NHS
Cheshire and Merseyside

Board Meeting

Held in PUBLIC

40/20 Lounge, Warrington Conference Centre, Halliwell Jones Stadium

24 July 2025

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Neighbourhood Health in Cheshire and Merseyside- A Framework for Delivery

Presentation to the ICB Board

25 July 2025

What is covered in the Framework:

NHS Cheshire and Merseyside

Aim: To set out a blueprint for Neighbourhood Health- the elements we want to see in each of our 9 Borough-based partnerships and emerging 59 neighbourhoods

- Vision
- Definitions and Foundations
- Scope (the 3 circles of neighbourhood health)
- Key elements of blueprint
- Key features of integrated neighbourhood teams
- Impact measures for a neighbourhood dashboard
- Roadmap
- Summary of Feedback
- Next steps

Introduction

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Cheshire and Merseyside will respond to the 3 NHS "missions":

- Shift services out of hospital and into the community
- NHS becomes as much a Neighbourhood Health Service as it is a National Health Service.
- A shift from Board to (electoral) ward

Our Framework outlines how all age Neighbourhood Health will be developed across Cheshire and Merseyside. It responds to national guidance and describes how Cheshire Mersey wide enabling actions will support Place led development and ensure that neighbourhood working reflects and models wider policy.

This Framework:

- **Establishes a clear and shared vision for the Neighbourhood Health Service,** so we can communicate clearly what it means for professionals, patients and service users, and communities across Cheshire and Merseyside.
- **Promotes consistency, whilst recognising the different levels of maturity that exist across nine places**, we will build from where we are, minimise disruption and be flexible and responsive to local needs.
- **Is clear on what success means for Cheshire and Merseyside** and the role of systems, providers, places and neighbourhoods in delivering this for neighbourhood health.
- **Sets out our roadmap for the next year** and begin to develop our long-term system delivery plan through ongoing communication and debate with our partners

NHSE Neighbourhood Guidelines 2025-26

NHS Cheshire and Merseyside

The NHSE guidance on neighbourhoods emphasises that we need to move to a neighbourhood health service that will deliver more care at home or closer to home, improve people's access, experience and outcomes, and ensure the sustainability of health and social care delivery.

It has set out 6 initial core components of a neighbourhood approach

1. Population Health Management
2. Modern General Practice
3. Standardising Community Health Services
4. Neighbourhood Multi-Disciplinary Teams
5. Integrated intermediate care with a 'Home First' approach
6. Urgent neighbourhood services

Guidance has indicated that the focus in 2025/26 should be supporting adults, children and young people with complex health and social care needs who require support from multiple services and organisations. In Cheshire and Merseyside for 25/26 this will be our proposed initial scope

The Ten-Year Health Plan- Outlining the key ambitions for Neighbourhood Health

NHS Cheshire and Merseyside

- **Neighbourhood Health Centres-** establish a NHC in every community, beginning with places where healthy life expectancy is lowest - a ‘one stop shop’ for patient care and the place from which multidisciplinary teams operate. NHCs will be open at least 12 hours a day and 6 days a week-40/50 of them in first year
- **Comprehensive community hubs** delivering GP, nursing, pharmacy, mental health, and allied health services.
- **Shift in capital investment** towards community centres and exploring private finance mechanisms in some cases
- **Launch of a new NHS workforce plan-**aligned to NH, increased GP numbers and broader recruitment and training of allied health professionals
- **Digital enablement for Neighbourhood Health-**transform the NHS app, including self-referrals, AI advice and guidance and digital patient access, empowerment and care planning. By 2028, the app will be a full front door to the entire NHS
- **Single Digital Patient Record** - to enable more co-ordinated, personalised and predictive care
- **Prevention and Public Health in the Community-**Embed prevention services in neighbourhood hubs: weight-loss support, smoking cessation, alcohol counselling
- **Strong public health measures**: obesity interventions, food advertising restrictions, sugary/fizzy drinks rules
- **Expand mental health**, genomics, and chronic disease prevention in the community setting
- **One-stop-shop hubs** offering healthcare and lifestyle support
- **Individuals to be cared for at home wherever possible**, reducing hospital reliance

Vision: Neighbourhood Health in Cheshire and Merseyside

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Make healthcare better by bringing it closer to where people live.

Health and care providers working together to help people before they get really sick and make it easier for everyone to get care

Integrated neighbourhood health teams will work with local people and other organisations so everyone can be healthier and have the same chance to stay well

What we mean by neighbourhood working (adapted from Liverpool)

Neighbourhoods

A specific geographical area or community that resonates with residents, that local services, organisations and communities can coalesce around to address needs and improve outcomes. This is broader than integrated neighbourhood teas and includes ongoing partnerships with community groups, residents, and local stakeholders to address a wide range of community issues, including community development and systemic improvements.

