Public Notice: Meetings of the Board of NHS Cheshire and Merseyside are business meetings which for transparency are held in public. They are not 'public meetings' for consulting with the public, which means that members of the public who attend the meeting cannot take part in the formal meetings proceedings. The Board meeting is live streamed and recorded.

NHS Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

(held in public)

25 July 2024, 09:00am – 13:45pm,
Bridge Suite, DCBL Stadium Halton, Lowerhouse Lane, Widnes, Cheshire, WA8 7DZ

Public Speaking Time: 09:00 - 09:30am

Further detail at: https://www.cheshireandmerseyside.nhs.uk/get-involved/upcoming-meetings-and-events/nhs-cheshire-and-merseyside-integrated-care-board-july-2024/

Agenda

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
09:30am	**Preliminary Business**				
ICB/07/24/01	Welcome, Apologies and confirmation of quoracy	Verbal	Raj Jain *ICB Chair*	For information	-
ICB/07/24/02	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 on the ICB website)*	Verbal		For assurance	-
ICB/07/24/03	Report of the ICB Chair	Paper		For information	5
ICB/07/24/04	Experience and achievement story	Film		-	
09:40am	**Leadership Reports**				
ICB/07/24/05	Report of the ICB Chief Executive	Paper	Graham Urwin *Chief Executive*	For assurance	33
ICB/07/24/06 **09:55am**	Report of the ICB Director of Nursing and Care	Paper	Chris Douglas *Director of Nursing & Care*	For approval	44
ICB/07/24/07 **10:10am**	NHS Cheshire and Merseyside Finance Report Month 2	Paper	Claire Wilson *Director of Finance*	For assurance	51
ICB/07/24/08 **10:20am**	Highlight report of the Finance, Investment and Resources Committee	Paper	Erica Morriss *Non-Executive Member*	For assurance	72
ICB/07/24/09 **10:25am**	NHS Cheshire and Merseyside Integrated Performance Report	Paper	Anthony Middleton *Director of Performance & Planning*	For assurance	76

Compassionate Inclusive Working Together Accountable

Leading integration through collaboration

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/07/24/10 **10:35am**	Highlight report of the Chair of the ICB Quality and Performance Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	103
ICB/07/24/11 **10:40am**	Report of the ICB Place Directors of Place	Paper	Anthony Leo *Place Director (Halton)* Carl Marsh *Place Director (Warrington)*	For assurance	111
10:55am	**Committee AAA Reports - matters of escalation and assurance**				
ICB/07/24/12	Highlight report of the Chair of the ICB Audit Committee	Paper	Neil Large *Non-Executive Member*	For assurance	141
ICB/07/24/13	Highlight report of the Chair of the ICB Remuneration Committee	Paper	Tony Foy *Non-Executive Member*	For assurance	144
ICB/07/24/14	Highlight report of the Chair of the ICB Children and Young Peoples Committee	Paper	Chris Douglas *Director of Nursing & Care*	For assurance	147
ICB/07/24/15	Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee	Paper	Hilary Garratt *Non-Executive Member*	For assurance	149
ICB/07/24/16	Highlight report from the North West Specialised Commissioning Committee	Paper	Clare Watson *Assistant Chief Executive*	For assurance	152
ICB/07/24/17	Highlight report of the Cheshire and Merseyside Health and Care Partnership	Paper	Raj Jain *Chair*	For assurance	156
11.10am	**COMFORT BREAK**				
11:25am	**ICB Business Items and Strategic Updates**				
ICB/07/24/18	Shaping Care Together – A Case for Change	Paper & Presentation	Rob Cooper *Managing Director, MWL*	For approval	161
ICB/07/24/19 **11:45am**	NHS Cheshire and Merseyside Children and Young People's Mental Health Plan 2024-2026	Paper	Claire James *Mental Health Programme Director*	For approval	257

AGENDA NO & TIME	ITEM	Format	Presenter	Action / Purpose	Page No
ICB/07/24/20 **12:05pm**	NHS Cheshire and Merseyside draft Involvement Plan 2024-2026	Paper	Clare Watson, *Assistant Chief Executive*	For approval	313
ICB/07/24/21 **12:20pm**	Cheshire and Merseyside Key Delivery Plans	Paper	Clare Watson *Assistant Chief Executive*	For approval	352
ICB/07/24/22 **12:30pm**	ICB Board Assurance Framework Quarter One 2024-2025	Paper	Clare Watson *Assistant Chief Executive*	For approval	389
ICB/07/24/23 **12:40pm**	ICB Corporate Risk Register Quarter One 2024-2025	Paper	Clare Watson *Assistant Chief Executive*	For approval	432
ICB/07/24/24 **12:45pm**	Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative - Annual Work Plan	Paper	Ann Marr *Partner Member*	For Endorsement	472
ICB/07/24/25 **13:05pm**	Cheshire and Merseyside Mental Health, Learning Disabilities and Community Services Provider Collaborative Progress to date and 2024-25 Workplan	Paper & Presentation	Joe Rafferty *Partner Member*	For Endorsement	505
ICB/07/24/26 **13:25pm**	Cheshire and Merseyside Consolidated Workforce Update	Paper	Chris Samosa *Chief People Officer*	For assurance	516
13:35pm	**Meeting Governance**				
ICB/05/24/27	Minutes of the previous meeting: • 28 March 2024 • 20 June 2024	Paper	Raj Jain *ICB Chair*	For approval	554
ICB/05/24/28	Board Action Log	Paper	Raj Jain *ICB Chair*	To consider	574
13:40pm	**Any Other Business**				
ICB/05/24/29	Closing remarks and review of the meeting	Verbal	Chair / All	For information	-
13:45pm	**CLOSE OF MEETING**				

Consent items

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

AGENDA NO	ITEM	Reason for presenting	Page No
ICB/07/24/30	Board Decision Log - **CLICK HERE TO VIEW**	For information	577
ICB/07/24/31	Confirmed Minutes of ICB Committees: • *Audit Committee – May 2024* • *Children and Young Peoples Committee – April 2024* • *Finance, Investment and Our Resources Committee – May 2024* • *Health and Care Partnership – March 2024* • *Quality and Performance Committee – May 2024* • *Quality and Performance Committee – June 2024* • *Women's Hospital Services in Liverpool Committee – March 2024*	For assurance	

Date and start time of future meetings

26 September 2024, 09:00am, The Wrights Lounge, The Mornflake Stadium, Gresty Road, Crewe, Cheshire, CW2 6EB
28 November 2024, 09:00am, Churchill Building, Queen's Park, Queen's Park Road, Chester, CH4 7AD
30 January 2025, 09:00am, Ballroom, Bootle Town Hall, Oriel Road, Bootle, L20 7AE

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

Following its meeting held in Public, the Board will hold a meeting in Private from 14:15pm

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Report of the Chair of NHS Cheshire and Merseyside

Agenda Item No: ICB/07/24/03

Responsible Director: Raj Jain, Chair

Report of the Chair of NHS Cheshire and Merseyside (July 2024)

1. Introduction

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **note** the updates within the report.

3. Key updates of note

3.1 **Re-appointment of Erica Morriss**
I am pleased to confirm that Erica Morriss has agreed to continue for a second term as a Non-Executive Member of the Board.

3.2 **Appointment to Partner Member positions on the Board**
Board members approved in November 2023 the establishment and inclusion of an additional Partner Member (VCFSE) position for the ICB Board. The ICB has been working with the regions VCFSE organisations to promote the opportunity and the closing date for applications to be considered as a nominee is the 22 July 2024. I hope to be able to provide you with a further update at the July Board.

3.3 The ICB currently has a Partner Member (Local Authority) vacancy on the Board following the results of the May 2024 local elections where Paul Cummins was unsuccessful in being elected. Engagement has been undertaken with the Merseyside Local Authorities to help determine a nominee to be considered for this Partner Member position. Whilst there has been an understandable pause in progressing this due to the general election being called, we hope to be in a position soon to announce the appointment to this Partner Member position. I hope to be able to provide you with a further update at the July Board.

3.4 Following the recent announcements that both Professor Joe Rafferty CBE and Ann Marr OBE will be retiring from the NHS this year, the ICB will progress the engagement with our NHS Trusts and NHS Foundations Trust to progress the nominations and appointment processes to ensure that these Partner Members positions continue to be filled. I will keep the Board updated as we progress these discussions and the process.

3.5 **Fit and Proper Persons Test – Annual Submission**. I can confirm that in line with the requirements of the Fit and Proper Persons Test (FPPT) regulations, that the ICB submitted our FPPT Annual Report to the Regional Director for NHS England North West, to provide assurance that NHS Cheshire and Merseysides Board is fit and proper to the appointments of Board members, and fit to continue in role for those in existing Board member positions. As Board members are aware the purpose of the revised FPPT Framework, developed in response to recommendations made by Tom Kark KC in his 2019 Review of the FPPT, is to strengthen and reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS. I would like to thank all Board Members for their support towards the completion of this important process.

3.6 **North West BAME Assembly Annual Report 2023/24**. I have been proud to be part of the development of the North West Black, Asian and Minority Ethnic Assembly and the great work it has done and continues to undertake. Board members will remember that we have considered and supported a key piece of work that came from the Assembly, namely the Anti-Racist Framework, and we continue to support and progress this work. I urge Board members to review and reflect on the Annual Report for the Assembly, which I append to this report (Appendix A), and which highlights the successes of the Assembly and the work that is planned for the coming years. I welcome the Boards thoughts on what we can do further as an ICB and as a system to further progress this important area.

Contact details for more information

Raj Jain
ICB Chair

Jennie Williams, Senior Executive Assistant,
Jennie.williams@cheshireandmerseyside.nhs.uk

NORTH WEST BLACK, ASIAN, AND MINORITY ETHNIC ASSEMBLY

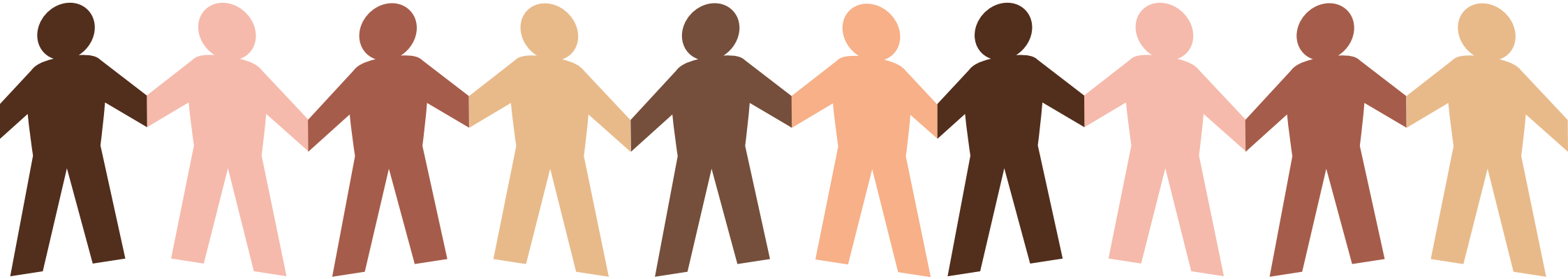
NORTH WEST
Black, Asian and Minority
Ethnic Assembly

Annual Report

2023/24

NHS
England
North West

Contents



Co-Chairs Forewords

In 2020, during the height of COVID-19, 70 Black, Asian and Minority Ethnic senior leaders across the NHS in the North West of England formed a strategic advisory group to address the disproportionality in the effects of the pandemic on minoritised communities. We then expanded our vision to tackle wider racial inequalities within healthcare that contribute to the poor health, care and experiences of ethnic minorities in the NHS.

Evelyn Asante-Mensah OBE
Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Pennine Care NHS Foundation Trust

Three years on, as we are recovering from the pandemic, we very much continue this work to influence the NHS in our region to become unapologetically Anti-Racist. There are persistent issues across the NHS workforce, such as career progression, bullying and harassment, lack of diversity in senior leadership, and discrimination for patients and staff.

We also highlight the racial inequalities in healthcare provision, such as the disparities in maternal and neonatal mortality and mental health provision and experience.

Over the past three years, we have developed an Anti-Racist Framework, to assist NHS organisations in our region to address racial inequalities faced by their workforce, patients and the communities served. This framework outlines the actions that are needed to embed Anti-Racism into the fabric of the organisation by emphasising the need for strong leadership, effective use of data and listening and investing in staff.

The Assembly has also hosted two conferences in Manchester, in 2022 and 2023, focused on race and health, where Chief Executives and Chairs across England were invited to learn, network and commit to reducing racial and health inequalities within their organisations.

As an Assembly, our vision remains the same as at inception – to advocate for minoritised communities, drive change towards racial and health equality and to promote Anti-Racism within healthcare in our region.

Co-Chairs Forewords

I have been proud to support the development of the North West Black, Asian and Minority Ethnic Assembly, which has grown fast in stature during its relatively short lifespan and facilitated some vital discussions about the NHS we want to work in, in the future and how we can respond best to the health needs and outcomes experienced by everyone who lives in our region.

Richard Barker

Co-chair of the North West Black, Asian, and Minority Ethnic Assembly and Regional Director for the North East and Yorkshire & North West regions

The importance of the platform it has provided to Black, Asian and Minority Ethnic leaders from NHS organisations across the region, to share their experiences and ensure they are heard and acted on, cannot be understated and I remain committed to helping it to grow further and ensure its influence is felt far and wide.

Within NHS England's North West regional team, the Assembly's work has helped us drive our own programme for looking at our commitment to becoming Anti-Racist, how we support other organisations to live those values, and really challenge ourselves to consider whether we are doing enough.

While the Assembly has undoubtedly continued to make impressive progress over the last 12 months, to which this report stands testament, it is clear there is still a lot of work to do and we must not be complacent. We must turn our ambitions into actions and draw on senior leadership from across the region, from NHS England, from the North West's Trusts, and from the Integrated Care Boards, to take another big step forward, ensuring we are not resting on our laurels, and we are making real, tangible improvements for our population, patients and staff.

Interim Director's Reflections

Last March, myself, Antemeka Cobham-Wilson, Race Programme Lead, and Harvinder Higgens, Co-ordinator and Project Support, formed the core team of the Assembly to drive the 2023/24 work plan, develop and promote the Anti-Racist Framework and raise the profile of the Assembly.

Sharmila Kar
Joint Director - Equality & Engagement (Manchester Locality/Manchester City Council) Interim Director for the NHS North West Black, Asian and Minority Ethnic Assembly

Over the course of this year, we have successfully refreshed and launched the Anti-Racist Framework and worked with organisations across the North West to support their journeys towards becoming unapologetically Anti-Racist.

We have tabled interesting discussions on learning disabilities and ethnicity, maternal health, gaps in patient data for ethnic minorities and mental illness in underserved communities.

We have hosted a conference, bringing together 100 senior leaders from across England to learn about and discuss race equity and health, and commit to tackling inequalities across their organisations. As we prepare to open submissions for the first tranche of applications for Bronze status recognition for the Anti-Racist Framework, we can clearly see that our work is very far from done.

We have made immense progress over this past year as a core team, with the support of the Co-Chairs, steering group members and wider members, and we look forward to building upon and advancing this work with our colleagues across the system.

Meet the NHS North West Black, Asian and Minority Ethnic Assembly team

Sharmila Kar

Interim Director

"Racism and discrimination are deeply ingrained within the social, political and economic fabric of our society and have a harmful impact on individuals and communities.

"We know that if we want to dismantle structures that are systematically Racist, we need to do some unlearning, and that starts with us. It starts with the people who are holding the power and influence. Race equality matters.

"In a world that is both diverse and deeply interconnected, organisations and institutions with greater levels of diversity and inclusive workplace practices are achieving better performance, engaged staff and higher levels of staff satisfaction and morale.

"I am proud of what we have achieved as a team working on behalf of the Assembly. We know we have more work to do, but I am hopeful about the future as we have an opportunity to work collaboratively on addressing racial inequality and making sure that inclusion is woven through the fabric of our organisations and systems."

Antemeka Cobham-Wilson

Race Programme Lead

"The last 12 months have been incredibly rewarding due to the fact that we have made immense strides in influencing the healthcare system to become Anti-Racist. The commitment and response from organisations across the region has been heartening, with the majority of Trusts, ICBs and the NHSE NW all on board with the initiative.

"I've had the opportunity to lead a wide-scale Anti-Racism programme and to work with senior leaders and colleagues across the North West region, and wider, to collaborate on advancing Anti-Racism.

"The work is not without is challenges, as we are attempting to disrupt long-standing inequalities that are embedded within our healthcare system and society. However, the connections and commitments made thus far, have highlighted how concerted and decisive action can bring about change."

Harvi Higgens

Co-ordinator & Project Support

"I have worked with the Assembly for two years, supporting the meetings, and as the Co-ordinator for the past 12 months. I link with regional and system colleagues across the whole of the North West region to embed the Anti-Racism Framework.

"During this time, I've met a range of people from different backgrounds and with wide-ranging experience. It's inspiring to see how collaboration, at scale, is making waves through the region and nationally, as demonstrated at the Health Inequalities conference last year.

"It's now time to further put the plans and ideas into action by continuing to raise awareness of and implement the Anti-Racism Framework, and ultimately, improve health outcomes for our region."

Tackling Racism – The regional perspective

The North West Anti-Racism Programme was designed to drive forward meaningful change, and build on existing positive practice across the North West, to move NHS organisations (including NHS England North West) in our region to be Anti-Racist. Following the outcome of the employment tribunal Cox v NHSE, which found that Michelle Cox, a North West nurse, experienced Racism and discrimination at work, Richard Barker and Evelyn Asante Mensah asked me to chair the North West Anti-Racism Steering Group.

Jackie Hanson

Joint Regional Chief Nurse & Chair, NW Anti-Racism Steering Group

"We are in the process of reviewing our staff network groups, which are focused on various dimensions of diversity, including race and ethnicity. These groups serve as forums for employees to connect, share experiences and collaborate on initiatives aimed at promoting inclusion and belonging. As part of this work, we are aiming to bring forward the introduction of the Black, Asian and Minority Ethnic Leadership Council, so actions going forward are co-produced, and we increase transparency in terms of progress and further action - transparency drives accountability and builds trust.

"Our approach is to mainstream and embed race equality into our policies, practices and decision-making processes, so that we can foster a culture that celebrates differences and addresses disparities and inequalities. We remain committed to advancing our Anti-Racism work and fostering a culture where all employees feel valued, respected and empowered to contribute their unique perspectives. We understand that this is an ongoing journey, and we will continue to listen, learn and take meaningful action to drive positive change.

"As we look forward, the next phase of work on becoming an Anti-Racist NHS, will be focused on embedding the Anti-Racism Framework and actions throughout organisations. This is a leadership priority for our regional team and ICBs. Despite our efforts, staff and patients are still experiencing Racist and discriminatory practice, which is why it is so incredibly important we continue with the momentum established in 2023.

"It has been a privilege to work alongside my steering group colleagues throughout the year and I look forward to continuing the develop the work further as we progress into 2024/25."

The steering group is made up of knowledgeable and committed colleagues from multiple agencies and NHS organisations across the North West, including the North West Black, Asian, and Minority Ethnic Assembly, ICBs, North West HRDs, CQC, RCN and NHS England North West. Working with these colleagues over the past few months has been a real privilege, and the level of engagement, commitment, challenge and motivation by each and every member of the programme has meant we are making good progress in our efforts.

Members have been working through task and finish groups to identify actions and recommendations in the following areas:

Group 1: Embedding understanding of Anti-Racism to make it easier for everyone to be comfortable when asking questions about race, culture and religion

Group 2: Learning from the recent Cox vs NHS England employment tribunal, so we are certain what is unacceptable behaviour, and implement ways to intervene when we witness Racism in all forms

Group 3: Implementing the Anti-Racism Framework to support the NHS in the North West to take positive action to eliminate Racism

Group 4: Data analysis and impact so we can measure progress

The groups have made some fantastic process, which has meant we have begun implementing some initiatives, which include:

- Fundamental to sustained action in all organisations, is the understanding of what it means to be Anti-Racist, as an individual and an organisation, and therefore the region has commissioned an Anti-Racism Allies Development Programme in 2024 for senior leaders in the ICBs & NHS England North West
- In the regional NHS England team have now signed up and committed to the implementation of the North West Black, Asian, and Minority Ethnic Assembly's Anti-Racism Framework
- The North West Anti-Racism Book Club has provided an environment for participants to increase their knowledge and provide a forum to discuss and explore the content further
- The Royal College of Nursing has supported our work to learn from employment tribunal cases, enabling the group to consider the key events as stepping stones for learning and make recommendations for further action
- The work of Group 4 has been looking at the current available data available at regional level, changing the way we can see and track trends and progress to support the sustainability and embedding of the Anti-Racist work

Thomasina Afful

Associate Director for Equality & Diversity Cheshire & Merseyside Integrated Care Board

"Cheshire and Merseyside (CM) ICB is extremely committed to achieving its vision of becoming Anti-Racist and is making steady progress in this regard.

"In September 2023, we published our ambition to achieve race equality for the CM ICS. To support this ambition, our Chief Executive, Graham Urwin, became the champion/sponsor for the Anti-Racism agenda. The board also approved the implementation of the North West Black, Asian and Minority Ethnic Assembly Anti-Racist Framework, aligning ourselves with the ambitions of other NW ICSs.

"The ICB is keen to continue collaborating with and learning from those organisations and systems, who are taking this journey to implement the North West Black, Asian and Minority Ethnic Assembly's Anti-Racist Framework."

Aisha Chaudhary

Director of Culture & Inclusion, Lancashire & South Cumbria Integrated Care Board

"Becoming an anti-racist organisation is a priority for LSC ICB. We have committed time and energy to adopt the anti-racism framework with our most senior leaders front and centre of ensuring implementation is enacted across our system. We appreciate we have a lot of ground to cover before we can claim to be an anti-racist system, with great work under way with our AHP leadership team, Finance directorate and One LSC I am proud that we are taking the necessary steps to make change happen."

Majid Hussain

Director of Equality and Inclusion, NHS Greater Manchester ICB

"As soon as the Anti Racist Framework was launched it was great to see the CEO and executive team declare their commitment to achieving 'Gold' within the framework, emphasising its importance in achieving the strategic aims of the ICB. The NHS GM ICB Board were the first to attend the anti-racism workshop, the workshop is now being rolled out to other parts of the organisation.

"Work continues on the review of policies and practices related to recruitment, retention and progression to strengthen inclusion and equity within these. We are also reporting on our ethnicity pay gap, as part of our commitment to being open, transparent, and building trusting relationships with our colleagues and communities. We will continue to publish this data to identify trends as we work to increase the ethnic diversity at NHS GM.

"We are making progress on establishing the Black, Asian Minority Ethnic Leadership Council, as part of implementing the Anti-Racist Framework, greater insights and co-production of actions."

Our Vision and Mission – In action

Over the next few pages, Assembly members share their experiences so far, which includes details of some of the proactive steps that are being taken to embed a culture of Anti-Racism throughout their organisations.

Nikhil Khashu

North West Regional Director of Finance, NHS England

"As an original member of the Black, Asian, and Minority Ethnic Assembly, I am so proud of its strengthening and unwavering ambition for its organisations to be 'Anti-Racist' by offering support to people and organisations through training/development opportunities, steering organisations to expected standards and embracing the NHSE Black, Asian, and Minority Ethnic community whilst recognising allies, who are on this journey with us - thank you."

Dr Yana Richens OBE PhD MPhil MSc BSc (Hons) RGN RM

Director of Midwifery, Senior Research Leader Programme: I NIHR Nursing and Midwifery, Liverpool Women's NHS Foundation Trust

"The Assembly has provided me with support and advice from colleagues across the North West, while the conference was inspirational and a great opportunity to share ideas and connect."

Aziz Rashid

Non-Executive Director Northern Care Alliance

"Being in the Assembly has really given me confidence right now to challenge what's happening at my Trust and learn from good practice at other organisations."

Dr Manju C.Pallam PhD, MSc, BSc (Hons), Senior Fellow HEA

Deputy Head of International for Faculty of Health & Education, Faculty of Health, Psychology & Social Care | Manchester Metropolitan University, Regional Joint Lead (North – West): Chief Nursing Officer's Black and Minority Ethnic Strategic Advisory Group

"Guiding the journey of the North West Black, Asian, and Minority Ethnic Assembly, I am honoured to be the voice of diversity, equity and inclusion as the CNO BME SAG representative. Our collective efforts are pivotal, navigating the Assembly through a meaningful journey that recognises the richness of our diverse experiences and underscores the importance of fostering an inclusive healthcare environment for all."

Naveed Sharif

Associate Director of Culture and Inclusion, Chair of NW NHSE Staff Race Equality Network (SREN)

"Lancashire and South Cumbria Integrated Care Board (L&SC ICB) are immensely proud of all of our Trusts for committing and signing up to the NW Anti-Racism Framework (ARF). L&SC ICB is leading on a dedicated project associated with supporting our system colleagues to navigate and achieve the Bronze, Silver and Gold stages of becoming an Anti-Racist organisation and achieving the ARF.

"As the lead for this project in L&SC, and my own lived experience as a man of colour working in the NHS, I am immensely proud that our leaders in L&SC are committing to resourcing, tackling and eradicating Racism from our organisations and our communities. The ARF is a fundamental tool for structuring and organising our strategies and operations to tackle the root cause of Racism in society and our organisations. The disease of Racism will be tackled."

At Warrington and Halton Teaching Hospitals NHS Foundation Trust (WHH), we are committed to uniting against discrimination and proactively putting steps in place to implement the North West Black, Asian, and Minority Ethnic Assembly Anti-Racist Framework.

Adam Harrison-Moran (he/him)

Head of Culture and Inclusion Warrington and Halton Teaching Hospitals NHS Foundation Trust

We recognise that at its core, the framework addresses the systemic inequalities faced by Black, Asian and Minority Ethnic communities – through both a patient and workforce lens. WHH has adopted a multi-faceted approach towards implement the framework, beginning with our Multi-Ethnic Staff Network, and other staff network leads (LGBTQ+, Women's, Disability and Armed Forces) – recognising the power of intersectional thinking. By ensuring our staff voice is the guiding driver, we have established an Anti-Racist Organisation Task and Finish Group, which is co-chaired by the chair of our network and reports to our Workforce Equality, Diversity and Inclusion Sub-Committee.

We have taken steps to refresh what zero tolerance means at our Trust, moving beyond words by focusing on the meaning of what zero tolerance is. In 2023, we launched our 'We are kind and inclusive' statement, which recognises the Trust's stance on Anti-Racism, as well as celebrating, recognising and respecting diversity across all of our workforce and wider communities. In addition, we are proud that we have seen steady year-on-year improvements within our workforce diversity profile, with significant improvements in our staff survey results for 2024 when reviewing through the lens of race. Although we still have work to do to address the disparity, we are committed to utilising the framework alongside the NHS EDI Improvement Plan to address the inequality experienced by our NHS workforce.

Additionally, the framework emphasises the importance of community and partnership engagement which is a continuing focus for WHH as we move forward with our aim of achieving the 'gold' level in the coming years. We have aligned our work around the framework and health inequalities with the Equality Delivery System – throughout the domains of provided services, workforce health and wellbeing and inclusive leadership.

Overall, at WHH we are continuing to evaluate further opportunities to embed the learning of the framework into our core business-as-usual processes. Together, with our staff networks and experts by experience (patient groups and community partners), we will aim to address racial injustice across our sites.

In 2022, Liverpool Women's NHS Foundation Trust made an express commitment towards transforming into an Anti-Racist organisation that was aligned with strategic ambitions to improve overall workforce representation and global majority representation in leadership. The Trust has prioritised embedding Anti-Racism into its organisational framework and executive leadership ethos; and places significant value on learning and education as crucial tools in identifying and addressing knowledge gaps.

Lisa Shoko
Anti-Racism Programme Lead
Liverpool Women's NHS Foundation Trust

Every six weeks, the EDI Lead attends the Executive Board to facilitate coaching sessions that explore the intricacies of race. This challenges Executive Leaders to confront biases and recognise the direct and indirect impact of systemic Racism on patients and staff from the global majority. In a psychologically safe space, Executive Leaders are encouraged to examine their positionality through targeted exercises and open dialogue as the EDI Lead guides conversations, employing critical race theory and decolonial approaches to learning.

In addition to focused EDI objectives, Executive Leaders actively participate in sharing their 'Anti-Racism Journey' through different mediums, influencing an environment of vulnerability and constructive challenge. As a reflection of the Executive Leadership's commitment, the Trust has identified this as a key area within its Improvement Plan. Furthermore, the Trust has dedicated resources to the Anti-Racism Hub, signalling a commitment to delivering on the commitment and sustained transformation through innovative and impactful approaches.

The work extends beyond meetings; the EDI Lead provides ongoing support to ensure Anti-Racism principles permeate every aspect of the organisation, shaping a future where equity and inclusion are developing into fundamental guiding principles at Liverpool Women's NHS Foundation Trust.

To read our full Vision and Mission click here

Anti-Racist Framework

In June 2023, we re-launched our Anti-Racist Framework, which is designed to take individuals and organisations through the learning journey - from the fear to the growth zone, enabling them to effectively challenge, address and tackle Racism within the NHS.

The framework is underpinned by:

- The principles of prioritising Anti-Racism
- Understanding lived experience
- Growing inclusive leaders
- Acting to tackle inequalities
- Reviewing and reflecting on progress

It also sets out actions that can be used to embed Anti-Racist practices organisation-wide.

Three levels of achievement

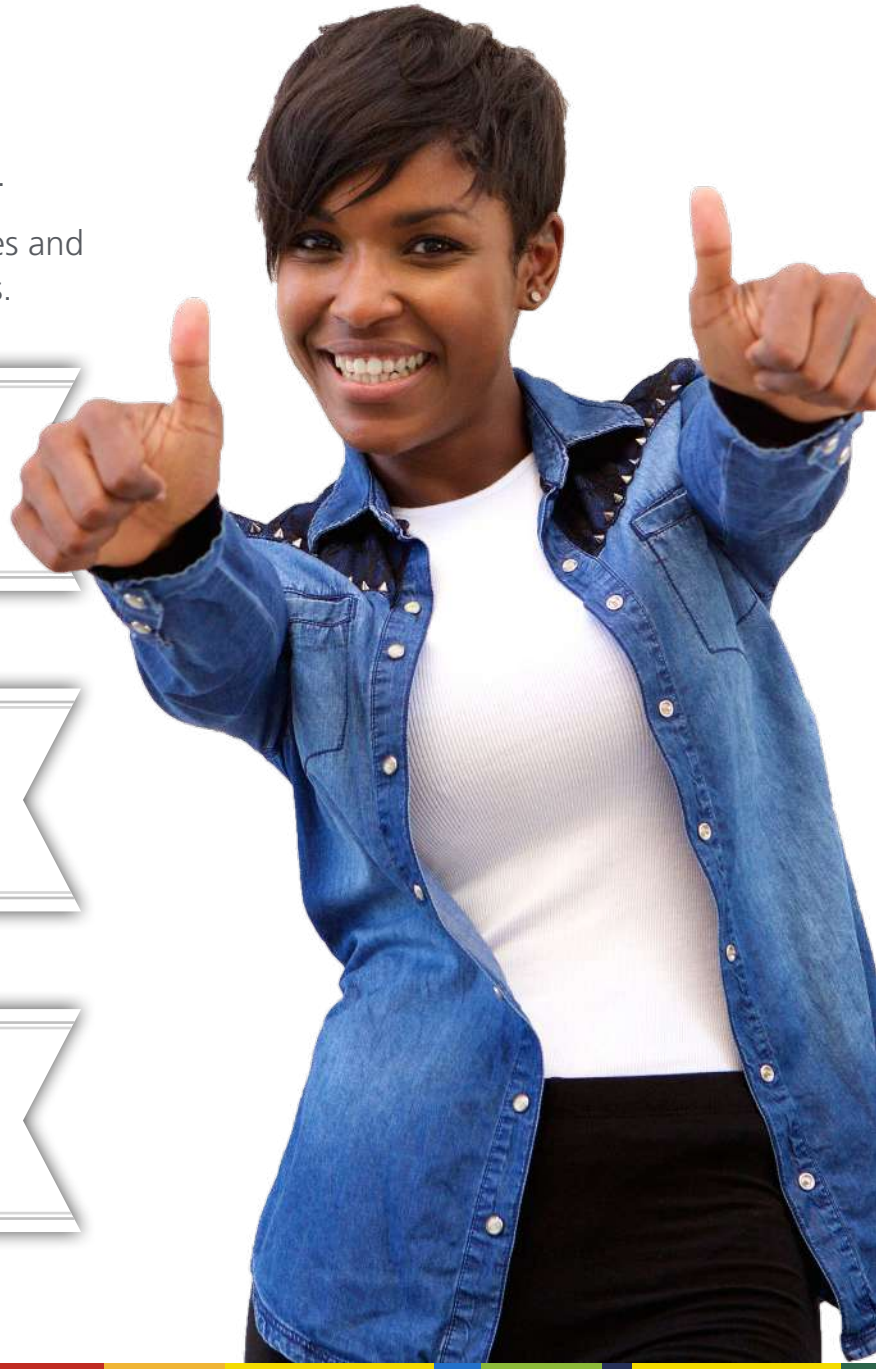
The framework is organised into three levels of achievement: Bronze, Silver and Gold.

Each level builds on the next, encouraging organisations to make incremental changes and take consistent actions towards eliminating racial discrimination in their organisations.

Signifies that an organisation has taken initial steps towards becoming an intentionally Anti-Racist organisation. These deliverables are those that embed structures and accountability for the delivery of racial equity in an organisation.

Shows that organisations have embedded structures to ensure commitment and accountability towards achieving Anti-Racism and have also developed actions to nurture and empower Black, Asian and Minority Ethnic talent, encourage culture change and improve data collection, quality and reporting.

Organisations can demonstrate that Anti-Racism has been embedded at all levels, with diverse representation at the most senior levels and parity in staff experience, as well as ensuring Anti-Racism is seen as being everyone's business through performance and engagement.



The current picture

To date, 30 Trusts in the North West have committed to the framework and are at various stages in their journey to achieving Bronze status. The three ICBs – Greater Manchester, Lancashire and South Cumbria, and Cheshire and Mersey are implementing the framework, as well as the NHS England North West region.

Cheshire & Merseyside ICB

- Alder Hey Children's NHS Foundation Trust
- Bridgewater Community Healthcare NHS Foundation Trust
- Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust
- East Cheshire NHS Trust
- Liverpool University Hospitals NHS Foundation Trust
- Liverpool Women's Hospital NHS Foundation Trust
- Mersey and West Lancashire Teaching Hospitals NHS Trust
- Mersey Care NHS Foundation Trust
- Mid Cheshire Hospitals NHS Foundation Trust
- Warrington and Halton Hospitals NHS Foundation Trust
- Wirral Community Health & Care NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust

Greater Manchester ICB

- Northern Care Alliance NHS Group
- Stockport NHS Foundation Trust
- Tameside & Glossop Integrated Care NHS Foundation Trust
- The Christie NHS Foundation Trust
- Wrightington, Wigan and Leigh NHS Foundation Trust
- Pennine Care NHS Foundation Trust
- Bolton NHS Foundation Trust
- Manchester University Foundation Trust - MUHT

Lancashire and South Cumbria ICB

- Blackpool Teaching Hospital NHS Foundation Trust
- East Lancashire Hospitals NHS Trust
- Lancashire and South Cumbria NHS Foundation Trust
- Lancashire Teaching Hospitals NHS Foundation Trust
- North West Ambulance Service NHS Trust
- University Hospitals of Morecambe Bay NHS Foundation Trust

One of the major successes to date, is that we have meaningfully engaged with all of the organisations within the NHS in the North West to socialise the framework, and we have received positive feedback.

Senior leaders and people, culture, organisation design and equality, diversity and inclusion colleagues across the region have shown genuine interest in the initiative, and have welcomed the structured approach the framework provides to supporting their racial equity and Anti-Racism workstreams.

We will be accepting our first tranche of submissions for Bronze status in late April/ early May. We are excited about all of the good work that is happening across the region and recognising the commitment of these trailblazers in achieving the common goal of creating an anti-racist healthcare system.

Over the next 12 months

The Assembly will be working with organisations to achieve Bronze status, with the ambition to have all organisations at this status by March 2025. The Assembly will support organisations through the implementation process, building on successes and troubleshooting issues as they may arise.

"We anticipate that this work will be long-term and evolve as organisations progress through the stages of recognition from Bronze to Gold."

Antemeka Cobham-Wilson,
Race Programme Lead, North West Black,
Asian and Minority Ethnic Assembly

Award win

The North West Black, Asian and Minority Ethnic Assembly's Anti-Racist Framework was announced as the winner of the Caribbean and African Health Network Anti-Racist Initiative Award 2023. The award was presented in recognition of all of the ongoing work that is being spearheaded by the framework to eliminate Racism NHS-wide.

Race Equity in Health Conference 2023

On December 4, 2023, we held our second conference, which took place at The Hilton Hotel in Manchester.

Sponsored by the NHS North West, Black Asian and Minority Ethnic Assembly in collaboration with the NHS BME Chairs and Chiefs Network, the event saw senior leaders from across the UK come together to discuss Racism and discrimination in healthcare.

Attendees heard from a number of guest speakers, including Evelyn Asante-Mensah OBE, Chair of Pennine Care NHS Foundation and Co-Chair of the NHS North West Black, Asian and Minority Ethnic Assembly. Other presenters included Richard Barker, NHS England's North West Regional Director, and the Rt Hon Patricia Hewitt, Chair of Norfolk and Waveney Integrated Care Partnership.

The leadership role of ICSs in reducing inequalities in race and health, and the delivery of the NHS long-term workforce plan and its role in advancing equality and inclusion in health and care were among the key discussion points.

> "Thank you to everyone who attended the conference and helped provoke and contributed towards challenging and important discussions.
>
> "The event provided a valuable forum for people to learn from each other. It also helped pave the way forward in relation to identifying and implementing future improvements to support both our healthcare colleagues and communities impacted by racial inequality."
>
> **Sharmila Kar, Interim Director for the North West BAME Assembly**

Delegates heard from:

- Evelyn Asante-Mensah OBE, Chair of Pennine Care Trust and Chair of the Northwest Black, Asian & Minority Ethnic Assembly
- Richard Barker, North West and North East and Yorkshire NHS England Regional Director
- Patricia Hewitt, Chair of NHS Norfolk and Waveney Deputy Chair of the Norfolk and Waveney Integrated Care Partnership
- Professor Kevin Fenton OBE, President of the Faculty for Public Health
- Dr Navina Evans, Chief People Officer NHSE
- Dr Owen William OBE, Chief Executive Officer Northern Care Alliance

The following key discussion points were covered:

- Hewitt Review: The leadership role of ICSs in reducing inequalities in race and health
- Racism and its impact on mental health
- The intersectionality of race and rural health inequalities – a clinical perspective
- Leadership actions on advancing race equity in health
- Racism is a public health issue
- Delivery of the NHS long-term workforce plan and its role in advancing equality and inclusion in health and care
- Addressing workforce race and health inequalities (Northern Care Alliance case study)

What some of the delegates had to say after attending the conference

"There is a lot of work to do in this area and there is a lot of best practice to learn from. There is also a hunger to drive out inequality."

"There is a lot of good practice that can be lifted and shifted."

"We need to keep talking about inequalities."

How some of the delegates are championing Anti-Racism within their organisations

"We have Appointed Directors for each protected characteristic in the Equality Act."

"I sit on the Health Inequalities and Inclusion Committee and will use this committee to drive through the inequalities agenda."

"We are referring more colleagues to the Anti-Racism Framework and are speaking up about this issue in senior calls more, however uncomfortable it may be."






Story one

Clinical academic, Dr Oladayo Bifarin, is passionate about promoting evidence-based practice and plays a prominent role in making Mersey Care NHS FT a research-active NHS Trust.

Oladayo led a team of clinicians and researchers for the introduction of Count Me In (CMI) at Mersey Care. CMI is a researcher-led recruitment initiative aimed at making sure everyone in contact with Mersey Care's services hears and knows about research opportunities relevant to their care and treatment.

A supervisor for the England for Equity in Doctoral Education through Partnership and Innovation (EDEPI) programme and a local site co-ordinator for the NIHR-funded EVOLVE study, Oladayo supported the CMI by recruiting people from North West minoritised ethnic communities to amplify their voice to better inform services provided post-pandemic.

He also recently led a consultation with Muslims residents, focusing on minoritised ethnic communities in a socio-economically deprived area of Liverpool. As a result of the consultation findings, plans are being developed for a place-based 'one stop shop' partnership intervention with NHS organisations in Liverpool, Integrated Care Boards, LJMU and local councillors, where statutory organisations will be expected to attend a local centre and offer their expertise to local residents.

Oladayo's work is underpinned by the principles of the Anti-Racist Framework and has been recognised in the form of a national award and a Star Award from Mersey Care.

Story two

Anne-Marie Davies

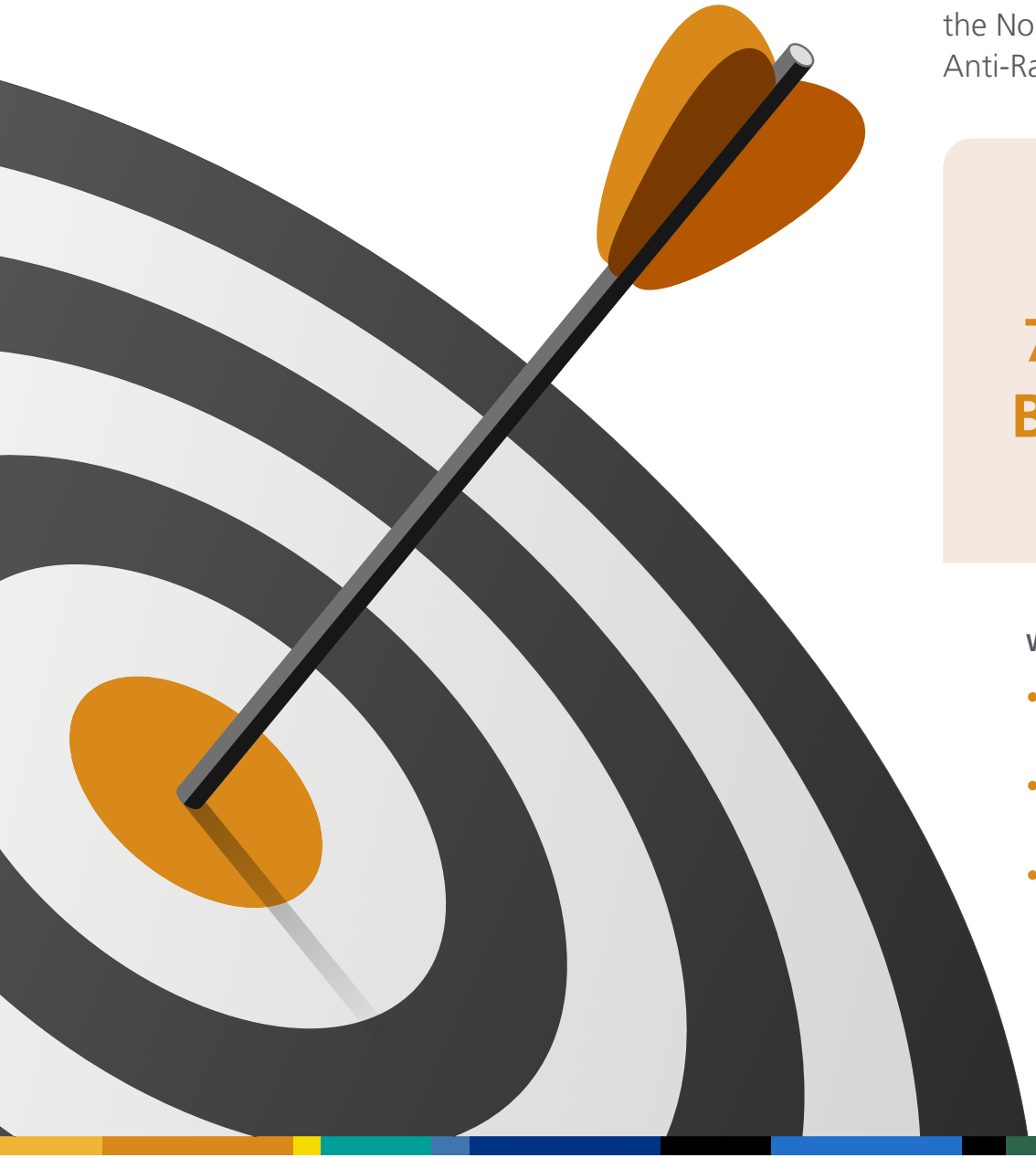
Head of Digital Portfolio
Northern Care Alliance NHS Group & Associate Non-Executive Director, Liverpool Heart and Chest Hospital NHS Foundation Trust

In September, I was appointed an Associate Non-Executive Director (NED) at Liverpool Heart and Chest Hospital NHS Foundation Trust through the NHS England NExT programme. The NExT Director Scheme is a development programme designed to find and support talented people from underrepresented groups into non-executive roles on NHS boards.

Six months into the programme, I have learnt a lot and feel really supported by the Executive team at the Trust. I have access to outstanding mentorship, a development plan and exposure and opportunities to engage in board-level discussions.

Operating at this level and undertaking a full-time role has been challenging, but I was supported by my line manager at Alder Hey Children's Hospital NHS Foundation Trust , who agreed to the national course as part of my PDR. The NEXT programme course has helped my career pathway no end, giving me the confidence to apply for senior roles. I am excited as I start a new permanent role at the Northern Care Alliance as the Head of Digital Portfolio.

I hope that more Trusts will participate in the NHS England NExT programme and offer Associate Non-Executive Director positions to underrepresented groups, thus increasing the diversity of future NHS leaders.



The Assembly's focus for 2024/25 will be to support organisations in the North West region to achieve recognition for their work on the Anti-Racist Framework.

"Our ambition is to have 75% of organisations achieve Bronze status by March 2025".

We will:

- **Further develop relationships with organisations within the wider health and care system -** to drive our agenda and collaborate on Anti-Racism initiatives
- **Host a series of round table discussions across the North West -** that focus on race and health inequalities
- **Continue to scope the horizon for opportunities to influence -** Anti-Racist action and advocate for ethnic minority groups across our workforce and communities

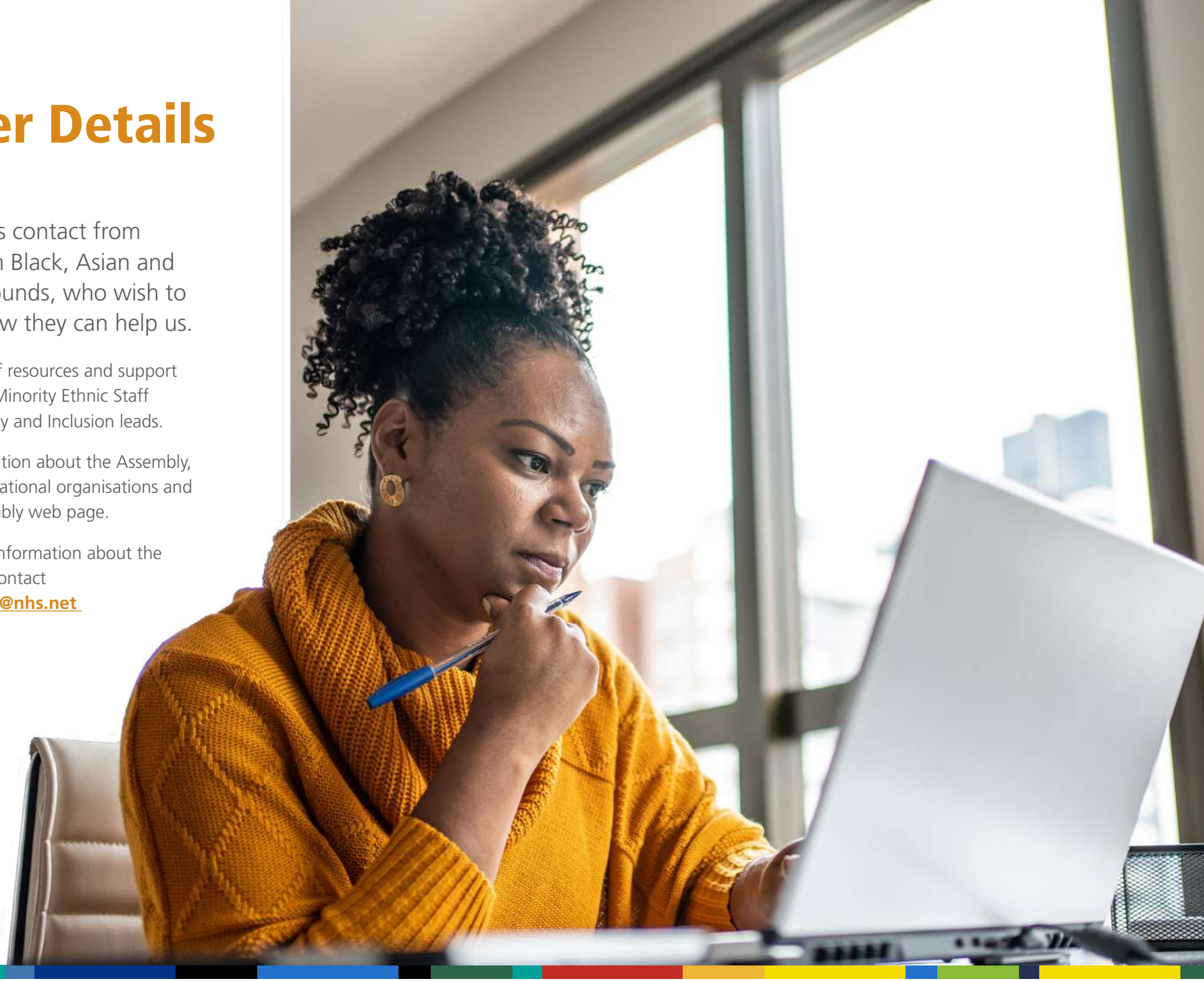
For Further Details

The Assembly welcomes contact from senior NHS leaders from Black, Asian and Minority Ethnic backgrounds, who wish to find out more about how they can help us.

We can also provide a range of resources and support for chairs of Black, Asian and Minority Ethnic Staff Networks and Equality, Diversity and Inclusion leads.

You can find out more information about the Assembly, our work, and links to useful national organisations and resources by visiting the Assembly web page.

In the first instance, for more information about the work of the Assembly please contact **england.nwbame_assembly@nhs.net**



Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Report of the Chief Executive

Agenda Item No: ICB/07/24/05

Responsible Director: Graham Urwin, Chief Executive

Report of the Chief Executive (July 2024)

1. Introduction

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

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

2. Ask of the Board and Recommendations

2.1 **The Board is asked to:**

- **consider** the updates to Board and seek any further clarification or details.

3. General Election 2024

3.1 Following the UK General Election on 04 July 2024, NHS Cheshire and Merseyside's Chair and Chief Executive issued a joint letter to all Cheshire and Merseyside MPs in the week commencing 08 July 2024. We are very much looking forward to working positively and constructively with new and returning MPs to continue our mission to deliver better health and care outcomes for the people of Cheshire and Merseyside. In keeping with usual custom and practice, we are often asked to take part in Ministerial visits to visit areas such as the Cheshire and Merseyside system. Once any of these have taken place, I will appraise the Board accordingly. I will also look to update the Board in September on any significant and relevant changes to health and care policies and potential legislative changes.

4. Regional Updates

4.1 Richard Barker – Regional Director for the North-West, as well as North-East and Yorkshire, retired on 30 June 2024 after many years working in the NHS. Dr Michael Gregory – Regional Medical Director will be acting as interim Regional Director role prior to a permanent arrangement being in place. At the time of publishing this report there has been no announcement regarding a permanent appointment, however if this changes prior to the Board meeting I will update the Board. I look forward to working with Dr Gregory in the interim and welcoming a new substantive Regional Director, once in post

5. 2024 - 2025 Plan Close Down

5.1 NHS England has a statutory duty to conduct a performance assessment of each Integrated Care Board each financial year. This assessment takes into account the ICBs role in providing leadership and good governance within the Cheshire and Merseyside Integrated Care System, as well as how the ICB has contributed to each of the four fundamental purposes of an ICS.

5.2 The assessment is informed by a variety of sources including:

- our annual report and accounts, including audit opinions,
- the outcome of formal quarterly meetings through which NHS England holds us to account,
- key lines of enquiry from NHS England which we have responded to over the course of the year,
- feedback from Cheshire and Merseyside Health and Wellbeing Boards.

5.3 The assessment is delivered in the form of a letter which seeks to provide a balanced picture of system achievements and challenges, and does not come with a specific rating. Our segmentation under the NHS Oversight Framework remains unchanged.

5.4 The letter from NHS England is currently in draft form, and is expected to be issued by the end of July 2024. This letter will be circulated to system partners and will be published on our website.

6. External Support

6.1 Board members will now be aware that NHS England has assessed the system as being at high risk of not delivering against the system financial plan submitted for the year ahead. Therefore, NHS England has mandated external support to undertake an urgent review. The ICB has engaged Price Waterhouse Cooper as the external support.

6.2 This External review will focus on actions that can be taken to immediately reduce the rate of in-year expenditure and to ensure that the financial plan for the year is delivered. This proactive support will cover controls over areas such as workforce, and will also look carefully at system efficiency plans to make sure that they are deliverable, or to agree actions where this is not the case. The support will be expected to show rapid results.

6.3 Any decisions to reduce spending that come from this review will be subject to our routine governance and oversight, to make sure that service delivery, quality and patient safety are not adversely impacted.

7. Executive Team Departure

7.1 The ICB Chief People Officer, Chris Samosa, has tendered her resignation and will be leaving the NHS after 37 years at the end of this calendar year. There will be a number of opportunities between now and then for us to mark Chris's career and to record our thanks for her leadership and commitment.

7.2 The process of recruiting for her successor will be undertaken via a robust and open selection process.

8. Thirlwall Update

8.1 On 02 July 2024 former neonatal nurse Lucy Letby was found guilty of a further attempted murder charge in addition to the convictions received last summer. The thoughts of everyone at NHS Cheshire and Merseyside are with the children at the heart of this case and their families and loved ones. The Thirlwall Inquiry, established to examine events at the Countess of Chester Hospital and their implications, is scheduled to begin its substantive hearings on 10 September 2024.

9. Annual Report and Accounts 2023 - 2024

9.1 I can confirm that following the extra-ordinary meeting of the Board on 20 June 2024 to consider the Annual Report and Accounts 2023- 2024 that the necessary documentation was completed and submitted to NHS England ahead of the national deadline of 28 June 2024. The final version of the Annual Report and Accounts 2023-2024 can be found on the ICB website.[1] At our Annual General Meeting on 26 September 2024 we will formally present our Annual Report and Accounts.

10. Health Inequalities Funding – Health and Care Partnership

10.1 The Cheshire and Merseyside Health and Care Partnership held an extra-ordinary meeting on 13 July 2024 to consider a **report** outlining proposals to direct an additional £3million of ICB investment into tackling health inequalities programmes across Cheshire and Merseyside for the 2024-25 period. I am pleased to say that there was wholehearted support from the Partnerships members towards investment in the following areas:

- **Population Health Programmes at Scale:**
  £1m for the All Together Smokefree Programme
  £422k for the Supporting Healthy Weight programme areas
  £50k for the Health and Housing Collaborative work programme

[1] https://www.cheshireandmerseyside.nhs.uk/latest/publications/reports/annual-reports/

- **Investing in All Together Fairer locally:**
  £1.5m allocated, using a national standardised health inequalities formula, across our nine Places to prioritise on the delivery of primary prevention, and in particular programmes focussed on improving health outcomes in children and young people, targeting the most deprived communities within each Place.

10.2 This is an important investment and a clear statement of our intention to meet our core purposes as an ICB, specifically 'to improve outcomes in population health and healthcare' and 'to tackle inequalities in outcomes, experience and access.' We are committed to investing more in this area in future years, working in partnership with other organisations to channel and prioritise funding toward prevention and tackling inequalities. Whilst the oversight of the delivery of the programmes from this investment and its outcomes will be undertaken by the Partnership, the Board will be kept updated on progress.

11. Prioritising Children and Young People's Oral Health.

11.1 To reduce the long waits for tooth extractions, the Cheshire and Merseyside Children and Young People's Alliance, hosted at Alder Hey, has implemented community dental hub(s) – the first of which saw 150 additional patients over 12 months, contributing to delivering a 10-12 week waiting time for Mersey Care, and supporting a reduction of waiting time down from 78 weeks to 39 weeks. The Alliance team are now working with partners to spread the approach across other parts of Cheshire and Merseyside.

11.2 To prevent poor oral health in the first place, the Beyond Programme is leading implementation of two focused work streams. The NHS England funded Early Years Intervention Pilot (Tiny Teeth Parent Champions - Liverpool) has already been rolled out to 23 nurseries for supervised brushing training, benefiting 643 children and young people. 11 Parent Champions have been recruited and trained to deliver home and community-based support, to over 1291 families directly to date. The plan is agreed with 0-19 services to support distribution of just under 3000 toothbrush and toothpaste packs throughout Liverpool.

11.3 'All Together Smiling' is the system-wide early years Oral Health improvement programme, funded through the ICS, delivered by the Beyond Programme, and driven in partnership with Local Authority oral health and children's education leads to enhance existing delivery. This is a 3-year evidence-based Supervised Toothbrushing programme which will increase access to free toothbrush / toothpaste targeting children most at risk of dental decay and deliver supervised toothbrushing targeting 2–7-year-olds within CORE 20 populations at Place, along with an additional epidemiological survey investment to help monitor and target and a targeted communication campaign. The programme will contribute to the CORE20+5CYP indicator for tackling under 10s tooth extractions reducing demand for dental and urgent services in forthcoming years and contribute to giving every child the best start in life. To date, just over 207,000 tooth brushing packs have been purchased including packs suitable for children

with additional needs, and Local Authorities across C&M will be taking their deliveries for local distribution throughout Summer 2024.

12. Cheshire and Merseyside – One of the Best for Diagnostics

12.1 Cheshire and Merseyside have maintained the waiting list target for 90% of patients to receive a diagnostic test within 6 weeks for March, April and May. We were the first ICB in the country post-covid to achieve this target and are only one of three ICBs currently achieving this target.

12.2 This target encompasses 15 key test areas (covered by the DM01 return) – many link to cancer diagnosis – including CT and MRI scans, colonoscopy and gastroscopy. The diagnostic programme is working with all providers to continue to push for 95% of patients being seen within 6 weeks and also to improve the time that it takes for patients to receive their results.

13. Radiology Imaging Network welcomes Getting It Right First Time (GIRFT) team

13.1 The National Getting It Right the First Time (GIRFT) team are reviewing all 22 Imaging Networks across the UK during 2024. First on their tour was the Cheshire and Merseyside Radiology Imaging Network (CAMRIN).

13.2 The GIRFT Team paid a visit to members from the network on the morning of the 12 June 2024. Attendees included CAMRIN Clinical Leads, Digital, Procurement & Diagnostic representatives, Radiology Service Managers, NHS England representatives, Cheshire and Merseyside Cancer Alliance colleagues, GP Leads, and members of the Royal College of Radiologists.

13.3 Following a request for key benchmarking data, CAMRIN prepared a detailed presentation to answer the GIRFT team's questions and share the outstanding work that the network has achieved. The CAMRIN central team were able to share case studies of the work they have completed to answer all of the questions asked by the GIRFT team including queries around improving outcomes, speed of access, efficiency, and innovation as well as benefits that have been realised so far.

13.4 The review meeting was a resounding success with GIRFT colleagues commenting that much of the work CAMRIN are doing is innovative and collaborative and they have shown themselves to be one of the most advanced networks in the country. CAMRIN have been asked to provide further case studies to share good practice and support the development of other networks, particularly in the areas of mutual aid and collaborative working.

14. Water Fluoridation Consultation

14.1 The Health and Care Act 2022 provides powers for the Secretary of State to introduce, vary and terminate community water fluoridation schemes. The *'Faster, simpler and fairer plan to recover and reform NHS dentistry'*[2] sets out a focus on prevention of tooth decay. This includes the long-term ambition to systematically bring water fluoridation to more of the country, with a particular focus on the most deprived areas, which stand to benefit most. Around 1 in 10 people in England currently have fluoride added to their drinking water supplies.

14.2 The Department of Health and Social care is currently out to consultation (closes end of July 2024) seeking views on expanding community water fluoridation schemes in the North East of England.[3] As part of this consultation there is the opportunity for other areas of the Country to support the proposal and also advocate for the consideration of water fluoridation in other parts of the country.

14.3 We know that Community water fluoridation is an effective, complimentary public health intervention.[4] Fluoride helps to prevent bacteria in the mouth from producing the acid which attacks the enamel on tooth surfaces. It also helps to restore and strengthen the surface enamel on teeth than may be weakened in the early stages of decay.[5] Anyone with natural teeth stands to benefit from water fluoridation. Whilst the recent Health Monitoring Reports for England (2022, 2018, 2014) shows benefits for all groups within fluoridated parts of England compared to non-fluoridated, greater benefits were demonstrated for more deprived communities.

14.4 At June's ICB Children and Young People's Committee, an oral health update was provided on the work being undertaken to prevent poor dental health. This included a proposed consultation response from NHS Cheshire and Merseyside ICB to the National consultation. This response has been composed and supported by the regions Directors of Public Health. The committee approved the response, which expressed our support for any future expansion of this programme to consider the North West, as part of a systematic strategy to improving oral health.

15 System Screening and Immunisation Oversight Group

15.4 One of our ICB Population Health priorities is to ensure the effective uptake and delivery of screening and immunisation services across Cheshire and Merseyside. Building on our recent partnership approach to tackling Measles, the ICB has established a new Screening and Immunisation Oversight Group in

[2] https://www.gov.uk/government/publications/our-plan-to-recover-and-reform-nhs-dentistry
[3] https://www.gov.uk/government/consultations/community-water-fluoridation-expansion-in-the-north-east-of-england
[4] McDonagh, M., Whiting, P., Bradley, M., Cooper, J., Sutton, A., Chestnut, I., Miso, K., Wilson, P., Treasure, E. and Kleiner, J., 2000. *A systematic review of public water fluoridation*. University of York, NHS Centre for Reviews & Dissemination.
[5] Horst, J.A., Tanzler, J.M. and Milgrom, P.M., 2018. Fluorides and other preventive strategies for tooth decay. *Dental Clinics*, *62*(2), pp.207-234.

July 2024. Co-chaired by the ICB and our NHS England regional leads, we brought partners together from across the Integrated Care System, including local authority public health teams, NHS partners and commissioners, United Kingdom Health Security Agency (UKHSA) and the Cheshire and Merseyside Cancer Alliance.

15.5 As part of this emerging work, a new immunisation strategy will be produced with partners, in advance of delegation of immunisation services to the ICB which is now scheduled to occur in April 2026.

15.6 On 01 September 2024, we will see a new national Respiratory Syncytial Virus (RSV) vaccination programme [6] introduced for those aged 75 and over and pregnant women. Last year the Joint Committee on Vaccination and Immunisation (JCVI) advised that a national RSV vaccination programme should be introduced for infants and older adults to help reduce the number of hospitalisations caused by the disease.

15.7 RSV is a common respiratory virus that that can cause serious lung infections. While RSV infection can occur at any age, the risk and severity of RSV and its complications are increased in older adults and in neonates and small babies, and it has a considerable impact on individuals and NHS services during the winter months.

15.8 The two RSV vaccination programmes are:

- Programme for older adults: All adults aged 75 on or after 01 September 204 will be eligible for the vaccine as well as a catch-up campaign for those already aged 75-79. This will be delivered via GP practices
- Programme for pregnant people to protect infants: All those that are at least 28 week pregnant will be eligible for the vaccine. This will be delivered alongside antenatal maternity settings and via GP practices opportunistically or on request.

16 Latest Annual Patient Survey Results

16.1 Patients across the country have shared their experience of GP practices, pharmacies, and dental services. The independent annual patient survey, run on behalf of NHS England, was published on Thursday 11 July 2024. The survey assesses people's experience of healthcare services, including access, making appointments and the quality of care received from healthcare professionals. Insights from the survey will help the NHS to improve local health services for patients and their families.

16.2 Overall, Cheshire and Merseyside benchmarks slightly higher than the national average with 76% of patients reporting a good experience of GP practices compared to 74% nationally. 88% of patients in Cheshire and Merseyside said they had a good experience of pharmacy services compared to 87%

[6] https://www.gov.uk/government/publications/respiratory-syncytial-virus-rsv-vaccination-programmes-letter/introduction-of-new-nhs-vaccination-programmes-against-respiratory-syncytial-virus-rsv

nationally, while 70% had a positive dental experience compared to 69% across the rest of the country.

16.3 It should be noted that GP practices in Cheshire and Merseyside are now delivering quarter of a million more monthly appointments than they did before the COVID-19 pandemic.

16.4 During March 2024, for example, practices delivered more than 1.2m patient appointments – which is nearly 250,000 more than in the same period pre-pandemic.

16.5 Nearly 830,000 of these appointments were face-to-face, with a further 400,000 consultations delivered remotely by telephone, online or video - with many patients now choosing this option where clinically appropriate and more convenient for them do so.

16.6 Data is published at GP practice, Primary Care Network (PCN), Integrated Care System (ICS), and national level – in a variety of formats – including a national report, national results and trends and organisation-level reports. To find out more about the survey and to see the full results, go to: https://gp-patient.co.uk/surveysandreports

17 Capital Funding success

17.4 We have received confirmation that the system has been successful in receiving £12.5m of capital funding from NHS England. This funding has been agreed for East Cheshire NHS Trust (ECT) and the Countess of Chester NHS Foundation Trust (COCH). The funding will be utilised to enable the expansion of capacity within the acute assessment area at ECT, and improvements to the urgent treatment centre estate, development of a mental health area within the emergency department and reconfiguration of the ambulance offloading area and emergency department resuscitation bays at COCH.

17.5 These developments are targeted at improvements across the whole of urgent care pathways and will support the sentinel objectives of the UEC recovery programme

18 NHS Cheshire and Merseyside fuel poverty project highly commended at analytics awards ceremony

18.4 I am delighted to announce that the ICBs entry '*Segmenting and Stratifying Fuel Poor Populations in Cheshire and Merseyside*' has been highly commended in this year's Florence Nightingale Award for Excellence in Health and Care Analytics.

18.5 The award, named after the Society's first female fellow and pioneer of data visualisation, Florence Nightingale, celebrates data analysts in the UK health

and care sector whose work has delivered better health outcomes, and is supported by the Health Foundation.

18.6 This project looked to deliver solutions for the problem of fuel poverty and its impact on the health of those affected to reduce the burden on the health and care system, using linked data to improve insight and deliver the intervention effectively. Two distinct cohorts were identified, and solutions offered included the payment of fuel bills and lifestyle reviews to improve their respiratory health.

18.7 The judges were impressed with the rigorous approach to evaluation of the initiative, the resources offered to support replication of their approach and thorough, creative engagement with stakeholders. Congratulations to the team for this well-deserved recognition.

18.8 You can read more about this year's award here: https://rss.org.uk/news-publication/news-publications/2024/general-news/the-florence-nightingale-award-for-excellence-in-h/

19 Cheshire and Merseyside recognised at the Palliative and End of Life Care Awards 2024

19.1 Cheshire and Merseyside ICS won the Integrated Care Systems Award at the inaugural Palliative and End of Life Care Awards, which took place in London last month. The award recognises Cheshire and Merseyside's whole-system approach to end-of-life care, joined-up population-based thinking across health and social care, innovative digital solutions and committed leadership. Congratulations to the team for this great achievement.

20 Decisions taken at the Executive Committee

20.1 Since the last Chief Executive report to the Board in May 2024, the following items have been considered by the Executive Team for decision:

- **NHS Talking Therapies Investment Requirements** – the Executive Team considered and approved proposals for additional investment which is required to support the recruitment of additional Talking Therapy trainees in 2024/25 to meet national ambitions and secure the release of new Autumn Statement funding.

- **Primary Care (GP) Service Development Funding** – the Executive Team considered and approved recommendations regarding the allocation of primary Care Service Development funding which will support improving access to primary care services /general practice.

21.2 At its meetings throughout June and July 2024, the Executive Committee has also considered papers on the following areas:

- Vacancy control
- Virtual wards
- Recovery Programme

- Primary Care (GP) Service Development Funding
- Joint Forward Plan
- Staff Survey Action Plan
- Annual Assurance meeting with NHS England
- ICB LGBTQI+ Network – Briefing Paper

21.3 At each meeting of the Executive Team, there are standing items on quality, finance, urgent emergency care, non-criteria to reside performance, industrial action, primary care access recovery, and Place development where members are briefed on any current issues and actions to undertake. At each meeting of the Executive Team any conflicts of interest stated are noted and recorded within the minutes.

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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Report of the Director of Nursing and Care

Agenda Item No: ICB/07/24/07

Responsible Director: Chris Douglas, Executive Director of Nursing and Care

Report of the Director of Nursing and Care

1. Purpose of the Report

1.1 The report provides an update on matters pertinent to the portfolio of the Executive Director of Nursing and Care regarding the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside.

2. Executive Summary

2.1 The paper provides progress on the delivery of core work from the Nursing and Care Directorate. This includes oversight of the statutory functions under the Executive Director of Nursing and Care portfolio.

2.2 Progress with regards to the All Age Continuing Care (AACC) review, response to the MIAA Safeguarding Review and response to SEND joint area inspections in Halton and Wirral are all captured. This includes the implementation of consultation around AACC due to complete on 21st August. The progress with regards to the MIAA Safeguarding Review covers both issues identified within the report and action has progressed.

2.3 With regards to Patient Safety there is work to ensure alignment between patient safety response and learning with quality improvement priorities and consideration as to the best approach to implement Patient Safety Response principles within other settings such as Primary Care without creating an unsustainable operational demand.

2.4 Ongoing regulatory activity is noted with recent CQC inspections at Cheshire and Wirral Partnership NHS FT and Inspection of Local Authority Childrens Services completed and planned in Halton, Cheshire West and Chester and Wirral areas.

3. Ask of the Board and Recommendations

3.1 The Integrated Care Board is asked to consider the updates and seek further clarification or details.

4. Reasons for Recommendations

4.1 This is current work that is taking place within Cheshire and Merseyside related to the Executive Director of Nursing and Care portfolio and is for consideration and to seek clarification.

5. All Age Continuing Care

5.1 A review of All Age Continuing Care (AACC) was commenced in January 2023 with findings and recommendations reported over the year. The previous Director of Nursing report to board in May 2024 highlighted several areas of progress including in housing the AACC service from Midlands & Lancashire Commissioning Support Unit and Mersey Care, improvements in governance with revised policies and procedures and improved information management processes.

5.2 Since the previous update the consultation process with regards to the AACC service structure has commenced on 8th July 2024 and will seek to understand potential future service models for efficiency and further productivity alongside staff impact assessments and equality impact assessments. The consultation period is 45 days and will end on 21st August 2024.

5.3 It is expected following the changes to the Target Operating Model, there will be a consistent approach to the delivery of All Age Continuing Care within NHS Cheshire and Merseyside in addition to the achievement of national performance targets.

6. Patient Safety Strategy

6.1 A review of system partner patient safety investigation priorities and quality improvement priorities has been completed, reviewing published Patient Safety Response Plans and Quality Accounts. This work has supported consideration of system wide opportunities for aligning quality improvement ambitions with those areas, providers are observing the greatest impact to patient safety. This work will continue to inform the development of system wide patient safety collaboratives.

6.2 Following successful implementation of the Patient Safety Incident Response Framework across all the NHS Trusts across the system, the team are now focusing on proportionate implementation across Primary Care and the Care Home sector. This will involve pilots with partners in these sectors to understand the appropriate models allowing the principles, and intended benefits of the framework to be realised whilst managing potential burden to smaller providers. Further details of pilots, once confirmed, will be discussed via the Quality and Performance Committee.

6.3 With the implementation of the Learning From Patient Safety Events (LFPSE) system for national collation of patient safety incidents, there have been opportunities to decommission local incident management systems previously procured through Clinical Commissioning Groups. This provides an opportunity for improving cost efficiency and supporting wider oversight of incidents occurring across the system, leading to greater opportunities for quality improvement. This however will involve changes in practice and management of this change is being supported by the directorate.

7. System Quality Oversight

7.1 The Nursing and Care Directorate continues to support the system with response to patient safety events that are high profile or potential significant impact to the system population. Full details of these cases are reported to the Quality and Performance Committee and include: Panorama exposure of Life School - Wirral, BBC coverage of St. Luke's Care Home – Halton and Liverpool Echo's reports regarding two deaths of children from Milstead School – Liverpool.

7.2 Further media attention was received following the sentencing of a former Care Worker at Merseyside and Lancashire Hospitals who was convicted for sexual assault of a patient whilst in work.

8. Safeguarding

8.1 The work to address workforce gaps (primarily Designated Doctors) continues, specifically with a review of potential models. The current model sees the 3 statutory Designated doctor roles for Child death, Safeguarding children and Looked after Children employed by our trusts as paediatricians and under a Service Level Agreement (SLA). There have been challenges with Trust delivery of the SLAs leaving vacancies and impacting on the ICB statutory functions. This is currently reflected on the ICB risk register.

8.2 The most significant risk has been aligned to the vacancy with regard to the Designated Doctor for Child Death in Merseyside, which has not been consistently delivered via current SLA for 6 years. The proposed model will see a post created within the ICB funded on a sessional basis. A job description has been developed and recruitment is on-gong and expected to progress by Quarter 3 2024/25.

8.3 A request has been made for BI support in development of a tool to collate incidents, interim arrangements have included the development of a spreadsheet to capture basic safeguarding incident details and allow thematic analysis.

9. Special Educational Needs & Disabilities (SEND)

9.1 To mitigate the risk against this statutory function several actions have taken place. This has included enacting a Business Continuity model within the current workforce to ensure that the ICB can fulfil its statutory function. Actions have included mutual aid to ensure that Designated Clinical Officer (DCO) resource is fully maximised. The identification of priorities and the cessation of non-Statutory work.

9.2 Halton Place - The Local Are Partnership continues to address the significant concerns that were identified following the SEND Joint Area Inspection in November 2023. An Improvement Board has been established with an Independent Chair. The Boards role is to ensure there is grip and oversight of each of the priority actions. Governance processes have been strengthened including reporting structures and the identification of a Senior Responsible Officer (SRO) to report progress against the plan.

9.3 Wirral Place - Progress continues against the revised plans following the issuing of the Improvement notice on 15th May 2024. Several deep dive sessions have been held to address issues relating to the Neuro Developmental Pathway and the Education Health and Care Plan process. This has led to the identification of solutions to reduce waiting times for key clinical services (Speech and Language and Community Paedatrics) and streamlining referral processes. A listening event took place with parent carers on 10th July to gain views on the current service provision and proposals of the new model.

10. Regulatory Activity

10.1 During this reporting period several Trusts and Local Authorities have been inspected or are due for inspection.

10.2 Cheshire Wirral Partnership Trust; The Trust have been subject to a Well Led inspection under the New Single Assessment Framework. This took place w/c 1st July. This is the first Mental Health Trust in the Northwest and the first Trust in Cheshire and Merseyside to be inspected under this framework for the Well Led Domain. Stakeholders and Partners were invited to provide views in relation to the criteria used. Feedback to CQC will be given regarding the process adopted. The Trust is expecting the draft report 60 days from the visit for factual accuracy, prior to publication.

10.3 Halton have undergone an Inspection of Local Authority Childrens Services (ILACs) in May. OfSTED have given an overall rating of Inadequate across the areas inspected. This rating was aligned with several areas of improvement required around; Governance to support multi-agency response, identification and response to risk, quality of social work across several key areas, timeliness of assessments and access to training and supervision of frontline practitioners.

10.4 In response Halton Borough Council Children, Young People and Families Policy and Performance Board have received a report describing significant changes over the past few months to prepare for the journey of improvement required. This includes detail around recruitment and retention of staff, training and development of the workforce and stabilisation of the management team. This is to be supported by input from the Transformation Delivery Unit to redesign the service to better meet the requirements of children and their families. The plans also specifically address the concerns related to Children in Care and Care Leavers as well as partnership and accountability requirements. There is full recognition that there will be significant improvement required and

NHS Cheshire and Merseyside will continue to work in partnership to support these requirements.

10.5 Cheshire West and Chester Council are subject to an ILACs inspection w/c 15th July. West Cheshire Place Leadership Team are included within the inspection process.

10.6 Notification has been received by Wirral Borough Council from CQC that a site visit will be conducted on 16th September 2024. Wirral Place Leadership Team are actively involved in the preparation of the visit.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience

Progress described with the SEND agenda is directly relevant to reducing health inequalities caused by varying outcomes for children and young people with SEND and aligns to the Marmot principle of giving every child the best start in life.

Objective Two: Improving Population Health and Healthcare

The work described with regards to seeking collaborative quality improvements across the system is designed to ensure measurable and sustainable change for areas affecting patient safety.

Objective Three: Enhancing Productivity and Value for Money

The work to improve efficiency and effectiveness of AACC with have a direct impact on ensuring the right support and care for patients needs with cost effective individualised care provision.

Objective Four: Helping to support broader social and economic development

This objective is a solid foundation of the SEND agenda and developments described in this paper.

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

12.1 The current workplan for the AACC programmes complements the CQC ICS Quality Statements and in particular:

- how we work as partners for the benefit of our population
- population health
- Children & Young People (CYP)
- Learning disability & autism
- personalised care

13. Link to meeting CQC ICS Themes and Quality Statements

Theme One (T1) - Quality and Safety	
QS1	**Supporting to People to live healthier lives.** We support people to manage their health and wellbeing so they can maximise their independence, choice and control. We support them to live healthier lives and where possible, reduce their future needs for care and support
QS2	**Learning culture.** We have a proactive and positive culture of safety based on openness and honesty, in which concerns about safety are listened to, safety events are investigated and reported thoroughly, and lessons are learned to continually identify and embed good practices.
QS3	**Safe and effective staffing.** We make sure there are enough qualified, skilled, and experienced people, who receive effective support, supervision, and development. They work together effectively to provide safe care that meets people's individual needs
QS6	**Safeguarding**. We work with people to understand what being safe means to them as well as with our partners on the best way to achieve this. We concentrate on improving people's lives while protecting their right to live in safety, free from bullying, harassment, abuse, discrimination, avoidable harm and neglect. We make sure we share concerns quickly and appropriately.
Theme Two (T2) - Integration	
QS7	**Safe systems, pathways and transitions**. We work with people and our partners to establish and maintain safe systems of care, in which safety is managed, monitored and assured. We ensure continuity of care, including when people move between different services 24
QS8	**Care provision, integration and continuity**. We understand the diverse health and care needs of people and our local communities, so care is joined-up, flexible and supports choice and continuity
QS9	**How staff, teams and services work together.** We work effectively across teams and services to support people. We make sure they only need to tell their story once by sharing their assessment of needs when they move between different services

14. Risks

14.1 Risks to delivery are outlined within programme risk registers and escalated to the appropriate ICB committee aligned to agreed governance routes.

15. Next Steps and Responsible Person to take forward

15.1 The next steps are to continue with the agreed strategy and priorities for the outlined programmes.

16. Officer contact details for more information

Richard Crockford, Associate Director of Nursing and Care (Patient Safety)
Lorna Quigley, Associate Director of Quality and Safety Improvement

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Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Cheshire and Merseyside System Finance Report Month 2 (2024/25)

Agenda Item No: ICB/07/24/07

Responsible Director: Claire Wilson, Executive Director of Finance

Cheshire and Merseyside System Finance Report Month 2 (2024/25)

1. Executive Summary

1.1 Regular financial performance reports are provided to the Finance, Investment and Resources Committee of the ICB who undertake detailed review and challenge on behalf of the Board.

1.2 As of 31 May 2024 (Month 2), the ICS system is reporting a YTD deficit of £68.8m against a planned YTD deficit of £64.5m resulting in an adverse YTD variance of £4.3m. The system has an agreed financial plan of £150m deficit for the year,

1.3 The system has therefore incurred 46% of its £150m deficit plan in the first 2 months of the year. This reflects the challenging profile of the plan where cost improvement plans (CIPs) have been assumed to deliver towards the end of the year. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP plans will be critical over the next few weeks.

1.1 The paper sets out the key financial metrics for the period for financial performance, cash, capital, and productivity. The paper also describes the risks to delivery and the work being done to mitigate and manage these risks during the year.

2. Background

2.1 The draft financial plan was submitted to NHSE England on 21st March 2024 which was reviewed and ratified by the Board in its meeting on 28th March. This reflected a system deficit of £280m (£3m surplus for the ICB, £344m deficit for providers and a £60m system stretch target). This position was not affordable and therefore rejected by NHS England.

2.2 Since then, system financial plans have been further developed across our 16 providers and ICB to reach a plan position of £150m deficit, which was the Revenue Financial Plan Limit set by NHSE in May 2024. These developments have been discussed at both Finance Resources and investment Committee (FIRC) and ICB Board meetings during April, May, and June. The final plan was submitted in June 2024 in line with those discussions.

2.3 It is expected that the system will receive a non-recurrent £150m cash backed allocation to support the deficit plan and will be required to re-forecast in year to a breakeven position.

3. Month 2 Financial Performance

3.1 NHSE did not require a detailed submission of ICB and provider financial positions at month 2, therefore, this report reflects a high-level summary of the financial performance against plan for providers and a more detailed analysis of the ICBs own position.

3.2 NHSE guidance issued as part of the final plan submission in June, required the month 2 YTD plan to match that of the month 2 YTD actual, with the remaining plan profiled as required.

3.3 This means that the YTD variance for providers at month 2 is likely to be minimal as the plan was deliberately reprofiled to match actual expenditure at that date. For this reason, risk to financial plan delivery at this point in the year is better understood through considering the required change to run rate for the remainder of the year and the maturity of CIP plans. This analysis is provided later in this report.

3.4 As of 31 May 2024 (Month 2), the ICS system is reporting a YTD deficit of £68.8m against a planned YTD deficit of £64.5m resulting in an adverse YTD variance of £4.3m.

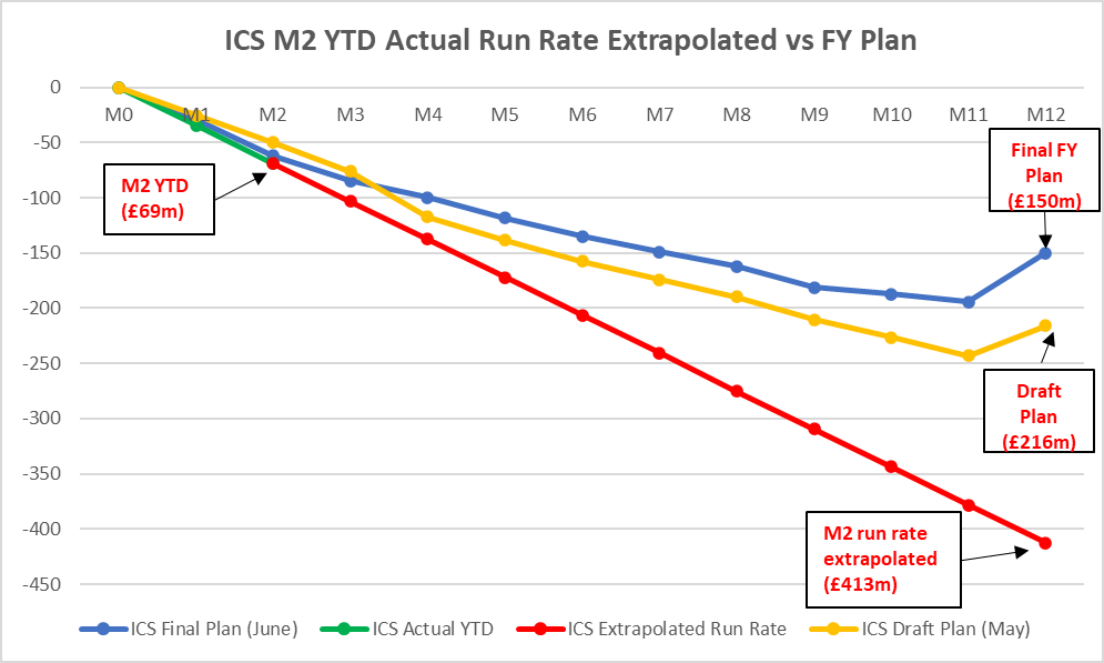
Table 1 – Financial Performance Month 2 YTD and FOT

	M2 YTD			24/25 New Plan		
	Plan	Actual	Variance	Plan	FOT	Variance
	£m	£m	£m	£m	£m	£m
ICB	6.8	1.7	(5.1)	62.3	62.3	0.0
Total Providers	(71.3)	(70.5)	0.8	(212.3)	(212.3)	0.0
Total System	**(64.5)**	**(68.8)**	**(4.3)**	**(150.0)**	**(150.0)**	**0.0**

3.5 **Chart 1** below shows the profile of the ICS I&E plan submitted to NHSE on 12th June against the actual M2 YTD run rate. It also shows the step change in the planned position between the May and June plan submissions.

3.6 It should be noted that at £69m YTD deficit, the system has incurred 46% of its £150m deficit plan in the first 2 months of the year. This reflects the challenging profile of the plan where CIPs have been assumed to deliver towards the end of the year. The current run rate will need to improve significantly in order for the system plan to be achieved and so focus and acceleration of CIP plans will be critical over the next few weeks.

Chart 1 – ICS Financial Performance – YTD Run Rate vs Plan Profile



3.7 The ICB has collected analysis from each of the 17 organisations across the system to better understand the key elements of run rate improvement which are required. This will be subject to review each month.

3.8 As part of the Month 2 local data collection a range of financial and operational metrics were collected covering financial performance and recent run rate trends across provider pay expenditure, workforce, efficiency, productivity, and cash. A summary of the key M2 metrics, and the position against the M1 metrics by comparison, is set out in **Table 2** below.

