it happen
- hold the system, Places and neighbourhoods to account by seeking assurance that involvement and co-production is happening

7.5 Our workforce

WE ARE ONE

'We Are One' is the term we use to create a 'one team' ethos for our ICS workforce. We must support and give our staff permission to innovate and collaborate in new ways and give them the permission and autonomy to try things out, to learn and to celebrate success.

Our staff are our most valuable resource, and we must invest in training and development opportunities to support them and the effective delivery of our Public Engagement Framework. In Cheshire and Merseyside, we believe involvement is everyone's business.

This requires a commitment for the resources, training and support to do so effectively, and allowing people time to build trust and relationships. One way of doing this effectively is using community-centred approaches that enable staff to work with diverse communities to develop their skills, in a way that supports people and communities to take more control of their health. This will help realise the potential of both groups.

Our Chair, Chief Executive and board members are all committed to creating the right conditions to ensure that our workforce collaborates to involve people and communities in Cheshire and Merseyside.

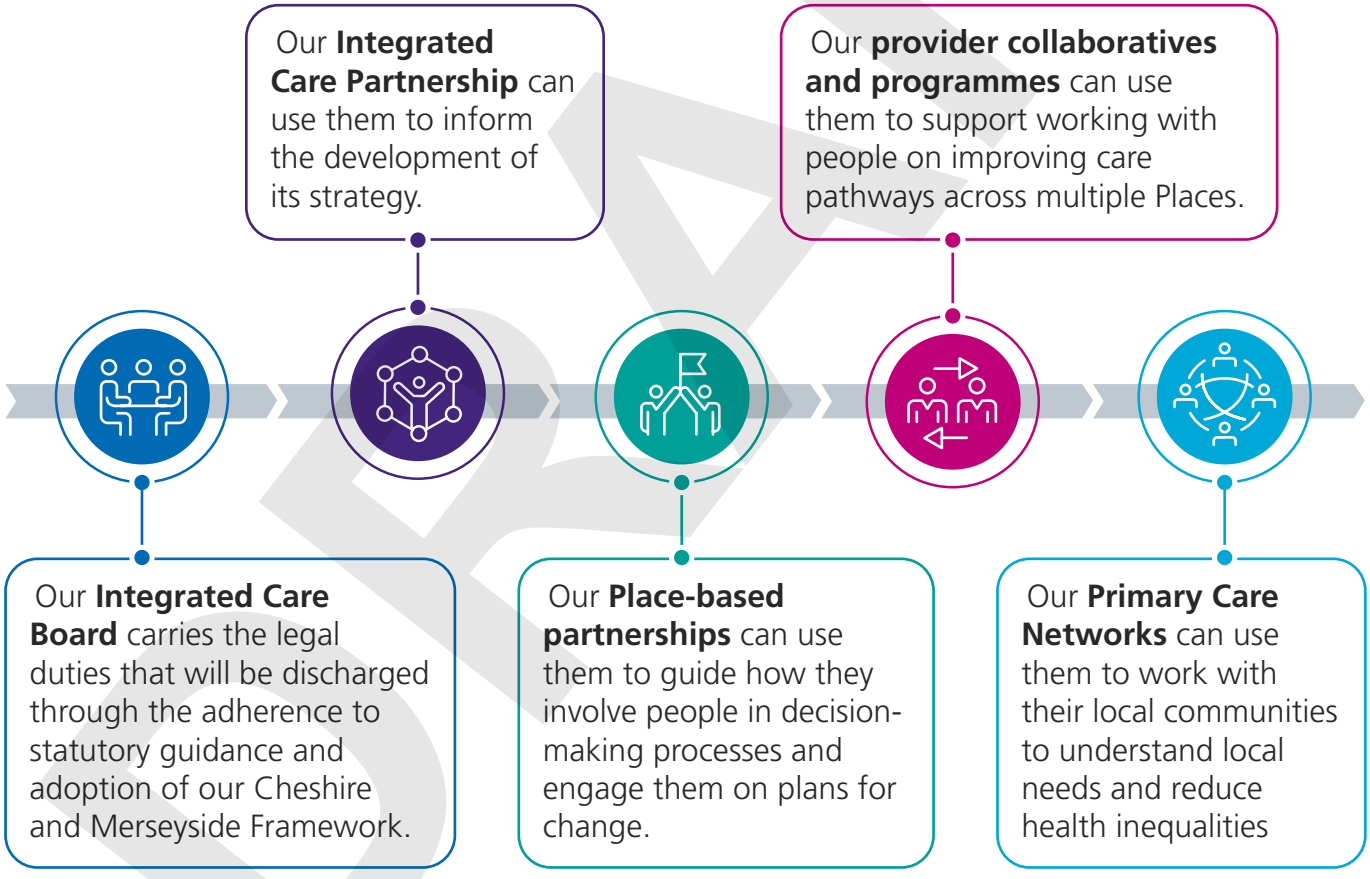
7.6 Meeting legal duties

Following national public consultation, the new **Statutory guidance for working with people and communities** was published in July 2022. The System Partnerships team at NHS England has also recently published (February 2022) **Major Service Change: An Interactive Handbook**.

ICS partners must give regard to this guidance alongside meeting other legal duties, such as;

- **Equalities:** The Public Sector Equality Duty (PSED), section 149 of the Equality Act 2010
- **Health inequalities:** The Health and Social Care Act 2012
- **Triple aim duty:** The Health and Care Bill 2021
- **Social value:** Public Services (Social Value) Act 2012.

National statutory guidance and our Cheshire and Merseyside Public Engagement Framework are relevant to the entire health and care system:



8. Resources

Effective involvement of people and communities requires an investment and resources;

8.1 Supporting people

- Expenses for those people who are participating – these will include travel expenses, carers expenses, childcare costs, additional costs of regularly joining online meetings and personal assistance reimbursement
- Consideration of budgets for commissioning organisations to undertake involvement activity and events on our behalf
- Venue costs for accessible meetings – additional costs may include interpreters, hearing loop systems.

8.2 Reward and recognition

It is essential that people and communities feel valued and are rewarded for their contribution – in addition to out-of-pocket expenses. We will consider offering prize draws and vouchers to encourage involvement and hold 'thank you' events.

8.3 Staff

Time is a major factor. There needs to be a clear understanding that for true co-design and co-production, time is needed and no involvement work is rushed or seen as a token gesture. This will impact on staff's capacity and resource, but it is essential that this is factored in.

8.4 Software and subscriptions

Resources will need to be considered that enable and support involvement including survey software and subscriptions to organisations such as the Consultation Institute.

8.5 Training

It is essential that staff have the appropriate level of training to enable them to effectively carry out their involvement roles. This can be sourced in-house and peer support will be encouraged though external training courses.

We will offer training that informs people about the health and care landscape and empowers them to effectively influence service developments.

9. Monitoring and evaluation

We are working with NHS England and other systems to develop a formative approach to the evaluation of our engagement with people and communities. This will be further informed by a new Oversight Framework.

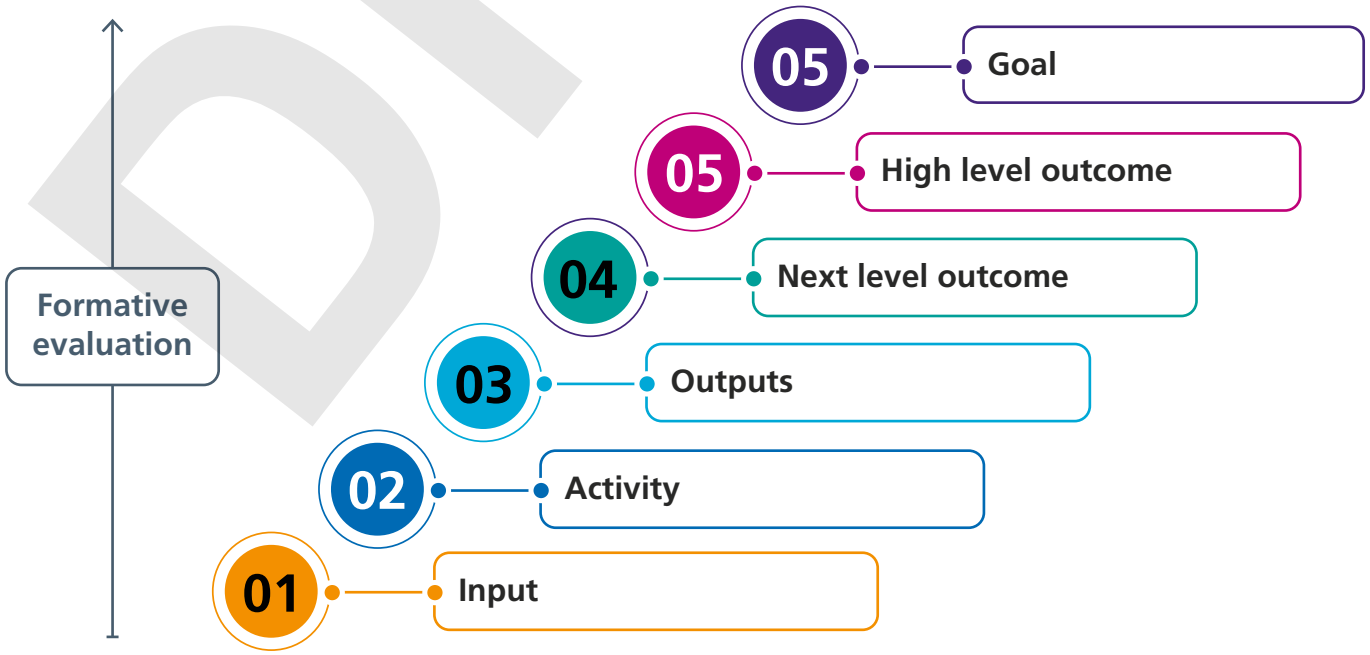
Our aim is to develop an evaluation approach (using a basic 'theory of change' model) that meets our specific ICS priorities, whilst being aligned to national oversight and quality assurance measures.

By working in this way, we can:

- demonstrate the impact of working with people and communities
- learn as we develop
- be held accountable to people, communities, regulators, and our partners.

Healthwatch will also play a vital role in the evaluation of our engagement. We are keen to have independent mechanisms to regularly review if our principles are working.

Approach	Benefits
1. Co-produce a 'people and communities' theory of change through workshops with other ICSs	Share good practice and inform national Quality Assurance Framework
2. Develop a shared evaluation toolkit	Practical tools that system partners can use to meet national standards
3. Develop a Local Evaluation Framework	Robust local mechanisms to assure people, communities, regulators and our partners



10. Progress and next steps

We have already made lots of progress in working with people, communities and health and care staff, but there is much work to do to build on this in 2022/23.