Multi-disciplinary working

Representatives from different disciplines coming together to share expertise, coordinate care, and contribute their specific skills to address the needs of an individual/family or group. Collaboration tends to occur at key points, such as MDT meetings, reviews, or case discussions and individuals typically maintain separate roles, responsibilities and different back-office functions.

Integrated Neighbourhood Teams

Developing Integrated Neighbourhood Teams will be part of how we deliver care at a neighbourhood level more broadly. INTs go beyond multi-disciplinary working by fully integrating representatives from health (primary, community, acute and specialist) social care, and the voluntary sector into a single, place-based team to deliver seamless, coordinated care within a defined area..

Basic Ingredients

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- ***Neighbourhood working is based on a different relationship between public services and residents.***

- Our initial focus: establishment of multi-agency integrated neighbourhood teams working on geographical footprints of 30-50k population where front-line public service staff know each other, can work collaboratively, and can build on the strengths and assets of residents.

- Multi-agency working addressing identified cohorts of the population to reduce, delay, or eliminate risk of escalated harm, poor outcomes, and unnecessary use of costly, reactive public service spend.

- Integrated neighbourhood teams (INTs) to include primary care, community care, adult and children's care, mental health services, and aspects of secondary care delivered in neighbourhoods. **These teams should ideally include social workers and social care providers .**

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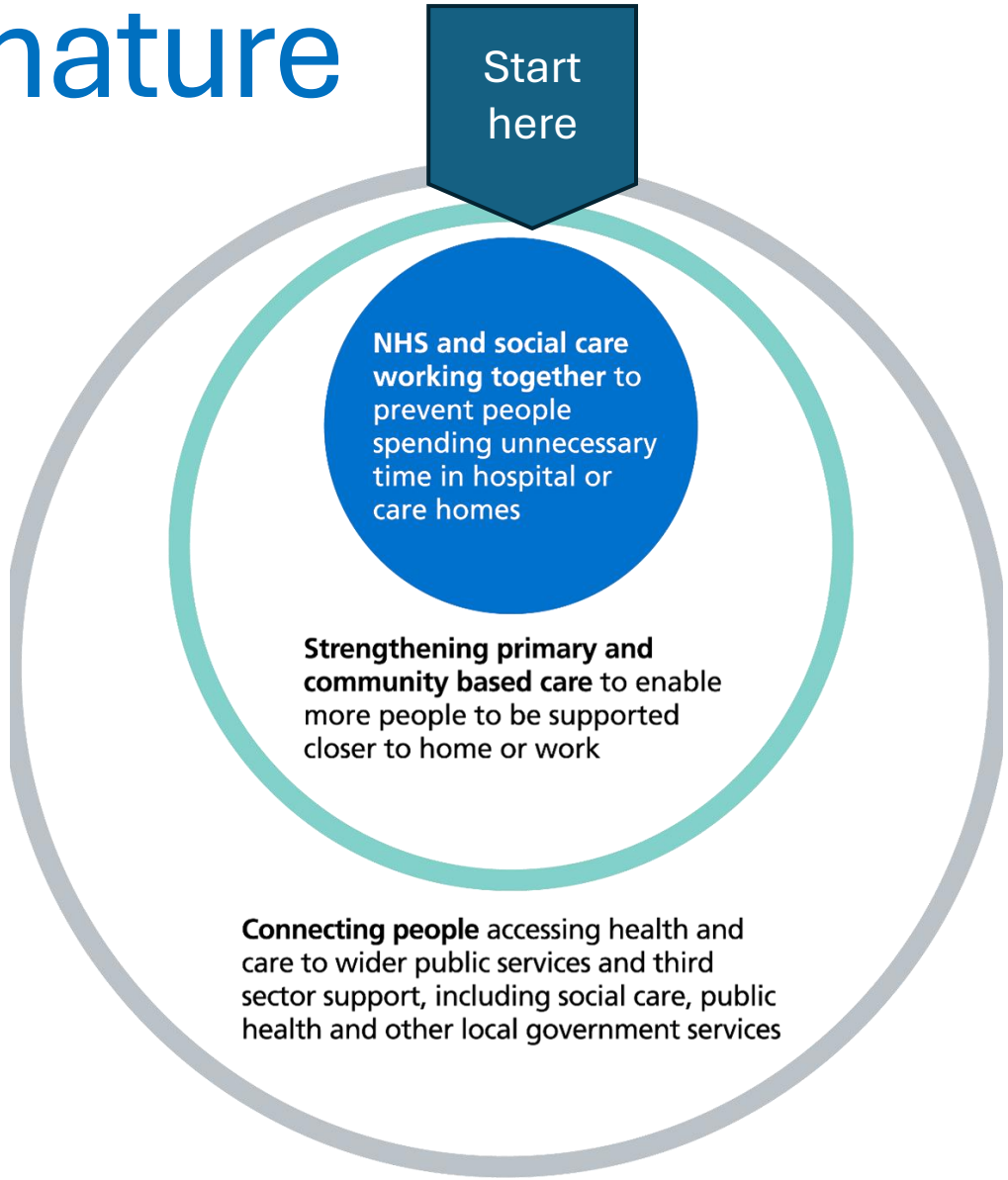
Wider scope – as we mature

- The guidance sets an ambition for systems to move to a broader approach to neighbourhood health:
- focusing on population groups with less complex needs to enable more people to be supported in their homes and community settings
- connect people to wider public services and third-sector support that can improve health and wellbeing.
- Recognition that **health is shaped by social conditions**—not just clinical care.
- Importance of **long-term, preventative collaboration** across NHS, voluntary sector, and public agencies.