Table 2 – M2 System level financial and operational indicators

Area	Aggregate System level indicators	Month 1 YTD			Month 2 YTD		
		£m	WTE	%	£m	WTE	%
System I&E	ICB - I&E Surplus / (Deficit) - YTD	3.4			1.7		
	Provider - I&E Surplus / (Deficit) - YTD	(34.3)		-6.6%	(70.5)		-6.7%
	ICS - I&E Surplus / (Deficit) - YTD	(30.9)			(68.8)		
Provider Pay Expenditure	Average Pay Increase / (Decrease) vs 23/24 Run Rate	4.9		1.4%	6.5		1.8%
	Pay Variance to plan - favourable / (adverse)	(5.0)		-1.4%	(13.5)		-1.9%
	Agency Variance to plan - favourable / (adverse)	N/A		N/A	(1.4)		-7.8%
WTE Workforce	M12 23/24 actual WTEs to Average 24/25 Actuals - *decrease / (increase)*		859	1.1%		1,104	1.4%
	In month 24/25 Actual vs 24/25 Plan - *favourable / (adverse)*		(851)	-1.1%		(891)	-1.1%
CIP Efficiency	TOTAL CIP Variance from YTD plan (provider & ICB)	(4.4)		-15.3%	(10.6)		-23.5%
	YTD Recurrent CIP delivery			64.6%			46.0%
	% of CIP schemes deemed High Risk - full year			51.0%			54.0%
Productivity - Acute Providers	*Implied Productivity Growth M10 23/24 vs 19/20			-18.6%			-18.6%
	*Implied Productivity Growth M10 23/24 vs 22/23			0.8%			0.8%
	**acute providers only*						
Cash	Provider Aggregate Cash Balance - March 2024	521			N/A		
	Provider Aggregate Cash Balance - April 2024	460			N/A		
	Reduction in cash in one month	(61)		-11.7%	N/A		N/A

3.9 Unachieved efficiencies are the main reason for the variance within the provider position at this point of the year. Whilst good progress has been made to reduce headcount over the last few months, in line with provider efficiency plans, this has fallen short of where workforce plans were set, both in terms of WTEs and financial value. The recurrent efficiency at month 2 reflects a YTD delivery of 46% of planned efficiencies which is also of concern.

3.10 Planned system efficiencies for the year (provider and ICB) amount to c6.5% of ICB allocations and currently, 49% of this is assessed as being high risk. The plan also assumes no industrial action impact, managing inflation to funded levels, and delivery of 'Elective Recovery Fund' ERF plans.

3.11 The reported month 2 position for Specialised commissioning delegated services is breakeven against plan year to date and forecast to deliver a surplus of £7.7m for the CM system. This assumes full utilisation of reserves to support local variable payments and in year commitments agreed at planning.

4. Financial Performance Month 2

Overall ICS financial performance

4.1 As of 31 May 2024 (Month 2), the ICS is reporting a YTD deficit of £68.8m against a planned YTD deficit of £64.5m resulting in an adverse YTD variance of £4.3m. The YTD deficit at month 2 is £68.8m representing 46% of the full year planned deficit of £150m. This reflect the significant improvement in run rate which is required before year end.

4.2 Given the reprofiling of provider plans explained above, the system YTD variance against plan is largely attributable to the ICB position at this stage, with the key pressure being the cost of current year Continuing Health Care (CHC) and Mental Health packages of care where growth is exceeding national planning assumptions and there is a shortfall in the delivery of efficiencies.

4.3 **Table 3** sets out the financial performance surplus / (deficit) at Month 1 at organisation level. NHSE requested reprofiling of plans at month 2 when final plans were submitted in June, this has meant that the variances reported at month 2 are minimal (see above). However, the fact that the system has incurred a £67m deficit in the first 2 months of the year, against a £150m full year deficit plan, demonstrates the extent of the improvement in run rate required in the remainder of the year.

Table 3 – ICS Financial Performance M2 YTD by organisation

Financial performance surplus/(deficit) for the purposes of system achievement	M2 YTD Plan	M2 YTD Actual	M2 YTD Variance	M2 Actual Surplus / (Deficit) as a % of YTD income	Full Year Annual Plan	Month 2 YTD as a % of FY plan
	£,000	£'000	£'000	%	£,000	£,000
C&M ICB	6,811	1,711	(5,100)		62,291	3%
Alder Hey Children's NHS Foundation Trust	(1,863)	(1,863)	(0)	-2.7%	3,382	-55%
Bridgewater Community Healthcare NHS Foundation Trust	(390)	(390)	0	-2.4%	2,138	-18%
Cheshire and Wirral Partnership NHS Foundation Trust	65	33	(33)	0.1%	1,495	2%
Countess of Chester Hospital NHS Foundation Trust	(5,749)	(5,749)	0	-9.8%	(23,559)	24%
East Cheshire NHS Trust	(3,307)	(3,307)	0	-9.8%	(14,376)	23%
Liverpool Heart and Chest Hospital NHS Foundation Trust	1,392	1,392	0	3.3%	14,141	10%
Liverpool University Hospitals NHS Foundation Trust	(27,428)	(27,428)	0	-13.8%	(80,481)	34%
Liverpool Women's NHS Foundation Trust	(5,583)	(5,579)	4	-22.6%	(28,529)	20%
Mersey Care NHS Foundation Trust (inc NWB)	518	938	420	0.8%	7,128	13%
Mid Cheshire Hospitals NHS Foundation Trust	(6,756)	(6,690)	66	-10.3%	(35,561)	19%
Mersey & West Lancashire Teaching Hospitals NHS Trust	(8,559)	(8,559)	1	-5.9%	(26,674)	32%
The Clatterbridge Cancer Centre NHS Foundation Trust	(133)	33	166	0.1%	876	4%
The Walton Centre NHS Foundation Trust	743	787	44	2.5%	5,347	15%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(8,256)	(8,174)	82	-14.6%	(27,793)	29%
Wirral Community Health and Care NHS Foundation Trust	(21)	(21)	0	-0.1%	6,500	0%
Wirral University Teaching Hospital NHS Foundation Trust	(5,969)	(5,899)	70	-7.4%	(16,325)	36%
Total C&M ICS	(64,485)	(68,765)	(4,280)		(150,000)	46%

ICB Financial Performance

4.4 The ICB has reported a YTD surplus of £1.7m compared to a revised planned surplus of £6.8m, resulting in an adverse variance to plan of £5.1m as per **Table 4** below.

Table 4 – ICB Financial Performance M2 YTD

	M2 YTD			
	Plan	Actual	Variance	Variance
	£m	£m	£m	%
ICB Net Expenditure:				
Acute Services	563.3	563.4	(0.1)	0.0%
Mental Health Services	116.6	119.5	(2.9)	-2.5%
Community Health Services	111.9	112.0	(0.1)	-0.1%
Continuing Care Services	70.1	72.4	(2.3)	-3.2%
Primary Care Services	103.8	103.7	0.1	0.1%
Other Commissioned Services	2.5	2.4	0.1	4.7%
Other Programme Services	8.9	9.0	(0.0)	-0.4%
Reserves / Contingencies	0.0	0.0	0.0	0.0%
Delegated Specialised Commissioning	94.8	94.8	0.0	0.0%
Delegated Primary Care Commissioning	135.9	135.9	(0.0)	0.0%
Primary Medical Services	87.3	87.3	0.0	0.0%
Dental Services	32.7	32.7	0.0	0.0%
Ophthalmic Services	4.5	4.5	0.0	0.0%
Pharmacy Services	11.4	11.4	(0.0)	-0.4%
Delegated Dental, Opthalmic and Pharmacy Ser	48.6	48.6	(0.0)	-0.1%
ICB Running Costs	7.0	6.9	0.1	1.0%
Total ICB Net Expenditure	**1,214.8**	**1,219.9**	**(5.1)**	**-0.4%**
Allocation adjustment for reimbursable items	0.0	0.0	0.0	0.0%
TOTAL ICB Surplus/(Deficit)	**6.8**	**1.7**	**(5.1)**	**-0.4%**

4.5 This early year to date pressure is driven by the following issues:

a) **Mental Health Services** – overspend relating to activity on packages of care outstripping planned levels and limited impact of efficiency plans to date. A

recovery plan is being developed and progress overseen by the ICB Recovery Committee.

b) **Continuing Care** – overspend relating to activity exceeding the levels funded and a shortfall in the delivery of efficiencies. External capacity has been commissioned to support timely reviews. A recovery plan is being developed with the 9 place teams and progress overseen by the ICB Recovery Committee.

c) **Prescribing** is reported to be in-line with plan for month 2. Actual prescribing data had only been received up to March 2024, so there is little information available to inform a robust position at this stage. Good early progress on the medicine efficiency programme is being made and this is also subject to scrutiny via the recovery committee.

d) **Efficiency** – The ICB reports a £3.2m shortfall against the efficiency savings plans for M2. Slippage on efficiency savings is a contributory factor to the overall adverse variance to plan.

e) **Running costs** - Costs remain within the running cost allowance following a 20% reduction in allocation this year. This is a result of the restructure undertaken in 2023/24 and a strict vacancy control process in place this year.

4.6 Details of ICB performance split by place is shown in Table 5 below. Further detail on each place variance was reported to FIRC. Place teams are now working to develop detailed forecasts which will be reported from month 3.

Table 5 ICB Place – Financial Performance

	M2 YTD Plan £m	M2 YTD Actual £m	M2 YTD Variance £m
Cheshire - East	(8.5)	(9.4)	(0.9)
Cheshire - West	(7.1)	(7.4)	(0.3)
Halton	(1.6)	(2.0)	(0.4)
Knowsley	2.0	1.7	(0.2)
Liverpool	1.8	1.4	(0.3)
Sefton	(1.8)	(3.3)	(1.5)
St Helens	(1.9)	(2.2)	(0.4)
Warrington	(0.8)	(1.2)	(0.4)
Wirral	(3.5)	(4.0)	(0.5)
ICB	28.1	27.9	(0.2)
Total ICB	6.8	1.7	(5.1)

4.7 The CEO and CFO is meeting with each place team to review in year performance and identify and agree where corrective actions need to be taken.

Provider Financial Performance

4.8 Table 6 sets out the provider year-to-date position compared to the June plan submission for income, pay and non-pay.

- The aggregate YTD pay position is £2.9m (0.4%) adverse to plan, which is explained by the incremental consultant pay award now agreed and funded within income positions.

- The remaining adverse variance in pay and non-pay is driven by unachieved efficiencies (see section 2.15).

Table 6 – Provider Income and Expenditure vs YTD Plan

	Income - Month 2 YTD			Total Pay - Month 2 YTD			Non Pay - Month 2 YTD			Pay YTD Variance
	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	YTD Plan	YTD Actual	YTD Variance	
	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	£,000	%
Alder Hey Children's	67,539	68,107	**568**	(43,639)	(43,361)	**278**	(25,762)	(26,608)	**(846)**	-0.6%
Bridgewater Community	16,133	16,133	**0**	(11,636)	(11,636)	**0**	(4,887)	(4,887)	**0**	0.0%
Cheshire & Wirral Partnership	44,644	45,562	**918**	(35,088)	(35,732)	**(644)**	(9,523)	(9,798)	**(274)**	1.8%
Countess of Chester Hospitals	55,878	58,471	**2,593**	(43,771)	(44,001)	**(230)**	(17,856)	(20,219)	**(2,363)**	0.5%
East Cheshire Trust	33,562	33,671	**109**	(24,186)	(24,690)	**(504)**	(12,683)	(12,284)	**399**	2.1%
Liverpool Heart & Chest	39,606	41,572	**1,966**	(18,304)	(18,697)	**(393)**	(19,910)	(21,483)	**(1,573)**	2.1%
Liverpool University Hospitals	191,689	198,169	**6,480**	(142,417)	(144,706)	**(2,289)**	(76,700)	(80,890)	**(4,190)**	1.6%
Liverpool Women's	24,684	24,692	**8**	(17,945)	(17,762)	**183**	(12,318)	(12,508)	**(190)**	-1.0%
Mersey Care	121,571	121,873	**302**	(93,887)	(92,444)	**1,443**	(26,746)	(28,491)	**(1,745)**	-1.5%
Mid Cheshire Hospitals	64,880	65,217	**337**	(47,486)	(48,658)	**(1,172)**	(24,084)	(23,249)	**835**	2.5%
Mersey & West Lancs	147,088	144,591	**(2,497)**	(100,925)	(100,259)	**666**	(54,721)	(52,891)	**1,830**	-0.7%
The Clatterbridge Centre	47,532	49,335	**1,803**	(17,690)	(17,978)	**(288)**	(29,809)	(31,325)	**(1,516)**	1.6%
The Walton Centre	30,985	31,719	**734**	(15,645)	(16,003)	**(358)**	(14,553)	(14,929)	**(376)**	2.3%
Warrington & Halton Hospitals	55,987	55,987	**(0)**	(45,131)	(45,131)	**0**	(19,030)	(19,030)	**0**	0.0%
Wirral Community	16,920	17,371	**451**	(12,680)	(12,992)	**(313)**	(4,261)	(4,400)	**(139)**	2.5%
Wirral University Hospitals	80,358	79,670	**(688)**	(58,879)	(58,123)	**756**	(27,394)	(27,446)	**(52)**	-1.3%
TOTAL	**1,039,056**	**1,052,139**	**13,084**	**(729,309)**	**(732,174)**	**(2,865)**	**(380,238)**	**(390,437)**	**(10,199)**	**0.4%**

4.9 A review of Month 2 provider expenditure against 23/24 run rates (average run rate from M9-M11) is set out in **Table 7** below. This indicates a £6.5m (1.8%) increase in M2 average pay run rate compared to M9-11 23/24.

4.10 This is being reviewed with targeted providers and is explained by:

- 0.6% relating to the 24/25 pay award increase funded by through an increase in national tariff.
- technical balance sheet items in M9-12 23/24 therefore deflating the 23/24 reference period;
- increases to pay expenditure through ringfenced allocations (MHIS/SDF)
- unachieved efficiencies in M2 compared to plan.

Table 7 – Provider Pay Expenditure M2 vs 23/24 M9-11 Run Rate

	23/24 M9-11 Average Pay Run Rate	24/25 M1 Pay Expenditure	24/25 M2 Pay Expenditure	Pay Expenditure Run Rate - Trend			
				M1 Pay Increase / (Decrease) vs 23/24 Av. Run Rate	% change M1 24/25 vs M9-11 average	M2 Pay Increase / (Decrease) vs 23/24 Av. Run Rate	% change M2 YTD Average 24/25 vs M9-11 average
	£,000	£,000	£,000	£,000	%	£0.00	%
Alder Hey Children's NHS Foundation Trust	20,514	21,653	21,708	1,139	5.6%	1,167	5.7%
Bridgewater Community Healthcare NHS Foundation Trust	5,859	5,827	5,809	(32)	-0.5%	(41)	-0.7%
Cheshire and Wirral Partnership NHS Foundation Trust	17,390	17,872	17,860	482	2.8%	476	2.7%
Countess of Chester Hospital NHS Foundation Trust	21,547	22,317	21,684	770	3.6%	454	2.1%
East Cheshire NHS Trust	12,612	12,592	12,098	(20)	-0.2%	(267)	-2.1%
Liverpool Heart and Chest Hospital NHS Foundation Trust	9,028	9,347	9,350	319	3.5%	321	3.6%
Liverpool University Hospitals NHS Foundation Trust	70,728	71,205	73,501	477	0.7%	1,625	2.3%
Liverpool Women's NHS Foundation Trust	8,633	8,759	9,003	126	1.5%	248	2.9%
Mersey Care NHS Foundation Trust (inc NWB)	46,249	45,384	47,060	(865)	-1.9%	(27)	-0.1%
Mid Cheshire Hospitals NHS Foundation Trust	24,837	24,245	24,413	(592)	-2.4%	(508)	-2.0%
Mersey & West Lancashire Teaching Hospitals NHS Trust	47,874	49,468	50,791	1,594	3.3%	2,256	4.7%
The Clatterbridge Cancer Centre NHS Foundation Trust	8,801	8,817	9,161	16	0.2%	188	2.1%
The Walton Centre NHS Foundation Trust	7,690	8,027	7,976	337	4.4%	312	4.1%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	22,626	22,590	22,541	(36)	-0.2%	(61)	-0.3%
Wirral Community Health and Care NHS Foundation Trust	6,023	6,546	6,446	523	8.7%	473	7.9%
Wirral University Teaching Hospital NHS Foundation Trust	29,215	29,852	28,271	637	2.2%	(154)	-0.5%
C&M Total	**359,626**	**364,502**	**367,672**	**4,876**	**1.4%**	**6,461**	**1.8%**

NHS Provider Agency Expenditure

4.11 ICS NHS Providers set a plan for agency spend of £91.7m, compared to actual spend in 2023/24 of £128.5m. The system is required to manage agency costs within a ceiling and to demonstrate reduced reliance on agency staffing year on year. The ICS agency ceiling for 2024/25 is £120.7m.

4.12 Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency.

4.13 At Month 2, year to date agency spend is £18.7m (£1.3m above plan), equating to 2.5% of total pay. 11 Trusts are reporting a year-to-date adverse variance to plan. Trust level information on agency spend can be found in **Appendix 1**.

4.14 Table 8 below sets out the aggregate agency performance as a system. This indicates that if the M2 YTD position was extrapolated for the year based on the current run rate this would equate to a £20m adverse variance to plan, however, would remain within the national agency gap by £8.8m. Work is ongoing within providers and forms a key part of provider CIP plans.

Table 8 – Provider Agency Expenditure

	23/24 Actual	23/24 Actual as a % of total 23/24 Pay	24/25 FY Plan	24/25 FY Plan as a % of Pay Plan	24/25 M2 YTD Plan	24/25 M2 YTD Actual	24/25 M2 YTD Variance	24/25 M2 Actual as a % of M2 Pay Actual	M2 YTD Extrapolated for year	Variance M2 Extraplorated vs FY Plan
	£,000	%	£,000	%	£,000	£,000	£,000	£,000	£,000	£,000
TOTAL C&M Providers	**(128,456)**	**2.9%**	**(91,787)**	**2.1%**	**(17,288)**	**(18,640)**	**(1,353)**	**2.5%**	**(111,842)**	**(20,055)**
Agency Cap set by NHSE	(127,322)		(120,662)			(20,110)			(120,662)	
Variance to Cap - favourable / (adverse)	(1,134)		28,875			1,470			8,820	

5. Workforce

5.1 Workforce and its triangulation with finance, performance and productivity will continue to be key focus across the system. **Table 9** below sets out the movement in provider WTEs between M12 23/24 to M2 24/25 and the position against the WTE Month 2 plan. **Appendix 3** sets out in more detail the movements at provider level.

Table 9 – M2 Workforce movements vs M12 23/24 and M2 24/25 Plan

	2023/24	2024/25		Change			
Workforce (WTEs) - source PWRs / June plan submission	**M12 Actuals**	**M2 Plan**	**M2 Actual**	**M12 23/24 to M2 24/25 Actuals decrease / (increase)**		**M2 24/25 Actual vs M1 24/25 Plan favourable / (adverse)**	
	WTE	**WTE**	**WTE**	**WTE**	**% move**	**WTE**	**%**
C&M Providers Total	**80,465**	**78,471**	**79,361**	**1,104**	**1.4%**	**(891)**	**-1.1%**

5.2 The Month 2 provider workforce data indicates that whilst WTE have reduced by 1,104 (1.4%) compared to Month 12 (23/24) they have not fallen to the levels planned, with an adverse 891 WTE position vs plan (-1.1%). This also triangulates with the CIP position being behind plan.

5.3 Further work is also ongoing with HR colleagues to understand each providers' methodology in recording and reporting WTEs to ensure a consistent system approach.

6. System Efficiencies

6.1 For 2024/25 providers and ICB are planning delivery of £368m and £72m efficiencies, respectively. The aggregate system efficiency plan of £440m (6.5% of ICB allocations) submitted as part of the June plan submission is set out by organisation in **Appendix 2A**.

6.2 **Table 10** shows at Month 2 there is currently a shortfall on planned CIP delivery of £8.7m against the ICS YTD plan, with £4.1m attributable against providers and £4.6m against the ICB. The £41.9m efficiencies delivered YTD represent 3.4% of provider and ICS expenditure/allocation against the annual plan of 6.5%, indicating a larger proportion of the savings required in the remaining months.

6.3 Furthermore only 49% of the system efficiencies YTD plan has been delivered recurrently as at Month 2. This increases the risk in the underlying financial position of the system and is subject to ongoing work by providers to both recover the YTD shortfall and address the recurrent position. Non-recurrent savings will need to be reviewed to identify opportunities for sustaining the efficiencies on a recurrent basis.

6.4 More detail on System efficiencies, by organisation, is included in **Appendix 2B**.

Table 10 – ICS M2 YTD Efficiency Delivery

	CIP Efficiency - YTD Delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M2 YTD Plan	M2 YTD Actual	M2 YTD Variance	% Variance	M2 CIP actual as a % of Op	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD old plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	£,000	£,000	%	£,000	%
TOTAL Providers	38,602	34,487	(4,115)	-11%	3.0%	5.5%	20,740	13,747	54%	367,710	9.4%
C&M ICB	12,033	7,409	(4,624)	-38%	0.6%	1.0%	7,409	0	62%	72,235	10.3%
TOTAL ICS	**50,635**	**41,896**	**(8,739)**	**-17%**	**3.4%**	**6.5%**	**28,149**	**13,747**	**56%**	**439,945**	**9.5%**

6.5 **Table 11** sets out the current risk and development status of efficiency schemes. As at the end of May 2024 54% of the CIP schemes are currently deemed high risk. Further detail at organisational level is included in **Appendix 2C.**

Table 11 – Efficiency Development and Risk status (as at May 2024)

	Low £m	Medium £m	High £m	Total £m	Fully £m	In Progress £m	Opportunity £m	Total
C&M ICB	12.0	33.6	26.7	72.2	43.2	12.0	17.0	72.2
C&M Providers	46.5	111.5	209.7	367.7	45.2	111.7	210.8	367.7
Total System	**58.5**	**145.1**	**236.4**	**439.9**	**88.4**	**123.7**	**227.8**	**439.9**
% of risk / development status	13%	33%	54%	**100%**	20%	28%	52%	**100%**

7. Productivity

7.1 The 2024/25 planning guidance set out an expectation for all providers, with a focus on the acute sector, to improve productivity towards pre-pandemic levels (recognising potential adjustments for case mix change, structural factors, and uncaptured activity). 'Implied Productivity Growth' of acute and specialist trusts is calculated by NHSE by comparing output growth (activity) to input growth (based on expenditure costs) against a baseline period. The measure examines the current year's YTD activity and costs with the same period in 19/20 and more recently, with 22/23. A negative value implies decreased productivity whilst positive implies productivity growth.

7.2 The most recently available productivity data is from M10 23/24, and **Table 12** below sets out the aggregate position across all C&M acute and specialist providers compared to the national average.

Table 12 - Implied Productivity Growth

Productivity Measure	C&M %	National Average %
Implied Productivity Growth M10 23/24 vs 19/20	-18.6%	-15.8%
Implied Productivity Growth M10 23/24 vs 22/23	0.8%	1.0%

7.3 NHSE have launched a number of workforce diagnostic productivity tools and productivity metrics to identify and benchmark opportunities for improvement. A summary of the current C&M system productivity metrics vs national averages are set out in **Appendix 5** and are widely available to all providers via the NHS online portal the 'Model System'.

7.4 We will be developing the reporting of system productivity metrics further over coming months for both the ICB Board and Finance, Investment, and resources Committee. The Cheshire and Merseyside Acute and Specialist Trust collaborative (CMAST) already use these metrics widely in their work, especially in the development of the efficiency at scale programme.

8. Cash

8.1 Providers cash balances were not formally reported to the ICB or NHSE for Month 2. The Providers' cash position at Month 1 was £459.8m, with the detail set out in **Appendix 5**. This is £60.9m lower than at the end of 2023/24. More detail will be available from next month on the drivers of cash movements. Most acute providers are forecasting a requirement for external cash support in 2024/25.

8.2 There are five organisations that have formally received and requested external cash support from NHSE for Q1 and Q2 of 24/25 to support their I&E deficit plans – Liverpool University Hospitals NHS FT, Mersey and West Lancs Teaching NHS Trust, Mid Cheshire Hospitals NHST, Warrington & Halton Teaching Hospitals FT and Liverpool Women's NHS FT. Table 12 below set out the distress cash requests received by NHSE.

Table 12 – External Cash Support Received and Requested Q1 and Q2 24/25

Name	Closing Cash Balance Yea End £m	Actual Cash Received In Year £m	Q1 Cash Received £m	Q2 Cash Requested £m	Total Q1 and Q2 Cash Request £m	Defict Plan £m	Q1 & Q2 Cash as a % of FY Plan £m
Mid Cheshire Hospitals NHS Foundation Trust	16.4	31.0	12.2	11.1	**23.3**	(35.6)	65%
Warrington and Halton Teaching Hospitals NHS Foundation	17.6	7.2	3.0	10.4	**13.4**	(27.8)	48%
Liverpool University Hospitals NHS Foundation Trust	40.6	0.0	0.0	30.0	**30.0**	(80.5)	37%
Countess of Chester Hospital NHS Foundation Trust	12.3	31.4	2.6	12.2	**14.8**	(23.6)	63%
Mersey and West Lancashire Teaching Hospitals NHS Trust	24.7	9.0	0.0	21.0	**21.0**	(26.7)	79%
Liverpool Women's NHS Foundation Trust	2.0	20.1	0.0	6.6	**6.6**	(28.5)	23%
TOTAL for providers with cash requests	**113.8**	**98.7**	**17.8**	**91.3**	**109.1**	**(222.6)**	**49%**

9. Recovery approach

9.1 Given the significant financial challenges being faced by the Cheshire and Merseyside system, the ICB has established a recovery programme for 2024/25. This is made up of a number of specific programmes, including:

- Urgent Care Improvement, with separate workstreams for the North Mersey, Mid Mersey and West Lancs, Wirral, Warrington & Halton, and Cheshire.
- Mental Health – Pressures in A&E/Out of Area Placements.
- All Age Continuing Healthcare.
- Non-clinical workforce efficiency.
- Neurodiversity.
- Unwarranted Variation.
- Medicines Management.
- Service Reviews - with separate workstreams for Liverpool, Wirral, Cheshire, and Warrington.

9.2 Each programme has an SRO with named support from Finance, PMO, Business Intelligence etc. The programme reports fortnightly to the Recovery Committee, which is an executive led committee of the ICB. A progress update was provided to the Finance, Investment and Resources Committee in its July meeting.

9.3 The scope, objectives, and deliverables for each workstream are being identified and financial targets being agreed. The efficiencies delivered in year from this work are aligned to the ICB cost improvement plans reported to Board.

10. System Risks & Mitigations

10.1 Several risks have been reported through the recent planning process and are subject to ongoing to monitoring and management by the respective organisations:

a. **Identification and delivery of recurrent CIPs** – CIP targets 6.5% of system resource which is a significant challenge. System wide focus and review is ongoing to identify areas for acceleration and improvement. The recovery approach set out in section 2.29 provides further detail on key elements of this.

b. **Non-achievement of Elective Recovery Fund (ERF) / activity requirements** – the C&M ICS system is planning to deliver 109.7% of in scope elective activity against its 104.7% target. The system has a strong track record of delivery in this area as a result of the elective recovery workstream within the CMAST programme, however, operational challenges continue to be a risk in achieving this level of activity.

c. **Inflation** – specifically; non-pay inflation for providers and prescribing and continuing care/packages of care for the ICB above national planning assumptions.

d. **Cost of out of area placements** arising from delayed transfers of care.

e. **Industrial action disruption** – the plan assumes no industrial or collective action throughout 24/25.

11. Provider and Primary Care Capital

11.1 The 'Charge against Capital Allocation' represents the systems performance against its operational capital allocation, which is wholly managed at the systems discretion. For 2024/25 the secondary care allocation in 2023/24 is £258.4m, and primary care allocation of £4.7m. Like last year, the plan sets out an over-commitment against allocation of c£12m with plans to spend £270.5m. It is expected that the over-commitment position will be managed in year through slippage.

11.2 No information has been collected over Month 1 and Month 2 on capital expenditure and this will be reported from Month 3.

12. Recommendations

12.1 The Board is asked to note:

- The financial position reported for month 2
- The risks to delivery of the financial plan together with the work being done to mitigate and manage the position in year.

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Appendices

Appendix 1: Agency Expenditure M2 YTD by provider
Appendix 2A: System Efficiencies: Current Full Year Plan
Appendix 2B: System Efficiencies: Current Performance M2
Appendix 2C: System Efficiencies: Risk and Development of CIP Plan (June 2024)
Appendix 3: Workforce Analysis M2 vs M12 trend and M2 Plan by Provider
Appendix 4: NHSE Productivity Metrics Benchmarking (Model System)
Appendix 5: Provider Cash: Current Cash Position as at Month 1

Appendix 1 – Agency Expenditure M2 YTD by provider

Organisation	23/24 Actual	23/24 Actual as a % of total 23/24 Pay	24/25 FY Plan	24/25 FY Plan as a % of Pay Plan	24/25 M2 YTD Plan	24/25 M2 YTD Actual	24/25 M2 YTD Variance	24/25 M2 Actual as a % of M2 Pay Actual	M2 YTD Extrapolated for year	Variance M2 Extraplor ated vs FY Plan
	£,000	%	£,000	%	£,000	£,000	£,000	£,000	£,000	£,000
Alder Hey Children's NHS Foundation Trust	(2,070)		(599)	0.2%	(100)	(323)	(223)	1.3%	(1,938)	(1,339)
Bridgewater Community Healthcare NHS Foundation Trust	(4,824)		(1,456)	2.3%	(415)	(431)	(16)	8.8%	(2,586)	(1,130)
Cheshire and Wirral Partnership NHS Foundation Trust	(9,649)		(8,161)	3.9%	(1,650)	(1,742)	(92)	18.1%	(10,452)	(2,291)
Countess of Chester Hospital NHS Foundation Trust	(6,026)		(4,948)	1.9%	(872)	(972)	(100)	4.9%	(5,832)	(884)
East Cheshire NHS Trust	(8,392)		(7,280)	5.2%	(1,161)	(1,247)	(86)	10.4%	(7,482)	(202)
Liverpool Heart and Chest Hospital NHS Foundation Trust	(922)		(900)	0.8%	(150)	(140)	10	0.7%	(838)	62
Liverpool University Hospitals NHS Foundation Trust	(18,136)		(10,013)	1.2%	(2,487)	(2,448)	39	3.2%	(14,685)	(4,672)
Liverpool Women's NHS Foundation Trust	(686)		(1,354)	1.3%	(228)	(152)	76	1.3%	(912)	442
Mersey Care NHS Foundation Trust (inc NWB)	(19,010)		(18,019)	3.2%	(3,000)	(2,535)	465	9.1%	(15,210)	2,809
Mid Cheshire Hospitals NHS Foundation Trust	(13,238)		(8,511)	3.0%	(1,449)	(1,914)	(465)	8.6%	(11,484)	(2,973)
Mersey & West Lancashire Teaching Hospitals NHS Trust	(22,657)		(17,916)	3.0%	(3,121)	(3,850)	(730)	8.3%	(23,100)	(5,184)
The Clatterbridge Cancer Centre NHS Foundation Trust	(1,809)		(726)	0.7%	(130)	(231)	(101)	0.7%	(1,385)	(659)
The Walton Centre NHS Foundation Trust	(670)		0	0.0%	0	(134)	(134)	0.9%	(804)	(804)
Warrington and Halton Teaching Hospitals NHS Foundation T	(8,900)		(7,313)	2.9%	(1,713)	(663)	1,050	3.6%	(3,978)	3,335
Wirral Community Health and Care NHS Foundation Trust	(1,170)		(362)	0.4%	(60)	(77)	(17)	1.7%	(464)	(102)
Wirral University Teaching Hospital NHS Foundation Trust	(10,298)		(4,229)	1.3%	(752)	(1,782)	(1,030)	6.7%	(10,692)	(6,463)
TOTAL C&M Providers	**(128,456)**	**2.9%**	**(91,787)**	**2.1%**	**(17,288)**	**(18,640)**	**(1,353)**	**2.5%**	**(111,842)**	**(20,055)**
Agency Cap set by NHSE	(127,322)		(120,662)			(20,110)			(120,662)	
Variance to Cap - favourable / (adverse)	(1,134)		28,875			1,470			8,820	

Appendix 2A - System Efficiencies: Current Full Year Plan

	CIP Metrics June FPR Submission		
	CIP £,000	CIP as % of Op Ex	Recurrent CIP as a % of total CIP
	£,000	%	%
Alder Hey Children's	19,950	4.8%	97%
Bridgewater Community	6,939	6.9%	100%
Cheshire & Wirral Partnership	13,913	5.0%	100%
Countess of Chester Hospitals	19,822	5.3%	100%
East Cheshire Trust	11,225	5.0%	100%
Liverpool Heart & Chest	10,644	4.6%	92%
Liverpool University Hospitals	114,600	8.5%	100%
Liverpool Women's	5,904	3.3%	77%
Mersey Care	25,967	3.5%	100%
Mid Cheshire Hospitals	22,437	5.2%	90%
Mersey & West Lancs	45,165	4.8%	80%
The Clatterbridge Centre	10,000	3.4%	100%
The Walton Centre	8,558	4.5%	100%
Warrington & Halton Hospitals	19,433	5.1%	100%
Wirral Community	6,275	5.4%	100%
Wirral University Hospitals	26,878	5.2%	100%
TOTAL	**367,710**	**5.5%**	**91%**
ICB	**72,235**	**1.1%**	**100%**
TOTAL ICS System Position	**439,945**	**6.6%**	**93%**

Appendix 2B - System Efficiencies: Current Performance M2

	CIP Efficiency - YTD Delivery						CIP Recurrent / Non Recurrent YTD			YTD CIP as a % of FY CIP Plan	
	M2 YTD Plan	M2 YTD Actual	M2 YTD Variance	% Variance	M2 CIP actual as a % of Op	FY CIP Plan % of Op Ex	Actual Recurrent	Actual Non Recurrent	Actual Recurrent as a % of YTD old plan	full year CIP (new plan)	YTD CIP as a % of FY CIP plan
	£,000	£,000	£,000	%	%	%	£,000	£,000	%	£,000	%
Alder Hey Children's	1,577	1,591	14	1%	2.3%	4.8%	1,489	102	94%	19,950	8.0%
Bridgewater Community	396	200	(196)	-49%	1.2%	6.9%	0	200	0%	6,939	2.9%
Cheshire & Wirral Partnership	2,084	1,274	(810)	-39%	2.7%	5.0%	721	553	35%	13,913	9.2%
Countess of Chester Hospitals	1,454	81	(1,373)	-94%	0.1%	5.3%	81	0	6%	19,822	0.4%
East Cheshire Trust	782	751	(31)	-4%	2.0%	5.0%	262	489	34%	11,225	6.7%
Liverpool Heart & Chest	1,611	790	(821)	-51%	1.9%	4.6%	169	622	10%	10,644	7.4%
Liverpool University Hospitals	10,587	9,969	(618)	-6%	4.3%	8.5%	4,068	5,901	38%	114,600	8.7%
Liverpool Women's	267	376	109	41%	1.2%	3.3%	213	163	80%	5,904	6.4%
Mersey Care	4,327	4,327	0	0%	3.5%	3.5%	4,327	0	100%	25,967	16.7%
Mid Cheshire Hospitals	3,490	3,465	(25)	-1%	4.6%	5.2%	2,272	1,193	65%	22,437	15.4%
Mersey & West Lancs	4,424	4,424	0	0%	2.9%	4.8%	2,924	1,500	66%	45,165	9.8%
The Clatterbridge Centre	1,666	1,667	1	0%	3.3%	3.4%	225	1,442	13%	10,000	16.7%
The Walton Centre	1,332	1,331	(1)	0%	4.1%	4.5%	960	371	72%	8,558	15.6%
Warrington & Halton Hospitals	1,128	1,128	0	0%	1.7%	5.1%	171	957	15%	19,433	5.8%
Wirral Community	789	425	(364)	-46%	2.4%	5.4%	170	255	22%	6,275	6.8%
Wirral University Hospitals	2,688	2,688	0	0%	3.1%	5.2%	2,688	0	100%	26,878	10.0%
TOTAL	**38,602**	**34,487**	**(4,115)**	**-11%**	**3.0%**	**5.5%**	**20,740**	**13,747**	**54%**	**367,710**	**9.4%**
C&M ICB	12,033	7,409	(4,624)	-38%	0.6%	1.0%	7,409	0	62%	72,235	10.3%
TOTAL ICS	**50,635**	**41,896**	**(8,739)**	**-17%**	**3.4%**	**6.5%**	**28,149**	**13,747**	**56%**	**439,945**	**9.5%**

Appendix 2C - System Efficiencies: Risk and Development of CIP Plan (April 2024)

	12th June Plan Submission								% of CIP High Risk	% of CIP Opportunity
	CIP RISK				CIP DEVELOPMENT					
	Low	Medium	High	Total	Fully	In Progress	Opportunity	Total		
	£m	£m	£m	£m	£m	£m	£m	£m	%	%
Alder Hey Children's NHS Foundation Trust	4.5	10.6	4.9	**20.0**	4.5	8.1	7.3	**20.0**	25%	37%
Bridgewater Community Healthcare NHS Foundation Trust	0.0	0.0	6.9	**6.9**	0.0	0.0	6.9	**6.9**	100%	100%
Cheshire and Wirral Partnership NHS Foundation Trust	0.0	6.7	7.2	**13.9**	0.0	6.7	7.2	**13.9**	52%	52%
Countess of Chester Hospital NHS Foundation Trust	0.0	0.0	19.8	**19.8**	0.0	0.0	19.8	**19.8**	100%	100%
East Cheshire NHS Trust	0.0	1.8	9.4	**11.2**	0.0	1.6	9.6	**11.2**	84%	85%
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.7	1.8	4.1	**10.6**	2.3	4.4	3.9	**10.6**	39%	36%
Liverpool University Hospitals NHS Foundation Trust	1.2	28.8	84.6	**114.6**	2.9	5.1	106.7	**114.6**	74%	93%
Liverpool Women's NHS Foundation Trust	0.4	3.4	2.1	**5.9**	0.4	3.4	2.1	**5.9**	35%	35%
Mersey Care NHS Foundation Trust (inc NWB)	12.2	13.8	0.0	**26.0**	12.2	13.8	0.0	**26.0**	0%	0%
Mid Cheshire Hospitals NHS Foundation Trust	2.5	9.9	10.1	**22.4**	6.5	6.5	9.5	**22.4**	45%	42%
Mersey & West Lancashire Teaching Hospitals NHS Trust	12.4	19.8	13.0	**45.2**	12.4	19.8	13.0	**45.2**	29%	29%
The Clatterbridge Cancer Centre NHS Foundation Trust	2.2	3.8	4.0	**10.0**	1.9	4.1	4.0	**10.0**	40%	40%
The Walton Centre NHS Foundation Trust	0.1	5.7	2.7	**8.6**	0.1	5.7	2.7	**8.6**	32%	32%
Warrington and Halton Teaching Hospitals NHS Foundation Tr	0.5	1.8	17.1	**19.4**	0.2	3.7	15.6	**19.4**	88%	80%
Wirral Community Health and Care NHS Foundation Trust	3.7	2.6	0.0	**6.3**	1.9	1.8	2.6	**6.3**	0%	42%
Wirral University Teaching Hospital NHS Foundation Trust	2.1	1.1	23.7	**26.9**	0.0	26.9	0.0	**26.9**	88%	0%
C&M ICB	12.0	33.6	26.7	**72.2**	43.2	12.0	17.0	**72.2**	37%	24%
Total	**56.5**	**114.4**	**248.2**	**419.0**	**85.0**	**128.0**	**206.0**	**419.0**	**59%**	**49%**

Appendix 3 – Workforce Analysis M2 vs M12 trend and M2 Plan by Provider

	2023/24	2024/25		Change			
Workforce (WTEs) - source PWRs / June plan submission	M12 Actuals	M2 Plan	M2 Actual	M12 23/24 to M2 24/25 Actuals decrease / (increase)		M2 24/25 Actual vs M1 24/25 Plan favourable / (adverse)	
	WTE	WTE	WTE	WTE	% move	WTE	%
Alder Hey Children's NHS Foundation Trust	4,368	4,340	4,347	21	0.5%	(7)	-0.2%
Bridgewater Community Healthcare NHS Foundation Trust	1,434	1,453	1,462	(27)	-1.9%	(9)	-0.6%
Cheshire and Wirral Partnership NHS Foundation Trust	4,072	3,983	4,024	47	1.2%	(42)	-1.0%
Countess of Chester Hospital NHS Foundation Trust	4,886	4,909	4,783	103	2.2%	126	2.6%
East Cheshire NHS Trust	2,675	2,656	2,633	42	1.6%	22	0.9%
Liverpool Heart and Chest Hospital NHS Foundation Trust	1,912	1,900	1,880	32	1.7%	20	1.1%
Liverpool University Hospitals NHS Foundation Trust	15,448	14,321	15,163	285	1.9%	(842)	-5.6%
Liverpool Women's NHS Foundation Trust	1,687	1,768	1,718	(31)	-1.8%	50	2.9%
Mersey Care NHS Foundation Trust (inc NWB)	11,623	11,383	11,224	399	3.6%	159	1.4%
Mid Cheshire Hospitals NHS Foundation Trust	5,687	5,366	5,425	262	4.8%	(59)	-1.1%
Mersey & West Lancashire Teaching Hospitals NHS Trust	10,614	10,586	10,538	77	0.7%	48	0.5%
The Clatterbridge Cancer Centre NHS Foundation Trust	1,893	1,742	1,919	(26)	-1.4%	(177)	-9.2%
The Walton Centre NHS Foundation Trust	1,562	1,558	1,522	41	2.7%	36	2.4%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	4,786	4,621	4,646	140	3.0%	(25)	-0.5%
Wirral Community Health and Care NHS Foundation Trust	1,560	1,560	1,579	(19)	-1.2%	(19)	-1.2%
Wirral University Teaching Hospital NHS Foundation Trust	6,258	6,326	6,499	(241)	-3.7%	(172)	-2.7%
C&M Providers Total	**80,465**	**78,471**	**79,361**	**1,104**	**1.4%**	**(891)**	**-1.1%**

Appendix 4 – NHSE Productivity Metrics Benchmarking (Model System)

Headline Productivity	Data period	System value	Peer average	National value	National value method	Chart	Actions
Implied Productivity Growth (year-to-date compared to 2019/20)	Feb 2024	-18.58%	-18.58%	-15.79%	System median		

Operational and Clinical Productivity	Data period	System value	Peer average	National value	National value method	Chart	Actions
Average LOS: All Ages: Total	25/02/2024	6.4	6.0	5.7	System median		
Bed occupancy classed as clinically ready for discharge (%, acute)	09/06/2024	32.5%	26.2%	25.3%	System median		
Capped Theatre Utilisation %: Touch time within planned session vs planned session time	02/06/2024	77.1%	77.1%	78.9%	Provider median		
Organisation level day case rates for British Association of Day Case Surgery procedures (3mths to month end)	Feb 2024	82.1%	82.1%	81.3%	Provider median		

Workforce Productivity	Data period	System value	Peer average	National value	National value method	Chart	Actions
Implied Workforce Productivity Growth (year-to-date compared to 2019/20)	Feb 2024	-20.00%	-20.00%	-16.25%	System median		
Non-elective admissions per clinical WTE	Feb 2024	1.50	1.46	1.59	System median		
Elective admissions per clinical WTE	Feb 2024	1.45	1.31	1.65	System median		
Outpatient attendances per consultant WTE	Feb 2024	98.60	78.49	80.33	System median		
A&E attendances (Type 1 and 2) per Emergency Medicine consultant	Feb 2024	509.36	509.36	541.23	System median		

Workforce Drivers	Data period	System value	Peer average	National value	National value method	Chart	Actions
Overall Temporary Staff Spend as a % of Total Spend	Jan 2024	11.0%	11.0%	8.5%	Benchmark value		
Registered Nurses: Sickness absence rate	Mar 2024	6.2%	6.1%	5.0%	System median		
Medical and Dental, Sickness absence rate	Mar 2024	2.3%	2.3%	1.9%	System median		
All Staff: NHS Turnover Rate	Mar 2024	13.0%	13.7%	14.9%	System median		

Non-Pay Efficiency	Data period	System value	Peer average	National value	National value method	Chart	Actions
Top 10 Medicines - Savings Delivered (2022-23)	To Mar 2023	£16.34m	£16.34m	£7.73m	System median		
Estates & Facilities cost (£ per m2)	2022/23	£451.48/m2	£449.61/m2	£489.39/m2	System median		

Appendix 5- Provider Cash: Current Cash Position as at Month 1

	2023/24 M12 Closing Cash Balance	M1 30 April Closing Cash Balance	Movement		No days closing cash M1
	£'000	£'000	£'000	%	Days
Alder Hey Children's NHS Foundation Trust	78,280	69,056	(9,224)	-12%	62
Bridgewater Community Healthcare NHS Foundation Trust	17,334	15,085	(2,249)	-13%	58
Cheshire and Wirral Partnership NHS Foundation Trust	28,106	26,401	(1,705)	-6%	35
Countess of Chester Hospital NHS Foundation Trust	12,342	12,673	331	3%	12
East Cheshire NHS Trust	17,850	16,051	(1,799)	-10%	27
Liverpool Heart and Chest Hospital NHS Foundation Trust	43,233	40,144	(3,089)	-7%	63
Liverpool University Hospitals NHS Foundation Trust	40,648	21,323	(19,325)	-48%	6
Liverpool Women's NHS Foundation Trust	2,049	4,579	2,530	123%	7
Mersey Care NHS Foundation Trust (inc NWB)	72,869	74,546	1,677	2%	38
Mid Cheshire Hospitals NHS Foundation Trust	16,448	10,725	(5,723)	-35%	9
Mersey & West Lancashire Teaching Hospitals NHS Trust	24,658	6,371	(18,287)	-74%	3
The Clatterbridge Cancer Centre NHS Foundation Trust	74,277	74,250	(27)	0%	96
The Walton Centre NHS Foundation Trust	51,594	54,850	3,256	6%	117
Warrington and Halton Teaching Hospitals NHS Foundation Tru	17,634	11,689	(5,945)	-34%	7
Wirral Community Health and Care NHS Foundation Trust	12,719	11,420	(1,299)	-10%	42
Wirral University Teaching Hospital NHS Foundation Trust	10,581	10,604	23	0%	8
C&M Total	**520,622**	**459,767**	**(60,855)**	**-12%**	**37**

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the Finance, Investment & Our Resource Committee

Agenda Item No: ICB/07/24/08

Report approved by: Erica Morris, ICB Non-Executive Member

Highlight report of the Chair of the Finance, Investment & Our Resources Committee

Committee Chair	Erica Morriss
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Meeting date	09 July 2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee considered the following areas/items:

- **External support regarding system finance.** Process has been mandated by NHS England, with Cheshire & Merseyside ICS identified as one of 9 high risk systems in England. ICB want to ensure we maximise the value of the intervention. Teams are working at pace with Providers to ensure that the investigation phase is undertaken quickly. Reporting on progress will be incorporated into future monthly FIRC meetings.

Advise

The Committee considered the following areas/items:

- **Procurement**
  - **Noted –** challenge received in respect of a contract award, which put the award on hold for a month. The ensuing review noted that further clarity could have been provided to bidders as part of the tender information. A revised selection questionnaire will be re-issued and evaluation will be against the revised SQ submissions.
  - **Noted – update to the** healthcare and non-healthcare procurement plan 2024/25.
  - **Noted –** procurement decisions approved or endorsed for approval in line with the SORD at the May/June Procurement Decision Review Group.
- **Meeting regularity.** FIRC Committee moving to monthly (3rd week of month), with a shortened meeting every other month focussing on recovery plan and financial position. Timing revised to provide Comm with current information.
- **Financial Plan 2024/2025.** Deficit plan submitted in June of £150m for C&M ICS. High risk associated with scale of efficiency and integration required to deliver this plan across both NHS Providers and the C&M ICB. Specialised Commissioning has been delegated to the ICB this year, will be working with NHS England to ensure delivery in 24/25. Plans ratified by FIRC.
- **Month 2.** System reporting a YTD deficit of £68.6m: £70m deficit for NHS Providers and £1.7m surplus for ICB. Represents 46% of FOT deficit, largely driven by unachieved CIP, CHC costs and mental health packages of care. Position noted, Recovery Comm will provide efficiency metrics at next meeting and will be tracked through FIRC.

- **ICB Recovery.** Paper presenting the approach taken to recovery and key programmes. Performance will be reported to Board and FIRC. Methology of delivery and key metrics for tracking performance will be shared with FIRC at next meeting.

- **Infrastructure Strategy.** First sight of draft, incomplete report. Further review of content will be undertaken by Executive Committee with a further iteration to be presented in September 2024. Increased links to overall NHS and Local Government strategic aims to be worked on.

- **People Committee minutes and HR Dashboard.** The committee considered the latest HR dashboard and the minutes of the ICBs People Committee.

Assure

- **Risk Report.** The Committee considered its risks register, with details outlined below.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
F8 – Common risk across places in relation to cost pressures resulting in potential overspends and may impact on the ICBs ability to achieve its statutory financial duties (20)	Agreed – work continuing to ensure consistency of Place approach
F9 – Common risk across places in relation to potential inability to deliver efficiency improvements an may impact on the ICBs ability to achieve its statutory financial duties (20)	Agreed – work continuing to ensure consistency of Place approach.

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
P7: The Integrated Care System is unable to achieve its statutory financial duties. (critical 25)	Risk has been revised to 20 in line with Acute transformational/recovery risk.
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic	Agreed to maintain this risk at 16.

Board Assurance Framework Risks	
objectives. (16)	

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Development and delivery of a Cheshire and Merseyside system-wide financial strategy for 2024/5	24/25 Financial Plan report for both ICB and Specialised Commissioning
Delivery of the Finance Efficiency & Value Programme	Month 2 finance report
Development and delivery of the Capital Plans.	N/a - Capital not reported at month 2
Development of System Estates Plans to deliver a programme to review and rationalise our corporate estates.	Draft Estates strategy presented, currently NHS focused and work to progress on system approach.

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Integrated Performance Report

Agenda Item No: ICB/07/24/09

Responsible Director: Anthony Middleton: Director of Performance and Planning

Integrated Performance Report

1. Purpose of the Report

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

2. Executive Summary

2.1 The integrated performance report for July 2024, see appendix one, provides an overview of key metrics drawn from the 2023/24 and 2024/25 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance.

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

3. Ask of the Board and Recommendations

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

4. Reasons for Recommendations

4.1 The report is sent for assurance.

5. Background

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

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

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

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

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

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

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

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

8. Link to meeting CQC ICS Themes and Quality Statements

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

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

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

9. Risks

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

9.2 Additionally, waits for cancer and elective treatment, particularly due to industrial action and winter pressures within the urgent care system could result in

reduced capacity and activity leading to poor outcomes, which maps to Board Assurance Framework Risk P3.

10. Finance

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

11. Communication and Engagement

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

12. Equality, Diversity and Inclusion

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

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Integrated Quality and Performance report

NHS
Cheshire and Merseyside

Integrated Performance Report

25th July 2024

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Integrated Quality & Performance Report – Guidance:

NHS Cheshire and Merseyside

Provider Acronyms:

ACUTE TRUSTS		SPECIALIST TRUSTS		COMMUNITY AND MENTAL HEALTH TRUSTS		KEY SYSTEM PARTNERS	
COCH	COUNTESS OF CHESTER HOSPITAL NHS FT	AHCH	ALDER HEY CHILDREN'S HOSPITAL NHS FT	BCHC	BRIDGEWATER COMMUNITY HEALTHCARE NHS FT	NWAS	NORTH WEST AMBULANCE SERVICE NHS TRUST
ECT	EAST CHESHIRE NHS TRUST	LHCH	LIVERPOOL HEART AND CHEST HOSPITAL NHS FT	WCHC	WIRRAL COMMUNITY HEALTH AND CARE NHS FT	CMCA	CHESHIRE AND MERSEYSIDE CANCER ALLIANCE
MCHT	MID CHESHIRE HOSPITALS NHS FT	LWH	LIVERPOOL WOMEN'S NHS FOUNDATION TRUST	SHLA	ST HELENS LOCAL AUTHORITY	**OTHER**	
LUFT	LIVERPOOL UNIVERSITY HOSPITALS NHS FT	TCCC	THE CLATTERBRIDGE CANCER CENTRE NHS FT	MCFT	MERSEY CARE NHS FT	OOA	OUT OF AREA AND OTHER PROVIDERS
MWL	MERSEY AND WEST LANCASHIRE TEACHING HOSPITALS NHS TRUST	TWC	THE WALTON CENTRE NHS FT	CWP	CHESHIRE AND WIRRAL PARTNERSHIP NHS FT		
WHH	WARRINGTON AND HALTON TEACHING HOSPITALS NHS FT						
WUTH	WIRRAL UNIVERSITY TEACHING HOSPITAL NHS FT						

Key:

Data formatting

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

C&M National Ranking against the 42 ICBs

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

C&M National Ranking against the 22 Cancer Alliances

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

Notes on interpreting the data

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

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

Local Trajectory: The C&M operational plan has been formally agreed as the ICBs local performance trajectory for 2023/2024 or 2024/2025 and may differ to the national target

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

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

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

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Urgent care	4-hour A&E waiting time	Jun-24	74.5%	73.6%	73.2%	71.0%	69.7%	68.9%	69.4%	68.9%	68.1%	71.9%	72.1%	71.1%	72.7%	73.4%	78% by Year end	72.1%	74.6%	30/42
	Ambulance category 2 mean response time	Jun-24	00:32:55	00:31:56	00:35:13	00:39:13	00:39:41	00:43:45	01:04:31	00:49:45	00:43:30	00:29:31	00:24:49	00:33:02	00:34:47	-	00:30:00	00:26:53	00:34:38	-
	A&E 12 hour waits from arrival	Jun-24	13.9%	14.0%	14.6%	16.5%	17.0%	16.6%	16.1%	18.5%	16.7%	15.7%	15.8%	16.8%	15.8%	-	-	12.9%	9.8%	38/42
	Adult G&A bed occupancy	Jun-24	95.40%	94.7%	95.0%	96.0%	96.5%	96.9%	95.3%	96.6%	95.9%	96.0%	95.3%	95.8%	95.9%	93.5%	92.0%	94.7%	95.7%	28/42
	Percentage of beds occupied by patients no longer meeting the criteria to reside	Jun-24	17.3%	17.7%	19.2%	20.8%	20.1%	20.6%	20.8%	21.0%	19.8%	20.1%	21.6%	21.8%	21.3%	13.4%	*	15.7%	13.8%	41/42
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	May-24	4,528	4,332	4,888	5,078	5,393	4,842	5,227	4,732	3,736	2,195	2,324	2,331		1,782	-	6,426	55,955	-
	Number of 52+ week RTT waits, of which children under 18 years.*NEW*	Jun-24									1,497	1,446	1,471	1,505	1,542	1,604	-	n/a	n/a	-
	Total incomplete Referral to Treatment (RTT) pathways	May-24	362,417	367,634	375,312	372,005	376,230	369,440	372,974	369,750	371,542	365,756	367,759	369,179		372,711	-	1,066,957	7,603,812	-
	Patients waiting more than 6 weeks for a diagnostic test	May-24	21.2%	21.8%	23.3%	23.0%	20.0%	16.0%	17.2%	16.2%	10.7%	10.0%	10.2%	10.0%		10.0%	10.0%	17.5%	22.1%	2/42
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	May-24	66.9%	70.7%	70.3%	71.3%	70.1%	70.9%	71.8%	67.2%	69.0%	75.4%	70.9%	71.8%		70.5%	85.0%	69.1%	65.7%	6/42
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	May-24	95.3%	93.9%	94.7%	94.1%	93.4%	94.0%	95.0%	91.9%	93.2%	92.4%	91.8%	95.4%		96.0%	96.0%	95.4%	91.8%	8/42
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	May-24	69.9%	70.3%	69.5%	68.6%	70.0%	68.9%	70.2%	67.2%	74.8%	76.0%	71.3%	71.4%		71.2%	75.0%	74.1%	76.4%	32/42
Mental Health	Access rate to community mental health services for adults with severe mental illness	Mar-24	106.0%	95.0%	98.0%	101.0%	103.0%	105.0%	107.0%	110.0%	117.0%	121.0%				100.0%	100.0%	105.3%	98.9%	4/42
	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	70.0%	67.0%	65.0%	68.0%	70.0%	72%	75%	75%	76%	78%				60.0%	60.0%	72.0%	69.8%	15/42
	Access rate for Talking Therapies services	Mar-24	59.0%	61.0%	63.0%	60.0%	72.0%	67.0%	47.0%	66.0%	66.0%	59.0%				100.0%	100.0%	62.3%	61.8%	25/42
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months *NEW*	Q4 23/24	45.7%		45.3%			45.0%			57.8%					-	75.0%	63.9%	68.5%	-
	Dementia Diagnosis Rate	May-24	65.6%	65.8%	66.0%	66.2%	66.5%	66.9%	66.4%	66.3%	66.8%	67.0%	67.0%	67.2%		66.7%	66.7%	69.7%	64.8%	15/42
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	May-24	110	110	110	110	110	110	110	100	100	100	95	95		≤ 60	-	285	1,815	33/42
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Apr 24 YTD	11.3%	16.0%	21.3%	26.9%	34.8%	40.1%	45.4%	61.1%	76.0%	91.4%	3.1%			3.4%	75% by Year end	3.4%	3.4%	30/42
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	May-24	83.4%	87.0%	86.0%	84.0%	85.0%	80%	83%	80.0%	82.9%	80.0%	84%	87%		70.0%	70.0%	90.0%	85.0%	22/42
Primary Care	Units of dental activity delivered as a proportion of all units of dental activity contracted	Apr-24	76.1%	81.7%	87.3%	71.2%	80.9%	94.9%	68.2%	82.8%	85.8%	92.8%	81.3%			100.0%	100.0%	90.7%	87.0%	28/42
	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	May-24	111.8%	105.5%	105.9%	106.9%	102.7%	98.6%	94.3%	106.8%	109.2%	92.8%	122.2%	106.9%		-	-	110.3%	109.8%	-
	Percentage of appointments made with General Practice seen within two weeks *NEW*	Apr-24	88.3%	89.4%	89.3%	88.7%	89.3%	89.8%	90.8%	91.0%	90.6%	90.1%	88.9%			85.0%	85.0%	88.1%	87.5%	13/42
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Mar-24	7.32%	7.34%	7.31%	7.29%	7.27%	7.24%	7.36%	7.33%	7.27%	7.19%				10.0%	10.0%	7.24%	7.76%	10/42
	Total volume of antibiotic prescribing in primary care	Mar-24	1.084	1.079	1.082	1.081	1.081	1.077	1.040	1.036	1.040	1.033				0.871	0.871	1.053	0.938	34/42
Note/s	* no national target for 2024/25																			

1. ICB Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Local Trajectory	National Target	Region value	National value	Latest Rank
Integrated care - BCF metrics	Unplanned hospitalisation for chronic ambulatory care sensitive conditions (average of place rates)	Q4 23/24	244.8	237.0			225.3			226.5						-	-	218.5	172.1	-
	Percentage of people who are discharged from acute hospital to their usual place of residence	Mar-24	92.5%	92.8%	92.7%	92.5%	92.4%	92.5%	92.4%	92.8%	92.8%	93.3%				-	-	92.9%	93.2%	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 (average of place rates)	Q4 23/24	527.3	510.9			463.7			413.7						-	-	367.9	324.4	-
Health Inequalities & Improvement	Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028**. (rolling 12 months)	Feb-24	59.0%	59.2%	59.2%	59.0%	59.4%	59.4%	59.0%	59.0%	59.1%	59.1%				70.0%	75% by 2028	56.9%	58.4%	19/42
	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 23/24	66.0%	65.84%			65.89%									77.0%	80.0%	67.11%	67.2%	30/42
	Children and young people accessing mental health services as % of LTP trajectory (planned number)	Mar-24	86.0%	87.0%	87.4%	89.0%	90.0%	88.0%	89.0%	89.0%	91.0%	90.0%				100.0%	100.0%	107.0%	94.00%	25/42
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Jun-24						14.3%	14.2%	14.2%	14.1%	13.9%	13.9%	13.8%	13.7%	12.0%	12.0%	-	12.7%^	-
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Mar-24	3.30	3.33	3.14	3.16	3.02	3.51	3.12	3.14	2.69	3.00				-	-	-	-	-
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to Mar 24	614	596	581	572	583	576	575	578	582	608				439	439	n/a	n/a	23/42~
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Mar 24	760	779	793	779	769	768	778	797	788	812				518	518	n/a	n/a	38/42~
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Feb-24	1.027	1.030	1.028	1.039	1.034	1.034	1.017	1.004	1.006					0.887 to 1.127 *		-	1.000	-
	Never Events	May-24	2	0	0	5	3	3	3	1	1	3	4	2		0	0	-	-	-
	21+ day Length of Stay	Jun-24	1,244	1,260	1,295	1,227	1,273	1,187	1,368	1,386	1,396	1,413	1,303	1,379	1,364	1,338	-	-	-	-
Workforce / HR (ICS total)	Staff in post	May-24	72,205	71,950	71,531	71,902	72,324	72,903	72,993	73,069	73,344	73,267	73,078	73,011		71,994	-	198,623	-	-
	Bank	May-24	4,633	5,036	5,372	5,386	5,425	5,662	5,246	5,739	5,881	6,086	5,230	5,262		3,246	-	16,424	-	-
	Agency	May-24	1,381	1,252	1,363	1,274	1,260	1,286	1,245	1,257	1,187	1,279	1,209	1,088		980.8	-	4,206	-	-
	Sickness	Apr-24	5.8%	5.6%	5.6%	5.6%	5.6%	5.6%	5.5%	5.5%	5.6%	5.6%	5.6%			6.2%	-	5.9%	5.04%	37/42
	Turnover	Mar-24	12.4%	12.3%	12.1%	12.0%	11.7%	11.5%	11.4%	11.2%	11.1%	11.2%				13.0%	-	12.3%	-	-

Note/s

* National average upper and lower control limits (UCL and LCL) for SHMI across all non-specialist trusts. This gives an indication of whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, for C&M was as expected when compared to the national baseline. This "rate" is different to the SHMI "banding" used for trusts on slide 8, therefore a comparison cannot be drawn between the two.
^ National figure is the latest ONS figure from 2022. local data is directly from GP systems. this has been reviewed against historic ONS data for LA's and the variation ranges from -0.9% to +5.9%
# Banding changed Aug 23 to reflect SOF bandings for providers. Green = no providers higher than expected, Amber = 1-2 providers higher than expected, Red = more than 2 providers higher than expected
~Banding based on SOF % against target not number of cases
** -From December 2023 this metric is now available at ICB level, previously this was only reported at Cancer Alliance level. historical data has been updated

2. ICB Aggregate Financial Position

NHS Cheshire and Merseyside

ICB Overall Financial Position:

Category	Metric	Latest period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Plan (£m)	Dir. Of Travel	FOT (£m) Plan	FOT (£m) Current	FOT (£m) Variance
Finance	Financial position £m (ICS) ACTUAL	May-24	48.2	-75.3	-103	-123.65	-128.2	-143.9	-80.8	-72.2	-79.8	-61.5	-98.7	-	-68.8	-49.7		0.0	N/A	0.0
	Financial position £ms (ICS) VARIANCE	May-24	-7.8	-20.5	-38.1	-49.9	-56.7	-70.0	-42.2	-40.8	-57.8	-50.5	-98.7	-	-19.1					
	Efficiencies £ms (ICS) ACTUAL	May-24	43.2	68.7	97.9	132.7	158.0	192.9	227.0	246.4	302.7	334.4	388.6	-	41.9	57.1		419.0	362.0	-57.0
	Efficiencies £ms (ICS) VARIANCE	May-24	-7.3	-8.2	-7.7	-4.6	-11.0	-12.2	-14.0	-30.7	56.3	-16.8	-0.1	-	-15.2					
	Capital £ms (ICS) ACTUAL	May-24	15.3	24	38.8	42.8	53.9	77.3	110.8	133.7	115.3	153.6	267.3	-	N/A	N/A		N/A	N/A	N/A
	Capital £ms (ICS) VARIANCE	May-24	2.6	6.3	6.0	16.8	41.2	17.8	2.8	7.1	49.7	51.8	1.1	-	N/A					

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

Category	Metric	Latest period	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Vs Target expenditure (Current)	Vs Target expenditure (Previous)	Dir. Of Travel
Finance	Mental Health Investment Standard met/not met (MHIS)	May-24	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	-	Yes	**Yes**	**Yes**	↔
	BCF achievement (Places achieving expenditure target)	May-24	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	9/9	-	9/9	**9/9**	n/a	↔

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Urgent care	4-hour A&E waiting time	Jun-24	58.4%	53.2%	59.2%	72.2%	71.0%	75.6%	77.6%	88.3%	-	90.9%		-	-	-	-	-	-	72.7%
	A&E 12 hour waits from arrival	Jun-24	23.6%	13.9%	16.4%	20.1%	19.0%	14.3%	17.3%	#	-	**	-	-	-	-	-	-	-	15.8%
	Adult G&A bed occupancy	Jun-24	98.3%	96.3%	95.2%	94.2%	97.2%	94.3%	97.8%	-	81.5%	55.7%	93.3%	88.1%					-	95.9%
	Percentage of beds occupied by patients no longer meeting the criteria to reside75.5	Jun-24	19.2%	no data	21.1%	16.1%	18.6%	27.8%	23.2%										-	21.3%
Planned care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	May-24	209	38	232	328	520	71	572	41	26	135	1	5	0	0	0	-	225	2,331
	Number of 52+ week RTT waits, of which children under 18 years.*NEW*	Jun-24	177	24	123	109	106	134	119	746	-	3	-	1						1,542
	Total incomplete Referral to Treatment (RTT) pathways	May-24	30,649	12,475	38,483	44,379	36,447	75,900	80,977	23,978	5,555	18,221	1,236	17,216	3,603	53	58	-	19,060	369,179
	Patients waiting more than 6 weeks for a diagnostic test	May-24	16.7%	13.2%	13.8%	4.4%	11.1%	2.6%	6.5%	12.9%	18.9%	9.2%	0.0%	0.9%	49.0%	0.0%	-	-	-	10.0%
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for	May-24	75.5%	67.6%	68.0%	73.2%	79.4%	64.1%	80.2%	100.0%	63.0%	35.6%	87.7%	81.0%	97.1%				-	71.8%
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	May-24	93.8%	100.0%	90.8%	93.9%	97.8%	87.7%	95.2%	100.0%	83.5%	93.9%	99.2%	100.0%	86.7%				-	95.4%
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	May-24	77.5%	71.3%	78.4%	76.9%	60.3%	74.7%	73.5%	100.0%	50.0%	63.4%	72.7%	100.0%	87.3%				-	71.4%
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	Mental Health service providers only														78.0%	78.0%	-	78.0%
Community	Percentage of 2-hour Urgent Community Response referrals where care was provided within 2 hours	May-24	78.0%	89.0%	88%	Community Service Providers only									88.0%	90.0%	81.0%	100%	84%	87.0%
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Indicates that provider did not meet to DQ criteria and is excluded from the analysis # Value supressed due to small numbers																			

3. Provider / Trust Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Providers																	
			Cheshire & Wirral Acute Trusts					Merseyside Acute Trusts		Specialist Trusts					Community & MH Trusts				Net OOA/ Other/ ICB	ICB *
			COCH	ECT	MCHT	WUTH	WHH	LUFT	MWL	AHCH	LHCH	LWH	TCCC	TWC	BCHC	WCHC	MCFT	CWP		
Quality & Safety	Still birth per 1,000 (rolling 12 months)	Mar-24	2.00	3.20	4.30	4.60	4.10	-	2.00	-	-	2.40	-	-						3.00
	Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation	12 months to Mar 24	(77 vs 56)	(11 vs 6)	(51 vs 31)	(109 vs 71)	(55 vs 36)	(160 vs 133)	(114 vs 85)	(5 vs 0)	(3 vs 2)	-	(12 vs 13)	(11 vs 6)						608
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Mar 24	(54 vs 35)	(46 vs 27)	(59 vs 24)	(90 vs 53)	(81 vs 54)	(258 vs 165)	(169 vs 121)	(9 vs 8)	(6 vs 6)	(8 vs 5)	(22 vs 10)	(10 vs 10)						812
	Summary Hospital-level Mortality Rate (SHMI) - Deaths associated with hospitalisation #	Feb-24	0.9650	1.2256	0.9112	1.0316	0.9320	0.9815	1.0673											1.006
	Never Events (rolling 12 month total)	12 Months to May 24	1	2	1	2	6	2	2	1	0	3	0	1	0	0	0	0	7***	28
	21+ day Length of Stay (ave per day)	Jun-24	114.9	55.5	122.2	139.8	125.8	459.2	271.5	2.3	18.0	0.0	26.2	32.6						1,364
Workforce / HR (Trust Figures)	Staff in post	May-24	4,448	2,378	4,899	5,896	4,215	14,015	9,448	4,143	1,808	1,618	1,875	1,460	1,404	1,514	10,173	3,719	-	73,011
	Bank	May-24	302	194	424	531	403	1,001	827	190	66	91	31	58	18	57	852	217	-	5,262
	Agency	May-24	33	62	103	71	29	147	263	15	7	9	13	3	39	7	200	88	-	1,088
	Sickness (via Ops Plan Monitoring Dashboard)	Apr-24	5.7%	5.5%	4.9%	5.8%	5.6%	6.3%	3.9%	5.6%	4.7%	6.1%	4.7%	5.5%	5.6%	6.3%	7.8%	6.6%	-	5.6%
	Turnover	Mar-24	11.5%	10.7%	10.0%	10.0%	10.1%	10.6%	10.1%	9.9%	12.6%	13.8%	13.5%	13.0%	10.2%	18.7%	12.0%	12.8%	-	11.2%
Finance	Overall Financial position Variance (£m)	May-24	0.15	0.12	-1.90	-1.33	-0.87	-5.94	-2.70	-0.68	-0.81	0.00	0.44	0.00	-0.45	0.00	0.04	0.00	-5.10	-19.10
	Efficiencies (Variance)	May-24	-1.37	-0.17	0.19	0.00	-0.17	-6.67	0.00	-0.35	-0.82	0.11	0.00	0.00	-0.20	-0.36	0.00	-0.81	-4.60	-15.22
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** The SHMI banding gives an indication for each non-specialist trust on whether the observed number of deaths in hospital, or within 30 days of discharge from hospital, was as expected when compared to the national baseline, as the UCL and LCL vary from trusts to trust. This "banding" is different to the "rate" used for the ICB on slide 5, therefore a comparison cannot be drawn between the two. *** Independent Providers / Other providers (1 at Alternative Futures - Weaver Lodge, 1 at Spire Hospital Liverpool, 1 at Spire Murrayfield,1 at Fairfield Independent Hospital and 2 at Isight Clinic – Southport, 1 at Spa Medica Wirral # Banding changed Aug 23 to reflect SOF rating by NHSE. 'As expected' rating is RAG rated Green, 'Higher than expected' is RAG rated Red.																			

4. Place Aggregate Position

NHS Cheshire and Merseyside

Category	Metric	Latest period	Sub ICB Place										ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside								
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton				
			East **	West **							South Sefton	S/port & Formby			
Urgent Care	4-hour A&E waiting time	Jun-24	57.0%	58.7%	41.8%	60.0%	77.9%	72.4%	77.5%	76.8%	65.2%		72.7%	73.4%	**78%** by Year end
	Ambulance category 2 mean response time	Jun-24	00:35:55		00:34:04	00:34:26	00:33:45	00:35:04	00:34:11	00:35:40	00:34:50		00:34:47		**00:30:00**
	A&E 12 hour waits from arrival	Jun-24	15.4%	20.5%	22.9%	18.5%	11.5%	21.7%	13.1%	21.6%	17.5%		15.8%	-	-
Planned Care	Incomplete (RTT) pathways (patients yet to start treatment) of 65 weeks or more	May-24	729		350	353	218	231	116	257	52	25	2,331	1,782	-
	Total incomplete Referral to Treatment (RTT) pathways	May-24	103,145		49,212	31,252	64,886	31,433	25,690	22,663	22,465	18,433	369,179	372,711	-
	Patients waiting more than 6 weeks for a diagnostic test	May-24	15.8%		5.2%	9.7%	3.3%	7.9%	4.3%	14.7%	8.8%	12.5%	10.0%	10.0%	**10%**
Cancer	2 month (62-day) wait from Urgent Suspected Cancer, Breast Symptomatic or Urgent Screening Referrals, or Consultant Upgrade, to First Definitive Treatment for Cancer	May-24	67.8%	73.0%	73.8%	80.6%	67.7%	82.4%	76.8%	77.0%	66.3%		71.8%	70.5%	**85.0%**
	1 Month (31-day) Wait from a Decision To Treat/Earliest Clinically Appropriate Date to First or Subsequent Treatment of Cancer	May-24	94.8%	93.0%	96.6%	94.5%	94.6%	97.5%	95.2%	95.7%	93.1%		95.4%	96.0%	**96.0%**
	Four Week (28 days) Wait from Urgent Referral to Patient Told they have Cancer, or Cancer is Definitively Excluded	May-24	75.5%	77.8%	76.3%	67.0%	73.9%	73.6%	73.9%	70.0%	72.7%		71.4%	71.2%	**75.0%**
Mental Health	Referrals on the Early Intervention in Psychosis (EIP) pathway seen In 2 weeks	Mar-24	79.0%		71.0%	100.0%	75.0%	75.0%	81.0%	79.0%	-	-	78.0%	60.0%	**60.0%**
	Access rate for Talking Therapies services	Mar-24	66.0%		72.0%	55.0%	45.0%	91.0%	51.0%	38.0%	58.3%		59.0%	100.0%	**100.0%**
	People with severe mental illness on the GP register receiving a full annual physical health check in the previous 12 months *NEW*	Q4 23/24	66.3%		64.7%	77.0%	65.9%	58.8%	36.4%	56.4%	20.7%		57.8%	-	**75.0%**
	Dementia Diagnosis Rate	May-24	67.3%		66.5%	72.6%	65.7%	70.2%	60.8%	67.5%	66.7%		67.2%	66.7%	**66.7%**
Learning Disabilities	Adult inpatients with a learning disability and/or autism (rounded to nearest 5)	Feb-24	30		5	5	25	10	10	5	10		100	-	-
	Number of AHCs carried out for persons aged 14 years or over on the QOF Learning Disability Register	Mar 24 YTD	3.0%		1.8%	2.6%	5.1%	2.6%	1.9%	5.1%	2.3%		3.1%	3.4%	**75%** by Year end
Primary Care	Number of General Practice appointments delivered against baseline (corresponding month same period last year)	May-24	106.3%	105.0%	107.6%	106.7%	105.7%	110.3%	111.4%	105.3%	108.1%		106.9%	-	-
	Percentage of appointments made with General Practice seen within two weeks *NEW*	Apr-24	88.2%		87.5%	85.0%	97.8%	89.5%	86.9%	83.7%	92.0%		88.9%	85.0%	**85.0%**
	The number of broad spectrum antibiotics as a percentage of the total number of antibiotics prescribed in primary care.	Mar-24	6.92%		8.80%	6.05%	7.48%	5.62%	6.66%	6.30%	8.09%		7.19%	10.0%	**10.0%**
	Total volume of antibiotic prescribing in primary care	Mar-24	0.928		1.112	0.937	1.042	1.152	1.192	1.077	1.102		1.033	0.871	**0.871**

Note/s

* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics

** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT.

4. Place Aggregate Position

NHS Cheshire and Merseyside

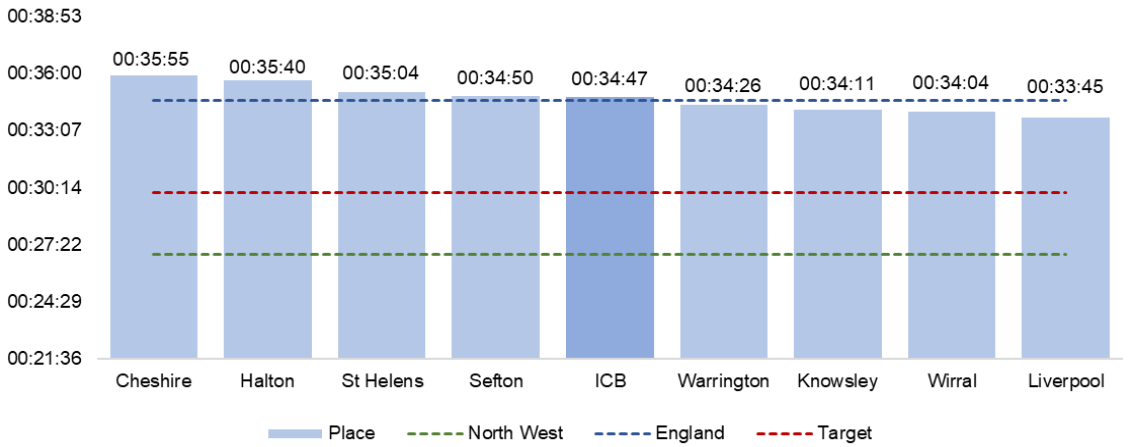
Category	Metric	Latest period	Sub ICB Place									ICB *	Local Trajectory	National Target
			Cheshire & Wirral				Merseyside							
			Cheshire		Wirral	Warrington	Liverpool	St Helens	Knowsley	Halton	Sefton			
			East **	West **							South Sefton	S/port & Formby		
Integrated care - BCF metrics ***	Unplanned hospitalisation for chronic ambulatory care sensitive conditions ***	Q4 23/24	160.5	221.2	198.4	96.6	388.2	237.5	315.6	213.3	207.6		226.5	-	-
	Percentage of people who are discharged from acute hospital to their usual place of residence ***	Mar-24	89.6%	90.3%	94.2%	94.5%	95.3%	94.0%	94.5%	94.7%	93.0%		93.3%	-	-
	Emergency hospital admissions due to falls in people aged 65 and over directly age standardised rate per 100,000 ***	Q4 23/24	376.9	403.6	335.1	213.3	632.1	413.0	549.4	382.2	417.9		413.7	-	-
Health Inequalities & Improvement	% of patients aged 18+, with GP recorded hypertension, with BP below appropriate treatment threshold	Q3 23/24	67.9%		64.4%	63.8%	67.0%	65.3%	61.0%	67.3%	64.2%		65.9%	77.0%	80.0%
	Children and young people accessing mental health services as % of LTP trajectory	Mar-24	82.6%		88.5%	92.3%	99.4%	123.6%	N/A	63.7%	81.1%		90.0%	-	-
	Smoking prevalence - Percentage of those reporting as 'current smoker' on GP systems.	Jun-24	10.9%	12.0%	14.2%	9.1%	16.5%	13.6%	17.1%	17.5%	13.5%		13.7%	12%	12%
Quality & Safety	Healthcare Acquired Infections: Clostridium Difficile - Place aggregation	12 months to Mar 24	(232 Vs 156)		(165 Vs 131)	(73 Vs 45)	(177 Vs 172)	(81 Vs 47)	(56 Vs 47)	(42 Vs 33)	(104 vs 100)		608	439	439
	Healthcare Acquired Infections: E.Coli (Healthcare associated)	12 months to Mar 24	(625 Vs 498)		(270 Vs 178)	(188 Vs 130)	(454 Vs 346)	(167 Vs 137)	(144 Vs 110)	(116 Vs 89)	(260 Vs 212)		812	518	518
Finance	Overall Financial position Variance (£m)	May-24	-0.9	-0.3	-0.5	-0.4	-0.3	-0.4	-0.2	-0.4	-1.5		-0.2	0.0	0.0
	Efficiencies (Variance)	May-24	-0.5	-0.6	-0.2	-0.4	-0.2	-0.5	-0.3	-0.3	-0.2		0.0	0.0	0.0
	Mental Health Investment Standard met/not met (MHIS)	May-24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	Yes	Yes
	BCF achievement (Places achieving expenditure target)	May-24	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		N/A	9/9	9/9
Note/s	* The latest period for ICB performance may be different to that of the trusts' due to variances in processing data at different levels. Please see slides 4 and 5 for the ICB's latest position on the above metrics ** Where available Cheshire East Place and Cheshire West Place data is split based on historic activity at COCH, ECT and MCHT. *** Local trajectories set by Place as part of their BCF submissions to NHSE, therefore RAG rating will vary for Places with lower/higher trajectories **** In order to report performance at Place the indicator "% of CYP accessing services following a referral" has been used - this is different to the NHS Oversight Framework indicator used in the ICB table														

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Ambulance category 2 mean response time

Latest ICB Performance (Jun-24)	00:34:47	National Ranking	n/a
Place Breakdown (Jun-24)			Deteriorated



Issue
- June performance was challenged and showed a further deterioration from May.
- Performance was worse than both the North West and National positions.

Action
- On site improvement support via AQUA is ongoing at Countess of Chester, and MWL (Whiston).
- Acute trusts have increased their focus on ambulance handover times to avoid holding patients on vehicles outside hospital and to ensure timely handover.
- The Cheshire & Merseyside Ambulance improvement at scale workstream has been set up to review and support ambulance improvement work and to track weekly data.

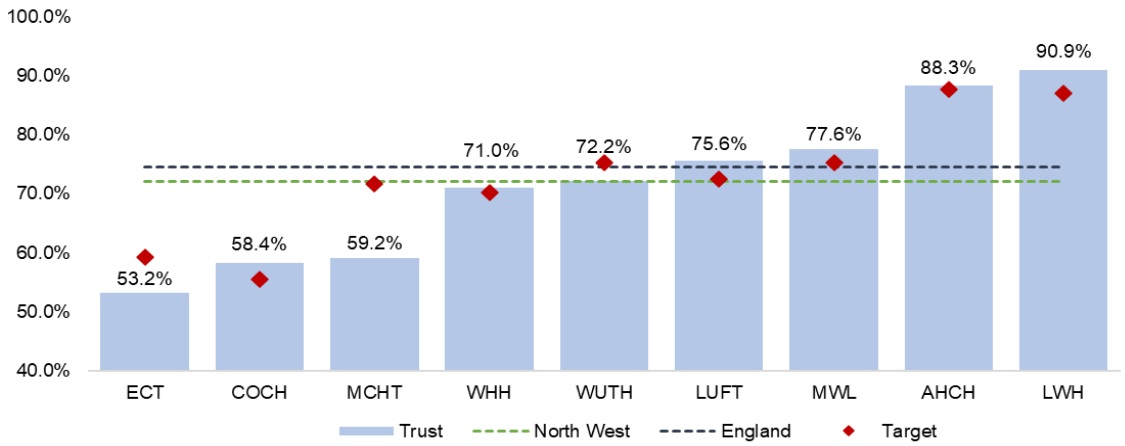
Delivery
- The Ambulance improvement at scale workstream is committed to supporting trusts to achieve timely handover to release NWAS crews to facilitate achievement of the 30-minute Cat 2 standard
- Work is ongoing to develop jointly owned improvement plans between each trust and NWAS

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

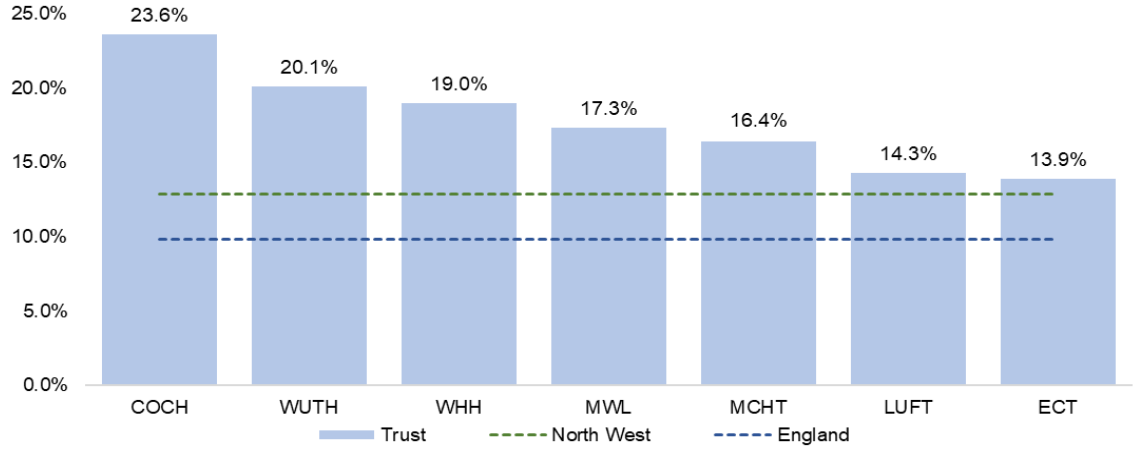
A&E 4 hour waits from arrival

Latest ICB Performance (Jun-24)	72.7%	National Ranking	30/42
Provider Breakdown (Jun-24)			Improved



A&E 12 hour waits from arrival

Latest ICB Performance Jun-24)	15.8%	National Ranking	38/42
Provider Breakdown (Jun-24)			Improved



Issue

- Cheshire and Merseyside performance is 0.7% below the in-year trajectory that has been set to achieve the 78% March 2025 ambition.
- 15.8% of Cheshire & Merseyside A&E patients were delayed over 12 hours compared to the England average of 9.8%.