10.1 Progress

- Ongoing engagement with elected members, hospital governors and non-executive directors in developing our ICS
- Work with the Institute for Health Equity to co-produce interventions and actions with communities, including nine Place-based health inequalities workshops
- Work with the Cheshire and Merseyside Public Health Collaborative (Champs) and Population Health Board to develop:
  - Combined Intelligence for Population Health Action (CIPHA)
  - Community alcohol licencing plans
- The national award-winning 'Getting Under the Skin' research campaign, to understand and respond to the impact of COVID-19 on ethnic communities in Cheshire and Merseyside
- The 'Kind to Your Mind' campaign – development of dedicated telephone and website for support for mental wellbeing, advice and signposting
- Cheshire and Merseyside Opening Doors programme – aimed at improving the health of people in social housing and offering opportunities for residents to develop the skills to work in social care
- Work with people with a learning disability and autism via the Cheshire and Merseyside Transforming Care Partnership
- Council-led Community Champion and inspirers initiatives to influence the policy agenda
- The draft Public Engagement Framework was presented to the public board meetings of both NHS Cheshire and Merseyside (the ICB) and Cheshire and Merseyside Health and Care Partnership (the ICP) following their establishment on 1 July 2022.

10.2 Next steps

The framework will be adopted following the publication of national statutory guidance.

A shorter document in plain English and that is jargon-free will be published and used to support engagement with people and communities.

NHS Cheshire and Merseyside's engagement team will use the Public Engagement Framework to respond to the feedback gathered through engagement activity led by Healthwatch and VCFSE partners. Engagement leads will also design specific mechanisms to deliver effective involvement opportunities at system, Place and neighbourhood levels, that ensure:

- clear and transparent mechanisms for developing integrated health plans with people and communities
- clear and accessible public information about its vision, plans and progress
- annual reporting on the involvement of people and communities at ICS and in Place
- collaboration with Healthwatch and the VCFSE sector as key engagement partners
- involvement with people and communities representing equality protected groups and people affected by inequalities

- that involvement is monitored and audited
- that people and communities are represented in priority setting and decision-making forums
- that the participation of people and communities is supported by ensuring there is a training and development offer that equips people to contribute to governance arrangements
- that the experiences and aspirations of people and communities are gathered, reviewed, and responded to
- that these experiences and aspirations are used to produce insight and intelligence reports to inform decision-making and quality governance.

NHS Cheshire and Merseyside's engagement team will develop and publish detailed action plans at both system and Place-levels.

The Senior Responsible Officer with oversight and responsibility for implementation of the framework and subsequent action plan is Maria Austin, Associate Director of Communications and Empowerment, NHS Cheshire and Merseyside.

11 Appendix

11.1 How the framework was developed

Cheshire and Merseyside's Public Engagement Framework was developed by a task and finish group which drew its membership from our Health and Care Partnership.

The task and finish group held fortnightly meetings, and members undertook extensive engagement with forums at system, Place and neighbourhood levels over a period of three months from 1 April to 30 June 2022.

The framework was developed in line with **ICS implementation guidance** for working with people and communities, and following the national content guide provided by NHS England.

Oversight of strategy development was provided by the following ICS forums:

- The Cheshire and Merseyside Partnership Assembly
- The Cheshire and Merseyside ICS Development Advisory Group
- The Cheshire and Merseyside Transition Programme Board.

The framework was co-produced with Healthwatch and the VCFSE sector who undertook the engagement activity set out below, to inform its development. The feedback and insights from this activity will be taken forward by NHS Cheshire and Merseyside's engagement team.

11.2 Healthwatch engagement activity

Healthwatch	Who	How feedback was collected
Liverpool	Community engagement board (made up of representatives of organisations working with local communities especially often ignored communities). Staff and volunteer team.	Online focus groups
Wirral	Survey sent through community networks.	Survey
Sefton	Focus groups with staff team, board, and volunteers.	Focus groups
Knowsley	Focus groups with Knowsley residents, and Healthwatch Knowsley board.	Focus groups
St Helens	Meetings, web form and survey for staff team, board, volunteers and local community groups.	Webform/survey, visits to groups, team meetings.s
Cheshire East and Cheshire West	Staff team, volunteers, board members. Supported conversations on engagement activities.	Using a mixture of: ▪ Comments on full draft ▪ Feedback collected verbally at meetings and recorded based on 10 principles ▪ Survey of small cohort of people, to include members of Healthwatch Cheshire's Citizen's Focus Panel.
Halton	Staff team Advisory board focus group Small group of volunteers Survey to virtual People's Panel	Focus group with staff, board and volunteers
Warrington	Staff, board members and volunteers, People's Panel, Virtual Voices Panel, small focus groups.	Survey feedback

11.3 VCFSE engagement activity

VCFSE	Who	How feedback was collected
VS6	VS6 is the Liverpool City Region network of Chief Executive Officers (CEOs) leading infrastructure support. It's membership includes: ▪ Together Liverpool (Faith) ▪ Sefton Council for Voluntary Service (CVS) ▪ One Knowsley ▪ Voluntary Sector North West (VCAW) ▪ Halton and St Helens Voluntary and Community Action (VCA) ▪ Liverpool Charity and Voluntary Services (CVS) ▪ Network for Europe ▪ Community Foundation Merseyside ▪ Merseyside Youth Association ▪ It is Chaired independently by Rev Canon Dr Ellen Loudon, Director of Social Justice and Canon Chancellor, Diocese of Liverpool.	Online facilitated focus group
CWIP	Cheshire and Warrington Infrastructure Partnership is a network of CEOs leading infrastructure support. Its membership includes: ▪ Warrington Voluntary Action (VA) ▪ Cheshire East Council for Voluntary Service (CVS) ▪ Cheshire West Voluntary and Community Action (VCA).	Online facilitated focus group
Liverpool	Health and Wellbeing Network	Online facilitated focus group
Wirral	Wirral CVS VCFSE Board and established network of VCFSE leaders	Online facilitated focus group
Sefton	Health and Wellbeing Network	Online facilitated focus group
Knowsley	Health and Wellbeing network, VCFSE Leaders network	Online facilitated focus group
St Helens	VCFSE forum	Online facilitated focus group
Halton	VCFSE forum	Online facilitated focus group

VCFSE	Who	How feedback was collected
Warrington	VCFSE Health and Wellbeing Alliance VCFSE Health Engagement Event	Face-to-face focus group
Cheshire East and Cheshire West	Sector Leadership Group from the membership of Cheshire West Voluntary Action (CWVA).	Facilitated conversation by Michelle Whitaker, Health and Wellbeing Programme Lead office for Health Improvement and Disparities, Northwest Region.

11.4 Emerging Place priorities

Place-based partnerships are starting to identify and develop priorities, in collaboration with Health and Wellbeing Boards, that will be further tested through engagement with people and communities in 2022/23.

Place	Key priorities
Cheshire East	We have some clear goals that we are working collectively to: ▪ deliver a sustainable, integrated health and care system ▪ create a financially-balanced system ▪ create a sustainable workforce ▪ significantly reduce health inequalities.
Cheshire West	To identify Cheshire West population health needs now and in the future, proactively detecting and preventing ill-health, whilst promoting wellbeing and self-care to our residents. To reduce health inequalities by continuing to develop our approach to population health management (PHM), using data and analytics to prevent ill-health, address health inequalities, and identify those residents who are at higher risk of their health deteriorating, enabling us to deliver preventive interventions. Improving the quality of services that are delivered within Cheshire West, expanding on efficiencies, and delivering safe and effective care.

Place	Key priorities
Halton	To improve the employment opportunities for people in particular where it affects children and families. To enable children and families to live healthy independent lives. To provide a supportive environment where systems work efficiently and support everyone to live their best life. To enable older adults to live full independent healthy lives.
Knowsley	A targeted approach to population health and reducing health inequalities starting with Northwood (our most deprived area). A single front door to health information, guidance and advice as part of the Knowsley Offer. To reduce avoidable attendances and admissions to hospital. To improve access to general practice.
St Helens	The St Helens People's Plan covers three priorities to improve the health and well-being outcomes of residents in the borough. The priorities are resilient communities, mental health and healthy weight. These are underpinned by the crosscutting theme of tackling health inequalities. **Resilient communities:** To support people to live independently, reduce social isolation and loneliness, embed a multi-sector/disciplinary team working in our four localities/networks and to develop a health innovation hub. **Mental wellbeing:** To prevent and reduce self-harm and suicide, to expand the voluntary and community service capacity to support mental health and wellbeing, and to improve the wellbeing of children and young people. An action plan is being developed using the Office for Health Improvement and Disparities (OHID) prevention concordat for better mental health. **Healthy weight:** To support healthy eating choices in the borough, to encourage residents to lead a more active life, and with a focus on diabetes prevention. The Active Lives strategy and action plan has been developed and the group are working with Food Active on a health weight declaration.
Liverpool	To target action on inequalities, at scale and with pace. To offer empowerment and support for wellbeing. To radically upgrade prevention and early intervention. To provide integrated and sustainable health and care services.

Place	Key priorities
Sefton	To improve mental health. To tackle obesity. To support community resilience by developing resources to enable people and communities to improve their quality of life and reduce health inequalities. We will be using a whole-life approach to tackling these priorities. This means our plans support local people from having the best start in life through to improving care for those in their older years. We will also aim to reduce health inequalities that lead to poor health and quality of life by adapting our work to the needs of our different communities across the borough.
Warrington	Mental health. Living well. Food poverty.
Wirral	To recover from the COVID-19 pandemic and transform our Place by implementing the Wirral Plan 2021-26. To refresh, refocus and strengthen partnerships and collaboration in Wirral to support delivery of our plans, including co-production. To improve population outcomes and tackling health inequalities by addressing the needs of our population in a more targeted way.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Audit Committee Chair

26 January 2023

Agenda Item No	**ICB/01/23/16**
Report author & contact details	Matthew Cunningham, matthew.cunningham@nhs.net
Report approved by (sponsoring Director/ Chair)	Neil Large, Chair of the Audit Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance Matthew Cunningham, Associate Director of Corporate Affairs and Governance

Report of the Audit Committee Chair

Executive Summary	The Audit Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 13 December 2022. The meeting was quorate and was able to undertake the business of the Committee. Declarations of interest where applicable where minuted. The meeting was quorate and was able to undertake its business. Main items considered at the meeting included: • External Audit procurement result • HFMA/Financial Controls Report • ICB Whistleblowing / Freedom to Speak Up Update • Paper on the proposed revisions to the ICB Operational SORD • Paper on ICB Procurement Waivers • An update on the Annual Report and Accounts 2022-23 • ICB Risk Management Update • ICB Declarations of Interest Progress Update • Internal Audit progress report • Counter fraud update report • External Audit plan (part year CCG)/ICB progress report • Bi-monthly Information Governance Update Report. The next meeting of the Committee is scheduled to be held on 07 March 2023. Subsequent to the December 2022 meeting, internal audit has identified and agreed with the ICB the primary audit areas which will support the Head of Internal Audit opinion for 2022-23 which informs the annual governance statement. These audit areas include: • Healthcare Contract Management • Primary Care Contracts • Continuing Healthcare • Delegated commissioning – Dentistry / Optometry • Serious Incidents • Mandatory Training • Patient, Carer and Resident Engagement.

Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X	X	X		

Recommendation	**The Board is asked to:** • **note** the items covered by the Audit Committee at its meeting on the 28 November 2022. • **note** and **decide** on the recommendation of the Committee regarding approving the proposed changes to the ICBs Operational SORD (Appendix Two).

Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**
	x		X	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
	x			
Management of Conflicts of Interest	Representatives from the ICBs External Auditors were excluded from the meeting when the result of the ICBs procurement for External Audit support was discussed and agreed. External audit representatives received a redacted Agenda and paper pack ahead of the meeting which excluded detail on the external procurement result.			
Next Steps	Following consideration of this paper and if approvals against the recommendations are provided by the Board, then: • the ICB will publish its amended Operational SORD within the Corporate Governance Handbook section of the ICB website and communicate the changes to relevant staff.			
Appendices	**Appendix One**	Revisions to the ICB Operational SORD – paper to December 2022 Audit Committee		
	Appendix Two	Revised Operational SORD		

Report of the Audit Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Audit Committee (Statutory Committee)	The main purpose of the Committee is to contribute to the overall delivery of the ICB objectives by providing oversight and assurance to the Board on the adequacy of governance, risk management and internal control processes within the ICB.	Neil Large, Non-Executive Director

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
-	13.12.22	**HFMA/Financial Controls Report** The Committee received a report that included the results of the self-assessment exercise undertaken against the *HFMA's checklist – Improving NHS Financial Sustainability: are you getting the basics right?* by each C&M NHS Trust and the ICB. Committee members were advised that this self-assessment exercise will become an annual process and will form part of the Audit Plan for each Trust and the ICB. Actions identified within the report will come back to the March 2023 Audit Committee meeting. Members noted the contents of the report.
	13.12.22	**ICB Procurement Waivers** The Committee received a paper that provided an update on the tender waivers approved by the ICB Executives and its various Place Directors / Associate Finance Directors between 1st July 2022 and 30th November 2022, since the formation of the ICB. During this time, there were 4 tender waivers approved that have either been reviewed and approved by the ICB Executives or Place Senior Leadership Teams, in line with the ICB SORD limits.

Decision Log Ref No.	Meeting Date	Issues considered
		There is currently a process in progress to make all ICB waiver documentation 'controlled stationary' to provide further assurance on compliance with the SORD requirements. The Committee noted the reasons for the 4 waivers approved between 01 July 2022 and 30th November 2022, and also noted the intention to publish the waivers on the procurement decision register on the public facing website.
	13.12.22	**Annual Report and Accounts 2022-23** Committee members received and noted a verbal update from the Director of Finance regarding progress in developing the Annual Reporting arrangements for 2022-23. A further update will be provided at the March 2023 Audit Committee meeting.
-	13.12.22	**ICB Conflicts of Interest Update**. Committee members received its regular update on the ICBs work around implementing the ICBs Conflicts of Interest (COI) Framework, and the population of and management of its COI registers. An ask of the Committee was that work was undertaken to further develop a SOP around the reporting and management of COI to accompany the ICBs COI Policy. This was seen to be essential to help both staff and the Conflicts of Interest Guardian understand and action any escalation process needed around COIs. The Committee noted the update report and will receive a further update at its next meeting.
-	13.12.22	**ICB Risk Framework Development.** Committee members received an update on the development of the ICB Risk Framework, the Board development workshop on risk that took place at the end of November and the steps that are being taken prior to the Framework and an initial Board Assurance Framework coming to the ICB Board for approval. The Committee noted the update report and will receive a further update at its next meeting.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
-	13.12.22	**External Audit procurement result** At its meeting in November 2022, the ICB Board had granted its Audit Committee the delegated authority to decide at its December 2022 committee meeting on the external audit procurement that the ICB had undertaken . The Committee received a paper that outlined that the existing external audit service contract for the ICB was due to expire by the end of March 2023 and Section 7 of the Local Audit and Accountability Act 2014 set out the requirement for an NHS body to appoint an External Auditor to audit its accounts by 31 December in the financial year preceding the one to which the audit relates. Therefore, it was necessary to conclude the procurement and contract award process by the end of December 2022 to ensure new contract mobilisation by 1 April 2023. Members noted the paper outlining the process undertaken and the conclusion of the procurement process. Members also approved the recommendation to award the External Audit Service contract to Grant Thornton UK LLP, initially for a 3-year period, commencing from 1 April 2023, with the option to extend for a further 12 months, subject to satisfactory performance and the contract remaining in line with ICB priorities.
-	13.12.22	**ICB Whistleblowing/Freedom to Speak Up Update (FTSU)** Committee members considered a report on the work underway within the ICB to harmonise the approach to FTSU and the development of supporting infrastructure for staff and Guardians. Members noted that an ICB FTSU guardian has been appointed to set up a network of FTSU champions across the ICB and that improved information is available to staff

Decision Log Ref No.	Meeting Date	Issues considered
		across websites and the staff hub. It was noted that there was more work to be done to develop SOPs for individuals to know what to do e.g., when a conflict of interest is provided. It was requested that the SOPs and progress on implementing FTSU arrangements was to be brought back to a future meeting of the Committee. The Committee endorsed the direction of travel in relation to FTSU development across the ICB and support the proposed next steps, namely: o Development of an FTSU Strategy which supports the further development and embedding of FTSU infrastructure within the ICB, including promoting awareness of FTSU, establishing robust reporting arrangements, increasing the network of FTSU Champions, and the methods of engagement with people across the organisation. o Develop a clear SOP for dealing with FTSU concerns/feedback. o Establish mechanisms for sharing and learning from occasions where people speak up, and evaluation of FTSU data within the ICB, including the establishment of an FTSU Summit. o Engage with primary care partners to support the development of FTSU infrastructure across the sector.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
-	-	-

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-		**Revision to the ICB Operational SORD** Committee members received a report (Appendix One) outlining proposed changes to the ICB Operational SORD (OSORD). Members were informed of the changes that had been made to further improve and refine the OSORD and to enable ICB staff and its Committees to operate. There were no major changes to the OSORD that would have an impact on the Constitution of the ICB. It was noted that the ICB was still in a year of transition and currently undertaking a consultation with its staff around its staffing structure, and that that it was recognised that the OSORD and Standing Financial Instructions (SFI) would need to be amended again to reflect these changes as the ICB and Place Operating models and delegations where confirmed. Following discussion around the paper, the Committee: • endorsed the updates to the NHS Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation. • RECOMMENDED APPROVAL of the proposed changes by the ICB Board at its January 2023 meeting • noted the further work required on the ICB authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation • noted the intention (once agreed structure is in place and the majority of senior staff HR processes have been implemented) to roll out further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training.

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
		Appendix Two to this report contains the updated Operational SORD that has been updated to take into account the feedback from the Audit Committee.

6. Recommendations

6.1 **The Board is asked to:**

- **note** the items covered by the Audit Committee at its meeting on the 28 November 2022.
- **note** and **decide** on the recommendation of the Committee regarding approving the proposed changes to the ICBs Operational SORD (Appendix Two).

7. Next Steps

7.1 Following consideration of this paper and if approvals against the recommendations are provided by the Board, then:

- the ICB will publish its amended Operational SORD within the Corporate Governance Handbook section of the ICB website and communicate the changes to relevant staff.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Audit Committee Chair

Appendix One:

Revised Operational Scheme of Delegation: Paper to December 2022 Audit Committee

NHS Cheshire and Merseyside Audit Committee Meeting

13 December 2022

Operational Scheme of Delegation Update – December 2022

Agenda Item No	**AC/22/12/12**
Report author & contact details	Mark Bakewell – Deputy Director of Finance Email: Mark.Bakewell1@nhs.net
Report approved by (sponsoring Director)	*Claire Wilson, Executive Director of Finance*
Responsible Officer to take actions forward	*Mark Bakewell – Deputy Director of Finance*

Operational Scheme of Delegation Update – December 2022

Executive Summary	The ICB has agreed its scheme of reservation and delegation (SoRD) at the inaugural board meeting on the 1st July 2022. As the organisation is now approaching its 6 months milestone, and to reflect further developments in the ICB governance structure and operating model. A review has been undertaken of the existing limits and a number of amendments have therefore been proposed to help improve / clarify a number of areas of decision making for the organisation. Once approved, it should be noted that further work is required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation This will be further supported by a roll out of further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training and education to ensure effective approach for the organisation.

Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
					X

Recommendation	**The Committee is asked to:** • **ENDORSE** the updates to NHS Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation. • **RECOMMEND APPROVAL** of the proposed changes by the ICB Board at its January 2023 meeting • **NOTE** the further work required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation • **NOTE** the intention (once agreed structure is in place and the majority of senior staff HR processes have been implemented) to roll out further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training and education to ensure effective approach for the organisation.
Key issues	• Planned review of Operational Scheme of Delegation has taken place and will be kept under review as organisational requirements continue to develop.
Key risks	• further work is required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation • further training required across organisationto increase knowledge and understanding on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training.

Impact (x)	**Financial**	**IM &T**	**Workforce**	**Estate**

(further detail to be provided in body of paper)	x			
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
Route to this meeting	*ICB Board – July 2022*			
Management of Conflicts of Interest	*No known implications – to kept under further review as changes are implemented and monitored operationally. Any conflicts will be addressed with due consideration of the ICB Conflict of Interests policy.*			
Patient and Public Engagement	*Not Required*			
Equality, Diversity and Inclusion	*No known implications – to kept under further review as changes are implemented and monitored operationally*			
Health inequalities	*No known implications – to kept under further review as changes are implemented and monitored operationally*			
Next Steps	*ICB Board Approval – January 2023*			
Appendices	Updated Operational Scheme of Delegation (v2)			

Operational Scheme of Delegation Update – December 2022

1. Executive Summary

1.1 The ICB has agreed its scheme of reservation and delegation (SoRD) at the inaugural board meeting on the 1st July 2022.