The 3 circles of neighbourhood ‘health’
(Kings Fund)

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1. The NHS Version

- Focuses on improving community-based health and social care.
- Aims to provide better coordinated and more responsive services.
- Targets high-resource users or those at risk of frequent service use.
- Emphasises prevention and proactive support to reduce hospitalisation.
- Common intervention: **integrated neighbourhood teams** (30,000–50,000 population), as recommended in the **Fuller stocktake**.
- Teams include a range of health and social care professionals.
- Forms part of NHS England’s neighbourhood health guidance.
- This is where we are starting in 25/26

Neighbourhood Health-Local Government

Cheshire and Merseyside

2. Local Government Version

- Also based on **multi-agency collaboration**, but broader in scope.
- Includes representatives from:
  - Children, families, and young people services
  - Adult social care
  - Housing, employment, welfare services
  - Police, antisocial behaviour teams
  - Voluntary sector and community health professionals

- Focus: support for individuals/families facing poverty, deprivation, and social exclusion.
- Addresses complex, multi-faceted needs—not always health as the main issue.

Neighbourhood Health-Community Led

NHS Cheshire and Merseyside

3. Community-Led Version

- Focuses on **community empowerment and local action**.
- Emphasis on working **with** communities rather than doing **to** them.
- Aims to build community leadership and leverage local assets and relationships.
- Hyper-local focus: often just a few streets, not tens of thousands of residents.
- Professionals act as **facilitators**, not primary drivers.
- The need for **resident, patient, and service user feedback** to be central to outcome measures.
- Emphasis on **community involvement** in leadership structures at Place level.
- Importance of **systematic and meaningful engagement** with the whole population (30–50k).
- A call to **shift power from institutions to communities**.
- Framing communities as **active agents of health**, not passive recipients.

The Model Neighbourhood – Driver Diagram

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Principles

Neighbourhood delivered place-led, Cheshire Mersey enabled

Builds on strengths of people and communities

Acts on the social determinants of health and gets to the root cause of problems

Names, not numbers (residents/patients and colleagues)

Scope

All-age services:

Start with 25/26:

All NHS primary and community services – including community mental health

Aim for:

All public health services

Adult Social Care

Community Services

VCFSE Services

Social Prescribing

Full delivery:

Public Services – Housing; DWP Employment Support; Police, Fire, Probation Services; Schools

Key Features

Start with:

30-50k population

Integrated leadership and accountability in Place and neighbourhood

Aim for:

Services aligned to neighbourhood geographies

Co-located integrated neighbourhood teams

Pooled public service budgets and shared outcomes frameworks

Budgets reprofiled to prevention and proactive care

Enablers

Local Leadership through Place-based partnership boards and identified lead provider organisation

Digital – NHS app as well as local and national innovation

Population Health Management system (CIPHA)

One workforce approach

One Public Sector Estate and better use of NHS Estates

Shared leadership development

Impact

Examples:

Start with 25/26

Reduced utilisation of acute, residential and crisis-based services:

- A&E Attendances

-Non-Elective Hospital Admissions

-Admissions to Residential Care

-Out of Area Placements

From 2026 onwards- Aim for reduction in:

-Pupil Referral Units

-Police Call Outs

-Households in Temporary Accommodation

Improvements in key public service measures:

-School readiness;

-Self-reported well-being

Integrated Neighbourhood Teams – key features

NHS Cheshire and Merseyside

Use data/intelligence such as CIPHA to help with early identification and prevention

Each team will serve a local area with about 30,000 to 50,000 residents.

They will include essential services like GPs, Mental Health, Community Nursing and Therapies, Children's Services (including pre- and post-natal care), Health Visiting, Social Prescribing, Community Pharmacy

They will also have a dedicated lead organisation at Place level e.g. GP practices, community providers, or local council

Staff will follow a "no wrong front door" policy—people can access support digitally, by phone, or in person, and will be directed to the right service.

Wherever possible, services will be based in shared locations (or hubs) with a single reception.

There will be transparency of resources within each INT, coordinated by the Place-based Partnership . Places will work with the provider collaborative as they develop the core community service offer

INTs will connect flexibly to services that work at a borough or regional level.