Action

- Updated Directory of Services (DOS) for NWAS and PTS to ensure consistent service naming convention and referral routes across all 9 Places in C&M to facilitate clearer pathways. This will also support ambulance improvement in mapping
- C&M is working with colleagues across the North West to scope a Single Point of Access (SPoA) / Care coordination approach to enable patients to access the right services rather than defaulting to ED.
- Single model / best practice framework for UCR and Falls to reduce variation
- Trust actions are focused on direct access pathways to enable NWAS conveyance to SDEC and other UEC services, along with direct referral from NWAS into UCR.
- A reduction in 12-hour time in department is dependent upon overall flow from ED to specialty wards. There is a focus on reducing in-hospital Length of Stay (LOS) and No Criteria to Reside (NCTR) within the LOS and acute discharge UEC recovery workstreams.
- WUTH, LUHFT and WHH continue to test continuous flow models to increase flow from ED on to AMU/wards.
- ECT, MCHT & COCH performance is particularly challenged. The Cheshire UEC Recovery programme focuses on 3 areas: a) Admission avoidance e.g. Virtual Wards, alternatives to conveyance; b) hospital inpatient flow e.g. increasing utilisation of SDEC and c) discharge e.g. focusing on reducing the time between decision and actual discharge

Delivery

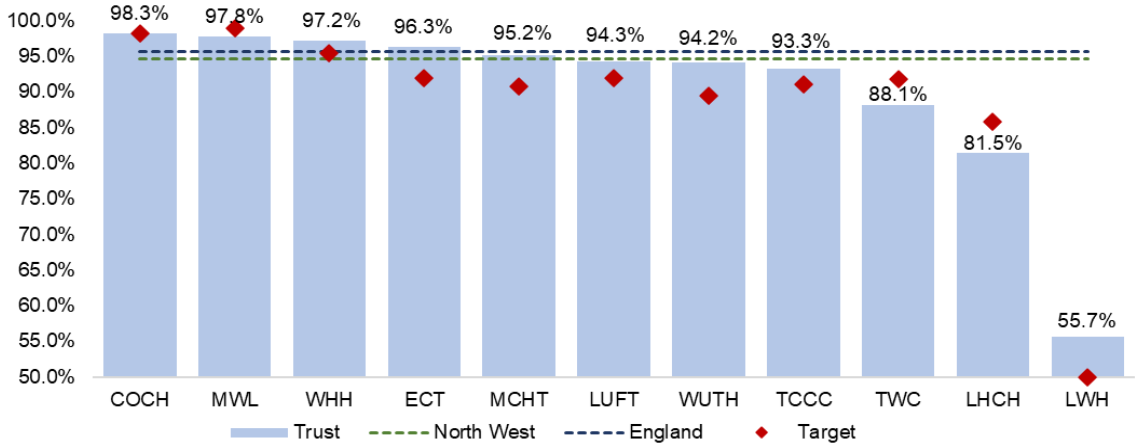
- C&M is adopting a recovery approach to UEC in 2024/25 and is committed to achieving 78% by the end of 2024/25 and a reduction in 12 hour waits

5. Exception Report – Urgent Care

NHS Cheshire and Merseyside

Adult G&A bed occupancy

Latest ICB Performance (Jun-24)	95.9%	National Ranking	28/42
Provider Breakdown (Jun-24)			Deteriorated



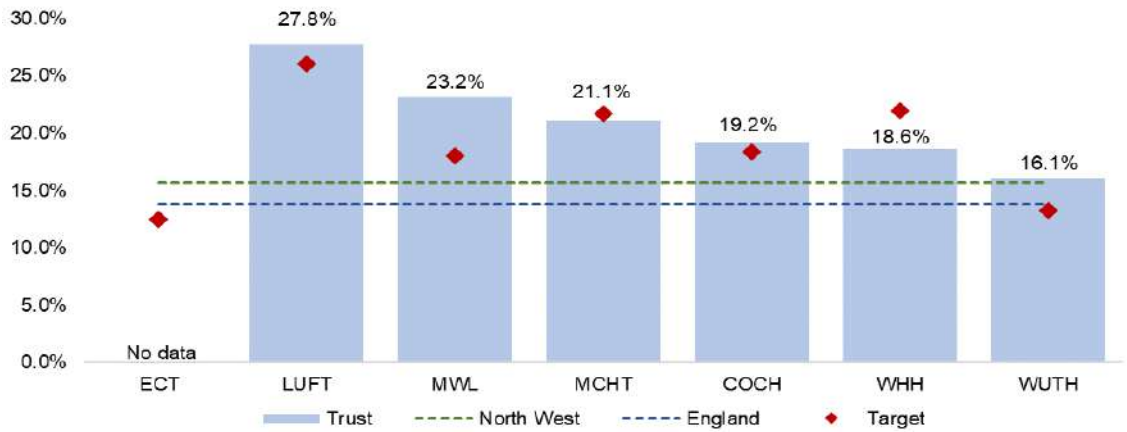
Issue
- General and acute (G&A) bed occupancy is consistently high across acute trusts in C&M.
- Long length of stay numbers are a key driver of high occupancy.

Action
- The Cheshire and Merseyside UEC Recovery Programme will focus on in hospital flow within the acute Length of stay workstream.
- C&M are preparing for Super MADE event to span the August bank holiday (7-day event)

Delivery
- Within the recovery approach to UEC in 2024/25, the ICB is committed to a reduction in bed occupancy as a key metric.

No Criteria To Reside (NCTR)

Latest ICB Performance (Jun-24)	21.3%	National Ranking	41/42
Provider Breakdown (Jun-24)			Improved



Issue
- NCTR is at 21.3%, higher than England (13.8%) and North West (15.7%).

Action
- The Cheshire and Merseyside UEC Recovery Programme for 2024/25 has been aligned to 5 acute catchment areas across Wirral, Liverpool, Mersey & West Lancs, Warrington & Halton and Cheshire.
- Within this programme of work, there is an acute length of stay workstream which will support improvement approaches aimed at reducing LoS. This is expected to include a refresh of weekly Long Length of stay reviews at every trust.
- ECIST are supporting LUHFT with a Trust wide approach to reducing LoS/NCTR and preventing deconditioning and reducing length of stay

Delivery
- Within the recovery approach to UEC in 2024/25, the ICB is committed to a reduction in long LOS and NCTR as a key metric.

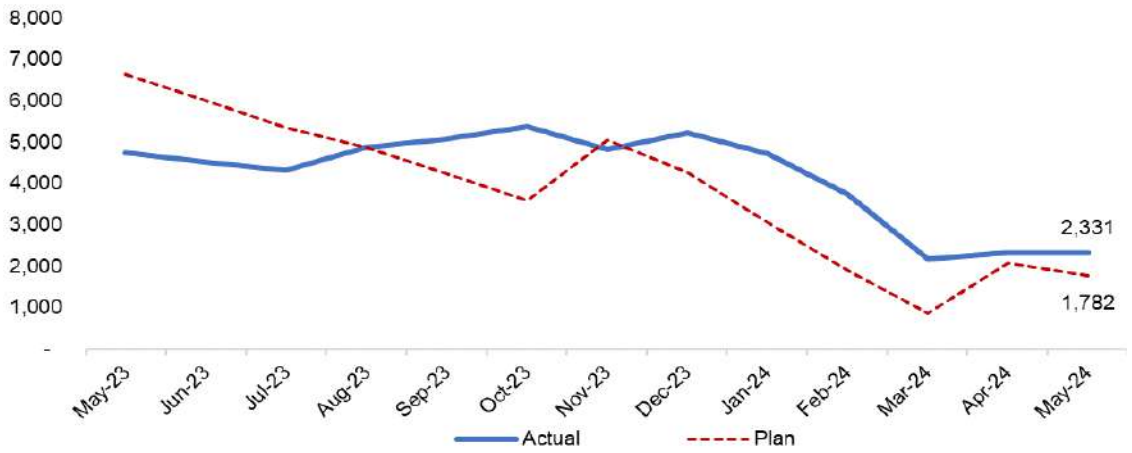
5. Exception Report – Planned Care

Cheshire and Merseyside

ICB incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (May-24)	2,331	National Ranking	n/a

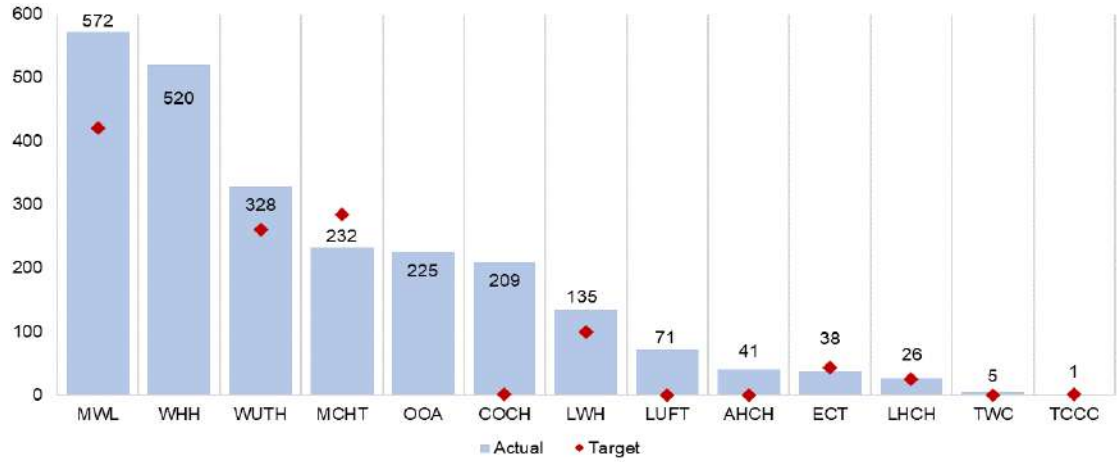
ICB Trend (May-24) — Deteriorated



Trust incomplete RTT pathways of 65 weeks or more

Latest ICB Performance (May-24)	2,331	National Ranking	n/a

Provider Breakdown (May-24) — Deteriorated



Issue
- There are challenges for several trusts to clear 65 week wait patients by end of September, given patient choice and complexity issues.
- As of 07th July, 2,300 patients had already breached 65 weeks and there are 13,862 patients that could breach if not treated by the end of September.

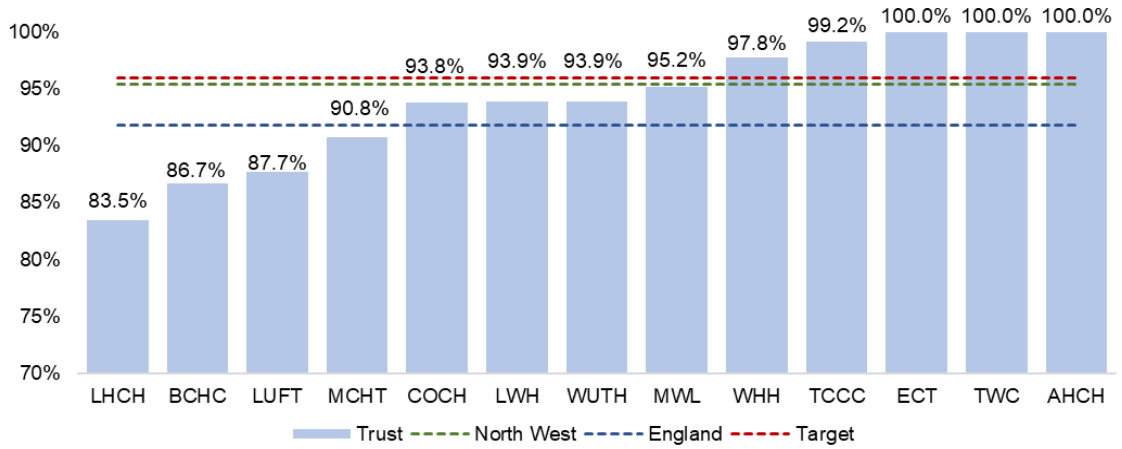
Action
- The six-week average clearance rate is 2,243 which is above the required clearance rate of approx. 1,694 per week.
- 58 breaches of over 78 weeks were reported for the end of June, of these, only 2 were capacity breaches.
- 62 breaches of over 78 weeks are predicted by the end of July, of which 26 are choice (14 have a confirmed TCI), 34 are complex (20 have a confirmed TCI), and 2 corneal graft patients.
- Continued focus on levelling out waiting times, using mutual aid, and use of our shared facilities such as elective surgical hubs.
- Balancing use of insourcing and outsourcing to support waiting list challenges, with the need to reduce unnecessary spend on external support.
- Managing key challenges for Gynae, Ear Nose and Throat (ENT), Dermatology, Trauma & Orthopaedics and Colorectal.

Delivery
- There is a continued focus on clearance of all 65 week waits by September.
- Major focus on 78-week clearance to eradicate these long waits.

5. Exception Report – Cancer Care

NHS Cheshire and Merseyside

Patients commencing first definitive treatment within 31 days of a decision treat			
Latest ICB Performance (May-24)	95.4%	National Ranking	8/42
Provider Breakdown (May-24)			Improved



Issue

- C&M is not yet achieving the 96% 31-day combined standard required however, the figure of 95.4% is 3rd amongst Cancer Alliances and 8th amongst ICBs.

Action

- A performance management forum has been agreed at CMCA Steering group with 28, 62, and 31-day standards as the sole focus. Pathway analyser tools will be utilised in line with planning guidance to understand any blockers to surgical treatments in C&M.
- The C&M performance forum has identified specific areas of work to improve 31-day performance.
- A short-term SBAR is being developed with the providers holding 90% of surgical breaches for additional capacity funding and a longer-term plan requested.
- NB: C&M 31-day performance was better than England by 3.6% in May 24 and improved by 3.6% from April 24. This remains excellent performance for C&M despite being off-target with plans to improve in place.

Delivery

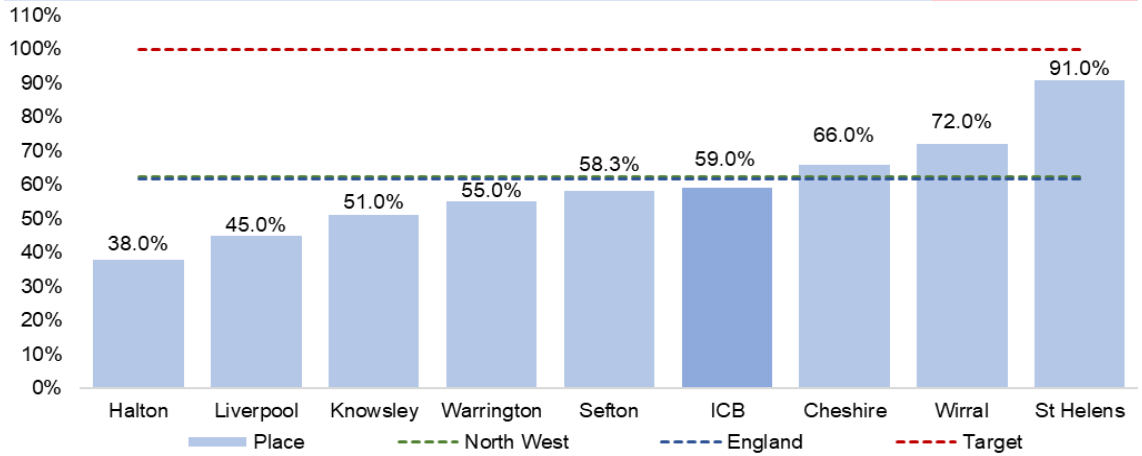
- C&M expects to meet the 96% performance standard by the end of Q4 24/25 because the specific areas of 31-day breaches are identified and are targeted with improvement plans.

5. Exception Report – Mental Health

Cheshire and Merseyside

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

Latest ICB Performance (Mar-24)	59.0%	National Ranking	25/42
Place Breakdown (Mar-24)			Deteriorated



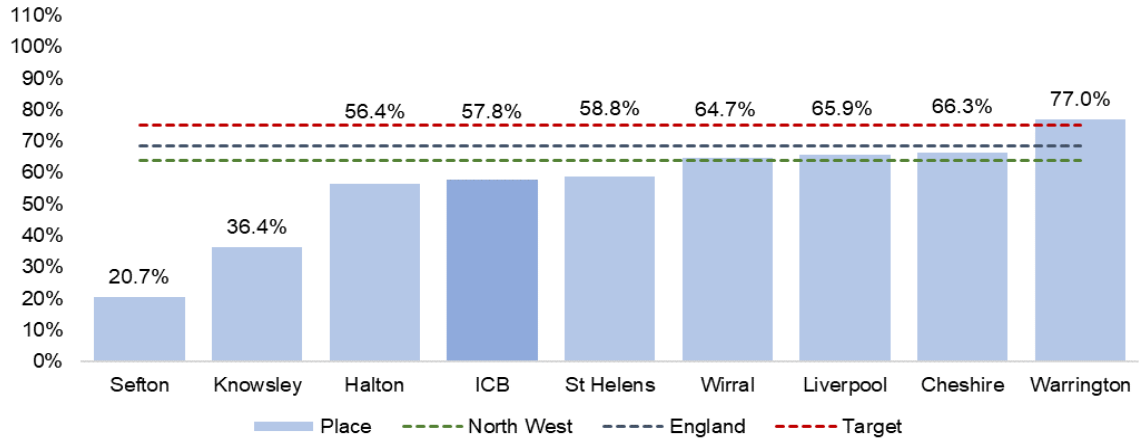
Issue
- Talking Therapies (TT) is not achieving the access ambition set out in the Long-Term Plan.
- ICB level performance in March has deteriorated from 66% to 59% of the LTP trajectory, which is lower than the national achievement of 62%. St Helens is the only place to have met their LTP trajectory in some months, but performance has reduced from 108% of trajectory to 91%.

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

Delivery
- C&M has a recovery access target of 72,724 based on a reprofiled national trajectory.
- Important to note that the Talking Therapies metrics have changed from Q1 24/25. There has been national recognition that there needs to be a focus on quality rather than access.

People with SMI receiving a full annual physical health check

Latest ICB Performance (Q4-23/24)	57.8%	National Ranking	n/a
Place Breakdown (Q4 – 23/24)			*NEW*



Issue
- C&M is not achieving the minimum 60% target for all 6 health checks. Changes to SMI health check QOF payments for GPs may have a further impact on achieving this target.

Action
- C&M workshop planned 11 July with Place leads and MH Primary Care Leads to review progress and determine next steps for C&M wide and local actions to support increase in checks, particularly for the 3 lowest performing areas.
- New dashboard for SMI checks under development to support streamlined and more focussed access to local data.
- Place leads are holding local meetings to support delivery and improvement.

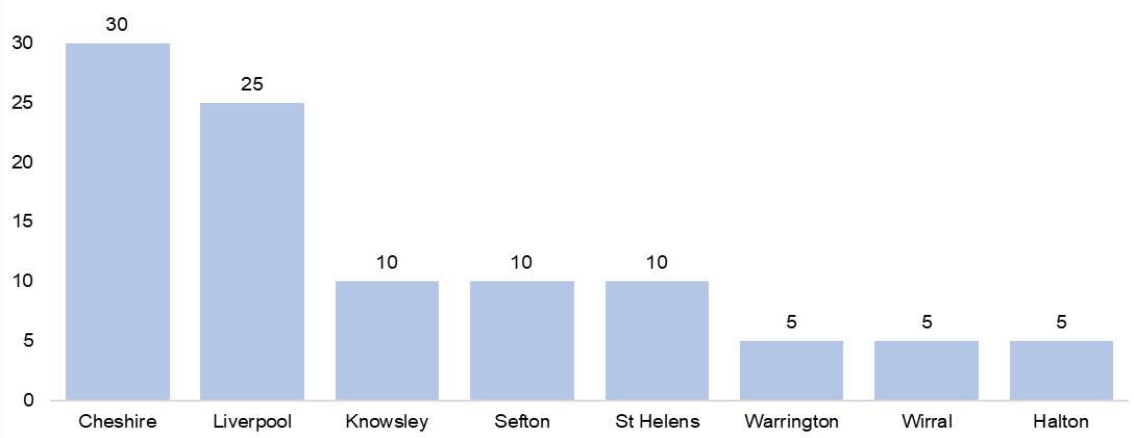
Delivery
- Four of the nine places are not meeting the minimum 60% national target for SMI Health checks . Focus on these areas is underway with the development of improvement plans.

5. Exception Report – Learning Disabilities

Cheshire and Merseyside

Adult inpatients with a learning disability and/or autism

Latest ICB Performance (Apr-24)	95 *	National Ranking	34/42
Place Breakdown (Apr-24)			No change



Issue
- There are currently 93 adult inpatients, of which 49 are Specialised Commissioning (Spec Comm) inpatients commissioned by NHSE, and 44 ICB commissioned. The target identified for C&M (ICB and Spec Comm) is 88 or fewer by the end of Q1 2024.

Action
- The Transforming Care Partnership (TCP) has scrutinised those clinically ready for discharge and there have been 6 adult discharges in Q1 to date. Of those 93 adults there are there are currently 21 individuals currently on Section 17 Leave. We expect that a number of these will be discharged in Q2.
- Data quality checks to be completed on Assuring Transformation to ensure accuracy.
- Weekly C&M system calls ongoing to address Delayed Discharges.
- Housing Lead continues to work to find voids which can accommodate delayed discharges, and is meeting with North West Housing Lead and analysts to map those individuals clinically ready for discharge with housing difficulties, with the C&M Housing Strategy in development.

Delivery
- C&M ICB and NHSE aim to reduce the number of inpatients, where appropriate, by the end of Q4 2024/25, where the target is 60.

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

Annual Health Checks for persons aged 14 or over on the LD register

Latest ICB Performance (Apr-24)	3.1% *	National Ranking	30/42
Place Breakdown (Apr-24) **YTD performance (Apr-24 target: 3.4%)*			*NEW*

Issue
- To continue to deliver annual health checks to people in Cheshire & Merseyside

Action
- NW AHC Working Group – current areas of focus is improving awareness of LD AHCs - CYP and parents/carers.
- Across all areas of C&M there is a focus on underperforming GP practices in 2023-24 and those LD patients who have not received an LD AHC in the previous 12 months .
- St Helens: We received 64 enquiries from parents/carers and had been able to add 30 young people between the ages of 12 & 17 to the LD registers. This is almost double the number of young people previously recorded. They had all been invited for their Annual Health Check. A survey was sent out asking for feedback.
- St Helens Bowel Screening Pilot 77% uptake which is above the Regional average, social prescribers have access to all easy read materials and are able to offer support where needed. The LD Digital flag will now form part of the information recorded on the NHS spine.

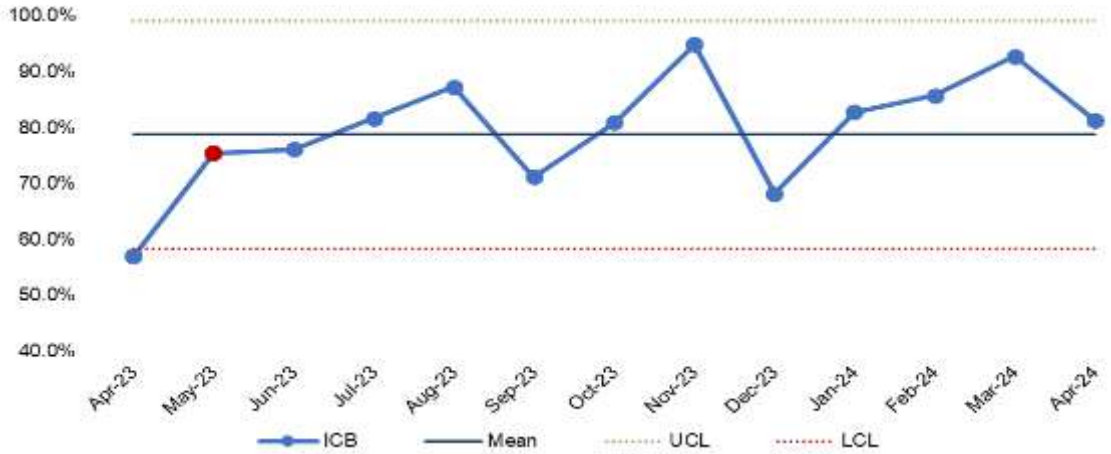
Delivery
- Delivery profile of LD AHCs has been higher in Q3 and Q4.
- To meet the agreed target of 75% across Cheshire & Merseyside at year end

5. Exception Report – Primary Care

NHS Cheshire and Merseyside

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

Latest ICB Performance (Apr-24)	81.3%	National Ranking	38/42
ICB Trend (Apr-24)	Deteriorated		



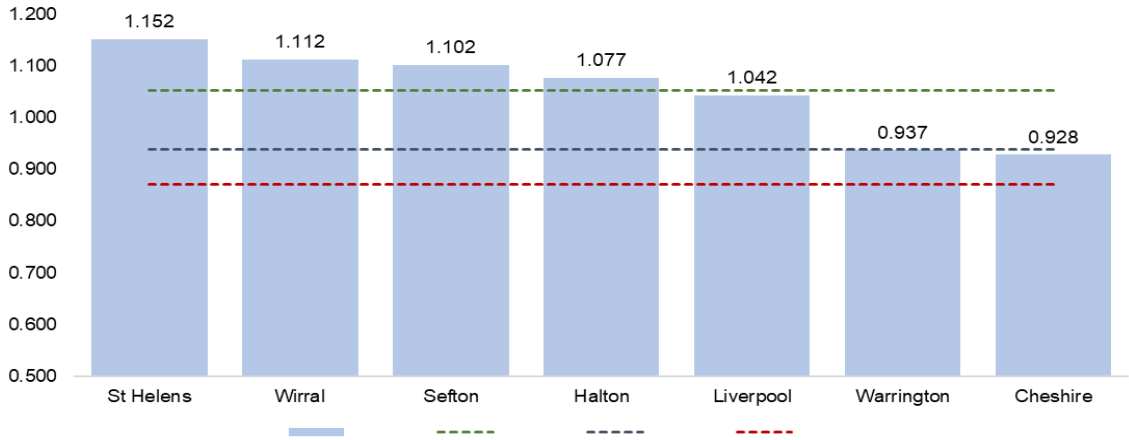
Issue
- C&M does not currently meet the 100% target

Action
- Continue to focus delivery on areas of highest need where there is poor oral health.
- Support contractors to continue to deliver and support those who can do more activity
- Implementation of local ICB Dental Improvement Plan.
- Contract management of providers follows national contract management policy and is overseen by Dental Operational Group.
- Urgent dental care pathways and provision remain in place across C&M.

Delivery
- Fluctuations in delivery of target are expected throughout the year and based on previous year's performance.
- 143 practices signed up as of 4/7/24 to the New Patient Premium payment scheme as part of national dental recovery plan.
- 63 practices have signed up to the ICB additional routine access scheme.

Total volume of antibiotic prescribing in primary care

Latest ICB Performance (Mar-24)	1.033	National Ranking	33/42
Place Breakdown (Mar-24)	Improved		



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

Action
- All Places working with primary care on the cascading of education, public communication work, reviewing prescribing data and decisions in relation to antibiotic prescribing.
- C&M antibiotic prescribing data dashboard is being utilised to support targeted work.
- C&M Antimicrobial Stewardship Working Group and C&M Anti-Infective APG Subgroup is in place to harmonise approach to antimicrobial stewardship.
- A new dashboard tracking admissions related to Urinary Tract Infections being used to track impact of specific work related to hydration across C&M.
- Development of systems for Assessment of UTI in a Care Home to allow timely triage of care home residents with a suspected UTI.
- AMR 5-year national action plan (NAP) launched across C&M with place MMT supporting prescribers on two of the four themes included in the plan. Theme 1 - Reducing the need for, and unintentional exposure to, antimicrobials and Theme 2 Optimising the use of antimicrobials.

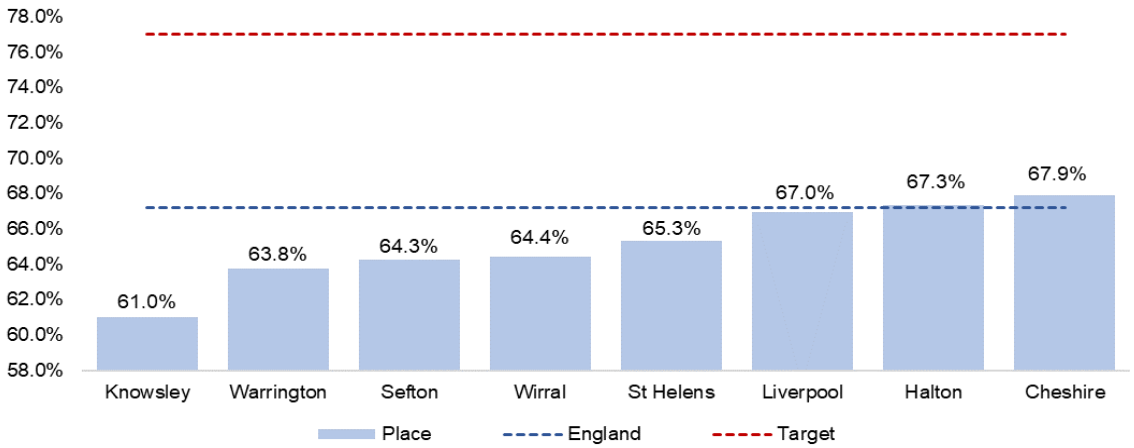
Delivery
- Improvement in Q1 of 2024/25 is expected, assuming the current levels of infection remain static. Further analysis will be undertaken on Q1 2024/25 data to identify if there are particular areas to focus on additional to the planned work happening across C&M.

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

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

Latest ICB Performance (Q3-23)	65.9%	National Ranking	30/42
Place Breakdown (Q3-23)			Improved



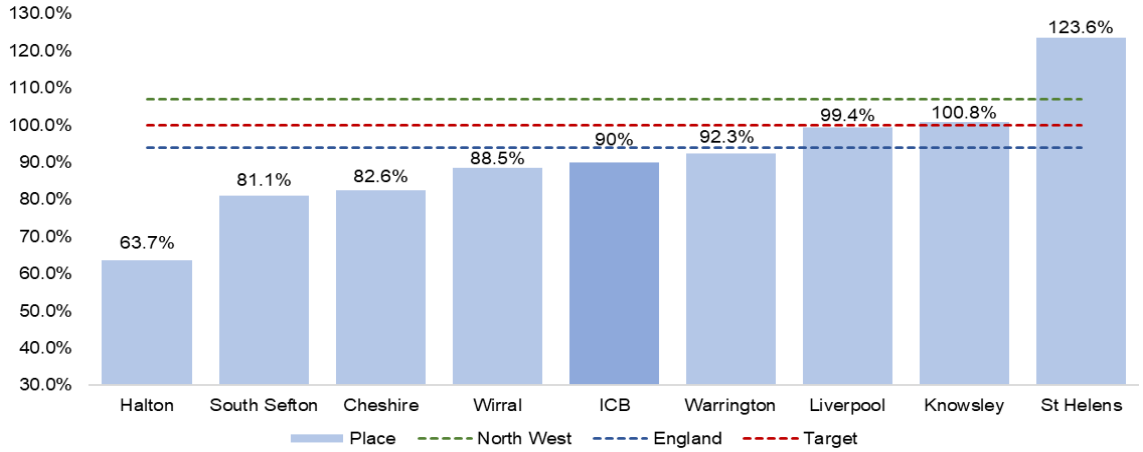
Issue
- Considerable variation in C&M, reductions in capacity & funding have affected performance.

Action
- New ICB Population Health leadership capacity identified and the new lead will take up post in mid-July
- Hosting arrangements for the programme manager role have been agreed locally with Liverpool Heart and Chest Hospital
- Strategic conversations taking place regarding transformation funded CVD-P work e.g. Familial Hypercholesteremia service
- National bid funding awarded for C&M level hypertension case finding pilots in optometry settings, which should help boost our treatment targets
- Feedback requested at the C&M Joint Cardiac Board with regards to local NHS health checks. Exploration with clinical leads to be arranged.

Delivery
- CVD-Prevention Board to be re-established once this resource is in place, which will help drive local Place CVD plans

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

Latest ICB Performance (Mar-24)	90.0% *	National Ranking	25/42
Place Breakdown (Mar-24) **			Deteriorated



Issue
- The CYP Access target is 37,590 to be achieved by 31st March 24 (LTP Period), the national NHS Mental Health Service Data Set (MHSDS) indicates that the C&M CYP Access target is not currently being met.

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

Delivery
- Overall, access levels for C&M have decreased from 91% to 90% of the LTP trajectory this month. However, Knowsley, Liverpool and St Helens are all achieving their place level targets. The other 6 places are delivering between 64% and 92% of trajectory.

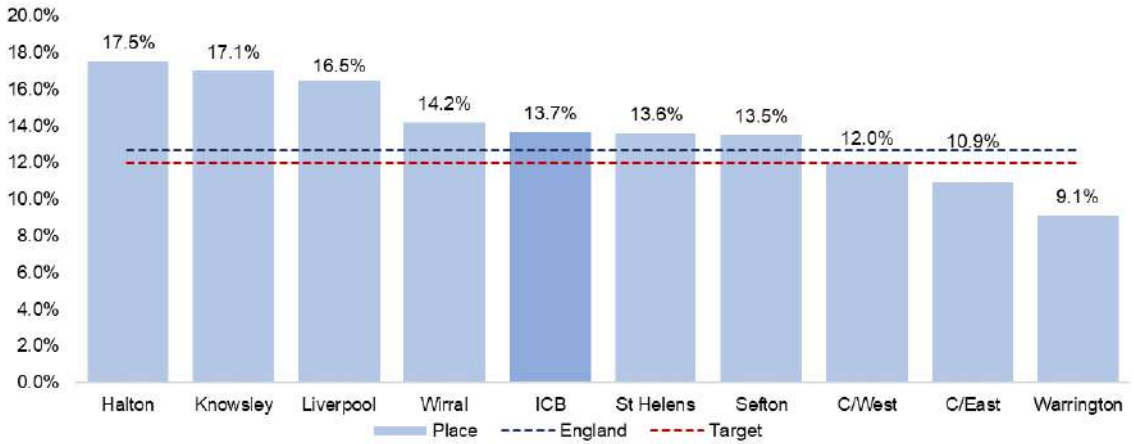
** ICB data uses number treated vs target*
*** Place data uses number treated vs no. referred*

5. Exception Report – Health Inequalities & Improvement

NHS Cheshire and Merseyside

Percentage of those reporting as 'current smoker' on GP systems

Latest ICB Performance (Jun-24)	13.7%	National Ranking	n/a
Place Breakdown (Jun-24)			Improved



Issue

- Radically reducing smoking remains the single greatest opportunity to reduce health inequalities and improve healthy life expectancy.

Action

- Achieved agreement on system wide Tobacco control plan approach for All Together Smokefree and developing a 3–5-year programme. A health inequalities and population health at scale paper is due to go to July HCP proposing investment in this area.
- Recently published annual data showed Cheshire and Merseyside Smoking at Time of Delivery (SATOD) rate reduced from 10% in 2022/23 to 8.2% n in 2023/24 compared to England rates of 8.8% and 7.4% for the same periods.
- The C&M Q4 data is 7.2% versus 6.9% for England - a closing of the national inequalities gap.

Delivery

- The SATOD success follows the move to implement an evidence based, more intensive model of support for smokefree pregnancies delivered within maternity services rather than through community stop smoking services. This is now in place across the CM Maternity System.

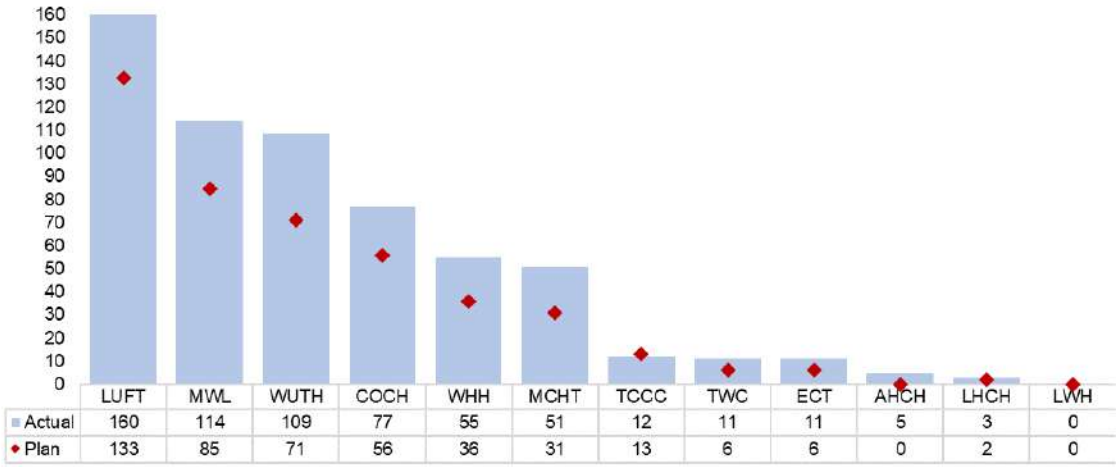
5. Exception Report – Quality

NHS Cheshire and Merseyside

Healthcare Acquired Infections: Clostridium Difficile - Provider aggregation

Latest ICB Performance (12 months to Mar-24)	608	National Ranking	23/42

Provider Breakdown (rolling 12 months to Mar-24)

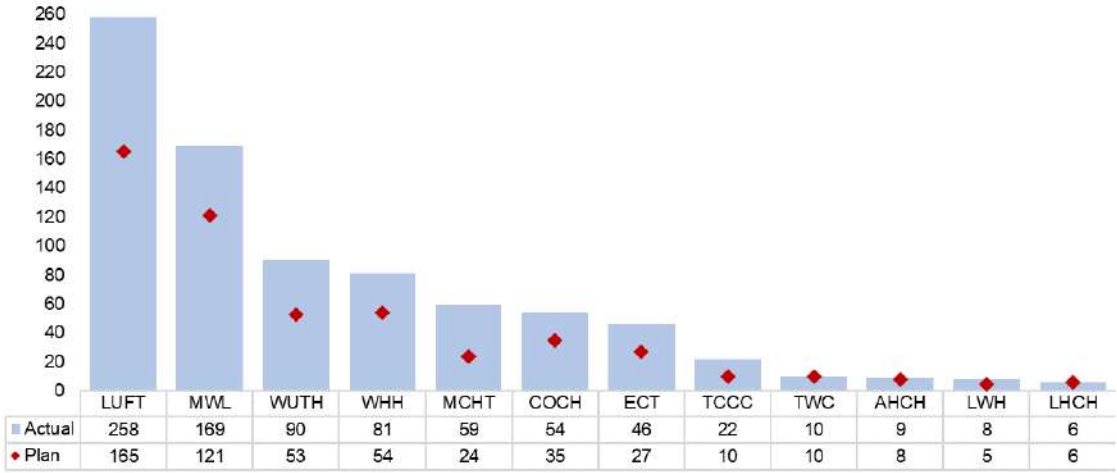


	LUFT	MWL	WUTH	COCH	WHH	MCHT	TCCC	TWC	ECT	AHCH	LHCH	LWH
Actual	160	114	109	77	55	51	12	11	11	5	3	0
Plan	133	85	71	56	36	31	13	6	6	0	2	0

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

Latest ICB Performance (12 months to Mar-24)	812	National Ranking	38/42

Provider Breakdown (rolling 12 months to Mar-24)



	LUFT	MWL	WUTH	WHH	MCHT	COCH	ECT	TCCC	TWC	AHCH	LWH	LHCH
Actual	258	169	90	81	59	54	46	22	10	9	8	6
Plan	165	121	53	54	24	35	27	10	10	8	5	6

Issue
- Majority of C&M trusts are above agreed trajectories for these HCAI.

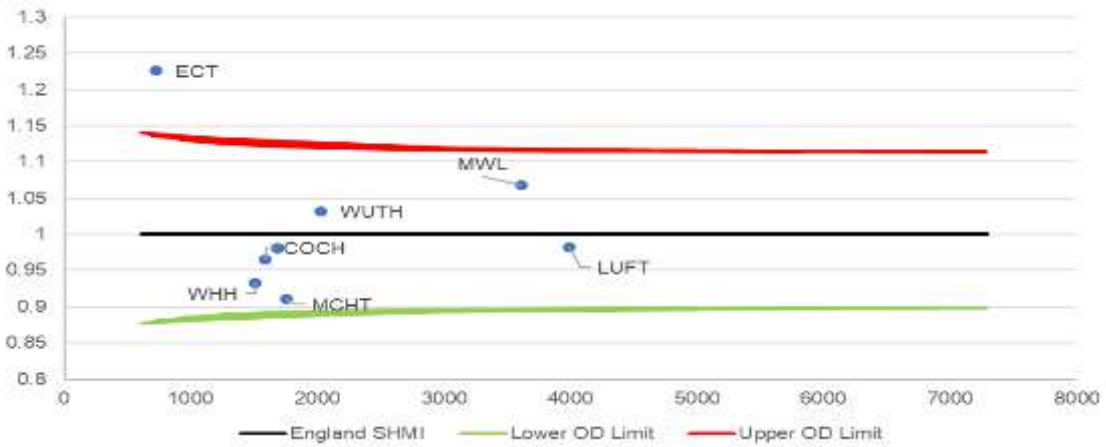
Action
- All place-based teams are receiving assurance from those Trusts identified as outliers on actions being taken to improve.
- Performance in relation to HCAI is a feature of provider oversight where appropriate.
- Post infection reviews are undertaken on each case to identify themes and trends and opportunities for learning.
- A review of IPC related governance has been undertaken, the findings are under review.

Delivery
- Performance is monitored monthly via place-based reporting into Quality & Performance Committee and improvement plans assessed for efficacy and impact by place-based teams.
- Awaiting publication of the 2024/25 HCAI thresholds.

5. Exception Report – Quality

Summary Hospital-level Mortality Indicator (SHMI)

Latest ICB Performance (Feb-24)	1.006	National Ranking	n/a
Provider Breakdown (Feb-24)*			Improved



Issue
- C&M trusts are within expected tolerances except ECT, with a current value of 1.2256 against the upper control limit for ECT of 1.1445.

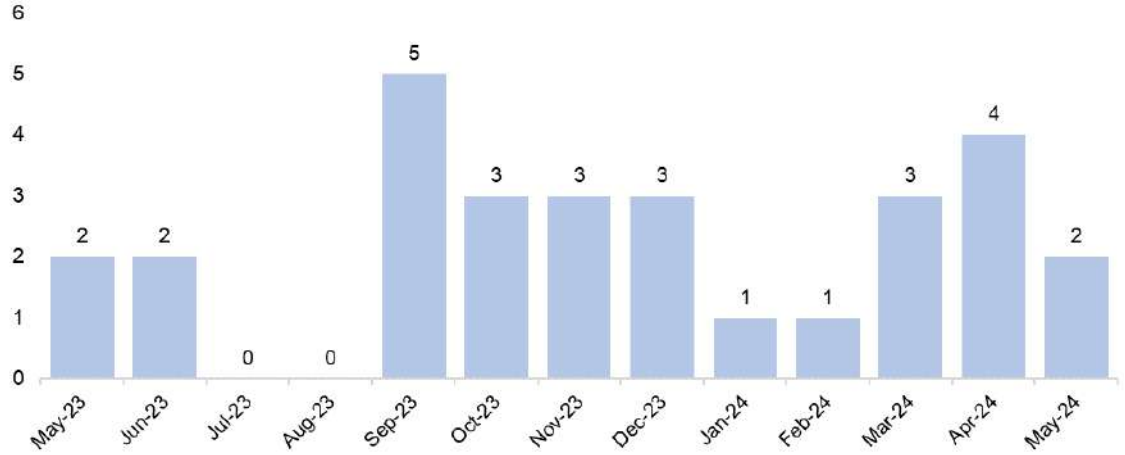
Action (ECT only)
- The trust has moved to quality improvement phase of quality governance/escalation.
- The ICB continues to work closely with the Trust to review positive progress and ensure the optimal support is in place to bring about best patient outcomes.
- Following the meeting of ICB and trust execs and board, further developed improvement plans and support have been agreed and a detailed timetable of support and assurance created.
- Early indication of improved rates of hospital acquired infection will not be reflected in SHMI, but monthly reporting scrutinised by trust and ICB MDs.

Delivery
- Measurable improvement in CRAB data by Q4 2023/24.

** OD, overdispersion, adds additional variance to the standard upper and lower control limits*

Never Events

Latest ICB Performance (May-24)	2	National Ranking	n/a
ICB Trend (May-24)			Improved



Issue
- C&M have had 29 Never Events over the last 12 month rolling period, which is consistent with the number in the previous year.

Action/s
- A Never Event summit was held in May bringing together every trust and lead by Aqua with expertise in human factors to further equip our organizations to robustly scrutinize their internal approaches to patient safety, the reduction of risk, the investigation of incidents and the construction and monitoring of resulting action plans. The event was well received and a patient safety forum for the system will be developed.

Delivery
- Improvement made in Q4 (5 in total)

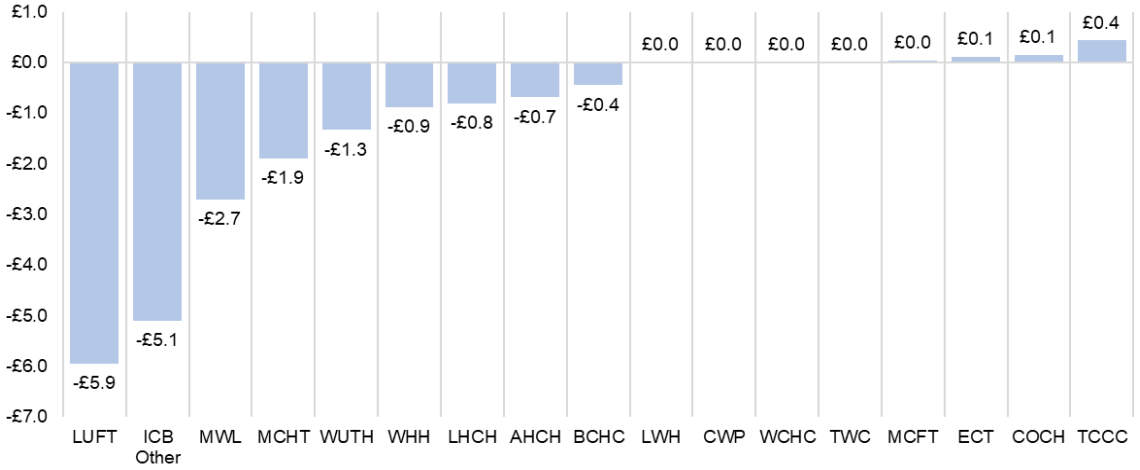
5. Exception Report – Finance

NHS Cheshire and Merseyside

Overall Financial position Variance (£m)

Latest ICB Performance (May-24)	-19.1	National Ranking	n/a

Provider Breakdown (May-24)



Issue

- The ICS reports a YTD deficit of £68.8m as at month 2 (May-24) which represents a £19.1m adverse variance to plan.
- The ICB adverse variance YTD (£5.1m) is almost exclusively driven by pressures in CHC and MH packages of care where growth continues to outstrip national funding assumptions and under achievement of efficiencies plan is based.
- The Provider adverse variance (£13.9m) is driven primarily by a shortfall on CIP delivery where approximately 50% of plans remain at the “opportunity/high risk” stage and further work is ongoing to develop delivery plans.

Action

- Recovery plan in development for key workstreams across the system.

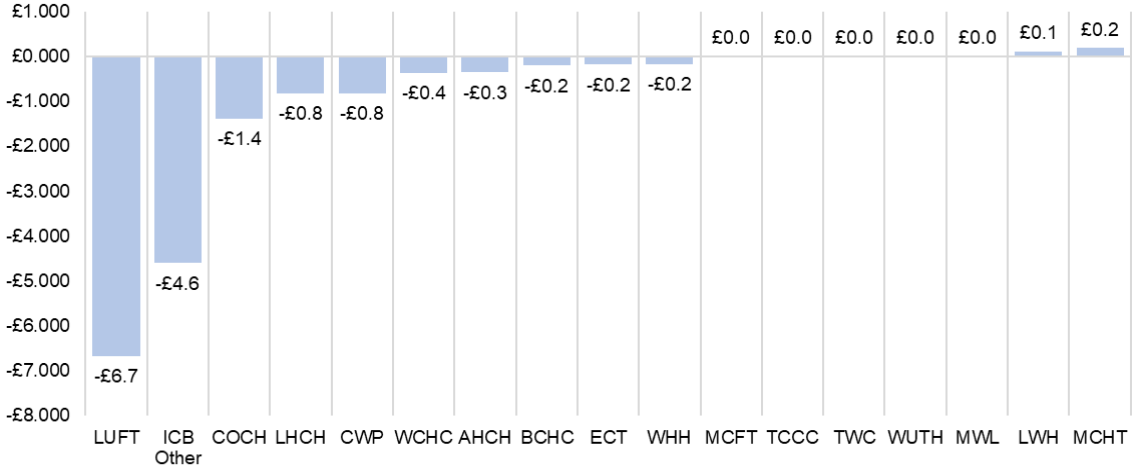
Delivery

- NHSE did not require systems to report a forecast or net risks at month 2, however the system recognises the significant financial challenge for 2024/25 which will be quantified and reported at month 3.

Efficiencies Variance (£m)

Latest ICB Performance (May-24)	-15.2	National Ranking	n/a

Provider Breakdown (May-24)



Issue

- ICS efficiencies - £41.9m achieved as at M2 – a £15.2m shortfall against the plan.
- Currently a £57m shortfall on delivery is being forecast – which is a contributing factor to the early year to date overspend against budget
- Continued concern over the level of recurrent QIPP delivery. Recurrent plans are forecast to slip by £86m (partially offset by £29m of additional non-recurrent measures)
- £52.7m of the ICB’s £72.2m efficiency plan classed as high risk.

Action

- Expenditure controls in place including additional vacancy controls.
- ICB on track to remain within running cost allowance following 20% reduction in allocation in 2024/25.

Delivery

- Review continuously as part of the monthly reporting process throughout 2024/25 financial year.

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the ICB Quality and Performance Committee

Agenda Item No: ICB/07/24/10

Report approved by: Tony Foy, Non-Executive Member, Committee Chair

Highlight report of the Chair of the ICB Quality and Performance Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date(s) of meeting	13 June 2024 and 11 July 2024

Key escalation and discussion points from the Committee meeting

Alert

The Committee at its 13 June 2024 meeting considered the following:

- **Special Educational Needs and Disabilities (SEND) Inspections.** Given inspection outcomes nationally, the ICB can expect that all areas will be found to be 'inconsistent' and there may be more Notices of Improvement forthcoming. Weaknesses in partnership working at senior strategic level is a key factor in poor inspection outcomes nationally and this is the case in C&M. It was cited as reason for downgrading the Wirral 'inconsistent' judgement to 'serious weaknesses.' acknowledging changes in leadership staffing within the local authority.

  Waiting times for community paediatrics, all therapies and neurodevelopmental assessment are too long and this features in all inspection outcomes with 'inconsistent' judgements or 'significant weaknesses.

  Prevalence of all types of needs and disabilities has increased by just under 400% nationally in the last ten years. Resources have not increased in line with this.

  Quality improvement will be more effective if it is a joint undertaking and involves Parent Carer Forums (co-production). The SEND Collaborative Unit proposes that improvement work is conducted jointly with the C&M DCS Transformation Programme Team.

The Committee at its 11 July 2024 meeting considered the following:

- **End of Life Care.** The committee received the presentation previously delivered to the System Quality Group . The aim of the C&M programme is to
  - meet NICE guidance and NHSE quality standards, enabling adults, young people, and children to live well before dying
  - ensure access to care is equitable.

  Principal KPIs are (GP register) 60% are recognised as being in the last 12 months of life and 60% have an advanced care plan.

  The programme is making strong progress including recognition in the EOL Care Awards for 'joined-up population-based thinking across health and social care, encouraging tangible outcome measures , innovative digital solutions plus consistent committed leadership' but gaps were identified:

- progress with advanced care planning at 35% in Q4 2023/4 against the 60% target but with wide variation across Places.
- the need to source specialist palliative care medicines is often the responsibility of those caring for the individual at the end of life.
- areas NOT providing 7-day face to face review/assessment are Cheshire East in either setting of hospital/community, Warrington & Halton hospital, and Halton community.
- not all areas have a single point of contact for professional advice during the hours of 9am-5pm but all areas have a single point of contact for health and care professionals from 5pm to 9am.

- **Cheshire East Significant decrease in Safeguarding Referrals.** Further to the Cheshire East Inspection of Looked After Children Services (ILACS) between February and March 2024, in which the local authority was rated as Inadequate. At the first Improvement and Impact Board held on the 01 July 2024 Cheshire East Council reported a significant drop in Safeguarding referrals for both children and adults in May and June 2024 compared to same period in previous years. An urgent deep dive has been requested to understand the reason for a drop of over 350 contacts for children and over 800 contacts for adults compared to previous months and June 24. Feedback will be provided at next month Improvement and Impact Board in August.

Advise

The Committee at its 13 June 2024 meeting considered the following:

- **Maternity.** In response to delays in the Induction of Labour (IOL) pathway which can create additional risks to the provision of safe quality care to women and babies identified in the e SITREP, the ICB has agreed to support an IOL Taskforce, the terms of reference are in development. The proposal is that the task force will use QI methodologies.

- **Quality.** The committee received an update on the National Quality Board's Framework – including new requirements for Workforce, SEND, Whistleblowing and Digital. Responsibility for delivering these functions will sit in different teams across providers, ICBs and NHS England, and not solely be the responsibility of a quality team or exec clinical quality lead (e.g., ICB Chief Nursing Officer). The structures, systems, and processes in place to manage these functions must:

  - provide a clear line of sight on quality
  - support effective intelligence-sharing and triangulation
  - enable proactive improvement and risk management, as set out in the NQB guidance

  An extensive review of the new demands will be carried out at the Committee's August meeting.

The Committee at its 11 July 2024 meeting considered the following:

- **Maternity - Maternity and Neonatal Digital Strategy.** A maternity and neonatal specific digital strategy has been co-produced with MIAA and has been submitted to the ICB Digital Team. An agreement was made that we need a system that allows access to data across all providers. However, providers have embarked on their own EPR - LMNS is to look at interoperability between systems. Lack of interoperability impacts on system-wide developments such as improved triage and performance dashboards. A meeting has been agreed to discuss this with the LMNS and ICB Digital Executive.

- **Performance.** As of May a number of indicators are showing some deterioration, with 4-hour AED waits significantly challenged in the 3 Cheshire providers, NCTR is deteriorating overall with the exception being East Cheshire – within the Recovery Programme there is an acute length of stay workstream which will support improvement approaches aimed at reducing LoS. This is expected to include a refresh of weekly Long Length of Stay reviews at every trust. Improvements were noted in antibiotic prescribing in Primary Care and a strong performance in 6 week diagnostic waits.

Assure

The Committee at its 13 June 2024 meeting considered the following:

- **Maternity.** There has been a sustained reduction in smoking at time of delivery across Cheshire and Merseyside since Q1 21/22. Data due to be published in June 2024 shows a further reduction from 8% (Q1 21/22) to an all-time low of 7.2%.

- **Paediatric Audiology.** This is a national safety issue which has identified a provider (WHH) within NHS Cheshire and Merseyside as an outlier. The Trust's review has identified 2 cases of low harm from 200 cases overall. NHSE has acknowledged the system-wide issues involved and have established a National Paediatric Hearing Improvement Programme to support providers and ICBs to improve the quality of these services. The Programme is undertaking several audits to understand the scale of the problem and the numbers of children who have been affected, to develop strategic tools and interventions to support improvement.

  Overall, we have RAG rated the C&M system as amber due to none of our providers being complainant with IQIPs (Improving Quality in Physiological Services). Providers are compliant in all other areas. A further in-depth audit has identified the degree of risk in each provider (not a measure of quality) with only two providers deemed to be 'low risk.' T

  The Exec Director Nursing and Care will coordinate and lead the panel process with providers scheduled for July 2024, reporting back to the Committee.

- **Cheshire West/CWP.** As previously reported, the ICB has been seeking further assurance into governance and performance oversight at CWP, due to several

emerging and ongoing risks to quality and safety. The Emerging Concerns Group identified that the primary key line of enquiry was to seek assurance about the effectiveness of the Trust governance and accountability frameworks in enabling them to identify, escalate & mitigate emergent issues in a timely responsive way.

At a subsequent extraordinary Contract, Quality and Performance Meeting Trust Directors explained that they have work underway to improve governance and accountability frameworks and we would see this reflected in their Committee and Board papers. The ICB is formulating a formal response to the Trust about next steps.

CQC is undertaking an assessment of CWP across multiple service lines using the new single assessment framework which will include a Well Led assessment in July 2024 and the ICB will contribute to this.

- **UEC Performance.** The Committee reviewed data on UEC Flow in an improved format, discussion focused around changed approach, now we have five geographical programmes of improvements around UEC. The objective is to eliminate corridor care across C&M in next 12 months, this encompasses extra wards and boarding. From 17 June 2024, detailed corridor care data from providers will be collected at a regular touch point in the day.

  The committee will utilise the new improved data over the next three months to evaluate the early findings that significant numbers of patients: -
  - attending a hospital could have been treated elsewhere in a community setting in a service that already has capacity.
  - may be following the wrong pathway, could have accessed same day emergency care, but instead were admitted to a bed.
  - are going to the wrong destination e.g., a higher level of social care than is necessary.

  - **Talking Therapies Deep Dive** into the provision and performance of NHS Talking Therapies services across the nine Places in Cheshire and Merseyside. The Presentation and discussion covered
    - performance on waiting times from first treatment contact to second treatment contact.
    - actions taken to reduce the number of people waiting more than 90 days for a second treatment contact including areas of improvement and concern.
    - overall activity and waiting times by provider/Place.
    - financial challenges - a follow-up discussion with FIRC to be arranged
    - the approach to developing a consistent service model.
    - feedback from people with lived experience
    - discussion around how as an ICB we can minimise risk to support patients who live in an area where services are under-performing
    - further assurance request to ensure robust oversight of waiting times in Chesire East place to be incorporated into place reporting.

- **Annual Complaints update.** The committee received the 2023/2024 Annual Complaints Report. The report provided oversight of the numbers and types of

complaints, MP enquiries and PALS enquiries received by the ICB in January to March 2024. The report provided an annual summary with detailed information including

- 1,170 (PALS, complaints, MP, and Councillor enquiries) were received in Q4, which is double the number of contacts received in Q1 (584).
- 747 PALS enquiries were received in Q4. This is consistent with the level of contacts in Q2 and Q3, and more than double that of Q1.
- Full compliance with 3-day acknowledgement across all Places was achieved.
- Compliance with responses to complaints within 6 months, was not achieved.

The Committee at its 11 July 2024 meeting considered the following:

- **Maternity.** Key points of the LMNS assurance report:
  - the development of a C&M Maternity Provider Metrics Dashboard remains ongoing, with the Data Quality exercise paused by the ICB BI Team due to other ICB priority work.
  - high sickness rates are reported across all maternity sites, with the C&M overall maternity absence rate reported presently as 6.4% (above the baseline of 3.5%). The LMNS is undertaking a further deep dive and will report the findings to the LMNS Assurance Board.
  - the LMNS has established a Maternity and Neonatal Safety Group to facilitate shared learning in relation to clinical incidents and safety-related topics across maternity providers.

- **Risk Register review (see Corporate Risk Register below).** Risk scores remain at levels previously reported including QU09 – East Cheshire Trust Summary Hospital Mortality Index (SHMI) which remains at 20 while several planned actions have been completed, or are close to completion, the Committee re-affirmed that the risk score should remain at the original score of 20. The planned Board to Board meeting in December will inform the scoring. The Committee was also informed of the newly developed governance structure supporting the Committee; three System Oversight Groups (Safeguarding, All Age Continuing Care and SEND), are working to describe risks that provide the greatest pressure to their workstreams.

- **Anti-microbial Prescribing.** Within C&M ICB there is significant work being undertaken to improve quality and outcomes in relation to anti-microbial prescribing. Cross-sector working, sharing of good practice, use of clinical evidence and data forms the foundation of the work undertaken to date and planned. The current National Action Plan confronting antimicrobial resistance was published on 8th May 2024. The NAP was officially launched across C&M via email to all practices from Place Medicines Management Teams (MMTs) AMR leads and included in the primary care bulletin to increase awareness with all prescribers.

  NHS C&M is currently not meeting the previously set target set for the overall volume of prescribing of antibiotics in primary care, however NHS C&M is currently meeting the target for the percentage of broad spectrum anti-microbial prescribing by primary care.

Penicillin allergy labels are associated with antimicrobial resistance, less effective healthcare, and increased healthcare costs. Most penicillin allergy labels prove to be incorrect when tested. The priority across C&M is to support the delabelling of patients with a penicillin allergy will be to agree the format of communication between secondary and primary care.

Place AMR leads across C&M are collaborating to create an electronic care home UTI assessment form to allow effective communication between the care home and primary care.

- **Stroke Outcomes. C**&M received an alert letter because Stepping Hill, Stockport was identified as an outlier for stroke mortality and a small number of Stroke patients from C&M present there as nearest Stroke Unit. Stockport Trust have presented an action plan to GM stroke network. The network has shared the plan with GM ICB, and both are happy the trust is taking the correct action but will continue to monitor. C&M has looked at the mortality data from that time in other C&M units and concluded there are no major concerns. LUHFT was on the cusp of being an outlier however the data is from April 21- April 23. Since then, the North Mersey Hyper Acute Stroke Unit (HASU) at Aintree opened (Oct 23) and routine Sentinel Stroke National Audit Programme (SNAPP) metrics have improved, so it is expected that future mortality report will reflect this positively.

  The biggest concerns for C&M are Wirral and CoCH as they do not perform as well in terms of SNAPP (especially, time in stroke unit and thrombolysis). There is now work being undertaken to increase the collaboration between those units. The longer-term plans are to consider a more formal arrangement along the lines of a single HASU.

Committee risk management

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

Corporate Risk Register risks	
Risk Title	**Key actions/discussion undertaken**
QU04 Safeguarding	MIAA Safeguarding audit highlights risk - the current gap in Designated Doctor provision within the ICB. Review to be undertaken on the existing Designated doctors are who are employed substantively by our NHS Trusts across C&M and have existing Service Level Agreements in place
QU08 Standards of Care	See Paediatric Audiology Audit . Higher scores in Liverpool, Sefton, Knowsley and Wirral (Recovery plan in place focusing on priorities). ICB wide - Work is continuing to provide quality oversight of Primary Care. See LMNS report. See Stroke Outcomes item.
QU05 Neurodevelopmental Assessment	See SEND report. Scores remain generally high (20) Liverpool - Improvement Plan being developed in partnership

Corporate Risk Register risks	
	with Alder Hey to support 0-18 diagnostic wait pathways. Wirral - Implementation plans are being established to clear the current backlog

Board Assurance Framework Risks	
Risk Title	**Key actions/discussion undertaken**
Board Assurance Framework Risk Urgent and Emergency Care P5.	The Committee reviewed the updated performance reporting format targeting the elimination of corridor care

Achievement of the ICB Annual Delivery Plan

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

Service Programme / Focus Area	Key actions/discussion undertaken
Urgent and Emergency Care	Review of standard performance data – deterioration in May and planned actions
Maternity Service Quality and Safety	LMNS report

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Report of the ICB Directors of Place

Agenda Item No: ICB/07/24/11

Responsible Directors:

Anthony Leo, Halton Place Director
Carl Marsh, Warrington Place Director

Report of the ICB Directors of Place

1. Purpose of the Report

1.1 The purpose of the paper is to provide Board members with an overview of key areas of focus and delivery being undertaken at Place within the Integrated Care System.

1.2 The paper provides insight into the activities of each place, based on these agreed key themes and areas of focus.

1.3 This paper is a regular update to the Board with regards to Place work, providing assurance to the Board on how teams are working towards the delivery of the ICS objectives by working with partners locally to improve health and wellbeing of local population.

2. Executive Summary

2.1 This report provides an overview of activities being undertaken at Place level describing the arrangements which support the ICB strategic priorities.

2.2 The report provides further detail on key aspects of each Place's operational activities describing key features where local teams work in partnership with partners and stakeholders in support of delivery of the organisation's objectives.

2.3 Further insight is provided within the report across focus areas including place partnership development, place risks, action on health inequalities, patient discharge and flow, primary care network development, provider market development, strategic issues as applicable to each place, children and young people's issues and use of resources.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- Consider the contents of the report and the work being undertaken at place to support delivery of the ICB strategic objectives.
- Note the progress being made in each of the sections as described within this report and areas of good practice.
- Note the relevant risks and issues as contained this report that are captured as part of the ICB risk management approach and are monitored through the Risk Committee on a regular basis.

4. Place Partnership Development

Key areas of focus for recent and upcoming Place Partnership meetings include:

4.1 **Cheshire East**

At the last meeting in early May the Cheshire East Health and Care Partnership Board received an update from the CHAW (Chelford, Handforth, Alderley Edge and Wilmslow) Care Community, as well as a broader discussion around care community development.

They also received the strategic outline case for Healthier Futures (the new hospital programme at Leighton). In a private session the ICB priorities and recovery programme approach to these were shared and discussed with partners.

4.2 **Cheshire West**

The most recent meeting included an opportunity to discuss ICB revised priorities with partners. There was significant concern regarding what the changes may mean for Place work and transformation and reassurance was needed regarding ongoing commitment to Place partnership and transformation work. It was agreed that fortnightly Place Committee briefing meetings would be stood up to keep partners in the loop on the changing priorities/ICB financial plan etc. The Committee also spent time discussing the patient experience of admission avoidance services and how valuable the virtual ward/urgent crisis response service infrastructure is in the community.

4.3 **Halton**

At its most recent meeting in June, One Halton Partnership Board received an update on the One Halton Delivery Plan and a series of recommendations regarding next steps which the Board considered and agreed to progress. Alongside this, presentations were made outlining progress relating to two key One Halton priorities: aligning same day access across general practice and urgent treatment centres; and long-term conditions management programmes. An update was also provided on the further development of the Integrated Neighbourhood Model with work underway in relation to health and social care teams.

4.4 **Knowsley**

The frequency of meetings has been reviewed and six meetings are scheduled for 24/25 (a reduction of three). The last meeting was held on the 7th May which focused on Urgent Care and Frailty. The meeting on Tuesday 2nd July will focus on the Northwood health inequalities programme.

4.5 **Liverpool**

The Liverpool Strategic Partnership (LSP) has been revitalised under new Liverpool City Council leadership, bringing together strategic partners, including Liverpool Place, to address the challenges the city faces in terms of the key determinants of health, social and economic prosperity. The contribution of the ICB Place team is integral to the development of a new city plan which will be published later in 2024.

4.6 **St Helens**

Over the last year, Place arrangements have evolved to ensure it meets the needs of all partners at Place. Membership has been extended to include not only voluntary sector, but also housing, YMCA and schools, as well as NHS and social care partners.

Meeting arrangements have also been updated to ensure that NHS performance is fully reported bi-monthly, with Place priorities being the focus of every second meeting.

4.7 **Sefton**

The Sefton Plan was produced in partnership with all key stakeholders in 2023 and sets out key priorities across the life-course. Key achievements include PCN pilots for ACES and Complex Lives that have been mainstreamed.

Community First is one of three cross-cutting themes in the Sefton Plan with social value and economic growth central to the approach. An innovative SROI tool has been developed by Sefton CVS to evaluate the wider economic impact of the sector in Sefton, in line with the anchor institutions approach.

£4.2 million of winter funding across health and care was jointly commissioned in schemes including enhanced therapy beds, which have been supported by Trust therapists and resulted in faster discharge and on reduced packages of care. A pioneering baby attachment and bonding (BABS) service is also jointly commissioned, providing much needed support for new parents who are struggling to form a relationship with their baby. Both initiatives form part of the ambition to grow integrated funding arrangements via the BCF.

<u>Sefton Borough Council CQC Inspection</u>

In June 2024 Sefton Borough Council received notification that it will be subject to the newly established CQC inspection regime for local authorities. This assessment will also look at the development of partnerships across systems and the extent to which integration has been achieved across key areas.

4.8 **Warrington**

The April meeting was a workshop; a stocktake of what had been delivered to date and what actions were will still needed.

The May meeting consolidated the output from the meeting and agreed on the 24/25 priorities:

- Children and Young People (specifically SEND) using a Think Family approach,
- Urgent and Emergency Care and
- Poverty.

It was agreed that partnership resources would be realigned to the priority areas and supporting infrastructure would be stood down/phased back to free up capacity.

4.9 **Wirral**

Items discussed at the most recent meeting were Quality and Performance Report, Planning 2024/25 Update, Wirral Health and Care Plan Programme Delivery Dashboard, Unscheduled Care Improvement Programme Update, and chair update reports from supporting groups to the Board.

Wirral's BCF 24/25 Plan has been submitted on 11th June to the national team.

The well-established s.75 and wider pooled budget report for Wirral was due to be discussed at the meeting of the Council's Adult Social Care and Public Health Committee on 11th June before the meeting was cancelled due to the general election. It is anticipated that discussions will be held at the next meeting due on 18th July.

The continued collaboration between the ICB and Wirral Council remains strong, and the recommendation is to pool funds worth £304.58m, including the additional discharge funding.

Link to Wirral Place Based Partnership Papers 7th May 2024 Agenda Template (wirral.gov.uk). June meeting cancelled due to purdah. Next meeting 25th July 2024.

5. Place Risks and actions to address

5.1 The top five risks common across places and key actions being taken to address them are set out in Table One.

Table One

Rank	Risk	Key Actions
1	**Finance:** Cost pressures driving overspends	Current controls include delegated budgets, budgetary control and expenditure approvals process and financial monitoring and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing.
2	**Finance:** Unable to deliver efficiency improvements	Current controls include financial recovery plans and efficiency schemes, programme and project management, monitoring and reporting. Key further actions planned include development of longer-term financial plans delivering recurrent efficiencies.
3	**Quality:** Neurodevelopmental assessment delays	Current controls include the assessment framework, performance monitoring of commissioned providers, clinical networks, SEND improvement plans, and quality and performance reporting. Key further action underway to develop joint and strategic

Rank	Risk	Key Actions
		approach to commissioning for Autism and ADHD.
4	**Quality:** Reduced standards of care	Current controls include key policies and standards, incident reporting and harm review process, standard contracts, System Quality Group and quality dashboard reporting. Key further actions planned include development of UEC patient safety principles, development of primary care quality forum and strengthening of host commissioner arrangements.
5	**Quality:** Inadequate compliance with CHC National Framework	Current controls include the System Oversight Group (SOG) which has responsibility for All Age Continuing Healthcare and onward reporting from the SOG to the System Oversight Board (SOB). Key further action underway to implement the target operating model, with the aim of standardising the service delivery model.

5.2 The scoring and distribution of these common risks across the 9 Places is illustrated in the heat map (Figure One) and may indicate where further action is required in a particular place/s to strengthen the effectiveness of an existing control or to implement additional controls.

5.3 In addition, there are several significant risks unique to specific places, including some which are yet to conclude local place governance reporting and escalation to the relevant ICB Committee. This aspect of the report including the inclusion of significant unique place risks will be further developed in future iterations of the report.

Figure One

NHS
Cheshire and Merseyside

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
F8	Cost pressures resulting in potential overspends and may impact on the ICB's ability to achieve its statutory financial duties	20	20	20	10↓	10	10 (New)	16↑	10	N/A	12↓
F9	Potential inability to deliver efficiency improvements and may impact on the ICB's ability to achieve its statutory financial duties	20	20	20	10 (New)	12	10↓	16 (New)	12↓	6↓	N/A
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	16	12↓	12↑	8	16	12↓	16↑	16↓	20↑
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	20	8↓	8↓	12	15↓	16	20	6↓	9↓	16↑
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm	20	20	N/A							

6. Action on Health Inequalities at Place

6.1 **Cheshire East**

A recent joint meeting of the Health and Wellbeing Board and the Health and Care Partnership Board has focused on how we can engage with partners – including different council functions – who influence the broader determinants of health.

6.2 **Cheshire West**

Work has been completed by CWVA to deep dive into those identified within the 'complex lives' cohort (including asylum seekers, victims of domestic violence, traveller communities etc) to understand through focus group discussions/interviews the challenges they face in accessing services and how their needs can be better met. These findings will be taken forward within the Mental Health programme.

6.3 **Halton**

At its most recent meeting on 10 July, Halton's Health and Wellbeing Board focused on *Housing and Health in Halton, and also Wider Determinants of Health: Responding to Poverty and Tackling Drivers of Health Inequalities*. The item on Housing and Health provided an overview of social housing activity and the connections that are being made to support improvement in health outcomes across health for local residents. Work has already commenced on developing a 'Living Conditions' workstream and action plan as part of the Wider Determinants theme within the Health and Wellbeing Strategy.

The Health and Wellbeing Board also received an update on the partnership work to address inequalities in Halton noting a long-term focus on prevention to combat the drivers of poverty and health inequalities. This included an overview of outreach approach, intervention approaches to the cost of living crisis, and prevention approaches relating to housing conditions, and home improvements to support affordable warmth.

6.4 **Knowsley**

Knowsley are taking a life course approach to tackling inequalities and addressing our top health challenges:

- Life expectancy
- Obesity
- Depression
- Long term conditions
- Smoking
- Population Health

Knowsley is also concentrating on one geographical area of the borough, Northwood, the ward with the biggest health inequalities. The programme aims to develop an asset-based approach to reducing identified health inequalities and improving health care. To date, 28 Northwood community members have taken part in themed sessions or events, proactively setting the direction of

improvement initiatives for the programme, which they have named 'Your Northwood'.

Cancer: Faecal Immunochemical Test (FIT) testing programme is being implemented across Knowsley.

Planned Care: All 104-week (2 year) elective waits have been eliminated.

6.5 **Liverpool**

The contribution of the ICB Liverpool Place team is integral to the development of a new city plan to address the key determinants of health, social and economic prosperity. This will be published later in 2024 including a refresh of the 'One Liverpool' strategy as a specific chapter including proposed actions on health inequalities and through its approach to population health management.

Through the work of the Liverpool Strategic Partnership, a North Liverpool 'prototype' is being developed. The prototype in Liverpool will test the impact of a data-led, multi-agency intervention approach to supporting residents in North Liverpool (North Docks and Stanley Park) who experience multiple complex needs. Persistent school absence has been chosen as an entry point as it is particularly high in North Liverpool and is likely a symptom of wider household needs such as housing, domestic abuse or poverty.

Recent approval of the ICS Health Inequalities funding will in part support targeted innovations in support of this project with options currently being developed.

6.6 **Sefton**

In Sefton, work has progressed on our complex lives programme. A key aspect of our wider strategic approach includes the PCN led, multi-agency Care Communities programmes involving proactive care of key groups in our population. In Southport, the focus is on those experiencing homelessness and addiction and in South Sefton delivering a key programme to those with Adverse Childhood Experiences (ACES.)

This work forms part of our wider integrated approach, whereby additional support from adult social care, housing colleagues and VCF sector partners are built into the programme. A workshop to progress the work is being held in early June and a business case is in development, ready for when health inequalities monies become available.

6.7 **St Helens**

The Inequalities Commission has continued to work on tackling inequalities in St Helens, through supporting the ongoing three key workstreams: "best start in life", with two family hubs opened in 2023-24, tackling food poverty, expanding the food pantry network from 3 to 11 sites as of March 2024, as well as fuel poverty, with the affordable warmth team assisting residents in over 1,000 individual enquiries providing support through various regional and national schemes, while collaborating with the commission in providing 'winter well packs' to 6,000 vulnerable residents.

The work of the Inequalities Commission was recognised via success in the 2023 Municipal Journal (MJ) award for “a whole council approach to tackling inequalities”.

The care communities approach aims to target people most at risk, often due to health inequalities. During 2023-24, St Helens has focused on developing relationships between providers that will enable them to work in a wider multi-disciplinary way to focus on the holistic needs of complex patients. Each Primary Care Network area has formed a Care Community, with named professionals aligned to it from across health and care. Care communities consist of multi-disciplinary GP practice staff, mental health, social care, voluntary sector and 0-19 services.

Care communities are focusing on frequent service users and 18-31 year olds, known to multiple health and care services, from the most deprived parts of our borough and providing increasingly proactive care. By focusing on the most deprived areas within our borough we can target the help at those where health inequalities are most prevalent.

St Helens North Care Community was the first to pilot this approach, starting to triage patients in February, with a view to wider roll out in 2024-25 to all other areas of the borough. The next phase of the programme will be to include services from wider areas than health and care, such as education and housing.

Active Lives partners have delivered four community mass participation events, and the innovative CYCLOPS junction was launched to increase pedestrian and cyclist safety and encourage active travel. Health, Exercise and Nutrition for the Really Young (HENRY) training has been delivered and an eight-week rolling programme parenting course was launched, with resource from Family Hubs and as a partner in a national research study.

The Community and Voluntary Action have co-ordinated the delivery and roll out of additional volunteer-run static and mobile food pantries to ensure access in key wards with highest need.

6.8 **Warrington**

As detailed in the Place partnership section, tackling Poverty has been identified as a key priority for the partnership and a Poverty Truth Commission is being created to ensure that people with lived experience have the opportunity to give their views on how it feels to be a resident of Warrington and the issues and challenges that the cost of living have created/exacerbated.

A poverty workshop is scheduled for 20th September to bring together key partners and influencers within the borough to progress this work.

Healthwatch Warrington have also identified health inequalities as one of their priority areas and will provide feedback from residents to identify gaps that can be addressed via the poverty commission.

An example of work being undertaken to reduce health inequalities is a project that Central and West Warrington Primary Care Network (CWW PCN) are piloting utilising Place transformation funding. The aim of the project would be to trial ways of improving BMI recording to identify patients with high BMI more accurately and offer an intervention to reduce risk as 17% of obese patients have diabetes, of these patients 95% are type 2 diabetic.

Health assessments will identify higher risk patients earlier and allow intervention plans to be put in place after consultation with the patient. Enhanced patient education via MDT groups delivered within our deprived areas will empower patients to make the advantageous lifestyle changes. We hope that this will provide a legacy of change within local families.

Through partnership workforce and onward referral, the correct support will be provided resulting in more linked and cohesive prevention services to use the Warrington pound more effectively.

We would hope that any successful areas are used as a blueprint to roll out across the town.

6.9 **Wirral**

Core 20 plus 5 system wide workshop held on 27th June set out future work programme across Wirral.

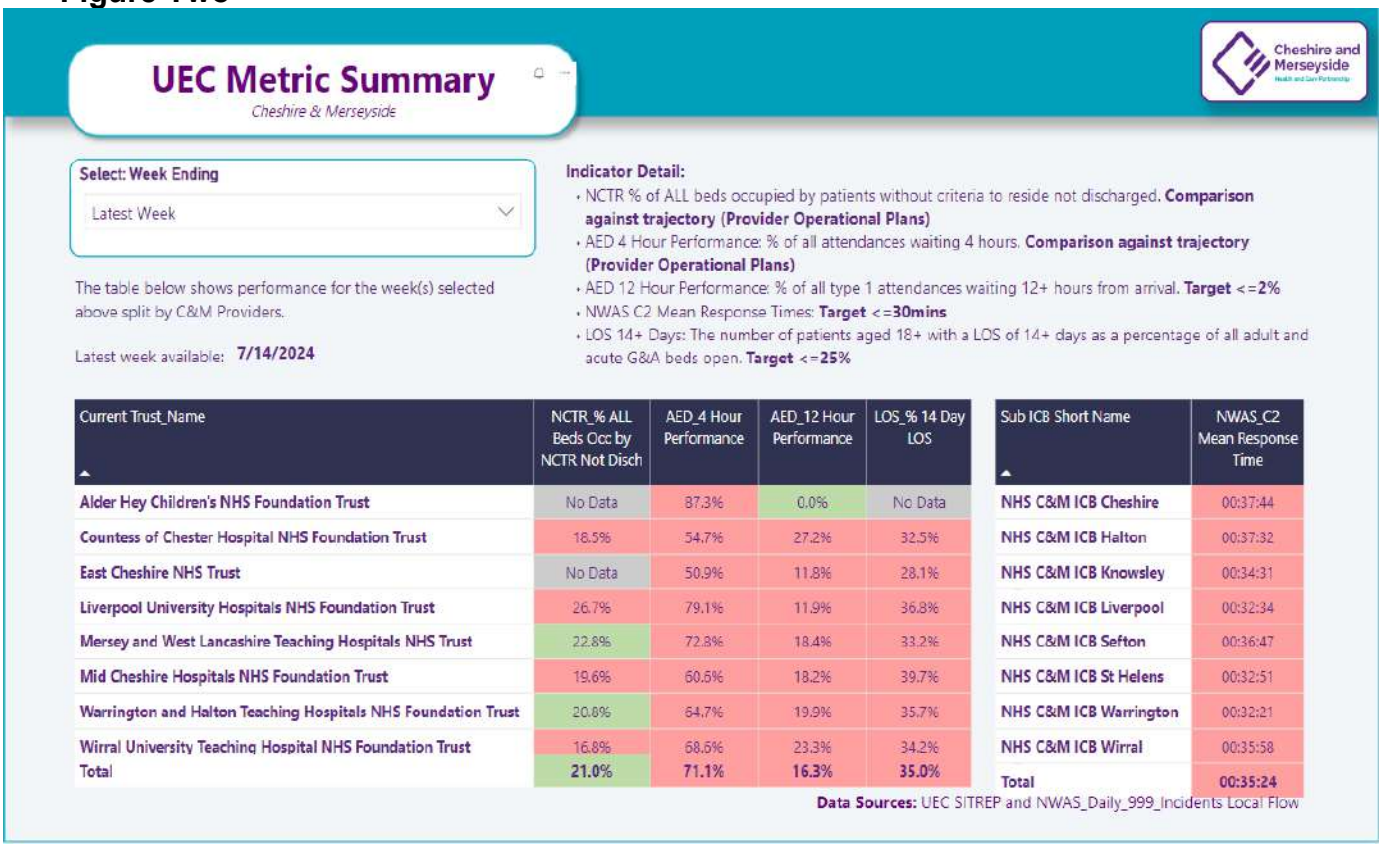
Targeted lung health checks programme is now live and communications activities are targeting community groups. This aims to improve awareness of the initiative and increase uptake.

Wirral has supported addressing the increasing demand on Mental Health services by approving an initial 10 property pilot across Wirral with a recognised housing association. The offer will provide properties with clinical wraparound and enhanced housing support as individual tenancies for complex patients to be supported in these settings. These patients may have otherwise been admitted to MH inpatient beds in and/or out of area.

7. Patient Discharge and Flow

7.1 Current performance as measured through the ‘Non-Criteria to Reside’ indicator is as per Figure Two based on provider footprints, and includes a range of other urgent and emergency care performance measures. Local Governance (such as Urgent Care Boards) bring partners together to review performance and monitor improvement plans on a regular basis.

Figure Two



UEC Metric Summary

Cheshire & Merseyside

Cheshire and Merseyside

Select: Week Ending

Latest Week

The table below shows performance for the week(s) selected above split by C&M Providers.

Latest week available: **7/14/2024**

Indicator Detail:

- NCTR % of ALL beds occupied by patients without criteria to reside not discharged. **Comparison against trajectory (Provider Operational Plans)**
- AED 4 Hour Performance: % of all attendances waiting 4 hours. **Comparison against trajectory (Provider Operational Plans)**
- AED 12 Hour Performance: % of all type 1 attendances waiting 12+ hours from arrival. **Target <=2%**
- NWAS C2 Mean Response Times: **Target <=30mins**
- LOS 14+ Days: The number of patients aged 18+ with a LOS of 14+ days as a percentage of all adult and acute G&A beds open. **Target <=25%**

Current Trust_Name	NCTR_% ALL Beds Occ by NCTR Not Disch	AED_4 Hour Performance	AED_12 Hour Performance	LOS_% 14 Day LOS
Alder Hey Children's NHS Foundation Trust	No Data	87.3%	0.0%	No Data
Countess of Chester Hospital NHS Foundation Trust	18.5%	54.7%	27.2%	32.5%
East Cheshire NHS Trust	No Data	50.9%	11.8%	28.1%
Liverpool University Hospitals NHS Foundation Trust	26.7%	79.1%	11.9%	36.8%
Mersey and West Lancashire Teaching Hospitals NHS Trust	22.8%	72.8%	18.4%	33.2%
Mid Cheshire Hospitals NHS Foundation Trust	19.6%	60.5%	18.2%	39.7%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	20.6%	64.7%	19.9%	35.7%
Wirral University Teaching Hospital NHS Foundation Trust	16.8%	68.6%	23.3%	34.2%
Total	**21.0%**	**71.1%**	**16.3%**	**35.0%**

Sub ICB Short Name	NWAS_C2 Mean Response Time
NHS C&M ICB Cheshire	00:37:44
NHS C&M ICB Halton	00:37:32
NHS C&M ICB Knowsley	00:34:31
NHS C&M ICB Liverpool	00:32:34
NHS C&M ICB Sefton	00:36:47
NHS C&M ICB St Helens	00:32:51
NHS C&M ICB Warrington	00:32:21
NHS C&M ICB Wirral	00:35:58
Total	**00:35:24**

Data Sources: UEC SITREP and NWAS_Daily_999_Incidents Local Flow

7.2 **Cheshire**

Following the establishment of NHS Cheshire and Merseyside's Recovery Programme, Cheshire East and West are working together on a single Cheshire Urgent and Emergency Care Recovery Programme. The key stakeholders include the three acute Trusts, community services, primary care, NWAS, two Local Authorities, voluntary sector and the ICB Place teams. The programme is aligned to the three thematic areas of admission avoidance, in hospital patient flow and discharge (known as Home First). Good progress has been made on implementation of the Home First model including development of a revised Discharge to Assess pathway. Further work is underway on addressing variation of Length of Stay and admission avoidance projects

7.3 **Halton**

Following the establishment of NHS Cheshire and Merseyside's Recovery Programme, Halton Place is part of two Urgent and Emergency Care improvement programmes: Warrington and Halton and also Mersey and West Lancashire. Halton Borough Council is a key partner in this work activity leading a workstream and contributing to the overall programme. A key priority is to address and improve No Criteria to Reside performance.

Alongside the work to support improvements in admission avoidance, hospital flow, and discharges, Halton Place continues its work at place level in relation to attendance avoidance and timely discharges, focusing on local actions with partners to make necessary improvements. This includes work focusing on

recovering access to primary care, developing a same day primary care access model and also a long-term conditions management model.

Healthwatch Halton has recently worked with residents to understand their experience of being discharged from Warrington and Halton Hospital. The findings and recommendations from the report will help inform the improvements needed.

7.4 **Knowsley**

We have collectively contributed to the improved No Criteria to Reside (NCTR) position. This has been achieved through additional support to discharge such as the 10 additional EMI (Pathway 3) beds available in the Borough and implementation of a voluntary sector provider to support patients on discharge. We will further progress this work in 24/25.