1.2 As the organisation is now approaching its 6 months milestone, and to reflect further developments in the ICB governance structure and operating model. A review has been undertaken of the existing limits and a number of amendments have therefore been proposed to help improve / clarify a number of areas of decision making for the organisation.

1.3 Once approved, it should be noted that further work is required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation

1.4 This will be further supported by a roll out of further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training and education to ensure effective approach for the organisation.

2. Introduction / Background

2.1 The purpose of a Scheme of Reservation and Delegation (SoRD) is to set out where, or to whom, functions and decisions have been delegated.

2.2 The SoRD sets out:
a) those functions that are reserved to the board
b) those functions that have been delegated to an individual or to committees and sub committees and
c) those functions delegated to another body or to be exercised jointly with another body,

2.3 The ICB has agreed its scheme of reservation and delegation (SoRD) at the inaugural board meeting on the 1st July 2022, noting that a) only the Board may agree the SoRD and b) amendments to the SoRD may only be approved by the board. In support of this an 'Operational Limits' SORD is produced in order to help with the implementation of the agreed delegations at an operational level and setting out the limits for committee/ officers as part of agreeing the organisations approach to decision making.

2.4 Given that the organisation is approaching its 6 months milestone, the plan was to revisit the SORD at this point and to reflect any required changes in terms of the developing ICB operating model and based on operational effectiveness review of the current approach to delegation. The first set of changes are proposed in this paper and will continue to be kept under review on a regular basis

3. Review of Changes

3.1 The specific proposed changes to the previously agreed SORD are set out below and highlighted in yellow in Appendix One of the paper (full version of the Scheme of the Delegation)

Terms of Reference Review Mersey Internal Audit Agency (MIAA)

3.2 The below extracts are from the recent review in relation to potential required changes with the Operational SORD

a) Finance, Investment & Resources Committee (FIR Committee)

In relation to delegated financial and investment matters within the C&M ICB SoRD the ToR of the FIR Committee is consistent with the delegations.

Suggested Action – No Further Amendment to be made to the Operational Limits in respect of delegated decision making (and updated Terms of Reference have been approved by FIR committee in October 2022 to reflect other comments)

b) Quality & Performance Committee (Q&P Committee)

In relation to delegated quality and safety matters within the C&M ICB SoRD (Section 6), the ToR of the Q&S Committee is consistent with the delegations.

Suggested Action – No Further Amendment to be made to the Operational Limits in respect of delegated decision making but column added to reflect the committee's place within governance structure of ICB

c) Transformation Committee

Within the C&M SoRD, the Transformation Committee is identified in a number of areas as responsible for recommending a course of action, however there are only two items noted as delegated (refs 2.12 & 2.13). These both relate to data and digital services. The scope of responsibilities detailed in the Transformation Committee ToR is comprehensive and consideration should again be given as the whether the links to the SoRD need strengthening.

Suggested Action – No Further Amendment to be made to the Operational Limits in respect of delegated decision making but additional column added to reflect committee's place within governance structure of ICB.

Delegation Limits / Description

3.3 The below proposed changes to the Operational Scheme of Delegation are as below relevant to each of the sub-sections as described

3.4 To note that no changes have been made to operational limits as per previous version.

a) Section E - Credit Card

- Amended for enabling use of a corporate 'Credit Card' transaction to support circumstances where approved purchase's require this method (e.g travel / marketing & communications)

This will require further work on the development of policy / procedure to support this and would be through an approved supplier (compliant with Government Banking Service requirements).

It is likely that cardholders would be restricted to a small number of individuals and relatively low credit limits to support organisational need in a minority of instances.

b) Section F – Agency / Consultancy

- Amended F1 / F2 to reference compliance with approved ICB IR35 policy (As approved at Finance, Investment , Resource Committee in November)

c) Section H – Healthcare Investment

- Removal of 'healthcare' aspect of section header as includes all 'Business' Case Approval processes.
- Amended H1 / H2 to revise language regarding 'within approved budget' to clarify arrangements re availability of funding
- Addition of H3 / H4 regarding approval of capital expenditure for primary / secondary care items in line with system role. To note it is expected that the planned utilisation of capital allocation will be agreed at the start of the financial year as part of the planning process.

d) Section I –Contracts

- Header Revised to reflect (all Contracts)
- Amended I3/ I4 - Clarification of role of Finance, Investment & Resource Committee in respect of procurement activities as per the agreed terms of reference. Majority of procurement decisions to be approved by committee with any 'Novel or Contentious Decisions' to be escalated to the ICB Board.
- Added I5 to specifically reference approval of non-healthcare contracts (As not currently clear where should be signed)

e) Section K – Quotations & Tenders

- Addition of K1 regarding use of Procurement 'Frameworks' as a compliant route to market, and levels of approval required at officer and committee level
- K2/ K5 - Amendment of wording re quotations in respect of 'additional' expenditure. Suggested removal of this wording to ensure clarity and approval up to delegated limits for expenditure.
- Re-numbering of Sections (K1-8)

f) Section L – Virement

- Addition of L1/L2 to clarify requirements regarding approval of virements in respect of
    - Transfer of existing / approved pay or non-pay budgets
    - Regarding the distribution of new in-year resource / capital allocations

g) Section O – Human Resources

- Clarification of role of Finance, Investment & Resource Committee in respect of 'Workforce' activities as per the agreed terms of reference

h) Section Q – Finance

- Addition of section to confirm committee approval of operational finance policies to support organisational requirements.

4. Recommendations

4.1 The Committee is asked to

- **ENDORSE** the updates to NHS Cheshire and Merseyside ICB Operational Scheme of Reservation and Delegation.
- **RECOMMEND APPROVAL** of the proposed changes by the ICB Board at its January 2023 meeting
- **NOTE** the further work required on authorised signatory list once staffing structures are confirmed and further cascade of operational limits to all levels of organisation
- **NOTE** the intention (once agreed structure is in place and the majority of senior staff HR processes have been implemented) to roll out further training on aspects of Operational Scheme of Delegation alongside further finance, contracting and procurement training and education to ensure effective approach for the organisation.

5. Next Steps

5.1 Seek ICB Board Approval at next meeting January 2023

6. Officer contact details for more information

Claire Wilson
Executive Director of Finance
Claire.Wilson@cheshireandmerseyside.nhs.uk

Mark Bakewell
Deputy Director of Finance
Mark.Bakewell1@nhs.net

NHS Cheshire & Merseyside Integrated Care Board (ICB) Scheme of Reservation & Delegation Operational Limits

Version: 2

November 2022

1. Operational Delegated Limits

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)							Gifts over £50	Gifts over £50		Gifts over £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHSLA	Over £1,000,000						£50,001 - £1,000,000	Up to £50,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £100,000						£50,001 - £100,000	£5,001 - £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**													
D1	Authorisation to set up float							Over £300	Over £300	Up to £300 float				
D2	Replenish petty cash float													Head of Financial Services (or equivalent role) Up to maximum float
D3	Issue petty cash								Up to £50	Up to £50				Associate Director of Finance (Place) Up to £50
E	**CREDIT CARD**													
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)							X	X	X				
E2	Authorise single transaction (single transaction limit £2,500)								X	X		X		X
F	**REQUISTIONING GOODS & SERVICES: NON-HEALTHCARE**													

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes) *Supporting Notes* *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation* and in line with agreed ICB IR35 policy	Over £500,000	Over £150,000					Up to £75,000	Up to £50,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000 (within place based structure)	Up to £25,000
F2	Utilisation of Consultancy (based on total expected cost as per below notes). *Supporting Notes* *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation* *and* in line with agreed ICB IR35 policy	Over £150,000	Over £150,000					Up to £75,000	Up to £50,000		Up to £25,000 (within approved budget)	Up to £25,000 (within approved budget	Up to £25,000 (within approved budget)	
F3	Services including IT, maintenance, and support services (over lifetime of contract) were not included within agreed annual budgets	Over £1,000,000	Over £500,00 and Up to £1,000,000					Up to £500,000	Up to £250,000		Up to £100,000	Up to £100,000		As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F4	Recharges from other public sector bodies not included within agreed annual budgets							Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
														limits outlined within the Authorised Signatory List
F5	Approval of non-healthcare expenditure within agreed budget *With appropriate consideration of procurement requirements	Over £1,000,000	Over £500,000			Over £500,000		Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F6	Approval of all other non-healthcare requisitions *With appropriate consideration of procurement requirements	Over £500,000						Up to £250,000	Up to £100,000	Up to £50,000	*Up to £50,000	Up to £50,000	Up to £50,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee							Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE 'NEW' ~~HEALTHCARE~~ INVESTMENT BUSINESS CASES**													
H1	Where funding is a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g new in-year) c) other identified income streams (e.g other agencies / recharges)	Over £1,000,000	Up to £1,000,000			Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £1,000,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where **not** included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without	Over £500,000	Up to £500,000			Up to £500,000 *Primary Care Related		Up to £250,000	Up to £100,000		Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	Executive team approval due to overall financial management requirements of the ICB.													Signatory List
H3	Primary Care Capital Expenditure Approval (within ICB allocation) *NB - Capital Plan to be approved by the ICB for each financial year*	Over £1,000,000				Up to £1,000,000 *Primary Care Related		Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
H4	Secondary Care Capital Expenditure Approval (within ICB allocation) *NB - Capital Plan to be approved by the ICB for each financial year*	Over £1,000,000	Up to £1,000,000					Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
I	~~HEALTHCARE~~ CONTRACTING													
I1	**Signing of Healthcare Contracts** (Annual Contract Value)							Over £150,000,000	Up to £150,000,000	Up to £50,000,000				
I2	**Approval of Healthcare Contract Payments** All healthcare contract payments must be supported by signed contract (see I1).							As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I3	**Procurement Route Decision Whether to put Healthcare Service Out to Tender** Committee to review and make risk-based decisions as appropriate on case by case basis	~~All – as required~~ X (For Novel or Contentious issues escalated by FIR Committee)	X (Novel or Contentious Procurement Decisions to be escalated to the Board)											
I4	**Approval of ICB Procurement Plan (on an annual basis and any ad-hoc procurement identified during the year) alongside the relevant specific elements of the ICB procurement activities** • Approve the commencement of any over threshold open tenders. • Approve the procurement of goods and services via approved national / local frameworks (over delegated budgeted limits) • Approve the award of a contract at the end of a tender process.		X											