They will also be able to access specialist services through hospitals and other specialist providers as needed.

Clear use of digital tools to engage patients, connect community assets and drive efficiency for staff

Need for broader integration of all providers: pharmacy, dentistry and optometry and inclusion of secondary care (hospital providers)

Recognition of differences in how people access and interact with different care providers

Impact measures

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NHSE has set out some key metrics to measure the impact of neighbourhood health. As a Cheshire and Merseyside system, we will need to consider how we evolve and translate these national metric into outcome focused neighbourhood dashboards

- Avoiding or slowing health deterioration, preventing complications and the onset of additional conditions, and maximising recovery whenever possible to increase healthy years of life
- Streamlining access to the right care at the right time, including continued focus on access to general practice and more responsive and accessible follow-up care enabled through remote monitoring and digital support for patient-initiated follow-up
- Maximising the use of community services so that better care is provided close to or in people's own homes reducing emergency department attendances and hospital admissions, and where a hospital stay is needed, reducing the amount of time spent away from home and the likelihood of being readmitted to hospital
- Reducing avoidable long-term admissions to residential or nursing care homes
- Reducing health inequalities, supporting equity of access and consistency of service provision
- Improving people's experience of care, including through increased agency to manage and improve their own health and wellbeing
- Improving staff experience
- Connecting communities and making optimal use of wider public services including those provided by the VCFSE sector
- Desire for **community-relevant outcome metrics**, not just clinical indicators.
- Need for **storytelling and qualitative insights** alongside quantitative data.

Logic Model - DRAFT

NHS Cheshire and Merseyside

Input	Activities	Outputs	Short Term Outcomes	Medium Term Outcomes	Long term Outcomes
Data to identify need Population Health Management Tools and identified patient cohorts Coproduction with communities Integrated workforce Integrated digital record Understanding of the evidence base for interventions Focus on social determinants of health Shared public sector estate	Population Health Management approach Identification of priority cohorts Conversations with communities, community leaders and wider system partners Multidisciplinary integrated teams Person-centred care plans Evidence based preventative interventions Social prescribing interventions Evidence based medical interventions	**Primordial prevention** Number of people receiving housing support Number of homes receiving retrofitting for energy efficiency Amount of energy vouchers secured and distributed Number of people accessing employment support Number of families accessing benefits related entitlements **Primary prevention** Number of people accessing smoking cessation services Number of people accessing weight management services Number of people participating in physical activity programmes Number of people receiving routine vaccinations Increase in the number of people being proactively identified for targeted support **Secondary prevention** Number of people being proactively identified for targeted support Number of eligible people participating in the national screening programmes Number of high intensity user care plans Number of drug and alcohol service referrals Number of mental health service referrals **Tertiary Prevention** Number of frailty care plans Number of falls assessments and referrals for patients with a medium and high frailty score Number of medication reviews Number of people accessing disease rehab programmes	**Primordial prevention** Reduced risk of eviction or homelessness Reduced energy bills Sustained employment for 6-12 months Increased benefits related income **Primary Prevention** Reduced smoking prevalence Reduced obesity prevalence Increased physical activity levels Increased vaccination rates Reduced risk of communicable disease **Secondary prevention** Increased screening programme rates Reduce ambulance usage Improving access to GPs appointments Reduced A&E attendances Reduced disease specific emergency hospital admissions Increased uptake of drug and alcohol services Increased uptake of mental health services **Tertiary prevention** Reduced frailty scores Improved medication adherence Reduced disease specific emergency hospital admissions	**Primordial prevention** Improved school attendance Secure housing for 6-12 months Increased household income Increased rates of secure employment **Primary prevention** Reduced prevalence of CVD Reduced prevalence of respiratory disease Reduced prevalence of preventable cancers Reduced prevalence of diabetes Reduced prevalence of vaccine preventable diseases Increase in the percentage of cancers diagnosed at stage 1 and 2 **Secondary prevention** Increase in the percentage of patients who describe their experience of their GP as good Reduced waiting times for diagnostic procedures Reduced readmission rates Reduction in drug and alcohol use Sustained abstinence from drugs and alcohol **Tertiary prevention** Reduced disease complications Increased Quality of Life Scores Increased wellbeing scores Reduced falls related emergency admissions Reduced polypharmacy Reduced social care admissions	**Primordial prevention** Improved educational attainment Reduction in homelessness Reduced fuel poverty rates Improved energy efficiency of C&M Housing Stock Reduction in unemployment rate Reduced poverty rates Increased life expectancy Reduced gap in life expectancy **Primary Prevention** Increased healthy life expectancy Reduced gap in healthy life expectancy Herd Immunity for vaccine preventable diseases Increased 5-year cancer survival rates **Secondary prevention** Reduction in ED waiting times Reduction in ambulance response times Reduction in number of bed days Reduction in mental health bed days **Tertiary prevention** Reduction in medication costs Reduced disease specific mortality

Road map for 2025-26: Place Led, Cheshire Mersey enabled.