Admission avoidance: Our 2-hour Urgent Care Response (UCR) service is in operation 8-8, 7 days a week, seeing an average of 150 referrals per month. Around 64 admissions are avoided per month. Virtual wards have capacity for up to 70 Knowsley patients at a time and this will increase over the next two months.

Falls pick up service: comparative data for one month, December 2023, shows that this service successfully lifted 39 patients, resulting in fewer NWAS callouts and hospital admissions, and reduced the need for packages of care due to decompensation (compared to 15 less patients in December 2022).

Urgent Community Response team (Integrated Social and Health Care offer) sees an average of 150 referrals per month, mostly referred by local GPs, and approximately 64 admissions into hospital are avoided per month.

7.5 **Liverpool**

Admission avoidance

- SRO workstream meetings with system partners are due to commence (as per agreed PID approach), with further development of project plans around improvement areas.
- 'Influencing Family & Patients' PID initiated as part of LOS workstream.
- Completion of initial performance / business intelligence dashboards – includes baseline measures and likely metrics.
- Completion of gap analysis for programme resource allocation / project risks.

Frailty & Falls - areas to be prioritised over the next 6-12 months under the admissions avoidance workstream include:

- Further development and usage of a Frailty Rapid Access Clinic at Broadgreen.
- Increase uptake of NWAS direct conveyancing to LUHFT's Frailty assessment unit.
- Testing of frailty virtual wards in a large multi-site care home with high acute admissions.
- Frailty virtual wards (step down) planned for go live in August 2024.

- Development of the Community Falls Prevention Services.
- Recommissioning of a 24/7 falls lifting service.
- Improve identification of osteoporosis in Primary Care
- Work with ICRAS to ensure the 2UCR minimum standard for falls is achieved.
- Falls in Care Home programme of work, in addition to a care home deep dive and implementation of action plan.
- Communications plan with NWAS re; accessing wider frailty and falls provision in the community/Care Homes.
- Technology enabled care, testing phase with community services to expand referral opportunities and testing of ambient sensors for falls.
- Dementia – improving to access and support when in crisis and improvement in Liverpool's dementia diagnostic rate.

Acute Discharge

- Work by external consultancies (GIRFT, ECIST and particularly the diagnostic undertaken by Newton) have identified opportunities to deliver a reduction in NCTR length of stay by 6.3%, a reduction of Long-Term bed starts by 17% and Short Term bed starts by 13.2%.
- Project deliverables identified including promotion of risk positive clinical decision-making, minimising risk of in-hospital deconditioning (review of ward-based therapy arrangements and responsibilities).

Acute Length of Stay

- Project / PID in place (linked to UEC) with aim to ensure admitted patients in LUHFT access appropriate care for needs within hospital whilst ensuring length of stay is optimised.
- Three key projects within the programme – Inpatient Diagnostics Requests, IV Antibiotics Reduction, Therapy workforce and model review.

7.6 **Sefton**

The vision for Sefton Place is that people should be supported to remain at home in their communities with family and friends. This may require formal care and support services, advice information and access to therapy or community health services. To make this happen Sefton have established an integrated Transformation Programme – Better at Home (B@H) which includes a focus on discharge and flow improvement.

Programme Objectives include,

- reduction in Adult Social Care waiting lists
- reduced lengths of hospital stay for those without a criteria to reside
- increased volumes of patients accessing home first services (Pathway 1)
- increased throughput of appropriate patients in community beds (Pathway 2)
- reduction in spend & volume of short & long-term care packages and overprescribed care (pathways 2&3).

To achieve the programme objectives the B@H programme is focusing on 5 areas:

1. Market management and commissioning the right quality services

2. Urgent and hospital to home transformation including increased use of admission avoidance services, establishing a Care transfer Hub to co-ordinate and prescribe appropriate care on discharge , mobilising a Home first model with additional reablement capacity, reviewing the community bed base, redesigning the health & social care front and working with trust colleagues on internal acute processes preparing patients for discharge. The scope of Sefton's programme 2 (Urgent and Hospital to Home are aligned to the ICB priorities will be delivered working with MWL, LUHT and other place Leads. Other Enablers Sefton will look to develop will focus on
3. Workforce,
4. Quality assurance
5. Digital enablement.

Challenges to delivery include:-

1. Supply of community services supported by the right workforce to deliver extra capacity at affordable costs. This will be mitigated through development of integrated models combining workforces and skills from relevant providers to maximise investment.
2. Variation in services and complexity of change effecting Sefton Place, which will be mitigated through engagement, visibility and awareness of what changes Sefton needs to make from its baseline position.

This work links in with the ICB UEC recovery programmes on the North Mersey and MWL footprints.

7.7 **St Helens**

A key focus for financial recovery is urgent and emergency care across MWL. The Place Director for St Helens is leading this programme, and the focus will be on:

- NHS & Social Care UEC performance metrics (e.g. A&E 4-hour target, ambulance handovers)
- Patient outcomes and experience measures
- Flow and discharge indicators such as Length of Stay, Non-Criteria to Reside / Pathway Discharges.
- Eliminating corridor care
- Social Care sustainability

This will require cross working with colleagues from Sefton Place (relating to the S&O sites), Halton and Knowsley as well as St Helens. Various system partners are part of each of these groups including social care, community services, mental health services and primary care. St Helens has started to implement a strong Home First Focus and is establishing processes to support people to go home as a priority where safe to do so, avoiding care home admissions where possible.

7.8 **Warrington**

Partners are working together to deliver improve urgent and emergency care and the work that has been undertaken is already having a positive impact as the No criteria to reside figure (NCTR) has been steadily reducing over the past month and is consistently below the national target of 15%.

Additionally, partners are using the findings from the recent Newton diagnostic review, as well as incorporating recommendations from GIRFT and ECIST to coalesce around the following key workstream themes:

- Attendance and Admission Avoidance
- Pre No Criteria To Reside (NCTR) Length of Stay (LoS)
- NCTR LoS
- Optimising intermediate care
- System visibility

Healthwatch Warrington have recently worked with residents to understand their experience of being discharged from Warrington and Halton Hospital, the findings and recommendations from this report will help inform changes being made in each workstream.

7.9 **Wirral**

NCTR for Arrowe Park remains at 13-16% lower than all C&M peers.

New UEC Recovery PID produced which includes initiatives to reduce attendances, admissions and improve discharges.

A Right Care Hub (single point of access) is being implemented with new clinical capability to redirect GP and other community health referrals. Other priorities include enhanced SDEC offer from WUTH and focus on improving complex discharge pathways (NCTR).

System wide dashboard for UEC metrics 24/25 drafted.

Urgent Care Upgrade Programme at Arrowe Park continues. Majors, Resus and Ambulance Arrival Zone now in new estate.

Falls Group reestablished in Wirral with aim to develop system wide improvement plan.

Wirral is being supported by AQUA in reviewing its Falls service provision with an initial stakeholder group having met in early May.

The roll-out of the Home First programme continues to prove successful and full capacity is now in place. More targeted interventions to provide additional support to frail elderly people within key areas in the borough have been introduced.

8. Primary Care Network Development

8.1 **Cheshire East**

Care communities – aligned to PCNs - have been in existence for six years and have evolved locally with numerous examples of good practice. Practical

challenges remain though in terms of reallocating resources across the place system and spreading – where appropriate – good practice more widely.

Care Communities do have early performance dashboards, which we are seeking to mature throughout the year. All Place Partners including acute Trusts are bought in to the Care Community model of care and are all seeking to prioritise their development into the future.

All practices across Cheshire East are now supporting regular surveys of GP workload, productivity, changes in practice list acuity, and measures of operational pressure. The broad intention is to align with existing insights on UEC performance which have historically been hospital focused.

8.2 **Cheshire West**

There are 9 PCNs geographically aligned to our Care Community Team and Community Partnership geographies. The only difference is that three Chester PCNs are working as one Community Partnership. This helps support alignment with Local Authority Ward Profiles

Good relationships are in place between GP practices, PCNs and the ICB with regular Practice Manager and PCN Clinical Director Forums which are well attended. We also hold GP Collaborative events monthly with representatives from all practices as an opportunity to focus on areas of development as well as providing an update on Place transformation work and Recovery programmes.

We have also developed a primary/secondary care interface meeting with practices that face the Countess of Chester and a separate meeting for those that face Mid Cheshire Trust. Challenges include the ongoing levels of demand faced by primary care as well as the financial implications of inflationary pressures.

8.3 **Halton**

Halton has two PCNs serving the towns of Widnes and Runcorn on either side of the River Mersey and each with a population of about 65k patients.

In addition to the Primary Care Access Recovery programme, both PCNs are actively involved in developing and exploring new, integrated approaches and opportunities with a range of different partners including primary, secondary, specialist, local authority and community organisations, for example in relation to health engagement for children and families in Runcorn, and also a heart failure integration project in Widnes.

We are also working on the development of a local general practice dashboard which will complement the ICB dashboard. This has the support of both Place and PCN Clinical Directors. A first draft is available and further work is being undertaken to develop it further in advance of wider discussion.

Halton's two PCNs provided an update on their progress against the maturity matrix at the last Primary Care Commissioning Group meeting. Both are making progress in relation to the various domains relating to leadership, driving

integration projects, use of data and population health management, and managing resources. They continue to focus on areas for development as well as seeking to maximise their contribution to transformation work.

8.4 **Knowsley**

Our three Primary Care Networks have developed plans that set out how they will work across the system to deliver health improvements ensuring alignment of their workforce, digital and estates strategies.

In July 2023 we reduced to 24 practices, following the merger of Trentham Medical Centre and Tower Hill Surgery.

Practices are seeing more patients than before the pandemic, both face to face and digitally. All practices are Care Quality Commission (CQC) rated 'good'. The number of registered patients using with the NHS App has increased from 49% to 55% since Dec 23.

8.5 **Liverpool**

PCN Local Health Inequalities forum is now in place, engaging with Prevention and Inequalities Group (PHIG). Challenges remain in terms of estates capacity and quality, whilst workforce issues in General Practice (recruitment and retention of all staffing levels) continue to pose a risk in terms of access and recovery.

Demand also continues to be a challenge, with variation in access across practices. End of year access recovery plans have been submitted and approved at PCG. These plans demonstrate improved position across all areas showcasing innovate models of delivery. The BI Team is supporting the development of a local 'Enhanced Access' dashboard to evidence additional capacity being delivered. This will be available across the ICB and shared with PCNs to facilitate discussions on improving utilisation and DNAs.

Support Level Framework (SLF) conversations will take place in all practices during 2023/24. The delivery team will communicate the offer to all General Practices and PCNs.

8.6 **Sefton**

In Sefton, the two PCNs align with community service providers and the PCNs 8 localities match the Integrated Care Teams footprint. Using the experienced clinical and managerial leadership within the PCN Collaborative, these configurations enable effective working relationships and have enabled better integrated working on areas such as Medicines Management, Social Prescribing, Mental Health, Complex Lives, Enhanced Health at Home and in Care Homes, Cancer Care, CYP Immunisations.

Challenges we experience include suitable estates to maximise roll out of PCN services and embed additional roles.

The ongoing demand in general practice means many practices are concerned about viability.

South Sefton PCN continue to operate their Access Hub which provides on the day access in 4 localities during core hours, both PCNs have introduced admin hubs that support practices with back-office functions.

The Sefton Local Quality Contract supports local priorities and aims to reduce unwarranted variation. The 23 /24 contract has seen an improvement in attainment by practices with only 36% of practices failing to reach the 75% delivery threshold compared to 49% the previous year. A full evaluation will be undertaken once the data has been analysed. The 24/25 contract is targeting secondary prevention through manual pulse checks for >65s with a diagnosis of hypertension, CHD, diabetes or heart failure, hypertension case finding and reviewing the 8 care processes for medium / high risk diabetics.

In 23/24 Sefton delivered a significant improvement in the Learning Disability Health check target. LD Health Checks were included in the LQC to ensure that hard to reach patients received a more targeted offer, South Sefton PCN used ARRS funding to employ a Trainee Nursing Associate to focus on health checks. The scheme included work on ensuring registers were accurate and action plans were recorded and updated.

8.7 **St Helens**

Primary Care Access remains one of the biggest challenges in the borough. Call back is now enabled in all practices and over 50% have had approval of transition funding having met all conditions to move to Modern General Practice.

PCNs are maturing well and are now in a position to be able to deliver more community services differently. One of the PCNs is piloting an urgent care hub that has potential to be extended across all 4 if successful, increasing availability of urgent appointments. Other PCNs are starting PCN wide services such as LARC implementation, menopause clinics, utilising specialist skills of staff on a wider footprint.

8.8 **Warrington**

Warrington has 26 practices which make up five PCNs. The PCNs and their Clinical Directors are well embedded within the Warrington Together system and are working collaboratively with each other and with partners. Examples of this collaborative working include:

A pilot that was funded from the C&M transformation fund to address the excess CVD deaths in Warrington from patients with poor lipid profiles, both in primary and secondary prevention being out of range. By proactively managing with a combination of lifestyle and medication interventions we look to reduce excess morbidity significantly and achieve a healthier Warrington. The scheme will be digitally managed and look to bolster the ongoing hypertension project with an element of ‘screen and treat’. This project was initially introduced in the Warrington Innovation Network (WIN) PCN but is in the process of being rolled out across the town.

East Warrington PCN successfully received Place transformation funding to pilot the implementation of a 12-month Primary Care led project to improve the outcomes, experiences, and management of people with 'Complex Pain' presentations. This pilot programme is taking a holistic approach to assessment, care planning and treatment/support and draws upon the skills and knowledge of a range services from across Primary, Community, Secondary and Voluntary Sector partners. The pain management programme is now underway with the first cohort of patients successfully enrolled and retention levels are good.

8.9 **Wirral**

New PCN – Proposal Prenton, Woodchurch, Paxton and Townfield (30,000) 1st August start. Wirral 6 PCNs and 2 SDUs.

Collaboration with system partners continues to develop, including working with wider partners such as VCSFE and Healthwatch in terms of care navigation training and enhanced access assurance work. PCN services well embedded such as home visiting service, Specialist Diabetic Service, Integrated Frailty Model.

The Access Recovery work has positively influenced greater collaboration both internally and externally, with information sharing across PCNs strengthening such as digital developments.

The Neighbourhood Model has commenced within two communities led by the VCSFE, with wider roll out planned during 24-25. Population health data will support the focus on local health needs. Wider engagement of primary care is to be undertaken over coming months. Further development is required to integrate a blended workforce across all partners.

Estates capacity continues to be a challenge for PCNs and practices – estates planning work will commence during 24-25, including wider system working to maximise existing estates amongst partners.

ARRS roles continue to be maximised Some challenges with MH practitioner roles – these are being progressed with providers and support of Place.

Service Development Fund: Access and Urgent Care focus and will work with Primary Care Collaborative to consider approach.

9. Provider Market Development/ Strategic Initiatives

9.1 **Cheshire East**

Key strategic initiatives include the Sustainable Hospital Services programme at East Cheshire Trust – this will be the subject of a board visit in early June. Perhaps of greater importance is Healthier Futures – the redevelopment of Leighton Hospital under the government's new hospital programme. The

Strategic Outline Case will be coming to Board in July, with the Outline Business case expected in summer 2025.

9.2 **Cheshire West**

The Cheshire West ICB team worked collaboratively with Cheshire West and Chester on a joint market position statement. We are continuing to collaborate on market development including working together to build provision of EMI Care Home capacity specifically. We are also developing joint Care Home contracts for 25/26.

We are working closely with the Local Authority on the development of in borough accommodation for those with escalating or step down mental health and learning disabilities/autism needs.

We also work closely with the Local Authority in commissioning the VCFSE sector including moving to a joint contract for CWVA and joint grant arrangements.

9.3 **Halton**

Work to facilitate the establishment of the Runcorn Health and Education Hub located in the library at Runcorn town centre continues with a range of key partners including health, local authority and Riverside College with funding from the national Towns' Fund. This facility will make it easier for local people to get the information, support and services they need to stay active and healthy as well as supporting the regeneration of Runcorn town centre.

9.4 **Knowsley**

Intermediate Care (IC) wider review in Knowsley is planned during 24-25, working collaboratively with partners to review a development opportunity in Roby on land owned by NHS Property Services.

Women's Health Hubs: Knowsley is working in partnership with the wider C&M network to reduce the fragmentation of Women's Health and access to services.

Living Well Bus: we continued to maximise the use of a roving health service across Knowsley in 2023, delivered by Cheshire and Wirral Partnership NHS Trust.

Liverpool Heart & Chest Hospital NHS Foundation Trust (LHCH) Quality Visit: The Knowsley quality team undertook a Quality Visit to LHCH on Thursday 21st March 2024. The visit was well coordinated by LHCH. The Team were shown both the medical and surgical pathway, visiting pre-op areas, procedure wards / units and post-op wards, meeting staff and patients. The visit team also attended the Trust's weekly patient safety meeting. The Team gained assurance of quality of care provided. A full report of the visit has been written and will be shared with the Trust following its presentation at the Knowsley Quality & Performance Group on 16th May 2024. The Trust will use this report as part of its adherence to CQC requirements. The Visit Team were impressed by the professionalism of all staff, excellent patient care witnessed, a clean and

calm environment and a dedication to ensure support to staff. Knowsley Place will look to schedule a further Quality Visit to the Trust in 2024/25.

9.5 **Sefton**

Our Better at Home integration programme focusing on the development of patient pathways to ensure they have a "home first" experience of discharge, includes development of the care market to provide suitable options the right care in the right place following a stay in hospital.

Our Shaping Care Together programme (a partnership between MWL Teaching Hospitals, NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria) has developed a Case For Change which, once approved, will support engagement with local residents on the development of options for future service development. Discussions are also underway regarding the establishment of a Joint Committee of the partners to ensure full oversight of the process and any proposed changes.

9.6 **St Helens**

This Market Position Statement is for adult social care is being developed and provides strategic direction for existing and potential adult social care providers and the voluntary, faith, and social enterprise sectors. A key aim of a Market Position Statement is to encourage all stakeholders to work together. In shaping the development of our Market Position Statement, St Helens Council has worked in partnership with a broad range of internal and external stakeholders. This Market Position Statement is for years from 2024 – 2027. While sharing data and priorities that stretch beyond this period, we know how quickly the social care landscape can change, so we consider it a 'living document' that will be refreshed every 12 months.

9.7 **Warrington**

The Place team are working in partnership with Warrington & Halton Hospital Trust, Warrington Borough Council and other health providers to coordinate use of land and property in line with the Warrington Health & Wellbeing Strategy.

An example of this includes:
The recently opened Health & Wellbeing Hub that utilises vacant property on the high street in Warrington to bring together a number of services (including the voluntary sector) making them more accessible, bringing much needed footfall to the town centre and in doing so, helping to support the local economy.

The Council and ICB are co-commissioning transitional care beds to assist people to leave hospital in a timely way and they are also co -working on the creation of new and much needed Nursing Dementia Capacity in one of our local Care Homes.

Combined investments through transformation funds and also Market Sustainability Funds are commissioning growth of the Health and Social Care Academy to support the independent sector workforce.

9.8 **Wirral**

Branch – New CYP mental health platform jointly commissioned with Wirral Borough council. Soft launch w/c 8th July.

Mental Health Crises beds – future engagement planned with market in conjunction with Cheshire West and east ICB Places.

APMS – PIN for Townfield APMS practice being released to support future procurement.

Integrated Housing Independent Living pilot go live – first patient acceptance in next month.

The Programme for the Wirral Review has been agreed between all partners. The review will focus upon identifying areas for improved clinical collaboration across Wirral and then set out a plan for delivery. A final report is expected to be available in September 2024.

10. Children and Young People

10.1 **Cheshire East**

Since the last report, children services across Cheshire East have been OFSTED rated as inadequate. This will lead to a significant multi-agency response and may hasten the anticipated inspection of services for children with special educational needs and disabilities.

As a result, we have a focus on:

- SEND sufficiency planning and evolving services to meet growing demand on EHCPs
- Redesigning CYP Neurodevelopmental pathways and support to focus on early help over diagnostics
- Focusing on transition pathways
- Developing healthy weight initiatives
- Developing Asthma care reviews
- Integrating family hubs into the care community model
- Maternity development
- New service commissioning of CYP SALT.

10.2 **Cheshire West**

We are progressing an in-depth review of Children in Care service with provider and Local Authority to consolidate efficiencies to deliver better outcomes for Children and Young People placed in care within Cheshire West.

A focused piece of work around Safeguarding and Transition for CYP is taking place.

A joint approach with Local Authority and Voluntary Sector is being developed to invest in Early Help and support to build emotional resilience in Children and

Young People in an effort to reduce the levels of demand for mental health services.

We are working on a neurodiversity pathway with single referral route and streamlined assessment aligned to the Neurodiversity Recovery programme.

10.3 **Halton**

The SEND Partnership Improvement Board last met on 20 June 2024. The Board discussed latest progress in relation to the Priority Action Plans which had been agreed by OFSTED and CQC following the SEND inspection outcome.

There is a significant, multi-agency programme of work underway which is being monitored by the Board which is led by an independent chair to provide independent scrutiny and challenge.

Within Halton there are currently four Family Hubs with further hubs to be rolled out. A range of multi-agency partners support Family Hubs which focus on staying well and early help. Halton recently held a Family Hubs Two Day Conference which shared and showcased a wide range of family hub services.

10.4 **Knowsley**

Starting well initiatives include: Review and redesign of the neuro developmental Pathway (NDP), exploration of appropriate places of care for complex children, family hub roll-out, development of a new antenatal offer and progression of the children's joint commissioning plan.

Successes include the funding of provision to support the NDP such as a Tics and Tourettes service, appointment of a Children's GP lead and funding for a ‘Collaborative Autism’ project hosted by the Sensory Hive to support families in Knowsley.

10.5 **Sefton**

ND advice, information and support for families has been jointly funded, levelling up to other Places.

Community Matron provision for children and young people with complex health needs has been levelled up across Sefton. Eliminating historic inequity.

The Building Attachment and Bonds Service (BABS) has been shortlisted for an MJ award for Care and Health Integration.

Place team has worked and supported the LA effectively so that there are zero illegal placements being made by Sefton.

ND demand continues to be challenging, but Place engaged with all C&M wide discussions and workstreams.

Positive visit from the national team to the Enhanced Support Team for Sefton & Liverpool (Framework for Integrated Care).

Recruitment freeze means key working team under capacity and will not be able to meet plans to expand from up to 18-25.

Initial Health Assessment (IHA) performance for Children in Care remains a concern with Alder Hey Trust not meeting the trajectory for improvement originally agreed for December 2023. The Trust submitted a further revised trajectory in April for October 2024 and a system solution has been expedited to support improvements for children.

The Minister for Children Families and Wellbeing has directed Sefton local authority to act on the report and recommendations from Sefton's Commissioner for Children's Services, to facilitate improvements required following Inspection of Local Authority Children's Services. Work to support partnership with findings is being progressed through production of the strategic plan 2024-2027.

Sefton Children's Services launched a new front door into their services from 1 May 2024. Two new teams, Sefton Children's Help and Advice Team (CHAT) and Sefton Family Advice and Support Team (FAST) are available for professionals and public in Sefton.

Performance and waiting times for: specialist children and adolescent mental health services (CAMHS), Speech & Language therapy, ASD/ADHD assessment and diagnostic services remain challenged.

10.6 **St Helens**

St Helens has a varied Thrive offer to support its Children and Young Peoples (CYP) mental health and emotional wellbeing, developed by the ICB Place Team, Local Authority and various Provider partners. As a result of this, in 2023-24 we exceeded our Access Target for the second year running and further positive trends are emerging, such as a reducing trend in CYP mental health admissions (23/24 forecast of 47 compared to 56 in 22/23) and CYP self-harm admissions (2023-24 forecast of 70 compared to 150 in 22/23).

Key schemes implemented to support these improving outcomes include 65% of schools with a Mental Health Support Team or Resilience Service; a Key Worker service to support some of our children and young people registered with a Learning Disability or Autism; introduction of a Tourette's Pathway; investment in third sector partners to deliver programmes such as Parents in Mind, Reflective Parenting and Parents in Mind Partners; and the establishment of a multi-agency Childrens Health and Maternity Hub (Lowe House) and Family Hubs (Sutton, Central Link and Newton) to improve access and support.

The local Voluntary Sector (VCSFE) have a large number of providers who offer support for mental health and wellbeing issues. Working through the VCFSE Mental Health Alliance they work to ensure that the system has a clear understanding of the VCSFE offer.

Over winter the 'warm homes for young lungs' programme was a real success, offering wider wrap around support to children with respiratory conditions whose health condition could be exacerbated by their living conditions. This has been a partnership arrangement between the Local Authority, the ICB, provider partners and the voluntary sector. This support ranges from support with inhaler techniques right through to referrals to the affordable warmth teams where households have been able to access funding towards heating bills or boiler replacement.

Household Support Fund Project. Delivered by St Helens Borough Council's School Traded Services with money from the Government's Household Support Fund (HSF), junior pupils in 54 primary schools across the borough received a variety of tasty fruits like apples, pears, clementines and satsumas – initially in the lead up to the February half-term break.

The scheme was renewed up until Easter following resoundingly positive response from school staff and pupils, and with confirmation from Government that the HSF would be extended, the scheme has now renewed to the end of the school year.

The programme supports the healthy approach of the council's wider school meals service, which delivers a selection of main meals and desserts, and access to a fresh fruit and salad selection.

Cradle to Career. Collective vision across the LCR: The Liverpool City Region becomes the capital of the national levelling-up agenda, by collectively transforming children's and young people's outcomes in the most left-behind communities.

Emerging themes from the project so far:
- inclusive schools
- support for vulnerable learners
- Access to services
- Youth offer.

Next steps: Final report from consultation will be written and circulated to partners for external funding and to the LA so consideration can be given around how services may be repurposed to meet the identified needs.

10.7 **Warrington**

Warrington Place is committed to preventing the avoidable admission of complex children and young people to care, custody and inpatient provisions. A consortium of stakeholders including the Local Authority, ICB, Mersey Care, Bridgewater and Youth Justice Services have subsequently developed a proposal and business case to establish a small 4 bedded therapeutic short stay and outreach provision we are calling the 'Complex Needs Hub'. Capital monies of c£750k have been secured via the Dept for Education for refurbishment of a property provided by the Local Authority. The revenue business case has been supported by the ICB at Warrington Place and WBC

Cabinet for the balance of the funding. This work is in line with and in support of the C&M Appropriate Places of Care steering groups aspirations. The offer is anticipated to go live in November 2024 and a phased recruitment plan is currently in development.

Warrington Place in conjunction with Halton, St Helens and Knowsley Places have worked in collaboration with Mersey Care NHS Foundation Trust to develop a proposal to deliver in line with National requirements an Intensive Support Provision for children and young people with LD/Autism in Crisis. The programme is being funded through the Cheshire and Merseyside Transforming Care Partnership Board.

Warrington ICB at Place in partnership with Bridgewater Community Foundation Trust, Mersey Care NHS Trust and Space 2B You Mental Health Support Services are working to improve the experiences and outcomes of children and young people and their families through a joint initiative between Child & Adolescent Mental Health Services (CAMHS), Community Paediatrics and Space 2B You that will provide intensive support to families in crisis where there are difficulties associated with Neurodiversity. This support offer using SDF Funding will go live in Quarter one of 2024/25.

Warrington Place access and waiting times to CAMHS continue to exceed the National standard with the access target for 2023/24 at 116% and wait times are the lowest they have been for many years, as of April 24 these were at 8 weeks for referral to second appointment, following initial screening and support.

Following the successful implementation of MyHappyMind https://myhappymind.org into most of Warrington's Primary Schools in 2023/24, Warrington schools, in partnership with MyHappyMind are trialling a new preventative Secondary School programme in 2024/25 in 6 Schools. This programme aims to equip pupils with skills and tools to protect their emotional health and wellbeing and thrive.

10.8 **Wirral**

Continued roll out of Family Hubs, 4 new hubs opened in Q1. Focussed on starting well/ early help. In convenient community locations including Children's centres, Primary schools, other convenient community locations. Model comprises a family help MDT approach in partnership with VCVF organisations.

Wirral Place has received assurance from health partners through the submission of the C&M Safeguarding Commissioning Standards. Initial Health Assessments for Children Looked After remains below threshold and this is reflected in C&M risk register. WUTH have submitted an action plan to address noncompliance which is monitored by the Designated Nurse via the Safeguarding Assurance quarterly submissions.

Wirral Place is focussing on the use of EHCPs to support and inform Children Looked After statuary Health Assessments.

Local improvement plans are progressing in response to the improvement notice and WSoA. These are being closely monitored by the new Local Area SEND Partnership Board.

An operational and strategic group is being led by the LA and the police in response to a BBC investigation and Panorama Broadcast on the 17/6/24 regarding an independent school for CYP with SEND in New Brighton and safeguarding concerns.

In addressing the risk relating to the current Neurodevelopmental pathway and current waiting times as workshop was facilitated by NHS C&M aiming to set clear expectations and timescales in relation to the management of the following three areas and the understanding what additional resources will be required:

- System role in embedding Graduated Approach to reduce demand on NHS Services
- Managing of current waiting lists
- Implementation of the new Wirral ND Model.

An improvement plan will be presented to the Local Area SEND Partnership Board in July.

Another significant area for improvement sits across the partnership regarding the statutory EHCP duties. Work is underway to ensure there are processes in place to effectively manage initial requests, needs assessment processes as well as the quality assurance and approval of EHCPs.

11. Use of Resources

11.1 **Cheshire East**

Cheshire East finished 2023/24 on an improving financial trajectory. Moving into 2024/25 we have a high level of planned achievement of cost improvements. The historic deficit however continues to weigh on our financial position. This is being addressed as part of the proposed Cheshire sustainability review. In the short term however, place partners recognise urgent and emergency care as affording the greatest opportunity for in year cost improvement. This Cheshire wide recovery programme is therefore a key local priority.

11.2 **Cheshire West**

Cheshire West has a much reduced discretionary 'Place transformation funding pot' that is utilised to pump prime the joint health and care transformation work particularly Learning Disabilities model of care and accommodation, Home First and Community Partnerships development. Some of this funding is also going towards a pilot of Joint Brokerage which is delivering savings on care packages/placements.

11.3 **Halton**

Halton's financial plan was achieved for the last financial year, 2023/2024. During 2024/25 we are undertaking an incremental review of BCF and wider Pooled Fund deployment with local authority partners.

11.4 **Knowsley**

There has been no discretionary funding available since the last report.

11.5 **Sefton**

2024/25 Financial Plan. The ICB financial plan for 2024/25 including Sefton Place has been approved by NHS England. The financial plan for Sefton Place is £10.5m deficit. There are further risks to this position as there are cost pressures relating to Continuing Care and prescribing which were not included in the financial plan.

The Cost Improvement target for Sefton Place in 2024/25 is £7.7m, efficiency schemes have been identified and work is in progress to deliver this in full.

Transformation schemes will support delivery of the Place CIP target and the ICB recovery programme.

- AACC service review.
- Sefton Better at Home / Discharge to Assess recovery programme.
- Achieving best value from new funding e.g. Health Inequalities, SDF, Community Growth

2024/25 Financial Position. The draft financial position for Month 3 (June 24), indicates there are financial pressures emerging in respect of Continuing Care and Prescribing, mainly in relation to growth and price inflation exceeding planning assumptions. Work is in progress to increase capacity to address data quality issues which may also be a factor in the reported financial position for AACC.

Warrington

Place transformation funding has been utilised locally by asking partners/voluntary sector to submit applications for funding that would have a positive impact on the key priorities in Warrington. Twenty applications were received, 10 applications were supported, and the projects have now commenced.

An evaluation of the impact of the project will be undertaken to understand the success of the project. The successful applications included a targeted obesity project in the high deprivation areas of the town and a project to make the Youth Zone fully inclusive by providing support for children and young people with Special Educational Needs and Disabilities (SEND) who have a high level of physical support needs.

Place Director contact details for more information:

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- **Simon Banks, Wirral Place Director**
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NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the ICB Audit Committee

Agenda Item No: ICB/07/24/12

Report approved by: Neil Large, Non-Executive Member, Audit Committee Chair

Highlight report of the Chair of the ICB Audit Committee

Committee Chair	Neil Large
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	17 June 2024 and 25 June 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a:

Advise

The Audit Committee at its 17 June 2024 meeting:

- received the External Auditors findings report. Committee noted that the report was substantially complete and that the audited accounts would be ready for Board approval on time. There were no major key findings and a few recommendations made
- received the External Auditors Annual report. Committee noted that the Auditors anticipated issuing an unqualified audit opinion, and noted the Auditors comments and recommendations around the Value for Money assessment of the ICBs arrangements. The Auditors recognised the ICBs significant progress over the last 12 months.
- received and approved the External Auditors Letter if representation on financial statement
- received and approved the Head of internal Audit Opinions annual report for 2023-24, noting the significant progress made by the ICB over the last 12 months resulting in receiving an overall substantial assurance rating.
- received the final draft of the ICBs Annual Report and Accounts 2023-24. Committee endorsed the Annual Report and Accounts and supported the recommendation that the Chair of the Committee recommend to the Board at its meeting on 20 June 2024 that the Board approves the Annual Report and accounts.

The Audit Committee at its 25 June 2024 meeting:

- received a report from the ICBs Chief Procurement Officer (Non-Health) regarding the ICBs adoption of the Atamis Health Family e-commercial system for the future management of contracts and procurement information. Committee noted that this had been procured and funded by NHS England for use by all NHS Organisations. Committee approved the corresponding changes to the approval and sign off processes
- received an update report from the ICBs Chief Procurement Officer (Non-Health) regarding the ICBs procurement waivers undertaken between 01.02.24 and 31.05.24. Committee noted that there had been 24 waivers during this period and that all had been approved within the ICBs governance processes. Committee discussed where improvement could be made to the waiver form, noted the report and the intention to reference tender waivers on the procurement decision register on the ICB website.

- received a report from the Head of Corporate Affairs and Governance seeking approval of proposed changes to the ICBs risk management processes. These changes incorporated changes to assurance ratings to enable greater delineation between levels of assurance, updated BAF summary, changes to risk management cycle and reporting. The Committee approved the proposed changes.
- received a report from the Associate Director of Corporate Affairs and Governance which provided an update on the ICBs controls and processes around managing declarations of interest. The Committee discussed progress in capturing all declarations from staff, training and noted the progress being made.
- received a report from the Head of Corporate Affairs and Governance which presented the ICB Freedom of Information and subject Access Requests Annual Report for 2023-24. Committee noted the performance of the service over the year, discussed how lessons learned could be incorporated into improving internal processes and access to information.
- received a report from the ICBs Internal Auditors outlining the completion of the Annual workplan for 2023-24.
- received and approved the proposed Internal Audit workplan for 2024-25
- received and noted a report from Mersey Internal Audit Agency outlining how it maintains its independence and objectivity in delivery both its Internal Audit function and its advisory and consultancy services.
- received and noted the progress report from the ICBs Anti-Fraud specialist in accordance with the ICBs agreed anti-fraud workplan.
- Received and noted the Committees risk register.

Assure

n/a

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the ICB Remuneration Committee

Agenda Item No: ICB/07/24/13

Report approved by: Tony Foy, Non-Executive Member, Committee Chair

Highlight report of the Chair of the ICB Remuneration Committee

Committee Chair	Tony Foy
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	11 June 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Remuneration Committee:

- received a report from the Chief People Officer providing the Committee with the learning outcomes and recommendations from an internal grievance panel and a recent relevant tribunal case (Moon vs Lancs & South Cumbria NHS FT) regarding contractual engagement of clinical staff. Committee heard how the ICBs grievance policy had been reviewed and was found to still be fit for purpose but supported the intention to update the Policy to mirror the national policy once released later this year. Committee were also informed that the findings and recommendations of the tribunal case has also required the ICB to review its contractual employment terms and conditions with clinical lead roles, further detail of which was to be discussed in a separate paper.

- received a report from the Chief People Officer outlining the proposed contractual changes for Place Clinical Director and Medical Optimisation Clinical Lead roles within the ICB. In light of the findings of the recent tribunal, development of the clinical roles since inception of the ICB, the Committee supported the recommendation that the contractual status with the ICB for individuals undertaking these roles be changed to that of an employee rather than a contractor/appointee. Committee noted that in adopting this recommendation that there would be no financial impact other than accrued continuous service which impacts on service benefits including sickness, holidays and redundancy. Committee noted that the next steps would be for the ICB to consult with the individuals in scope.

- was provided with an up-to-date position by the Chief People Officer regarding the historical and current terms and conditions of engagement for the Pharmacy, Optometry and Dentistry (POD) Clinical roles that TUPED into the ICB from NHS England. Committee members noted that the inherited and existing contractual arrangements for POD Clinical roles were complex and varied, and that work was still required to develop recommendations around a standardised approach. The Committee approved the recommendation that there is an extension to the existing contractual arrangements up until the end of October 2024, with recommendations around changes to come to a future meeting of the Committee.

- received a report from the ICB Chair seeking the consideration by and approval of the Committee for remuneration terms and conditions for the roles of Health and Care Partnership Chair and Vice Chair. Following discussion, the Committee agreed a remuneration rate of £350 per day, with the ICB Chair having the flexibility to agree the minimum and maximum days per month

- was provided with an update on progress around the undertaking of the annual assurance process regarding the Fit and Proper Persons Test by the Associate Director of Corporate Affairs and Governance. Committee members noted that the annual self-attestations for all of the Board Members, Executive, Corporate and Place Directors had been completed and returned and that the searches and checks were underway and on track to be completed prior to the submission of the annual return to the NHS England Regional Director. Committee members also discussed possible changes to the list of individuals who would fall in scope of the ICBs Fit and Proper Persons Policy following a review of costs and benchmarking of other organisations. Following discussion, the Committee agreed to limit the annual attestation process and searches this year to just the Board, Executive, Corporate and Place Directors and to review further proposals for changes to the list of individuals in scope at a subsequent meeting of the Committee.

- received a report from the Chief Executive outlining the process undertaken and assessment outcomes from the annual appraisals of the Executive Team and Place Directors. Committee members were informed of progress against the agreed 2023-24 objectives and the agreed key objectives for 2024-25. The Committee noted the report.

- received a report from the ICB Chair outlining the process undertaken and assessment outcome from the annual appraisal of the ICB Chief Executive. Committee members were informed of the key objectives and developmental areas agreed with each individual. The Committee noted the report.

- received an update from the Chief People Officer on and the detail regarding the changes to the NHS Pension scheme in relation to retire and return provisions, and the subsequent amendments to the ICBs Retirement Policy. Committee members noted the changes and that there were no financial implications to the ICB as a result of these changes.

- received and reviewed the retire and return requests from two very senior ICB managers. Following discussion amongst committee members, including seeking assurance around the interim cover arrangements and any financial implications for the ICB, the two requests were approved.

Assure

n/a

The next meeting of the Committee is scheduled for 10 September 2024.

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the ICB Children and Young Persons Committee

Agenda Item No: ICB/07/24/14

Report approved by: Christine Douglas, Director of Nursing and Care

Highlight report of the Chair of the ICB Children and Young Persons Committee

Committee Chair	Raj Jain
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	12 June 2024

Key escalation and discussion points from the Committee meeting
Alert
n/a
Advise
The Committee: • received a presentation on the Lundy Model for children and young peoples engagement and participation and discussed the development of a Children and Young Persons Summit and membership of the Committee • received an update on the Cheshire and Merseyside Children and Young Persons Neurodiversity Pathway programme of work • received and supported the Cheshire and Merseyside Children and Young Persons Mental Health Plan for 2024-2026. The Plan would be recommended for approval and adoption to the ICB Board at its meeting in July 2024. • considered the Children and Young Persons Thought Leadership Report and recommended that this is presented to the ICB Board at a future meeting for consideration • received and approved the proposed response from the ICB to the current national consultation on water fluoridation expansion programme • received and reviewed the consolidated single line of sight report outlining work being undertaken by multiple agencies across Cheshire and Merseyside working with and for children and young persons.
Assure
n/a

The next meeting of the Committee is scheduled for 14 August 2024.

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Agenda Item No: ICB/07/24/15

Responsible director: Christine Douglas, Director of Nursing and Care

Highlight report of the Chair of the Women's Hospital Services in Liverpool Committee

Committee Chair	Hilary Garratt
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	03 July 2024

Key escalation and discussion points from the Committee meeting

Alert

n/a

Advise

The Committee considered the following:

Draft Case for Change

The Committee received the draft clinical case for change for women's hospital services (maternity and gynaecology) in Liverpool.

The near final draft included key evidence demonstrating and illustrating the case for change. There was discussion about the significant evidence that women from socially deprived backgrounds and those from ethnic minority groups are disproportionately affected by the current service arrangements.

It was noted that the draft case for change has been shared with the four provider boards that are directly involved in the delivery of the programme (Liverpool Women's FT, Liverpool University Hospitals FT, Alder Hey Children's FT and The Clatterbridge Cancer Centre FT) and other key stakeholders; to date, the draft case for change has been supported and endorsed by all.

It was noted that engagement will continue prior to a final draft being received by the Committee in September.

The Committee supported and endorsed the draft case for change and agreed to recommend the current draft to the Board of NHS Cheshire and Merseyside.

Assure

The Committee considered the following:

- **Programme Update.** The Chair of the Programme Board provided an update on programme activity since the March meeting. This included:
  - progress and activity related to developing the draft clinical case for change.
  - plans for communication and engagement.
  - progress on delivering clinical improvement plans at LWFT.
  - activities planned for July – September.

The Committee noted the programme update and progress made to date.

- **Clinical Engagement Event.** The Committee received a report about the engagement event held in May. 70 delegates including clinicians, service leads, network leads and patients with lived experience attended. They provided feedback on the developing draft case for change and shared their experiences as members of the workforce and as users of services. The outcomes from the event are being incorporated into the programme work. **The Committee noted the report.**

- **Strategic Communications and Engagement Plan.** The Strategic Communications and Engagement Plan for the programme was presented. It is a working document and is already being actioned by the programme's Communications and Engagement Group. Recruitment to the lived experience panel and lay advisors had been paused due to the pre-election period but is now being actioned. The Programme Board will be considering the pre-consultation and engagement plan at its July meeting.**The Committee noted the progress made with the delivery of the strategic communications and engagement plan and the development of the pre-consultation and engagement plan.**

- **Programme Risks.** There were no changes to risk scores. A discussion was held regarding the potential for a long term plan requirement for obstetrics across Cheshire and Merseyside. It was agreed this is not an immediate risk to the programme but something the Committee needs to be aware of in the event of longer term plans being developed. It was agreed that the Executive ICB SRO for the programme pursue a discussion with ICB executive team. **The Committee noted the programme risk register and the update on actions taken.**

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the North West Specialised Commissioning Committee

Agenda Item No: ICB/07/24/16

Report approved by: Clare Watson, Assistant Chief Executive

Highlight report of the North West Specialised Commissioning Committee

Committee Chair	Clare Watson
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	06 June 2024

Key discussion points and matters to be escalated		
Item	**Issue**	**Action**
Alert: ***requires the boards' attention or action including action taken***		
Inter Arterial Thrombectomy Surgery for the treatment of Ischaemic Stroke	The thrombectomy service Royal Preston Hospital is generating media coverage as there have been a number of incidents whereby patients have experienced poorer outcomes as the service is not currently available 24/7.	A Rapid Quality Review is planned across all three North West ICBs around mechanical thrombectomy services given continuing challenges to deliver 24/7 services in Lancashire and South Cumbria.
Advise: ***Advises of ongoing monitoring or development where there is negative assurance***		
Thirwall Public Inquiry update	Interviews will be conducted over the summer for September hearings relating to the Thirlwall Public Inquiry to examine events at the Countess of Chester Hospital and their implications following the trial, and subsequent convictions, of former neonatal nurse Lucy Letby of murder and attempted murder of babies at the hospital.	Communications handling - media coverage and interest expected.
NW Specialised Commissioning Team	For 2024/25, the current NW Specialised Commissioning team will continue to be hosted by NHS England, with budgets and commissioning responsibilities delegated to ICBs. The recruitment freeze in NHSE has now been lifted. A national Target Operating Model for retained specialised in development. This will inform the form and function of the NW regional Specialised Commissioning Team that will transfer to the Lancashire and South Cumbria ICB in April 2025.	A new operating model for the regional specialised commissioning team is in development. Vacancies have been made available to internal applicants initially and a full complement of staff should soon be in place.
Complex Termination of Pregnancy Procurement	The procurement process for a Complex Termination of Pregnancy service for the population of the NW has been halted and is being reviewed.	A new process is planned to start in Quarter 2 of 2024/25 under the Provider Selection Regime.
Specialised Service Suitable but not ready for Delegation in 2024/25	In March 2024 a national review of the 57 services 'suitable but not yet ready for delegation' was undertaken and identified that a further 25 services are now suitable for delegation to ICBs in April 2025.	The NWSSC will lead work to oversee the planning of these services throughout 2024/25.

Assure: ***Informs the board where positive assurance has been achieved***		
Specialised Commissioning Contracts 2024/25	Contract offers have been issued to all NW providers.	Detailed conversations are in progress to finalise 2024/25 contracts.
Governance documents	Signed Delegation and Commissioning Team Agreements have been fully executed by NHS England.	Documents to be circulated to ICBs.
Risk processes	To ensure consistency of how risks are reported through the respective Boards risk processes are being reviewed and aligned to ICB processes.	Clinical risk review meeting in planned with ICB and NHSE medical directors and directors of nursing.
Pipeline for new drugs	Work continues nationally on the NICE appraisal pipeline for new drugs for Alzheimer's disease.	NICE evaluation of the first two new drugs will be decided in the summer that will inform regional implementation plans.
Risk: Advise the board which risks were discussed and if any new risks were identified.		
Ref.	**Risk**	**Action taken/update**
Thrombectomy service (L&SC)	The Thrombectomy Service at L&SC is generating media attention due to a number of incidents whereby patients have experienced poorer outcomes as the service is not currently 24/7.	A Contract Performance Notice has been issued to Lancashire Teaching Hospitals NHS Foundation Trust. Plans for a North West regional rapid quality review relating to Thrombectomy availability focusing on access to the service. Improved coverage already in place.
Adult Critical Care Transport Service Procurement	Work is underway to design, develop and implement a single Adult Critical Care Transfer Service (ACCTS) for the North West of England to ensure a sustainable, standardised model across the region from April 2025. ACCTS provides coordination, triage, decision-support and transfer of critically ill patients between hospitals for escalation to specialist care, repatriation and capacity reasons.	The project is being led by a dedicated project manager and clinical lead. Leadership and management oversight for the project is provided by the Adult Critical Care (ACC) network director in LSC. All three ACC networks have collaborated on service model options. A Procurement Group has been established comprising representatives from all three ICBs.
Cancer Waiting Time Standards	Risks of patient harm as a result of non-delivery of cancer waiting time standards for specialised cancer surgery/chemotherapy/radiotherapy	Work with cancer alliances on 24/25 cancer delivery plans and to support trusts to improve performance. Work through the performance tiering system led by regional and national teams for the highest risk Trusts.
Neurosciences	Poor recovery of GM neurosciences activity, including spinal surgery, could lead to patient harm.	Regular service level meetings with neurosciences providers to discuss actions being undertaken to improve their positions. Regular

		dialog and involvement with the system to review performance. Internal processes in place to monitor performance. Bimonthly board in C&M, Similar arrangements being established in LSC.
Cardiac Surgery	Poor recovery of cardiac surgery and complex cardiology waiting lists and unmet increased demand, which could result in patient harm.	Regular service level meetings with cardiac providers to agree action plans being undertaken to improve their positions. Regular dialog and involvement with the system to review P2 performance. Internal processes in place to monitor performance.
Retinopathy Prematurity Screening	Risk that premature babies will have avoidable childhood visual disability due to lack of skilled Retinopathy of Prematurity retinal screening staff in neonatal units across the NW.	A new clinical model is in development, led by the NW Neonatal ODN.

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Agenda Item No: ICB/07/24/17

Report approved by: Councillor Louise Gittins, HCP Chair

Highlight report of the Chair of the Cheshire and Merseyside Health and Care Partnership

Committee Chair	Councillor Louise Gittens
Terms of Reference	https://www.cheshireandmerseyside.nhs.uk/about/how-we-work/corporate-governance-handbook/
Date of meeting	19 March 2024

Issues considered

ICB Financial Update

The item referenced the month 9 financial position paper which was contained within the meeting pack. In summary, the collective deficit plan for the ICB at the start of the year was £51m. Month 9 was £40.8m off-plan, of which £7m was contributed to the industrial action (December and predicted costs for January) in addition to funding provided at the beginning of the year. Financial variations for the ICB related to both the increase in volume and complexity of CHC joint funded packages of care and in addition, inflation had been higher than anticipated.

Providers had also experienced similar pressures related to inflation and the cost of drugs and utilities which impacted upon some of the contracts they had with other organisations. They had also been impacted by the industrial action which totaled £22m for December and January across Cheshire and Merseyside. Although additional funding had been provided, this did not sufficiently cover the costs incurred and has had a knock-on effect on their saving plans. The amount of income earned was also reduced by the industrial action as some provider contracts are based on activity. The total financial impact to date with industrial action within Cheshire and Merseyside is £50m and work was ongoing to mitigate this.

Health Inequalities Funding

Ian Ashworth advised that Place Directors have been asked to have conversations with elective members and Directors of Public Health to consider opportunities to work collaboratively towards the joint HCP and All Together Fairer Strategy.

Members felt that the fairest way to distribute health inequalities funding would be at ward level. Members were advised by the Chair that Marmot principles referred to proportional universalism. Members were advised that ICB Place Directors were leading on discussions in local areas to determine where to best target the available resources. Some of the proposals had been made using the national health inequalities formular or the NHS Core 20+5 approach.

The paper had also been discussed at the Mental Health and community collaboration meeting and there had been a long discussion how to ensure the small numbers of people who were high need were not lost in the process, particularly people with learning disabilities who have been historically poorly advocated for in terms of service provision. It was felt that minimising the distribution of funds to Places without effective framing could increase unwarranted variation and some of the funds could be best utilised at scale to disseminate best practice. It was also felt to be important that the decision making was not too NHS centric and other system partners had a voice. It was acknowledged that some projects did work

better locally but cautioned that match funding may not support some of the strategic objectives.

It was confirmed that the HCP will make the final decision about how budgets were allocated as well as oversight and authority of the allocation formula. There will not be a bidding process and the formula will sit with Place and Public Health Directors but be a partnership process. It was noted that not all support from partners would be financial but that they will be asked to participate in the process to allocate the funding.

A plan will be brought back to the next meeting in June and representatives from local government were asked to liaise with their Place and Public Health Directors with their ideas for the allocation of funds. Priority should be given to how the partnership can collectively deliver Marmot principles and the All Together Fairer Strategy with new innovative preventative ideas.

All Together Active Update

The Speaker was welcomed by the Chair to the meeting where he undertook a presentation on All Together Active (to be circulated following the meeting). A paper is also contained in the meeting pack for information.

The Chair stated that it was important for partnership members to advocate this initiative within their workplace, as well as within the Anchor networks.

Members were advised that there were cost effective ideas which could have a big impact and the simplest opportunity is to normalise the wearing of trainers within the workplace to encourage staff to go for a walk at lunch time and be generally more active during the day.

The evidence around the positive health impacts of physical activity is irrefutable and it was explained that stronger evidence base needed to be established on the benefits of daily activity and in sharing best practice. Members were asked to provide evidence of any initiatives that that have been successful within their Place to increase the uptake of physical activity in the community.

The speaker was asked how well All Together Active were partnered with Mersey Travel and noted the importance of prioritising cycling to work schemes and improving walking routes to encourage the reduction on use of cars. It was felt that access to nature should be a high priority as there was a mass of evidence of the benefit of physical activity in green spaces.

The use of social prescribing was discussed as a lever to promote physical activity and green spaces, as well as the benefit of horticulture. It was discussed that a piece of research was undertaken 18 months ago which indicated 9 out of 10 clinicians were not comfortable prescribing a physical activity and a stronger evidence base was required to improve this.

It was noted that there was a significant component on social prescribing contained within the Primary Care Strategy and members were advised that social prescribing was also part of the Primary Care Access Recovery Plan.

It was reported that one of the key priority areas for Knowsley as part of the All Together Fairer Strategy was tackling childhood obesity and there were lots of green spaces in Knowsley which held local activities to encourage the public to be more active. It would therefore be

beneficial to collate all similar initiatives occurring within Cheshire and Merseyside and to share good practice.

As part of the launch of the All Together Active last year it was evidenced that there were 2.7m people in Cheshire and Merseyside who did not do 30 minutes of exertion per week. Members were asked what could be done to change this behaviour and to encourage physical activity and proposed introducing a daily mile for all schools in Cheshire and Merseyside. Also, as the largest employee body within Cheshire and Merseyside, the NHS could work to encourage their staff to become more active, including cycling to work and daily mile schemes.

The Chair shared that the idea of having a daily mile across all C&M schools and that a similar project called Smile for a Mile had been successful in previous years. She asked that further thought be given as to what can be achieved and that this could be a topic for a future meeting or workshop.

All Together Fairer/ HCP Strategy Update

The Speaker referenced the paper contained within the meeting pack and summarised progress made to date on developing the joint forward plan. There were 3 core elements of the NHS Delivery Plan which included wider partnerships, Place based partnership plans as well as work with CHAMPS and wider social determinants.

Members were asked to endorse the content of the draft outline plan and to comment if they wanted to add anything. Feedback should be provided to ICB staff.

All 9 Places had been asked to provide 3 case studies, and this will then be reduced to one case study per patch. The HCP will collectively agree 3 core principles to help address the wider health determinants and inequalities. The All Together Fairer Board have suggested identifying big ambitions that the HCP could adopt. It was recommended that 5-6 headline ambitions for the HCP be identified which can be threaded into the joint forward plan for final approval at the June meeting.

The following options were listed for consideration by members:

- ‘All Together Smoke Free’ - ending smoking for everyone. The interim target is to deliver a smoke free environment by 2030 which is fair and equitable for all our adult population, and a tobacco free future for every child.
- Agreement for NHS and Local Authorities to commit to becoming anchor institutes by 15%.
- Housing and health; warmer homes
- Work and health strategies related to disability and illness.
- Children and young people 95% uptake of healthy start vitamins. (current range is 69% to 85%).
- Improving physical activity of the population (daily mile for schools).

The members agreed that it was appropriate to identify 5-6 ambitions. Twelve options would be distributed to members for their consideration as part of a voting poll that would look to address as many of the strategic priorities as possible. Members would then be asked to provide their feedback by 12th April 2024.

Items for Escalation

The members were advised that there had recently been a roundtable held in relation to homelessness concerns, specifically for the LGBTQ and asylum seeker and refugee population. Members felt that this warranted a future agenda item at the HCP.

It was queried whether it would be beneficial to have an update on the progress on the Anchor Institutes. It was noted that an update had been provided at the last HCP meeting in January and that frequent reports were being received that organisations were continuing to sign up.

The Chair asked for future agenda item in relation to SEND and the challenge for partners across the system.

Review of Meeting / Forward Plan Items

It was noted by the Chair that a decision had been made to cancel the April meeting due to local elections.

Members were also asked if they could nominate any suitable venues for future meetings. The Cunard Building has been identified as an alternative but ideally, we would like to hold the HCP in different venues across the region. All possible venues would need to seat up to 30 people and hybrid facilities to be provided if possible. It was noted that the hybrid option needs to continue as it was not always viable for members to attend different venues face to face.

The next meeting of the Committee is scheduled for 20 August 2024.

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Shaping Care Together – A Case for Change

Agenda Item No: ICB/07/24/18

Responsible Director: Clare Watson, Assistant Chief Executive

Shaping Care Together – a Case for Change

1. Purpose of the Report

1.1 The purpose of the paper is to seek approval from the NHS Cheshire and Merseyside ICB of the newly developed Case for Change (Appendix One) for the Shaping Care Together (SCT) programme and the commencement of a period of pre-consultation engagement.

1.2 The approval and publication of the Case for Change will enable the commencement of an eight to ten week period of pre-consultation engagement involving patients, public, staff and other key stakeholders in the shaping of urgent and emergency care services in Southport, Formby and West Lancashire.

2. Executive Summary

2.1 The Shaping Care Together (SCT) programme is a health and care transformation programme operating across Southport, Formby and West Lancashire. This partnership programme is supported by Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), NHS Cheshire and Merseyside Integrated Care Board (ICB) and NHS Lancashire and South Cumbria ICB. The aim is to improve the quality of care for local residents by exploring new ways of delivering services and utilising staff, money and buildings to maximum effect.

2.2 Following months of development, input and feedback being sought from a wide range of stakeholders, including clinicians, commissioners, Healthwatch, CVS and patient/public groups, the programme has now produced a newly developed Case for Change (Appendix One).

2.3 Approval of the Case for Change has to be sought from the commissioners of the services in scope of the Case for Change. Subject to the approval from NHS Cheshire and Merseyside ICB and NHS South Lancashire and Cumbria ICB , the Case for Change will be published, and pre-consultation engagement will commence to gain insight from public, patients, staff and other key stakeholders to shape the options for this transformation programme, which is predominantly focussed on the shaping of urgent and emergency care services in Southport, Formby and West Lancashire.

2.4 The Case for Change document has been considered by the Board of NHS Lancashire and South Cumbria on 17 July 2024[1] where approval was received for the Case for Change and the commencement of the pre-consultation engagement process. The Board of MWL also considered and supported the Case for Change at its meeting on 29 May 2024.

[1] https://www.lancashireandsouthcumbria.icb.nhs.uk/about-us/board/meetings-and-papers/future-board-meetings/17-july-2024-board-meeting

2.5 The Shaping Care Together programme has also completed the NHS England Stage 1 Assurance sense check on 03 June 24. Feedback from NHS England has been positive in the work undertaken so far regarding clinical engagement and work to identify sustainable solutions for the services described in the case for change.

2.6 It is anticipated, subject to approval from NHS Cheshire and Merseyside ICB in July 2024, that the pre-consultation engagement will commence soon after the 25 July 2025 for a period of between 8-10 weeks.

2.7 Whilst this draft Case for Change has so far been presented separately to each ICB and to MWL for their approval and support, further governance options have been explored to determine the optimal governance arrangements going forward. It is considered that a Joint Committee of the two ICBs, with MWL as a member, would provide a more effective and streamlined governance vehicle for consideration and approval of the key decisions that are required to progress this programme over the next year. If the Board of Cheshire and Merseyside ICB supports progressing the establishment of a Joint Committee with NHS Lancashire and South Cumbria ICB, then a further update will come to both Boards in September 2024 seeking approval of the Joint Committees Terms of Reference and Committee establishment. It should be noted that at its meeting on 17 July 2024, the Board of NHS Lancashire and South Cumbria ICB supported progressing the work to establish a Joint Committee between the two ICBs

3. Ask of the Board and Recommendations

3.1 The Board is asked to:

- review and approve the draft Case for Change
- approve the commencement of the pre-consultation engagement
- approve progressing the work to establish a Joint committee of the two ICBs
- note that a further update will be provided to the Board at its meeting in September 2024, including the recommendation to approve the Terms of Reference of and establishment of a Joint Committee between the two ICBs.

4. Reasons for Recommendations

4.1 Approval of the Case for Change will enable the Case for Change to be formally published and allow the programme to commence the pre-consultation engagement with patients, public, staff and various key stakeholders in the shaping of urgent and emergency care services in Southport, Formby and West Lancashire.

4.2 Support to the establishment of a Joint Committee will provide a more effective vehicle for decision making over the next year.

5. Further Information

5.1 The Shaping Care Together programme has focused on the potential transformation of service provision in North Sefton and West Lancashire and has undertaken extensive engagement with local residents to gain views on future service provision.

5.2 Recovery post Covid-19 pandemic is ongoing and the Shaping Care Together programme has continued to engage and review its purpose in light of system changes. In July 2023, Southport and Ormskirk NHS Hospitals Trust and St. Helens and Knowsley Teaching Hospitals Trust came together as one Trust to form Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL). This has provided an opportunity to review the scope of what is possible in terms of service development, as the case for change for bringing the Trusts together noted the potential to address some service challenges (for example, workforce and finance) across a wider footprint.

5.3 Following the formal creation of MWL, our system partners agreed that a refresh of the programme was required and will initially focus on developing options for improving the provision of urgent and emergency care in Southport, Formby, and West Lancashire.

5.4 The programme objectives for the first phase of the rescoped Shaping Care Together programme is to improve the safety and quality of urgent and emergency care in Southport, Formby and West Lancashire. In doing so we want to:

- deliver sustainable, responsive urgent and emergency care services.
- improve the integration of services across the health and care system.
- deliver services close to the local community, wherever possible.

5.5 This does not mean that other services fall outside the remit of the programme, just that Phase 1 of the refreshed programme will focus on Urgent and Emergency Care in Southport, Formby and West Lancashire as a priority.

5.6 It is worth noting that the decision making is based on NHS England major service change guidance. This includes the approval of the Case for Change, and the approval of the Pre Consultation Business Case. The two ICBs have the remit with regards to approval, noting that the lead commissioner of MWL is NHS Cheshire and Merseyside and therefore this makes Cheshire and Merseyside the lead commissioner in this programme.

5.7 Assuming that both ICBs support the establishment of a Joint Committee, a further paper will come to the September 2024 Board meetings of each ICB presenting the Committee Terms of Reference to review and approve, and seeking agreement on the delegated authority that Committee will have to act for and on behalf of each ICB. It is anticipated that approval will be sought to delegate authority to the Committee to approve:

- any Pre-Consultation Business case (assured by the outcome of the Case for Change engagement)

- commencement of any consultation with the public, patients and stakeholders, ensuring effective engagement and consultation processes has been undertaken, meeting the key requirement of public consultation (Gunning principles)
- receive the findings and outcomes of any consultation undertaken with respect to Shaping Care together
- receive and approve any Outline Business Case of Full Business Case, ensuring it meets all relevant tests/staged.

5.8 **Case for Change.** A Case for Change comprehensively describes the current and future needs of the local population, the provision of local services and the key challenges facing the health and care system. It provides the platform for change and needs to present a compelling picture of what needs to change and why, as well as linking to the benefits that the proposed service change will aim to deliver. It is a key requirement as outlined within the NHS England major service change guidance.

5.9 Using the Shaping Care Together Challenges and Opportunities paper, published in March 2021,[2] and various publicly available information, the Case for Change has now been developed for the Shaping Care Together programme. Following months of development, input and feedback has been sought from the following key stakeholders:

- Clinicians (inc. medical, nursing and AHP staff) from the following organisations:
  - Mersey and West Lancashire Teaching Hospitals NHS Trust o Cheshire and Merseyside ICB
  - Lancashire and South Cumbria ICB
  - North West Ambulance Service NHS Trust
  - Mersey Care NHS Foundation Trust
  - HCRG Care Group
- ICB commissioners
- NHS England (informally)
- The Consultation Institute
- Shaping Care Together programme board
- Shaping Care Together workstream leads (clinical, estates, finance, Business Intelligence , Communications and Engagement)
- Healthwatch
- Council for Voluntary Service
- Patients and public.

5.10 The Case for Change has been informed by insights from engagement and involvement previously undertaken with public and patients and a summary of insights from focus groups of members of the public and community organisations which took place in May 2024 and how this is being used to inform this version of the case for change. Key themes from the public engagement related to information needing to be presenting using clear language and simple visuals, in addition to requests for realism and clear timelines which people felt are needed in order to build trust.

[2] https://council.lancashire.gov.uk/documents/s192874/Appendix%202%20Shaping%20Care%20Together%20Programme%20Engagement%20Update.pdf

6. Officer contact details for more information

Rob Cooper – Managing Director, Mersey and West Lancashire Teaching Hospitals NHS Trust (rob.cooper@sthk.nhs.uk)

Halima Sadia – Programme Director – Shaping Care Together, Mersey and West Lancashire Teaching Hospitals NHS Trust (halima.sadia@sthk.nhs.uk)

7. Appendices

Appendix One: Shaping Care Together – A Case for Change Urgent and Emergency Care

Appendix Two: SCT – A Case for Change – summary presentation

A case for change

Urgent and Emergency Care

JULY 2024

Contents

1. What is Shaping Care Together?

Much of the NHS was designed decades ago to respond to the health needs of the population at that time. It's right therefore, that from time to time, we take stock of how we do things so that we can make sure that we're set up to face today's challenges. Shaping Care Together is an NHS programme aimed at improving the way we provide health and care in Southport, Formby and West Lancashire.

Our responsibility is to provide the highest quality of care to meet the needs of the patients and communities we serve. However, some pressures which are being felt right across the NHS, are making it harder for us to do this where we live. Staffing shortages, a need to invest in our buildings and estates, and funding challenges are putting services under pressure. We also have an ageing population which means that demand for services will continue to rise in the future.

"We are starting by looking at how we offer urgent or emergency care to those who need it."

Find out why in section seven

We need to prepare our local NHS to meet those future needs and expectations, delivering high-quality services that are both safe and sustainable.

Shaping Care Together is about finding ways to make the best use of our staff, money, and other resources to do just that.

We know that changing too much and too often can be disruptive and costly, but we are confident that now is the right time to look for new and better ways to organise our local NHS. Working together with our patients, our dedicated healthcare professionals, and our partners, we are confident we can get this right.

Since the start of Shaping Care Together, we have been listening to people and organisations affected by and involved in the provision of health and care services. We have tried to get as many people as possible to share their experiences and to contribute their thoughts and ideas about what works well, and what doesn't, and to help us see what good should look like.

What we've learnt so far

Our initial listening and engagement has helped shape the way we approach change, based on the priorities of the people we serve. We now know some of the things that matter most to people, such as:

- Receiving excellent quality care, even if that means having to travel a little further.
- Having care provided closer to home and in the local community wherever possible.
- Reducing waiting times for outpatient appointments.

We are now taking these priorities forward to the next phase of Shaping Care Together in which we are looking at how we offer urgent and emergency care to those who need it. The way we do this can have a big impact on how we operate many other NHS services. Our ambition is to ensure that urgent and emergency care services are organised in a way that can help deliver:

- Reduced waiting times at A&E and for urgent care.
- 24/7 dedicated emergency care for all ages.
- NHS services that meet patients' needs, today and in the future.
- Fewer cancelled operations.
- Better urgent care provided closer to home.

As we continue to involve, engage and listen to people, we will develop a long-list of options for how urgent and emergency care service could look in the future, ensuring that the views of those we serve are central to shaping these services.

The standard we set for everything is that we have services which are safe and sustainable, and which are built around excellent patient care.

Our ultimate goal continues to be improving the health and wellbeing of our communities and enabling people to live longer and healthier lives.

WHO IS INVOLVED?

This programme is a partnership between Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), and the integrated Care Boards (ICBs) of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria.

Find out more about how the work of the Shaping Care Together programme fits with the ambitions of each of our partner organisations.

2. Our ambition for your local NHS

Our local NHS in Southport, Formby and West Lancashire is there to provide excellent quality care, to everyone, all of the time. We are committed to reducing health inequalities for the populations we serve.

"Our vision is to improve the health and wellbeing of local communities, enabling people to live longer and healthier lives. We want to do this by creating and delivering safe, integrated, and sustainable services."

The Shaping Care Together programme was set up to help us meet these ambitions through the care we provide. Our goal is to organise NHS services built on the provision of safe and high-quality care, today, and in the future.

Working together with patients, our dedicated healthcare professionals, and our partners, we need to get this right with the buildings, staffing, funding, and other resources we have available to us.

We are confident that we can.

PROGRAMME OBJECTIVES FOR URGENT AND EMERGENCY CARE

In January 2024, the following set of objectives were agreed for the current phase of the programme on urgent and emergency care:

Delivering urgent and emergency care services that are responsive, safe and sustainable.

Improving the integration of services across the health and care system.

Delivering services close to the local community, wherever possible.

3. Where we live

As we consider how best to reorganise NHS services, we have to look at levels of poverty and deprivation across the areas we serve. This is often a good way of identifying differences in the health of the population (often referred to as health inequalities), which in turn can indicate where there might be more demand for NHS services and care.

HOW WE MEASURE DEPRIVATION

One method is to use IMD ratings **(Index of Multiple Deprivation)**. This is a set of widely used measures used to classify the relative deprivation (essentially a measure of poverty) of small areas.

The index uses six different measures, each given its own weighting in calculating overall deprivation scores. Rates of employment are given the most weighting followed by education and health. The three measures with the lowest weighting are crime, living environment and barriers to housing and services.

More affluent areas have lower IMD ratings (because they have lower levels of deprivation). Higher scores indicate higher levels of poverty and deprivation.

Southport and Formby

The predominantly coastal and semi-rural area of Southport and Formby is in the Metropolitan Borough of Sefton, to the north of Liverpool.

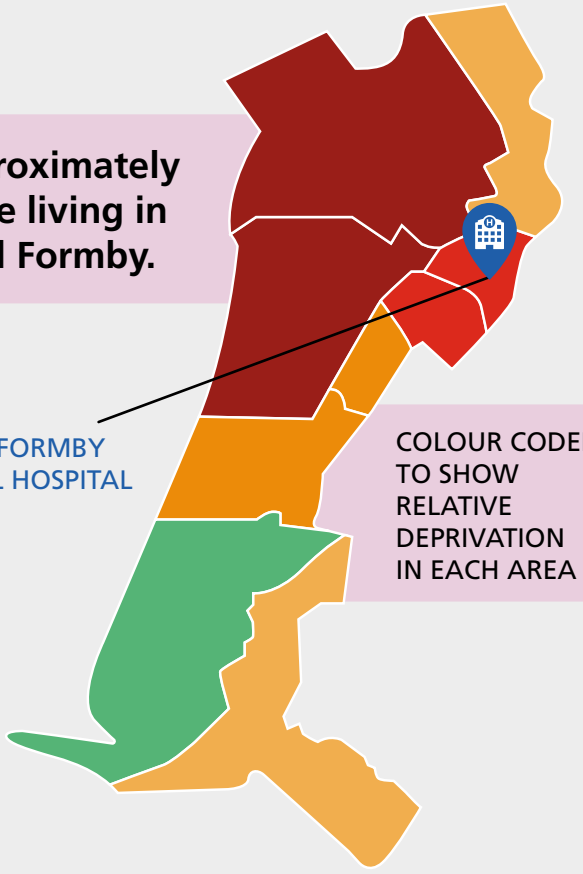
With a population of 118,000 it stretches along the Irish Sea coastline. While Southport itself is a sizeable coastal town, the surrounding areas are relatively less urbanised. Scattered villages and suburban residential areas are interspersed with open countryside, farmland, and pockets of woodland.

The area is considered relatively affluent compared to other parts of Merseyside. There are, however, significant levels of social inequality. Areas such as Ravenmeols, and particularly Harrington, are relatively affluent. Harrington has a rating of 6.7 on the Index of Multiple Deprivation (see information box). By contrast, Cambridge has a rating of 29.4 and Duke's a rating of 31.1. The all-England average is 21.7 and the average for Southport and Formby is 19.2.

We see a similar pattern with peoples' incomes, with Harrington residents earning the most on average, and the lowest earners living in Cambridge and Duke's, behind both the all-England average and Southport and Formby as a whole.

Kew and Norwood also have relative high levels of overall deprivation, whereas Ainsdale, Birkdale and Meols all fare relatively better than the Southport and Formby average.

There are approximately 118,000 people living in Southport and Formby.



IMD deprivation ratings	
21.7	England
19.2	S&F Average
17.8	Ainsdale
16	Birkdale
29.4	Cambridge
31.1	Duke's
6.7	Harrington
23.6	Kew
13.8	Meols
22.5	Norwood
12.2	Ravenmeols

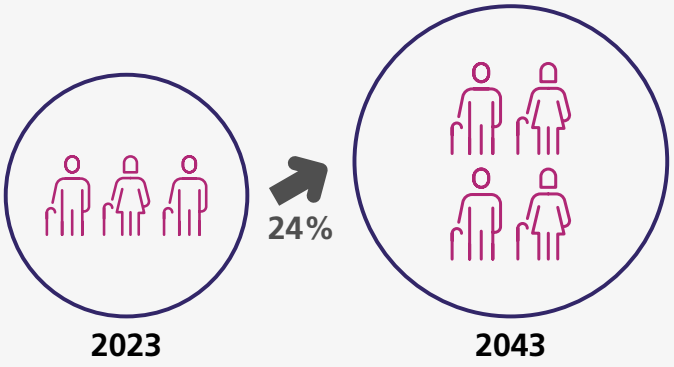
Population growth

The population is ageing at a faster rate than the national average, increasing future demand for health and care services.

SOUTHPORT AND FORMBY PROJECTED POPULATION GROWTH 2023 - 2044

Age	2023	2028	2033	2038	2043	% change
0 - 17	22,176	22,009	21,396	21,258	21,637	-2.43
18 - 64	62,030	61,002	60,475	61,341	61,388	-1.03
65+	33,986	37,210	40,242	42,177	42,229	+24.25
All Ages	118,192	120,221	122,113	123,776	125,254	+21

People above working age (65+)



The number of working age people (16-65) in Southport and Formby is expected to remain at **around the same level over the next twenty years.** However, for every three people above working age now living in the area, projections suggest that by 2043 there will be four - **a rise of over 24 per cent or 8,000 people.**

WHY LOOK AT POPULATION GROWTH?

Compared to people of working age, older people often have more complex healthcare needs, sometimes requiring care for more than one condition at any one time. If the support they need is not available to them in the community, or at home, older people often stay in hospital care, even when that is no longer needed to help improve their condition.

Our goal is to prevent this from happening as much as we can so that hospital beds can remain available for those people who need to be admitted to hospital.

When designing future NHS services we need to account for the changing healthcare needs of an ageing population.

Poverty and deprivation

With an overall IMD rating of 19.2, Southport and Formby has slightly lower rates of poverty and deprivation than all-England (21.7) but is a **little higher than West Lancashire** (18.6). However, data shows that a number of neighbourhoods close to Southport and Formby Hospital are among the most deprived areas in England.

There are many ways we can measure deprivation in our communities. The table below shows some key indicators which help us to appreciate the relatively high levels of social inequality across Southport and Formby. We can see significant differences between the most and least deprived areas, especially in terms of child poverty, poverty amongst older people, and households in fuel poverty.

Deprivation indicators	All England	Southport & Formby	Most deprived	Least deprived	Gap
Index of Multiple depravation (weighted)	**21.7**	**19.2**	**31.1**	**6.7**	**25**
Child poverty (IDACI)	17.1	12.7	17.6	3.5	14.1
Older people in poverty (IDAOPI)	14.2	13.3	18	5.4	12.6
Fuel poverty (% of households)	13.2	12.7	16.4	7.4	9
Unemployment (% of working age)	5	4.4	7.9	2.9	5

If we consider just the selection of indicators in the table above, the area appears to be a little less deprived than England as a whole. **The most significant gap we see is in the level of child poverty, with Southport and Formby rated at 12.7 and all-England at 17.1.**

The weighted IMD ratings show the most deprived area (Duke's, rated at 31.1) has much higher rate of deprivation than all-England, whereas Harrington (rated 6.7) is significantly less deprived. While Harrington is the least deprived area on every measure in the table, both Meols, and Ravenmeols also have relatively low levels of deprivation.

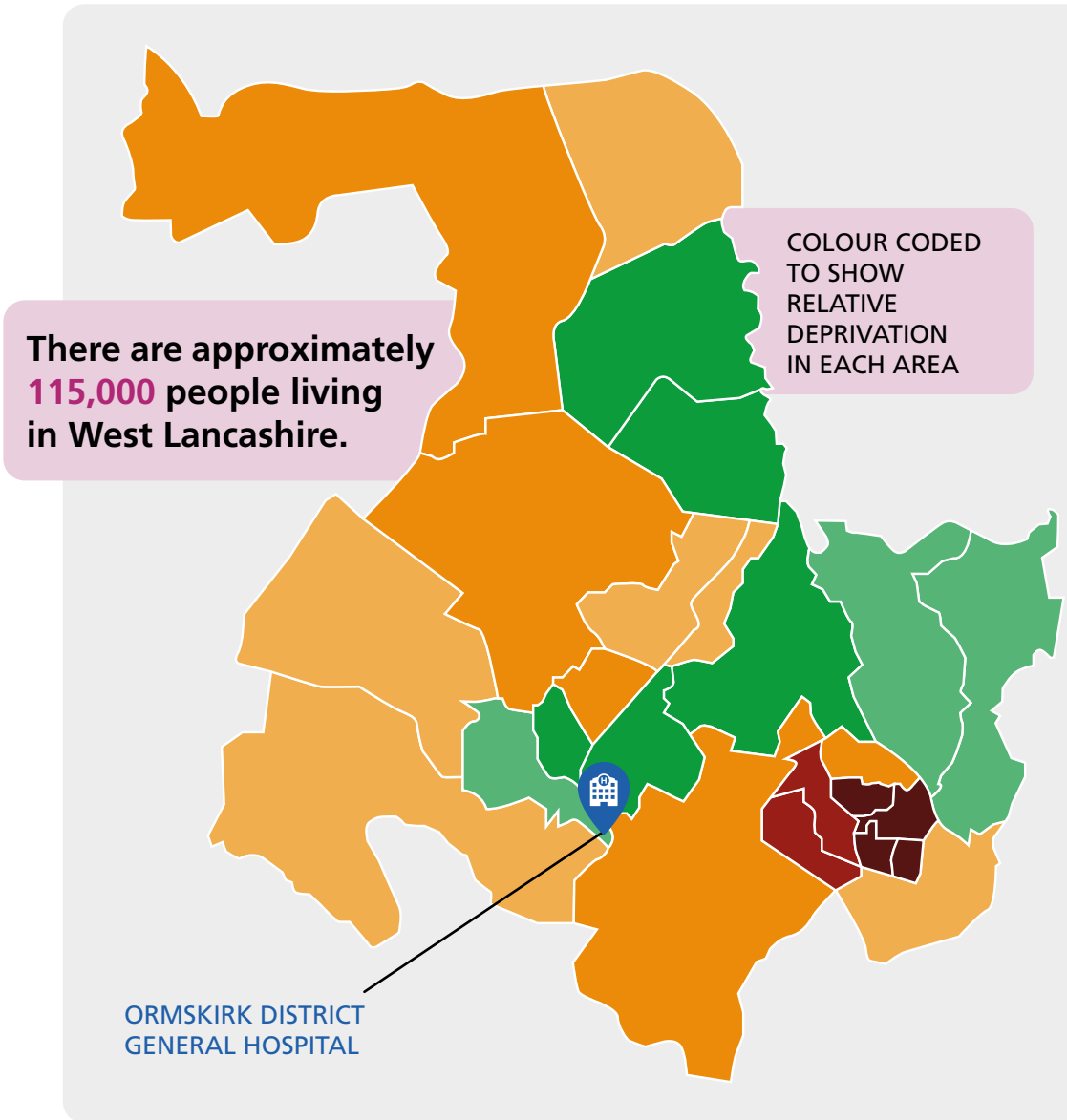
West Lancashire

West Lancashire is a predominantly rural district to the north-east of Liverpool. It has a population of 117,000 and is made up of the 1960s new town of Skelmersdale, the historic market town of Ormskirk, and a number of villages situated primarily in the rural Northern Parishes.

Much of West Lancashire could be considered relatively affluent, however, there are significant pockets of poverty and deprivation.

For example, Wrightington, Tarleton, Aughton Park, Parbold, Rufford, Newburgh, Knowsley and Derby all have overall IMD deprivation ratings of under 10. These areas are relatively affluent when compared with the all-England rating of 21.7.

However, poverty and deprivation is concentrated in a small number of electoral wards in Skelmersdale, namely Digmoor (IMD rating of 49.9), Birch Green (43.5), Moorside (43.2) and Tanhouse (41.5), leading to significant social inequalities.



IMD deprivation ratings	
21.7	England
18.6	W Lanc average
19.1	Ashurst
10.7	Aughton & Downholland
5.3	Aughton Park
18.1	Bickerstaffe
43.5	Birch Green
13.3	Burscough East
12.8	Burscough West
8.2	Derby
49.9	Digmoor
14.6	Halsall
10.6	Hesketh-with-Beconsall
9.8	Knowsley
43.2	Moorside
9.2	Newburgh
16.9	North Meols
5.0	Parbold
8.8	Rufford
16.7	Scarisbrick
16.5	Scott
31.0	Skelmersdale North
26.5	Skelmersdale South
41.5	Tanhouse
8.4	Tarleton
14.7	Up Holland
7.8	Wrightington

Population growth

WEST LANCASHIRE PROJECTED POPULATION GROWTH 2023 - 2044

Age	2023	2028	2033	2038	2043	% change
0 - 14	18,607	18,349	18,136	18,339	18,824	+1.17
15 - 64	69,755	69,170	68,110	66,966	67,574	-3.13
65+	26,671	28,777	30,901	32,279	31,877	+19.52
All Ages	115,032	116,295	117,146	117,585	118,275	+2.82

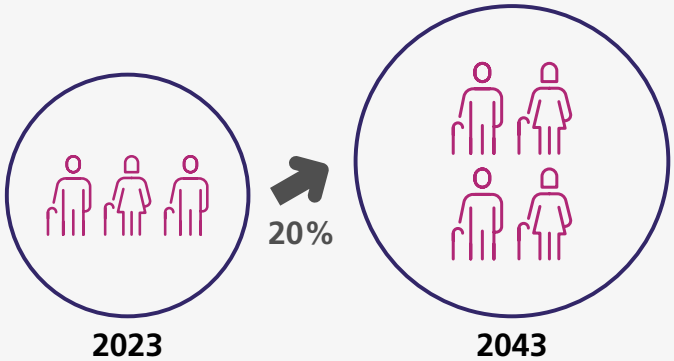
We see a similar pattern of projected population growth in West Lancashire as we do in Southport and Formby. The number of working age people (16-65) is expected to shrink a little between now and 2043. By contrast, as in Southport and Formby, the number of people above working age (the over 65s) is expected to rise by about 20 per cent, or over 5,000 people.

Poverty and deprivation

The IMD deprivation index shows West Lancashire to have an overall rating of 18.6, which is below the all-England average of 21.7.

However, we shouldn't take this to mean that all of West Lancashire is less deprived than the rest of England. As we know, there are some concentrated areas of deprivation. Approximately one in five neighbourhoods in West Lancashire are among the twenty percent of most deprived areas in England, all within Skelmersdale.

People above working age (65+)



Deprivation indicators	All England	West Lancashire	Most deprived	Least deprived	Gap
Index of Multiple depravation (weighted)	**21.7**	**18.6**	**49.9**	**5**	**44.9**
Child poverty (IDACI)	17.1	15.9	36.2	4.3	31.9
Older people in poverty (IDAOPI)	14.2	14.0	34.0	7	27
Fuel poverty (% of households)	13.2	13.1	20.1	7.2	12.9
Unemployment (% of working age)	5	4	9.5	1.8	7.7

Whilst the weighted IMD rating for West Lancashire (18.6) is only a little lower than for Southport and Formby (19.2), there are much wider gaps between the most and least deprived areas on each of the individual measures in the table.

For example, based on overall weighted IMD ratings, the gap between the most and least deprived areas of Southport and Formby is 25. It is approaching double this figure in West Lancashire, at 44.9. This suggests higher overall levels of social inequality in West Lancashire than in Southport and Formby.

Parbold is overall the least deprived area (rating 5.0) in contrast to Digmoor (49.9). Parbold also comes lowest for levels of child poverty (4.0, compared to Moorside at 36.2) and older people living in poverty (7.0, compared to Birch Green at 34.0). Unemployment is lowest in Derby and highest in Digmoor. Aughton Park has the lowest levels of fuel poverty (rated 7.2), while Birch Green has the highest at 20.1.

The most deprived areas of Southport and Formby were quite close to the all-England average on some of these indicators. **In West Lancashire the more deprived areas are significantly more deprived than all-England on every measure.**

4. Our health

There are some significant differences in people's health and wellbeing across Southport, Formby and West Lancashire. For example, if you live in Tarleton, one of the more affluent areas of West Lancashire, you can expect to live over 10 years longer than somebody in Birch Green. In fact, Birch Green has the lowest female life expectancy in all of Lancashire.

And some health inequalities seem to have worsened since the COVID-19 pandemic. According to 2022 data from The Office for Health Improvement and Disparities, there has been a ten percent increase in cardiovascular death in the most deprived areas of England since the pandemic. That means that people living in these areas are now four times more likely to die from a heart condition than those in the least deprived areas.

There are many other things that also affect population health. For example, the 2021 NHS Health Survey for England showed that the proportions of adults who were current smokers was significantly higher in more deprived areas. As a result, the people who live there are likely to be more at risk of premature death.

By understanding more about these factors, often known as 'the social determinants of health', we can develop a better understanding of which groups of people are likely to have more need for NHS services, and the reasons that they might need our care.

WHAT ARE HEALTH INEQUALITIES?

Health inequalities are unfair and avoidable differences in health between people or groups of people.