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	• Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract. • Approve the sign off of a tender waiver in line with the SORD and Signatory list. • Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice (CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT)													
I5	**Signing of Non-Healthcare Contracts** (Annual Contract Value)		Over £250,000						Up to £250,000	Up to £100,000		Up to £100,000	Up to £100,000	Up to £100,000
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.	Over £1,000,000	Up to £1,000,000			Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £1,000,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**													
K1	**Procurement through approved national / local framework agreement (in line with call off rules)**		From £20k to delegated budgeted limit for expenditure within budget (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval											
K2	**Quotation Waiver Approval** (Total Contract Value – see detailed financial policy on tendering when permissible)		From £20k to delegated limit for ~~additional~~ expenditure within budget											
K3	**Tender Waiver Approval**	Above Tender Limit for Healthcare / Non-Healthcare	Nil – N.B. Reporting of all Tender Waiver Approval to Audit Committee											
K4	**Approval to issue a Formal Tender** In compliance with 'Public Contract Regulations 2015 and amendments'.		All - Threshold and above approved by ICB Board Threshold is £213,477 (including VAT) unless light touch regime applies for healthcare services (see I3)											
K5	**Approval to seek 3 quotes (up to identified tender limit)** In compliance with 'Public Contract Regulations 2015 and amendments'.		Up to delegated limit for ~~additional~~ expenditure within budget £20,000 to Threshold Minimum of three written quotes required											

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K6	Non Healthcare -Expenditure below quite threshold (quotes still recommended to secure VFM)		Up to £19,999											
K7	**Opening of Tender Documentation** (where not received electronically) (at least 2 people from list)							X	X	X	X			
K8	**Approval of ICB Procurement Plan (on an annual basis and any ad-hoc procurement identified during the year) alongside the relevant specific elements of the ICB procurement activities** • Approve the commencement of any over threshold open tenders. • Approve the procurement of goods and services via approved national / local frameworks (over delegated budgeted limits) • Approve the award of a contract at the end of a tender process. • Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract. • Approve the sign off of a tender waiver in line with the SORD and Signatory list. Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice (CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT)		X											
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources *All Transfers must be:* *• affordable within budget; and* *• agreed by both budget holders* *Virements may not be used to create new budgets*												
L1	**Within Existing Approved Pay or Non-Pay Budgets**							Over £1,000,000	Up to £1,000,000	Up to £500,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
														within the Authorised Signatory List
L2	**With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)**								Up to £50,000,000	Up to £25,000,000				As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000						Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)													
O	**HUMAN RESOURCES**													
01	**Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies** (e.g. additional compassionate leave or exceptional carry forward of leave days)							X	X	X	X	X	X	
02	**Decisions As Set Out Within HR Policies** (where there is some management discretion e.g. study leave authorisation)							X	X		X	X	X	
03	**Approval of Operational Structure** (re staffing and departments), and in accordance with organisation change policy							X						
04	**Approval of Appointment to Posts Below Executive Directors**								X	X	X	X	X	X
05	**Approval of the below arrangements as required by the the ICB** • Approval of the arrangements for discharging the ICB statutory duties as an employer • Approve human resources policies for ICB employees and for other persons working on behalf of the ICB • Approve any other terms and conditions of services for ICB AFC employees • Approve disciplinary arrangements for ICB employees • Approve arrangements for staff appointments (excluding matters detailed within the Constitution)		X											

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	• Approve the ICBs organisational development plans													
P	EXTERNAL COMMUNICATIONS & REPORTING													
P1	**Approve Complaints Responses** and Letters to **Politicians and Media Responses**							X				X (Assistant Chief Executive)		
P2	**Approve Public Consultation Material**							X				X (Assistant Chief Executive)		
P3	**Approve Public & Staff Engagement Material** inc Website							X				X (Assistant Chief Executive)		
P4	**Approve FOI Responses**											X (Assistant Chief Executive)		X* Corporate Affairs / Governance Lead
P5	**Approve Annual Engagement & Communication Plan**	X										X (Assistant Chief Executive)		
Q	FINANCE													
Q1	**Approval of Operational Policies as required by the organisation**		X											

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Audit Committee Chair

Appendix Two:

Revised Operational Scheme of Delegation

NHS Cheshire & Merseyside Integrated Care Board (ICB) Scheme of Reservation & Delegation Operational Limits

Version: 2

January 2023

1. Operational Delegated Limits

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
A	**ACCEPTANCE OF GIFTS, HOSPITALITY & SPONSORSHIP** (Governance Lead to maintain a register of declared gifts and hospitality received)							Gifts over £50	Gifts over £50		Gifts over £50	Gifts up to £50	Gifts up to £50	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
B	**LITIGATION CLAIM PAYMENTS** Medical negligence and other litigation payments made on the advice of NHSLA	Over £1,000,000						£50,001 - £1,000,000	Up to £50,000					
C	**LOSSES & SPECIAL PAYMENTS** (CFO to maintain a register of losses and special payments (including bad debts to be written off). All payments to be reported to the Audit Committee.	Over £100,000						£50,001 - £100,000	£5,001 - £50,000	Up to £5,000				
D	**PETTY CASH FLOAT**													
D1	Authorisation to set up float							Over £300	Over £300	Up to £300 float				
D2	Replenish petty cash float													Head of Financial Services (or equivalent role) Up to maximum float
D3	Issue petty cash								Up to £50	Up to £50				Associate Director of Finance (Place) Up to £50
E	**CREDIT CARD**													
E1	Account signatories (who can make changes to the account, authorise additional card holders, amend card limit)							X	X	X				
E2	Authorise single transaction (single transaction limit £2,500)								X	X		X		X
F	**REQUISITIONING GOODS & SERVICES: NON-HEALTHCARE**													
F1	Utilisation of External Agency Staff (based on total expected cost as per below notes)	Over £500,000	Over £150,000					Up to £75,000	Up to £50,000	Up to £25,000	Up to £25,000	Up to £25,000	Up to £25,000 (within	Up to £25,000

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	Supporting Notes *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation* and in line with agreed ICB IR35 policy												place based structure)	
F2	Utilisation of Consultancy (based on total expected cost as per below notes). *Supporting Notes* *a) Prior approval from NHSE must be sought for:* • *Any appointments over £600 per day; or* • *Any appointments for over a 6 month period, or* • *Any appointment with significant influence (e.g. ICB roles)* *b) prior to recruitment HR must conduct and sign off with relevant Director acknowledgement of IR35 compliance and/or status confirmation and* in line with agreed ICB IR35 policy	Over £150,000	Over £150,000					Up to £75,000	Up to £50,000		Up to £25,000 (within approved budget)	Up to £25,000 (within approved budget	Up to £25,000 (within approved budget)	
F3	Services including IT, maintenance, and support services (over lifetime of contract) were not included within agreed annual budgets	Over £1,000,000	Over £500,00 and Up to £1,000,000					Up to £500,000	Up to £250,000		Up to £100,000	Up to £100,000		As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F4	Recharges from other public sector bodies not included within agreed annual budgets							Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
F5	Approval of non-healthcare expenditure within agreed budget *With appropriate consideration of procurement requirements	Over £1,000,000	Over £500,000			Over £500,000		Up to £500,000	Up to £250,000	Up to £100,000	Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
F6	Approval of all other non-healthcare requisitions *With appropriate consideration of procurement requirements	Over £500,000						Up to £250,000	Up to £100,000	Up to £50,000	*Up to £50,000	Up to £50,000	Up to £50,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
G	**RELOCATION EXPENSES** In line with Policy approved by ICB Remuneration Committee							Over £8,500	Up to £8,500					
H	**DECISION TO APPROVE 'NEW' ~~HEALTHCARE~~ INVESTMENT BUSINESS CASES**													
H1	Where funding is a) available and identified within agreed financial plan or b) from additional notified resource allocations (e.g new in-year) c) other identified income streams (e.g other agencies / recharges)	Over £1,000,000	Up to £1,000,000	?		Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £750,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H2	Where **not** included in approved financial plan (but still subject to ICB Executive / Place Leadership Team Approval) N.B any material underspend / variation from plan at individual budget holder level cannot be reinvested / redirected (see Virement Policy - Section L) without Executive team approval due to overall financial management requirements of the ICB.	Over £500,000	Up to £500,000	?		Up to £500,000 *Primary Care Related		Up to £250,000	Up to £100,000		Up to £100,000	Up to £100,000	Up to £100,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
H3	Primary Care Capital Expenditure Approval (within ICB allocation) *NB - Capital Plan to be approved by the ICB for each financial year*	Over £1,000,000				Up to £1,000,000 *Primary Care Related		Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
H4	Secondary Care Capital Expenditure Approval (within ICB allocation) *NB - Capital Plan to be approved by the ICB for each financial year*	Over £1,000,000	Up to £1,000,000					Up to £1,000,000 (in urgent cases)	Up to £500,000 (in urgent cases)					
I	~~HEALTHCARE~~ CONTRACTING													
I1	**Signing of Healthcare Contracts** (Annual Contract Value)							Over £150,000,000	Up to £150,000,000	Up to £50,000,000				
I2	**Approval of Healthcare Contract Payments** All healthcare contract payments must be supported by signed contract (see I1).							As per agreed plan / budget value	As per agreed plan / budget value)	As per agreed plan / budget value)		As per agreed plan / budget value	As per agreed plan / budget value	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
I3	**Procurement Route Decision Whether to put Healthcare Service Out to Tender** Committee to review and make risk-based decisions as appropriate on case by case basis	~~All – as required~~ X (For Novel or Contentious issues escalated by FIR Committee)	X (Novel or Contentious Procurement Decisions to be escalated to the Board)											
I4	**Approval of ICB Procurement Plan (on an annual basis and any ad-hoc procurement identified during the year) alongside the relevant specific elements of the ICB procurement activities** • Approve the commencement of any over threshold open tenders. • Approve the procurement of goods and services via approved national / local frameworks (over delegated budgeted limits) • Approve the award of a contract at the end of a tender process. • Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract. • Approve the sign off of a tender waiver in line with the SORD and Signatory list. • Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice		X											