NHS Cheshire and Merseyside

Confirm Foundations in Place

- Confirmed neighbourhood footprints at c30 to 50k population covering whole locality
- All local partners align health and care service delivery to neighbourhoods
- INTs in all neighbourhoods
- Clear arrangements in place for working with partners in neighbourhoods – including all local authority services, VCFSE and Housing providers

By End of June 2025

Confirm Approach for NHSE Neighbourhood Components

- Population Health Management
- Modern General Practice
- Standardising Community Health Services
- Neighbourhood Multi-Disciplinary Teams
- Integrated intermediate care with a 'Home First' approach
- Urgent neighbourhood services

NHSE Neighbourhoods Guidance 2025-26

Plus confirmation of neighbourhood implementation of national model for MDTs for Children and Young People –

By End of June 2025

Implement Population Health Management Approach

- PHM established and embedded: understanding of neighbourhoods through data and community connections driving preventative approach
- Processes in place for risk stratification. In 2025/26, the focus should be on adults, children and young people with complex health and social care needs who require support from multiple services and organisations (NHSE 2025/26 guidance)
- Dashboards established covering all aspects of neighbourhood delivery (to be developed with leaders at Place level and building on existing dashboards e

By end of 2025/26

Confirm Road Map to reach Optimal Model

- Optimal model to be co-designed with Cheshire Mersey system, Places and other partners – first workshop 22/5/25
- Places develop roadmap to deliver optimal model (by end Q2 202526)

Road Map in Place by end of Q2 i2025/26

National Neighbourhood Health Implementation Programme

NHS Cheshire and Merseyside

- Launch of a National Implementation programme. An open invitation for places to join the first wave of the Programme. Will be 42 Places chosen across England.
- Aims to support Places that are already making progress but who may be impeded by problems like misaligned incentives and performance management processes that are not aligned with system priorities
- Focus on learning together, sharing solutions, tackling challenges and delivering improvement. Working at scale both within Place and alongside Places across the country simultaneously, accelerating the learning.
- The first phase will begin in 2025 and will see Places and ICBs receive access to a range of support including a national coach, networks to support peer learning and evidence, best practice and tools and materials which support development. The Programme will inform future strategy and policy, including identifying barriers and enablers.
- An experienced national coach will be allocated to assist places on the programme
- Places (through the ICB) to identify a full-time place-based coach for 12 months of the programme, who will be coached in large scale change, and be the Place coach to work alongside the national coach. Places must also have clinical and managerial leads for all their neighbourhood teams.

Next Steps

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- Sign off the framework as presented today
- Deliver the initial focus as per 25/26 guidance
- Build the programme governance and resource that can support and enable the nine places to progress
- Support Places as required with their applications for the National Neighbourhood Health Implementation Programme (closing date is 8th of August 2025)
- Further develop the public health logic model/driver diagram to be clear on outcomes and success measures

Meeting of the Board of NHS Cheshire and Merseyside, 24 July 2025

Seasonal Vaccinations: Improving vaccination uptake in Health Care Workers

Julie Kelly
Associate Director of Population Health
NHS Cheshire and Merseyside

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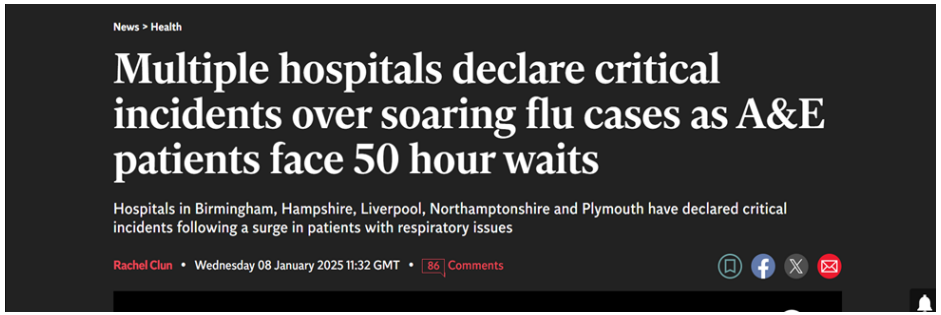
Seasonal vaccinations can save lives and keep communities healthier. They:

- Protect individuals from illness and significantly reduce their likelihood of infection
- Reduce the severity of illness if they do become infected
- Help to protect vulnerable populations
- Can help to reduce pressures on the health service
- Keep the workforce well and able to continue to be productive and care for others

- At the March 2025 ICB Board, the Chair asked for an update on seasonal vaccinations within the context of broader winter pressures with a focus on Health Care Worker vaccinations to come to a future Board.
- Extensive insight work has been undertaken since then with over 1500 Health Care Workers and Domiciliary staff from across Primary Care, Secondary Care and Specialist Trusts to better understand the reasons behind their vaccination choices in 2024/ 2025.
- The key findings and recommendations were presented at the ICB June Quality and Performance Committee and committee members offered further insights and suggestions.