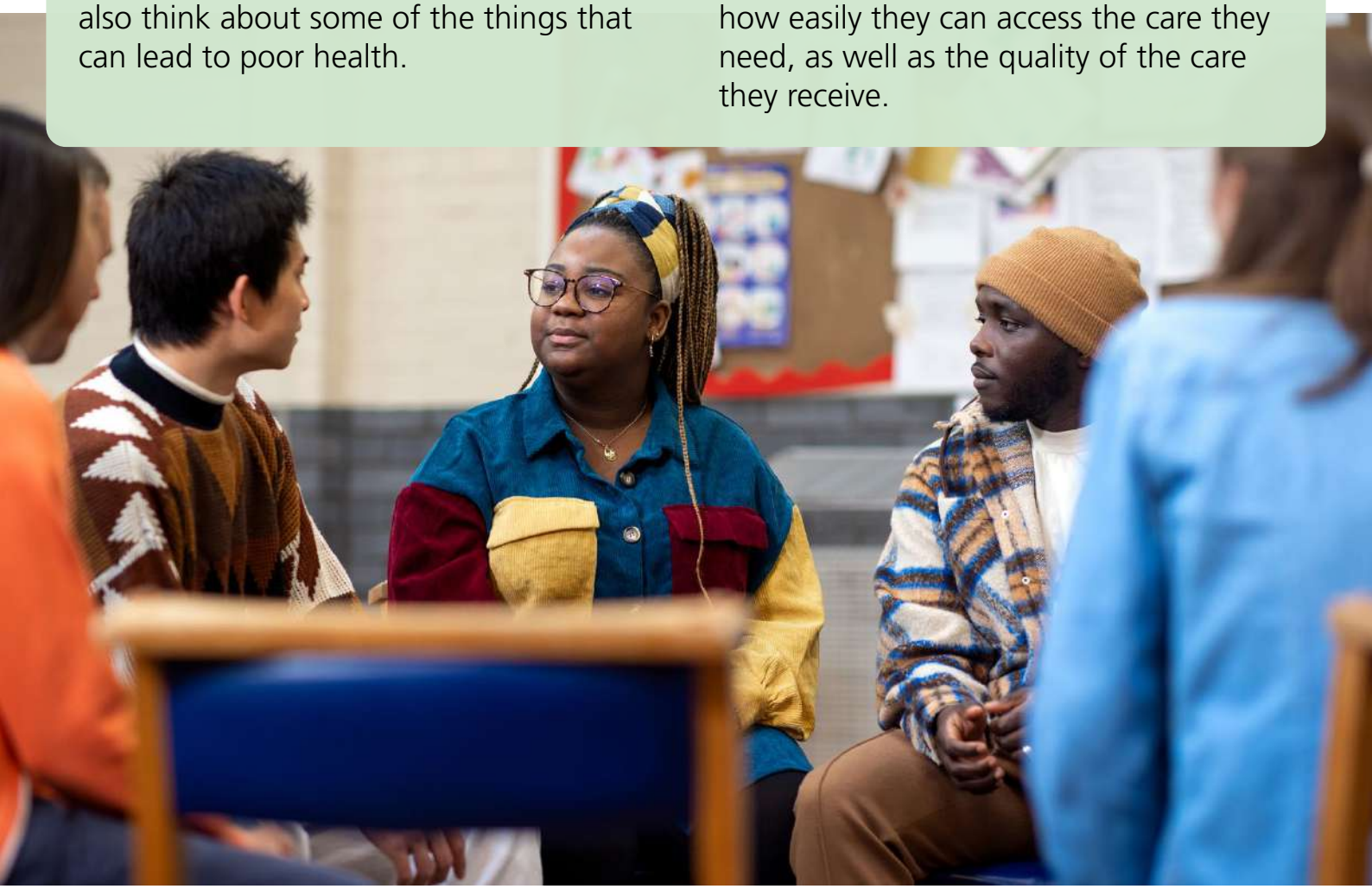
Our health and wellbeing can be affected by many things outside of the care provided by the NHS. For example, someone who is unemployed may be more likely to live in poorer quality housing, with less access to green space or fresh, healthy food. This can have a negative impact on their health.

There are many ways we can look at health inequalities between different groups of people. One measure is differences in life expectancy. We can also think about some of the things that can lead to poor health.

This might be whether people smoke or are alcohol dependent, but can also be things like quality of housing, air quality, access to transport or literacy levels.

We know that some groups and communities are more likely to experience poorer health. These groups are also more likely to experience challenges in accessing care.

There are clear links between the health and wellbeing of different groups of people in our communities, and their need for NHS care. And when people do need the NHS, we have a duty to look at how easily they can access the care they need, as well as the quality of the care they receive.



Southport and Formby

The number of people in Southport and Formby with long term health conditions, sensory impairment, dementia, cancer and other health problems is growing, as is the number of children with complex health and care needs.

Life expectancy

There is considerable social, economic and health inequality across Southport and Formby. Where you live can have a big impact on how long you live. For example, females in Ainsdale, can expect to live more than 9 years longer than females in Kew (88.8 years in Ainsdale compared to 79.7 years in Kew). The gap is less for males (7 years) where those living in Dukes can expect to live 75 years compared to 82 years in Ainsdale.

LIFE EXPECTANCY

Kew
9 years less than
Ainsdale

Dukes
7 years less than
Ainsdale

As well as thinking about how long we might live, it is also important to measure how many years we can expect to live in good health. Studies show that up to half of the healthy years of life lost for people in Southport and Formby are due to preventable causes. This loss of healthy years might be caused by things such as **smoking, alcohol and drug use, or obesity**, but it could equally be due to **fuel poverty, poor living conditions or the level of food processing in our diet.**

Premature deaths and infant mortality

Infant mortality is an important indicator of health inequalities and is reflective of a population's health more generally. The infant mortality rate in Southport and Formby is higher than the England average and has been rising since 2014-16.

The area also experiences higher rates of premature deaths (people under 75) caused by cancer, cardiovascular diseases, liver diseases and respiratory diseases than for the whole of England. These conditions contribute significantly to the gap in life expectancy between the richest and poorest areas in Southport and Formby.

Reasons for attending A&E

Most recent data from the Office for Health Improvement and Disparities shows that, across Southport and Formby, the rate of emergency hospital admissions is around nine per cent higher than the England average.

In the relatively affluent Harrington ward it is more than 20 per cent lower and in the more socially deprived area of Cambridge it is 33.4 per cent higher.

If we look at some of the more common reasons for emergency hospital admissions, the four most deprived wards of Duke's, Cambridge, Kew and Norwood show the highest rates in comparison to the all-England average.

- Cambridge has a 23.8 per cent higher rate for coronary heart disease.
- Kew is 15.7 per cent higher for stroke related admissions.
- Norwood is 5.3 per cent above the all-England rate for heart attacks. Interestingly, the other three most deprived wards all have lower rates than all-England, with Duke's as much as 28.1 per cent lower.
- For chronic obstructive pulmonary disease admissions (COPD - a group of diseases that cause airflow blockage and breathing-related problems) Norwood has a 35.2 per cent higher admissions rate than all-England.

A&E admissions compared to all England

CAMBRIDGE
+23.8%
coronary heart disease

KEW
+15.7%
stroke related admissions

NORWOOD
+5.3%
The all-England rate for **heart attacks**

NORWOOD
+35.2%
COPD admissions rate than all-England.

If Southport and Formby were a village of 100 people

To get a better picture of overall population health, let us imagine that Southport and Formby was a village of 100 people. It would look like this.

Health Condition	Southport & Formby	All-England
Depression	**15**	13
Smokers (Age 15+)	**13**	14
Obesity (Age 18+)	**12**	11
Coronary Heart Disease	**4**	3
Diabetes (Age 17+, all types)	**8**	7
Asthma*	**7**	7
COPD**	**2**	2
Cancer***	**5**	3

Source: NHS England Quality of Outcomes Framework. Data relates only to people who are currently registered with a GP, and not the whole population.

* Registered patients prescribed with asthma-related drugs.

** Registered patients with diagnosis of COPD before 01.04.2020 and patients with diagnosis of COPD after 01.04.2020 with diagnosis confirmed by a quality assured spirometry test (including those unable to take test)

*** Diagnosis of cancer excluding no melanotic skin cancers diagnosed on or after 1 April 2003

Based on these measures alone, we can see that the overall population health of Southport and Formby is similar to that of England as a whole.

However, whilst some of the differences may seem small, it is worth noting that Southport and Formby has higher rates than England on 5 of the 8 selected health measures. The biggest of these differences are to do with depression and cancer.

The rates are the same for asthma and COPD (chronic obstructive pulmonary disease). The single measure by which Southport and Formby shows a better health outcome than England is the proportion of the population who smoke.

West Lancashire

Despite many areas of West Lancashire having low relative levels of poverty, we know that there are also some very deprived areas and some significant social inequalities.

The wards of Birch Green, Moorside, Skelmersdale North and Tanhouse, all within Skelmersdale, are known as 'priority wards' due to high levels of deprivation and high rates of A&E attendance.

Life expectancy

Life expectancy in West Lancashire is slightly lower than the national average. However, where you live in West Lancashire can have a significant impact on how long you can expect to live. For example, in Birch Green in Skelmersdale, life expectancy is 10 years less than for people living in Tarleton. This is 6 years (males) and 8 years (females) less than the average life expectancy across England.

Females born in Birch Green can expect to live 12 years less than females born in Parbold, just three miles away. This is a significant indicator of health inequality.

LIFE EXPECTANCY

Birch Green
12 years less than
Parbold

Birch Green
10 years less than
Tarleton

PRIORITY WARDS

In 2021 Professor Chris Bentley and John Brittain, conducted a review for NHS England and NHS Improvement into COVID-19 and health inequalities. Part of this was to look at communities in England with the greatest socioeconomic disadvantages. Their work identified a number of 'priority' electoral wards with high levels of deprivation as well as higher than expected rates of urgent and emergency care admissions.

Premature deaths

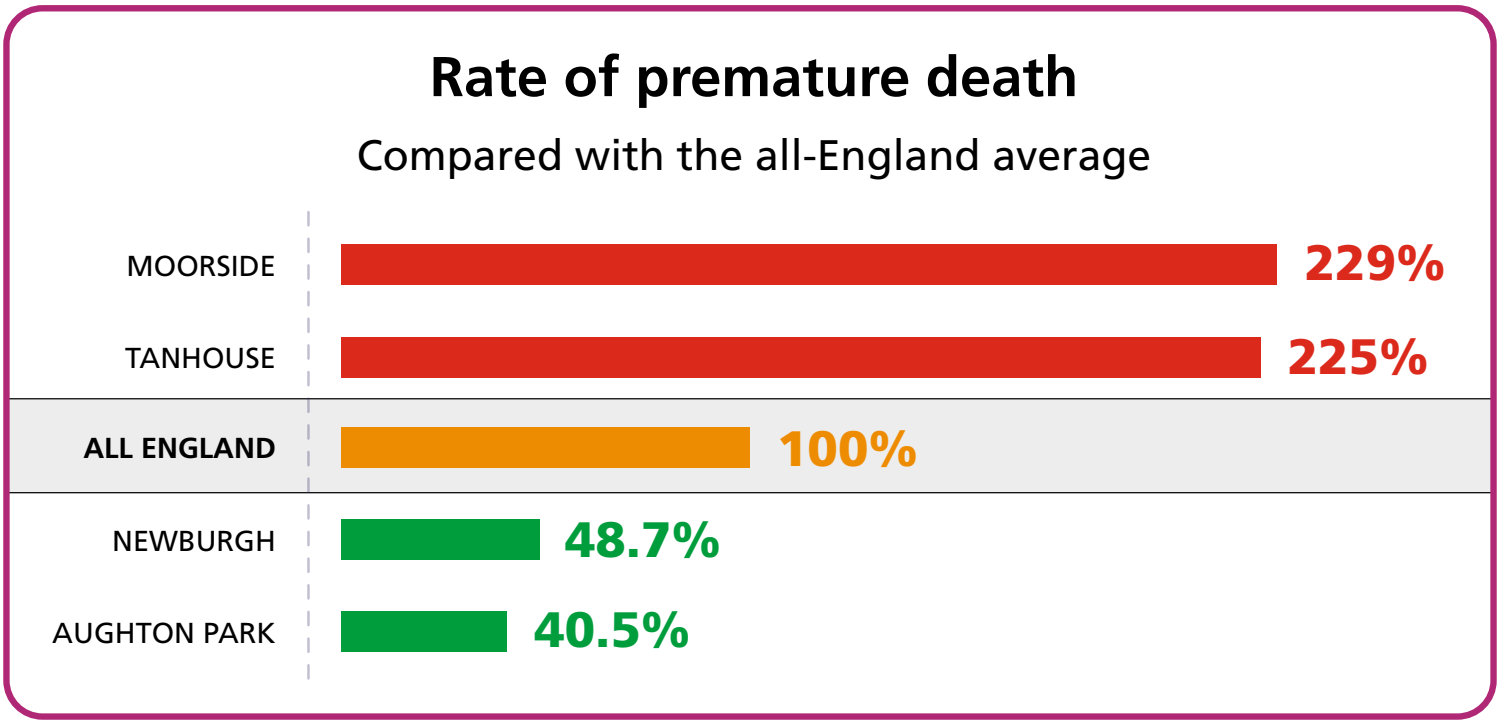
One way to measure the health of a population is to look at the number of people under 75 who die from causes that are considered preventable. On this score, there is a wide range across West Lancashire, suggesting there are some broad social and health inequalities.

For example, in **Aughton Park and Newburgh the rate of avoidable premature deaths is relatively low.** In both cases it is less than half the all-England average (Aughton Park 40.5 per cent, Newburgh 48.7 per cent). By contrast, in Moorside and Tanhouse the premature death rate is more than double the all-England rate (229 per cent and 225 per cent).

WHAT ARE PREMATURE DEATHS?

These are deaths among under 75s considered to be avoidable, treatable, or preventable through effective healthcare and public health measures.

Lung cancer deaths are often considered premature as the majority are related to smoking. In fact, almost half of premature deaths in England can be explained by 'neoplasms' such as lung cancer, with a large portion of the remainder caused by cardiovascular issues and drug and alcohol abuse.



Reasons attending A&E

People in the four priority wards of West Lancashire attend A&E more often than the people of West Lancashire as a whole. When we look at why people come to A&E, we can see evidence of clear health inequalities between these areas and more affluent parts of West Lancashire. When compared to the whole of west Lancashire, the priority wards score:

- 74 per cent worse for coronary heart conditions.
- 28 per cent worse for strokes.
- 52 per cent worse for heart attacks.
- 166 per cent worse for chronic obstructive pulmonary disease, or COPD (a group of diseases that cause airflow blockage and breathing-related problems).

In all but one of the West Lancashire wards, rates of emergency hospital admission for under 5s are significantly above the England average. Around one in ten under 5s have attended A&E in the past 12 months.

Some of the more affluent, rural wards, such as Aughton Park, Halsall, Parbold, Rufford and Tarleton have relatively low rates of people attending A&E for alcohol related reasons. In the four priority wards, however, the rate is well above the all-England average.

When compared to the whole of West Lancashire, the priority wards score:

+74%

Worse for **Coronary heart disease**

+166%

Worse for **COPD**

+52%

Worse for **Heart attacks**

+28%

Worse for **Strokes**

If West Lancashire were a village of 100 people

To get a better picture of overall population health, let us imagine that Southport and Formby was a village of 100 people. It would look like this.

Health Condition	West Lancashire	All-England
Depression	**17**	13
Smokers (Age 15+)	**13**	14
Obesity (Age 18+)	**12**	11
Coronary Heart Disease	**4**	3
Diabetes (Age 17+, all types)	**7**	7
Asthma*	**7**	7
COPD**	**2**	2
Cancer***	**4**	3

Source: NHS England Quality of Outcomes Framework. Data relates only to people who are currently registered with a GP, and not the whole population.

* Registered patients prescribed with asthma-related drugs.

** Registered patients with diagnosis of COPD before 01.04.2020 and patients with diagnosis of COPD after 01.04.2020 with diagnosis confirmed by a quality assured spirometry test (including those unable to take test)

*** Diagnosis of cancer excluding no melanotic skin cancers diagnosed on or after 1 April 2003

Similar to Southport and Formby, based on these measures alone, we see that the overall population health of West Lancashire is very close to that of England as a whole.

As with Southport and Formby, the only health outcome that is slightly better in West Lancashire than in England is the proportion of people who are smokers.

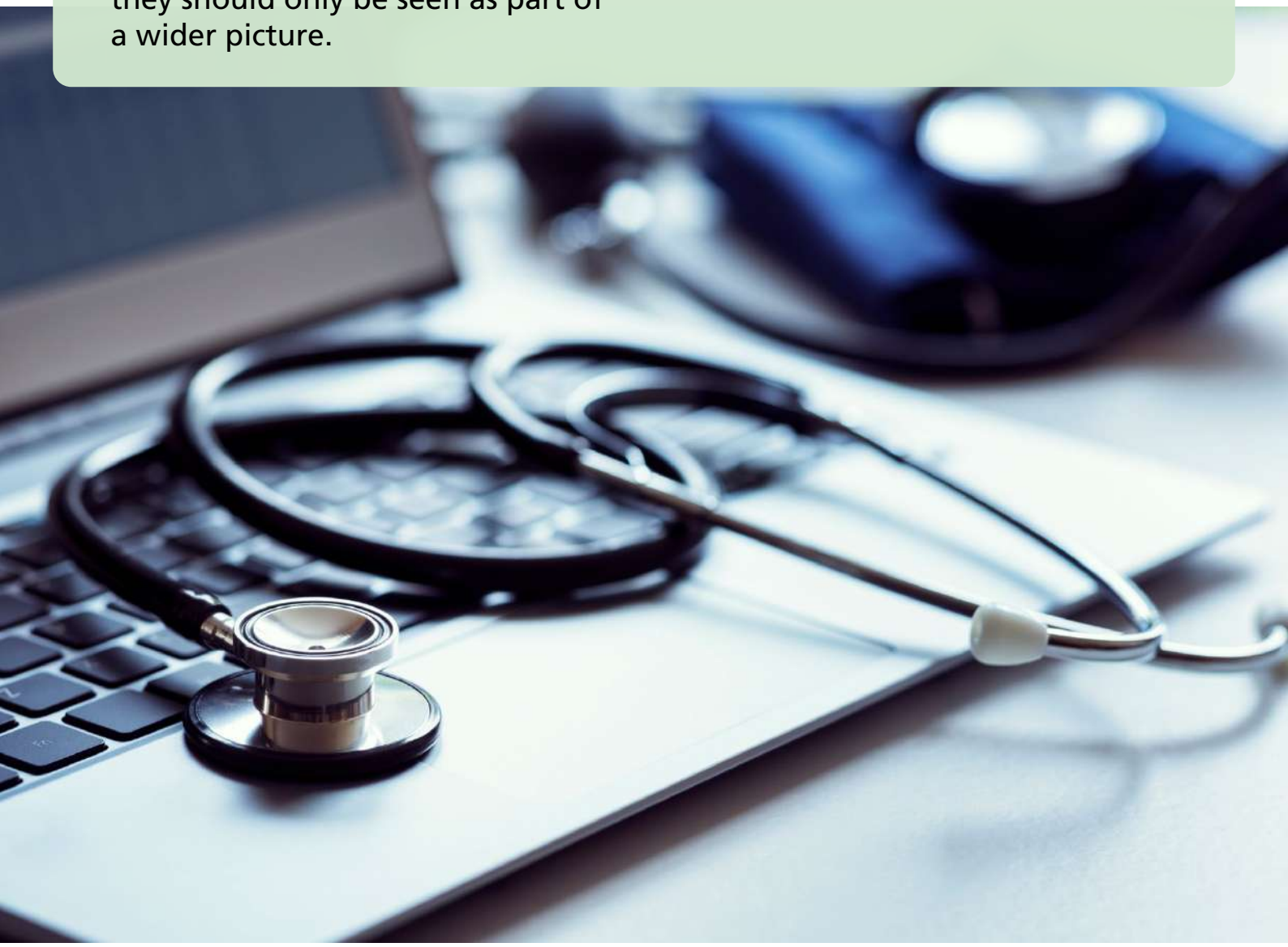
The one notable measure by which West Lancashire can be seen to have a worse outcome than England is on **rates of depression**, which affects around 13 in every 100 people across England, and 17 in every 100 in West Lancashire.

POPULATION HEALTH: CONSIDERING THE FULL PICTURE

There are many ways we can measure the overall health of a population (often referred to as 'population health').

In our 'village of 100 people' for both Southport and Formby, and for West Lancashire, we are only looking at 8 different measures. While these measures are considered important to help in understanding population health, they should only be seen as part of a wider picture.

We should also remember that, by looking at these areas as a whole, we are not seeing differences in population health and health inequalities that exist between some of the more localised areas. This data provides a wide snapshot of population health but is not meant to be a complete picture.



5. The need for change

Our responsibility is to provide excellent quality care and to meet the needs of the people and communities we serve. However, several challenges, which are being felt right across the NHS, are making it harder for us to do this in Southport, Formby and West Lancashire.

Workforce | Infrastructure | Quality | Financial | Ageing

Workforce

A workforce recruitment and retention problem that is making it harder to improve quality, performance, and safety of care.

There are high levels of unfilled vacancies for healthcare assistants and consultants in Southport, Formby and West Lancashire, just like in many other parts of the NHS. This means we often have to turn to temporary agency staff, which is more expensive for us, and makes it harder to build team spirit and morale.

We've put an extra £1million into recruiting more nurses and healthcare assistants, but we know this does not go far enough. Across the UK, there are not enough people training in medicine to fill the gaps. If there are not enough people training, then it stands to reason that there may not be enough people to recruit.

We also know that, as our population gets older, and there are more people living with complex health conditions, we are likely to need even more staff in the future.

Infrastructure

Important infrastructure challenges. Sites across our local NHS need investment and reconfiguration to allow us to meet a rising demand for services in a way that provides excellent care, in a safe environment.

Our buildings and sites need ongoing investment and care to make sure that they are fit-for-purpose. With so many other pressures to manage, it could be tempting to just do the minimum required and save as much as we can to invest in staff and services. But this approach could mean that repairs are needed more often, which could be more expensive and wasteful in the longer term.

We are often providing care in older buildings which may not be ideally suited to our patients' needs, especially some of our older and frailer patients. We must find better solutions and make sure that our buildings are in the right condition for us to deliver high quality, safe services, today and in the future.

Making sure services remain of the highest quality.

The standard we set for everything is that we offer services which are safe and sustainable, and which are built around excellent quality patient care.

The latest Southport and Formby District General Hospital report from the Care Quality Commission, the independent regulator for health and adult social care in England, recognised some of the improvements that had been made. However, it also pointed out how we need to adapt and change the ways care is delivered to meet future needs. The report highlighted some of the issues involved with working across two main hospital sites and how it can put more strain on our staff.

Financial

Significant financial challenges made tougher by providing some services across multiple sites. In some areas, our local NHS is operating with substantial annual deficits.

Our challenge is to find ways to deliver excellent quality, safe services, today and in the future. We must do this with the staff, money, and other resources we currently have available.

New funds to build new, or upgrade existing hospitals, to invest in services, or to help us develop the workforce we need, could certainly help, but there is currently no new funding on offer.

The solutions we need will have to come through finding innovative ways to deliver services differently, and more efficiently. That doesn't mean reducing the number of services we offer, but it will mean addressing inefficiencies, and cutting out duplication where that can be done without affecting the quality of care we provide.

Ageing

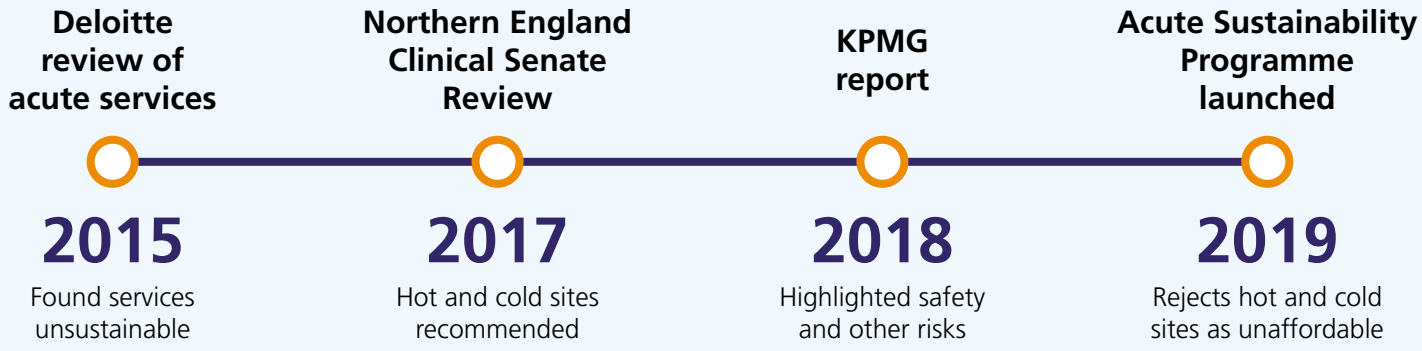
An ageing population, high rates of disease, high demand for services and significant health inequalities.

The population in Southport, Formby and West Lancashire is ageing at a faster rate than the national average. It is estimated that one in three people in Sefton and one in four people in West Lancashire will be above working age (65+) by 2036.

As the population has aged, demand for healthcare services has also risen, including for emergency care and long-term medical care. It also means that a higher proportion of people are living with long-term conditions and sometimes multiple health conditions. Not only has this increased demand, but it also means that more people require more complex types of care. This in turn means we need more complex ways of delivering that care.

In order to maintain a healthier population, it will be even more important in the future to consider how we can become more effective at reducing preventable or modifiable disease. Any model of care we develop today will rely on effective programmes of prevention if it is to succeed in delivering safe and excellent care, that meets patients' needs, today and in the future.

Where are the pressures felt most?



In 2015, an external review of acute services at Southport & Formby and Ormskirk hospitals was carried out by Deloitte. They concluded that services were unsustainable from a quality, workforce and financial perspective. They recommended a hot and cold site solution.

HOT AND COLD SITES?

This is a way of organising hospital services so that one site deals with planned care (the 'cold' site) and another site (the 'hot' site) manages complex urgent and emergency care.

This was supported by the Northern England Clinical Senate Review in 2017.

In 2018, work by KPMG also highlighted ongoing risks around workforce, safety, and financial viability. A Yorkshire & Humber Clinical Senate Review also noted the need for change and recommended a new build hospital. As this was not an option, they recommended a hot and cold site solution.

In 2019, the Acute Sustainability Programme was launched, aimed at delivering a new model of sustainable acute care. Plans were costed for a hot and cold site model. The costs were estimated to be around £1.3bn for a remodelling that would take 13-16.5 years to complete. A hot and cold site solution was rejected as unaffordable and undeliverable.

Following these reports, and other internal evaluations, we decided to categorise a number of our services as 'fragile'. We needed to take action and along with our partners, we have been working to stabilise these services.

However, our ambitions go beyond just that of stabilising services. We now want to explore solutions that will mean we can offer safe, excellent quality urgent and emergency care, today, and in the future.

WHAT IS A CLINICAL SENATE?

Clinical senates give independent advice and guidance to organisations who are planning and buying healthcare services to help them make the best decisions for the people who use the services.

They are made up of patients, members of the public and healthcare professionals.

What are fragile services, and are patients at risk?

We regularly check services to make sure that we are providing them in the safest possible way. We take safety very seriously. There are a number of ways we do this, including:

- Having the right number of staff, with the right skills, in place to be able to manage expected levels of demand.
- Assessments on whether we rely too heavily on support from other NHS services, or private providers, to deliver core services.
- Accounting for likely staff sickness levels to make sure we can carry on offering access to services for those who need them.

We set standards for each of these. When these standards cannot be met, a service may be labelled as 'fragile'. That might mean that we will need to take action to ensure that patients can continue to access the care they need, in a safe way.

Our initial focus will be on how to organise urgent and emergency care services. Find out more.

This is the case with the paediatric A&E department at Ormskirk District Hospital which is currently not open to see children and young people between midnight and 8.00 am. While this means that children who need emergency services overnight would have to travel further (typically to Alder Hey Children's Hospital in Liverpool), this is the safer option. When a fragile service is no longer available, we will always find safe, alternative places to offer care.

When we started the Shaping Care Together programme we identified seven service areas that were considered fragile. Stabilising these services, and making them fit for the future, is the focus of the programme.

Change is vital but we know that it will not always be easy. Developing the right solutions together today will help to futureproof our local NHS. We are certain, however, that if we do not act now, we will have to face more serious challenges in the future.

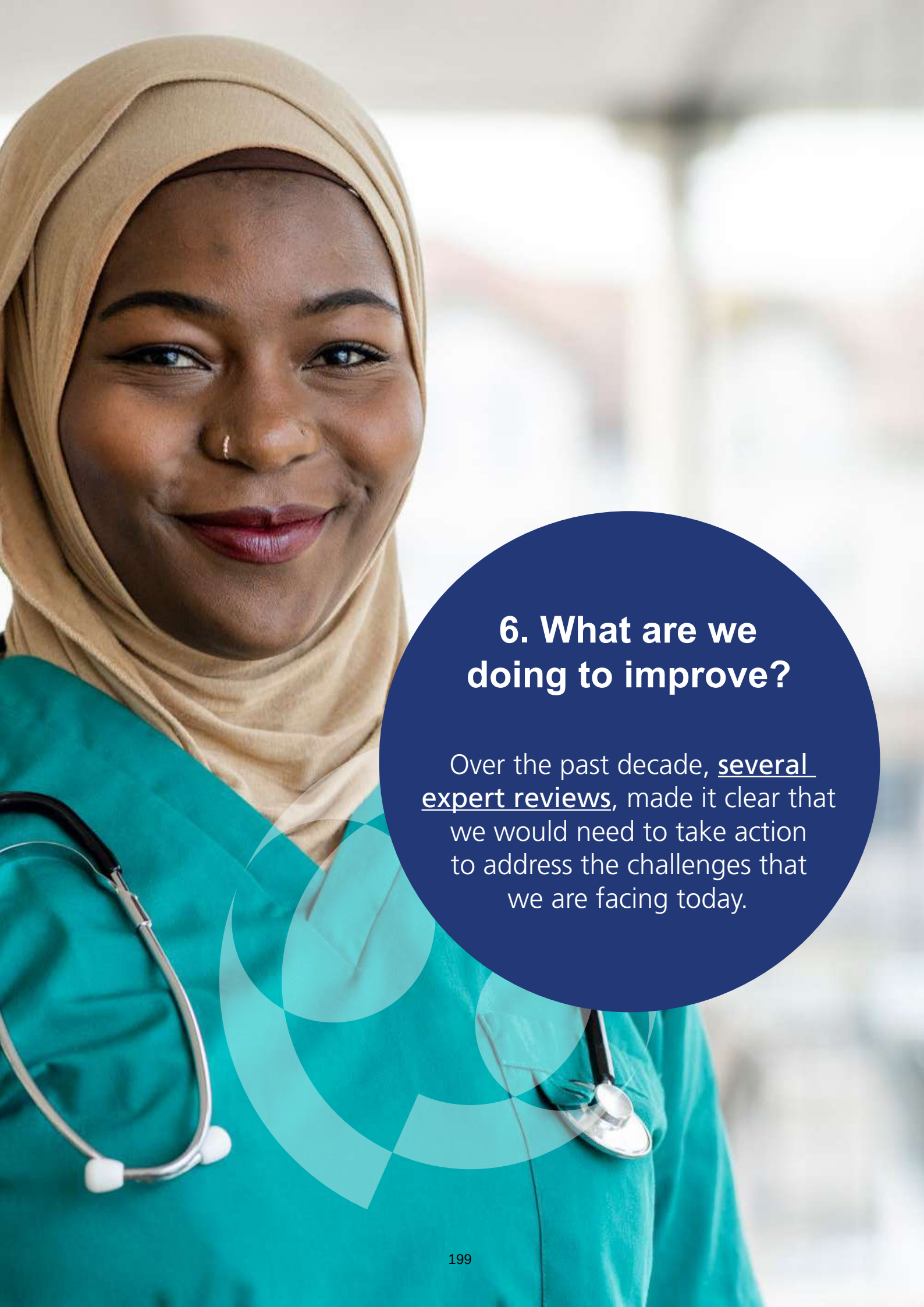
SEVEN SERVICE AREAS

The seven service areas which we are looking at as part of the Shaping Care Together programme are:

- Care for the frail and elderly
- Care for those who need urgent or emergency treatment
- Care for children
- Maternity care for pregnant women and new-born babies
- Care relating to women's reproductive and urinary systems (gynaecology)
- Sexual health care
- Planned care (for example, outpatient appointments)

Our initial focus will be on how to organise urgent and emergency care.

To find out more about each of the seven service areas see our **Challenges and Opportunities paper**, published in 2021.



6. What are we doing to improve?

Over the past decade, **several expert reviews**, made it clear that we would need to take action to address the challenges that we are facing today.

What are we doing to improve?

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In 2017 and 2018, in two separate clinical senate reviews, the former Southport and Ormskirk Hospitals NHS Trust was described as 'unsustainable in its current form'.

In 2019, the Care Quality Commission, the independent regulator for health and adult social care in England, gave the trust a rating of 'requires improvement'.

In 2021, the trust's board agreed that outside help was needed to address some of the issues to do with financial and clinical sustainability. With the help of NHS England, the neighbouring St Helens and Knowsley Teaching Hospitals NHS Trust was identified as an appropriate partner to support Southport and Ormskirk.

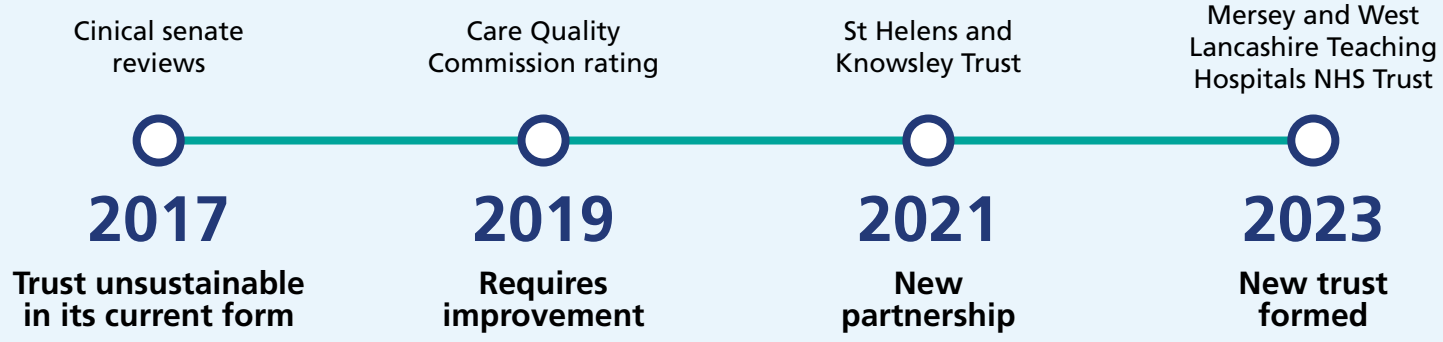
Work then began on finding opportunities for better ways of working by bringing the two trusts closer together. These included:

- Improved clinical sustainability
- Making better use of our buildings and estates
- Better ways of organising clinical services
- Benefiting from economies of scale
- Opportunities to develop the workforce
- Improved digital services and integration

In 2023 the two trusts were formally joined together as one to form Mersey and West Lancashire Teaching Hospitals NHS Trust. This was an important step towards stabilising fragile services.

That was just a first step, however. Alongside the creation of the new trust, the Shaping Care Together programme has been looking at how we can organise fragile services to be sustainable in the long term.

Towards a new trust



7. Starting with urgent and emergency care

When we launched the Shaping Care Together programme, we identified a number of NHS services that may need to change so that we can continue to offer excellent quality services, in a safe environment, in the years to come. Of these, we will start by looking at how we offer care to those who need urgent or emergency treatment.

Urgent and emergency care services have a big impact on how many other NHS services operate. For example, trauma surgery, intensive care and high dependency units often sit alongside emergency care. And the way in which urgent care is provided can affect how we care for and support people in their own homes and in their communities.

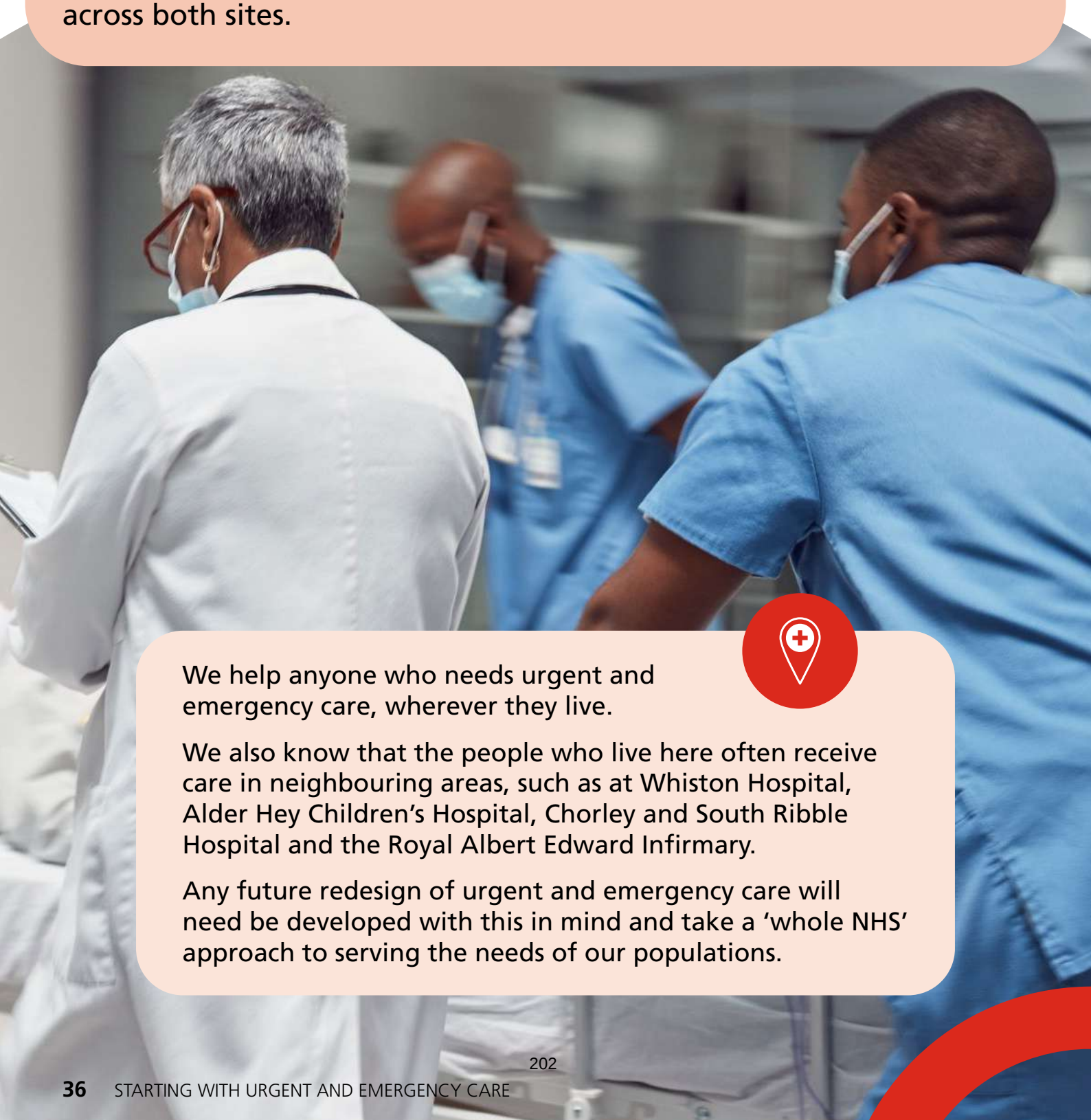
Levels of demand for urgent and emergency care can be highly unpredictable. When emergency care services come under strain, the impact can be felt across the wider health and care system. This can lead to longer waiting lists and potentially more cancellations for people waiting for operations.

Southport & Ormskirk Hospitals NHS Trust was set up in 1999.

It was agreed at the time that critical care services would be based in Southport, along with adult A&E.

Paediatric and maternity services were set up at the Ormskirk site, including the children's A&E.

Not everyone supported this at the time. Clinicians continue to raise concerns today about the risk of delivering acute services across both sites.



We help anyone who needs urgent and emergency care, wherever they live.

We also know that the people who live here often receive care in neighbouring areas, such as at Whiston Hospital, Alder Hey Children's Hospital, Chorley and South Ribble Hospital and the Royal Albert Edward Infirmary.

Any future redesign of urgent and emergency care will need be developed with this in mind and take a 'whole NHS' approach to serving the needs of our populations.

Our urgent and emergency care services are feeling the strain like never before. Several expert reviews over the past decade have made it clear that we need to change, highlighting factors such as:

- Children's emergency and urgent care services are not provided 24/7, meaning that children may not be getting the same quality of care as adults.
- Staff shortages can sometimes make it harder to provide the high levels of patient safety we aim for.
- The way we currently provide services is not financially sustainable in the longer term.
- If pressure increases in one area of care, it can often be felt right across the system. When urgent and emergency care services in our hospitals come under strain, it is often felt across the range of services we provide in our communities.
- Many people we treat are older people who go on to occupy hospital beds, sometimes for lengthy periods whilst they wait for the support they need to be put in place closer to home.

Simply put, now is the right time to address these issues. How exactly we do this, and how services are delivered, will have a big impact on the success of the whole Shaping Care Together programme. For these reasons, the NHS partner organisations behind Shaping Care Together have taken the decision to focus on urgent and emergency care first.

A&E PATIENT COSTS

The costs of A&E attendances at the Southport & Formby and Ormskirk sites are 33 per cent higher than the national average.

Southport & Formby and Ormskirk hospitals - A&E department performance

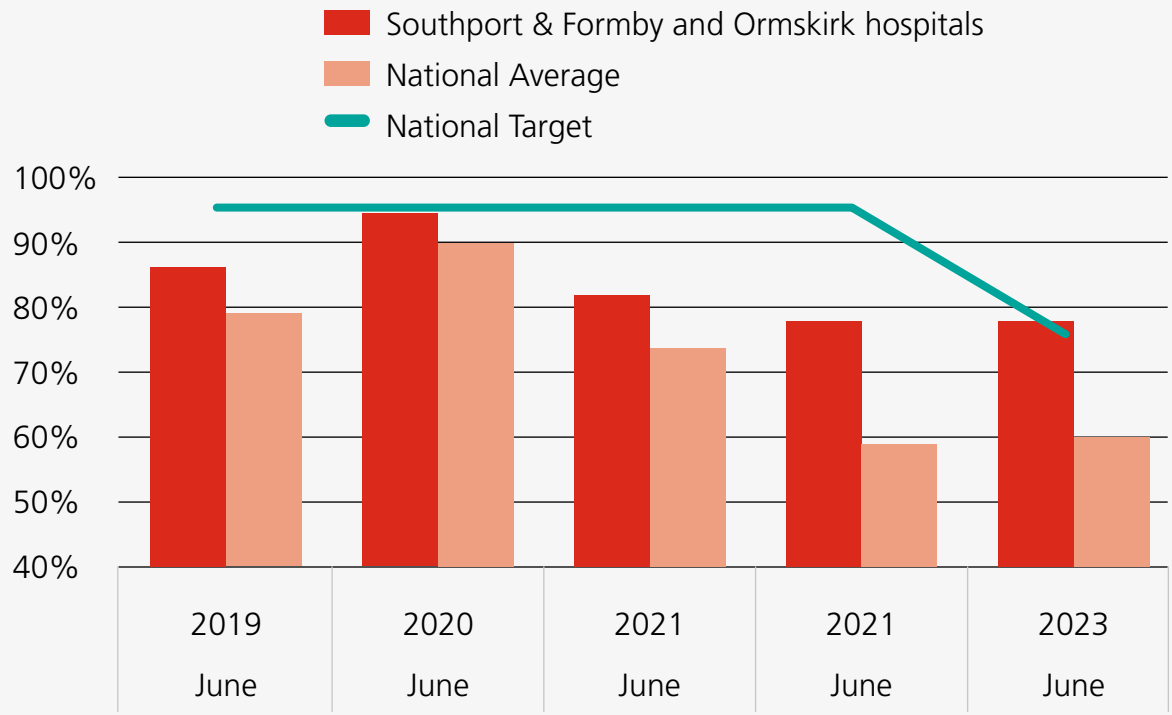
When patients who need emergency care have to wait longer for assessment and treatment, the chances of an unsatisfactory outcome start to rise. That's why the NHS sets targets for A&E waiting times. A key measure for how well we're doing is to look at how many people are seen within four hours of arrival. The NHS England target for this was that 95 per cent of people should be seen within that time. In December 2022 this target was lowered to 76 per cent.

Data shows that our A&E departments at Southport & Formby and at Ormskirk district hospitals consistently outperform the English average for the number of people waiting less than four hours to be seen (with this gap increasing slowly over time).

The data also shows, however, that we are seeing progressively fewer people within four hours of arrival. In mid 2020, around 95 per cent of people arriving at A&E were seen within four hours. This had fallen to just over 70 per cent by December 2022.

Southport & Formby and Ormskirk hospitals

People seen within 4 hours at A&E



Suspending overnight children's A&E at Ormskirk hospital

In April 2020 we had to take the difficult decision to reduce A&E opening times at Ormskirk Hospital. This means that today there is no dedicated A&E service for children and young people between midnight and 8.00am.

Importantly, we do not currently have enough appropriately skilled staff to allow us to re-open the paediatric A&E service overnight in a way that is safe.

To provide paediatric A&E services safely, and to ensure that emergency departments are supported by medical staff with the right training and skills, support is needed from anaesthetics and paediatrics. When the children's service is located at the same site as adult A&E, this support can be available in the wider workforce. If additional support is needed at Ormskirk, this currently means calling in the consultant from home, or transferring staff from Southport and Formby, leaving adult services at increased risk.

If a 24-hour service was resumed, the average cost of each patient seen there would be 59 per cent higher than the national average.

8. What will be better for you?

The Shaping Care Together programme is about providing everyone with excellent quality, safe care, today and in the future.

We aim to tackle some of the challenges our local NHS is facing today and to find the best ways to organise how services are offered.

Everything we do should come down to making things better for the people we care for.

Our ultimate goal continues to be improving the health and wellbeing of our communities, reducing inequalities, and enabling people to live longer and healthier lives.

Here are some of the benefits we hope to realise through the work we are doing on the urgent and emergency care phase of the programme.

- Reduced waiting times at A&E and for urgent care
- Fewer cancelled operations
- Dedicated emergency care for everyone, all-day, every day
- Better urgent care provided closer to home
- An NHS that can meet your needs, today and in the future

Reduced waiting times at A&E and for urgent care

We want to make sure that fewer people come to A&E if they would be better off receiving treatment from another service. This is in everybody's best interest. Of course, we will need to make sure that other services, such as urgent care, are operating smoothly. For some people, we also need to make them aware of the range of services we offer and do all we can in supporting them to access the support they need.

Fewer people coming to A&E would mean a better flow of patients through the department and fewer patients needing a hospital bed once they leave A&E. Better patient flow should mean we will be able to get to you quicker once you are in the waiting room.

Fewer cancelled operations

Levels of demand for urgent and emergency care can be highly unpredictable. When emergency care services come under strain, the impact can be felt across the wider health and care system.

Busy emergency departments often lead to more people needing hospital admission. That means fewer beds will be available for people already waiting to come into hospital for operations. The knock-on effect can be more cancellations and growing waiting lists.

Making improvements to how we run A&E isn't a guarantee of reduced waiting lists, but it can certainly help by reducing the pressure.

Dedicated emergency care for everyone, all-day, every day

Our goal is to provide 24/7 A&E access to everyone, all of the time, however, there has been no 24/7 children's A&E since we suspended the overnight service at Ormskirk Hospital in 2020. Evidence suggests that re-opening overnight, making sure we have the recommended number of staff, with the right set of skills, would mean that the cost of each patient seen at Ormskirk would be 59 per cent higher than the national average.

We would need additional workforce capacity and greater financial resources to do this. However, we know that we must work with what we currently have. Re-opening overnight would need to be funded either through significant new service efficiencies (in other words by providing the same services but in a less expensive way) or by moving resources from other service areas.

Better urgent care provided closer to home

Urgent and emergency care doesn't begin and end at the hospital, but also happens closer to where people live. It can start with how we care for ourselves at home, with advice at the pharmacy or treatment from our GP. And once we leave hospital, we may often need ongoing support for a fuller recovery.

NHS guidance states that people should not be admitted to hospital if they can access the same or higher quality of care in their own home.

The focus of service redesign will need to be on urgent and emergency services, however, to make this work, we will need to be sure that the wider network of services is able to give people the support they need, closer to home.

An NHS that can meet your needs, today and in the future

We know that we face some difficult choices and that some of our services are currently classed as fragile. We are confident we can find significant improvements by looking at reorganising some of these services. We want to do that in a way that means you can be sure of receiving safe and high-quality care, now and in the future.

9. What is urgent and emergency care?

Urgent and emergency care services perform a critical role in keeping the population healthy. The NHS responds to more than 110 million urgent calls or visits every year, so it is essential that the system works effectively.

Urgent and emergency care is much more than just A&E, although that is the service that might first come to mind for many people. There are lots of ways we provide urgent and emergency care both in our hospitals, and also in the community.

The numbers of people attending A&E in our area is increasing every year, and services are feeling the strain. We know that we need to organise our urgent and emergency care services better, so that we can meet rising demand while also making sure we give people the high quality, safe care they need. That is what this phase of Shaping Care Together is all about. We also know that services are put under extra pressure by the number of people going to A&E when they could be treated by another service.

There may be many reasons why this happens. Some people may prefer services that don't require an appointment, and others may just not be aware of the other ways that they could get help.

Below we outline the different types of urgent and emergency care that we offer people in Southport, Formby and West Lancashire.

For a variety of reasons, some people may use NHS urgent and emergency care services outside of Southport, Formby and West Lancashire. That is fine of course, however, the services we are looking at are all physically located in our local area.

Our emergency care services and what they are for

Emergency care involves life-threatening illnesses or accidents which require immediate treatment from the ambulance service (via 999) and an emergency department (often more commonly known as A&E or casualty).

Life-threatening emergencies are different for adults and children. For adults, this could mean, signs of a heart attack or stroke, heavy bleeding, choking, sudden confusion (delirium) or attempted suicides. For children it could also mean when they are unable to stay awake, if they are limp and floppy, or if they are non-stop crying. For a more complete list see the latest NHS advice.

A&E SERVICES IN OUR LOCAL NHS

- **Southport and Formby District Hospital - 24/7 A&E service for adults**
- **Ormskirk District Hospital - A&E service for under 16s**

In April 2020 we had to take the difficult decision to reduce A&E opening times at Ormskirk Hospital. This means that today there is no dedicated A&E service for children and young people between midnight and 8.00 am.

Our urgent care services and what they are for

Urgent care involves any non-life-threatening illness or injury needing urgent attention. People needing urgent care might first ask for advice from a pharmacy or receive a referral to an urgent treatment centre from NHS111, or from a GP.

When urgent treatment centres can help instead of A&E

Urgent treatment centres are available to adults, children and young people without an appointment. They can help with things like sprains and strains, suspected broken bones, injuries, cuts and bruises, chest and water infections or high temperatures in children and adults.

If you need one, you can get tests like an ECG (electrocardiogram), blood tests or an X-ray. If you need a prescription, one can be organised for you. Emergency contraception is also available.

Our Urgent Treatment Centre is operated from Ormskirk hospital and is open 12 hours a day, every day.

Minor injuries units and walk-in centres

You don't need an appointment to be seen at our walk-in centre, which you can find at the Concourse Shopping Centre, Skelmersdale. The unit can help with some of the same problems as our urgent treatment centre, but it doesn't have all the same facilities.

Same day emergency care (SDEC)

Our SDEC unit at Southport and Formby District Hospital provides same day care for emergency patients who would otherwise be admitted to hospital.

Patients with certain conditions, who are seen at our SDEC, can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if medically safe to do so, they will go home the same day.

Patients can be referred to the SDEC through different routes, including:

- Following streaming or triage in A&E.
- Direct referral from GPs.
- Direct transfer from ambulance services.
- Direct referral from NHS 111.

URGENT CARE SERVICES IN OUR LOCAL NHS

- Urgent treatment centre at Ormskirk District Hospital
- Walk-in centre (or minor injuries unit), Concourse Shopping Centre, Skelmersdale
- Same day emergency care unit at Southport and Formby District Hospital
- GP out-of-hours service, via NHS 111 by phone and online

Which services are we looking at?

Urgent and emergency care doesn't begin and end at hospital, but also happens closer to where people live. It can start with how we care for ourselves at home, with advice at the pharmacy, or treatment from our GP. And once we leave hospital, we may often need ongoing support from other services for a fuller recovery.

Whilst these other community services are often part of the patient journey for people who receive urgent or emergency care, they are not being looked at as part of this programme. The urgent and emergency care services we are currently looking at are:

Adult A&E at Southport and Formby District Hospital

Same day emergency care unit at Southport and Formby District Hospital

Walk-in centre (or minor injuries unit), Concourse Shopping Centre, Skelmersdale

Urgent treatment centre at Ormskirk District Hospital

GP out-of-hours service, via NHS 111 by phone and online

A&E for children and young people at Ormskirk District Hospital

Our approach to reviewing urgent and emergency care will look at all of the above, seeking ways to ensure that together these services can support the urgent and emergency care needs of our population.

The role that all of these services have to play will be considered in the review. That is not to say that they will all need to change or undergo restructuring.

10. What people say matters most to them

When we start to think about redesigning NHS services, we need to make sure that all interested individuals and organisations have a chance to express their views and be a part of the conversation.

That can mean listening to patients, their carers and families, to NHS staff, and to politicians such as MPs and local councillors. It also means connecting with organisations working in the voluntary sector, with faith groups, and with community groups.

It's our responsibility to make sure that the voices of all those who want to take part can be heard, particularly those people living in our communities who may be heard less often. And we need to make sure that everyone is supported in getting involved, especially people who may sometimes be discriminated against on the basis of what are known as the **nine protected characteristics**, as set out in the Equality Act 2010.

We do this, not just because we have to, but because learning from the real-life experiences of the people we serve is the most effective way of designing services that meet their needs.

Previous engagement and listening (2021-2022)

Our initial listening and engagement activities helped shape our thinking about service change. We heard from a broad range of people and groups representing voices in our local communities. Activity included:

- **2000+** responses to our online survey.
- **18.9K** visits to the programme website.
- **29** online discussion groups.
- **Conversations with 18+** community and voluntary sector organisations.
- **2** public engagement events.
- **27** one-to-one telephone interviews.

Gathering insight

Our online survey received an impressive 2000+ responses, and proved an invaluable insight into stakeholder views and experiences.

This helped us to understand some of the things that matter most to people, such as:

Reducing waiting times for outpatient appointments.

Receiving the best possible care, even if that means having to travel a little further.

Having care provided closer to home and in the local community wherever possible.

In the survey, we also asked for personal experiences of urgent or emergency care and for views on how we could improve these services. We received a diverse range of responses which included:

"A&E overcrowded and local hospital too small. We need an A&E either on the Southport site or the Ormskirk site. Don't agree with moving A&E when it means somebody may need to travel an hour to access emergency care - simply not acceptable."

"Excellent care and treatment attending Accident and Emergency Department."

"Urgent and emergency should be provided at both Ormskirk and Southport sites."


"Accident and emergency need more staff, a bigger setup, and a place of their own. Waiting times are ridiculous."
"The emergency department is very overwhelmed with many patients who do not require urgent care."
"All services, irrespective of it being elderly, emergency care for adults or children and maternity should all be available at all hospitals."
"It would be very good, if we could have emergency care at Ormskirk."
"In relation to urgent/emergency treatment - working in the stroke service, there is reconfiguration work taking place to ensure patients receive specialist, timely intervention but for this to happen it will take a multi-agency response to ensure a seamless pathway from point of pick-up by ambulance to discharge."

Community engagement

As a key way for patients and the public to inform us, advise us and ensure that engagement was done properly throughout the programme, we set up an Engagement Process Advisory Group (EPAG).

EPAG members were independent voices in their local communities. They were not asked to be formal representatives of, or spokespeople for Shaping Care Together, and served on the group in a personal capacity. They were encouraged to speak openly and honestly about their views.

The aims of the group were to:

- Consider and advise on the programme's approach to ensuring the widest possible engagement of staff and stakeholders, patients and public.
- Identify patient and community groups that could contribute to the engagement programme.
- Promote the widest possible engagement within and beyond the members' own networks.
- Provide assurance that outputs from engagement activity were fed into programme thinking. In other words, demonstrating a culture of 'you said, we did'.

Engagement for the urgent and emergency care phase (2024)

This latest phase of the programme is focussing specifically on urgent and emergency care. We are starting fresh conversations about how to organise these services in a way that can help deliver the healthcare people need. As we do so, we will continue to involve, engage and listen, ensuring that the views of the people we serve are central to shaping future services.

Online engagement and insight gathering

In July 2024 we launched a new survey, asking for views on how we should approach the organisation of our urgent and emergency care services. The survey asked about what matters most to people and what they feel are the right priorities for any redesign.

The survey will close at the beginning of October. Shortly after, we will publish an interim report, outlining some of the initial findings.

The survey is hosted on a **dedicated programme website** which provides useful information and background on the programme and offers various ways to get involved.


"Caring for those who need urgent or emergency treatment who have a disability - need to have relevant staff trained to cater for those who have neurological conditions."
"Emergency treatment appears excellent at Southport. Staff dedicated to ensuring no corridor care is delivered, a huge success story."
"There should be emergency treatment available at both Southport and Ormskirk, as the road link between the two sites is often congested and there isn't really an alternative mode of transport."
"Southport A&E too busy and distant - not good in an emergency. There should be an A&E at Ormskirk."
"I recently had two emergency visits to A&E at Southport. I was driven there by private car to avoid ambulance waiting time. My emergency of severe bleeding could not wait, and I was referred there by my GP. At the age of 87 I could not have travelled further."

Community engagement

As well as asking for views from individuals, we have also been engaging with organisations and officials to ensure full transparency around the work that we are doing. This includes giving regular updates to both the Lancashire and Sefton Oversight and Scrutiny Committee for Health and Social Care. These committees are made up of elected local officials. Their aims are to strengthen the voice of local people and provide accountability. They help ensure that local people's needs and experiences are considered as an integral part of the commissioning and delivery of health services, and that those services are effective and safe.

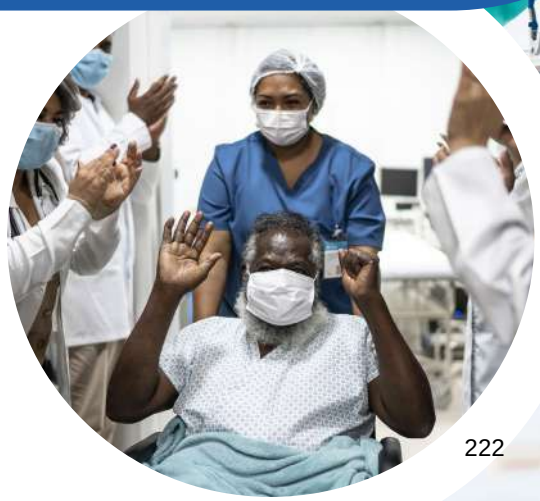
There is a communications and engagement steering group that meets every two weeks to share views on the best ways to deliver programme messaging and make sure that it is heard by the right groups of people. In addition to communications professionals from each of the partner organisations, this group also includes representatives from local Healthwatch groups, and from the wider community and voluntary sector in our area.

There is also an extensive programme of stakeholder engagement taking place between July and October. We plan to re-establish the Engagement Process Advisory Group and to take our case for change out into the communities we serve, making sure that underrepresented and seldom heard voices are part of the discussion.

And finally, we are in regular conversation with colleagues from NHS England, and executive representatives of each of the programme's partner organisations.

We want to make sure that we get this right, which means hearing a range of views and seeing things from different perspectives.

To find out how you can get involved, and to take part in our online survey on local NHS urgent and emergency care, visit the Shaping Care Together website at: www.yoursayshapingcaretogether.co.uk/




"There should be emergency treatment available at both Southport and Ormskirk, as the road link between the two sites is often congested and there isn't really an alternative mode of transport."
"I am an Emergency Medicine Consultant and I work at both Southport and Ormskirk sites. It is ABSOLUTELY ESSENTIAL in my professional opinion that the paediatric and adult Emergency Departments are combined on one site as soon as possible."
"My experience of emergency care was excellent. I had septicaemia due to burst appendix. I had an op within hours and was home after a week."
"There is no emergency care for children in my area. Getting to Ormskirk is very difficult and expensive, even time consuming for disabled people and patient transport is unreliable and we can be waiting eons for the return journey."

11. How does this fit with what's happening across the NHS?

The NHS is facing an unprecedented level of funding and operational pressures, with many organisations in deficit and missing key performance standards. Nationally, there's recognition that we also need to reform and provide a better experience for patients.

Over the last four years, urgent and emergency care services have been through the most testing time in NHS history, with a perfect storm of pressures impacting the whole health and care system. These are perhaps often most visible at the front door – our emergency departments.

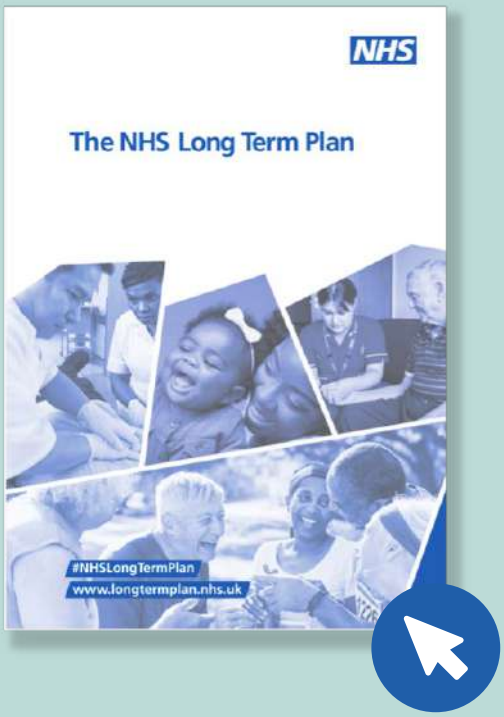
Despite the best efforts of staff, the demands of flu and COVID-19 peaking together means we are finding it increasingly difficult to discharge patients to the most appropriate care settings. Alongside this, hospital occupancy is at record levels. This means patient 'flow' through hospitals has slowed. As a result, patients spend longer in A&E and wait longer for ambulances.

Hospitals are fuller than pre-pandemic, with 19 out of 20 beds occupied across the NHS in England. Importantly, at any one time, up to 14,000 beds are occupied by someone who no longer needs hospital care. The number of the most serious ambulance callouts is now sometimes one third higher than pre-pandemic levels. These pressures have also taken their toll on staff, who have to work in an increasingly challenging environment.

However, the solutions are not to be found just in ambulance services or emergency departments. Recovery will require coordination and partnership working between different parts of the NHS. We also know this is not unique to England, with many similar challenges faced by nations across the UK and the world.

Even before the pandemic, pressure on urgent and emergency care and demand for services had been growing every year. Our ageing population means that we are going to see this continue.

Published in January 2019, The NHS Long Term Plan aims to make the NHS fit for the future. The plan sets out to make sure everyone gets the best start in life, to deliver world class care for major health problems and to support people to age well. It sets out a new NHS service model for the 21st century with a focus on:



- Out of hospital care.
- Reformed and expanded emergency care services.
- People having control over their own health.
- More personalised care for people when they need it.
- Digitally enabled primary and outpatient care.
- A focus on population health.

There is a clear ambition to improve the quality of care we give patients, as well as care outcomes. The NHS Long Term Plan looks to provide support for staffing challenges, improving digital infrastructure and to support local NHS systems to balance the books.

Shaping Care Together strategic context

The system for health and care provision in Southport, Formby and West Lancashire is not sustainable as it is today. However, there are a number of opportunities to help us be more efficient, to improve the care we provide and to make our NHS what it needs to be, today and in the future. We want to provide the best possible health and care services for the people we serve. We will only be able to harness these opportunities fully through partnership and joined-up working across our local NHS.

The reality is that services have been organised in a way that reflect old NHS structures and the needs of our population from decades ago. Keeping those structures in place no longer makes sense. To keep operating in that way we would need extra resources, although we know that is not currently a possibility. We need to make the most of our workforce, buildings, budgets and other resources across all of the partner organisations of our local NHS.

A good fit with our partners

Shaping Care Together is a partnership programme between Mersey and West Lancashire Teaching Hospitals NHS Trust (MWL), and the Integrated Care Boards (ICBs) of NHS Cheshire and Merseyside and NHS Lancashire and South Cumbria.

The programme is in line with the strategic goals of all partner organisation where there are clear aims to develop urgent and emergency care services, and to make them more sustainable.

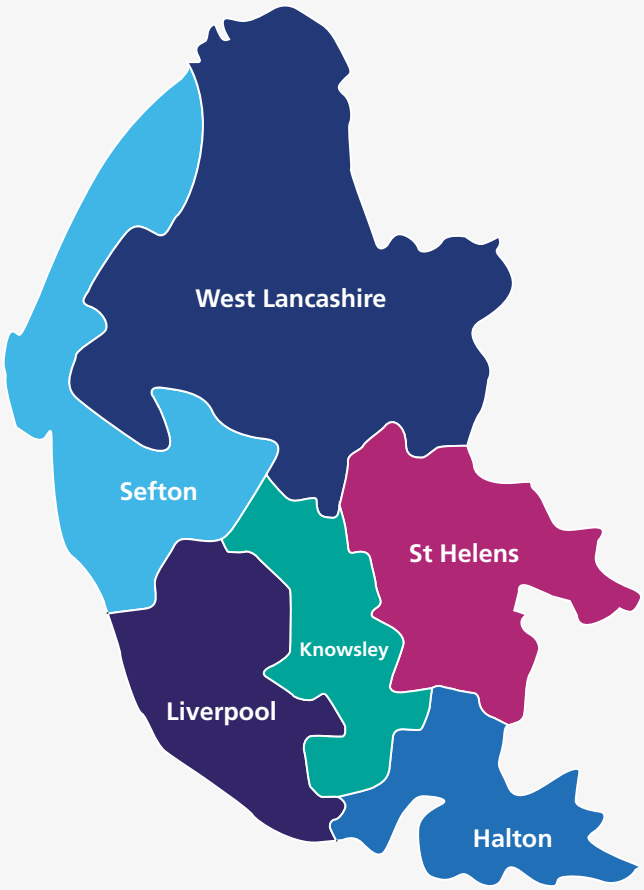
Mersey and West Lancashire NHS Teaching Hospitals NHS Trust (Southport & Formby and Ormskirk sites)

A driving factor behind the creation of the trust was that there would be opportunities to stabilise a number of services that had been identified as fragile. These opportunities included:

- Improving clinical sustainability.
- Clinical reconfiguration.
- Workforce development.
- Estates optimisation.
- Delivering economies of scale and,
- Improved digital services and integration.

The Shaping Care Together programme was established to harness some of these opportunities and make services sustainable.

Shaping Care Together focuses on possible service reconfiguration across Southport & Formby and Ormskirk hospitals. The hospitals serve communities spread across two healthcare systems (known as integrated care boards or ICBs). Southport and Formby Hospital serves communities in the area covered by NHS Cheshire and Merseyside. Ormskirk Hospital serves West Lancashire which is in the area covered by NHS Lancashire and South Cumbria. This is why all three organisations are partners in the Shaping Care Together programme and why it is important that the programme is a good strategic fit with each.



MERSEY AND WEST LANCASHIRE NHS TEACHING HOSPITALS

The trust serves a population of over 600,000 people and delivers a wide range of local health and care services in Halton, Knowsley, Liverpool, Sefton, St Helens and West Lancashire.

The trust also provides regional services for burns, plastic surgery and spinal injuries across Merseyside, West Lancashire, Cheshire, the Isle of Man and North Wales. A combined workforce of around 9,000 are employed across 21 locations including 5 hospitals.

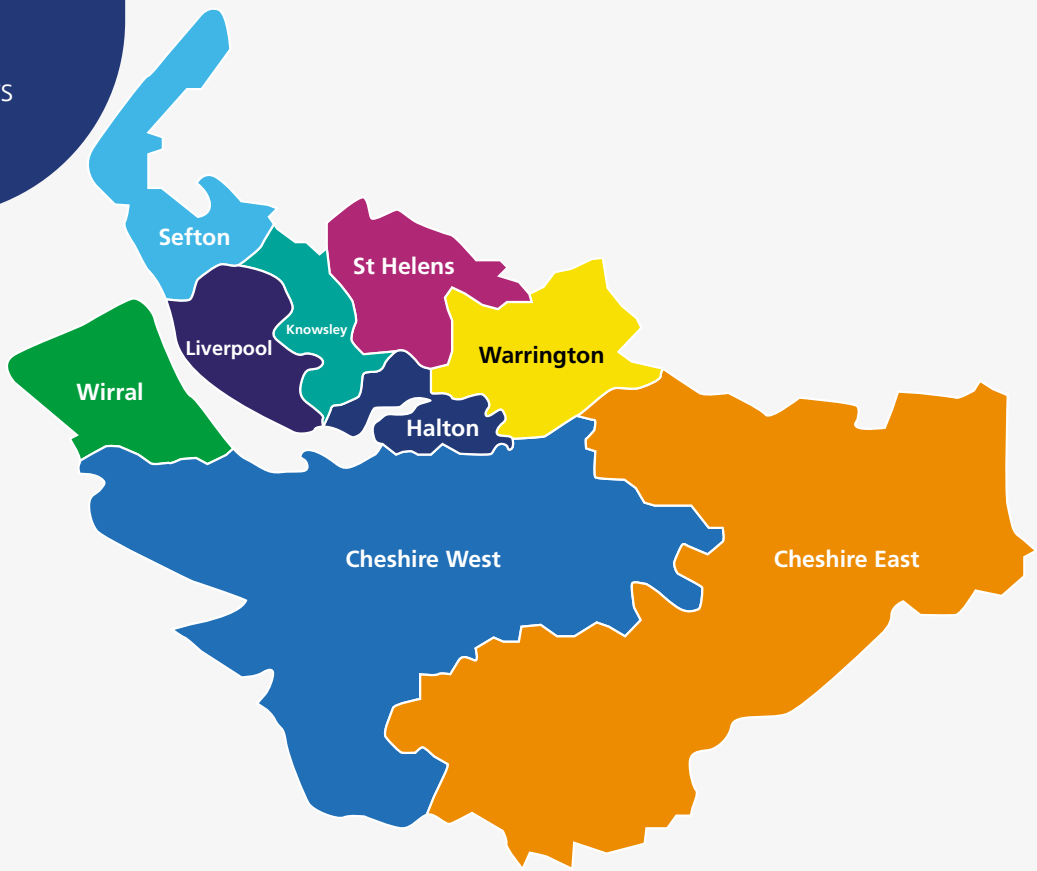
NHS Cheshire and Merseyside Integrated Care Board (ICB)

NHS Cheshire and Merseyside have developed a draft Health Care Partnership Strategy and a **Joint Forward Plan (2023-2028** which aim to improve urgent and emergency care. These include commitments to:

- Improving waiting times for emergency care.
- Drive uptake of COVID-19, flu and pneumonia vaccines which in turn will help to reduce hospital admissions.
- Reduce unnecessary emergency department admissions.
- Improve the speed with which patients are discharged through ongoing development of community services and collaborative working.
- Do more to separate planned and emergency care and to maximise use of independent sector capacity.

NHS CHESIRE AND MERSEYSIDE

Serving 2.7 million residents, NHS Cheshire and Merseyside is one of the largest Integrated Care Boards in England. It covers the nine areas shown below.

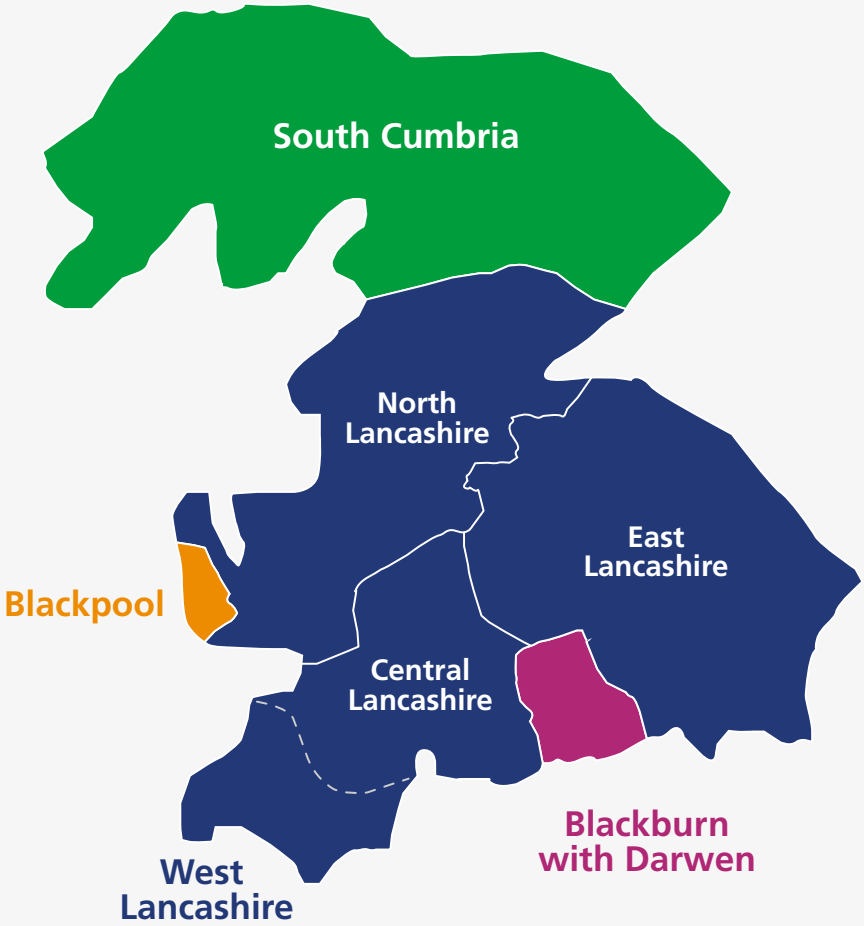


NHS Lancashire and South Cumbria Integrated Care Board (ICB)

In its Joint Forward Plan published last year, Lancashire and South Cumbria ICB outlined a clear ambition to make sure people have equal access to high-quality, efficient and joined-up services.

The plan includes several commitments to improving service quality and patient outcomes, many of which focus on urgent and emergency care. These include:

- Reducing the number of people needing to enter the hospital 'front door' (A&E departments).
- Moving care closer to home wherever possible.
- Avoiding unnecessary hospital admissions.
- Improving access to urgent care.
- Targeting reduced waiting times for care.



NHS LANCASHIRE AND SOUTH CUMBRIA

Serving 1.8 million residents, NHS Lancashire and South Cumbria serves the areas shown on the map. Only West Lancashire, which is part of the wider Central Lancashire area, is within the Shaping Care Together programme area.

12. What happens next?

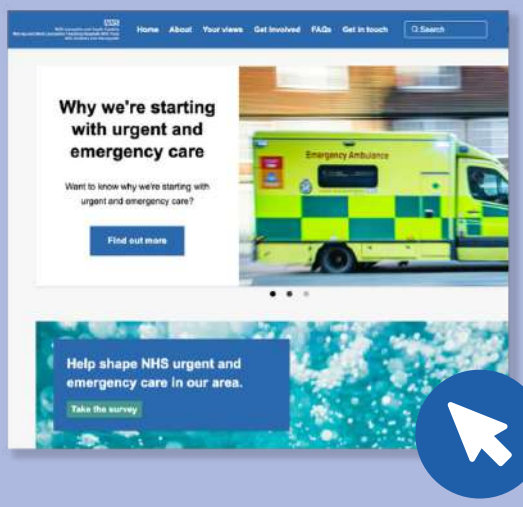
By listening to people's views, working with partners, and by harnessing the extensive experience and expertise of our dedicated staff, we will explore different approaches for how to make urgent and emergency care services fit for the future in Southport, Formby and West Lancashire.

We will be looking at how, with the buildings, staffing and funding and other resources we have available to us, we can:

- Provide excellent quality care to everyone, all of the time.
- Always ensure that care is provided in the safest possible way, even during busier periods.
- Improve how urgent and emergency care is designed to work in partnership with other NHS services in Southport, Formby and West Lancashire, to deliver best outcomes for patients.
- Provide services that are local where possible and specialist where necessary, ensuring that people can be treated in their communities and closer to home where appropriate.
- Help reduce pressures on other NHS services and reduce waiting times for outpatient appointments.
- Ensure that services are sustainable in the long term.

To help us do this we will engage extensively with our partners and with the communities and people we serve, ensuring that everyone can help shape any plans for the future.

There will be a range of ways to get involved, from in-person events to webinars and surveys (both online and in print). We will inform and engage on social media. We will also take our ideas out into the communities we serve, making sure that underrepresented and seldom heard voices are part of the discussion.



We want to make sure that we get this right, which means hearing a range of views and seeing things from different perspectives.

To find out how you can get involved, and to take part in our online survey, visit the Shaping Care Together website at www.yoursayshapingcaretogether.co.uk

NHS

SHAPING CARE TOGETHER

To learn more about the programme, stay up to date with latest news and developments, discover ways to get involved and to have your say, visit our dedicated programme website, or contact us directly.

WWW.YOURSAYSHAPINGCARETOGETHER.CO.UK

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

SHAPING CARE TOGETHER

Shaping Care Together
Case for change

Rob Cooper, Managing Director, MWL

SRO Shaping Care Together Programme

Contents

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

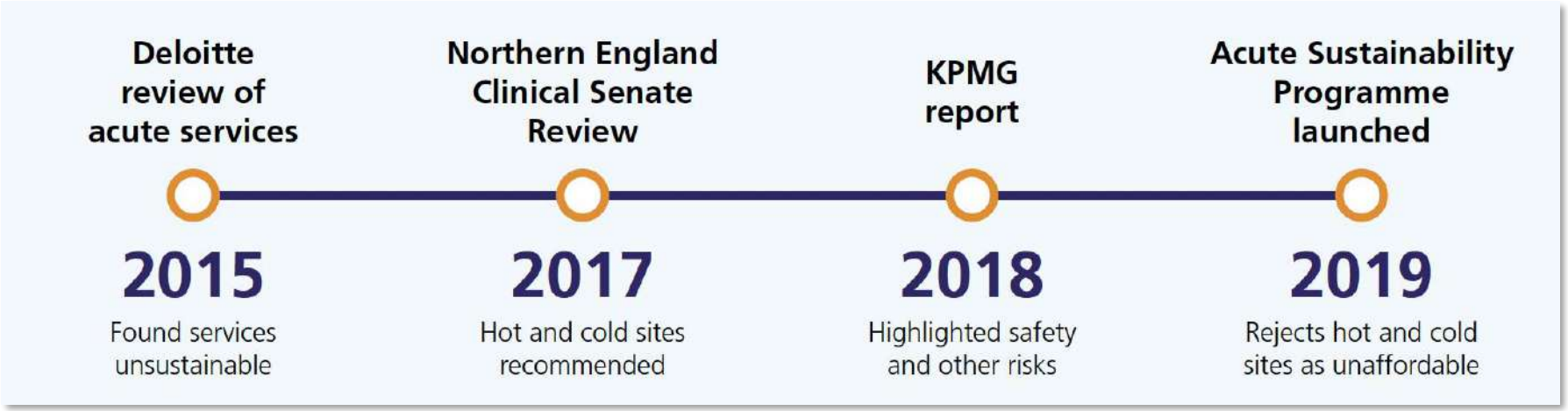
Programme Background

NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Shaping Care Together (SCT) covers the areas Southport, Formby and West Lancashire
- Southport and Ormskirk Hospital sites
- Programme sits across two ICBs (NHS Cheshire and Merseyside ICB and NHS Lancashire South Cumbria ICB)
- One Acute Trust (Mersey and West Lancashire NHS Teaching Hospitals)
- NHS Cheshire Mersey ICB Lead commissioner

Programme background

Identifying fragile services



- Several services identified as ‘fragile’.
- Solutions needed to stabilise fragile services.

Programme background

Towards a new trust

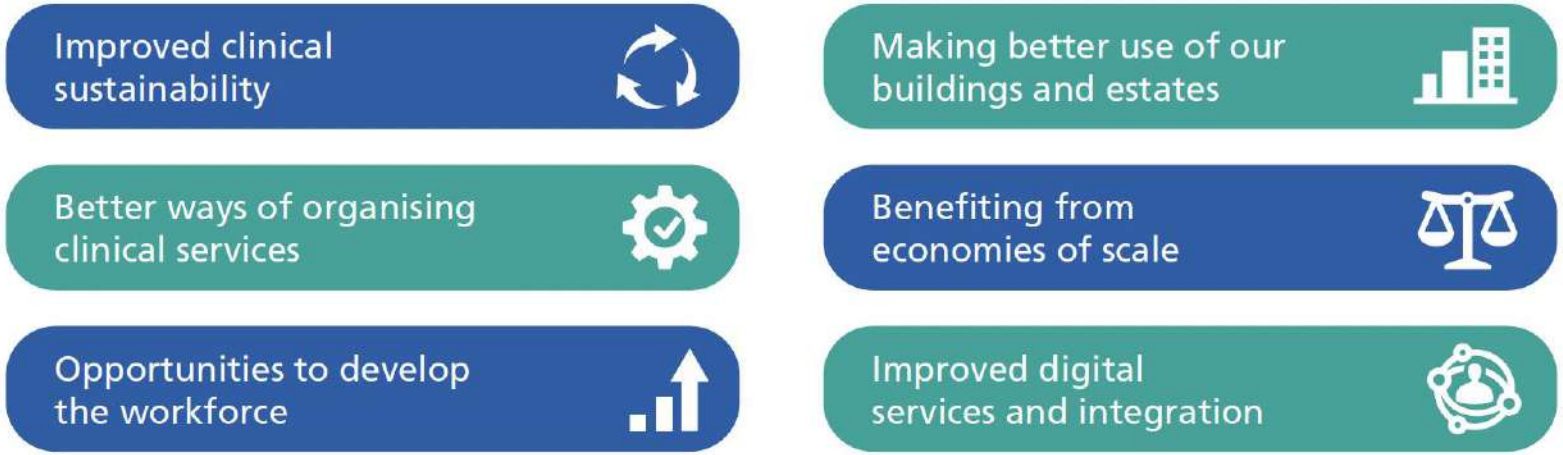
NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- STHK identified as a strategic partner for S&O.
- Sept 2021: Agreement for long term collaboration (ALTC).
- July 2023: The two trusts came together to form MWL.

Programme background

Towards stabilising fragile services

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust



- Delivering benefits that can help stabilise fragile services
- SCT runs in tandem to the creation of MWL, and is designed to find sustainable solutions with existing resources (funding, workforce and estates)
- Phase 2 of the plans to make S&O services sustainable, following the transaction - cannot be delivered by the Trust alone
- MWL (S&O sites) will not be sustainable until this issue is resolved and will require capital and transition funding.

Programme background

Co-dependent programmes

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- The creation of ICBs and change to local system leaders
- Covid Elective Recovery Programme (addressing planned care)
- ALTC, the creation of MWL and stabilising fragile services
- CMAST Clinical Pathway Prioritisation Programme (Orthopaedics, ENT and Dermatology)
- Alignment to C&M UEC recovery programme

Programme background

Public engagement to date

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Extensive public engagement 2021-22
- 2000+ survey responses
- Widespread engagement with public, community groups and the voluntary sector.
- Helped shape thinking around service change
- Underpins today's case for change
- Councillors and MPs

Urgent & emergency care phase

Why we are starting here

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

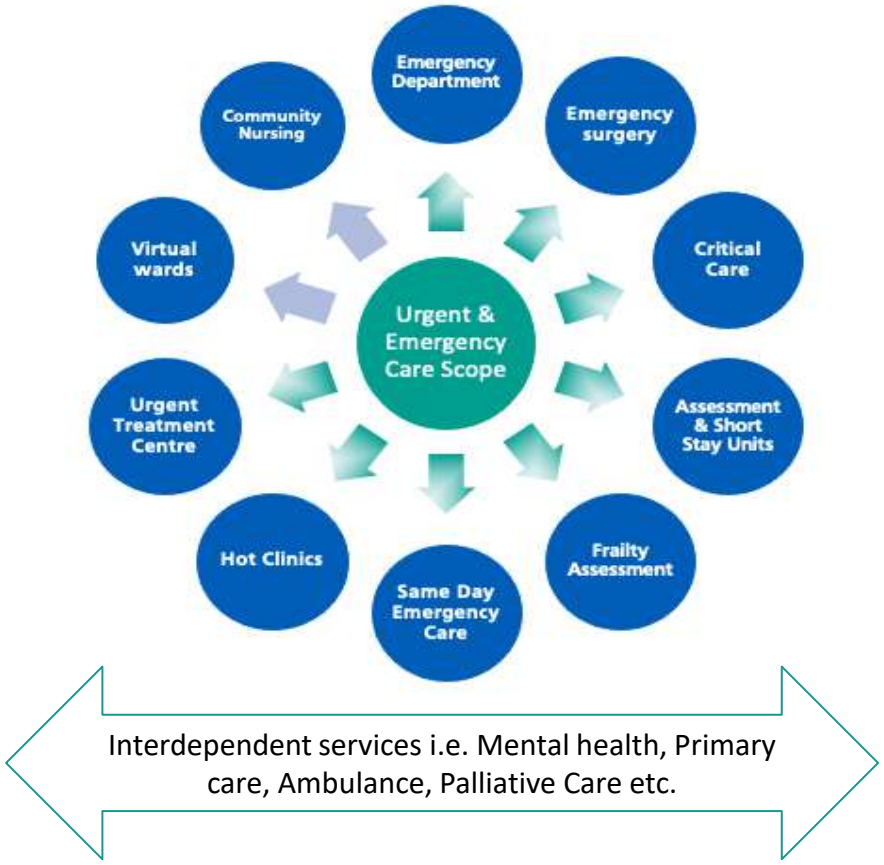
- Opportunity to access safer, high-quality services that are fit for the future
- Significant service co-dependencies
- Lacking 24/7 paediatric ED
- Workforce, quality and safety pressures
- Financial sustainability challenges
- An ageing population (more comorbidities).