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	(CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT)													
I5	**Signing of Non-Healthcare Contracts** (Annual Contract Value)		Over £250,000						Up to £250,000	Up to £100,000		Up to £100,000	Up to £100,000	Up to £100,000
J	**APPROVAL OF OTHER HEALTHCARE PAYMENTS WITHIN BUDGET** See authorised signatory list for approval limits for other officers.	Over £1,000,000	Up to £1,000,000			Up to £1,000,000 *Primary Care Related		Up to £1,000,000	Up to £750,000	Up to £100,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	Up to £250,000 (within approved budget)	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
K	**QUOTATIONS AND TENDERS HEALTHCARE / NON-HEALTHCARE**													
K1	**Procurement through approved national / local framework agreement (in line with call off rules)**		From £20k to delegated budgeted limit for expenditure within budget (with approval from procurement team) Above delegated budgeted limits, subject to Finance, Investment & Resources Committee Approval											
K2	**Quotation Waiver Approval** (Total Contract Value – see detailed financial policy on tendering when permissible)		From £20k to delegated limit for ~~additional~~ expenditure within budget											
K3	**Tender Waiver Approval**	Above Tender Limit for Healthcare / Non-Healthcare	Nil – N.B. Reporting of all Tender Waiver Approval to Audit Committee											
K4	**Approval to issue a Formal Tender** In compliance with 'Public Contract Regulations 2015 and amendments'.		All - Threshold and above approved by ICB Board Threshold is £213,477 (including VAT) unless light touch regime applies for healthcare services (see I3)											
K5	**Approval to seek 3 quotes (up to identified tender limit)** In compliance with 'Public Contract Regulations 2015 and amendments'.		Up to delegated limit for ~~additional~~ expenditure within budget £20,000 to Threshold Minimum of three written quotes required											
K6	Non Healthcare -Expenditure below quite threshold (quotes still recommended to secure VFM)		Up to £19,999											
K7	**Opening of Tender Documentation** (where not received electronically) (at least 2 people from list)							X	X	X	X			
K8	**Approval of ICB Procurement Plan (on an annual basis and any ad-hoc procurement identified during the year) alongside the relevant specific elements of the ICB procurement activities** • Approve the commencement of any over threshold open tenders.		X											

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
	• Approve the procurement of goods and services via approved national / local frameworks (over delegated budgeted limits) • Approve the award of a contract at the end of a tender process. • Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract. • Approve the sign off of a tender waiver in line with the SORD and Signatory list. Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice (CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT)													
L	**VIREMENT**	Relating to a transfer of funds from an unspent or underspent budget to another; within virement rules to allow greater financial flexibility in using available resources *All Transfers must be:* *• affordable within budget; and* *• agreed by both budget holders* *Virements may not be used to create new budgets*												
L1	**Within Existing Approved Pay or Non-Pay Budgets**							Over £1,000,000	Up to £750,000	Up to £500,000		Up to £250,000	Up to £250,000	As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List
L2	**With regards to transfers from reserves (including distribution of new in-year resource / capital allocations)**								Over £25,000,000	Up to £25,000,000				As delegated by Chief Executive/ CFO at the limits outlined within the Authorised Signatory List

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
M	**DISPOSALS AND CONDEMNATION** All assets disposed at market value.	Over £50,000						Up to £50,000	Up to £10,000	Up to £5,000				
N	**CHARITABLE FUNDS** (Not applicable to ICB)													
O	**HUMAN RESOURCES**													
O1	**Approve HR Decisions Not Covered By ICB HR Policies or Is Exceptional To Policies** (e.g. additional compassionate leave or exceptional carry forward of leave days)							X	X	X	X	X	X	
O2	**Decisions As Set Out Within HR Policies** (where there is some management discretion e.g. study leave authorisation)							X	X		X	X	X	
O3	**Approval of Operational Structure** (re staffing and departments), and in accordance with organisation change policy							X						
O4	**Approval of Appointment to Posts Below Executive Directors**								X	X	X	X	X	X
O5	**Approval of the below arrangements as required by the the ICB** • Approval of the arrangements for discharging the ICB statutory duties as an employer • Approve human resources policies for ICB employees and for other persons working on behalf of the ICB • Approve any other terms and conditions of services for ICB AFC employees • Approve disciplinary arrangements for ICB employees • Approve arrangements for staff appointments (excluding matters detailed within the Constitution) • Approve the ICBs organisational development plans		X											
P	**EXTERNAL COMMUNICATIONS & REPORTING**													
P1	**Approve Complaints Responses** and Letters to **Politicians and Media Responses**							X				X (Assistant Chief Executive)		
P2	**Approve Public Consultation Material**							X				X (Assistant Chief Executive)		
P3	**Approve Public & Staff Engagement Material** inc Website							X				X (Assistant Chief Executive)		

Section	Description	Reserved by	Delegated to											
		Integrated Care Board (ICB)	Finance, Investment & Resources Committee	Transformation Committee	Quality & Performance Committee	Primary Care Committee	'Place' Committee's	ICB Chief Executive	ICB Executive Director of Finance	ICB Deputy Director of Finance	ICB Executive Directors (Nursing / Medical)	Other ICB Directors (Named as Applicable)	'Place' Directors	Other named ICB Officer (or as per ICB authorised signatory list)
P4	Approve FOI Responses											X (Assistant Chief Executive)		X* Corporate Affairs / Governance Lead
P5	Approve Annual Engagement & Communication Plan	X										X (Assistant Chief Executive)		
Q	FINANCE													
Q1	Approval of Operational Policies as required by the organisation		X											

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Remuneration Committee Chair

26 January 2023

Agenda Item No	**ICB/01/23/17**
Report author & contact details	Matthew Cunningham, matthew.cunningham@nhs.net
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair of the Remuneration Committee
Responsible Officer(s) to take actions forward	Chris Samosa, Chief People Officer Matthew Cunningham, Associate Director of Corporate Affairs and Governance

Report of the Remuneration Committee Chair

<table>
<tr><td>Executive Summary</td><td>The Remuneration Committee of the NHS Cheshire and Merseyside Integrated Care Board met on 28 November 2022. The meeting was quorate and able to undertake the business of the Committee. Declarations of interest noted where applicable.

Main items considered at the meetings included:

• Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board
• Terms and Conditions for the ICB Medical Director.
• ICB Board Partner Member Remuneration.

In early January. members of the Committee also received via email a further updated paper on the proposed Terms & Conditions for Clinical Roles (GP) and for the ICB Medical Director. Members were asked to consider the updated paper and approve the recommendations within.

The next meeting of the Committee is scheduled to be held on 20 March 2023.</td></tr>
<tr><td>Purpose (x)</td><td><table><tr><th>For information / note</th><th>For decision / approval</th><th>For assurance</th><th>For ratification</th><th>For endorsement</th></tr><tr><td>X</td><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>Recommendation</td><td>The Board is asked to:
• note the items covered by the Remuneration Committee at its meeting on the 28 November 2022 and subsequent considerations
• note the decisions made by the Committee.</td></tr>
<tr><td>Impact (x)
(further detail to be provided in body of paper)</td><td><table><tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr><tr><td>X</td><td></td><td>X</td><td></td></tr><tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr><tr><td></td><td></td><td></td><td></td></tr></table></td></tr>
<tr><td>Management of Conflicts of Interest</td><td>No conflicts of interest were identified or noted at the meeting on the 28 November 2022. Whilst the content of the Chairs report does relate to individuals on the ICB Board, the Committee has already made the decision (where applicable) and as such Board members in scope of the decisions made at the meeting 28 November 2022, and subsequently virtually, are not conflicted by being informed at the January 2023 Board meeting.</td></tr>
<tr><td>Next Steps</td><td>n/a</td></tr>
<tr><td>Appendices</td><td>n/a</td></tr>
</table>

Report of the Remuneration Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Remuneration Committee (Statutory Committee)	The Committee's main purpose is to exercise the functions of the ICB relating to paragraphs 17 to 19 of Schedule 1B to the NHS Act 2006. In summary the committee is required to: • confirm the ICB pay policy including adoption of any national or local pay frameworks for all employees including senior managers/directors (including board members) and non-executive directors. The Committee will: • adhere to all relevant laws, regulations, and company policy in all respects, including (but not limited to) determining levels of remuneration that are sufficient to attract, retain and motivate Executive Directors whilst remaining cost effective • advise upon and oversee contractual arrangements Directors, including but not limited to termination payments. The Committee's duties are as follows: For the Chief Executive, Directors, and other Very Senior Managers: • determine all aspects of remuneration including but not limited to salary, • determine arrangements for termination of employment and other contractual terms and non-contractual terms. For all staff: • determine the ICB pay policy (including the adoption of pay frameworks such as Agenda for Change). • oversee contractual arrangements • determine the arrangements for termination payments and any special payments following scrutiny of their proper calculation and taking account of such national guidance as appropriate.	Tony Foy, ICB Non-Executive Member

Committee	Principal role of the committee	Chair
	For Non-Executive Directors (NEDs): • determine the ICB remuneration policy (including the adoption of pay frameworks) • oversee contractual arrangements. Additional functions that the ICB has chosen to include in the scope of the committee include: • functions in relation to nomination and appointment of (some or all) Board members through convening an ICB Appointments Panel • functions in relation to performance review/ oversight for directors/senior managers • succession planning for the Board • assurance in relation to ICB statutory duties relating to people such as compliance with employment legislation including such as Fit and proper person regulation (FPPR) • board development which maybe progressed through a discreet working group.	

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision /Action Log Ref No.	Meeting Date	Issues considered
	28.12.22	**Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board.** The Committee considered a report that provided the committee with the proposed key terms and conditions for the four roles of Associate Medical Director, Senior Clinical Lead, Clinical Lead and Named GP for Safeguarding. Members were advised that GPs engaged by the nine CCGs prior to the 1 July, had been transferred to the ICB, and all redeployed and recruited GPs had retained current pay and terms and conditions until the outcome of this paper had been approved. Upon approval, each 'Place' would be expected to adhere to the committee's decision to ensure consistency and avoid inequity.