Vaccination of Health Care Workers

NHS Cheshire and Merseyside



News > Health

Multiple hospitals declare critical incidents over soaring flu cases as A&E patients face 50 hour waits

Hospitals in Birmingham, Hampshire, Liverpool, Northamptonshire and Plymouth have declared critical incidents following a surge in patients with respiratory issues

Rachel Clun • Wednesday 08 January 2025 11:32 GMT • 86 Comments

Lynette Horsburgh
BBC News

7 January 2025 · 2604 Comments

Patients at Royal Liverpool University Hospital's accident and emergency unit have been facing waits of up to 50 hours.

Liverpool University Hospitals NHS Foundation Trust has declared a "critical incident" due to "exceptionally high demand" on services and urged people to only go to A&E in a genuine medical emergency.

The hospital said it was "extremely busy" amid a rising number of patients with flu and other respiratory conditions, prompting Liverpool Riverside Labour MP Kim Johnson to call on the government to immediately come up with a plan to increase NHS funding.

Last winter saw high levels of Flu, Covid, RSV and other respiratory conditions circulating with a number of local Trusts citing sighting significant additional pressures as a result of this

Frontline Health Care Worker vaccination rates have been declining for the last 6 seasons in the North West

	Cheshire & Merseyside	Greater Manchester	Lancashire & South Cumbria	North West	England Total
	% vaccinated	% vaccinated	% vaccinated	% vaccinated	% vaccinated
2019 to 2020 Seasonal Influenza vaccination	82.5	75	85.3	78.1	74.3
2020 to 2021 Seasonal Influenza vaccination	84.5	77.7	81.8	79.9	76.8
2021 to 2022 Seasonal Influenza vaccination	74.7	61.1	58.1	64.6	60.5
2022 to 2023 Seasonal Influenza vaccination	56.4	39.1	47.8	46.9	49.9
2023 to 2024 Seasonal Influenza vaccination	47.7	34.6	40.7	41.2	42.8
2024 to 2025 Seasonal Influenza vaccination (data to 31 January)	41.4 *FDP data	27.5	37.1	33.8	37.9

Flu Vaccination of Health Care Workers 2024/2025

NHS Cheshire and Merseyside

The number of individuals who are frontline healthcare workers who have had a vaccination for flu in England during the Autumn 2024/25 campaign by NHS Trust; 1 September 2024 to 31 March 2025; DPS (Data Processing Service) Direct Flow, NHS England; 10 July 2025; Published
Final-Autumn-Winter-2024-25-Flu-vaccinations-to-FHCWs-31-March-2025.xlsx

NHS Cheshire & Merseyside ICB		
Trust Name	**FDP Active FLHCW uptake 24/25 campaign**	**25/26 ambition +5%**
Liverpool Women's NHS Foundation Trust	32%	37%
Mersey Care NHS Foundation Trust	33%	38%
Liverpool University Hospitals NHS Foundation Trust	35%	40%
The Clatterbridge Cancer Centre NHS Foundation Trust	35%	40%
Liverpool Heart and Chest NHS Foundation Trust	37%	42%
Alder Hey Children's NHS Foundation Trust	42%	47%
Cheshire and Wirral Partnership NHS Foundation Trust	43%	48%
Mersey and West Lancashire Teaching Hospitals NHS Trust	43%	48%
Countess of Chester Hospital NHS Foundation Trust	45%	50%
Warrington and Halton Hospitals NHS Foundation Trust	45%	50%
Mid Cheshire Hospitals NHS Foundation Trust	46%	51%
Wirral Community Health and Care NHS Foundation Trust	47%	52%
The Walton Centre NHS Foundation Trust	47%	52%
Wirral University Teaching Hospital NHS Foundation Trust	50%	55%
Bridgewater Community Healthcare NHS Trust	53%	58%
East Cheshire NHS Trust	56%	61%
Totals	41.40%	46.40%

Vaccine uptake varies by setting – highest in Acute and Specialist Trusts, lowest in Care Homes and Social Care

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Vaccine Status Last AW	Acute Trust	Care Home	Community and/or Mental Health Trust	Domiciliary Care	General Practice	'Other' Social Care	Specialist Trust	Total Sample
Both	40%	21%	35%	37%*	30%	21%	44%	34%
COVID-19	1%	4%	0%	5%*	0%	3%	4%	2%
Flu	32%	23%	42%	20%*	35%	28%	13%	31%
Neither	28%	52%	24%	38%*	36%	48%	39%	34%
Total n =	**503**	**128**	**267**	**60***	**104**	**186**	**112**	**1362**

- Acute Trusts and Specialist Trusts are more likely to get both vaccines.
- Care homes and Social Care settings are least likely to get either vaccine.
- Care homes and Specialist Trusts are more likely to get the COVID-19 vaccine only.
- Staff working in Community and/or Mental Health Trusts are more likely to get the flu vaccine only

These findings indicate that within some health and care settings, there is more appetite for vaccine uptake than other settings.