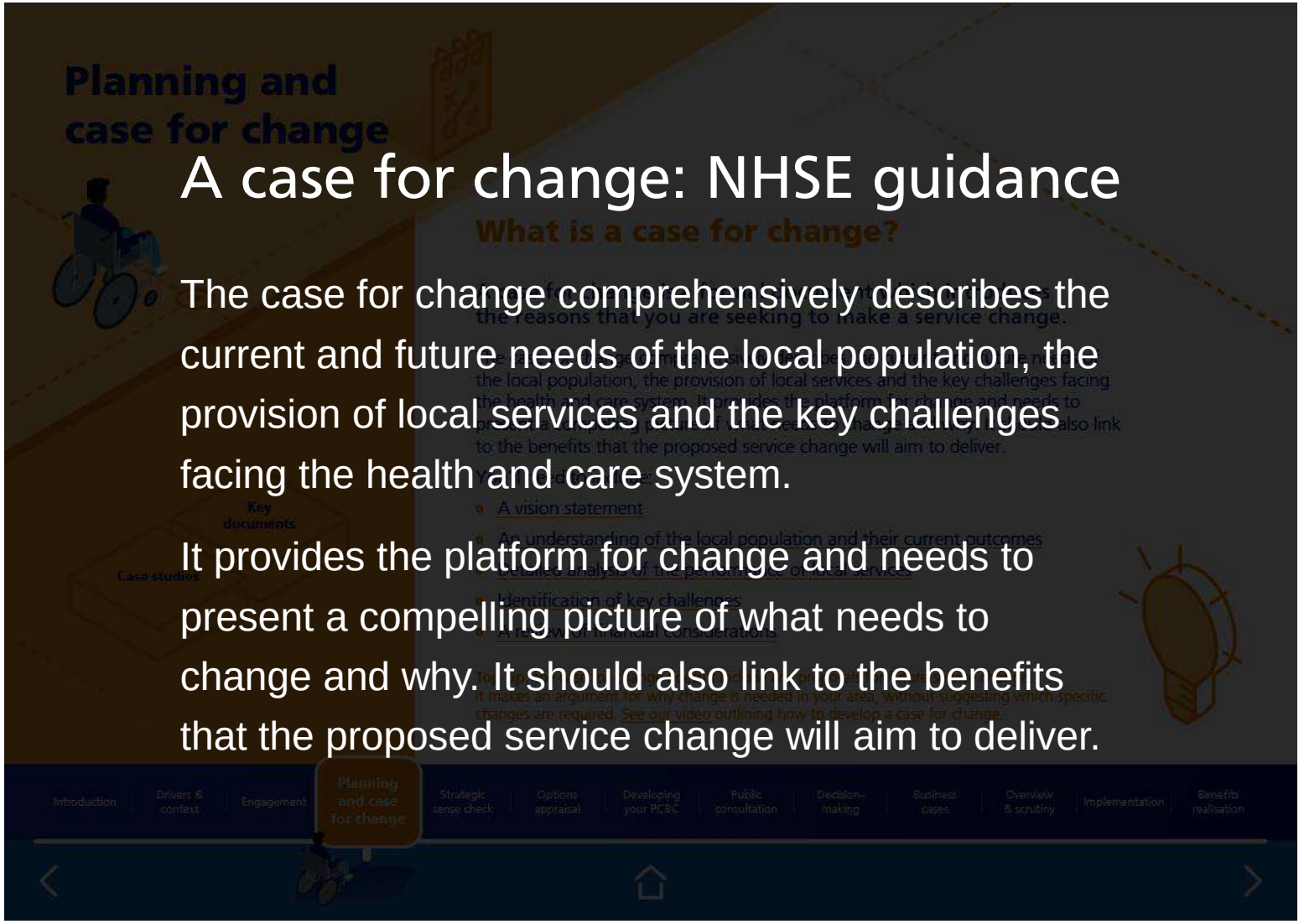
Urgent & emergency care phase

What we are working towards

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Address immediate issues of current configuration through pathway & service change
- Make more efficient and effective use of available resources to provide better care and better value
- Ensure that resources are used in a way to help improve patient flow and safety
- Strategic alignment between place-based work and this programme to ensure cohesion





A case for change: NHSE guidance

The case for change comprehensively describes the current and future needs of the local population, the provision of local services and the key challenges facing the health and care system.

It provides the platform for change and needs to present a compelling picture of what needs to change and why. It should also link to the benefits that the proposed service change will aim to deliver.

The core elements

A case for change: NHSE guidance

The case for change should include:

- A vision statement
- An understanding of the local population and their current outcomes
- Detailed analysis of the performance of local services
- Identification of key challenges
- A review of financial considerations

The core elements

The core elements

What it is and what it is not

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

The case for change is there to objectively inform and enable participation….

… it DOES NOT seek to lead stakeholders towards a preferred option.

……It's led by ICBs

Our approach

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

A BASIS FOR ENGAGEMENT

A THOROUGH BUT PLAIN ENGLISH APPROACH

ENHANCED ACCESIBILITY

COMMUNICATION THROUGH DESIGN

Case for change: contents

Core messaging

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Delivering safe, excellent quality, sustainable services.
- Solution that make best use of the funding, staffing, buildings, and other resources available today.
- Providing the same quality of care, to everyone, all the time.

What will be better?

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Reduced waiting times at A&E and for urgent care
- Less cancelled operations
- Dedicated emergency care for everyone, all day, everyday
- Better urgent care provided closer to home
- An NHS that can meet your needs, today and in the future

Coproduction

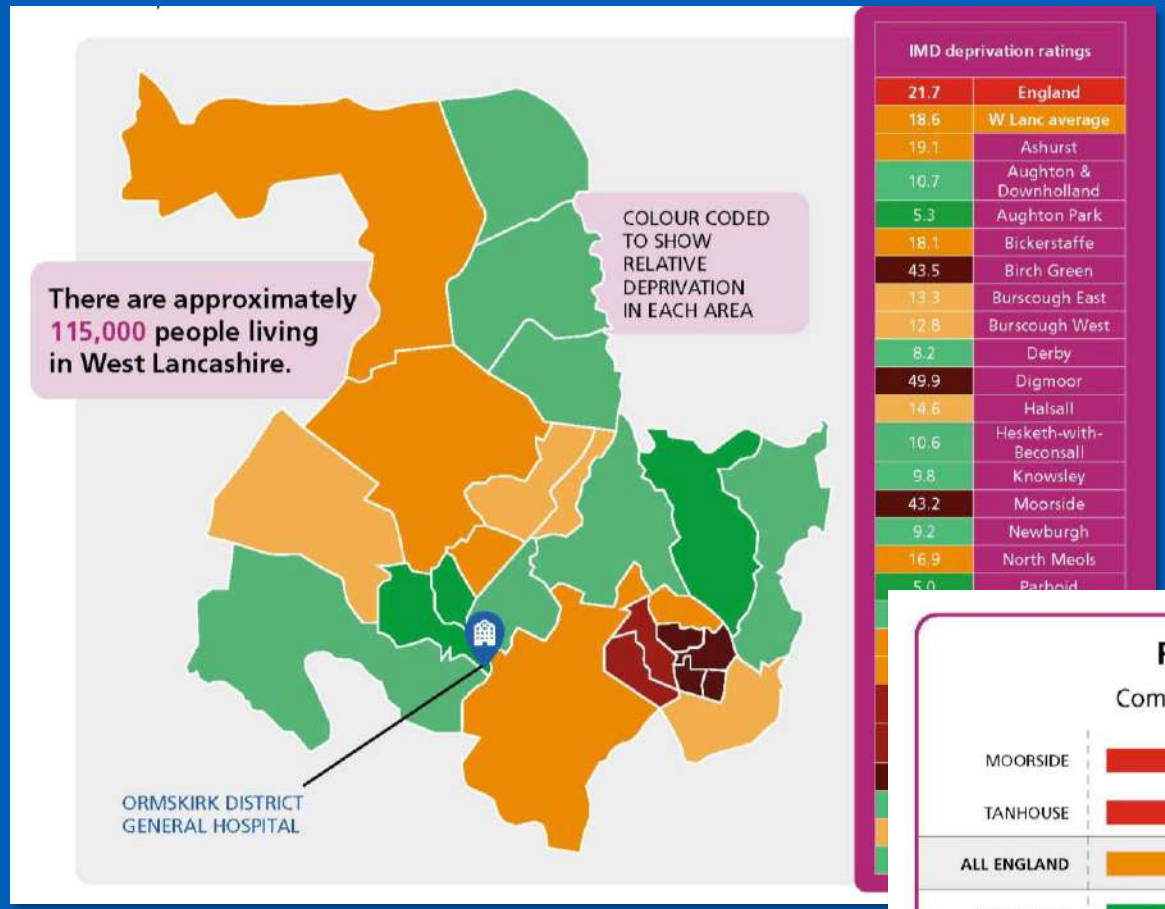
NHS
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust
NHS Cheshire and Merseyside

- Clinicians (Nursing, Consultants, GPs, Allied Health professionals)
- MWL, NWAS, Mersey Care, HCRG Care Group, Primary Care
- C&M commissioners
- L&SC commissioners
- SCT Programme Board
- SCT workstream leads
- Healthwatch and CVS
- Patients, public, service users
- NHS England

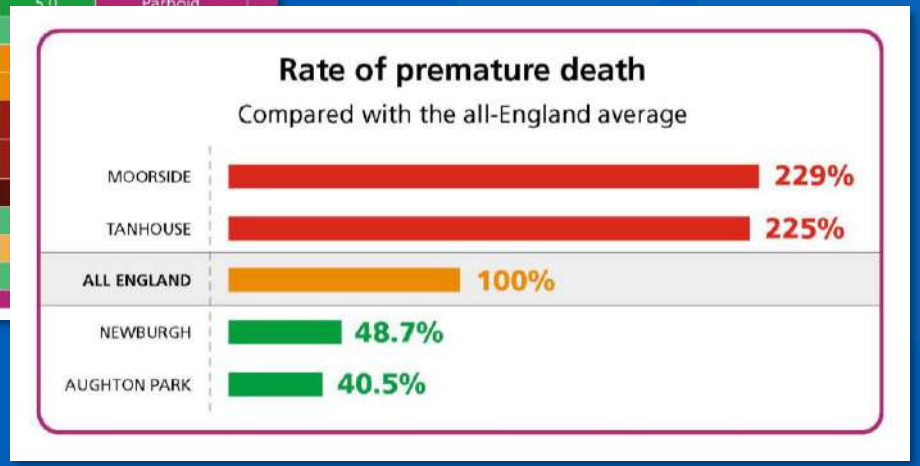
Stakeholder feedback

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Targeted stakeholder engagement in first half of May:
  - That we distil the content appropriately for different audiences
  - That we ensure maximum accessibility
- Feedback accounted for in pre-engagement phase activity



IMD deprivation ratings	
21.7	England
18.6	W Lanc average
19.1	Ashurst
10.7	Aughton & Downholland
5.3	Aughton Park
18.1	Bickerstaffe
43.5	Birch Green
13.3	Burscough East
12.8	Burscough West
8.2	Derby
49.9	Digmoor
14.6	Halsall
10.6	Hesketh-with-Beconsall
9.8	Knowsley
43.2	Moorside
9.2	Newburgh
16.9	North Meols
5.0	Parbold



Our approach

Communication through design

Where this sits in the programme

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

Communications & engagement phasing					
1	**2**	3	4	5	6
Targeted pre-publication engagement	Tripartite board review for Case for Change	Stakeholder engagement	Options appraisal	Final reporting	PCBC
May	July	2 months	1 month	1 month	

Joint Committee

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- A Joint Committee of the two ICBs and partners would provide a more effective vehicle for consideration and approval of the Pre-Consultation Business Case
- Terms of reference to be developed and shared with board to support development of Joint Committee in September 24.

Ask of Board

NHS
NHS Cheshire and Merseyside
NHS Lancashire and South Cumbria
Mersey and West Lancashire Teaching Hospitals NHS Trust

- Approve Case for Change
- Approve the commencement of the pre-consultation engagement
- Approval to establish a Joint Committee

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

NHS Cheshire and Merseyside Children and Young People's Mental Health Plan 2024-2026

Agenda Item No: ICB/07/24/19

Responsible Director: Simon Banks, Place Director (Wirral) and Strategic Lead for Mental Health, Learning Disabilities and Autism

NHS Cheshire and Merseyside Children and Young People's Mental Health Plan 2024-2026

1. Purpose of the Report

1.1 The purpose of the report is to provide the Board with opportunity to review the proposed Cheshire and Merseyside Children and Young People's Mental Health Plan 2024-2026, which the ICB Children's Committee endorsed on the 12 June 2024. The Board is being asked to approve the Plan.

2. Executive Summary

2.1 Local transformation plans have been in use across England since 2015 and NHS England have required assurance of these plans annually, which has included support and sign off by local Health and Wellbeing Boards. The plans and assurance build on the former key lines of enquiry, to support the development of clear, realistic, and transparent plans for the future.

2.2 In April 2020, the Cheshire and Merseyside Mental Health Programme and the Northwest Coast Strategic Clinical Network received a request from NHS England and Improvement National Team to create one Cheshire and Merseyside Children and Young People's Mental Health Plan, which was to cover the ICS by September 2021. The Plan was to replace the historic nine Clinical Commissioning Groups' (CCGs) Local Transformation Plans, and was published in December 2021, delayed due to the COVID pandemic.

2.3 In June 2023, NHS England contacted mental health system transformation leads to communicate national and regional expectations of a 2023/24 annual refresh. Further details can be found in Appendix One.

2.4 There was a strong appetite across system stakeholders in Cheshire and Merseyside to review the 2021 published plan and align this with ICB/ICS strategies, and with consistent themes outlined in place level Health and Wellbeing Strategies and/or Partnership Plans, including but not exclusive of:

- All Together Fairer 2022
- NHS Cheshire and Merseyside Joint Forward Plan (2023-2028)
- Cheshire and Merseyside Health and Care Partnership (HCP) Interim Strategy 2023-2028.

2.5 In developing the new/refreshed plan, a period of system wide engagement took place during January 2024- March 2024 to inform the plan priorities and ensure that the voices of our children and young people, parents/carers, professionals, and stakeholders are included throughout.

2.6 A supporting Engagement Report can be seen in Appendix Two of this paper. The intention is to publish this report alongside the new Cheshire and

Merseyside Children and Young People's Mental Health Plan (and an accompanying CYP friendly animation and easy read document) on the ICB website in August 2024, subject to ICB Board approval.

2.7 Having reflected on the current challenges faced by the system, understood the emerging and unmet need, and listened to children, young people, and their families/carers, we have identified ICS priorities where it makes sense to plan, develop or deliver transformation and improvements at scale to enable us to deliver our commitments.

2.8 To demonstrate our commitment to advancing mental healthcare equality for children and young people and their families across Cheshire and Merseyside, our transformation plan is organised into eight priority areas:

- **Inclusive:** Co-production with children, young people and families to support transformation and continuous improvement
- **Timely Access:** For children and young people needing emotional wellbeing and mental health support
- **18–25 years offer**: Design and develop an equitable offer of mental health support for young adults
- **Eating Disorders:** Children and young people have timely and equitable access to high quality and evidenced based eating disorder support
- **Crisis Response:** To anticipate and support children and young people who may experience mental health crisis or escalating needs
- **Appropriate Places of Care:** Address gaps in our current support offer for children and young people with the most complex needs
- **Specialist Mental Health Care:** Provide high quality and evidence-based specialist mental health care based on the needs of our Cheshire and Merseyside population
- **Innovative:** System change and transformation to be actively driven through research and innovation.

2.9 On 12 June 2024 the ICB Children's Committee endorsed the plan and identified the following priority next steps:

a) **implementation Plan** – the plan will be further worked up to provide timelines, definitions of outcomes and benefits (financial and non-financial), and include baselines and trajectories

b) **development of Business Case to support Appropriate Places of Care** - the Committee discussed which of the areas of focus was highest priority. They concluded that Appropriate Places of Care is and should be the key area of focus. This links to the aspiration of NHS Cheshire and Merseyside to improve urgent care flow, patient experience, quality of care and to reduce excess costs that arise from inappropriate care. The business case will focus on access to the provision of a place of care for young people who are at risk of escalation or in need of a temporary placement away from their normal residence; or short term alternatives to emergency department/paediatric ward following breakdowns in care needing a crisis response.

2.10 The proposed Cheshire and Merseyside Children and Young People's Mental Health Plan can be viewed in Appendix Three.

3. Ask of the Committee and Recommendations

3.1 **The Committee is asked to:**

- **note** the requirements for the ICB to develop and publish a Children and Young People's Mental Health Plan.
- **note** the Engagement Report and activities that have taken place in supporting development of the plan priorities.
- **approve** the Cheshire and Merseyside Children and Young People's Mental Health Plan (2024-2026) (Appendix Three)
- **agree** that the plan will be reviewed after the first year and will be overseen by the Cheshire and Merseyside Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership on behalf of the Children's Committee. A supporting illustration can be found in Appendix Four.

4. Reasons for Recommendations

4.1 The 2024-2026 plan outlines our high-level aspirations for children, young people and families and will support in the identification and reduction of unwarranted clinical variation. The plan will support decision making regarding any national funding allocations and any future investment decisions in respect of the Mental Health Investment Standard (MHIS).

4.2 The plan supports delivery of the Marmot principles to give every child the best start in life and to enable all children, young people, and adults to maximise their capabilities and have control over their lives.

4.3 If the Board did not support the recommendation, the impact would be that NHS Cheshire and Merseyside ICB would not have an updated Children and Young People's Mental Health Plan, as required by NHS England.

4.4 Each of our nine places will assess their progress against the eight priority areas to be addressed and implementation plans will be developed at the appropriate geographic level to reduce unwarranted clinical variation.

5. Background

5.1 The Plan has been developed with all nine Places, along with stakeholders to identify the priorities. The proposed plan has also been supported via Place governance processes during May 2024. Further detail can be found in Appendix Five.

5.2 The Plan has been established as a system plan and provides an opportunity to:

- Empower children, young people, families, local communities, and partner organisations across sectors to share ownership in creating and delivering a vision for the continued improvement of services.
- Set out the mandatory requirements of NHS England in respect to Children and Young Peoples Mental Health Services and achievement of the NHS Long Term Plan for Mental Health.
- Be transparent about and accountable for improvement plans.
- Ensure that plans are embedded into and/or align with wider strategic programmes such as Special Educational Needs and Disabilities (SEND) and Transforming Care. The plan also aligns with documents and core governance, such as Joint Strategic Needs Assessments (JSNAs) and more recently those developed by Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs).

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

6.1 The Cheshire and Merseyside Children and Young People's Mental Health Plan for 2024-2026 supports the ICB strategic objectives and priorities including, but not exclusive of:

- All Together Fairer 2022
- NHS Cheshire and Merseyside Joint Forward Plan (2023-2028)
- Cheshire and Merseyside Health and Care Partnership (HCP) Interim Strategy 2023-2028.

Objective One: Tackling Health Inequalities in access, outcomes, and experience

- The plan seeks to drive improvements in access to mental health support and improve outcomes and experience for infants, children and young people who require support. We will 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. We will continue to target the most deprived 20% of the population to ensure that a tailored healthcare approach to the Core20Plus5 Programme is maintained and strengthened in order to prevent disparities later in life.

Objective Two: Improving Population Health and Healthcare

- Work to develop clear pathways of care from mental health promotion and early intervention (including improving integration with public health, Education, Social Care, Voluntary, Community, Faith and Social Enterprise (VCFSE) partners, Criminal Justice System and Primary Care) through to specialist inpatient care. As part of this work, our nine Places, along with services in our system, are working towards implementing the THRIVE Framework. THRIVE promotes cross agency working and a shared language and understanding across health, education, and social care. This is in line with the SEND (Special Educational Needs and Disabilities) agenda, which

also requires collaboration across services who support children with additional educational and emotional needs. The Framework is needs-led which means that mental health needs are defined by the children, young people, and their families, alongside professionals, through shared decision making. Needs are not based on severity, diagnosis, or care pathways. Children, young people, and their families are empowered through active involvement in decisions about their care, which is fundamental to the approach.

Objective Three: Enhancing Productivity and Value for Money

- It is anticipated that the 2024-2026 plan will help drive priorities at scale in addition to supporting governance and any investment decisions in respect of the Mental Health Investment Standard (MHIS) and wider resources to deliver successfully.

Objective Four: Helping to support broader social and economic development

- Our Cheshire and Merseyside population data highlights that the health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances and are protective factors for children and young people's mental health.
- Our mental health system makes a vital contribution to the local economy through job creation, purchasing of local services and keeping people healthy for work.
- The health and wellbeing of our workforce, our ability to retain, develop and grow will contribute to wider social and economic sustainability.
- As health and care leaders working in an ICS, we have this opportunity to take a holistic view of how the mental health and wellbeing of our children and young people's lives can be improved, including via a good education, accessible healthcare, quality housing and aspirations for employment.

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

7.1 The Children and Young People's Mental Health Plan brings together a collaborative and system wide approach to improving the emotional health and wellbeing of our children and young people. This is aligned to the ICS annual delivery plan with regards to mental health system flow (Recovery Programme priority for 2024/25) via the work of all age Mental Health Programme. Collaborative working with established programmes of work also aligned to the ICB annual delivery plan include the Beyond Programme, Transforming Care Programme and the Directors of Children's Services Change and Integration Programme.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety

- Sitting as a key enabler at the core of this plan is the importance of ensuring we have an appropriate and confident workforce with a common core of knowledge and understanding about children's mental health and emotional needs.
- In Cheshire and Merseyside, we have adopted a combined service and workforce modelling approach that asks the key questions to be able to define what the right service models need to be to meet population need and to match the workforce to the delivery of the service models and associated interventions.

Theme Two: Integration

- We will be using the THRIVE Framework across Cheshire and Merseyside, which is a needs-led approach. This means that mental health needs are defined by the children, young people, and their families, alongside professionals, through shared decision making. Needs are not based on severity, diagnosis, or care pathways. Children, young people, and their families are empowered through active involvement in decisions about their care, which is fundamental to the approach.

Theme Three: Leadership

- The collaborative leadership approach to develop a single ICB plan, engaging with system wide stakeholders demonstrates the cross sector leadership and commitment to improve the mental health and wellbeing of our children and young people.
- Each of our nine places will assess their progress against the eight priority areas of the plan and implementation plans will be developed at the appropriate geographic level to reduce unwarranted clinical variation.

9. Risks

9.1 The Children and Young People's Plan 2024-2026 aims to support the delivery of the ICB's statutory duty to address health inequalities and improve population health and healthcare.

9.2 However, while mental health services are seeing far more children and young people, the increase in prevalence, demand, complexity, and severity of need means that services are often struggling to meet that demand.

9.3 There is a risk of being unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives. Mitigation includes the establishment of a workforce planning infrastructure to support the delivery of the new Cheshire and Merseyside Mental Health Workforce Strategy.

9.4 There is a further potential risk that investment requirements restrict the pace of development as the Integrated Care System strives to achieve its statutory financial duties. This will be mitigated by ensuring that productivity and value for money are maximised.

10. Finance

10.1 The approval of the Cheshire and Merseyside Children and Young People's plan does not have immediate financial implications. However, the plan does include ambitions relating to increasing access and reducing waiting times which may result in a requirement for increased investment.

10.2 ICBs are required to meet a minimum MH investment standard in each financial year and consideration of any additional funding for children and young people's MH will therefore be made in the context of this requirement and considering any specific national funding allocations.

11. Communication and Engagement

11.1 A supporting Engagement Report can be seen in Appendix Two of this paper. A total of 223 professionals and stakeholders responded to a system wide engagement questionnaire and 10 engagement activities were held with children, young people and parents/carers. Some of these groups were children and young people with protected characteristics.

11.2 The intention is to publish this report alongside the Cheshire and Merseyside Children and Young People's Mental Health Plan on the ICB website in August 2024, subject to Children's Committee approval.

12. Equality, Diversity, and Inclusion

12.1 An Equality, Diversity, and Inclusion Assessment (EIA) was undertaken to support the refreshed plan. This can be viewed in Appendix Five.

12.2 Work to deliver the proposed Children and Young People's Mental Health Plan will have a strong health inequalities lens and all related impacts, mitigations and management will be identified via EIAs to ensure the ICB has given regard to the need to reduce / tackle inequalities (ICB Priority One).

13. Climate Change / Sustainability

13.1 The proposed Children and Young People's Mental Health Plan supports the ICB Green Plan (2022) and its net zero obligations. To deliver a successful plan we will be working in partnership with our stakeholders and local populations to

improve patient pathways, create less waste, develop sustainable skills, and nurture good mental health and wellbeing.

13.2 Sustainability principles will be included in service planning, commissioning, patient safety and quality improvement. By transformation of mental health services, and embracing digital advances, we will be working as a system to create sustainable clinical pathways.

14. Next Steps and Responsible Person to take forward

14.1 Following approval by the ICB Board the plan will be published on the ICB website, along with a friendly animation and easy read document suitable for children and young people (August 2024).

14.2 Each of our nine places will assess their progress against the eight priority areas to be addressed and implementation plans will be developed at the appropriate geographic level to reduce unwarranted clinical variation.

14.3 Updates on the plan delivery and progress will be brought to ICB Children's Committee during the year. Oversight of the delivery of the plan will take place via the Cheshire and Merseyside Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership.

15. Officer contact details for more information

Rachel Smethurst, Programme Manager, Cheshire and Merseyside Mental Health Programme

16. Appendices

Appendix One: June 2023 NHS England contacted mental health system transformation leads to communicate national and regional expectations of a 2023/24 annual refresh. **(CLICK HERE)**

Appendix Two: Engagement Report, April 2024

Appendix Three: Proposed Cheshire and Merseyside Children and Young People's Mental Health Plan

Appendix Four: Cheshire and Merseyside Children and Young People's Emotional Wellbeing and Mental Health Programme Partnership Governance

Appendix Five: Place governance support processes during May 2024

Appendix Six: Equality, Diversity, and Inclusion Assessment **(CLICK HERE)**

NHS
Cheshire and Merseyside

Children and Young People's Mental Health Plan Engagement Report

May 2024

Contents

1 Executive Summary

1.1 Background

In June 2023, NHS England contacted mental health system transformation leads to communicate national and regional expectations of a 2023/24 annual refresh of the Children and Young People's Mental Health Transformation Plan.

This provided the opportunity to rethink and renew our plan to ensure close alignment with system-wide strategic objectives, particularly focusing on prevention and early intervention, tackling the social determinants of poor mental health, and reducing inequalities in access and health outcomes for our younger population.

We also wanted to ensure that, in this refresh, our priorities are informed by the voices of our children and young people, their parents and carers, and the professionals who work with them. We have therefore undertaken a period of engagement with our local stakeholders to ensure that they play a key role in the design and delivery of services, and to champion infants, children, and young people and their parents/carers and families as 'Experts by Experience', helping us to understand what is working well and where we need to improve.

1.2 Aims

The aim of this engagement work was to:

- Hear the thoughts of children, young people, parents/carers, professionals, and stakeholders in relation to children and young people's mental health in Cheshire and Merseyside
- Gain insight from those whose voices are less heard and understand barriers to access and inequalities in outcomes and experiences.

1.3 Methodology

The engagement activity took place over six weeks between Friday 19th January and Friday 1st March 2024. Two different methods of engagement were used.

To engage with professionals and stakeholders, a questionnaire was developed and distributed across Cheshire and Merseyside system partners.

To engage with children, young people, and parents/carers, we asked our system partners to support us in engaging with specific groups and communities. A discussion guide, including the same key questions, was shared with existing forums and participation groups to carry out the engagement work on our behalf and share feedback on their findings.

In total, there were 223 responses to the questionnaire from professionals and stakeholders. Feedback was received from ten partner organisations, which included responses from children and young people and parents/carers.

1.4 Key Findings and Conclusions

Six key themes were identified to inform the priorities of the transformation plan:

- Barriers to Access
- Equality, Diversity, and Inclusion
- Health and Wellbeing
- Service Development
- Service Improvement
- Workforce

The insights gathered from the analysis of responses and feedback have been used to inform the priorities of the NHS Cheshire and Merseyside Children and Young People's Mental Health Transformation Plan. The plan will ensure that the voices of these children and young people, parents/carers, professionals, and stakeholders are heard and that their responses are included throughout.

We are committed to ensuring that our services deliver the best possible outcomes for our children and young people, and we know that this is achieved by involving and engaging with those who use them. We will therefore be making this one of the key priorities within our plan:

"Priority 1 - Inclusive co-production with children, young people and their families to support transformation and continuous improvement."

We would like to thank all who took part in, supported, and promoted the engagement activity.

2 Introduction and Background

In December 2021, Cheshire and Merseyside Integrated Care System developed a Children and Young People's Mental Health Transformation Plan. This replaced the nine separate Local Transformation Plans that different areas of Cheshire and Merseyside previously had in place and combined them to create one co-ordinated strategy.

The transformation plan aims to:

- Empower our children and young people, their families and carers, our local communities, and our partner organisations across sectors to share ownership in creating and delivering a vision for the continued improvement of Children and Young People's Mental Health Services

- Set out the mandatory requirements of NHS England concerning Children and Young People's Mental Health Services
- Be transparent about and accountable for improvement plans
- Ensure that plans are embedded into, and aligned with, strategic programmes, including the Special Educational Needs and Disabilities (SEND) and Transforming Care programmes, central documents and core governance, such as the Joint Strategic Needs Assessments (JSNAs) and, more recently, those developed by the Integrated Care Board (ICB) and Health and Care Partnership (HCP).

In June 2023, NHS England contacted mental health system transformation leads to communicate national and regional expectations of a 2023/24 annual refresh of the plan.

This provided the opportunity to rethink and renew our plan to ensure close alignment with system-wide strategic objectives, particularly focusing on prevention and early intervention, tackling the social determinants of poor mental health, and reducing inequalities in access and health outcomes for our younger population.

We also wanted to ensure that, in this refresh, our priorities are informed by the voices of our children and young people, their parents and carers, and the professionals who work with them. We have therefore undertaken a period of engagement with our local stakeholders to ensure that they play a key role in the design and delivery of services, and to champion infants, children, young people, and their parents/carers and families as 'Experts by Experience', helping us to understand what is working well and where we need to improve.

3 Engagement Overview

3.1 Engagement Objectives

The aim of this engagement work was to:

- Hear the thoughts of children, young people, parents/carers, professionals, and stakeholders on what does and does not work in relation to children and young people's mental health services in Cheshire and Merseyside
- Gain insight from those whose voices are less heard and understand barriers to access and inequalities in outcomes and experiences.

The feedback provided from the engagement has informed the priorities set out within the refreshed Children and Young People's Mental Health Transformation Plan.

3.2 Pre-engagement

A process to refine our questions took place before the engagement period to ensure that we were asking about the right issues, in the right way.

Rather than using ranking or sliding scale-style questions, free-text questions were used in order to effectively capture participants' and respondents' voices, which was essential for informing the plan's priorities.

Our proposed questions were reviewed during November and December 2023 by colleagues from youth participation and support groups and mental health provider trusts, as well as the children and young people's mental health commissioners.

In December 2023, our revised questions were shared with the Camhelions group, a youth participation group at Alder Hey Children's NHS Foundation Trust, who were asked to provide feedback. The questions were then edited in response to this feedback and finalised at the beginning of January 2024.

3.3 Methodology

The engagement activity took place over six weeks between Friday 19th January and Friday 1st March 2024. The stakeholders identified were children and young people, parents/carers, and professionals working with children and young people. As the target audience was varied, two different methods of engagement were used.

To engage with professionals and stakeholders, a questionnaire was developed (Appendix A) with access available via QR Code and paper copies available on request. The QR Code was included on a flyer (Appendix B) that was distributed across Cheshire and Merseyside system partners.

To engage with children and young people and parents/carers, we asked our system partners to support us in engaging with specific groups and communities. A discussion guide (Appendix C) was developed that focused on the same core questions, but that could be utilised by engagement leads in a way that reflected different needs. This was shared with existing forums and participation groups to carry out the engagement work on our behalf and share feedback on their findings. NHS Cheshire and Merseyside Communications and Engagement team offered to support engagement activity upon request.

3.3.1 Responses

In total, there were **223 responses** to the questionnaire from professionals and stakeholders. Appendices D and E show a breakdown of the responses by Place and sector.

Feedback was received from **ten partner organisations**, which included responses from children and young people and parents/carers. The groups involved in the engagement were:

- Alder Hey Youth Forum
- Cheshire and Merseyside Voluntary, Community, Faith, and Social Enterprise (VCFSE) Children and Young People's Network
- Liverpool Young Person's Advisory Service (YPAS)

- Liverpool Young Person's Advisory Service (YPAS) LGBTQ+ Focus Groups
- Liverpool Young Person's Advisory Service (YPAS) - Parent Peer Support Group session
- Level Up Provider Collaborative Lived Experience Experts
- Mersey and West Lancashire Teaching Hospitals, St Helens Sexual Health Service, Over the Rainbow
- Sefton Youth Ambassadors and Making A Difference Group
- St Helens Deafness Resource Centre
- Wirral CAMHS, Young People's Participation and Engagement Group

4 Key Findings

4.1 Considerations

The responses gathered from both the questionnaire and focus groups have produced qualitative data which, while not statistically significant, offers an understanding of participants' and respondents' perspectives, experiences, and opinions.

It is important to acknowledge any potential biases within the responses and to recognise that these do not fully represent the experiences of all young people, parents/carers, and professionals across Cheshire and Merseyside.

Another consideration is the potential conflicts between the wants and needs of different stakeholders involved in the engagement activity, and that certain topics or themes may be both praised and identified as areas for improvement by respondents/participants. This reflects the diverse range of experiences across and within groups, as well as likely variations across the system. It is essential that these different perspectives are balanced when designing and delivering services to address the specific needs of the Cheshire and Merseyside population.

4.2 Partner Activity

Also incorporated within the analysis of focus group responses are the insights offered by Cheshire and Wirral Partnership NHS Foundation Trust. The Trust gathered useful feedback from the community via various channels, such as the Experience of Service questionnaire, case studies, digital stories, and engagement with local community groups, and analysed this to identify key themes for improving services and meeting community needs.

The children and young people and parents/carers who took part in the engagement sessions and provided feedback will be referred to here as participants.

4.2.1 Children and Young People

Barriers to Access

Long waiting lists were identified by many participants as a key barrier to accessing support services, as were stigma, the fear of judgment and misunderstanding from family members and professionals, and the issue of not feeling listened to when accessing services.

Other participants shared that not meeting referral criteria can be a barrier since they are not able to access services despite needing to, and highlighted the difficulties for young people transitioning between child and adult services who can fall through the gap in provision and face uncertainty about where they will go next.

"Each young person agreed that as the waiting times for accessing mental health services are too long, most young people would just give up and think 'what's the point'".

"Not getting support at age 17 as you are between children's and adult's services".

Equality, Diversity, and Inclusion

Some participants commented positively on the availability and inclusivity of youth groups for LGBTQ+ and neurodiverse young people, sharing that they feel respected, welcomed, and understood in these settings.

Other responses, however, highlighted the need for services to be more accessible for neurodiverse young people, offer more support for ethnic communities, and not stereotype LGBTQ+ young people, demonstrating that more can be done to improve inclusivity and accessibility of services.

"More support for Ethnic communities… Needs more awareness in the community to share knowledge to explain to people how it can feel and how it is normal and acceptable to receive help and support".

"Not a lot of mental health counsellors know about neurodiversity and didn't understand me".

Health and Wellbeing

A number of participants praised youth groups for offering them new experiences, encouraging them to step out of their comfort zone, and teaching them the skills to cope with mental health difficulties; some commented that they would benefit from more of these opportunities.

Participants shared a range of activities that they feel improve and maintain their mental health, including physical activity, spending time outdoors, and engaging in hobbies.

"This [group] helped by giving me a reason to get up and out, I had somewhere to be, which also helped me get into a routine, I was able to socialise and meet like-minded people who are going through similar things to me".

Service Improvement

Waiting times, crisis prevention, and transition between different services were all raised as key areas for improvement by participants. Mental Health Support Teams were recognised as being beneficial, although not a consistent offer across Cheshire and Merseyside.

Other suggestions for improvement raised include making appointment times and locations more flexible to improve accessibility.

"We don't need help in 8 weeks, we need help now".

"Services are not always dispersed evenly or fairly across all areas – all young people should have access to good quality services".

Workforce

Participants generally praised staff for being friendly, supportive, and respectful. Having support staff and clinicians who are personable and can build strong relationships was highlighted as being very important to children and young people.

Lack of consistency of staff, however, was raised as an issue, with participants sharing that having to retell their stories and develop relationships with new clinicians makes their experience of accessing support more difficult.

"When your key worker is the right person, allowing you to build trust and feel you can access the support available".

"I don't like it when a therapist claims to understand your experiences without having lived through them".

4.2.2 Parents and Carers

Barriers to Access

Participants reported a number of barriers for children and young people accessing mental health support, including stigma, financial difficulties, lack of transportation, and families not being aware of available services. Other participants raised that autistic children and young people and those with SEND who experience language or communication difficulties can often face issues when accessing services.

Participants with experience of Deaf CAMHS highlighted the difficulties that they and their children had faced when trying to access mental health support services.

"Stigma surrounding mental health issues can prevent children and their families from seeking help".

"Child not being deaf enough to access [Deaf CAMHS], but then have accessibility issues at CAMHS – gap in services that these children and young people fall through".

Equality, Diversity, and Inclusion

Some participants raised a number of equality issues for deaf children and young people, including a lack of consideration of their needs, failure to offer extra time at appointments, and failure to guarantee a British Sign Language interpreter.

"Schools have supported us but there has been discrimination from other services where they've not provided an interpreter and just said to me, 'Oh, can you not just sign for her?'".

Health & Wellbeing

Activities that do not solely focus on mental health, such as play therapy and youth groups, were highlighted by participants as being beneficial to the mental health of children and young people.

They raised that activities and groups that encourage and facilitate communication and socialisation support young people to improve their own emotional well-being and reduce social isolation.

Accessible and inclusive support groups were highlighted as being particularly important in improving the mental health of deaf children and young people.

"Activity-based work that does make a difference with young people and acts as early help intervention and supports wellbeing".

"Deaf children and young people flourish in deaf environments".

Service Improvement

Waiting times were repeatedly raised as a concern for many participants.

Some shared that they felt inadequate resources and funding have negative impacts on the availability and quality of mental health support for children and young people, and others highlighted the need to appropriately involve families in the care provided.

Areas for improvement raised also included the inequity of the Mental Health Support Team offer in schools, the transition between child and adult services, and the complexity of pathways.

"Waiting times are long and children and young people's mental health conditions can deteriorate further while waiting for support".

"The need to reach crisis point before you can access support… parents/carers are left feeling desperate and unsupported".

Workforce

Participants generally praised professionals for being skilled, communicating well, and offering support for families. The importance of having staff who encourage and engage well with children, and who have an understanding of additional needs like autism, was evident within the responses.

"Parents/carers have described how skilled [and] empathetic clinicians are when they do finally access the support".

4.3 Professionals and Stakeholders

The professionals and stakeholders who engaged with the survey and provided feedback will be referred to here as respondents.

Barriers to Access

Respondents identified a number of barriers to children and young people accessing mental health support services. A prevalent issue highlighted was the limited availability of services, with numerous mentions of long waiting times for assessments and support services and the high threshold for referral.

Additionally, some respondents highlighted that inadequate knowledge about available services due to poor promotion or signposting contributes to difficulties in accessing support. Logistical issues, such as transport, cost and time, also emerged as significant barriers from the responses.

Respondents further identified the persistent stigma that exists around mental health issues and support services, deterring individuals from seeking help.

"Service [is] overwhelmed so lots of young people don't meet [the] threshold, but then unclear where support/help could come from".

"Still a stigma in some cultures around mental health and the reasons why mental health concerns occur".

Equality, Diversity, and Inclusion

A significant concern highlighted by many was the need for reasonable adjustments for children and young people with additional needs. This includes those with physical or learning disabilities, neurodivergence, and children who are looked after.

Cultural competency and representation also emerged as key factors which can affect access and outcomes.

Many respondents highlighted the lack of suitable services for children under five and young people transitioning between child and adult services. The need for child-friendly services was also emphasized, with respondents noting that overly clinical environments and inaccessible language can alienate young people.

"More support for neurodiverse young people, rather than exclusions".

"Lack of visibility for minority groups".

Health and Wellbeing

Many respondents commented on the positive impact of social prescribing, creative and alternative therapies, and physical activity in supporting and maintaining good mental health in children and young people.

A significant number of respondents also highlighted the importance of open-access groups and services, including online support, drop-in centres, and youth clubs provided by VCFSE organisations.

The need for a safe, secure household environment and a supportive network was also highlighted by respondents as fundamental to supporting young people's mental health.

Many suggested that services could be enhanced by increasing the capacity of support groups, both through additional funding and expanding their availability across different locations, and through greater investment in social and emotional education within schools.

"Access to groups and socialising with their peers in a safe environment. Groups are a great thing for [young people] to access once they finish support but still stay connected to a service".

"Increased focus on social and emotional skills for children".

Service Development

Respondents shared that services are successful when they are flexible and adaptable to the needs of the child or young person, offered within the community and in non-clinical settings, and work collaboratively with families and other partners. Mental Health Support Teams in schools were commented on particularly positively.

Early intervention and early years offers were praised by some respondents for their effectiveness in preventing young people from reaching crisis points. However, some respondents expressed concerns about the limited availability of early intervention services, noting that more needs to be done to support parents and intervene at the earliest possible opportunity.

Despite the positive aspects of service provision, a key challenge highlighted by many respondents was the issue of insufficient resources and funding.

Many commented on the excessive waiting times as being a consequence of this and the implications this has for children and young people. A number of respondents shared that the limited length of treatment time causes further challenges.

“More investment in the early years - greater importance placed on early intervention and prevention”.

“Accessibility, providing intervention within their community, flexibility to provide interventions in school environments also”.

Service Improvement

An area for improvement identified by some professionals was the fragmentation of services, characterised by poor communication and coordination between different partners. Others raised the need for clearer communication with - and involvement of - children, young people, families, and schools about care and treatment plans.

Reduced waiting times within particular services were identified as a successful aspect of service improvement by some respondents, however many commented on the need to reduce waiting times further. Streamlining the referral process and reducing the complexity of pathways were also repeatedly identified as key areas for improvement.

Addressing the gap between services and improving transition pathways, particularly for young people transitioning between child and adult services, was highlighted as a priority for service improvement.

"*Improved pathways and models for 16-25-year-olds, including youth-friendly models with access to clinical, psychological, youth and social support*".

"*Better links across services and more networking opportunities*".

Workforce

Many respondents praised professionals working within these services for their dedication, knowledge, and friendliness. A number of respondents expressed confidence in the genuine care and commitment demonstrated by most staff toward their job and the young people they serve.

However, several respondents suggest that challenges within the system hinder the ability of staff to provide optimal support; time constraints within appointments and the shortage of frontline staff emerged as significant barriers within the responses.

One of the most common suggestions for improvement revolved around enhancing mental health education within schools from an early age. Embedding a whole-school approach to mental health and wellbeing and training school-based practitioners in therapeutic care were identified by respondents as key strategies to promote early intervention.

“Not have such time-limited expectations/session limits put on us by funders/organisations”.

"More frontline staff needed to identify, support with and refer on for mental health issues e.g. health visitors, school nurses".

5 Conclusions and Next Steps

The analysis of the responses fed back to us by key stakeholders has identified a number of themes which have been used to inform the priorities of the NHS Cheshire and Merseyside Children and Young People's Mental Health Transformation Plan. The plan will ensure that the voices of these children and young people, parents/carers, professionals, and stakeholders are heard and that their responses are included throughout.

The children and young people involved in this engagement process have made it clear that they want their voices and opinions to be listened to and that they should be involved in the decisions that affect their lives. We are committed to ensuring that our services deliver the best possible outcomes for our children and young people and we know that this is achieved by involving and engaging with those who use them. We will therefore be making this one of the key priorities within our plan:

"Priority 1 - Inclusive co-production with children, young people, and their families to support transformation and continuous improvement"

In having this as one of our plan's main priorities, partners across the system will be committing to making engagement and co-production with children and young people standard practice. This will involve building on existing networks and forums to harness the collective power of engagement leads across our system, ensuring that infants, children, young people, parents, and carers are represented in our priority workstreams, and tailoring our engagement to hear the voices of children and young people who may need more targeted support and interventions.

NHS Cheshire and Merseyside are committed to working across our geographical area with stakeholders. We will work in partnership with children, young people, families, and carers to support our infants, children and young people to be the best that they can be and to lead healthy and happy lives.

6 Appendices

Appendix A: Questionnaire for professionals

1. In your experience as a professional working with children and young people, what works well in children and young people's mental health services?

2. What do you think could be done better?

3. Do you have any ideas for how we could improve?

4. Is there anything else that you think improves the mental health of children and young people outside of traditionally commissioned support services?

5. In your experience, what are the barriers that children and young people face when accessing mental health support services?

6. In your experience, are there any groups of children and young people that may be treated differently or unfairly when accessing mental health support services?

Appendix B: Flyer for professionals

NHS
Cheshire and Merseyside

Engaging on NHS Cheshire and Merseyside's Children and Young People's Mental Health Transformation Plan

Introduction

From Friday 19 January to Friday, 1 March NHS Cheshire and Merseyside is holding a six-week period of engagement to help inform a refresh of the Children and Young People's (CYP) Mental Health Transformation Plan.

As part of this, we want to gather views about people's experience of using children's and young people's mental health services as patients, carers or family members – what works well, and what could be done better? What barriers have they faced, and do they feel they have been treated differently or unfairly when accessing services?

Although the engagement includes an online survey, to help ensure that we reach as many people as possible, we're asking partners to use existing groups to discuss some key questions raised in the engagement.

This discussion guide has been produced to support this. It contains:

- Some general guidance for holding discussions
- A link to a video introducing the engagement
- A list of questions for discussion
- A form for providing feedback

If you would like help and support in facilitating your group discussions, please contact NHS Cheshire and Merseyside's Engagement Team at engagement@cheshireandmerseyside.nhs.uk

General guidance for holding discussions.

Think about how you can best support children and young people to best share their views. Consider:

- Methods can be face-to-face or online and should include break-out group opportunities if the group is large.
- Group sessions can help stimulate ideas and enable collaboration.
- Good to have practical, hands-on engagement options – not everyone likes sitting around a table talking, flip charts round the room where they can leave comments.
- Simple and anonymous feedback options are good for those who are shy about sharing ideas.
- Activity based engagement, learning and sharing – all the activities are designed to be directly connected to the research questions and conversation.
- Weave the story – the engagement should tell a story that children and young people understand, feel included and reflected in, and will remember.

Short Video Introduction

Questions/themes for discussion

Here are a series of questions that we have developed with CYP. The additional information under each question is there to support group discussion if needed.

Questions for Children and Young People

1. In your experience of children and young people's mental health services, what works well?	*Think about any positive experiences, what you've enjoyed, what's been helpful, etc.*
2. As a child or young person, what do you think could be done better?	*How did you find support, did you feel listened to or understood, what wasn't helpful, etc.*
3. Do you have any ideas for how we could improve?	*What changes could be made that would be more helpful?*
4. Please tell us about anything else that helps your mental health.	*Can you share any hobbies or activities that you find help your mental health? This might be things like exercising, being creative, seeing friends etc.* *Are there any places or environments that you find improve your mental health? This could be your home, the outdoors, with animals etc.*

	What helps you to manage things when you're struggling with your mental health that could be helpful to others?
5. We would like to know if you, or someone you know, has faced any barriers when accessing mental health support services?	*Think about any reasons why children and young people don't access mental health services.*
6. Have you, or someone you know, been treated differently or unfairly when accessing mental health support services?	*Have you or someone you know felt judged based on your age, gender, ethnicity, sexuality, or any other reason when accessing mental health services?* *How important is it for children and young people's mental health services to be inclusive? Do you think more could be done to improve this?*

Questions for Parents & Carers

1. In your experience as a parent or carer, what works well in children and young people's mental health services?

2. What do you think could be done better?

3. Do you have any ideas for how we could improve?

4. Is there anything else that you think improves the mental health of children and young people outside of traditional support services?

5. Has your child, young person, or anyone you know faced any barriers when accessing mental health support services?

6. Has your child, young person, or anyone you know been treated differently or unfairly when accessing mental health support services?

Engagement Recording Form

Date: **Service/Staff Member:** **The area of Cheshire and Merseyside you are discussing:** **Total Number of people at the table:** **Number of children and young people at the table:** **Number of parents and carers at the table:**

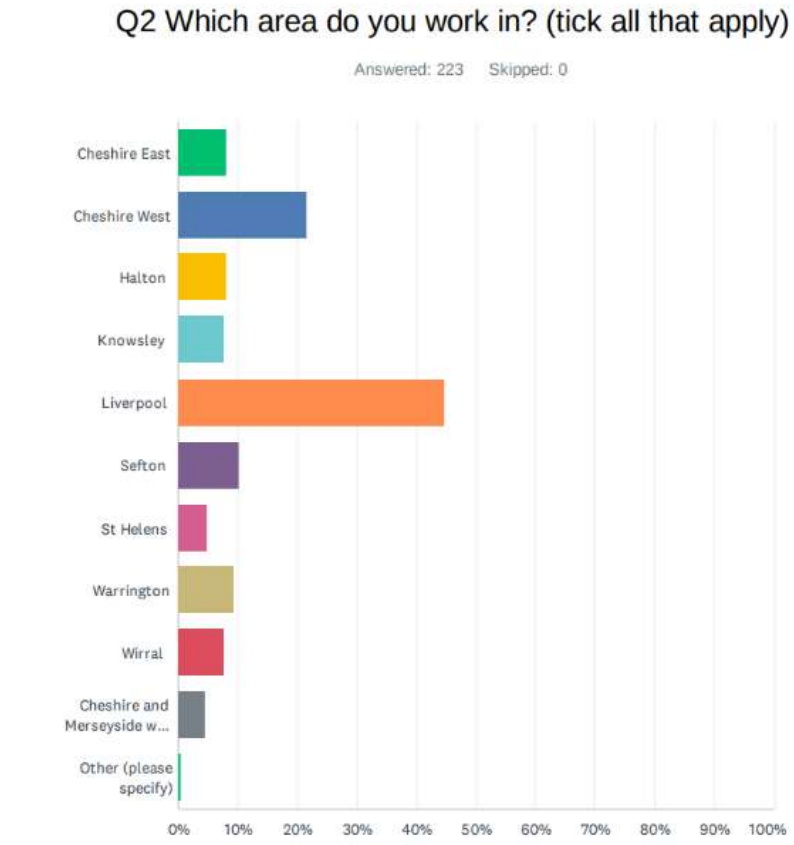
Q1.	
Q2.	
Q3.	
Q4.	
Q5.	
Q6.	

Please return this form to:

engagement@cheshireandmerseyside.nhs.uk

Appendix D: Breakdown of questionnaire responses by Place.

NHS Cheshire and Merseyside's Children and Young People's Mental Health Transformation Plan - Professionals



NHS Cheshire and Merseyside's Children and Young People's Mental Health Transformation Plan - Professionals

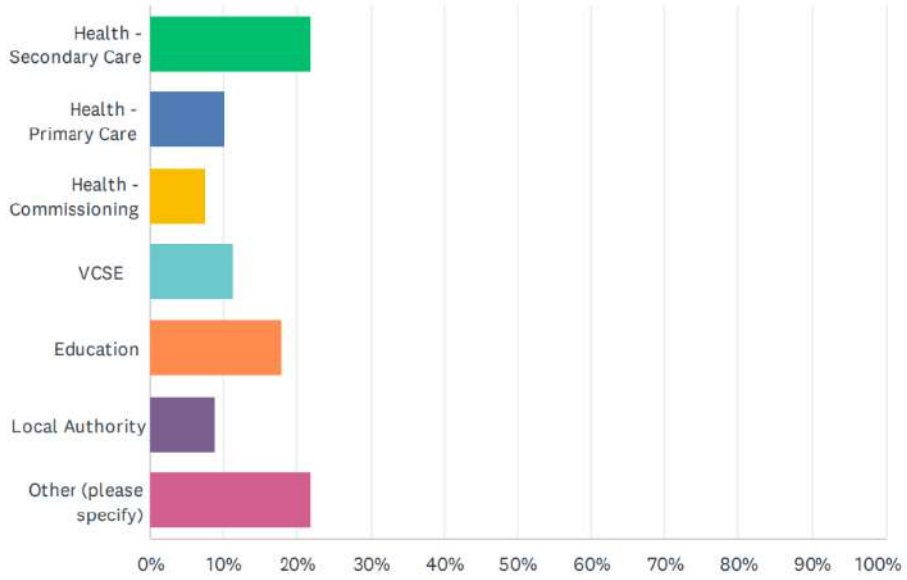
ANSWER CHOICES	RESPONSES	
Cheshire East	8.07%	18
Cheshire West	21.52%	48
Halton	8.07%	18
Knowsley	7.62%	17
Liverpool	44.84%	100
Sefton	10.31%	23
St Helens	4.93%	11
Warrington	9.42%	21
Wirral	7.62%	17
Cheshire and Merseyside wide	4.48%	10
Other (please specify)	0.45%	1
Total Respondents: 223		

Appendix E: Breakdown of questionnaire responses by sector.

NHS Cheshire and Merseyside's Children and Young People's Mental Health Transformation Plan - Professionals

Q1 In your professional role please select which sector you work within.

Answered: 223 Skipped: 0



ANSWER CHOICES	RESPONSES	
Health - Secondary Care	21.97%	49
Health - Primary Care	10.31%	23
Health - Commissioning	7.62%	17
VCSE	11.21%	25
Education	17.94%	40
Local Authority	8.97%	20
Other (please specify)	21.97%	49
TOTAL		223

DRAFT

NHS
Cheshire and Merseyside

Children & Young People's

Mental Health Plan

2024 - 2026

Our overall ambition for children and young people's mental health and wellbeing is to enable ***every infant, child and young person with mental health needs to achieve their goals and life potential.***

Foreword

NHS Cheshire and Merseyside are committed to working across our geographical area with stakeholders. We will work in partnership with children, young people, families, and carers to support our infants, children and young people to be the best that they can be and to lead healthy and happy lives.

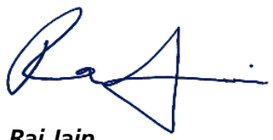
Our Cheshire and Merseyside population data highlights that the health of children and young people is determined by far more than healthcare. Household income, education, housing, stable and loving family life and a healthy environment all significantly influence young people's health and life chances and are protective factors for children and young people's mental health. By itself, better healthcare can never fully compensate for the health impact of wider social and economic influences.

High quality and effective plans are as important as ever and NHS Cheshire and Merseyside, now as an established Integrated Care Board, along with children and young people, partners and other stakeholders, have worked together to refresh our Mental Health Plan for children and young people. Our plan builds on the **Cheshire and Merseyside Health and Care Partnership (ICP) Interim Strategy for 2023-2028** and is aligned with All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside which highlights the needs of children and young people within its key recommendations.

As part of building this plan, several engagement activities have taken place across our geography. I'd like to sincerely thank everyone who has taken the time to tell us what works well, how we can make improvements and shared their ideas on what the future of mental health services for children and young people should look like so that we can realise our ambition.

The mental health and wellbeing of our children and young people is everyone's business

Our high-level aspirations for children, young people and families are set out in this document. Each of our nine places will assess their progress against the eight priority areas to be addressed and implementation plans will be developed at the appropriate geographic level to reduce unwarranted clinical variation. We will review progress against our plan in the recently established ICB Children's Committee, our forum for ensuring that we focus on driving improvements in outcomes for our children and young people.



Raj Jain

You may find you are not familiar with some of the language in this document, so we have created a glossary for you, to help you understand better. You can find this at the back of the document.

Contents

The Purpose of the Plan

This plan outlines Cheshire and Merseyside 'at scale' priorities for infant, children and young people's mental health. The priorities have been identified collectively by our 9 geographical Places, using the data and intelligence available to us, and with system wide stakeholder engagement.

The Plan is heavily influenced by what children and young people and their parent/carers have told us. It sets out why these priorities have been chosen and how working in collaboration across the Integrated Care System (ICS), in partnership with all key stakeholders and with children and young people and families, we can strive to improve both outcomes and experience and reduce inequalities for our population. This document has been produced to support our ICS partner organisations and stakeholders. A children and young people and family friendly version is available via the ICB website.

Our Ambition

Our Cheshire and Merseyside ambition is to enable every child and young person with mental health needs to achieve their goals and life potential.

We have come a long way in transforming mental health services for children and young people in Cheshire and Merseyside. The NHS Long Term Plan for Mental Health (2019-2024) contained specific ambitions around mental health services for those aged 0 to 25 years, and NHS Cheshire and Merseyside is committed to the delivery of these national ambitions across our footprint.The North West CAMHS Review (2021-2022) also made a number of recommendations which have been mobilised as priority areas for improvement. Local Place plans and priorities have also driven improvements. Although significant progress has been made, we still have further work to do.

Our Cheshire and Merseyside Principles underpinning the plan

- ✔ Effective and meaningful engagement with children, young people and families will be at the core of all transformation work
- ✔ Opportunities and services for children and young people should be inclusive
- ✔ A person centred and trauma informed care approach will be adopted
- ✔ A 'think family' approach will be adopted
- ✔ Reducing inequalities and improving equity in access, outcomes and experience of care will be central to our ambition
- ✔ An integrated approach to supporting our children and young people will be undertaken (with a clear focus on early intervention and prevention)
- ✔ There will be a strong focus on learning, improvement and innovation to meet the needs of our children and young people
- ✔ We will ensure sustainable and effective use of resources

Where are we now?

We are proud of Cheshire and Merseyside's record of collaborative working and there are countless examples of great care, but there are also examples of variation in service which only serve to exacerbate health inequalities.

Our vision 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.

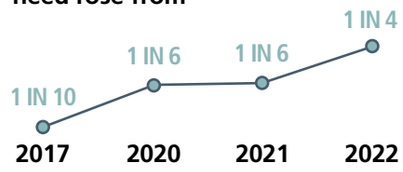
We will do this by working together, as equal partners, to support seamless, person-centred care and tackle health inequalities by improving the lives of the poorest fastest. We will continue to target the most deprived 20% of the population to ensure that a tailored healthcare approach to the Core20Plus5 Programme is maintained and strengthened in order to prevent disparities later in life.

Our Cheshire and Merseyside Population

Children eligible for free school meals have significantly lower expected levels of development, (23%) by the end of reception compared to children not eligible for free school meals.

The population of the Cheshire and Merseyside System is around 2.7million, a third of which are children and young people.

In young people aged 17-19 years, rates of a probable mental health need rose from



As of 2023 1 in 5 children and young people aged 8 to 25 years had a probable mental disorder.
20.3% of 8 to 16 year olds
23.3% of 17 to 19 year olds
21.7% of 20 to 25 year olds

Adverse childhood experiences (ACEs) contribute to poorer mental health outcomes later in life – with children from the poorest 20%of households more likely to experience. There has been a 10% increase in abuse/ neglect as a primary need for children in need from 2021-2022.

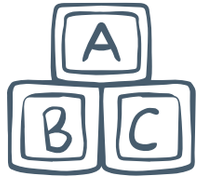
The average Index of Multiple Deprivation score in Cheshire and Merseyside is **28.6** compared to **19.6** in England. Cheshire and Merseyside is the **6th most deprived** ICB in the country.

35% of our population are deprived and **26%** of our children live in poverty as compared to the England average of **15.6%**.

Across Cheshire and Merseyside, it is estimated that **64,446** children and young people aged 6-18 have a probable mental health need.

Nearly half of 17–19-year-olds with a diagnosable mental health difficulty have self-harmed or attempted suicide at some point, rising to 52.7% for young women.

10-25% of young children experience a disorganised attachment relationship with their main carer(s). This can significantly increase the risk of poor social, emotional and cognitive outcomes (First 1001 Days Movement, 2021).



The mental health and wellbeing of children and young people is a huge public health concern, which has been heightened in light of the Covid-19 pandemic.

The first 1001 days in a child's life has an impact on their health and wellbeing later in life. More children reaching good development milestones will support their later development physically, emotionally and socially.

Children from the poorest 20% of households are four times as likely to have serious mental health difficulties by the age of 11 as those from the wealthiest 20%.

TRANSGENDER PEOPLE UNDER THE AGE OF 26 ARE TWICE AS LIKELY TO ATTEMPT SUICIDE.

Self-harm is more common in young people than any other age group. In 2018-19, 24% of 17-year-olds reported having self-harmed in the previous year, and seven per cent reported having self-harmed with suicidal intent at some point in their lives. 16% reported high levels of psychological distress.

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.

Children aged 8 to 16 years with a probable mental need were 7 times more likely than children unlikely to have a mental need to have missed more than 15 days of school.

Research suggests that 75% of mental health problems become established before the age of 24.

THE NUMBER OF A&E ATTENDANCES BY YOUNG PEOPLE AGED 18 OR UNDER WITH A RECORDED MENTAL HEALTH NEED MORE THAN TRIPLED BETWEEN 2010 AND 2018-19. THERE HAS BEEN A 37% INCREASE FROM 2018-2023 IN CHESHIRE AND MERSEYSIDE.

1 in 10 in **2004**
1 in 9 in **2017**
1 in 6 in **2022**

7-16 YR-OLDS HAD A PROBABLE MENTAL HEALTH PROBLEM

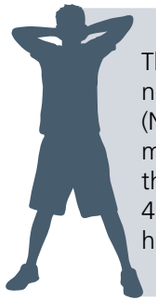
THE NUMBER OF LOOKED AFTER CHILDREN IN CHESHIRE AND MERSEYSIDE IS 47% HIGHER THAN THE ENGLAND AVERAGE.

Approximately half of those have a probable mental health disorder. The proportion of children and young people with good development at 2-2.5 years old is 15.5% lower than children not Looked After.

There has been an increase in children starting to be looked after by year from 2019-2023 (16.1% increase). The total number of Looked after children has increased by 8.63% during the same time period.

As a whole, children in Cheshire and Merseyside are comparable to the national average for school readiness. However there is significant variation with only 61.7% of Liverpool children and 62.2% of Halton children ready for school at the end of their school reception year. 5 of 9 Places showed lower than average school readiness in comparison to the national average.

Refugees and asylum seekers are more likely to experience poor mental health (including depression, post traumatic stress disorder and other anxiety disorders) than the general population.



Those young people at the age of 16-17 who are no longer in education, employment and training (NEET) are at higher risk of both poor physical and mental health outcomes. In England as a whole, the percentage of young people NEET in 2021 was 4.7%. Liverpool and Knowsley are significantly higher than England at 7.6% and 5.9%.

Social media is now a part of almost everyone's life, but none more so than our young population. The highest prevalence of social media use is seen amongst those aged 16-24. These years are a crucial period for emotional and psychosocial development and reinforces the need for greater understanding of social media's impact.

8 of our Places have rates higher than the national average of under-18 conceptions in England. In a MBRRACE-UK (2022) report all teenagers who died via suicide had high Adverse Childhood Experiences, vulnerabilities and were under the lens of Children's Social Care or had their baby removed.

Children and young people with a learning disability are three times more likely than average to have a mental health problem.

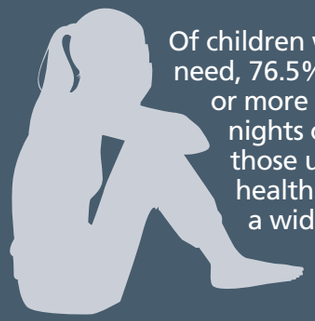
YOUNG PEOPLE WITH CARING RESPONSIBILITIES HAVE A HIGHER PREVALENCE OF SELF-HARM. YOUNG CARERS ARE TWICE AS LIKELY TO ATTEMPT TO TAKE THEIR OWN LIFE THAN NON-CARERS. THEY ARE SIGNIFICANTLY MORE LIKELY TO EXPERIENCE PSYCHOLOGICAL DISTRESS, 56% COMPARED TO 43% OF NON-CARERS. FOR THOSE CARING FOR AT LEAST TWO YEARS, THE FIGURE WAS EVEN HIGHER, AT 60%.

Neurodevelopmental conditions such as autism and ADHD are not mental health conditions. But just like everyone, neurodivergent people can sometimes face mental health difficulties and struggle with their emotional wellbeing. Being neurodivergent in a neurotypical world can lead to challenges that may increase the risk of stress, anxiety or depression, and research indicates that neurodivergent people are more likely to experience mental health issues than neurotypical people.

In a class of 30, at least 1 or 2 young people will experience difficulties understanding, following and instructions, and concentrating on work tasks, teaching activities and group discussions.

Over the last few years we have seen a significant increase in the number of Cheshire and Merseyside up to age 25 requiring an Education Health Care Plan in England. In Cheshire and Merseyside this is an increase of 71.5% since 2019.

7,118 children across Cheshire and Merseyside are known by schools to have autism – 77.7% of them are estimated to have a probable mental health disorder.



Of children with a probable mental need, 76.5% had a sleep problem 3 or more times over the previous 7 nights compared with 25.0% of those unlikely to have a mental health need. Poor sleep is linked to a wide range of both physical and mental health conditions in adults including depression.

What works well in Cheshire and Merseyside

We have come along way in transforming mental health services for children and young perople. Significant improvements include:

- ✔ Increased access to MH support year on year: 2019 2020 2021 2023 2024
- ✔ Introduced Mental Health Support Teams in schools
- ✔ Increased mental health support to meet the needs of infants (our youngest citizens) via expansion of community perinatal mental health teams and parent-infant teams
- ✔ Introduced community mental health crisis/urgent support via 24/7 telephone and community based crisis response services
- ✔ Successfully piloted Crisis Alternatives for children and young people - supporting them closer to home and avoiding the need to attend an Emergency Department
- ✔ Introduced a new model of care for our more complex children and young people which includes Place Based Gateway meetings with multi-professional engagement to ensure children and young people get the most appropriate support if their needs change or escalate, preventing admission to care, custody or inpatient settings where appropriate.
- ✔ The development of the Cheshire and Merseyside children and young people's Complex Needs Escalation tool supports this process
- ✔ New career pathways and new mental health workforce roles introduced, many based on recruit to train roles to expand and grow our workforce
- ✔ Health Equity Collaborative – established an innovative partnership which brings together children's charity Barnardo's, the University College London's Institute of Health Equity (IHE) and Integrated Care Systems (ICSs) from Birmingham and Solihull, South Yorkshire and Cheshire and Merseyside. The aim of the Health Equity Collaborative is to identify and address the social determinants of health which both affect and matter most to children and young people across the key issues of Education, Home, and Community. This valuable data will form the basis of a new Children and Young People's Health Equity Framework

Children and young people, Parents and Carers told us it works well when….

- ✔ You see the same professional for help e.g. Care Navigators and Key worker
- ✔ You are listened to
- ✔ Allowed to be involved
- ✔ Communication is good
- ✔ There is a range of services and choice
- ✔ You can access mental health and wellbeing support via youth based groups in the community

Professionals & stakeholders told us it works well when….

- ✔ Co-location of good quality support is provided in community based and non-clinical settings with trained and trauma informed staff
- ✔ Children and young people can input into their own care
- ✔ Children and young people can access help and support via school
- ✔ Collaboration and good communication exists across services that may be supporting a young person. Working together and wrapping around support
- ✔ Staff are friendly, approachable and committed
- ✔ A range of services are available to meet different levels of needs
- ✔ Parental support is provided
- ✔ Online support is offered

Where do we have challenges / gaps?

There are a range of mental health and emotional wellbeing services delivering evidence-based care to children and young people, from universal services focused on early identification and prevention through to specialist inpatient services.

However, there is not always parity in provision of services across our nine Cheshire and Merseyside Places. While some variation in services is warranted based on local need, there are some services we would like to scale up or improve the offer of for all children and young people.

We know that:

- We need to focus on populations of highest inequality
- Mental Health services for children and young people are seeing an increase in referrals and our waiting times are long in some areas
- We are seeing an increased prevalence of eating disorders and disordered eating
- Some children and young people present to Accident and Emergency Departments or have to stay in an acute hospital, with increased demand on Ambulance and Police services
- There has been an increase in self harm behaviours
- There is a rising prevalence of and increase in waiting times for diagnosis of Autism and ADHD which can impact on mental health and wellbeing
- Our service providers report an increase in complexity and acuity of mental health and wider social challenges for children and young people
- There has been an increase in the use of media device and Internet access since the Covid-19 pandemic. A focus on risks correlated to social media use by children and young people is needed to identify rising problems and engage in preventive recommendations
- A skilled, trained and competent workforce (both NHS and other providers) plays a vital part in the delivery of good quality mental health support for our children and young people

Children, Young People, Parents and Carers told us….

- The workforce could be better equipped to support young people:
  - from LGBT+ communities
  - with a suspected neurodiversity and/or learning disability
  - who have experienced trauma
- Professionals could work better together to provide more seamless and joined up care – no wrong door approach across services
- We need to improve our communication and pathways of care so children and young people only need to tell their story once
- Families would value support with early family/ Infant relationships from birth to age 5
- Waiting times can be long to access support
- Children and young people would like to see improvements in support when transitioning to adult support, but also between services depending on their needs
- We need to increase access to early help and support and provide this in a place that children and young people (and their parents and carers) can easily access
- We need to work towards no age-based thresholds and focus on the needs of each individual
- Co-occurring needs should be better supported e.g. Mental Health and Autism

Professionals and stakeholders told us

- Waiting times are too long
- There is a need to focus more on earlier intervention and prevention
- Thresholds to access services can be high and too rigid.
- To build relationships based on trust takes time (patience and tenacity), a different (skilled) way of working.
- That Eating Disorder services need to be trauma informed and services provided for Avoidant Restrictive Food Intake Disorder (ARFID)
- We need to better understand the impact of services
- Early years services are a gap and there is an inequitable offer across places

Developing our system-wide priorities - our Core20PLUS5 approach

Michael Marmot's review of health inequalities in England identifies "giving every child the best start in life" as a key policy objective (Marmot et al., 2020). There are two versions of NHS England's (NHSE) Core20PLUS5 framework for reducing health inequalities – one for adults (NHS England, 2021) and the other for children and young people (NHS England, 2022a).

This approach further demonstrates the need to differentiate actions by age, to address different clinical needs at different stages of development as well as to take into account social, educational and communication skills as children and young people develop.

The Core20PLUS5 approach is designed to support integrated care systems like ours to drive action in health inequalities improvement.

Target population Core20: The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD).

PLUS: Integrated care system-chosen population groups experiencing poorer-than-average health access, experience and/or outcomes, who may not be captured within the Core20 alone and would benefit from a tailored healthcare approach e.g. inclusion health groups.

Mental health: Improve access rates to children and young people's mental health services for 0-17 year olds, for certain ethnic groups, age, gender and deprivation.

By adopting this approach throughout our work we will continue to target the most deprived 20% of the population to ensure that a tailored healthcare approach to the Core20Plus5 Programme is maintained and strengthened in order to prevent disparities later in life.

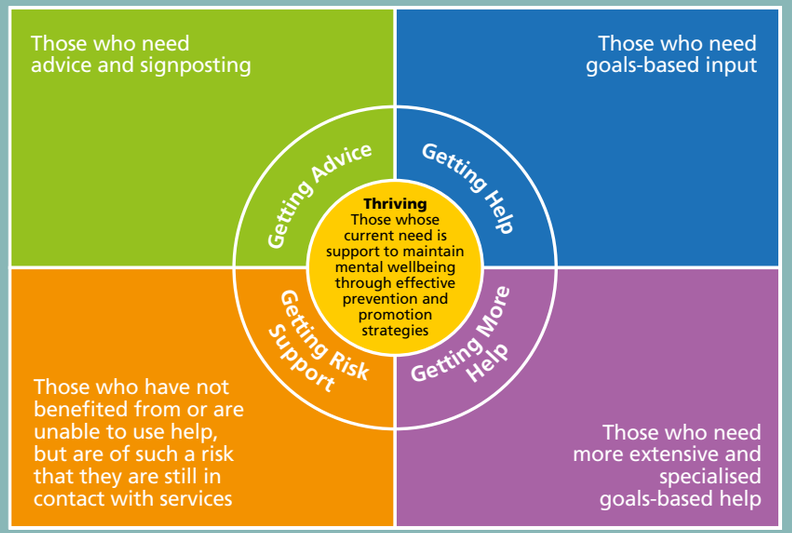
Developing our system-wide priorities – using the THRIVE framework

We will continue to work together to actively protect children and young people and families emotional health and wellbeing, helping them to develop the skills and resources to be able to cope and be resilient to life's challenges. Work to develop clear pathways of care from mental health promotion and early intervention (including improving integration with public health, Education, Social Care, Community/VCSFE partners, Criminal Justice System and Primary Care) through to specialist inpatient care. As part of this work, our nine Places along with services in our system are working towards implementing the THRIVE Framework. That means that our pathways and care offer is being organised to follow the THRIVE framework: Getting Advice, Getting Help, Getting More Help, Getting Risk Support. It is recognised that children and young people may move between domains and occupy more than one.

THRIVE promotes cross agency working and a shared language and understanding across health, education, and social care. This is in line with the SEND (special educational needs and disabilities) agenda, which also requires collaboration across services who support children with additional educational and emotional needs.

The Framework is needs-led which means that mental health needs are defined by the children, young people and their families, alongside professionals, through shared decision making. Needs are not based on severity, diagnosis or care pathways.

Children, young people and their families are empowered through active involvement in decisions about their care, which is fundamental to the approach.



System Wide Priorities and Delivery Programmes for 2024/25 and 2025/26

Having reflected on the current challenges faced by the system; understood the emerging and unmet need and listened to children, young people and their families/carers, we have identified ICS priorities where it makes sense to plan, develop or deliver transformation and improvements at scale to enable us to deliver our commitments.

To demonstrate our commitment to advancing mental healthcare equality for children and young people and their families across Cheshire and Merseyside our transformation plan is organised into 8 priority areas.

1. Inclusive co-production with children, young people and families to support transformation and continuous improvement

What is the need we are trying to address?

Young people have a right to influence the key decisions that shape their lives. This right is recognised in Article 12 of the United Nations Convention on the rights of the Child.

We are committed to work towards the Lundy Model of Participation to ensure services are improved and made more relevant by the involvement of users.

Research has shown that a third of children struggle to understand information given to them from healthcare staff and over half of children do not feel like they are involved in decision-making around their health and care (NICE, 2021). We want to improve this.

Cheshire and Merseyside is required to assure the delivery of high quality evidenced based care with a better understanding of the outcomes for children and young people. We want to develop a better understanding of this so that we can meet the needs of our children and young people in ways that work best for them.

Children and young people told us…

We would like more opportunities for public participation across services.

Family support is often crucial for the success of mental health services for children and young people.

Theme	What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Strategic Transformation	Lundy Child Participation Training rolled out across the ICS to ensure that children's voices are considered within strategic transformation, service improvement and service delivery.	• Organisational Checklists to be created and circulated to colleagues across the ICS, to ensure consistency in approach before engaging with children and young people, inline with the Lundy principles. • Children and young people Feedback Forms to be created and circulated to colleagues across the ICS to capture honest opinions on the engagement piece.
	To build on existing networks, youth forums, advisory groups working with engagement leads across the ICB footprint to hear the collective voice of our children, young people and families.	Work with the VCSFE children and young people Network to harness the collective power, relationships and resources of nine ICB Places to create a sustainable and more effective regional force for change. Address current barriers to accessing services including young people from vulnerable groups and CORE20PLUS5 population.
	Infant, children and young people, Parent/Carer/family representation through transformation governance, including representation in all of the priority workstreams.	Ensuring their needs and lived experiences are at the centre of any integrated service design and delivery. All transformation workstreams to include representation and/or the voice of children and young people and families as standard.
	Work with partners at place and within the ICS to increase understanding of children and young people's health needs in their local area through joint analysis of JSNA information and health service data.	Place based governance and action plans.
	CORE20PLUS5 - Identification of specific groups of children and young people that require targeted support and interventions, which may vary in each locality (the 'PLUS' groups). Review existing initiatives to reduce health inequalities and consider whether they address inequalities in access and outcomes experienced by children and young people and share best practice.	CORE20PLUS5 outcomes measured.
Service delivery/ development	Services to collect ongoing feedback from children and young people as part of quality improvement and service development.	Children and their families feel that their views have been heard and this leads to improvements in the help and support that they receive.
	Ensure families are, where a CYP requests it, engaged and part of the support offered.	Communication of family support approach available online. Families and CYP report feeling part of the process.

2. Children and Young People (children and young people) to have timely and appropriate access to emotional wellbeing and mental health support

What is the need we are trying to address?

1 in 10 in **2004** | 1 in 9 in **2017** | 1 in 6 in **2022**

7-16 YR-OLDS HAD A PROBABLE MENTAL HEALTH PROBLEM

Across Cheshire and Merseyside, it is estimated that 64,446 children and young people aged 6-18 have a probable mental health need.

Accessing support can be harder for some communities for example our children and young people with learning disabilities and autism or those groups with protected characteristics.

Demand for children and young people's mental health services has also grown as a result of the Covid pandemic.

Children and young people and parents/carers told us…

- Waiting times to access support are too long
- A constant worker, where possible it appreciated to build rapport and understanding
- More support is needed for Ethnic communities. We need more awareness in the community to share knowledge to explain to people how it can feel and how it is normal and acceptable to receive help and support
- Autistic children and young people sometimes find it hard to communicate and talk about problems
- Stigma surrounding mental health issues can prevent children and their families from seeking help
- Barriers such as limited financial resources, lack of transportation, or inadequate awareness of available services can hinder access to mental health care

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Continue to increase access to MH support to meet the NHS England Long Term Plan target.	Cheshire and Merseyside and Place level children and young people MH Access Metric.
Early Intervention & Prevention: • Increasing partnership co-ordination of early intervention and prevention offers. Focusing on the areas of greatest deprivation and population health need • Greater Integration between all system partners. Working collaboratively with partners such as our Local Authorities, Primary Care, VCSFE, community and faith groups to reach more infants, children, young people and families – alignment with Healthy Child Programme • Agencies will share information effectively and work together to identify children who display signs of mental ill health, intervening to ensure that children get the right help at the right time and monitoring the impact of interventions so that their needs are met, with focused efforts to support our Looked After Children • Assess current provision against the 'Improving the mental health of babies, children and young people: a framework of modifiable factors published by the Department for Health and Social Care' (January 2024)	System is intelligence driven and directed by the Marmot Review Principles and our CORE20PLUS5 population with a focus on those with protected characteristics. Services are developed at Place to meet needs of local populations. Increased collaboration with the VCSFE to develop services tailored to the need at Place and effectively engage with harder to reach communities. Robust data and intelligence monitored to better understand the demographics and characteristics of children and young people using services against the known prevalence and population health needs. • Develop local frameworks to improve infant/children and young people mental health • Identify where there might be gaps and opportunities for taking further action
Phase 2 implementation of As One Platform (digital single point of access).	Mobilisation agreed for phase 2 and sustainable funding agreed.
Expansion of Specialist Parent Infant Relationship Support services. Services to evolve to support relationships and mental health from conception to age 5 ensuring alignment with family hubs.	Increase in services to support the relationships and mental health of our 0-5 years across Places. Support the development of Family Hubs led by Local Authority partners. Family hubs as a place for families to access Start for Life services.
Be clear about the resources, services and support available across our Places. Continue to develop parent support as a universal offer.	Range of interventions offered for families and parents which are evidence-based Increase equitable access to resources so that families are supported to improve resilience.
Mental Health in School Team Expansion: Implement wave 11 of Mental Health Support Teams.	Teams mobilised and population coverage increased.
Children and young people Primary Care Mental Health Pilots mobilised to explore the effectiveness of mental health professionals working in Primary Care Networks as part of increasing access to emotional wellbeing and mental health support.	Pilot evaluation. Recommendations for future models.
Robust data collection and analysis of clinical and patient reported outcome measures to ensure services are effective.	Develop a consistent approach to collecting, reporting, and analysing activity and outcomes data across Places.

2. Continued

What is the need we are trying to address?

Neurodivergent children and young people do not necessarily have poor mental health. However, due to social expectations and a lack of support and understanding, neurodivergent children and young people may be particularly susceptible to mental health problems - especially in environments where differences are not understood and respected.

Across Cheshire and Merseyside 7,118 children are know by schools to have autism - 77.7% of them are estimated to have a probable mental health disorder.

Children and young people with a learning disability are three times more likely than average to have a mental health problem.

Children and young people and parents/carers told us…

- Getting support early is important to us. Young people currently feel that they need to reach crisis before they get the right support
- We would like opportunities to engage online or in person
- Having groups that can be accessed without waiting times, "while you wait" before being able to access therapy
- More promotion of services available for young people would be helpful
- Some children who are currently being cared for said they often feel different and are treated differently by other adults and their peers. The young people said they sometimes feel judged, and this is a barrier to opening up about their mental health as they feel misunderstood
- Being a deaf young person can make it hard to access to right level of support

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Work with MH service providers to ensure services can flex to meet the needs of CYP with co-existing 'suspected' or 'diagnosed' neurodiversity. Mental health service providers to consider the required reasonable adjustments to improve access and treatment for autistic children and young people and those with a learning disability.	Increase in children and young people who are neurodiverse reporting positive experience in services.
Reasonable adjustments and sensory considerations are facilitated where possible to support people with a Learning Disability and/or Autism.	The increased use of autism/LD communication/health plans in services. Ensuring that there is a descriptor of any sensory needs. Services to undertake a sensory audit of their current environment to establish safe areas for waiting, or look at the waiting areas as a whole.
Autism training and Oliver McGowan training is considered for NHS MH providers to strengthen skills when supporting those with LD/Autistic young people.	Training completed for all children and young people workforce (NHS providers). Continued improvement of policies within Trusts to provide training for staff, students, and volunteers, increased use of health passports, digital flags on hospital records, improved early identification of patients with learning disabilities. Strengthen skills when supporting those with LD/Autistic young people.
The Cheshire and Merseyside Children and Young People's Neurodiversity Pathway Group will collaborate on the development of the Cheshire and Merseyside Children and Young People's Neurodiversity Pathway; focusing on Autism and ADHD initially. *Detailed here in this plan to ensure synergy and alignment with access to mental health support and waiting times.*	• Place variance understood • Opportunities to ensure greater consistency identified • Cheshire and Merseyside children and young people neurodiversity capacity and demand model developed, enabling more effective service and workforce planning • Collaboratively designed Cheshire & Merseyside Neurodiversity Pathway developed, that supports diversity and need over disability, using a graduated response
Trauma informed practice and supporting behaviours that challenge: • A programme of work designed with a range of stakeholders, to include trauma informed training and peer support, with the aim of embedding positive behaviour support across services • A review and recommissioning across a broader footprint of a specialist behaviour support service in Cheshire and Merseyside *Detailed here in this plan to ensure synergy and alignment with access to mental health support.*	• Reduce admissions to tier 4 beds • Reduced length of stay • Greater consistency of service available across Cheshire and Merseyside, with clear pathways in place • Uptake of behaviour training to families • Training completed for CAMHS staff • Training needs analysis across Cheshire and Merseyside
Partnership for Inclusion of Neurodiversity in Schools (PINS). A Department for Education funded NHSE project whereby health provides support for whole school development in pilot schools. *Detailed here in this plan to ensure synergy and alignment MH Support Teams in Schools.*	Reported via ICB SEND Collaborative Unit. • Number of schools involved in project • Baseline comparison of key school based measures
A collaborative Health and LA approach is required to address the 71.5% increase in requests for Education Health Care Plans. *Detailed in this plan to ensure synergy and alignment MH Support Teams in Schools.*	Reported via ICB SEND Collaborative Unit. • A Cheshire and Merseyside graduated response process designed as a practical tool of good practice to include steps that should be followed in school

3. To design and develop an equitable offer of mental health support available to young adults (18-25 year olds)

What is the need we are trying to address?

The nature of support within child and adult services can be different and the experience for our young people varies significantly. In young people aged 17 to 19 years, rates of a probable mental disorder rose nationally from 10.1% in 2017 to 17.7% in 2020.

17 to 25 year olds with a probable mental disorder were 3 times more likely to not be able to afford to take part in activities such as sports, days out, or socialising with friends compared with those unlikely to have a mental disorder (26.1% compared with 8.3%).

In 2023, 12.0% of young people aged 17 to 22 years reported often or always feeling lonely, this was double the figure for children aged 11 to 16 years (5.5%). Loneliness was higher among young people with a probable mental disorder: 29.5% reported that they often or always felt lonely, compared with 5.2% of those unlikely to have a mental disorder.

Children and young people and parents/carers told us…

- Transition points are very difficult, both internal transitions e.g. from children/young peoples services to adult services or transition to another service
- Understanding who does what, referral pathways, it's a confusing picture
- Waiting times during transitions need to be decreased. Not knowing how long you will have to wait or not meeting criteria for support is really hard. Young people need to understand what's happening for them so they know what to expect

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
MH access & waiting times (18-25 years) – Overview of current provision to understand the engagement of communities harder to reach/engage where we see highest inequality for this population.	Cheshire and Merseyside and Place level increase total number of 18-24s receiving at least one contact from an NHS funded services. Cheshire and Merseyside and Provider level Waiting Times & Outcome Measures.
Cheshire and Merseyside scoping exercise of current MH support for 18-25 years olds, including the collation of data and intelligence available to us. Student population and those children and young people not in employment, education or training to be included.	Cheshire and Merseyside Scoping exercise complete and recommendations made to ICB.
To consider evidence-based models to co-design a best practice model of care for 18-25 year olds working with children and young people, stakeholders, professionals, parents and carers across Cheshire and Merseyside.	• Develop local expertise and knowledge about the needs of young people aged 18-25, with an emphasis on diverse, cultural and vulnerable groups. • Cheshire and Merseyside best practice model for young adults co-produced and published.
• Establish and understand our current workforce competency and skills and identify areas that require training and development • Consideration of new and emerging roles to support workforce challenges	• Identify gaps in training and education • Consider new and emerging roles to support this population group based on population need and co-designed model
Support joint working arrangements between children and young people and Adult services to support effective, strategic transition planning ending the use of rigid age-based thresholds that mean automatic transitions for 18-year olds. Specifically focused on: 1. Young people (YP) who transition from children and young people mental health services and are accepted by adult mental health services (AMHS); 2. YP who do not meet the criteria for AMHS but have continuing needs and require care; 3. YP presenting for the first time (including those with pre-existing need but not previously seen by children and young people). 4. YP known to children's social care who require transition to adult support	Cheshire and Merseyside Transition Policy in place.
Development of a Cheshire and Merseyside wide Transition Policy that has been co-produced with young people.	Cheshire and Merseyside Transition Policy in place and adherence to this by providers.

4. Children and Young People have timely and appropriate access to high quality and evidenced based eating disorder support

What is the need we are trying to address?