Decision /Action Log Ref No.	Meeting Date	Issues considered
		Members were advised of the difference between contract 'of' service and contracts 'for' service coverings aspects such as annual leave, sick pay, redundancy, pension, service accrual and NI. The paper also provided a summary of the arrangements held previously by the nine CCGs, which highlighted the range of contract types and sessional rates previously held by clinical leads across Cheshire and Merseyside. Following discussion by the Committee with regards the proposed remuneration rates and contract types it was agreed that the Committee was not in a position to approve the recommendations within the report. An updated report was requested to be composed considering the comments raised during the Committees discussions and remuneration and contract types and for it to be considered at the next meeting of the Committee in December 2022, or which could be circulated and considered by members virtually before this time due to pending recruitment issues if approval of rates and contract types were deferred.
	28.12.22	**Terms and Conditions for the ICB Medical Director.** The Committee considered a paper that outlined proposed amendments to the Terms and Conditions of employment for the ICB Medical Director. Following discussion an updated report was requested to be composed considering the comments raised during the Committees discussions and for it to be considered at the next meeting of the Committee in December 2022, or which could be circulated and considered by members virtually before this time if required.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision /Action Log Ref No.	Meeting Date	Issues considered
	28.12.22	**Partner Member remuneration** The Committee considered a report that outlined proposals for remuneration for ICB partner members. National guidance was that where members were not already fully salaried employees of a partner organisation, remuneration would be paid, however there is no national remuneration guidance for ICB Partner members. Following benchmarking with other ICBs and NHS organisations a role remuneration at a rate of £13k per annum was considered reasonable as this this equaled the minimum rate paid to NHS Non-executive directors. Members were advised that there was no employment commitment nor pension connected to the roles. The Remuneration Committee approved a remuneration rate of £13k for those Partner members entitled to payment. Agreement was with the caveat of reviewal if and when guidance was received and also subject to annual review.
	Decision agreed virtually by email 14.01.23	**Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board.** An updated paper was circulated to the members of the Committee at the beginning of January 2023 seeking their support to the recommendations within. On the 14 January 2023 it was confirmed by the Remuneration Committee Chair that all Committee members had approved the recommendations within the updated report; namely: • remuneration for the Associate Medical Directors to be set at £155,530pa and that in line with their legacy pay protection policies they will be entitled to 2 years pay protection effective from the date of employment to the role. post holders will be

Decision /Action Log Ref No.	Meeting Date	Issues considered
		engaged under a contract of employment (contract **of** service). • remuneration for senior Clinical Leads at a sessional rate of £330 (for a 4-hour 10-minute session) and that they be engaged under a contract **for** services. • remuneration for clinical leads at a sessional rate of £320 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract **for** services. • remuneration for the named GPs for safeguarding at a sessional rate of £330 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract **of** service.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision /Action Log Ref No.	Meeting Date	Issue for escalation
-	-	-

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision / Action Log Ref No.	Meeting Date	Recommendation from the Committee
-	-	-

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the items covered by the Remuneration Committee at its meeting on the 28 November 2022 and subsequent considerations

- **note** the decisions made by the Committee, namely:
  - **Partner Member Remuneration**
    Approval of a remuneration rate of £13k for those Partner members entitled to payment

  - **Terms & Conditions for Clinical Roles (GP) at NHS Cheshire & Merseyside Integrated Care Board**
    - approval of the remuneration for the Associate Medical Directors to be set at £155,530pa and that in line with their legacy pay protection policies they will be entitled to 2 years pay protection effective from the date of employment to the role. post holders will be engaged under a contract of employment (contract **of** service)
    - approval of the remuneration for senior Clinical Leads at a sessional rate of £330 (for a 4-hour 10-minute session) and that they be engaged under a contract **for** services
    - approval of the remuneration for clinical leads at a sessional rate of £320 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract **for** services
    - approval of the remuneration for the named GPs for safeguarding at a sessional rate of £330 (for a session of 4 hours and 10 minutes) and that they be engaged under a contract **of** service.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Quality & Performance Committee Chair

26 January 2023

Agenda Item	**ICB/01/23/18**
Report author & contact details	Kerry Lloyd, Deputy Director of Nursing & Care kerry.lloyd@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Tony Foy, Chair
Responsible Officer to take actions forward	Kerry Lloyd, Deputy Director of Nursing & Care

Report of the Quality & Performance Committee Chair

Executive Summary	The purpose of this report is to provide assurance to the C&M Integrated Care Board in regard to key issues, considerations, approvals and matters of escalation considered by the C&M ICB Quality & Performance Committee in securing continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centered, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	x		x		
Recommendation	**The Board is asked to:** 1. Section 2 - note the content 2. Section 3 - note the content and the issues considered by the Committee and actions taken. 3. Section 4 - Consider the matters escalated to the ICB Board regarding: ▪ Urgent Care Performance and the need for inclusion of social care dataset and insights by Spring 2023 ▪ the undertaking of a Rapid Quality Review meeting with Cheshire & Wirral Partnership ▪ the need for greater oversight and improved reporting by the C&M LMNS.				
Key issues	The committee were presented with the key issues facing the urgent care system in Cheshire and Merseyside (C&M) alongside a need to have better oversight of the adult social care system and associated metrics.				
Key risks	The committee were presented with the place based reports for Cheshire East and Cheshire West, as well as Wirral, that detailed the cumulative risks in relation to quality and performance at Cheshire & Wirral partnership Trust and the associated actions being taken. The committee were presented with the findings of the review into maternity services at East Kent Trust, alongside a safety and surveillance report provided by the C&M LMNS (Local Maternity and Neonatal Services). The committee were of the view that the current reporting infrastructure regarding maternity services in C&M required further work, and that a report should be submitted monthly to the committee that gave assurance as to the development of reporting maturity and metrics of the quality and safety of maternity services in C&M by its LMNS.				

Impact (x) (further detail to be provided in body of paper)	Financial	IM &T	Workforce	Estate
			x	
	Legal	**Health Inequalities**	**EDI**	**Sustainability**
		x	x	
Management of Conflicts of Interest	No conflicts of interest declared at the Committee.			
Next Steps	Noted in the body of report.			
Appendices	None			

Report of the Quality & Performance Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Quality & Performance Committee	The Quality and Performance Committee has been established to provide the ICB with assurance that it is delivering its functions in a way that secures continuous improvement in the quality of services, against each of the dimensions of quality (safe, effective, person-centred, well-led, sustainable, and equitable), set out in the Shared Commitment to Quality and enshrined in the Health and Care Act 2022. This includes reducing inequalities in the quality of care, coupled with a focus on performance. The Committee exists to scrutinise the robustness of, and gain and provide assurance to the ICB, that there is an effective system of quality governance and internal control that supports it to effectively deliver its strategic objectives and provide sustainable, high quality care. The committee will focus on quality performance data and information and consider the levels of assurance that the ICB can take from performance oversight arrangements within the ICS and actions to address any performance issues. In particular, the Committee will provide assurance to the ICB on the delivery of the following statutory duties: • Duties in relation children including safeguarding, promoting welfare, SEND (including the Children Acts 1989 and 2004, and the Children and Families Act 2014); and • Adult safeguarding and carers (the Care Act 2014).	Tony Foy

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
QPC/ 12/22/07	5/12/2022	**Feedback from System Quality Group (28th November 2022)** The committee heard an update from the System Quality Group that considered the themes of pressures within the North-West Ambulance Service and the residential sector for care of older people. The committee heard how the cross-cutting theme of falls within care homes was agreed as an important area for quality improvement. The committee also heard how this work chimes with the work linked to the Winter Collaborative and so will ensure that this work dovetails with the work already being undertaken. The Associate Director for Quality in Cheshire East is the SRO for care homes and will lead the quality improvement work required.
QPC/12/22/08	15/12/2022	**Complaints Thematic Analysis** The Committee received an update on the ongoing work with the 9 Places and were advised the reporting process is still under development. Software used to create reports differs across Place areas and this impacts how data is captured. A Task and Finish Group will be set up to establish a consistent reporting process for the whole of the ICB, but this is expected to be a large piece of work and will take a while to complete In response to a query about the number of inherited complaints and if there had been an increase since the formation of the ICB, Rebecca advised the data is available but has not yet been analysed and this is a piece of work that could be carried out and fed back to the committee as part of an assurance report. It was agreed to work more closely with the Quality team to create a reporting template for this committee, identifying and reporting on areas requiring improvement. The committee asked for quarterly updates to be provided as to how the integration work is developing and any associated risks and mitigation.
QPC/12/22/12	15/12/22	**All Age Continuing Health Care** The committee were provided with an update on All Age Continuing Care (AACHC) and advised most areas are performing within the nationally mandated quality

Decision Log Ref No.	Meeting Date	Issues considered
		metrics, with the exception of Wirral, Cheshire and Liverpool, as they did not achieve the 28-day performance standard in Quarter 2 2022/23, action plans have subsequently been developed to support improvement. The committee heard how AACHC is delivered differently across each of the 9 places in C&M, which is why a comprehensive review is being undertaken to support improvement in efficiency and population outcomes as part of the transfer to the ICB. It was noted the biggest challenge faced by AACHC is ensuring equity across the system The committee were advised there would be regular updates as to the ongoing outputs and outcomes of the review through the quarterly reporting schedule to Q&PC.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
QPC/ 12/22/09	15/12/22	**System Oversight Board Development** The committee approved the Terms of Reference for the establishment of the System Oversight Board which will allow the Executive Director of Nursing & Care to discharge statutory responsibilities in relation to: • All Age Continuing Health Care • SEND • Safeguarding.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
QPC/ 12/22/05	15/12/22	**The Quality & Performance Dashboard** The Chair of the committee opened the item with a discussion regarding the recent CQC State of Care report and how the reporting of pressures within the urgent care system in C&M need to be wider than the performance figures presented but include reporting that details patient and public experience of using systems in times of pressurised demand. The committee then received a presentation from the Associate Director of Performance & Planning that detailed the urgent care system performance during November 2022, suggesting that despite activity/demand being broadly lower or the same as pre-pandemic levels, performance has deteriorated across most metrics. Data reviewed included NWAS performance and handover delays, AED attendances and 4 hour performance, occupancy and NCTR rates across all relevant trusts. The committee then discussed how managing risks in one part of the system such as an Emergency Department can create risks elsewhere, so there needs to be a systematic view of pressures. The committee also requested inclusion of social care activity within the dataset, as this will then show a rounded view of pressure points and demand. It was requested that this data be available for the Spring 2023 reporting cycle.
QPC/12/22/06	15/12/22	**Place Based Key Issues Report:** The committee were informed that due to cumulative risks within Cheshire & Wirral Partnership across a number of areas, the organisation will be engaged to participate in a Rapid Quality Review (RQR) process, in line with National Quality Board guidance for risk management. The RQR will take place in January 2023 and the committee requested an update in the February 2023 place based report.

QPC/12/22/12	15/12/22	**The Cheshire & Merseyside LMNS Ockenden Update & Findings of the Review into Maternity Services at East Kent Hospital** The committee were presented with the findings of the East Kent review into Maternity Services and discussed whether there was sufficient assurance that similar events were not happening within maternity services in C&M. The committee felt that they were not sufficiently assured by the current reporting infrastructure and would like to receive monthly reports from the C&M LMNS that details quality and safety assurance of maternity services.