Question: Did you get a flu vaccine last autumn or winter 2024/2025?/Did you get a Covid-19 vaccine last autumn or winter 2024/2025?

Key findings

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Practical Barriers
Main issue is lack of time/convenience, not opposition

Staff Suggestions:
- Advance notice of on-site, drop-in, and mobile clinics
- Peer vaccinators

Post-Pandemic Vaccine Attitudes:

COVID-19: Distrust due to coercion, inconsistent guidance, fast development, conspiracy theories. Seen as low risk by some

Flu: More accepted and trusted, seen as routine, with better exposure to campaigns

Information & Communication
- COVID info often unclear or inconsistent
- Staff want evidence-based info on:
- Vaccine safety & side effects
- Personal relevance: "why it matters to me"

Recommendations:
- Aligned, consistent messaging across systems
- Info accessible via NHS app & internal channels

Key Enablers
- Transparency on risks/benefit
- Trusted peer messengers
- Routine, integrated messaging with emphasis on choice
- Small incentives
- Flu & COVID co-administration, with sensitivity to side effects

Common Barriers for not accepting both Covid and Flu:
- Side effects or illness post-vaccine
- Misunderstanding vaccine purpose ie. prevention vs. severity of illness reduction
- Low perceived personal risk
- Vaccine fatigue
- Perceived rollout inequality frontline vs. admin

Reactance & Resistance
- Resistance often due to perceived loss of autonomy, not vaccine itself
- “It’s not the vaccine; it’s how they forced it.”

Reducing Reactance:
- Emphasise choice and personal agency
- Acknowledge concerns without judgement
- Use trusted messengers and value-driven messaging

Motivators for Uptake
- Protecting loved ones: emotional resonance
- Rising infection rates and visible impact
- Access to accurate info from trusted sources
- Workplace support and peer influence

Employer Motivation & Trust
Staff support motivations like:
- Reducing absence
- Protecting patients/workforce.

Avoid target-driven messaging; instead build trust by:
- Open communication
- Listening to concerns
- Non-judgemental Q&As
- Peer champions building social norms

Changing minds through compassionate conversations

“I’ve had one staff member who was very closely affected by somebody that passed away with COVID. I didn’t think she was going to have a vaccine this year.

I just talked through the benefits of having it, discussing the dangers of not having it and the downsides. She did get it in the end, and it really surprised me that somebody's attitude could change when they were so closely affected.

You don't realise how easy it is to forget, and I think you just need to recall the reasons why they did take it in the first place. So, it was just gentle reminders and talking it through - there wasn't any force about it.

Everybody in my team ended up getting the COVID vaccine.”

Flu & COVID-19 vaccine, Acute Trust, Line Manager, Warrington and Halton Hospitals NHS Foundation Trust

Key recommendations

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Increase Capability

- Provide clear, credible Information
- Address misconceptions and knowledge gaps
- Enable informed, personal conversations

Increase Opportunity

- Convenience and access
- Clearly communicate the vaccine clinics in good time
- Promote vaccine choice
- Use peer influence and relatable stories to make vaccination the ‘norm’

Increase Motivation

- Emphasise autonomy and shared values
- Use real stories and local data
- Listen and co-create
- Offer incentives like a cup of tea and a biscuit

Rebuild Trust

- Acknowledge past mistakes
- Deliver a sensitive and timely message
- Create space for reflection and dialogue
- Strengthen two-way communication between leadership and staff
- Acknowledge broader pressures

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The Board is asked to:

- **ENDORSE** the need for a co-ordinated and systemwide response from the ICB, primary care, secondary care, specialist trusts and Local Authorities to improve seasonal vaccination uptake in all eligible groups, including health care workers and domiciliary staff.
- **ENDORSE** that NHS Providers develop staff vaccination plans which act on the recommendations of the ICB commissioned Health Care Worker insight work.
- **APPROVE** regular flu vaccination uptake reporting to ICB Board meetings throughout winter 2025/ 26 in line with requirements in NHS England » Urgent and emergency care plan 2025/26 to ensure a continued focus.

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Thank you for listening

Any questions?

Cheshire and Merseyside GP Access Report

Louise Barry
Healthwatch Cheshire

NHS Cheshire and Merseyside ICB Board Meeting
24th July 2025

healthwatch Cheshire East
healthwatch Cheshire West
healthwatch Halton
healthwatch Knowsley
healthwatch Liverpool
healthwatch Sefton
healthwatch St Helens
healthwatch Warrington
healthwatch Wirral

Project overview

The **9 Healthwatch** organisations from across Cheshire and Merseyside were asked to engage with the public to:

- understand people's experiences of GP primary care services
- and to see if actions that were put in place as a result of Primary Care Access Recovery Plan were having a positive impact.