- Increasing prevalence and acuity
- Online influence (social media impact / positive body image)
- Changing demographics (increased recognition of ED in boys)
- Increased diversity of eating disorders including presentations such as Avoidant Restrictive Food Intake Disorder (ARFID)

In England during 2023, eating disorders were identified in 12.5% of 17 to 19 year olds, with rates 4 times higher in young women (20.8%) than young men (5.1%).

2.6% of 11 to 16 year olds were identified with eating disorders, with rates 4 times higher in girls (4.3%) than boys (1.0%).

5.9% of 20 to 25 year olds, were identified with eating disorders with no difference in rates evident between women and men.

This is a significant increase in prevalence.

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
To meet waiting time standards for children and young people ED (Urgent and Routine waiting times). Where not met to investigate and recover.	National waiting times standards (Urgent and Routine).
Review the NHS England National children and young people Eating Disorder Commissioning Guidance (2024) to consider how community eating disorder services and integrated care pathways can be further developed to better support children and young people with an eating disorder / disordered eating.	Development of Eating Disorder pathways in line with national guidance and best practice models.
Establish and embed a Cheshire and Merseyside children and young people Medical Emergencies in Eating Disorders (MEED) Oversight Group to improve pathways of care for children and young people with an eating disorder or disordered eating in line with MEED Guidance. Development of tools, advice and guidance and management protocols to improve quality of care and the management of risk for children and young people in line with MEED guidance.	Reduction in the number of unplanned admissions for eating disorders. Lived experience indicators – improved experience of care through services, between teams and along the care pathway.
Development of an early detection Avoidance Restrictive Food Intake Disorder (ARFID) Tool and online resources to support all children and young people with ARFID including those with a learning disability and/or Autism. This work will include universal health visiting and early years to increase skills around early identification /early help.	Reduction in admissions for disordered eating.
Align eating disorder community pathways with specialist eating disorder bed-based care with a focus on the experience and outcomes of those transitioning in and out of specialist services.	Reduction in admissions to specialist eating disorder bed-based care and reduction in length of stay. Reduction in children and young people going out of Cheshire and Merseyside footprint for support.

Children and young people and parents/carers told us…

- Accessing support quickly when you most need it is really important
- More awareness of eating disorders is needed across professionals
- Services could be more accessible in terms of location (outside of hospital settings) and more appointments available out of school hours

5. To anticipate and support children and young people who may experience mental health crisis or escalating needs

What is the need we are trying to address?

A mental health crisis is a situation in which a child, young person, family member, carer or any other person requires immediate support, assistance, and care from an urgent and emergency mental health service. This includes situations where there is significant intent or risk of harm to themselves or others.

Self-harm is more common in young people than any other age group.

Rates of self-harm are increasing in our children and young people population.

Children and young people and parents/ carers told us…

- When you are at crisis point getting support from the right person in the right way can really make a difference
- We should teach families how to support a young person in crisis
- Better communication is needed
- Young people should be involved in their safety plan
- There needs to be increased awareness of autism. My daughter was unable to know or ask for what she needed due to autism

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Implementation of the children and young people Crisis 4 functions, combining crisis assessment in the community 24/7, including brief response and intensive home treatment functions across 3 NHS Mental Health Provider Trusts.	• Activity measures across all 4 functions • Increase in the number of children and young people being successfully managed in the community • Reduction in the number of Crisis related admissions
Design an all age Crisis Alternatives best practice model that highlights the key principles to support a children and young people from reaching crisis in the first place and how they can be better supported when in Crisis as an alternative to A&E. Establish funding streams to increase this provision across areas of highest need.	• An increase in the number of Crisis Alternative Service Providers for children and young people • For children and young people with an LD/A need to ensure Intensive Support Function and/ or Key Worker support is available
Ensure that all age crisis transformation developments such as NHS 111 option mental health, mental health response vehicles, Right Care, Right Person and S136 consider the experiences and outcomes required that are specific to children and young people.	• Implementation of all age transformations to increase access and speed to Crisis care for children and young people • A reduction in the number of children and young people experiencing a mental health crisis presenting to hospital A&E • Develop a Cheshire and Merseyside process for children and young people who are placed on a 136. This will include clear escalation support and handover routes, multidisciplinary lines of accountability and appropriate places of care / places of safety
MH Champions in Acute – 8 Acute Trusts have an allocated MH champion to 'champion' the mental health and wellbeing of children and young people in their care and to act as a facilitated support into wider Crisis support and mental health teams.	• MH Health Champions (MHCs) in post across all 8 provider Trusts • Trusts should ensure that MHCs within their organisation have dedicated time to carry out the functions of the role, share learning and to advocate for children's mental health
Safe spaces in Urgent and Emergency Care departments - A hospital can be a stressful environment for any child or young person but particularly those in mental distress and or those who have a neuro-developmental condition.	Improve the design of paediatric wards and emergency settings to ensure they are fit for purpose and take into account the increase in children and young people presenting in acute mental needs.
Review of C&YP self-harm practice guides and where appropriate implement changes. Undertake a pilot on safety planning for C&YP in education settings. Support for Liverpool John Moore's University Multimodal Approach to Preventing Suicide in Schools (MAPSS).	• C&YP self-harm practice guide review complete • C&YP friendly safety planning guidance for education • Settings developed for testing across Cheshire and Merseyside • Pilot is complete and full evaluation undertaken
Place children and young people Gateways – Continue to develop and hold Place Gateways working across health and social care in all 9 Places in Cheshire and Merseyside. To collectively identify escalating risks in children and young people to prevent admission (care, custody and inpatient). Support timely, appropriate care, for mental health needs.	Professionals supporting children using the CNEST tool and actively contribute to multi-agency plans to support children's care and treatment. This includes health and care staff, and the voluntary and community sector commissioned to provide mental health services for children.
Establish and understand our current workforce competency and skills for children and young people Crisis services, including our acute and specialist trust providers working alongside the Cheshire and Merseyside Acute and Specialist Trust (CMAST) children and young people Alliance.	Development of new and emerging roles to support workforce challenges for children and young people.
Working as part of the Cheshire and Merseyside Crisis Oversight Group, monitor crisis transformation impacts to ensure services are operating as planned and to share learning to inform next steps. This will be included within an overall framework for crisis intelligence and data that is being developed.	Data set developed that captures the new all age crisis transformations to evaluate impact and share cross learning / independencies.

6. To design and develop Appropriate Places of Care where we have gaps in our current support offer for children and young people with the most complex needs

The North-West CAMHS review, commissioned in 2020, focussed on the need to transform delivery of care for complex children and young people (children and young people) who required responsive Mental Health support and inpatient care.

The review identified that there remained a cohort of children and young people who need support that crosses organisational delivery boundaries and:

- Cannot be supported in their family home
- Are assessed as not being suitable for inpatient mental health provision
- Where Local Authorities are unable to source regulated provision that can meet the breadth of children and young people needs

Data indicates a rising prevalence in children experiencing complex social and emotional difficulties within the context of a changing commissioning landscape.

There is increased pressure on health and social care systems resulting in children and young people being placed in settings that do not meet their needs effectively.

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Develop a cross organisational data set to explore rising prevalence of children and young people experiencing complex social and emotional difficulties to support the development of a best practice model.	To provide oversight of health and local authority quantitative data. To develop associated data sets to maintain an understanding of the number of children and young people classified as “not at home”.
To design with system-wide stakeholders a best practice model known locally as an ‘Appropriate Place of Care’. The model is to meet the needs of our most complex children and young people, likely known to both mental health services and Local Authorities.	Children and young people with complex needs will have access to responsive mental health provision to meet their needs. Children and young people with complex needs will be able to access appropriate places of care to support their needs.
To develop business case/s based on population need at the appropriate scale to support the development and mobilisation of ‘Appropriate Places of Care’.	There is reduced pressure on both health and social care systems with no children and young people being placed in settings that cannot effectively meet their needs. Care provision will be supported across organisational delivery boundaries.

Children and young people and parents/carers told us…

- Being passed between services and not knowing what will happen next increases anxiety

7. To provide high quality and evidence-based specialist mental health care based on the needs of our Cheshire and Merseyside population

What is the need we are trying to address?

Some young people may have more complex mental health needs and require a higher level of support.

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Undertake an assessment and re-design of our local Inpatient Mental Health services for young people aged 13 up to their 18th birthday with a focus on the following developing programmes and needs: • New national Transformation and Quality CAMHS Model of Care for specialised mental health services, reviewing opportunities to commission at scale across the North West if appropriate • Specialist Eating Disorder Services, taking account of the pathway wide review undertaken in 23/24	A reduction in the number of avoidable admissions and the length of stay in Children and Young People's Mental Health inpatient services. A reduction in out of area placements for young people requiring specialist mental health care.
Enhance our collection, analysis and use of data to understand and improve patient care and experience.	Gather and utilise patient feedback to improve the experience of care in specialist services.
Continued focus on delivery and analysis of impact of the three elements of the co-design New Care Model: • Cheshire and Merseyside Children and Young People's Complex Needs Escalation and Support Tool (CNEST) • Gateway • Ancora CARE	A reduction in the number of avoidable admissions and the length of stay in Children and Young People's Mental Health inpatient services. Reduction in delayed transfer into and out of specialist services.
Further integrate and align specialist mental health provision with place based community services across Cheshire and Merseyside.	Joint children and young people mental health dashboards accessible by key stakeholders.

LEVEL UP
Cheshire & Merseyside Young People and Families Provider Collaborative

Our Cheshire and Merseyside NHS-Led Provider Collaborative, known as Level Up is a new way of planning and providing specialist mental health, learning disability and autism services for young people aged 13-18 years. NHS-Led Provider Collaboratives mark a new era for specialised mental health, building on the success of New Care Models for tertiary mental health services. Ne para - The Level Up Provider Collaborative will work towards delivering care closer to home and as much as possible out of hospital, seeking to drive improvements in patient outcomes and experience. The Provider Collaborative is working with people who use these services as well as people who deliver these services to plan what needs to change in the future. New para - Children of a younger age currently access services such as these via NHS England. Further information about Level Up can be found here **https://www.levelupcm.nhs.uk/**

8. To lead system change and transformation by actively engaging and developing opportunities for research and innovation

What is the need we are trying to address?

Reduce inequalities of access to support by developing existing and new services.

Ensure commissioned services are safe, effective and give children, young people and families the best experience.

Professionals told us…

We aim for the highest standards and seek to continually improve our services, harnessing our ingenuity

What work will support us to deliver this?	Key indicators to measure our improvement or beneficiary impact
Together with children and young people, their families and industry partners, we will co-produce research priorities, realising the importance of research and innovation to find answers to current challenges with the overall aim to improve the outcomes for children and young people.	Establishing clinical networks for clinicians where research projects can be developed and supported. This will be a vehicle for developing the culture of research and innovation across our workforce and services.
There are numerous research activities underway across Cheshire and Merseyside a few examples are highlighted below. We will endeavour to connect our transformation and innovation work to: • Explore the use of new digital tools, such as apps and gaming, to assess and support mental health • Scale up place-based arts initiatives that support the mental health of children and young people • Bring together, education, training and research in the fields of neurodevelopmental disorders and intellectual disabilities	Together with children and young people and industry partners, we will co-produce and evaluate low-intensity (<2 hours per week) digital interventions to improve educational attainment, wellbeing, life chances and quality of life. Increase capacity and capability in children and young people digital technology research with industry investment and NIHR funding. Create digital platform with arts-based interventions, therapies and activities that have been evaluated with recommendations for applicable age groups and mental health needs. Creating evidence-based innovations and service improvements addressing health inequalities for CPY with learning disabilities and neurodiversity.
Evaluation and publication of local innovations.	Monitor the impact of recent innovations which include: • CNEST – Complex Needs Escalation and Support Tool • Place based Gateways – Multiagency collaboration to meet the needs of children and young people with escalating risk and/or complexity • Ancora Care – new non-bed-based offer of specialist Tier 4 MH support • children and young peopleMH waiting time initiatives – with a view to potentially to scale up to support a reduction in waiting times
• Undertake a review of the impact of social media on the emotional and mental health of C&YP • Raise public and medical awareness over the use of social media and identify new prevention measures to tackle associated problems such as sleep, addiction and anxiety in conjunction with caregivers, health practitioners and websites/application developers	To inform a set of recommendations for consideration across Cheshire and Merseyside.

Key enablers – things that we need to help us

Our data commitments include:

- Establishing a data rich and intelligence driven children and young people mental health system across Cheshire & Merseyside. This needs to be multi-agency to include Social Care, Education, Health and VCSFE sectors as examples
- Collecting high quality data in a timely way that can be appropriately shared to avoid duplication and making sure that people have access to high-quality evidence and information to make the right choice for them or their patient
- Greater data sharing and linkage across system partners to support hard to reach groups to access services
- To ensure that all providers, including in-scope third sector and independent sector providers, submit comprehensive and valid data to the MHSDS on a monthly basis, the breadth and completeness of which should reflect a true picture of local activity and enable national reporting of data. This includes ensuring that all providers are flowing accurate data using SNOMED CT, with particular focus on interventions and outcome measures
- Having high quality and timely data to inform service planning and development, commissioning, and understand patient outcomes and ensure that Cheshire and Merseyside can rapidly demonstrate the delivery of mental health services, the extent to which they are meeting the needs of patients and local populations
- Work to ensure that all providers are improving quality of data in line with national ambitions and monitor the progress of data quality via the MHSDS Data Quality Dashboard and SNOMED DQ Dashboard
- Address the underlying determinants of health inequalities and overcome inequalities in access, experience and outcomes via partnership working. Improving the quality of data based on protected characteristics is key to this, including age, disability, gender, marriage/civil partnership, ethnicity, religion/belief, sexual orientation, deprivation, accommodation status, looked after child status, and ex-British armed forces status
- Work with NHS England, Improvement and Digital to support providers in increasing the reporting of outcome measures to the MHSDS and monitor the progress of the children and young people's outcomes metrics and data quality via the NHS England outcomes dashboard
- To continue to make use of National data and reporting tools published on Future NHS by the National Analytical Services and Performance Analysis Teams, including the Core Data Pack, along with additional resources from NHS Digital and Public Health England to support activity and performance monitoring and to drive performance across Cheshire & Merseyside's Mental Health services
- To develop local Business Intelligence products (to be shared via Cheshire & Merseyside's Business Intelligence Portal) to support transformation of services, working with stakeholders using our collective intelligence better

Our digital commitments include:

- To support the development of an ICB Digital Sub Strategy for Mental Health which will support the transformation of our services
- To align our digital investment plans to improve the efficiency, safety and quality of our Mental Health Services with the Digital Mental Health Priorities which outline a mission that "we will help meet the increasing demand for mental health services and address unequal access and outcomes, using digital and data to design new and more flexible care options, identify and respond to unmet needs earlier, release more time to care, and effectively share information across people's circle of care"

Our Workforce commitments

Sitting as a key enabler at the core of this plan is the importance of ensuring we have an appropriate and confident workforce with a common core of knowledge and understanding about children's mental health and emotional needs and how to support these across a spectrum of need. This involves:

- Streamlining ways of working to ensure pathways for services are integrated and accessible
- Embed 'whole setting' approaches to promoting and delivering good mental health services which include changes to how support is delivered and workforce development
- Developing a learning culture, which includes investment in developing opportunities for restorative practice and trauma informed approaches to be implemented across the whole of the children and young peoples' workforce
- Ensuring there is a clear and consistent understanding and application of the Spectrum of Support, particularly focusing upon early and targeted support
- Building local partnerships around our Schools and Community and/or Family Hubs
- Valuing voluntary and community services
- Supporting our workforce to work with all family members

In Cheshire and Merseyside we have adopted a combined service and workforce modelling approach that asks the key questions to be able to define what the right service models need to be in order to meet population need and to match the workforce to the delivery of the service models and associated interventions.

It is important to have a children and young people workforce that is multi-disciplinary and maximises the potential for workforce innovation through embracing new roles and diversification and is representative of the patient.

Children and young people and parents/ carers told us…

- It works well when I can see the same professional who knows me
- We want to feel listened to by professionals
- I want to not feel judged and be accepted as I am
- It's important to me to get support from someone who can relate to me and my experiences
- It would be better if people did not assume stuff about me (being LGBT and autistic)
- I sometimes have felt that clinicians seem overworked, exhausted and pressured
- Constant changes in key worker, either because of transition to another service or because of staff changes means you have to tell your story again and again
- People are welcoming and encourage you out of your comfort zone
- Having someone to oversee treatment or care plan such as a care coordinator/navigator has helped as they were able to see gaps in my care plan and could then suggest other options/places/treatment
- Having a clinician who has personal experience or lived experience of mental health is helpful. This helps you to see and believe there is light at the end of the tunnel

This diagram outlines the six step model we will adopt to support workforce development

What are the needs of the population?

- Profile of population needs and conditions to be met by the service

The age range covering 0 -25 years.

A change in the profile of needs of children such as neurodevelopmental needs; eating disorders; increasing self harm prevalence.

Transition into adulthood.

Admissions to, and the length of stay in, Children and Young People's Mental Health inpatient services.

Targeted support for 18-25 year olds.

Learning Disability and Autism.

What is/are the model(s) of care?

- Considering the pathway of need for population groups
- How population needs are to be met

Mental Health Support Teams in education settings.

Children and young people Primary Care Pilots.

Access to Community MH Support.

Community crisis/urgent support via 24/7 telephone and community based crisis response services.

Place Based Gateways with multi-professional engagement.

Supporting children closer to home.

What interventions & support needs to be provided?

- The interventions, support and services are to be provided in line with the model of care/ pathway

THRIVE framework: Getting Advice, Getting Help, Getting More Help, Getting Risk Support.

What are the skills and competencies needed?

- What skills, knowledge and competencies staff (and volunteers) need to deliver the interventions and model of care

Common competency framework for children and young people staff in mental health services.

Multi-disciplinary workforce.

C+M children and young people clinical supervision availability (for clinical and non-clinical staff).

Trauma informed practice.

Expansion of apprenticeship opportunities.

Who can do it?

- The roles that have the skills, competencies, knowledge and qualifications
- The care groups and teams they can work in
- Recruitment strategies

The utilisation of Recruit to Train posts.

Expansion of Children's Wellbeing Practitioners and Education Mental Health practitioners with the ability to move between roles.

The rate of growth of new initiatives, projects and services is faster than the recruitment and training of a new workforce.

Movement between CYWP and EMHP.

Ability to move between adults and children's roles.

Expansion of Peer support workers.

Increased use of AHPs (e.g arts and music therapists).

What do they need to do their role?

- Training
- Induction
- Supervision and CPD
- Career progression routes

Equitable access for new and existing clinical and non-clinical staff to a consistent training and development programme in line with the pathway of care.

Effective on-boarding and induction arrangements for new staff.

Robust supervision arrangements.

Career development pathways.

We cannot show our progress and success without being clear about what we are aiming to achieve and how we will measure this:

This plan has been supported by local partners and stakeholders (including children, young people and families/care-givers).

Being accountable to children, young people and families/caregivers, as well as our workforce and wider stakeholders requires transparency regarding our success measures and quality indicators.

Throughout the detail of the plan 'Key indicators to measure our improvement or beneficiary impact' have been highlighted. This will help us understand our progress over time.

Delivery of the plan will be overseen by the Cheshire and Merseyside CYP Mental Health Programme Partnership (nine Places, MH, Beyond, Transforming Care, Directors of Children Services Programmes) on behalf of the ICB Children and Young People Committee.

All Programmes/Places will take a lead on a range of the deliverables.

Oversight and assurance of this plan will be carried out by the ICB Children and Young People's Committee.

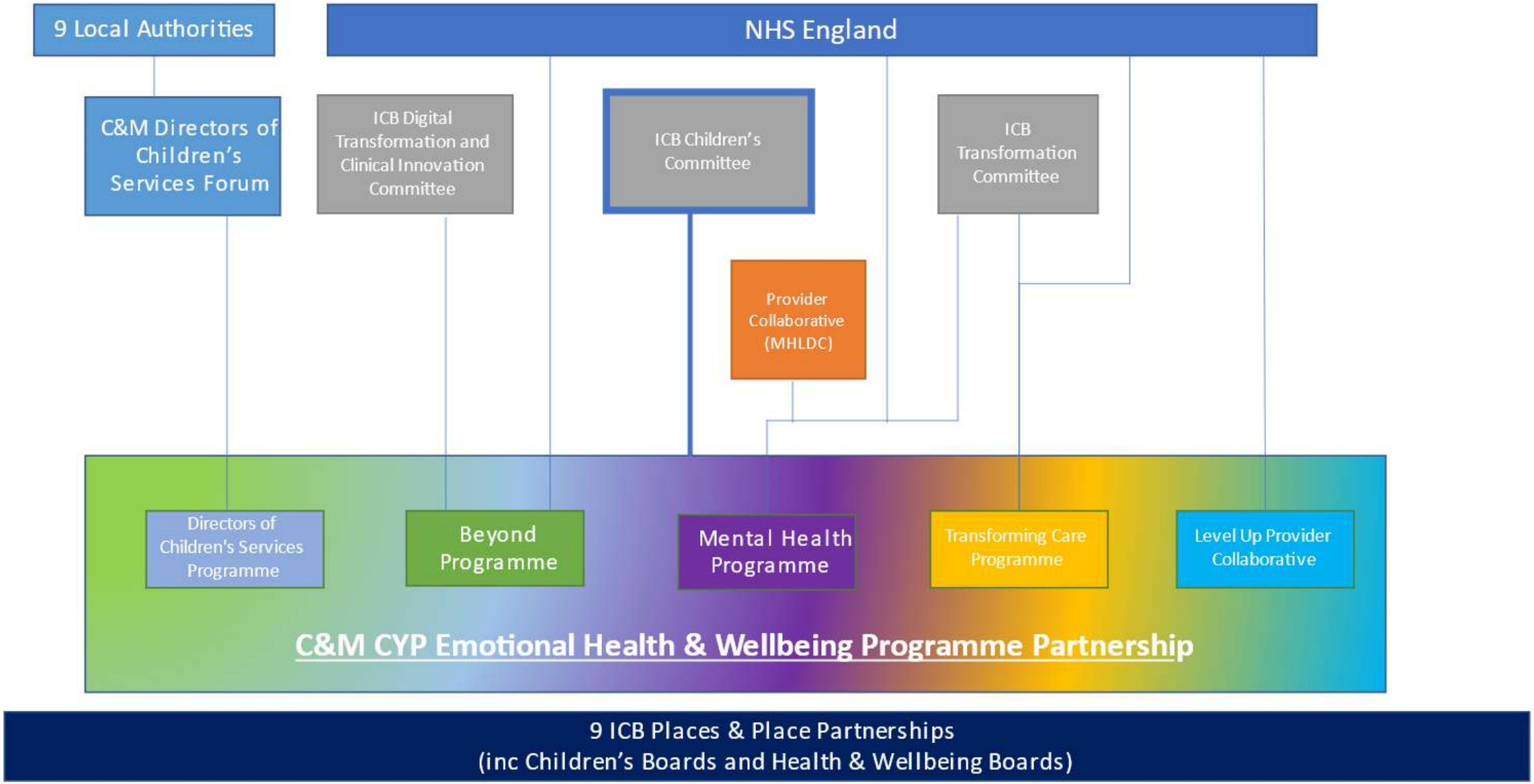
The Plan will be published on the ICB website.

Our children and young people are at the heart of our plan. We are committed to delivering this plan and our ambition to enable every child and young person with mental health needs to achieve their goals and life potential.

Glossary of terms

You may find you are not familiar with some of the language in this document, so we have created a glossary for you, to help you understand better.

Acronym	Meaning
ACES	Adverse childhood experiences
ADHD	Attention Deficit Hyperactivity Disorder
AHP	Allied Health Professionals
AMHS	Adult Mental Health Services
ARFID	Avoidant Restrictive Food Intake Disorder
ASD/ASC	Autistic Spectrum Disorder or Condition
Cheshire and Merseyside	Cheshire and Merseyside
CAMHS	Child and Adolescent Mental Health Services
CBT	Cognitive Behavioural Therapy
CNEST	Complex Needs Escalation Support Tool
CPD	Continual Professional Development
CTO	Community Treatment Order
Children and young people	Children and Young People
Children and young peopleMHS	Children and Young Peoples Mental Health Services
ED	Eating disorder
EHCPs	Education Health Care Plans
ICB	Integrated Care Boards
ICP	Integrated Care Partnership
ICS	Integrated Care Systems
JSNA	Joint Strategic Needs Assessment
LAs	Local Authorities
LEAs	Lived Experience Advisors
LD	Learning Difficulty
LGBT	Lesbian, Gay, Bisexual and Transgender
MBRRCE	Mother and Babies Reducing Risk through audits and Confidential Enquires
MEED	Medical Emergencies in Eating Disorders
MH	Mental Health
MHSDS	Mental Health Service Data Set
MHST	Mental Health School Teams
NEETs	Young People not in Education, Employment or Training
NHSE	NHS England
NICE	National Institute of Health and Care Excellence
NIHR	National Institute for Health and Care Research
SEND	Special Educational Needs and Disabilities
SNOWMED CT	Systematized Nomenclature of Medicine Clinical Terms
SNOWMED DQ	Systematized Nomenclature of Medicine Data Quality
VCSFE	Voluntary community faith sector enterprises
YP	Young Person


9 Local Authorities
NHS England
C&M Directors of Children's Services Forum
ICB Digital Transformation and Clinical Innovation Committee
ICB Children's Committee
ICB Transformation Committee
Provider Collaborative (MHLDC)
Directors of Children's Services Programme
Beyond Programme
Mental Health Programme
Transforming Care Programme
Level Up Provider Collaborative
C&M CYP Emotional Health & Wellbeing Programme Partnership
9 ICB Places & Place Partnerships
(inc Children's Boards and Health & Wellbeing Boards)

	Place	Meeting Dates	Date
1	Halton	Halton Senior Leadership Team	16/05/2024
2	Warrington	Starting Well Programme Board	13/06/2024
3	Liverpool	Healthy Children and Families meeting as part of One Liverpool	17/05/2024
	Liverpool	CYP MHEWB Strategic Partnership	13/05/2024
4	Knowsley SLT	Knowsley Leadership team	07/05/2024
5	St Helens	St Helens Peoples Partnership Board	28/05/2024
6	Cheshire West	CW Emotional Health and Wellbeing Board	20/05/2024
	Cheshire West	Cheshire West Children's Trust	03/06/2024
7	Wirral	Wirral's Strategy and Transformation group	24/05/2024
8	Sefton	Sefton Place Senior Leadership Team	09/04/2024
9	Cheshire East	Cheshire East Planning and Delivery Group	28/05/2024
	Cheshire East	Cheshire East Mental Health Partnership Board	05/06/2024

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

NHS Cheshire and Merseyside draft Involvement Plan 2024-26

Agenda Item No: ICB/07/24/20

Responsible Director: Clare Watson, Assistant Chief Executive

NHS Cheshire and Merseyside draft Involvement Plan 2024-26

1. Purpose of the Report

1.1. At the first meeting of NHS Cheshire and Merseyside Integrated Care Board (ICB), on 01 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 prescribed content guide.

1.2. Building on the framework, NHS Cheshire and Merseyside will now move to producing a two-year Involvement Plan, which sets out the organisation's overall approach, drawing on national guidance.

1.3. This report presents the first edition of the plan, for Board approval.

2. Executive Summary

2.1. NHS England published Working in partnership with people and communities: statutory guidance in summer 2022. It explains the importance of involvement, introducing ten principles for building effective partnerships with people and communities, and setting out legal duties.

2.2. As an integrated care board (ICB) NHS Cheshire and Merseyside has a legal duty to involve people in its work, but our commitment to involvement goes beyond what we must do: meaningful engagement helps us to develop more effective services that better meet the needs of our population.

2.3. While the Involvement Plan provides details of some key initiatives that will support our work, it is intended as a practical overview of our involvement approach, rather than a comprehensive account of all activity taking place. Similarly, it isn't designed to explain how we will engage on specific themes, in particular areas, or with particular groups of people, as we need to look at how we do this on a case-by-case basis.

2.4. This document is NHS Cheshire and Merseyside's plan for how we meet our duties as an organisation – it aims to complement rather than duplicate or replace the plans of other organisations. Working with partners, including local authorities, NHS trusts, Healthwatch and VCFSE organisations, is a key part of our involvement approach.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **approve** the NHS Cheshire and Merseyside Involvement Plan for 2024-26.
- **note** that there are resource requirements associated with involvement activity, including engagement and consultation linked to service change. NHS Cheshire and Merseyside will need to consider and review how this area is adequately and consistently resourced across programmes, as appropriate.
- **note that** there will also be a review of NHS Cheshire and Merseyside's involvement governance and the Public Involvement Policy.

4. Reasons for Recommendations

4.1. 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.

4.2. The current draft engagement framework was produced for establishment, nearly two years ago. It is important that the organisation has an up-to-date plan, which clearly sets out how we will meet our legal duties and take a clear, consistent approach to involvement.

4.3. As well as having a plan in place, NHS Cheshire and Merseyside requires a consistent approach to resourcing involvement requirements, and a clear governance route for reporting and assuring involvement work.

5. Background

5.1. Prior to being presented to Board, the Involvement Plan was endorsed by the Quality and Performance Committee of NHS Cheshire and Merseyside, at its meeting on 09 May 2024.

5.2. The plan was first presented to the Quality and Performance Committee in February 2024. The version presented to Board today reflects feedback made by committee members, including Healthwatch representatives, through that meeting.

5.3. The plan references the importance of having clear involvement governance in place, both for regular reporting, to provide assurance, and to allow sign-off of plans and activity where required. To support this, NHS Cheshire and Merseyside intends to finalise a draft involvement governance framework during summer 2024, so that this can be put forward for the Board's consideration. To support this, the communications and empowerment team has contacted

neighbouring ICBs to better understand their arrangements and look for opportunities to learn from what is already working well elsewhere.

5.4. The communications and empowerment team also intends to review NHS Cheshire and Merseyside's Public Involvement Policy, which focusses on the role of public representatives. Since the policy was introduced in July 2022, the range of programmes and projects overseen by NHS Cheshire and Merseyside has expanded, and the number of ways in which we might want to seek the input of those with lived experience has grown. The current policy does not address all of these scenarios – for example, while it covers payment of expenses for people offering their time on a voluntary basis, it does not allow for the creation of public advisor roles which compensate people for their time. Once the review is complete, the communications and empowerment team will produce an overview of the findings, and make recommendations to update the existing policy. The intention is to embed a consistent approach across all NHS Cheshire and Merseyside-led programmes and projects.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience
The Involvement Plan sets out NHS Cheshire and Merseyside's intention to work in partnership with people and communities, in line with statutory guidance. Ensuring that we hear the voices of our communities, including those who experience health inequalities, allows us to understand more about the issues and barriers faced by people when accessing services, which can in turn inform the plans we put in place to address them.

Objective Two: Improving Population Health and Healthcare
By listening to people, we can help to ensure that the services we have in place better meet their needs, supporting improved experience and outcomes.

Objective Three: Enhancing Productivity and Value for Money
Services that are co-produced with those who use and depend on them, and therefore better meet their needs, are a better use of NHS resources.

Objective Four: Helping to support broader social and economic development
While the plan does not directly relate to this objective, it should be noted that on an individual level, being involved can reduce isolation, increase confidence and improve motivation towards wellbeing.

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

7.1 This report is directly related to how we work with partners for the benefit of our population, with a focus on delivery of actions around communications and

engagement, and compliance with statutory guidance on working in partnership with people and communities.

8. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
The Involvement Plan sets out NHS Cheshire and Merseyside's intention to understand more about our population's views and experiences, including seeking insights from across our diverse communities. This relates to the 'equity in experiences and outcomes' quality statement within theme one.

Theme Two: Integration
While the Involvement Plan does not directly relate to this theme as it is articulated in the quality statements, the principle of working with partners is central to our involvement approach. This is reflected in the two final objectives referenced on pages 10 and 11 of the plan:

- *Work with partners to develop and deliver involvement activity, so that we make the most of skills and expertise across the system, while utilising different routes for reaching our audiences*.
- *Look for ways to share the insights we gather with system partners, to maximise the impact of the feedback our local population gives us.*

Theme Three: Leadership
The Involvement Plan provides an overview of NHS Cheshire and Merseyside's approach to engaging with our population, and a commitment to using this feedback to improve services. This relates to the 'partnerships and communities' quality statement within theme three.

9. Risks

9.1. As an ICB, NHS Cheshire and Merseyside has a legal duty to involve the public, as set out in the National Health Services Act 2006, as amended by the Health and Care Act 2022: section 14Z45.

9.2. A failure to meet our duties could lead to legal challenge, as well as impacting on the confidence and trust of our communities and wider partners.

10. Finance

10.1. While the Involvement Plan itself does not have a specific financial implication, it should be noted that delivery of involvement activity may require resource, and NHS Cheshire and Merseyside will need to consider how this is adequately resourced across programme areas.

10.2. NHS Cheshire and Merseyside's communications and empowerment team leads the organisation's involvement approach, however not all of the activity

required can be delivered in-house. Potential additional costs cover a host of activities and scenarios, across a number of different programmes and pieces of work. These range from providing funding to support people with lived experience to take part in groups and communities, to the specialist reporting and analysis of feedback required for public consultation.

10.3. During summer 2024, the communications and empowerment team will review likely/potential requirements during 2024-26, so as to assess likely costs and make a recommendation for the anticipated nature and level of resource required. This will include considering the most cost-effective way to deliver those activities which could potentially be delivered in-house or through commissioning external support.

11. Communication and Engagement

11.1 The Involvement Plan sets out how NHS Cheshire and Merseyside intends to utilise communications and engagement to involve local people and work with partners.

12. Equality, Diversity and Inclusion

12.1 NHS Cheshire and Merseyside's involvement duties link with separate duties around equalities and health inequalities (section 149 of The Equality Act 2010 and section 14Z35 of the National Health Service Act 2006).

12.2. The Involvement Plan contains a number of objectives which relate to EDI, including:

- *ensure that a focus on hearing underrepresented voices underpins our involvement plans (objective 2).*
- *provide a range of different routes for people and communities to be involved in the work of NHS Cheshire and Merseyside (objective 3).*
- *identify barriers to participation, and design communication and engagement mechanisms which recognise different needs, preferences, and styles (objective 4).*

12.3. As noted above, the Involvement Plan is not intended as a guide to how NHS Cheshire and Merseyside will engage on specific issues, or with particular communities. This will be set out in an individual plan for each piece of work, informed by Equality Impact Assessments (EIAs).

13. Climate Change / Sustainability

13.1 While the Involvement Plan does not directly link to the NHS Cheshire and Merseyside Green Plan, the wider approach it describes to working with people and communities can be applied across our organisational priorities, including potential future conversations around sustainability.

14. Next Steps and Responsible Person to take forward

14.1. Subject to approval by the Board, the Involvement Plan will be adopted by NHS Cheshire and Merseyside for the next two years.

14.2. A number of different formats will be produced once the document is approved, including an Easy Read version.

14.3 The plan will be published on the NHS Cheshire and Merseyside website, and shared with partners, including Healthwatch and Place Partnership Communications and Engagement Collaboratives.

14.4 Where relevant (and where these are not already in place), individual action plans will be developed for the activity set out in the plan. In addition, the reviews of involvement governance and the Public Involvement Policy will be progressed.

14.5 Further reporting on the activity set out in this place will be made via NHS Cheshire and Merseyside's People and Communities Insight and Experience Group to Quality and Performance Committee (this arrangement is subject to any changes that might arise from the review of involvement governance referenced above).

14.6 The work will be taken forward by NHS Cheshire and Merseyside's communications and empowerment team, which comes under the direction of Assistant Chief Executive, Clare Watson.

15. Officer contact details for more information

Helen Johnson, Head of Communications and Engagement:
helen.johnson@cheshireandmerseyside.nhs.uk

Maria Austin, Associate Director, Communications and Empowerment:
maria.austin@cheshireandmerseyside.nhs.uk

16. Appendices

Appendix One: NHS Cheshire and Merseyside draft Involvement Plan 2024-26

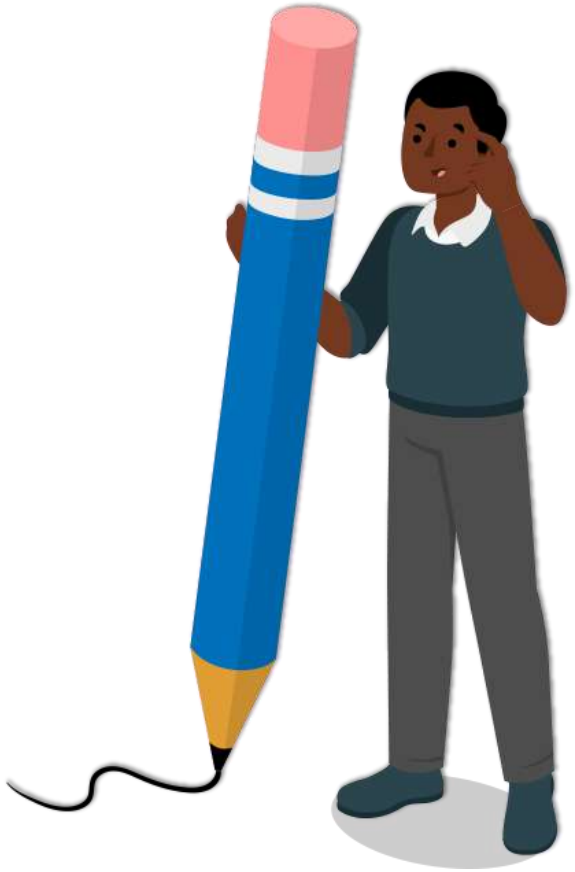
NHS
Cheshire and Merseyside

Involvement plan 2024 - 2026

How NHS Cheshire and Merseyside will work with people and communities to plan, develop and improve health and care services

Spring 2024

Contents



1. Introduction

- As an integrated care board (ICB) NHS Cheshire and Merseyside has a legal duty to involve people in its work, but our commitment to involvement goes beyond what we **must** do: meaningful engagement helps us to develop more effective services that better meet the needs of our population.

  NHS England published Working in partnership with people and communities: statutory guidance in summer 2022. It explains why involvement is so important, introducing ten principles for building effective partnerships with people and communities, and setting out legal duties.

- In spring 2022, local Healthwatch and voluntary, community, faith and social enterprise (VCFSE) organisations were involved in producing a draft public engagement framework for NHS Cheshire and Merseyside. It explained our intentions as a new organisation (established on 1 July 2022) for involving the public.

  Using the draft framework as a foundation, we are now moving to a two-year involvement plan – this is the first edition – which provides a practical overview of **how** we will work with people and communities.

2. About this plan

This plan **explains our overall approach to involvement**, rather than how we will engage on specific themes, in particular areas, or with different groups of people, as we need to look at how we do this on a case-by-case basis.

For example, engagement around children and young people's mental health will have its own plan, designed around the most relevant and effective routes for creating a two-way dialogue on this subject.

Working with partners, including local authorities, NHS trusts, Healthwatch and VCFSE organisations, is a key part of our involvement approach, but **this document is NHS Cheshire and Merseyside's plan** for how we meet our duties as an organisation.

The plan provides a basis for how we will involve people in the actions set out in the Cheshire and Merseyside Joint Forward Plan for 2023-28, the document which describes how NHS Cheshire and Merseyside, our partner NHS Trusts and wider system partners will work together to arrange and provide services to meet our population's physical and mental health needs.

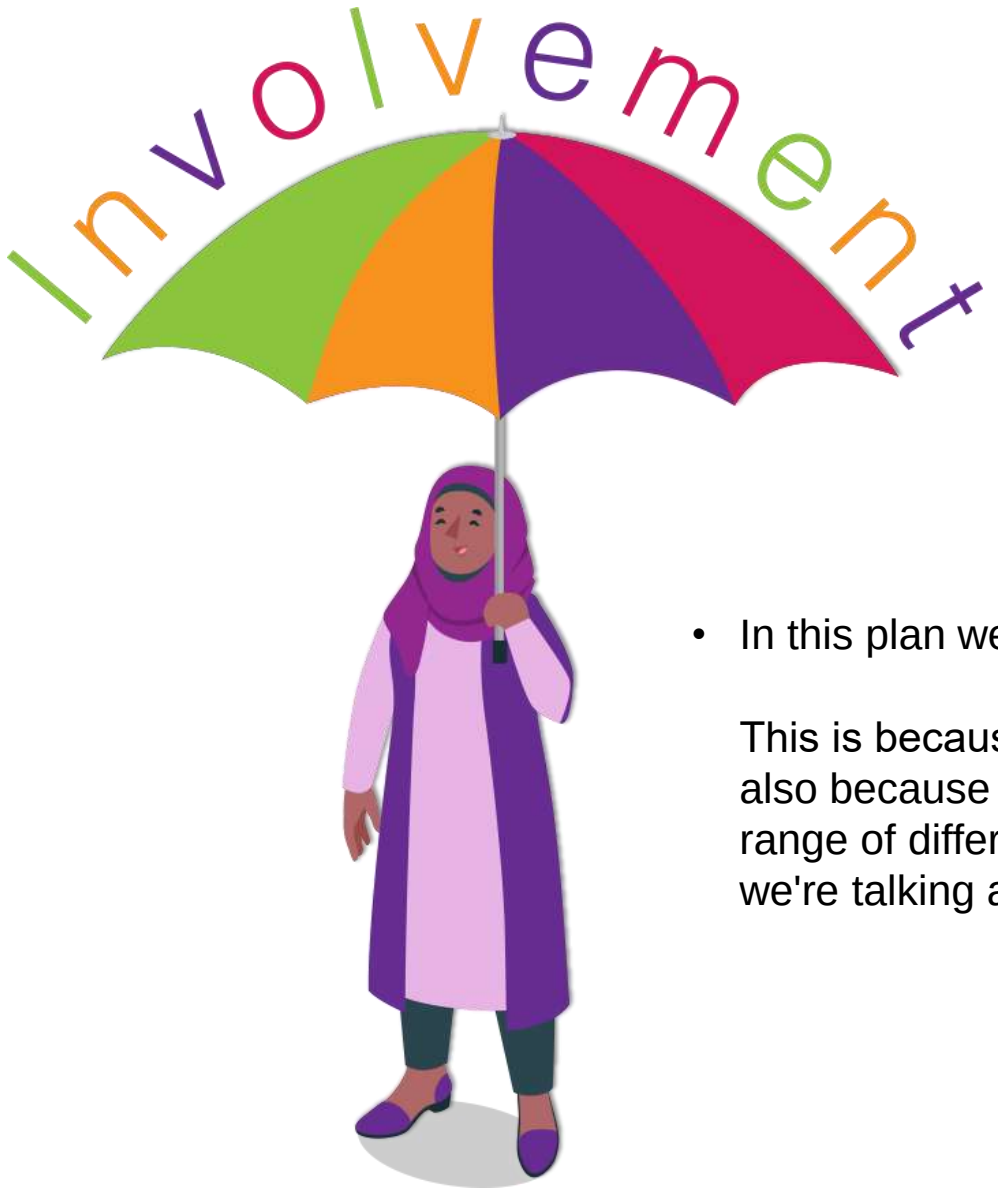
This plan should be read alongside the communications and engagement plans of our partners, including those which will be developed by the nine Place partnership boards across our system.

It aims to **complement rather than duplicate or replace** these plans. Similarly, we don't go into lots of detail about the benefits of involving people, because this is already covered in the national guidance – our focus is **how** we will involve people.

3. Terminology

The terms communications / engagement / involvement / public consultation are often used in relation to this area of work, sometimes interchangeably. In its statutory guidance, NHS England sets out five different ways of working with people and communities:

1. **Inform**
   Sharing information about proposed changes so people understand what they mean.
2. **Consult**
   Asking for people's opinions on one or more ideas or options.
3. **Engage**
   Listening to people to understand issues and discuss ideas for change.
4. **Co-design**
   Designing with people and incorporating their ideas into the final approach.
5. **Co-production**
   An equal partnership where people with lived and learnt experience start together from start to finish.



- In this plan we use the umbrella term **involvement**.

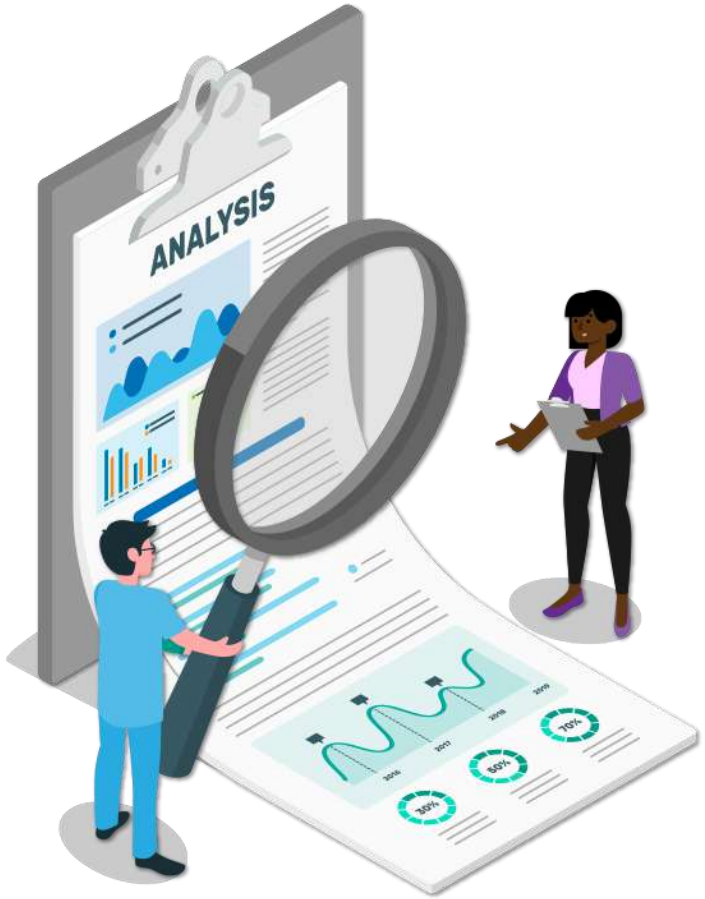
  This is because it's the basis of our legal duties and also because it can be used to describe a wide range of different activities, which we'll use when we're talking about a specific method.

4. Our principles

Our principles for working with people and communities

The **ten principles for working with people and communities** listed below appear in the **national guidance**, and will be used by NHS England as the basis for assessing how well we meet our legal duties.

1. Ensure people and communities have an active role in decision-making and governance
2. Involve people and communities at every stage and feed back to them about how it has influenced activities and decisions
3. Understand your community's needs, experiences, ideas and aspirations for health and care, using engagement to find out if change is working
4. Build relationships based on trust, especially with marginalised groups and those affected by inequalities
5. Work with Healthwatch and the voluntary, community and social enterprise sector as key partners
6. Provide clear and accessible public information



7. Use community-centred approaches that empower people and communities, making connections to what works already
8. Have a range of ways for people and communities to take part in health and care services
9. 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

These principles have been used as the basis for a series of objectives which are specific to NHS Cheshire and Merseyside – set out on the following slides – which will provide shape and purpose to our involvement approach over the next two years.

5. Our objectives

In 2024-6, the following ten delivery objectives will set the direction for how NHS Cheshire and Merseyside will focus its involvement resources:

1. Ensure that involvement is embedded in our governance and decision-making as an organisation.
2. Ensure that a focus on hearing underrepresented voices underpins our involvement plans.
3. Provide a range of different routes for people and communities to be involved in the work of NHS Cheshire and Merseyside.
4. Identify barriers to participation, and design communication and engagement mechanisms which recognise different needs, preferences, and styles.
5. Ensure that tailored plans are developed for involving people in specific programmes and pieces of work, including service change.
6. Ensure that our staff understand our involvement duties and recognise the benefits that come from working with people and communities. Support and empower staff to be proactive in identifying opportunities to embed involvement, including co-production, through their own roles.

7. Actively find opportunities to share involvement skills and best practice amongst our provider organisations.
8. Demonstrate how feedback is used to develop services and influence plans.
9. Work with partners to develop and deliver involvement activity, so that we make the most of skills and expertise across the system, while utilising different routes for reaching our audiences.
10. Look for ways to share the insights we gather with system partners, to maximise the impact of the feedback our local population gives us.

The next sections of this plan set out how we will begin delivering on these objectives, either with specific projects (for example, rolling out involvement training for our staff), or identifying where we need to establish specific arrangements (for example, refreshing our involvement governance).

At the end of the document, we provide a short overview of some key initiatives planned for 2024/25.

6. Involvement infrastructure

In general, our involvement approach is designed around the specific needs of each piece of work, and how best to engage with the audience we want to reach. For this reason, we only have a limited number of generic involvement mechanisms – for example, rather than creating a general engagement group for NHS Cheshire and Merseyside, we advocate recruiting those with lived experience on a project-by-project basis.

However, there are a number of key mechanisms which underpin our involvement infrastructure – the following slides provide more information about:

- **Listening to our population**
- **Communications channels**
- **Involvement governance**
- **Working with partners**

As with all elements of this plan, this infrastructure will be reviewed at least every two years, to ensure that it is still fit for purpose, and so that our approach can grow and evolve over time.

Listening to our population

- Established in October 2022, our Citizens' Panel is designed to gather insights about peoples' views and experiences from across the Cheshire and Merseyside population.
- Panel members are regularly sent short questionnaires on a range of subjects – an example topic in recent months has been primary care access – with response levels typically high.
- Different methods have been used to recruit to the panel since its launch, including social media promotion and face-to-face events in different locations across Cheshire and Merseyside, and people can sign up at any time at www.cheshireandmerseyside.nhs.uk

  Currently, there are around 700 people registered with the panel, but increasing the number of people we engage with in this way means we will increase our reach and provide more detailed insights.
- During 2024/25, we will look at how we expand the range of people we actively seek views from, as well as considering how best to keep existing members engaged by creating regular opportunities for them to provide feedback on key issues.

Communications channels

NHS Cheshire and Merseyside oversees a range of different channels for communicating with the public and stakeholders, including:

Our social media accounts

X (formerly Twitter), Facebook and YouTube

GP newsletters

A dedicated fortnightly newsletter for people working in Cheshire and Merseyside's 349 GP practices.

Partnership newsletters

Monthly NHS Cheshire and Merseyside and Health and Care Partnership newsletters, which people can sign up for via our website.

Meetings

Bi-monthly meetings of NHS Cheshire and Merseyside Integrated Care Board, held in public, including a public question time session at the start of the meeting.

Our main website

www.cheshireandmerseyside.nhs.uk includes an involvement section, which is currently being redeveloped to better highlight opportunities for people to share their views in engagements or public consultations.

- Like many organisations, our core communications channels are largely online, and during 2024/25, we will explore how we better reach those who are not digitally engaged, particularly during specific engagement and public consultation activity.

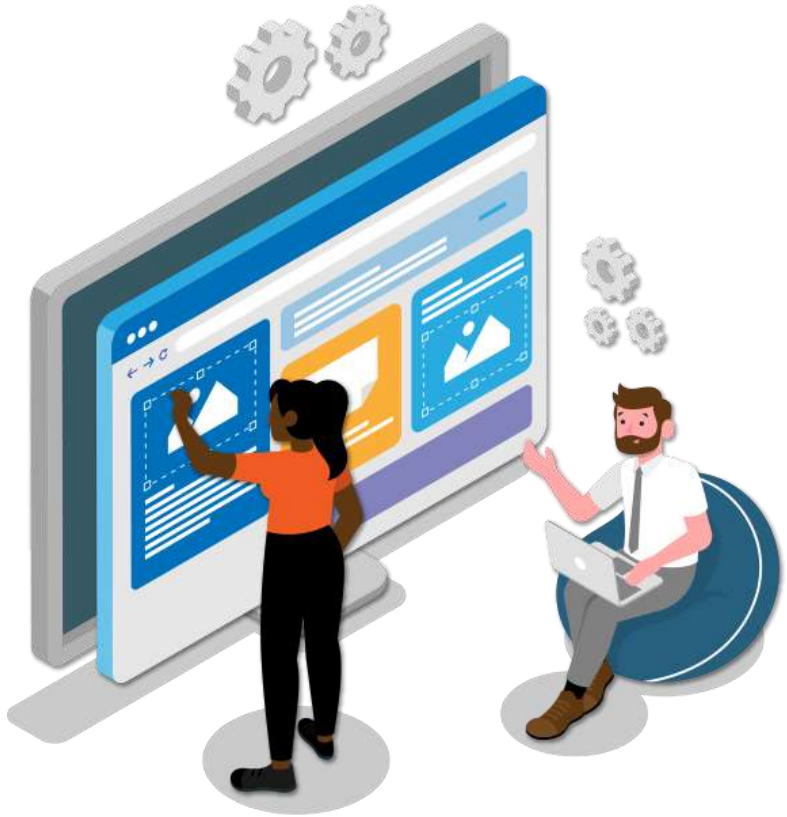
  To do this we'll work with partners, such as Healthwatch and NHS trusts, to make the most of existing groups and networks.

Involvement governance

It’s crucial that NHS Cheshire and Merseyside has a robust governance process for involvement, which includes:

- Clear sign-off routes for individual involvement activity plans – including the process for agreeing the required level of involvement
- Clear routes for reporting back on involvement activity, including public consultation
- Regular reporting arrangements

A draft involvement governance framework which addresses each these points has been developed and will be finalised during summer 2024.



Involvement governance continued

- The governance framework will also reflect the recent establishment of a new People and Communities Insight and Experience Group, which reports to NHS Cheshire and Merseyside's Quality and Performance Committee and has responsibility for considering involvement plans and outputs.
- When the framework is agreed, an explanation of the relevant structures and processes will be published on the Get Involved section of the NHS Cheshire and Merseyside website.

  Once this is in place, we will consider opportunities for further embedding involvement in governance, for example through the direct input of individuals with lived experience in project/programme structures.

Working with partners

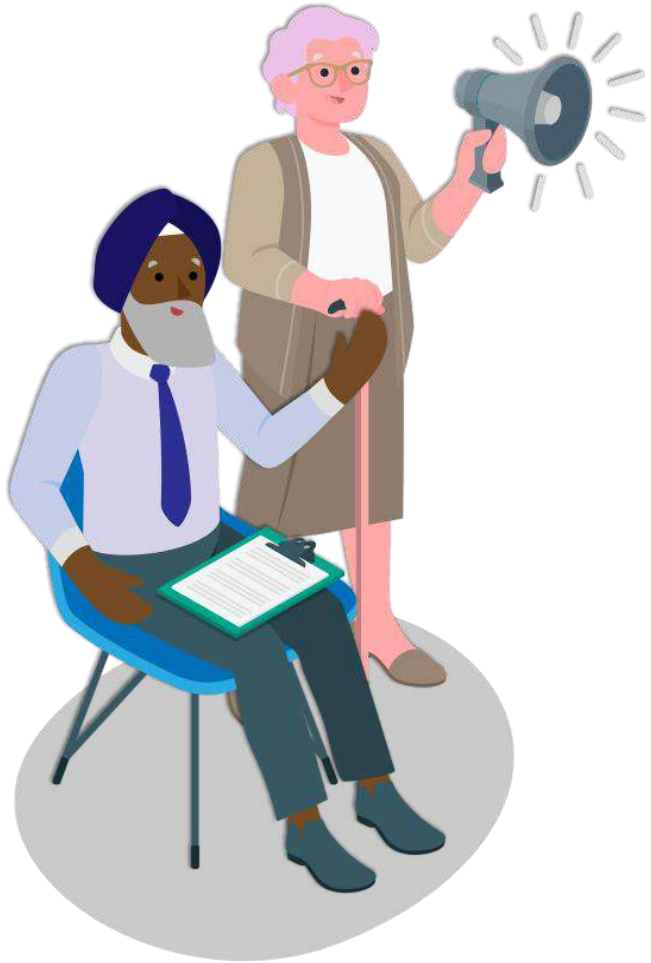
As an organisation serving a population of 2.7 million people, it’s critical that our involvement approach recognises the huge number of existing groups and networks that exist across Cheshire and Merseyside.

The following section provide an overview of how we will continue to work with partners to ensure that our plans have the greatest impact.

- **Healthwatch** are a key partner, at both Place and system level, occupying a unique position as local health and care champions. As well as attending NHS Cheshire and Merseyside Integrated Care Board (ICB) meetings and System Primary Care Commissioning Committee, our local Healthwatch organisations are regularly asked to get involved in other projects and programmes.
- NHS Cheshire and Merseyside's communications and empowerment team are now coming together on a quarterly basis with colleagues from each of the nine Healthwatch organisations across Cheshire and Merseyside. We want this to be a place where we can share information, get feedback and seek input on plans at an early stage.
- During 2024/25 we want to continue to embed and develop our relationship with Healthwatch, so that we can maximise the benefits of working together, and utilise our collective reach and experience.

Communications and engagement at Place

- Place-based Partnerships should seek to communicate and engage with their local communities with **one voice** in relation to their local plans and priorities. This includes talking to local people about wider determinants of health and wellbeing, such as education, housing, employment and leisure.
- NHS Cheshire and Merseyside's communications and empowerment team has produced draft guidance, and an accompanying maturity matrix, to inform the development of **Place communications and engagement collaboratives**.
- The guidance is intended to help Places as they establish groups to discuss, plan and deliver local engagement, but it's up to each area to decide on the format that best meets local needs. Across Cheshire and Merseyside's nine Places, a number of collaboratives or groups are already established.
- During the first part of 2024, we are focussing on supporting the initial set up of those where there are still gaps, with the intention that all will be functioning by spring/summer 2024.



- Place collaboratives aren't part of NHS Cheshire and Merseyside's involvement infrastructure – we're a member of these groups, in the same way as other system partners are – but they're an important route for establishing two-way dialogue with local communities.
- A representative from our communications and empowerment team will join the membership of each collaborative, to provide input on Cheshire and Merseyside-wide programmes, brief on any wider activities (including service change), and help share involvement best practice.

Wider groups and forums

- We recognise the benefit of working with partners to reach specific communities and parts of our population, using both their specialised skills and experience, and the relationships and communications routes that they already have in place.

  On a project basis, and subject to resources being available, we will explore commissioning groups and organisations, including those in the voluntary sector, to deliver engagement on our behalf.

- There are also a number of professional groups developed by NHS Cheshire and Merseyside, which provide further potential opportunities to gather feedback on plans, share information and identify engagement routes.

- These include a Minority Ethnic CDW (community development worker) Steering Group, made up of VCF (voluntary, community and faith) organisations and NHS providers who support and represent the interests of racialised communities across all nine Places; and a patient equality-focused forum, made up of EDI (equality, diversity and inclusion) and patient experience leads across 17 NHS providers who have access to a range networks of people with protected characteristics.

Wider groups and forums continued

- During 2024/25 we will work with these groups to improve and refine involvement plans for specific programmes and projects.

- In addition to working with NHS trusts around public involvement opportunities, we believe there is further potential to join up with our colleagues in general practice. A project designed to harness this is described later in this plan.

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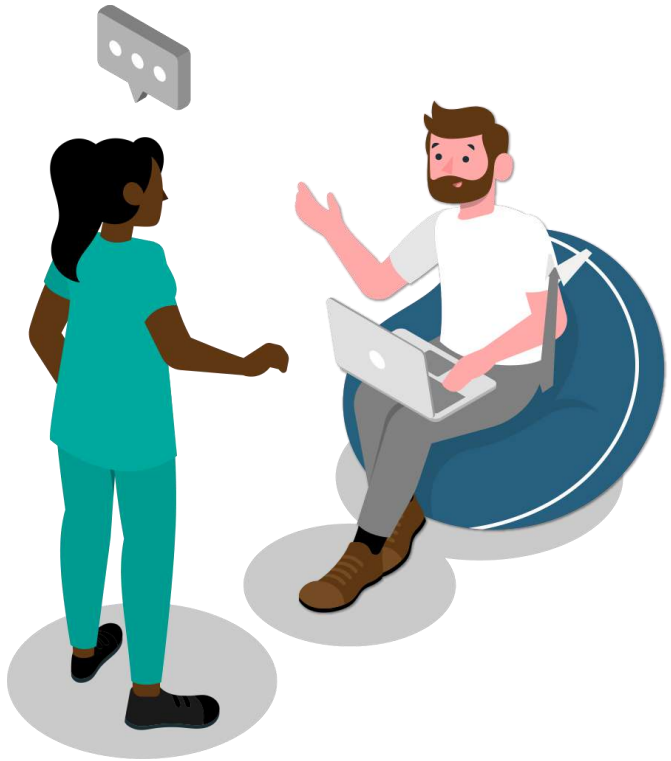
7. Starting with staff

Starting with staff Involvement in general practice

- Many NHS Cheshire and Merseyside staff are also members of our local population, and therefore an important audience for our engagement activity.
- It’s important that we promote opportunities for people to get involved using our internal channels, and ask our partner organisations to do the same, encouraging staff to share these messages in their own networks and communities.
- We have a communications and empowerment team with specific responsibilities for involvement, but to realise the full potential of working in partnership with people and communities, we need to ensure that our wider workforce understands our duties.
- During summer 2024, we will roll out a programme of involvement awareness training for NHS Cheshire and Merseyside employees, utilising our internal communications channels, including monthly all-staff calls and staff hub (intranet site).



- This activity will include a more detailed training programme targeted at staff whose roles are focussed on commissioning and transformation, aimed at equipping them with the skills and knowledge to embed involvement activity in their own roles. This will be accompanied by a toolkit of supporting resources.
- We will also establish an organisation-wide process for recording involvement activity, so that we have a clear picture of what is happening across NHS Cheshire and Merseyside, not just those processes overseen by the communications and empowerment team.
- Initially, an overview of this activity will be reported through the People and Communities Insight and Experience Group, but we will also look for opportunities to share it with wider partners, to maximise the impact of the insights that we gather.

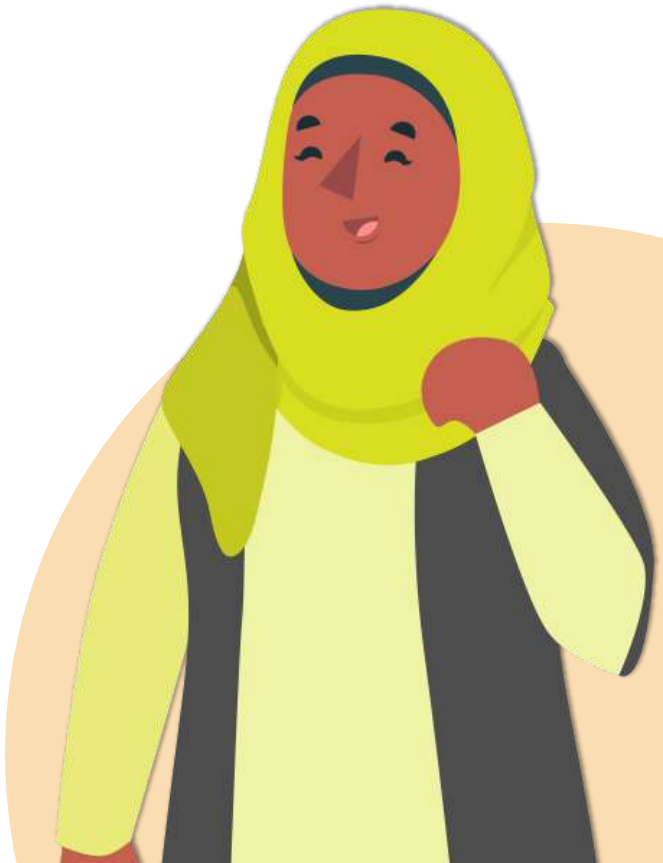
8. Involvement in general practice

- As most people's main touchpoint with NHS services, general practice presents a great opportunity to engage with people, but skills and capacity to support patient involvement in primary care can be limited. We are therefore working with practices and primary care networks (PCNs) to build knowledge and confidence, so that we can better harness patient insights.
- There's already some great involvement work taking place in primary care, and we want to encourage practices to routinely share best practice and learning. Alongside these events, dedicated sessions for PCNs will explore the potential for using patient voice at a network level.
- During early 2024, we rolled out a series of events for practices and PPG (patient participation group) leads, aimed at helping improve the way they involve patients. This included a focus on making groups more representative, and better utilising the feedback that is gathered.

- As well as improving and expanding patient involvement for individual practices and networks, we believe this work offers wider benefits.
- These include creating potential new routes for engaging with people about health and care issues, and helping generate additional feedback which can be used to improve services and inform how we talk to people about primary care.
- Although initial activity has been focussed on general practice, we want to use the evaluation of this work to look at how where there might be opportunities to use the learnings in other areas of primary care, such as dental and pharmacy.

9. Service change

- Our involvement duties play a key role when we are considering potential changes to services, and it's crucial that that we have clear arrangements in place for involving people from the outset of each programme of work.
- While equalities and health inequalities are both the focus of separate duties, they also have a strong connection with involvement. We need to make sure that we involve people with protected characteristics, social inclusion groups and those who experience health inequalities.
- To ensure a consistent approach across programmes, NHS Cheshire and Merseyside is currently developing involvement guidance for service change, which will clarify different roles and responsibilities, and internal processes.
- The guidance will sit alongside this plan, and the forthcoming involvement governance framework, and will be highlighted as part of the upcoming staff awareness training covered in earlier slides.



- Involvement arrangements will be designed around the needs of each service change programme. This means that we will always aim to involve those with lived experience, including carers and family members, of the specific services we are looking at.
- NHS Cheshire and Merseyside is currently developing the involvement approach for the women's services programme. Over summer 2024, the intention is to appoint two people to act as independent public advisors to our involvement approach for the programme.
- We'll also be establishing a Lived Experience Panel, bringing together those who have experience of women's services, and a Virtual Reference Group, for people who want to sign up for updates and details of opportunities to share their views.

10. Evaluation and impact

- Understanding the effectiveness of our involvement plans helps to improve future activity by providing insight about those techniques and methods that allow us to reach our target audience(s). Where relevant, we build feedback measures into our plans – for example, asking people to say where they heard about a particular engagement opportunity – so that we can consider this in reporting.
- Forums such as NHS Cheshire and Merseyside's People and Communities Insight and Experience Group, and the communications and engagement group recently established with Healthwatch, also allow us to discuss the involvement effectiveness, and develop clear actions which can be applied to future activity.
- Making sure that we 'close the loop' on involvement activity, by providing details of the feedback we have received, and clearly demonstrate how we have used this is an important element of our work. Working through the People and Communities Insight and Experience Group, in 2024/25 we will look at how we take a consistent approach to feedback, and how insights from involvement activity are then shared both across NHS Cheshire and Merseyside, and the wider health and care system.

11. Overview of planned activity

This plan details a number of key involvement initiatives for 2024/25, including:

- Reviewing the NHS Cheshire and Merseyside Citizens' Panel, to maximise the way that we gather views and insights from our local population.
- Establishing arrangements for recording involvement activity taking place across both NHS Cheshire and Merseyside and wider NHS providers, and using this to share ideas and best practice.
- Launching involvement awareness training for NHS Cheshire and Merseyside staff
- Putting in place involvement arrangements for the Women's Hospital Services in Liverpool programme.
- Rolling out involvement activity to support harmonisation of a range of clinical policies across Cheshire and Merseyside.

Please note:
As this plan extends into 2025 - 2026, this overview is only intended as a snapshot of work currently underway.

12. Tell us what you think

- We intend to publish a refreshed version of this plan every two years.
- As part of this, at the end of the two-year period each plan covers, we'll be asking both the public and partners like Healthwatch, to provide feedback on our involvement approach over the previous two years and let us know what they'd like to see in our next plan.
- We're always keen to hear what people think about our approach to involvement, and how we can improve what we do. We'll always ask for this feedback when we're engaging on a particular topic.
- You can also provide views and input at any time by emailing us at **engagement@cheshireandmerseyside.nhs.uk**

NHS
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Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Key ICB Delivery Plans

Agenda Item No: ICB/07/24/21

Responsible Director: Clare Watson, Assistant Chief Executive

Key ICB Delivery Plans

1. Purpose of the Report

1.1 This paper provides the Board with a final copy of the NHS Delivery Plan which is a core component of the refreshed 2024 - 2029 Cheshire and Merseyside Joint Forward Plan (JFP).

1.2 The paper references the development of ***All Together Fairer: our Health and Care Partnership Plan*** which will replace the Health and Care Partnership (HCP) Interim Strategy as the strategic plan of the HCP.

1.3 An update on progressing an NHS Cheshire and Merseyside Annual Business Plan is also covered.

2. Executive Summary

2.1 During 2024-25 a revised Health and Care Partnership (HCP) Strategy has been developed: ***All Together Fairer: Our Health and Care Partnership Plan.*** Due to the General Election this has being presented to the August HCP meeting pending a review of the Kings speech on the 17th July. The content of All Together Fairer and the HCP implementation plan will be shared with ICB Board members when available as final draft documents.

2.2 The first Cheshire and Merseyside Joint Forward Plan (JFP) was approved by the Board in June 2023. A summary Annual Delivery Plan was also developed detailing the work to progress the core JFP themes and outlining the priority programmes, enabler functions and system development work. The JFP describes how we will implement both national and local Cheshire and Merseyside strategic priorities.

2.3 The publication of the JFP (2024-29) will be hosted on the ICB website and will be comprised of four documents; a short overarching introductory document to outline the purpose of the Joint Forward Plan and three independent but interrelated plans to ensure the prominence of the wider partners priorities:

- **HCP/All Together Fairer Delivery Plan.** (This is to be presented to the HCP Meeting 20th August 2024 for approval)
- **Place Partnership Delivery Plans.** (This is a document comprising of short – two page – summaries of the work programmes of each of our nine Place Partnerships. These have been refreshed from the previous 2023-28 Joint Forward Plan)
- **NHS Cheshire and Merseyside 2024/25 Delivery Plan** (Appendix One)

2.4 This NHS Delivery Plan describes how NHS Cheshire and Merseyside and our partner NHS Trusts and Foundation Trusts (referred to collectively as partner trusts) and our wider system partners intend to work together to arrange and provide services to meet our population's physical and mental health needs.

2.5 The plan presents our Cheshire and Merseyside vision and mission, our strategic objectives and the strategies and plans which support delivery of these objectives. It focuses on our 2024-25 Recovery Programme alongside a wider set of priorities and approach to continuous improvement and our core strategies.

2.6 A number of key priorities and principles have been included which articulate key improvements our residents can expect to see through delivery of the plan. These include and align with the proposed HCP headline ambitions. Further detail on milestones and metrics are being developed to support these ambitions and aligned with the detail in the programme and operational plans.

2.7 The NHS Delivery Plan is a summary document including plans under four delivery themes:

2.8 The document includes links to summaries for all the projects/programmes contained within both our Recovery and Transformation delivery themes.

2.9 An ICB Annual Business Plan is in development which outlines the Delivery Place milestones and outcomes for 2024-25. This is planned to be completed by the end of August 2024.

3. Ask of the Board

3.1 The Board is asked to:

- **approve** the attached NHS Delivery Plan element of the Joint Forward Plan and authorise publication in advance of 31st July 2024 ensuring that the final linked plans related to the Recovery Programme and Transformation Plans are included.

- **endorse** the proposal to provide the Board with an NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan by the end of August 2024.

- **note** that the Cheshire and Merseyside Health and Care Partnership are due to receive the revised strategic plan ***All Together Fairer: our Health and Care Partnership Plan*** and the associated HCP/All Together Fairer Delivery Plan at the next meeting on 20th August 2024. Copies of the final draft documents will be shared with the ICB Board as soon as they are available.

4. Reasons for Recommendations

4.1 The 2023-28 JFP was developed following the nationally defined statutory and advisory requirements identified in the NHS England Guidance on developing the JFP. This has resulted in a significant amount of content and detail in our plans. A summary Annual Delivery Plan was developed that provided detail on the work taking place to progress the core JFP themes and outlining the main outcomes from each of the priority programmes, enabler functions and system development work.

4.2 The JFP and the associated Annual Delivery Plan were approved by the Board in June 2023. This plan included details on the reporting routes for the core themes and enablers. The revised 2024-29 NHS Delivery plan builds on our initial JFP.

4.3 Health and Wellbeing Boards and the Health and Care Partnership membership provided feedback that both the HCP Strategy and JFP content is too centred on NHS activities and in response to this feedback the intention is to align the HCP Strategy with the All Together Fairer Report and to make the JFP content more balanced and reflective of the plans of the whole health and care system.

4.4 The revised JFP reflects this feedback but by aligning the development processes of NHS Cheshire and Merseyside and our Health and Care Partnership maintains a consistent approach to planning across the system, which will help us by:

- proactively identifying and communicating the totality and alignment of all our plans both internally and externally
- prioritising plans and assigning financial resources across our system more effectively.
- provide cross ICB/S visibility of plans reducing duplication in plans and assigning our combined workforce more efficiently.
- aligning resources to support public engagement and co-production contained within plans.

5. Background

5.1 The JFP is a nationally mandated document which will combine the Cheshire and Merseyside delivery plans to:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

5.2 Whilst the JFP covers a five-year period there is a statutory requirement to update and republish the plans each year, inevitably this annual update means the document focuses more on the early part of this time period and includes the key actions identified in our plans.

5.3 The NHS Delivery Plan section of our JFP outlines our Vision, Mission and Strategic Objectives alongside some key ambition ambitions. It builds on the 2023-28 JFP and the priorities outlined in the interim HCP Strategy to support this it focuses on four core themes that provide the framework for the

- Recovery Programme (focus for 2024-25)
- Transforming our Services (additional transformational change programmes)
- Innovation and use of new technology
- Improving outcomes in Population Health and addressing Health Inequalities.

5.4 The plan also describes how we work as part of the wider system outlining how our core enabling strategies to enhance and support delivery.

5.5 The impact of ongoing recovery from the impacts of the covid-19 pandemic, industrial action and the financial pressures being experienced in the public sector and society have influenced the tone and content of the NHS Delivery Plan. The Recovery Programme therefore takes a prominent role in the document with a strong focus on urgent and emergency care and managing our resources effectively.

5.6 The description of our other three programme areas (Transformation, Innovation and Technology and Population Health and Inequalities) offers a balance in recognising a wider ongoing commitment to these vital strategic priority areas.

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

Objective One: **Tackling Health Inequalities in access, outcomes and experience**
Objective Two: **Improving Population Health and Healthcare**

Objective Three: **Enhancing Productivity and Value for Money**

Objective Four: **Helping to support broader social and economic**

6.1 All of the above are core elements in the Joint Forward Plan, including the NHS Delivery Plan, as well as the alignment of the Health and Care Partnership (HCP) Strategy with the All Together Fairer report.

6.2 The revised HCP strategic plan (***All Together Fairer: Our Health and Care Partnership Plan)*** reflects the 8 All Together (Marmot) Themes. All nine of our Cheshire and Merseyside Health and Wellbeing Boards have committed to the recommendations in ***All Together Fairer*** and form part of our ***Marmot Community***; our plans reflect the strong support, enthusiasm and shared ambitions of partners.We have summarised the recommendations into three principles:

- Shifting investment to Prevention and Equity
- Anti-Poverty Work
- Social Justice, Health and Equity in All We Do.

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

7.1 As outlined this paper focuses on the current Joint Forward Plan and the associated NHS Delivery Plan – an NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan has been developed and will be completed by 31St August 2024 which will include enhance programme governance and reporting processes to ensure a robust delivery approach.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The key themes above are included in the developing Joint Forward Plan, NHS Delivery Plan and will be integral to the associated NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan.

9. Risks

9.1 The NHS Delivery Plan will be directly mapped to delivery of the Board Assurance Framework. In addition, there are a range of related additional risks that are being considered.

9.2 That current plans do not provide sufficient detail or stretch in their timelines to fully assess progress, or it may be that the reporting regime is not robust enough to provide the necessary stretch or challenge.

9.3 The programme management resources to support this ongoing development need is limited and will need to be enhanced to support and assure delivery and an ongoing assessment of priorities and use of resources by the Executive Team and Board.

10. Finance

10.1 Financial planning for 2024/25 is reflected in the 2024-29 JFP in all plans with a specific focus on the Recovery Programme and as one of our core strategies.

11. Communication and Engagement

11.1 Much of the content of the JFP and subsequently the NHS Delivery Plan has been developed through existing programmes, which have established mechanisms for engagement in developing the plans.

11.2 A public survey was undertaken in March/April 2023 to look at the content of the draft Interim Cheshire and Merseyside HCP Strategy, with the results assessed as part of developing the JFP. We have subsequently closed the loop on this and fed back via a ‘you said we did’ approach.

11.3 A copy of the draft NHS Delivery Plan has been shared with stakeholders at the start of May 2024, feedback received has been incorporated into the appended version. The plan has also been reviewed by the ICB corporate executive team and Place Directors.

11.3 An engagement plan has been developed which focuses on our Recovery Programme.

12. Equality, Diversity and Inclusion

12.1 An Equality Impact Assessment (EIA) has been completed for the JFP, NHS Delivery Plan and the Recovery Programme, individual EIAs will be produced as required to assess the impact of the individual programmes and plans, including the Recovery Progamme.

13. Climate Change / Sustainability

13.1 Climate change and sustainability are included as priorities in the ***All Together Fairer: Our Health and Care Partnership Plan*** and associated HCP delivery plan and as one of our headline ambitions.

14. Next Steps and Responsible Person to take forward

14.1 The Strategy and Collaboration team will:

- finalise the content for the Joint Forward Plan/NHS Delivery Plan to ensure all accessibility checks are complete and to include links to the final Recovery Programme and Transformation Plans.

- work with system partners to finalise All Together Fairer: Our Health and Care Partnership Plan and the associated HCP/ATF plan by early August, with a final designed version being presented for final approval at the 20th August 2024 meeting of the Health and Care Partnership.

- finalise the more detailed NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan which sits behind the NHS Delivery Plan – this will provide the detail of delivery plans containing agreed outcomes metrics and milestones of key priorities.

- in monitoring progress in delivering the NHS Delivery Plan and NHS Cheshire and Merseyside Integrated Care Board Annual Business Plan and specifically the Recovery Programme, agree a consistent approach across our sub-committees to capturing delivery of plans, and progress in impacting the agreed metrics through our existing sub-committees noting this will require additional programme management office support.

15. Officer contact details for more information

Neil Evans, Associate Director of Strategy and Collaboration
(neil.evans@cheshireandmerseyside.nhs.net or 07833685764)

Stephen Woods, Head of Strategy
(stephen.woods@cheshireandmerseyside.nhs.net or 07826513643)

16. Appendices

Appendix One: NHS Delivery Plan section of the Joint Forward Plan

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Cheshire and Merseyside

Joint Forward Plan - NHS Delivery Plan

19/07/2024

Introduction

The challenges faced by our residents and communities are immense, but so is their passion to overcome them. We strongly believe that our local communities and frontline teams are best-placed to know what matters most and to determine the best way to make improvements. Along with our partners we are committed to working with all communities to support them to improve their health and wellbeing and reduce inequalities.

Going into 2024-25, it is clear that the cumulative impact of multiple rounds of industrial action, combined with increasing pressure on NHS budgets and reduced levels of satisfaction with the NHS, drive some of the challenges we face.

With demand for services and inflationary cost pressures rising faster than budgets, NHS organisations across the country are facing a very challenging financial outlook this year. We have agreed a budget with a £150m deficit with NHS England and face a significant challenge to ensure we live within the resources available to us and to increase our productivity in 2024-25.

Whilst focusing on efficiency; ensuring high quality, safe services for our population will always be our key priority and has been at the forefront of our minds as we have worked with partners to identify and implement solutions to the challenge.

Despite this backdrop, we should remain both proud of everything we are doing and optimistic for the future as we continue to improve our offering to patients for example by achieving the fastest growth in the country in access to diagnostic testing, by making significant progress in reducing long waits for planned care and by outperforming both the England and North West averages against both the 31-day and 62-day cancer waiting time standards.

We recognise that in 2024-25 we need to address our immediate priorities of improving access to and quality of urgent and emergency care and better use of our resources. By delivering these improvements we will be able to progress with the longer-term aims of investing in prevention and early support for our residents.

Raj Jain,
Chair

Graham Urwin,
Chief Executive

What does our Joint Forward Plan cover?

This NHS Delivery Plan section of our Joint Forward Plan (JFP) describes how NHS Cheshire and Merseyside, partner NHS Trusts and wider system partners intend to work together to provide financial sustainability whilst providing safe high-quality services to meet our population's physical and mental health needs.

It presents our Cheshire and Merseyside vision and mission, our core objectives and the strategies and plans which will support delivery of our objectives.

The NHS is faced with rising costs and budgetary constraint at the same time as seeing growing need and demand for services, and we know we have more work to do in recovering timely access to services following the pandemic, workforce challenges and NHS industrial action.

As a result of these pressures, in 2024-25 we will maintain a strong focus on achieving **financial balance**, **protecting patient safety** and prioritising **access and quality** of services with a strong emphasis on Urgent and Emergency Care.

In 2023-24 only 71.4% of people attending an A&E Department were seen within 4 hours, 15.6% waiting more than 12 hours with patients being cared for on hospital corridors. Whilst these delays are seen in hospitals this is a measure of the challenges across the wider health and care system and requires a whole system response.

Our plans have a relentless focus on transformation and continuous improvement in our service delivery.

Through this we can achieve the triple aims:

- improve the health and wellbeing of our population.
- improve the quality of services.
- make efficient and sustainable use of NHS resources.

We are committed to working on all three of these simultaneously to best meet our population's needs.

Our Key Principles and Priorities

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We will work collaboratively with our partners to: -

- Provide safe, effective and timely care
- Improve Outcomes in Population Health and Healthcare and reduce inequalities in all we do
- Make decisions based on evidence (Data into Action) and have a culture of innovation and continuous improvement
- Increasingly focus on prevention reducing the need to treat ill health
- Find the optimum way to provide services, working to integrate and simplify how we work
- Provide services within the funding available to us
- Deliver our Anchor principles to have a positive impact on our communities socially, economically and environmentally

Table 1

Our Joint Forward Plan NHS Plan on a Page

Vision

We want everyone in Cheshire and Merseyside to have a great start in life and get the support they need to stay healthy and live healthier for longer.

Mission

We will prevent ill health and tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership

Strategic Objectives

1: Tackling health inequalities in outcomes, experiences and access	2: Improve outcomes in population health and healthcare
3: Enhancing productivity and value for money	4: Helping the NHS to support broader social and economic development

Our Enabling Strategies

Clinical and Care	Workforce Strategy	Finance and Efficiency at Scale	Digital and Data	Population Health and Reducing Inequalities

Quality and Safety, Integration and Leadership	Research and Innovation Data into Action	Creating a culture of Continuous Improvement:	Putting the Patient at the Heart of delivery and decision making

These drive Our Key Priorities for 2024-29

Our priorities for 2024-25 - Urgent and Emergency Care and Financial sustainability

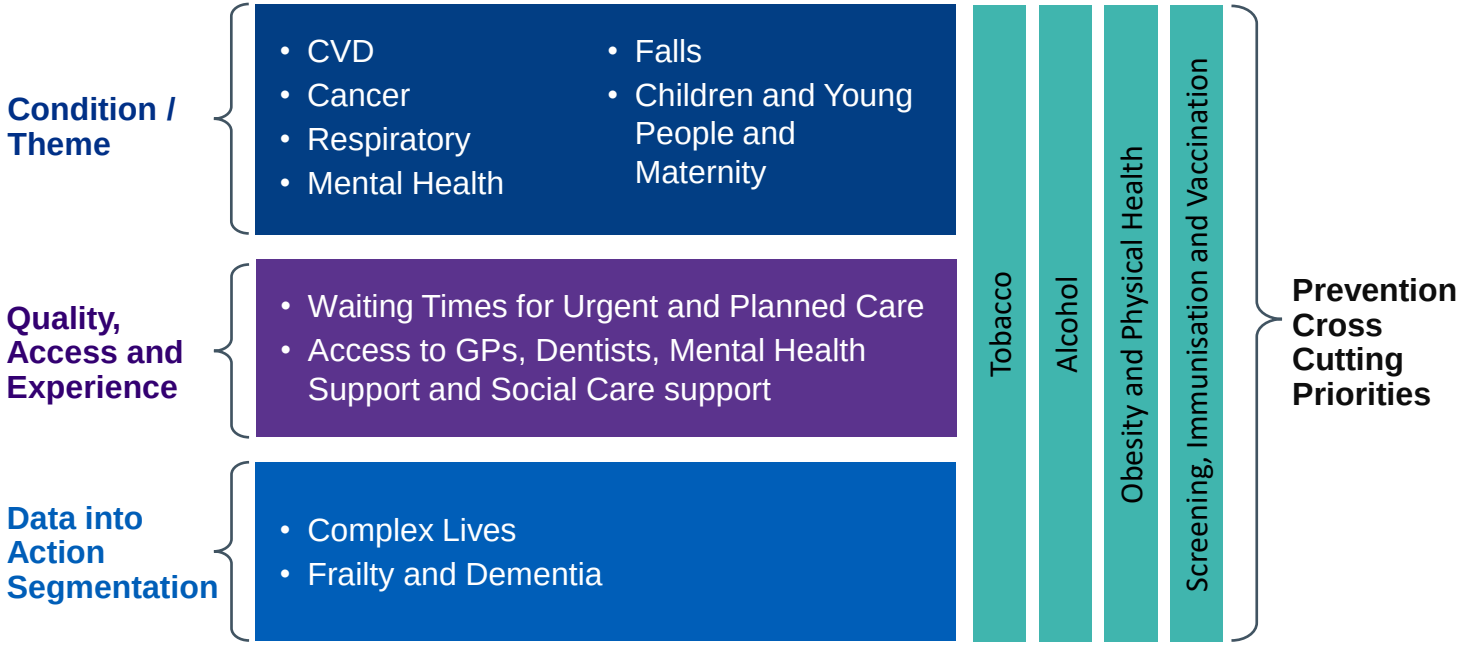
Defining our priorities

As well as our immediate focus on urgent care and use of resources we also know that we need to maintain our focus on longer term plans to improve population health and reduce inequalities.

Evidence shows that often the social determinants of health are the cause of poorer outcomes and inequalities across our communities. This is why as a health and care partnership we are committed to addressing these and promoting good health and wellbeing.