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date		Recommendation from the Committee
		-	**-**

6. Recommendations

6.1 **The ICB Board is asked to:**

1. Section 2 - note the content
2. Section 3 - note the content and the issues considered by the Committee and actions taken.
3. Section 4 - Consider the matters escalated to the ICB Board regarding:
   - Urgent Care Performance and need for inclusion of social care dataset and insights by Spring 2023
   - The undertaking of a Rapid Quality Review meeting with Cheshire & Wirral Partnership
   - The need for greater oversight and improved reporting by the C&M LMNS.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the System Primary Committee Chair

26 January 2023

Agenda item	**ICB/01/23/19**
Report author & contact details	Christopher Leese c.leese@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese c.leese@nhs.net

Report of the System Primary Care Committee Chair

<table>
<tr><td>Executive Summary</td><td colspan="5">The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy.

The System Primary Care Committee held meetings on the 20 December 2022 and 11 January 2023. Attendance at both meetings enabled quoracy to be met and decision making to be undertaken. Declarations of interest where applicable where minuted.

Topics discussed at both meetings are as outlined below.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• note the contents of the report and decisions undertaken at the System Primary Care Committee meetings held in public and in private on 20 December 2022 and the discussions undertaken at an extra-ordinary meeting of the Committee held in private on 11 January 2023.</td></tr>
<tr><td>Key issues</td><td colspan="5">The Committee discussed the following business as listed at its meetings on 20 December 2022:

In Part A , the meeting in private section:

• Edge Hill Incorporation Application Liverpool
• APMS contracts Procurement
• Security in General Practice and Staff Safety
• Minutes of NHS England Pharmaceutical Services Regulations Committee (PSRC)
• Dental and GOS (General Ophthalmic Services) Handover Documents including update on Dental Deep Dive and next steps
• Capital Monies
- Primary Care Capital update
- Winter Capital Bids
• Update in relation to A Strep / Primary Care Pressures.

In Part B, the meeting in public section:

• Community Pharmacy: Challenges/Update/Integration
• Primary Care Workforce Update
• Delegated Areas – General Medical and Community Pharmacy</td></tr>
</table>

<table>
<tr><td></td><td>

- Policy and Contracting Update including place reports from place primary care forums
- Finance Update
- Update on the Primary Care Operating Model.

The Committee discussed the following business as listed at its meeting in private on 11 January 2023:

- unsecured APMS contracts in Liverpool.

</td></tr>
<tr><td>Key risks</td><td>Key risks were noted and mitigating actions confirmed for the transfer of Dental services, and the overall finance/budget.</td></tr>
<tr><td rowspan="3">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>x</td><td></td><td>x</td><td>x</td></tr>
<tr><td>

<table>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td>x</td><td>x</td><td></td><td>x</td></tr>
</table>

</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>General declarations of interest where minuted but no members of the Committee where conflicted / material affected in relation to any of the agenda items considered at both meetings.</td></tr>
<tr><td>Next Steps</td><td>A detailed dispersal plan for the Practice within Liverpool Place will be circulated to SPCC members. A review of the full Primary Care Estate has already been requested) but priority given to those holding APMS Contracts which will expire by April 2024 o before.

Both of these actions are with the teams at Liverpool Place, supported by the ICB Associate Director of Primary Care.</td></tr>
<tr><td>Appendices</td><td>None</td></tr>
</table>

Report of the System Primary Care Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
System Primary Care Committee	The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy.	Erica Morriss

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
	22.12.2022	• The Committee received an update on the Primary Care Operating Model • The Committee received an update escalated from Liverpool place in respect of security issues in general practice. • The Committee received a financial update in respect of future capital monies/winter funding. • The Committee received an update on national and local Primary Care Contracting which defines much of the work undertaken by primary care (medical). This included place updates on place primary care forums – key items/discussions/decision and anything requiring escalation – from each place, as agreed as part of the operating model. • The Committee received a presentation on place actions in relation to primary care workforce • The Committee received an update on the position relating to Primary Care finance • The Committee received the minutes and decisions of the (PSRC) Pharmaceutical Services Regulations Committee which were endorsed. The

Decision Log Ref No.	Meeting Date	Issues considered
		PSRC Committee regulates the Community Pharmacy Contract within the ICB, and is a mandatory Committee required under the Community Pharmacy contract policy book. • The Committee received a presentation in relation to Community Pharmacy challenges, opportunities for future integration and ideas for further actions as an ICB to maximise opportunities. • The Committee received a further update on the ICB's transfer from NHS England of Dental and General Ophthalmic Services (GOS) for assurance and information. • As part of the above the Committee received a further version of key handover documentation in relation to Dental and General Ophthalmic Services (GOS).

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
	22.12.2022	• Decision was made in respect of an incorporation request, with legal background information supplied to support this (Escalated from Liverpool Place) • A Decision was made in respect of 5 APMS (Alternative Providers of Medical Services) Contracts agreed under Board delegation rights. For information it was stated in the meeting that the position for a further 2 outstanding contracts will be decided at an extra ordinary meeting of the Committee being held in January, with Chair agreement.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
	11.01.2023	• An Extra-Ordinary meeting was held in private to consider a paper on two unsecured APMS contracts in Liverpool Place. Committee members discussed in detail the risks associated with the unsecured APMS Liverpool Contracts. • The recommendations were upheld which were proceeding with an existing bidder who did not meet all the requirements for one contract and a list dispersal for one. • It should be noted that one contract could have a financial risk of max. £200k although options are being considered around estate(s) and other areas to mitigate this. • The Committee acknowledged that after a full procurement the second contract would be terminated and the list dispersed (under the List dispersal allowance of the Policy and Guidance Manual (PGM)) as there were no other viable options.

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendations
-	-	None

6. Recommendations

6.1 **The ICB Board is asked to:**

- note the contents of the report and decisions undertaken at the System Primary Care Committee meetings held in public and in private on 20 December 2022 and the discussions undertaken at an extra-ordinary meeting of the Committee held in private on 11 January 2023.

NHS Cheshire and Merseyside Integrated Care Board Meeting

26 January 2023

Report of the Transformation Committee Chair

Agenda Item No	**ICB/01/23/20**
Report author & contact details	Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson; Assistant Chief Executive
Responsible Officer to take actions forward	Neil Evans; Associate Director of Strategy and Collaboration neilevans@nhs.net

Report of the Transformation Committee Chair

<table>
<tr><td>Executive Summary</td><td colspan="5">The Transformation Committee has been established to support NHS Cheshire and Merseyside in the delivery of its statutory duties and provide assurance to the Board in relation to the development and delivery of our strategic plans.

The meeting considered:
• The Integrated Care System Digital and Data Strategy
• A programme reviewing the current transformational change activity occurring across the Cheshire and Merseyside system and the work to develop priorities, delivery, and governance approaches
• Development of the Integrated (Health and) Care Partnership Strategy.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td></td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
Note the areas discussed in relation to:
• The draft Integrated Care System Digital and Data Strategy, which was recommended for approval at the November ICB Board Meeting
• A programme is established reviewing the current transformational change activity occurring across the Cheshire and Merseyside system in order to inform future priorities, delivery approaches and governance
• Development of the Integrated (Health and) Care Partnership Strategy</td></tr>
<tr><td>Key issues</td><td colspan="5">The national planning information was not yet available for 2023-24 which will impact on the timescales available locally for developing our plans. Historically a number of transformation programmes have been resourced from budgets “top sliced” from CCG allocations. This funding is not available in 2022-23 and a prioritisation process will need to reassess work priorities</td></tr>
<tr><td>Key risks</td><td colspan="5">Resource availability(human and financial) may be insufficient to deliver the programme priorities across our system. In section 2 a review exercise of existing change programme content, delivery and governance approaches is taking place, which will inform our future programme content and delivery approach.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td></td><td>X</td><td></td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td colspan="2">X</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">Not applicable</td></tr>
<tr><td>Next Steps</td><td colspan="5">The Transformation Committee has asked for further reports to be presented to their next committee in relation to:</td></tr>
</table>

	• Work with system stakeholders to develop the ICP Strategy by the nationally set deadline of December 2022 *(noting that this date was advised by Department of Health and Social Care as not being mandatory after the Committee and the HCP is now considering the draft on January 17th, 2023)* • A programme delivery and assurance review of current transformation activity and recommendations on future transformation plans and governance arrangements for the programme activity • The Digital and Data Strategy has been recommended to ICB Board for approval at the November Meeting
Appendices	

Glossary of Terms	Explanation or clarification of abbreviations used in this paper
ICB	Integrated Care Board
HCP	Health and Care Partnership
ICP	Integrated Care Partnership
ICS	Integrated Care System

Report of the Transformation Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Transformation	Provide a leadership forum, across the system, to consider the development and implementation of the ICP strategy and policy and plans of the ICB securing continuous improvement of the quality of services Retain a focus on health inequalities and improved outcomes and ensure that the delivery of the ICP / ICB's strategic and operational plans are achieved within financial allocations.	Clare Watson

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
-	10.11.22	A programme reviewing the current transformational activity occurring across Places, Corporate Programmes and Provider Collaboratives, within the Cheshire and Merseyside system. This work is assessing the current progress in delivery and associated governance arrangements to inform our future plans and priorities. A further report was requested confirming the outcome of this work at the next meeting.
-	10.11.22	An update on the production of the ICP (Health and Care Partnership Strategy was provided to the group including delivery against the December publication date set by the Department of Health and Social Care.

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered, and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
		Not applicable -

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Issue for escalation	Recommendation from the Committee
-	10.11.22	Digital and Data Strategy	The Committee recommended that the Strategy should be presented to the ICB Board for approval.

6. Recommendations

6.1 **The ICB Board is asked to:**

- **Note** the areas discussed in relation to
  - The draft Integrated Care System Digital and Data Strategy, which was recommended for approval at the November ICB Board Meeting
  - A programme is established reviewing the current transformational change activity occurring across the Cheshire and Merseyside system in order to inform future priorities, delivery approaches and governance
  - Development of the Integrated (Health and) Care Partnership Strategy

7. Next Steps

7.1 The Transformation Committee has asked for further reports to be presented to their next committee in relation to:

- Work with system stakeholders to develop the ICP Strategy by the nationally set deadline of December 2022 *(noting that this date was advised by Department of Health and Social Care as not being mandatory after the Committee and the HCP is now considering the draft on January 17th 2023)*
- A programme delivery and assurance review of current transformation activity and recommendations on future transformation plans and governance arrangements for the programme activity
- The Digital and Data Strategy has been recommended to ICB Board for approval at the November Meeting.