Engagement and survey 25th October 2024, until 20th March 2025 receiving **views from 6,944 people** across Cheshire and Merseyside. Circulated in **9 Places** – mixed methodology – electronic, presentation to small groups, general engagement in communities etc.
Significant variation in response rates across the 9 Places, however overall themes were consistent.

Overarching report gives high level findings with an additional **9 individual Place Reports**. There is an opportunity to drill down to individual practice level to understand the variation in feedback, but this would be an activity for each Place.

Key themes and trends include:

Access and Booking

- First point of contact remains a challenge – scramble to get through at 8am with no guarantee of an appointment
- The 'competition' for same-day appointments often led to multiple call attempts and long waiting times, causing some patients to seek alternative care options ~ (inc. A&E) or postpone seeking treatment

Challenges with Digital Services

- Digital services provided convenience for many, but they also created barriers for others –a 'digital gap'
- Some elderly patients and people without reliable internet access reported feeling excluded by the growing trend toward online booking systems such as PATCHS

Key themes and trends include:

Inconsistent Staff Experiences

- Patient experiences of practice staff were mixed - still a need to raise awareness of the roles of other health professionals outside of the GP
- While many praised the professionalism and empathy of the practice staff, some reported frustrations with the reception staff, especially regarding triage decisions and appointment allocation

Other Ways to Access Care

- The use of alternative services, such as pharmacies and NHS 111, produced mixed results
- Some people took care of their health issues using alternative options, but others had to go back to their GPs

Next steps – local Healthwatch will:

- Continue to listen to the experiences of local people in accessing GP services and encourage residents to share their feedback.
- Share the individual Place reports with respective Place Leads, Primary Care Networks, Local Authority and VCSFE system partners to support discussions and improvements in access to GP services.
- Monitor the impact of the actions and activity that is generated as a result of these findings through our independent engagement and feedback gathering activities.
- Provide regular updates to the ICB System Primary Care Committee to ensure that independent patient insight and intelligence continues to inform and shape future services.
- Follow closely the move to closer Neighbourhood working and implementation of the NHS Ten Year Plan aspirations for public/patient voice.

Full report with links to access individual Place reports available here.
The views of Cheshire and Merseyside Residents on the GP Access Survey

NHS
Cheshire and Merseyside

Patient Experience – Access to General Practice

National GP Patient Survey 2025

Key Areas comparison

Survey sample – 38,222 responses (ICS 27 %/National 25.8 %)

NHS
Cheshire and Merseyside

Question	2024	2025	National	LSC	GM
Patients knowing next steps / contact	82	83	83	83	83
Good Experience of contact	68	70	70	73	72
Had Confidence and Trust	93	93	93	93	92
Felt Involvement in decisions	92	92	91	92	91
Felt Needs were met	91	91	90	91	90
Good Overall Experience	76	78	75	78	77

Focus Areas (2 year comparison results in brackets)

NHS
Cheshire and Merseyside

- Previous concern areas – process of making an appointment in particular by phone / convenience of and face to face.
- Access by telephone (68/64) remains most popular way of accessing - experience Easy (48/52) Difficult (40/36)
- Mixture of functionality use of telephone systems in evidence, including call back/queue waiting
- Other forms of access wider usage - NHS App – Easy (45/50) Difficult (41/36) Use of on- line booking – risen across all reasons - making an appointment / repeat prescriptions etc
- Contact outcomes – Services offered - appointment (72/72) and a prescription (20/20) most common
- Couldn't contact – outcome - try again (56/51) no action (17/19)
- Time till appt – varied timescales but overall – about right (70/71) too long (30/29)
- How appt took place – remote (29/26) face to face (71/74) - appt with a GP (65/63)

Action Areas

NHS
Cheshire and Merseyside

Addressing variation

Good overall experience range (100 to 19)

Very difficult - phone access (55 to 0)

Very difficult - NHS App - (60 to 0)

Appointments within 2 weeks (ICB ambition was 90 per cent appts within 2 weeks)

The June plan covers actions to support this (addressing variation framework etc)

Sharing success/best practice

Improvements across some key question areas in line with national trends - learning/ sharing across place and other ICBs. Utilisation of national practice level support scheme

Actions underway and outlined in the June Plan

Modern General Practice – actions to further support/understanding

Recognising challenges from the Healthwatch local survey in areas such as care navigation/additional roles - Further support for digital / on- line tools - and telephone as still most popular access point NHS App usage varies

Demand/ future models

Using this and continued feedback to inform our ‘Access’, 10 YP response/strategy and June plan actions - and as part of Neighbourhood Health‘ model/outcomes’.

Use of demand ‘data’ such as telephony