- There is a difference in life expectancy of 15 years (Male) and 14.7 years (Female) between our highest and lowest wards.
- Deprivation and poverty, 35% of our population are deprived and 26% of our children live in poverty.
- Deaths due to heart disease, cancer, respiratory conditions, alcohol and drugs are higher than the England average.

Table 2 – Improving Outcomes



The table above identifies the areas where our population outcomes and access to services are comparably worse than the average for England and/or have been identified by our population as a key area of focus for them.

This work has influenced the development of our NHS Delivery Plan delivery themes described later in the document.

All Together Fairer: Our Health and Care Partnership Plan

The All Together Fairer: Our Health and Care Partnership Plan **describes three core Principles and six Headline Ambitions that the system will collaborate on : -**

Table 3

Principle 1 - Shifting investment to Prevention and Equity

Principle 2 - Anti-Poverty Work

Principle 3 - Social Justice, Health and Equity in All We Do.

Children and Young People	Physical Activity and Healthy Weight	Housing and Health	All Together Smokefree	Work	Social Value
• We will address the health inequality gap for children living in households with the lowest incomes by focusing on action that will relieve poverty. (Barnardo's health Equity linked) • We will promote good social, emotional and psychological health to protect children and young people against behavioural and health problems.	• We will take action to tackle obesity by focusing on increasing Physical Activity and promoting healthier diet and food environments, helping adults and children to live healthier lives.	• We will work with our Housing partners to maximise the access to health promoting homes and help improve the service offer for people with complex health needs.	• We will take action to end smoking Everywhere for Everyone.	• We will work with our employers to help them to create the environments that support our population to start, stay and succeed in work. 'Work' covers both paid and non-paid activity	• We will ensure that the Cheshire and Merseyside Health and Care Partnership member organisations become Anchor Institutions by 2026.

We will thread these throughout our programmes and workstreams.

How we will deliver our Plan

Accountability

NHS Cheshire and Merseyside - an Integrated Care Board (ICB) - is a statutory body responsible for planning and funding local NHS services and is directly accountable to NHS England for spending NHS money and associated service performance.

Governance and monitoring

Whilst the system plan is owned and overseen by our Health and Care Partnership Board, the plans to deliver it and the NHS Delivery Plan elements of it are owned and overseen by the NHS Cheshire and Merseyside Board.

Each of the programmes outlined in our plan will focus on a number of key outcomes and a set of agreed measures and milestones. In 2024-25 we are adopting a consistent approach across our plan, using a robust programme management approach, aligned to our Board Assurance Framework to report progress to the Board and its sub committees. Recovery schemes will be managed via a single Programme Management Office.

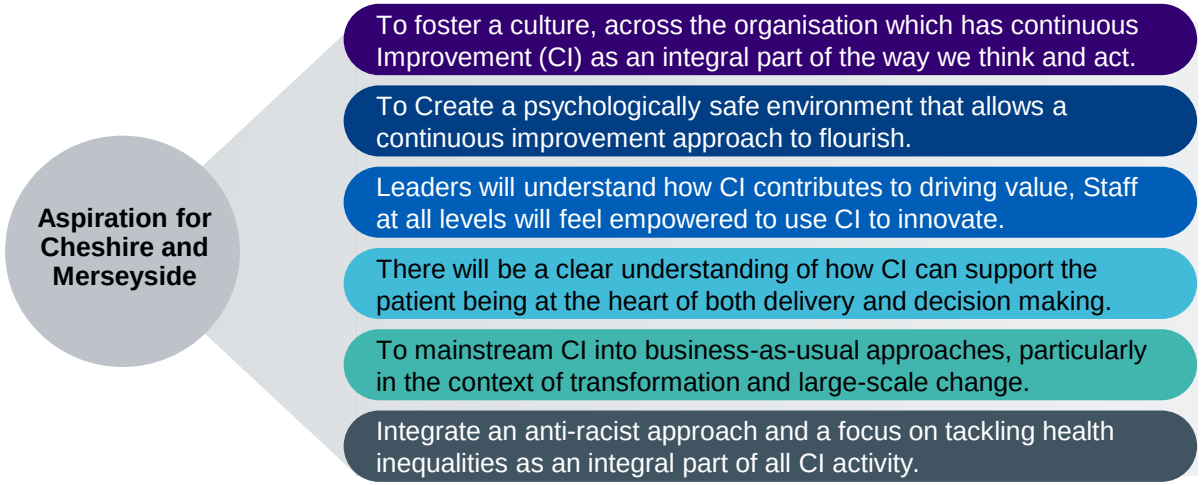
Our Statutory Duties

The national requirements of a Joint Forward Plan include confirming how the statutory duties of an Integrated Care Board are to be delivered. For further detail on this please click the link Our Statutory Duties

Continuous Improvement

To ensure services across Cheshire and Merseyside are the best they can be we will develop a culture of continuous improvement and innovation. To improve patient outcomes and experience we must maintain our collective focus on the overall quality and safety of our services, based on the approach set out in A shared commitment to quality and The NHS Patient Safety Strategy. This includes applying the Patient Safety Incident Response Framework (PSIRF) in the development and maintenance of patient safety incident response policies and plans.

We will invest in developing a system-wide quality improvement methodology and support staff across the system to deliver improvement through Improvement Networks aligned to Provider Collaboratives to promote innovation, share learning and build on existing improvement capacity and capability.



Developing as a system

We will simplify the way we do business and continue to build on the work we have done to develop our system - emphasising the importance of Place Partnerships, Provider Collaboratives, wider system collaboration, clinical and care professional leadership and system organisational development.

How we work

What is different about how we work in NHS Cheshire and Merseyside

- As NHS partners looking after the health and wellbeing of the 2.7 million people who live in Cheshire and Merseyside gives us a unique opportunity to collectively consider the added value we can bring by working increasingly closely together.
- Decisions around services that support people's health are not taken by individual health and care organisations, but by a wider set of partners.
- Decisions about transport, housing, parks and countryside, community facilities, the economy, public safety or air quality all have a causal link to health. It is our ambition to add value by working with all key organisations, sectors and communities.
- We are proud of what we have achieved since the publication of our first Joint Forward Plan in July 2023 please click **HERE** to see a few example Case Studies.

Table 4 - Our stakeholders/ key participants

16 NHS providers

2 NHS provider collaboratives

344 GP practices

570 pharmacies

Other partners

9 local authorities

9 Healthwatch

12 hospice providers

313 dental services

286 eye services

48 primary care networks

1 North West ambulance service

1 Combined Authority with a second collaboration developing

Voluntary, community, faith and social enterprise (VCFSE) sectors

Supporting a population of **2.7 million people** across **9 places**

Working with people and communities

As NHS partners we are committed to listening to 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 more effective services, removing barriers where they exist. Specifically with relation to vulnerable groups and those with protected characteristics.

We will also focus on PLUS groups – these groups are population groups, defined by Integrated Care Systems (ICS's), which experience poorer than average health access, experience and / or outcomes across their communities.

How we work

Working across the system

We are committed to simplifying the way we work and making decisions as locally as possible but recognise that being part of a large Integrated Care System also provides opportunities for working at scale where it makes sense to do so.

Our aim is to work at the optimal footprint to support continuous improvement and transformation, deliver efficiencies and effectively manage service development.

Neighbourhoods and Communities

We will look to design services as locally as possible and we will continue to strengthen local community networks, including community and voluntary sector services and health and care services. Working in this way will enable our services to focus on smaller local populations and provide greater flexibility to find unique solutions to more local challenges. We are also committed to working with and supporting our Carers, vulnerable communities and those with protected characteristics.

Local Authority (Place) and Combined Authority Footprints

Alternatively, we may design services at the level of one of our nine Places or, if relevant, across multiple Places. This would be driven by natural communities, existing arrangements or by local authority or provider configurations. As Central Government progressively moves towards a standardised approach to devolution this will also reflect these ways of working.

Across Cheshire and Merseyside

It may be that some programmes are best designed and delivered at a Cheshire and Merseyside level. At a system-level, health and care partners work together to develop shared plans to improve health and care services and improve health and wellbeing outcomes. Working at this larger footprint can enable us to share good practice and be more effective, efficient and consistent in how we can improve services.

Our role in Market Management and System Leadership

Working in partnership with our providers, we can play a pivotal role in enabling system collaboration and exploring options to manage NHS resources through working together at ***Place*** or at ***Scale,*** for example through Place-based partnerships or cross-system provider collaboratives.

This presents us with the opportunity to support providers to develop service solutions that cut across individual providers. NHS Cheshire and Merseyside is ideally placed to operate as a system convenor, bringing interested parties together for common aims.

We will support our Health and Care Partnership aims:

- Ensure a reduction in variation of experience and outcomes across our communities.
- Prioritise resource and investment in areas with the greatest need.

Our two NHS Provider Collaboratives provide an example of how we might work at a multi-Place or Cheshire and Merseyside level to support NHS providers to work together to join up care, deliver continuous improvement and enhance the sustainability of services.

As an example, we have seen how we have been able to make significant improvements in waiting times for planned care by this system-wide approach. Focusing on the areas identified in our Recovery plans during 2024-25 will enable us to work at pace to transform services.

NHS
Cheshire and Merseyside

Our Enabling Strategies

Our NHS Delivery Plan is underpinned by a number of enabling strategies:

- Population Health and Addressing Inequalities
- Clinical and Care
- Workforce
- Finance and Efficiency
- Digital and Data

Our Enabling Strategies – Population Health and Addressing Inequalities

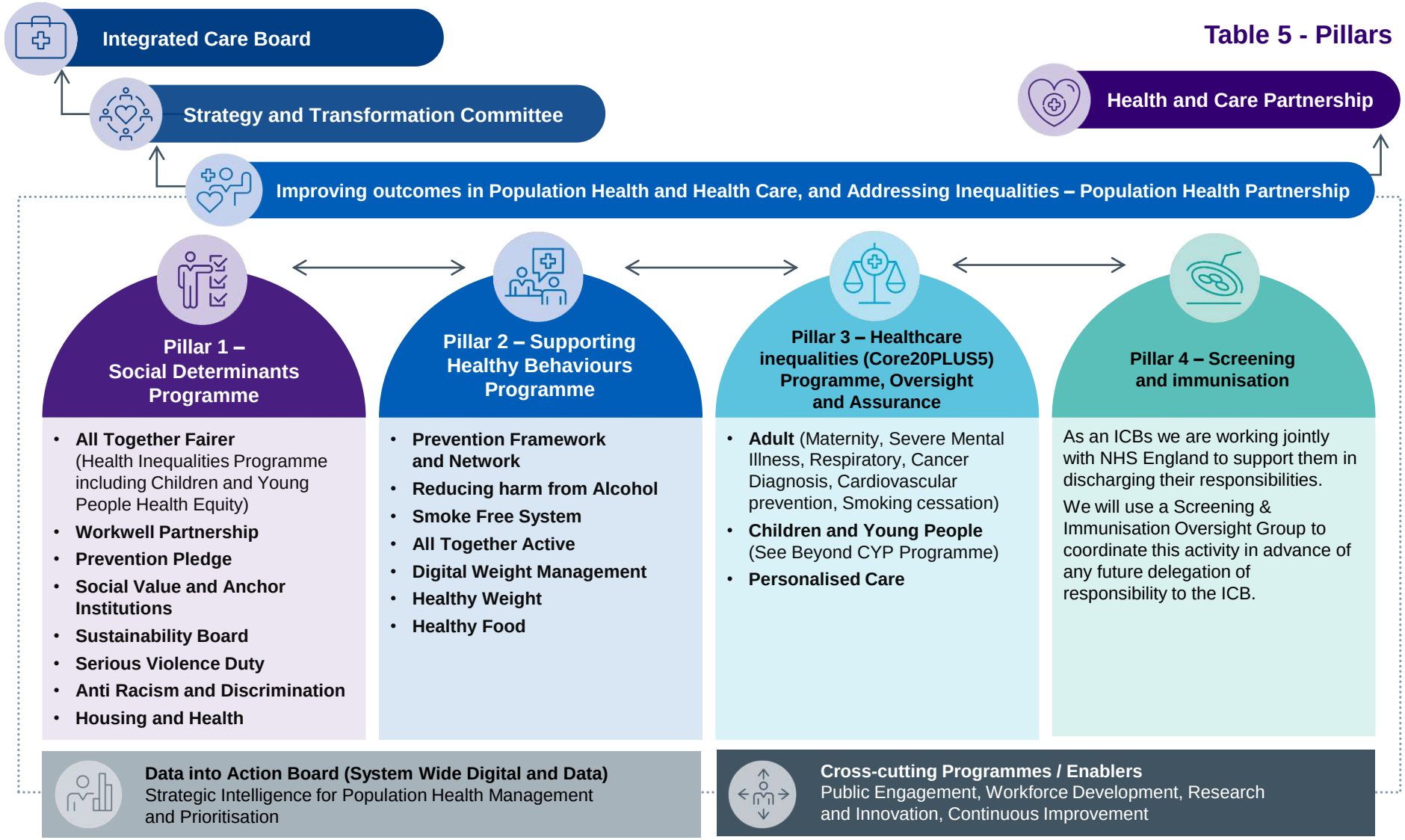


Table 5 - Pillars

Pillar 1: This describes how we will deliver All Together Fairer: Our Health and Care Partnership Delivery Plan

Pillar 2: supports healthy behaviours is built around a number of priority prevention programmes.

Pillar 3: Outlines our Core20PLUS5 priorities and Personalised Care approach for Adults and Children and Young People. We have a dedicated Children and Young People Committee with a structured delivery plan.

Pillar 4: this programme will support the NHS England delegation expected by April 2026

Our Enabling Strategies – Clinical and Care

Our Clinical and Care strategy is based around the core principles of:

1. **Better integrating our care both within and across partners**
2. **Making our care more specific to reflect the needs of our residents and ensuring that our care is as consistently high quality as possible.**

The NHS Long Term Plan also describes shifting the focus to population health to enable us to reduce health inequalities, which we know increased during the pandemic. We will do this by working in partnership across health, local authorities and wider partners.

The NHS IMPACT Framework will help us support delivery of clinical and operational excellence, helping to develop the leadership and organisational capacity, capability and infrastructure to create the conditions for improvement.

In line with the four core elements of our Clinical Care Strategy we will:

- ✓ Seek to improve health outcomes concentrating on our Clinical priorities as outlined in our Health and Care Partnership plan.
- ✓ Ensure that quality and safety is our prime consideration in our pathway redesign and transformation programmes, working consistently to address variation in and fragility of services.
- ✓ Adopt a culture of continuous improvement working collaboratively with all our providers and delivery partners.
- ✓ Invest in leadership through our Clinical and Care Professional Leadership (CCPL) framework.

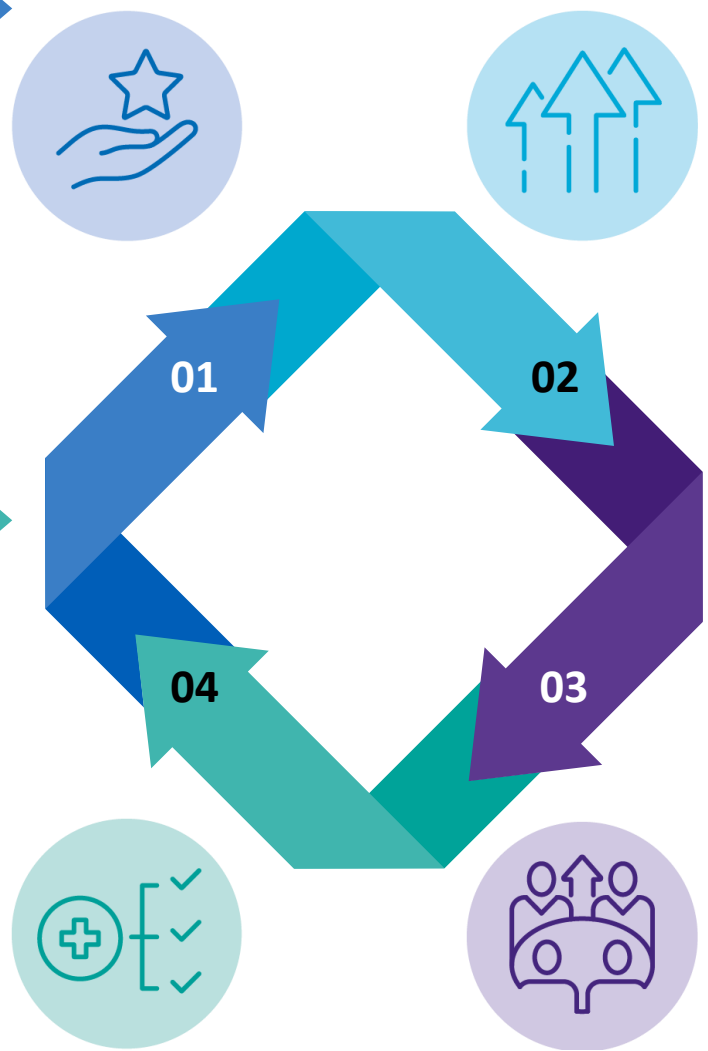
Table 6 - Clinical and Care Strategy (CCS)

01 Quality

- Services, pathways and commissioning that impact upon quality of care
- Address fragile services in the system e.g. women's health
- Draw upon the evidence from sources including NICE, GIRFT and latest research
- We must harmonise both service offering and policy and this will include medicines optimisation.

04 Clinical Priorities

- Clearly documented in the Joint forward plan and Health and Care Partnership
- They are evidenced based to not only improve health outcomes of our population, but also to make best use of resources to avoid ill health.
- These cover diagnostic groups of cancer, cardiovascular disease, respiratory disease and mental health . We also recognise *segments* – complex lives (physical health, mental health, drug/alcohol misuse and children in the care system) and frailty and dementia.



02 Improvement

- Launch of NHS Impact -delivering continuous improvement across the system
- Deliver care that is to care that is safe, positively experienced, accessible, as well as effective.
- Culture of continuous improvement in every aspect of system business
- The clinical/care element of this needs to become a common shared approach to delivering and measuring/evidencing improvement
- Our entire workforce will need to be engaged in this endeavor.

03 Leadership

- Successful delivery of quality, improvement and clinical priorities demands effective leadership.
- The CCPL framework must give our clinical and care leaders a clear, shared understanding of our CCS and how we will deliver it across the system.
- Communicating the strategy, the programmes of work that underpin it and the improvement methodology that will evidence it are an essential enabler.

Our Key Enablers:

Wide engagement with all our providers and delivery partners

Data into Action and a Continuous Improvement methodology

World Class Research and Innovation

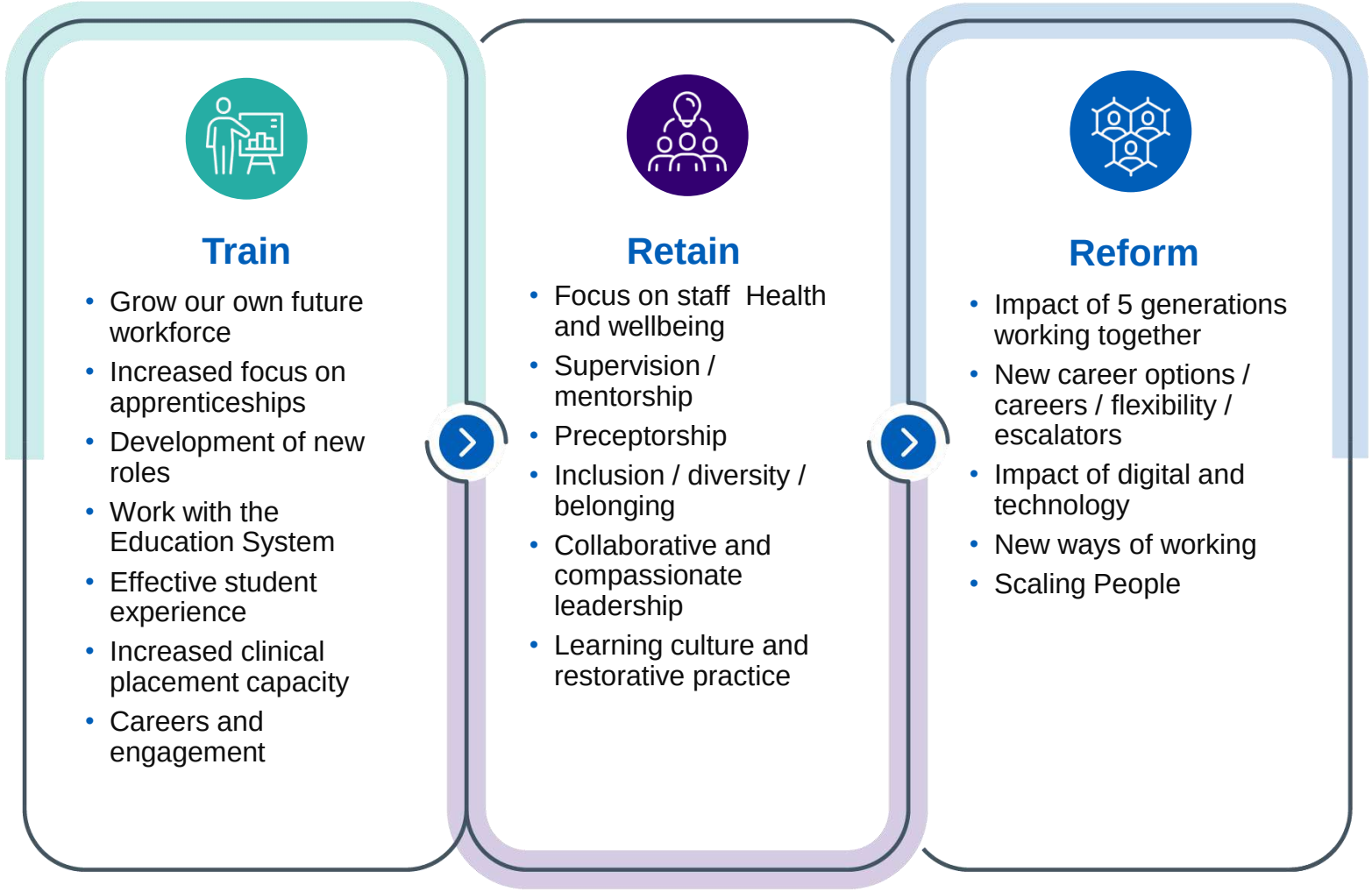
Our Enabling Strategies – Workforce

Our Workforce strategy outlines how we will meet these challenges by working together to build a strong workforce by working differently.

Many of our staff are also carers and have to balance the needs of their families and dependents with managing challenging and busy roles.

We want Cheshire and Merseyside to be a great place to work and an outstanding place for care; whether in the community, in one of our hospitals or online.

Table 7



Our Enabling Strategies – Workforce

NHS Cheshire and Merseyside recognises that our most valuable asset is our dedicated, skilled and knowledgeable workforce. We recognise that our staff consistently go above and beyond what is required of them to deliver outstanding care for our communities.

To support our workforce, we have made a People Promise and are committed to developing skills and opportunities.

Cultural Transformation:

- Organisational and system redesign for integration
- Competency and capability development
- Team cohesion to drive resource optimisation
- Growth mindset to stimulate system leadership thinking
- A shared cultural identity, values and behaviours.

Digital upskilling of the workforce:

- Digital and data skills training at scale
- Developing Digital and Data champions
- Identifying future clinical and care digital and data leaders.

Equality, diversity and inclusion:

- Deliver our public sector equality duty (2010 Act) to be an employer of choice, investing in positive action to attract, retain staff from underrepresented groups and to achieve the ambition to be an Anti-racist organisation and system.

Talent Management:

- Robust succession planning for business-critical roles and hard to fill roles
- Reward and recognition strategies to ensure that success is recognised.

Our Enabling Strategies – Finance and Efficiency

Table 8

Our Financial Strategy aims to: Achieve Financial stability maximising the value of every pound we spend to ensure that we are best meeting the needs of our patients and communities.

We will:

- Demonstrate a 3-year recovery plan for health budgets in line with statutory objectives of ICB and its healthcare system partners
- Enable and support the achievement of our wider HCP system objectives through greater integration at place and neighbourhood level
- Support productivity and Value for Money to maximise benefit to the population of Cheshire and Merseyside.

Pillar 1 Modelling and Analysis	Pillar 2 Supporting Value through Behaviours & Accountability	Pillar 3 Delivering Value through Efficiency & Productivity	Pillar 4 Transformation for Value
• Quantifying the size of our challenge and assessing our areas of opportunity	• Behaviours & accountabilities to support collaboration / shared risk	• Driving safe and sustainable improvement in our productivity and efficiency	• Transformation to address our financial gap. These will be Place / multi-Place, or at scale programmes

Mechanisms for Change:

- Allocations to Place to be based upon weighted population needs analysis
- Increase proportion of funding delegated to Place
- Full Place position to be reported in 2024/25 plans
- Different approach to 'growth funding' to support out of hospital investment.
- Intention to reinstate health inequalities and dental budgets

Key Enablers:

- Allocation Strategy to support strategic system objectives
- Investment and benefits realisation framework
- Funds flow, payments and incentives
- Capital strategy and prioritisation framework

Mission: Working as one to maximise value for every pound we spends

Strategic Principles:

Economy: spending less

Efficiency: spending well

Effectiveness: spending wisely

Equity: spending fairly

There are significant financial pressures across Public Sector and NHS budgets. With limited resources available, we need to maximise the value of every pound we spend to ensure that we are best meeting the needs of our patients and communities.

Our Recovery will focus on delivering value through efficiency and productivity, through transformational schemes which help deliver our financial duties.

Our Integrated Care System Joint Capital Work Plan can be seen HERE.

Our Enabling Strategies – Digital and Data

Table 9

Our Digital and Data Strategy aims to:
- Improving health and well-being by weaving our digital and data infrastructure, systems and services throughout our pathways of care.
- Turn 'intelligence into action'. to bring focused, and therefore meaningful, interventions to those who most need it.

- Improve outcomes for individuals and the population
- Support Health and Care delivery, planning and transformation

- A digitally empowered population
- A digital and data confident and competent workforce
- A secure and reliable intelligence provision

Goal 1	Goal 2	Goal 3
Strong digital and data foundations	**'At Scale' Digital and Data Platforms**	**Safe and sustainable improvement in our productivity and efficiency**
Mechanisms for Change: • Transformation Programmes • Robust governance, leadership and management • Partnerships • Future proofing and innovation	**Strategic Principles:** • Outcome focused • Care profession led • Inspired by a rich diversity of people	**Critical Success Factors:** • Increasing Digital Inclusion • Developing and retaining a highly skilled workforce • Ensuring sustainable financial investment • Working towards Net Zero targets

Key Priorities:
- Cyber security
- Electronic Patient Record (EPR) maturity
- Shared Care Records
- Digital Primary Care Transformation
- Data into Action
- Laboratory Information Management System (LIMS)
- Robotic Process Automation (RPA) and Generative Artificial intelligence (AI)
- Patient empowerment (NHS app, patient portals, digital inclusion)
- Staff digital skills development

Mission: - We will be the most digitally advanced and data driven ICS in England by 2025

We know that Digital and Data is a vital component of how we can make a difference.

We published our three-year Digital and Data Strategy in November 2022 following endorsement from the NHS Cheshire and Merseyside Board.

The strategy described an ambition to improve the health and wellbeing of our region by weaving digital and data infrastructure, systems and services through the pathways of care we provide. It also outlines a commitment to turn **'data into action'** to bring focused and meaningful interventions to those who most need it.

The table opposite describes the overall aims and outlines the three key goals along with our priority areas of focus. We will also scope the potential saving and impact on the priority areas outlined in our 2024-25 Recovery Programme.

NHS
Cheshire and Merseyside

Delivery Themes 2024-29

The following section focuses on 4 thematic areas
It outlines:

- Our Recovery initiatives for 24-25
- How we will transform services
- Our use of new technology
- Our plans for Improving Outcomes in Population Health and Healthcare & Addressing Inequalities
- The design and delivery level
- Links to our core strategies

Delivery Themes 2024 - 29

In developing our plans, we have adopted a thematic approach identifying 4 core delivery areas:

Theme 1

Recovery

Our 24/25 focus

Theme 2

Transforming our services

Theme 3

Innovation and use of new technology

Theme 4

Improving Outcomes in Population Health and Healthcare & Addressing Inequalities

There are known interdependencies between these themes

Key

Strategic Drivers:

- All Together Fairer
- Clinical and Care
- Digital and Data
- Finance
- Workforce

Design and Delivery:

- Design
- Deliver
- Design and Deliver

Theme 1 Recovery - our focus for 24/25

Theme 1	Primary Strategic Drivers	Priority Programme	How we'll deliver				Key focus of the work:	How will we know if we've delivered
			9 Places	Supra Place	Once C&M	Provider Collaborative		
Recovery our focus for 24/25 *** Known interdependencies between these programmes**		**Urgent Care Improvement, improving the quality and performance in Urgent and Emergency Care***	■	■			North Mersey Urgent Care Improvement	• Patients seen within 4 hours (target 24/25 78%) • Maintain the peak increase in capacity agreed through operating plans in 2023/24. (all bed types including virtual wards) • Avoiding care on hospital corridors • Integrated Neighbourhood Team (INT) model • Greater system stability and resilience
			■	■			Mersey and West Lancs Urgent Care (Including Shaping Care Together priorities)	
			■				Wirral Urgent Care Improvement	
			■	■			Cheshire Urgent Care Improvement	
			■	■			Warrington and Halton Urgent Care Improvement	
			■			■	Community Care developing a consistent offer (Inc. Falls Prevention and Response)	
		Efficiency at Scale Programme	■	■	■	■	Driving safe and sustainable improvement in our productivity and efficiency	• Delivered system Value through Efficiency & Productivity
		Improving collaboration and integration across our acute and community providers *	■	■			Liverpool Review	• Greater collaboration and integration between providers of health and care delivering a community, acute and specialist system that is clinically and financially sustainable.
			■				Wirral Review	
			■	■			Warrington and Halton Integration Programme	
			■	■			Cheshire Review	

Digital and Data – enabler role across each of the programmes

Theme 1 Recovery - our focus for 24/25

Theme 1	Primary Strategic Drivers	Priority Programme	How we'll deliver		Key focus of the work:	How will we know if we've delivered
			9 Places	Once across our ICB		
Recovery our focus 24/25		**Improving patient experience by transforming pathways and service delivery**			To improve mental health system flow for adults with mental health conditions focusing on Accident and Emergency and Out of Area Placements	• Eradication of clinically inappropriate 72+ hour waits in Emergency Departments • No more than 10% of the mental health bed base to be occupied by people who are Clinically Ready for Discharge • Reduction in average length of stay in mental health inpatient bed. • Maintain position of no inappropriate out of area placements.
					Neurodiversity standardised pathways/models of care for Children and young people and adults with a focus on Attention Deficit Hyperactivity Disorder (ADHD) and Autism	• Reduced waiting times/numbers on waiting list reduced • Reduced Mental Health demand from undiagnosed/unmet neurodiversity need • Improved Patient experience / reduction in complaints • Improved diagnosis & stratification of need
					All Age Continuing Health Care (AACHC) improved quality safety and experience	• Efficient and effective commissioned services offering individuals and families improved quality, safety and experience

Digital and Data – enabler role across each of the programmes

Theme 1 - Recovery - our focus for 24/25

Theme 1	Primary Strategic Drivers	Priority Programme	How we'll deliver		Key focus of the work:	How will we know if we've delivered
			9 Places	Once across our ICB		
Recovery our focus 24/25		**Commissioning and contracting for added value**			Reducing Unwarranted Variation	• Reduction in unwarranted variation in patient outcomes
						• Optimised productivity - levelling up of patient waiting times across specialties
					Non-statutory sector value to provide sustainability and a consistent approach to commissioning	• Reduction in variation and a consistent approach to commissioning of services • Greater sustainability within the non-statutory service provider market.
					Medicines Management to reduce unwarranted variation and create an equitable service	• Potential Optimisation maximised in Place reduction in unwarranted variation and improved equitable access
		**Workforce**			Optimising our resources to support implementation of the workforce plan for 2024/25	• Collaborative working across the ICB and providers with a consistent approach to workforce planning

Digital and Data – enabler role across each of the programmes

Theme 2 - Transforming our Services

Theme 2	Primary Strategic Drivers	Priority Programme	How we'll deliver: 9 Places	How we'll deliver: Once across our ICB	Some of our Key Initiatives	How will we know if we've delivered
Transforming our Services		Children and Young People (CYP)			Improving Oral Health	• Year 1 - Children supported with tooth brushing, Year 2 - Reduction in Dental Caries
					CYP Mental Health transformation plan - Appropriate Places of Care	• Implementation of a model of best practice for safe places for CYP who need alternatives to hospital care due to emotional well-being or social needs
					System Approaches to Children and Young People Edging towards Care	• C&M model developed for place delivery
		Palliative and End of Life Care			Palliative and End of Life Care (PEOLC)	• Proportion on EOLC Register with a support plan (60%)
		Primary Care			Delivering against our Primary Care Recovery Plan (PCARP)	• Workforce levels against plan (Dr, Nurse/ARRS) • Appointments in General Practice and Primary Care Networks (E.D.19) • Percentage of appointments seen within two weeks (E.D.21)
					Dental Recovery Plan Click to access the full detail	• Improvement in Dental activity levels (against baseline) - Units of Dental Activity Delivered

The link below provides further detail on our core transformation programmes and specific detail on Long term Conditions and other priority areas

Theme 2 -Transforming our Services continued

Theme 2	Primary Strategic Drivers	Priority Programme	How we'll deliver			Some of our Key Initiatives	How will we know if we've delivered
			9 Places	Provider Collaborative	Once across our ICB		
Transforming our Services		**Elective and Cancer Care** Links to recovery section		■		Elective Outcomes and Access	• Eliminate waits of over 65 weeks for elective care • Value weighted activity (VWA) targets, same as those agreed at the start of 2023/24
						Theatre Efficiency Programme and Shared Elective Hubs - CMAST	• Increased numbers of patients treated in NHS theatre capacity
			■		■	Cancer Outcomes and Access	• Proportion of cancers diagnosed stage 1 or 2 • Improve performance against the headline 62-day standard to 70% by March 2025 • Improve performance against the 28 day faster diagnosis standard to 77% by Mar 25 towards the 80% ambition by Mar 26
				■		Diagnostics - Community Diagnostic Centres	• Increase the % of patients receiving a diagnostic test within 6 weeks to a minimum of 95% in March 2025
					■	North West Specialised Services Women's and Children's Programme	• Liverpool Neonatal Surgery Unit open in Nov 2025
		**Outpatient Transformation**		■		• Advice and Guidance roll out • Patient initiated follow up	• Reduction in missed and unnecessary appointments

Theme 2 Transforming our Services continued

Theme 2	Primary Strategic Drivers	Priority Programme	How we'll deliver		Some of our Key Initiatives	How will we know if we've delivered
			9 Places	Once across our ICB		
Transforming our Services		Cheshire and Merseyside Women's Health and Maternity			Continue to implement the Three-Year Delivery Plan for Maternity and Neonatal services	Reduction in stillbirths, neonatal brain injuries, neonatal deaths, maternal deaths, and preterm births
					Improve women's health outcomes and healthcare services whilst addressing the health and social inequalities.	9 women's health hubs open by December 2025 (in each Place) with 3 by December 2024
					Women's Health Services in Liverpool Programme	• Reduction in clinical risks in hospital-based maternity and gynaecology services in Liverpool. • Reduction in health inequalities and gender inequalities for people accessing hospital-based maternity and gynaecology services in Liverpool.
		Mental Health Learning Disability and Autism Transforming Care (Inc. dementia and Suicide Prevention)			• Improving access, and equity of access, to CYP Mental Health services (0-17). • Ensuring Annual health checks for 60% of those living with SMI • Supporting delivery of the Suicide Prevention Strategy • Development of a Cheshire and Merseyside wide strategy for dementia • Reduce reliance on mental health inpatient care for people with a learning disability and or autism • Improve patient flow and work towards eliminating inappropriate out of area placements	• Improved access, quality and increase delivery annual physical health checks. • Increased access to talking therapies and Individual Placement and Support (IPS) • Improved patient flow and reduced pressure in crisis and acute care, continued improvement in the quality of care • Meet the Mental Health Investment Standard • 75% of people aged 14 and over on GP learning disability registers receive an annual health check and action plan • Reduced number of autistic people in a mental health inpatient setting and continue to reduce the number of inpatients with a learning disability (60 adult and CYP by March 2025)

Theme 3 Innovation and use of new Technology

Theme 3	Primary Strategic Drivers	Priority Programme	How we will deliver Once across our ICB	Some of our Key Initiatives	How will we know if we've delivered
Innovation and use of new Technology		**Research and Innovation (R&I)**		Develop a R&I Strategy that maximises inward investment and system capacity	• Identification of local research priorities and needs and development of plans to address these • Extended research in settings such as primary care, community care, mental health services, public health and social care • Improved co-ordination and standardisation within and between localities for the delivery of research • Increase in funding for research and innovation
		**Digital and Data** **See Digital and Data Enabling Strategy described earlier**		Implement Electronic Patient Records (EPR)	Successful implementation and optimisation of EPR functionality in clinical practice across organisations implementing or significantly upgrading their EPR
				Roll out of Bed Management Solution	Improved patient flow as a result of system wide roll out of Bed Management solutions
				Patient empowerment (NHS app, patient portals, digital inclusion)	Self-management and improved patient care as the result of a digitally empowered population
				Development of Laboratory Information Management System (LIMS)	Implementation of system wide digital diagnostic solution
				Staff digital skills -developing and retaining a highly skilled workforce	Increased use of digital and data delivered by a confident and competent workforce

Theme 4 - Improving Outcomes in Population Health and Healthcare & Addressing Inequalities

Theme 4	Primary Strategic Drivers (noting all schemes have some link to our core strategies)	Priority Programme (Further details on the scope of the work we are undertaken by clicking on the title below)	How we'll deliver		Some of our Key Initiatives	How will we know if we've delivered (our sentinel indicators)
			9 Places	Once across our ICB		
Improving Outcomes in Population Health and Healthcare & Addressing Inequalities		Pillar 1 - Social Determinants Programme			See the detail described in Slide 12 Our Enabling Strategies – Population Health and Addressing Inequalities Under Pillar 1 – Social Determinants Programme	The Delivery Plans and milestones are being presented to the Health and Care Partnership in July 2024 and will form the Cheshire and Merseyside Health and Care Partnership Delivery Plan
		Pillar 2 - Supporting Healthy Behaviours			Reducing Harm from Alcohol	Reduced hospital admissions for alcohol-related conditions
					Healthy Weight and Exercise	• Reduced percentage of adults classified as overweight or obese • Increased percentage of physically active people
					Smoke Free Cheshire and Merseyside	• Reduction in smoking prevalence
					Oral Health* (in Children and Young People CYP)	Year 1 - Children supported with tooth brushing, Year 2 - Reduction in Dental Caries

Theme 4 - Improving Outcomes in Population Health and Healthcare & Addressing Inequalities - continued

Theme 4	Primary Strategic Drivers (noting all schemes have some link to our core strategies)	Priority Programme (Further details on the scope of the work we are undertaken by clicking on the title below)	How we'll deliver		Some of our Key Initiatives	How will we know if we've delivered (our sentinel indicators)
			9 Places	Once across our ICB		
Improving Outcomes in Population Health and Healthcare & Addressing Inequalities		Pillar 3 - Healthcare Inequalities Programme			Personalised Care - increasing the numbers of personal health budgets in line with the targets from NHSE	Over the next 3 years - increase the percentage of PHBs by 16% per year to bring us in line with the current England average
					Delivery of Implementation prevention priorities including the nationally defined Core20PLUS5 clinical priorities	80% of people with hypertension whose blood pressure is below treatment threshold
						65% of patients aged 25–84 years with a CVD risk score greater than 20% on lipid lowering therapies by March 2025
		Pillar 4- Screening and Immunisation and Vaccinations			Working with NHS England between 2024/26 around supporting improvements and delivery in the commissioning of vaccinations and immunisations through establishing Screening and Immunisation Steering Group. (Delegation is anticipated April 2026)	Increase in the vaccination uptake for children and young people year on year towards WHO recommended levels

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Board Assurance Framework 2024-2025 and Quarter One Update Report

Agenda Item No: ICB/07/24/22

Responsible Director: Clare Watson, Assistant Chief Executive

Board Assurance Framework 2024-2025 and Quarter One Update Report

1. Purpose of the Report

1.1 The purpose of the report is to present the 2024-25 Board Assurance Framework (BAF) for approval and provide an update on progress at quarter one.

2. Executive Summary

2.1 Risk owners and the Risk Committee have reviewed the principal risks in light of progress during 2023-24, current assessment of strategic challenges, and revised priorities and plans for 2024-25. The principal risks are those which, if realised, will have the most significant impact on the delivery of the ICB's strategic objectives.

2.2 The proposed BAF for 2024-25 is provided in section 9 and appendices one and two. This retains 9 of the existing principal risks and proposes that risk P2 is de-escalated to the operational risk register and the addition of a new risk P11 in respect of digital infrastructure for key clinical systems.

2.3 The proposed BAF contains 2 critical risks, 5 extreme risks and 3 high risks. Of these, 3 are at the proposed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 7 remain above the proposed target for 2024-25 and the focus will be on delivering the planned actions to further mitigate these risks by year end.

2.4 The critical risks are:

- P5 - Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience, currently rated as critical (20).
- P7 - The Integrated Care System is unable to achieve its statutory financial duties, currently rated as critical (20).

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

2.6 Acceptable assurance is available in relation to 4 of the principal risks but further assurance is required in respect of the remaining 6 and further details are provided in section 9.12 and appendix two.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **APPROVE** the refreshed Board Assurance Framework for 2024-25 including the proposed target scores at section 9.5, the de-escalation of risk P2 and the addition of a new risk P11.

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

4. Reasons for Recommendations

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

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

5. Background

5.1 As part of the annual planning process the Board undertakes a robust assessment of the organisation's emerging and principal risks. This aims to identify the significant external and internal threats to the achievement of the ICB's strategic goals and continued functioning. Risk owners and the Risk Committee have reviewed and refreshed the BAF for 2024-25 in light of revised priorities and plans and recommend that it is approved for adoption by the Board.

5.2 The ICB must take risks to achieve its aims and deliver beneficial outcomes to patients, the public and other stakeholders. Risks will be taken in a considered and controlled manner, and the Board has determined the level of exposure to

risks which is acceptable in general, and this is set out in the core risk appetite statement.

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

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

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

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

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

7.1 The Annual Delivery Plan sets out linkages between each of the plan's focus areas and one or more of the BAF principal risks. Successful delivery of the relevant actions will support mitigation of these risks.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the BAF underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management and sustainability.

9. Risks

Proposed BAF 2024-25

9.1 Risk owners and the Risk Committee have reviewed the BAF in light of progress during 2023-24, current assessment of strategic challenges, and revised priorities and plans for 2024-25. The Recovery Programme is focused on the priorities of urgent and emergency care recovery and improving use of resources, and the impact of this reprioritisation has been reflected in the review.

9.2 The principal risks align to the ICB's strategic objectives, spanning multiple years. The review has concluded that the majority of the principal risks should continue onto the 2024-25 BAF. The exception is *P2 - the ICB is unable to address inadequate digital and data infrastructure and interoperability, which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities*. This risk has been successfully mitigated to the targeted moderate (6) and it is proposed to de-escalate from the BAF and monitor quarterly via the operational risk register.

9.3 The remaining 9 risks have been reviewed and refreshed with a focus on:

- Updating the planned mitigations to reflect the recovery programmes established for 2024-25 and the scaling down or deferral of activity to release resource to focus on the Recovery Programme.

- Reviewing the inherent, current and target scores based on the current environment, progress made and the revised mitigation strategies. In particular, target scores have been reviewed to ensure that they are consistently set and clarify what is anticipated based on planned actions in the 2024-25 BAF year and the optimal position aligned to the ICB Risk Appetite but only achievable over a longer timescale.

- Aligning to revised assurance ratings (as agreed by Audit Committee on 25 June 2024) to provide greater delineation between levels of assurance as follows:
  - **Significant Assurance** - High level of confidence in delivery of existing mechanisms / objectives
  - **Acceptable Assurance** – General confidence in delivery of existing mechanisms / objectives
  - **Partial Assurance** – Some confidence in delivery of existing mechanisms / objectives, some areas of concern
  - **No Assurance** – No confidence in delivery.

9.4 A new BAF risk is proposed **P11 – *The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside***. This risk has been mitigated from critical (20) to extreme (16) through cyber security systems and processes, local and national oversight. Key further

actions include C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

9.5 The refreshed 2024-25 BAF is summarised in the heat map below:

ID	Risk	Inherent			Current (Q1)			Target 2024-25			Risk Appetite (Optimal)	
		L	I	R	L	I	R	L	I	R	Rating	Timescale
P1	Health inequalities	4	5	**20**	3	5	**15**	3	5	**15**	High (8)	2026-27
P3	Elective care	5	5	**25**	3	5	**15**	2	5	**10**	Moderate (5)	2026-27
P4	Major quality failures	3	5	**15**	2	5	**10**	2	5	**10**	Moderate (5)	2026-27
P5	Urgent & emergency care	5	5	**25**	4	5	**20**	3	5	**15**	Moderate (5)	2026-27
P6	Primary care access	5	4	**20**	4	4	**16**	4	3	**12**	Moderate (6)	2025-26
P7	Statutory financial duties	5	5	**25**	4	5	**20**	3	5	**15**	High (8)	2026-27
P8	Provider sustainability	4	4	**16**	3	4	**12**	3	4	**12**	Moderate (6)	2026-27
P9	ICS workforce	4	4	**16**	4	4	**16**	3	4	**12**	Moderate (6)	2026-27
P10	Focus on long term strategy	4	4	**16**	3	3	**9**	3	3	**9**	Moderate (6)	2025-26
P11	Digital infrastructure	5	4	**20**	4	4	**16**	4	4	**16**	High (8)	2025-26

9.6 The key changes proposed from the 2023-24 Q4 position are as follows:

P1 – **an increase in the inherent score from 16 to 20 and the current score from 12 to 15** aligned to the updated impact criteria in the risk matrix **and an increase in the target score from 8 to 15 for 2024-25**, reflecting resource allocation and capacity constraints.

P4 – **an increase in the target score from 5 to 10 for 2024-25**, reflecting the challenging environment, and need to embed processes and deliver progress in mitigating related BAF risks (P3, P5 and P8).

P7 – a reduction in the current score from 25 to 20, reflecting the progress made with the 2024-25 Financial Plan and establishment of the Recovery Programme and **an increase in the target score from 12 to 15 for 2024-25,** reflecting anticipated timescales for financial impact of recovery activity.

P8 – **an increase in the inherent score from 12 to 16** aligned to the updated impact criteria in the risk matrix **and an increase in the target score from 6 to 12** for 2024-25, reflecting the lead in time required to develop, consult upon and secure approval to cases for change across multiple transformation programmes.

P9 - an increase in the target score from 6 to 12 for 2024-25, reflecting resource allocation and limited capacity to develop the required infrastructure.

BAF 2024-25 Q1 Review

9.7 A summary of the principal risks and high-level mitigation strategies is provided at appendix one. Further detail in respect of each risk, including the assessment and scoring rationale, current controls and assessment of their effectiveness, gaps identified, planned actions and progress, assurances provided and a current position statement in relation to progress towards target, is provided in the individual risk summaries at appendix two.

9.8 There are currently 2 critical risks, 5 extreme risks and 3 high risks. Of these, 3 are at the proposed target for 2024-25 and the focus will be on assurance that controls remain effective and on continuing to progress actions to further mitigate the risk over the longer term. The remaining 7 remain above the proposed target for 2024-25 and the focus will be on delivering the planned actions to further mitigate these risks by year end.

9.8 The majority of the planned actions are on track, but there are two actions assessed as problematic - delivery remains feasible, actions not completed, awaiting further interventions. These are:

- In relation to P7 – statutory financial duties, action to conclude and secure agreement to the medium-term financial strategy. This reflects the scale of the challenge and the work still to complete in testing and finalising delivery metrics, timescales and quantifying associated financial impact for recovery programmes.
- In relation to P9 – ICS workforce, action to develop and enhance workforce planning capabilities across the system. This reflects the withdrawal of workforce development funding in light of the financial position. In response to this realignment of existing Peoples Team resources is planned to enable a more limited work programme in the short term.

9.9 As progress is made in implementing and strengthening controls, with resulting reductions in the level of risk, the focus will shift to assuring that key controls are embedded and effective in continuing to mitigate the risk to an acceptable level. The ICB's committees provide scrutiny and challenge of risk independent of the management line and are an important source of 2nd line assurance to the Board. Their discussion and decisions in relation to BAF risks were summarised in the chair's highlight reports considered by the Board on 30/5/24 and appearing elsewhere on this agenda.

9.10 In addition the following assurance reports have been provided to the Board during quarter one:

- Director of Nursing Report – 30/5/24 (P4)
- Integrated Performance Report – 30/5/24 (P3, P4, P5, P6, P9).

9.11 A summary of the assurance ratings for each of the principal risks is provided below:

ID	Risk	Committee	Current Score (Q1)	Controls					Assurance Rating
				Policies	Processes	Plans	Contracts	Reporting	
P1	Health inequalities	S&T	**15**	**G**	**A**	**A**	**A**	**G**	**Partial**
P3	Elective care	Q&P	**15**	**G**	**A**	**G**	**G**	**G**	**Acceptable**
P4	Major quality failures	Q&P	**10**	**A**	**A**	**A**	**A**	**G**	**Acceptable**
P5	Urgent & emergency care	Q&P	**20**	**G**	**A**	**A**	**G**	**A**	**Partial**
P6	Primary care access	SPCC	**16**	**G**	**A**	**A**	**G**	**G**	**Acceptable**
P7	Statutory financial duties	FIRC	**20**	**G**	**G**	**A**	**A**	**G**	**Partial**
P8	Provider sustainability	S&T	**12**	**G**	**G**	**A**	**A**	**A**	**Partial**
P9	ICS workforce	FIRC	**16**	**A**	**A**	**A**	**G**	**A**	**Partial**
P10	Focus on long term strategy	Execs	**9**	**G**	**G**	**A**	**A**	**G**	**Acceptable**
P11	Digital Infrastructure	S&T	**16**	**A**	**A**	**A**	**A**	**A**	**Partial**

9.12 There are a number of risks assessed as having only partial assurance - some confidence in delivery of existing mechanisms / objectives, some areas of concern. These are:

P1 where additional assurance is required in relation to funding, programme reporting and metrics and establishing the assurance role of Population Health Group Sub-Groups.

P5 where key performance measures indicate that, despite existing controls, service delivery is not yet meeting required national and local standards.

P7 where additional assurance is required that there is an agreed and approved ICS medium-term financial strategy to address the financial deficit.

P8 where additional assurance is required that there is a credible case for change and sustainable transformation plans in relation to a number of fragile services.

P9 where further assurance is required regarding action planned to address priority gaps in control with the reduced resource available.

P11 where additional assurance is required regarding organisation and system level cyber security compliance and risk, and robust plans to address any identified gaps.

Further detail is provided in the risk summaries at appendix two.

10. Finance

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

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

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

12.2 Principal risk P1 has the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix two.

13. Climate Change / Sustainability

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

14. Next Steps and Responsible Person to take forward

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

15. Officer contact details for more information

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

16. Appendices

Appendix One: Board Assurance Framework Summary
Appendix Two: BAF Risk Summaries

Board Assurance Framework 2024/25 – Quarter 1 review

Appendix One – Summary

Principal Risks	Responsible Committee & Executive	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Change from previous quarter	Target Risk Score 2024-25	Priority Actions / Assurance Activities
Strategic Objective 1: Tackling Health Inequalities in Outcomes, Access and Experience						
P1: The ICB is unable to meet its statutory duties to address health inequalities	Strategy & Transformation Committee Clare Watson	**4x5=20**	**3x5=15**	No change	**3x5=15**	Further action to strengthen controls. Key actions are to secure ringfenced budget, agree All Together Fairer and Health Inequalities approaches with place-based partnerships and implement Population Health Group sub-groups aligned to population health programme.
P2: The ICB is unable to address inadequate digital and data infrastructure and interoperability which inhibits development of system-wide population health management and effective targeting of initiatives to reduce health inequalities **FOR DE-ESCALATION**	Strategy & Transformation Committee Rowan Pritchard-Jones	**4x3=12**	**2x3=6**	No change	**2x3=6**	Successfully mitigated to target score. Proposed to de-escalate and manage through directorate risk register.
Strategic Objective 2: Improving Population Health and Healthcare						
P3: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the	Quality & Performance Committee Anthony Middleton	**5x5=25**	**3x5=15**	No change	**2x5=10**	Further action to strengthen controls. Key actions are the Elective Recovery Team and increasing diagnostics capacity through Community Diagnostic

impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes						Centres and elective capacity through elective hubs
P4: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience	Quality & Performance Committee Chris Douglas / Rowan Pritchard-Jones	**3x5=15**	**2x5=10**	No change	**2x5=10**	Significant controls in place. Priority will be to continue to embed and strengthen controls and provide assurance on continuing effectiveness of control framework.
P5: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience	Quality & Performance Committee Anthony Middleton	**5x5=25**	**4x5=20**	No change	**3x5=15**	Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes.
P6: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population	Primary Care Clare Watson	**5x4=20**	**4x4=16**	No change	**4x3=12**	Further action to strengthen controls. Key actions are continued delivery of Primary Care Access Recovery Plan and Dental Improvement Plan.
Strategic Objective 3: Enhancing Quality, Productivity and Value for Money						
P7: The Integrated Care System is unable to achieve its statutory financial duties	Finance, Investment & Our Resources Committee Claire Wilson	**5x5=25**	**4x5=20**	Score reduced from 25 to 20	**3x5=15**	Key aim of Recovery Programme is to improve use of resources. Key further action is to secure agreement to the Medium-Term Financial Strategy.

P8: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services	Strategy & Transformation Committee Rowan Pritchard-Jones	**4x4=12**	**3x4=12**	No change	**3x4=12**	Further action to implement and strengthen controls. Ongoing action to progress the development of case for change across multiple programmes.
P9: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives.	Finance, Investment & Our Resources Committee Chris Samosa	**4x4=16**	**4x4=16**	No change	**3x4=12**	Further action to implement and strengthen controls. Key actions are to develop and enhance system workforce planning and scaling up of Peoples Services.
Strategic Objective 4: Helping the NHS to support broader social and economic development						
P10: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population.	ICB Executive Graham Urwin	**4x4=16**	**3x3=9**	No change	**3x3=9**	Further action to strengthen controls. Key actions are to re-focus the HCP Strategy aligned to All Together Fairer and refresh the Joint 5-Year Forward Plan.
P11: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.	Strategy & Transformation Committee Rowan Pritchard-Jones	**5x4=20**	**4x4=16**	N/A	**4x4=16**	Further action to implement and strengthen controls. Key actions are C&M wide baseline analysis and benchmarking, identifying and progressing opportunities for collaboration and standardisation, and identifying and addressing supply chain risks.

Appendix Two – BAF Risk Summaries

ID No: P1	Risk Title: The ICB is unable to meet its statutory duties to address health inequalities
Risk Description (max 100 words)	Longstanding social, economic and health inequalities across Cheshire and Merseyside, when comparing outcomes both between different communities in our area and the national average for HI. Population health and wellbeing is shaped by social, economic, and environmental conditions in which people are born, grow, live, and work. This can only be addressed through collective systemwide effort and investment across the partnership, our communities, the NHS, Local Government, and Voluntary and Private sectors. This risk relates to the potential inability of the ICB to secure the necessary investment and influence priorities across multiple organisations, agencies and communities covered by the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Prof. Ian Ashworth	Assistant Chief Executive	Strategy & Transformation

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

Date Raised	Last Updated	Next Update Due
13/02/23	20/06/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3				3	31/03/25	Our longer-term ambition is to moderate to a (2x4=8) level of risk but will only be achievable over 2-3 years due to resource allocation and capacity. This equally applies to systemwide inequalities due to financial pressures and capacity.
Impact	5	5				5		
Risk Score	20	15				15		

Rationale for score & progress in quarter (max 300 words)	There is potential for a major reduction in health outcomes and/or life expectancy and major increase in the health inequality gap in deprived areas or for socially excluded groups (impact 5). Current controls are effective in reducing the likelihood, but this is still possible (3). Planned mitigation is focused on delivering the All Together Fairer: Our Health and Care Partnership Plan, including securing health inequalities investment allocation. The planned actions are currently on track, and it is anticipated that these will be sufficient to maintain the risk at its current level during 2024-25, and continue to build the foundations for a reduction in health inequalities to contribute to our ambition of a score of 8, over the next 2-3 years. It is vital that our Recovery Programme consistently reviews opportunities to reduce demand and avoidable admissions, whilst taking action on reducing the impact of health care inequalities. A new contract schedule on health inequalities for all NHS Trust has been developed and introduced for 2024/25.

Current Key Controls		**Rating**
Policies	Constitution, membership & role of HCP Partnership Board, 'All Together Fairer;(Marmot Review)' Core 20+5 stocktake, Prioritisation Framework, Public Engagement / Empowerment Framework.	**G**
Processes	Strategic planning, consultation & engagement, financial planning, Population Health Partnership group support, advice, and scrutiny of the Population Health Programme.	**A**
Plans	***All Together Fairer: Our Health and Care Partnership Plan,*** HCP Interim Strategy, 5 Year Joint Forward Plan, Financial Plan (including ringfenced health inequalities funding), Joint Health and Wellbeing Strategies	**A**
Contracts	NHS Trust contracts (including contract schedule to support reducing health inequalities)	**A**
Reporting	C&M HCP Partnership Board, Population Health Partnership Group, Place-Based Partnership Boards, Strategy & Transformation Committee, ICB Board.	**G**

Gaps in control

Until the Population Health Target Operating model is fully established, the scoping of health inequalities investment and allocation to priority programmes, the risk rating for the population health programme delivery will remain high and above our ambitious target score.
The development of the Population Health Groups sub-group meetings in line with population health programme plan on a page, are delayed until the commencement of the Population health Consultants in Public Health in mid July 2024.

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Finalise Joint 5-year Forward Plan aligned to All Together Fairer	Reduce	Reduce	Neil Evans	30/06/24	**On Track**
Secure ICB ring-fenced Health Inequalities budget allocation	Reduce	Reduce	Clare Watson	31/07/24	**On Track**

Agree All Together Fairer and Health Inequalities approaches with place-based partnerships (incl allocation, guidance & reporting)	Reduce	Reduce	Ian Ashworth	30/09/24	**On Track**
Implement Population Health Group sub-groups aligned to population health programme plan on a page	Reduce	Reduce	Population Health Consultants	31/12/24	**On Track**
Further develop prioritisation framework, underpinning data & intelligence to enable demonstration of progress	Reduce	Reduce	Neil Evans	31/03/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
ICB Board approval to Joint 5 Year Forward Plan	July 2024		**Partial**
Progress reports to C&M HCP Board on delivery & implementation of programmes and projects.	Quarterly		
Progress reports to Strategy & Transformation Committee on delivery & implementation of programmes and projects.	Bi-monthly		
Core20+5 Health Inequalities Stocktake for NHSE/I reported to Population Health Partnership Group & C&M HCP Board.	Quarterly		

Gaps in assurance
Limitations on scale and pace of investment due to challenging financial environments for all partners. Population Health Group Sub-Groups to be established. Programme metrics and impact reporting requires review.

Actions planned	**Owner**	**Timescale**	**Rating**
Secure ICB ring-fenced Health Inequalities budget allocation	Clare Watson	31/07/24	**On Track**
Review of Programme reporting metrics and Impacts	Ian Ashworth	31/12/24	**On Track**
Develop assurance role of Population Health Group Sub-Groups	Ian Ashworth	28/02/25	**On Track**

ID No: P3	**Risk Title: Acute and specialist providers across C&M may be unable to reduce backlogs for elective and cancer care, due to capacity constraints related to industrial action or other supply side issues or the impact of winter Urgent and Emergency Care pressures. This may result in inability to meet increased demand, increase in backlogs of care, resulting in poor access to services, increased inequity of access, and poor clinical outcomes**
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. Supply side constraints, including the ongoing impact of industrial action, impact on the available capacity in the system to tackle the longest waits. This risk relates to the potential inability of the ICB in this context to deliver these plans against national targets for recovery of electives, diagnostics and cancer services, which may result in patient harm and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Andy Thomas	Finance	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Performance	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	25/06/24	15/10/2024

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	**5**	**3**				**2**	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve in line with national improvement trajectories.
Impact	**5**	**5**				**5**		
Risk Score	**25**	**15**				**10**		
Rationale for score & progress in quarter	There is potential for multiple deaths or irreversible health effects, or harm to more than 50 people, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood to possible (3). Elective Recovery, Diagnostics and Cancer Programmes are focused on increasing activity, faster diagnosis and treatment and reducing long waits. The planned actions are currently on track, and it is anticipated that this will reduce the likelihood further to unlikely (2)							

(max 300 words)	and that the target risk score of 10 will be achieved by year-end. The safety and quality impacts will also be lessened but due to the breadth and nature of the service, the potential remains for catastrophic (5) impact.

Current Key Controls		**Rating**
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, NHS elective recovery plan published February 2022 '**Delivery plan for tackling the COVID-19 backlog of elective care'**	**G**
Processes	System level operational planning, performance monitoring, contract management, system oversight framework, diagnostics mutual aid,	**A**
Plans	C&M Operational Plan, Elective Recovery Programme and Plans, Diagnostics Programme and Plans, Cheshire & Merseyside Cancer Alliance work programme, Place Delivery Plans, Winter Plan, EPRR	**G**
Contracts	NHS Standard Contract – contracting round for 23/24 concluded	**G**
Reporting	Programme level reporting, Quality & Performance Committee, Primary Care Committee, ICB Board, Regional Elective Board (chaired by NHSE)	**G**

Gaps in control

Scale and frequency of future industrial action unknown and likely to continue to impact on workforce capacity.

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
CMAST Elective Recovery Improvement Programme	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**
Increase diagnostics capacity through CDCs and elective capacity through elective hubs	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**
Cancer Alliance targeted investment and support to priority cancer pathways	Reduce	Reduce	Anthony Middleton	2024/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly	30/5/24	**Acceptable**
Programme delivery reporting to Strategy & Transformation Committee, ICB Board	Bi-monthly		
Gaps in assurance			
All Trusts are committed to eliminated waits over 65 weeks by September per 24-25 operational plans, however it is noted that certain specialties are particularly pressured, including ENT, T&O, Plastics and Gynaecology.			

Actions planned	Owner	Timescale	Rating
Weekly patient tracking list meetings all trusts	Anthony Middleton (via CMAST)	2024-25	**On Track**
C&M Elective Recovery Mutual Aid Team broker mutual aid	Anthony Middleton (via CMAST)	2024-25	**On Track**

ID No: P4	Risk Title: Major quality failures may occur in commissioned services resulting in inadequate care compromising population safety and experience
Risk Description (max 100 words)	The ICB has a statutory responsibility to improve the quality of commissioned services and safeguard the most vulnerable, the quality governance framework that has been established supports early identification and triangulation of risks to quality and safety. This risk pertains to the potential failure of the established framework, with the consequence of a major impact on the safety and experience of services by our population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Chris Douglas / Rowan Pritchard-Jones	Kerry Lloyd	Nursing & Care / Medical	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	27/06/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	3	2				2	31/3/25	The ICB has a low appetite for risk that impacts on patient safety. Our longer-term aspiration remains to reduce further to a moderate (1x5=5) level.
Impact	5	5				5		
Risk Score	15	10				10		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, to unlikely (2). Good progress has been made in establishing the quality oversight framework providing a firm foundation for identifying emerging concerns and appropriate intervention. The increased focus on the resources available and our need to increase our productivity in 2024-25 makes it increasingly important to mitigate any potential impact to the quality and safety of commissioned services, and as a result it is anticipated that progress in further reducing this risk will be limited during the current financial year.							

Current Key Controls		Rating
Policies	Clinical Quality Strategy, National Quality Board guidance on risk management and escalation, Safeguarding legislation and policy alignment, Patient Safety policy alignment, including Patient Safety Incident Response Framework	**A**
Processes	System Quality Group, Emerging Concerns Group, Clinical Effectiveness Group, Multi- agency safeguarding boards/partnerships, Infection Prevention Control/Anti-Microbial Resistance Board, Place based quality partnership groups & serious incident panels, Quality Assurance Visits, Rapid Quality Reviews, Independent Investigations & other reviews and responses to national enquiries and investigations.	**A**
Plans	Development of Clinical and Care Professional Leadership Framework & Associated Steering Group, Approach to NHS Impact	**A**
Contracts	Place based quality schedule within NHS standard contract, Development of standardised C&M quality schedule, Service specifications, Safeguarding commissioning standards	**A**
Reporting	System Oversight Board, Quality & Performance Committee ICB Board, National quality reporting	**G**

Gaps in control
Need to ensure NHS Impact & PSIRF are embedded and extended Development of data and intelligence platforms to identify and triangulate quality concerns / failures.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Closedown Serious Incident Framework	Reduce	Maintain	Richard Crockford	01/10/24	**On Track**
Continuous review and alignment of quality reporting requirements	Reduce	Maintain	Chris Douglas	2024-25	**On Track**
Embedding NHS Impact approach	Reduce	Maintain	Fiona Lemmens	2024-25	**On Track**
Extending and embedding PSIRF	Reduce	Maintain	Richard Crockford	2024-25	**On Track**
Continue to develop BI capability to support intelligence led approach	Reduce	Maintain	Becky Williams	2024-25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Quality reporting to Quality & Performance Committee & ICB Board	Monthly	30/5/24	**Acceptable**
Executive Director of Nursing & Care report to ICB	Bi-monthly	30/5/24	
Regional quality group reporting	Quarterly		
Gaps in assurance			
Work to strengthen quality, safety and experience reporting through intelligence led approach			

Actions planned	Owner	Timescale	Rating
Continue to develop ability to be intelligence led	Chris Douglas / Rowen Pritchard Jones	2024-25	**On Track**

ID No: P5	Risk Title: Lack of Urgent and Emergency Care capacity and restricted flow across all sectors (primary care, community, mental health, acute hospitals and social care) results in patient harm and poor patient experience.
Risk Description (max 100 words)	The wider urgent and emergency care system, spanning all sectors, is under significant pressure with similar demand, capacity and flow challenges impacting on the ability of patients to access the right urgent or emergency care at the right time in the right place. Within the acute sector, high bed occupancy, driven by delayed discharges and longer stays, results in reduced flow from emergency departments, which in turn impacts waiting times in ED and ambulance response times. Such delays may result in patient harm and poor patient experience, and increased health inequalities.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Anthony Middleton	Claire Sanders	Finance	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Quality	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	28/06/24	15/07/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4				3	31/3/25	The ICB has a low tolerance for risks impacting patient safety and the aim is to reduce to a moderate/low level acknowledging that this will take 2-3 years to achieve.
Impact	5	5				5		
Risk Score	25	20				15		
Rationale for score & progress in quarter (max 300 words)	There is potential for multiple deaths, permanent injuries or irreversible health effects, or harm to more than 50 people, totally unacceptable quality of clinical care, and gross failure to meet national standards (impact 5). Current controls are effective in reducing the likelihood, but this is still likely (4). Urgent Care Recovery Programmes in 5 areas are focused on the key objective of eliminating corridor care in 24-25, as well as reducing the number of hospital attendances and admissions and improving discharge pathways and processes. The planned actions are currently on track, and it is anticipated that this will reduce the likelihood further to possible (3) and that the target risk score of 15 will be achieved by year-end. The safety and quality impacts will also be lessened but due to the scale and nature of the service, the potential remains for catastrophic (5) impact.							

Current Key Controls		Rating
Policies	NHS Delivery plan for recovering urgent and emergency care services. Winter Planning Guidance. SCC Review of Standards. Revised OPEL framework	**G**
Processes	System Coordination Centre, System wide operational planning, NHS Oversight Framework. Winter Planning process	**A**
Plans	UEC Recovery Programme, C&M Operational Plan, Place Delivery Plans	**A**
Contracts	NHS Standard Contract	**G**
Reporting	UEC Recovery and improvement Group, Strategy & Transformation Committee, Quality & Performance Committee, ICB Board	**A**

Gaps in control

Scale and frequency of future industrial action unknown and likely to continue to impact on workforce capacity.
Demand exceeds planned capacity levels in a range of sectors, and fuller understanding of demand and capacity across all sectors is required.
Variation in processes C&M wide, e.g. application of patient choice, discharge processes.
Revaluation of NEPTS is required as part of procurement process.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
At scale work stream admission avoidance	Reduce	Reduce	Tony Mayer	2024/25	**On Track**
At scale work stream ambulance improvement	Reduce	Reduce	Claire Sanders	2024/25	**On Track**
At scale work stream acute discharge	Reduce	Reduce	Claire Sanders	2024/25	**On Track**
At scale work stream acute length of stay	Reduce	Reduce	Claire Sanders	2024/25	**On Track**
At scale work stream oversight resilience	Reduce	Reduce	Claire Sanders	2024/25	**On Track**
Urgent Care Improvement Programme – Liverpool	Reduce	Reduce	Mark Bakewell & Deb Butcher	2024/25	**On Track**
Urgent Care Improvement Programme – Mersey and West Lancashire	Reduce	Reduce	Mark Palethorpe & Deb Butcher	2024/25	**On Track**

Urgent Care Improvement Programme – Cheshire	Reduce		Laura Marsh & Mark Wilkinson	2024/25	**On Track**
Urgent Care Improvement Programme – Warrington and Halton	Reduce		Carl Marsh	2024/25	**On Track**
Urgent Care Improvement Programme – Wirral	Reduce		Simon Banks	2024/25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
UEC Recovery and Improvement Group	Monthly		**Partial**
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Monthly & bi-monthly		
Performance reporting to Quality & Performance Committee & ICB Board	Monthly & bi-monthly		
Gaps in assurance			
Performance against the majority of urgent and emergency care measures is below target and England average.			

Actions planned	**Owner**	**Timescale**	**Rating**
Urgent Care Improvement Programmes (as above)	Place Directors (as above)	2024/25	**On Track**

ID No: P6	Risk Title: Demand continues to exceed available capacity in primary care, exacerbating health inequalities and equity of access for our population
Risk Description (max 100 words)	The COVID 19 pandemic generated significant backlogs due to reduced capacity to meet routine healthcare needs and people delaying seeking healthcare interventions, exacerbating existing inequalities in access to care and health outcomes. This risk relates to the potential inability of the ICB to ensure that local plans are effective in delivering against national targets for recovery of primary care access, which may result in poorer outcomes and inequity for patients and loss of stakeholder trust and confidence in the ICB.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Clare Watson	Chris Leese & Tom Knight	Assistant Chief Executive	Primary Care

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health and Healthcare	Primary Care	A – within the next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
10/05/23	27/06/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4				4	31/03/25	The aim is to reduce to a moderate level of risk over the 2024-26 lifetime of access recovery / improvement plans.
Impact	4	4				3		
Risk Score	20	16				12		
Rationale for score & progress in quarter (max 300 words)	There is potential for significant reduction in health outcomes and/or life expectancy, significant increase in health inequality gap in deprived areas or socially excluded groups, adverse public reaction and significant impact on trust and confidence of stakeholders (impact 4). Current controls are effective in reducing the likelihood to likely (4). Ongoing delivery of Primary Care Access Recovery and Dental Improvement Plans is on target and expected to moderate the potential impact from 4 to 3 during 2024-25 achieving the target risk score of 12 by year-end.							

Current Key Controls		Rating
Policies	NHS Long Term Plan, NHS Operational Planning Guidance, National Stocktakes and Guidance in relation to Primary Care, Primary Care Access Recovery Plan, National Dental Recovery Plan 2024	**G**
Processes	System and place level operational planning, performance monitoring, contract management, system oversight framework, place maturity / assurance framework.	**A**
Plans	Primary Care Strategic Framework version 1, Developing Primary Care Access Recovery Plan, System Development Funding Plan, Dental Improvement Plan, ICS Operational Plan, Place Level Access Improvement Plans x 9.	**A**
Contracts	GMS PMS APMS Contracts, Local Enhanced/Quality Contracts, Directed Enhanced Services – Primary Care Networks – Enhanced Access, GDS&PDS Contracts	**G**
Reporting	System Primary Care Committee, NW Regional Transformation Board, Quality & Performance Committee, ICB Board, HCP Board. Place Primary Care forums. Local Dental improvement plan delivery board	**G**

Gaps in control

Primary Care Strategic Framework version 2 to be completed & formally signed off.
Ongoing successful delivery of the access recovery / improvement plans required over a 2-3 year period to close gap, specifically dental workforce and funding for primary medical baselines as reported by contractors.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Complete & secure approval to Primary Care Access Recovery Plan Y2			Chris Leese	30/11/24	**On Track**
Delivery of Access Recovery and Improvement Plans			Corporate & Place Primary Care Leads	2024-26	**On Track**
Delivery of Dental Improvement Plan 2024-26			Tom Knight	2024-26	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Reporting on delivery to System Primary Care Committee & ICB Board	Quarterly		**Acceptable**
Performance Reporting to ICB Board	Bi-monthly	30/5/24	
ICB Board approval to Primary Care Access Recovery Plan Y2	November 24		
Gaps in assurance			
No Phase 2 of strategic framework			

Actions planned	Owner	Timescale	Rating
Secure approval to Primary Care Access Recovery Plan Y2	Chris Leese	30/11/24	**On Track**

ID No: P7	Risk Title: The Integrated Care System is unable to achieve its statutory financial duties
Risk Description (max 100 words)	There is a substantial underlying financial gap across the Cheshire and Merseyside healthcare system between current spending levels and the national formula-based allocation. If the ICB is unable to secure agreement to and deliver a long-term financial strategy which eliminates this gap whilst also enabling delivery of statutory requirements and strategic objectives, then it will fail to meet its statutory financial duties. This is further exacerbated by the relative' distance from target, convergence adjustments for both core ICB allocations and specialised services and inflationary pressures anticipated in the short -medium term above funding settlements.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Claire Wilson	Rebecca Tunstall	Finance	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Finance	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	04/07/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4				3	31/03/25	The ICB is willing to pursue higher levels of risk while maintaining financial sustainability and efficient use of resources. The aim is to reduce to a moderate level over the 3-year financial plan.
Impact	5	5				5		
Risk Score	25	20				15		

Rationale for score & progress in quarter (max 300 words)	There is potential for a major financial loss, special measures and major impact on trust and confidence of stakeholders (impact 5). The scale of the financial gap means that the likelihood is currently likely (4). Planned actions to secure ICS wide agreement and NHSE approval to a Medium-Term Financial Strategy are in progress. It is anticipated that will reduce the likelihood to possible (3) achieving the target risk score of 15 by year end. The longer-term aim is to reduce to a moderate level over the lifetime of the medium-term financial strategy.

Current Key Controls		**Rating**
Policies	Standing Financial Instructions, Scheme of Reservation & Delegation, Delegation Agreements (ICB / Place), Financial Policies	**G**
Processes	Financial planning	**G**
Plans	ICS Financial Plan 2024/25, Medium Term Financial Strategy	**A**
Contracts	NHSE/I Funding allocations (Revenue & Capital), NHS Standard Contracts	**A**
Reporting	ICB Executive Team, Finance Investment and Resources Committee, ICB Board, NHSE/I	**G**

Gaps in control

Medium Term Financial Strategy including Recovery Plan to be agreed.

Actions planned	**Expected outcome**		**Owner**	**Timescale**	**Rating**
	Likelihood	**Impact**			
Conclude 24-25 contracts	Reduce	Reduce	Claire Wilson	31/07/24	**On Track**
Develop Medium Term Financial Strategy including Financial Recovery Plan	Reduce	Reduce	Claire Wilson	30/09/24	**Problematic**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
ICB Board approval of Medium Term Financial Strategy	September 24		**Partial**
System Financial Report to ICB Board	Bi-monthly		
NHSE ICB Assessment	Annual (July)		
Gaps in assurance			
ICS Medium Term Financial Strategy including Recovery Plan yet to be agreed			

Actions planned	Owner	Timescale	Rating
Secure approval to Medium Term Financial Strategy	Claire Wilson	30/09/24	**On Track**

ID No: P8	Risk Title: The ICB is unable to resolve current provider service sustainability issues resulting in poorer outcomes for the population due to loss of services
Risk Description (max 100 words)	There are significant service sustainability challenges across the Cheshire and Merseyside system, including significant clinical risk and challenges identified by the Liverpool Clinical Services Review, and Trusts at SOF3, and a number of fragile hospital and other services across C&M. This risk concerns the potential inability to maintain services in their current configuration and inability to deliver the necessary transformational business cases in relation to our most challenged services.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard Jones	Fiona Lemmens	Medical	Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity and Value for Money	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	25/06/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3				3	31/03/25	The ICB has a low appetite for risk that impacts on patient outcomes. Our longer-term ambition is to moderate to (2x3=6) level of risk but will only be achievable over 2-3 years.
Impact	4	4				4		
Risk Score	16	12				12		
Rationale for score & progress in quarter (max 300 words)	There is potential for major effect on quality of clinical care and non-compliance with national standards posing significant risk to patients, and significant impact on trust and confidence of stakeholders (impact 4). Current controls are maintaining the likelihood at possible (3). Strategic transformation programmes have been established to address service sustainability issues and work will continue to develop case for change and consultation proposals during 2024-25 but are not expected to be complete or impact on the risk level until 2025-26 and beyond.							

Current Key Controls		Rating
Policies	NHSE Major Service Change Guidance, NHSE Standard Operating Framework	**G**
Processes	NHSE Major Service Change Process	**G**
Plans	C&M Clinical Improvement Hub and NHS Impact programme, Liverpool Place provider collaboration on urgent care pathways, CMAST Clinical Pathways Programme, Shaping Care Together Programme in Sefton Place, ECT/Stockport Foundation Trust (SFT) Programme in East Cheshire Place, Women's Services Programme in Liverpool Place	**A**
Contracts	Provider contracts held at Place. NHSE Specialist Commissioning Contracts held at NHSE region	**A**
Reporting	Provider Boards and internal governance arrangements, Programme Boards, Liverpool Provider Joint Committees, ICB Women's Services Committee, ICB Strategy & Transformation Committee, ICB Board	**A**

Gaps in control
Progression through business case development, consultation and approval of key strategic transformation programmes is required to improve controls

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Continuous Improvement Approach	Maintain	Maintain	Fiona Lemmens	2024-25	**On Track**
Oversight of Shaping Care Together Programme delivery and milestones	Maintain	Maintain	Deb Butcher, Fiona Lemmens, Clare Watson	2024-25	**On Track**
Oversight of ECT Sustainable Hospitals Programme delivery and milestones	Maintain	Maintain	Mark Wilkinson, Fiona Lemmens, Clare Watson	2024-25	**On Track**
Oversight of Liverpool Clinical Services Review Programme delivery and milestones	Maintain	Maintain	Mark Bakewell	2024-25	**On Track**
Oversight of Womens Services in Liverpool Programme delivery and milestones	Maintain	Maintain	Fiona Lemmens, Chris Douglas	2024-25	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Continuous Improvement updates to ICB Executives Committee	Bi-monthly?		**Partial Assurance**
Shaping Care Together Programme Board updates to Strategy & Transformation Committee	Bi-monthly		
ECT Sustainable Hospitals Programme Board updates to Strategy & Transformation Committee	Bi-monthly		
LCSR Programme updates to One Liverpool Board and Strategy & Transformation Committee	TBC		
Womens Services in Liverpool Programme updates to ICB Women's Services Committee	Quarterly		
Recovery Programme delivery reporting to Recovery Committee & ICB Board	Monthly & Bi-monthly		

Gaps in assurance
Issues in relation to affordability and timescales will need to be addressed in pre consultation business cases for key programmes. The impact of the current ICB financial situation and associated planning processes on the various transformation processes remains uncertain.

Actions planned	Owner	Timescale	Rating
Shaping Care Together case for change	Deb Butcher, Fiona Lemmens, Clare Watson	March 25	**On Track**
All other programmes - oversight and assurance of milestone progress and development of pre-consultation business cases	Mark Bakewell, Mark Wilkinson, Fiona Lemmens, Clare Watson, Chris Douglas	Beyond 2024-25	**On Track**

ID No: P9	Risk Title: Unable to retain, develop and recruit staff to the ICS workforce reflective of our population and with the skills and experience required to deliver the strategic objectives
Risk Description (max 100 words)	Ensuring that we have a workforce with the necessary skills and experience, and that is reflective of our local population, is essential to the delivery of our strategic objectives. The C&M system has significant workforce challenges including recruitment, retention and sickness absence.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Samosa	Sarah Smith	Nursing & Care	Finance, Investment & Our Resources

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Quality, Productivity & Value for Money	Workforce	B – within financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	25/06/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	4				3	31/03/25	Our longer-term ambition is to moderate to a (2x3=6) level of risk but will only be achievable over 2-3 years due to resource allocation and capacity.
Impact	4	4				4		
Risk Score	16	16				12		
Rationale for score & progress in quarter (max 300 words)	There is potential for a major effect on quality of clinical care and significant financial loss (impact 4). Current controls are maintaining the likelihood at likely (4). Workforce Recovery Programme, supporting the implementation of the C&M Workforce Plan in 2024-25, is focused on identifying opportunities to optimise our resources to support a reduction in workforce costs whilst not compromising quality of care and the patient experience. Financial constraints have limited ability to increase workforce planning capacity but realignment of existing Peoples Team resources will enable a more limited work programme in the short term. Based on planned actions, it is anticipated that a reduction to likelihood to possible (3) will be achieved by year-end with further reductions over a 2-3 year period.							

Current Key Controls		Rating
Policies	Provider Recruitment & Selection, Apprenticeship, Retention Strategies.	**A**
Processes	Organisational development, workforce planning, PDR, training & development, communication & engagement, recruitment, demographic profiling, international recruitment, apprenticeship levy, C&M retention forum, NHSE/HEI supply data	**A**
Plans	C&M People Plan, NHS People Promise, provider workforce plans	**A**
Contracts	TRAC, ESR, Occupational Health, Payroll, EAP	**G**
Reporting	WRES, WDES, Staff survey, reporting to People Board. System workforce dashboard (manual).	**A**

Gaps in control

Financial constraints have limited / deferred investment in workforce development capacity
While manual System Workforce dashboard has been developed, need still exists for broader automated options.
Limited maturity of collaborative working at system level
Inconsistent workforce planning process/methodology across the system
Insufficient links to educational institutions and local authorities
Technology and inconsistent use of workforce systems across the region (ESR, ERoster, TRAC, NHS jobs, OH system)

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Develop and enhance workforce planning capabilities across the system	Reduce	Maintain	Emma Hood	30/09/24	**Problematic**
Scaling of Peoples Services	Reduce	Maintain	Sarah Smith	TBC?	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Integrated Quality & Performance Reports to ICB Board	Bi-monthly	30/5/24	**Partial Assurance**
System workforce reporting to People Board	Quarterly		
NHS Equality Diversity and Inclusion Improvement Plan updates	Quarterly		
WRES & WDES reporting	Annual		
CQC Well Led review	Annual		
Gaps in assurance			
CQC approach to assessing integrated care systems is still evolving.			

Actions planned	Owner	Timescale	Rating
Respond to CQC framework	Clare Watson	2024/25	**On Track**

ID No: P10	Risk Title: ICS focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of our population
Risk Description (max 100 words)	Delivery of our shared aims, strategy and 5-year plan is dependent on collective ownership and collaborative effort by communities and organisations across Cheshire & Merseyside. The ICB has a key role in system leadership and promoting greater collaboration across the NHS and with local partners. This risk relates to the potential that focus on responding to current service priorities and demands diverts resource and attention from delivery of longer-term initiatives in the HCP Strategy and ICB 5-year strategy on behalf of the population.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Graham Urwin	Clare Watson	Assistant Chief Executive	ICB Executive

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Helping the NHS to support broader social & economic development	Transformation	C – beyond financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
13/02/23	01/07/2024	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	4	3				3	Achieved	Interim target score achieved based on what is feasible for 2024/25. Our longer-term aim is to limit to a moderate level of risk, but this is unlikely before 2025/26.
Impact	4	3				3		
Risk Score	16	9				9		

Rationale for score & progress in quarter (max 300 words)	The current national and local quality, safety, performance and financial pressures during the post COVID recovery period gives rise to potential for significant reduction in health outcomes and/or life expectancy and significant increase in health inequality gap in deprived areas or socially excluded groups, criticism or intervention by NHSE and significant impact on trust and confidence of stakeholders (impact 4). This is mitigated by a refreshed Joint Forward Plan which includes a focus on urgent care and financial recovery during 24/25 which also need to reflect impacts on Core20+5 populations and our strategic ambitions. In addition a revised HCP Strategy is due to be implemented in summer 2024 which aligns the HCP to the All Together Fairer plan to address health inequalities. In support of this a delivery plan is being developed and plan for investment into health inequalities is presented to the Health and Care Partnership in July 2024 with a focus on smoking, healthy weight and housing, building on previous commitments, for example children and young people schemes. It is

	recognised that in the short term the level of resources available for this wider focus on longer term population health investments is constrained and may limit further progress in reducing this risk during the current financial year.

Current Key Controls		Rating
Policies	Constitution & membership of ICB Board & HCP, Public Engagement / Empowerment Framework, Prioritisation Framework.	**G**
Processes	Strategic planning, communication & engagement, programme & project management, culture & organisational development, Provider Collaboratives, C&M and sub-regional networks	**G**
Plans	HCP Refreshed Strategy, Joint 5-year Forward Plan, Joint Health & Wellbeing Strategies x 9 places, Operational Plan, Communications & Engagement Plan, Provider Collaborative Business Plans, Financial Plan.	**A**
Contracts	MOU with NHSE for system oversight is in development	**A**
Reporting	C&M HCP Partnership Board, Place-based partnership boards & H&WB Boards, ICB Board	**G**

Gaps in control

An interim HCP Strategy has been in place since January 2024, and is to be replaced with a refocussed and updated HCP Strategy 2024-2029 in summer 2024. Alongside this is the Joint Forward Plan which will incorporate a delivery plan for the HCP revised Strategy.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Refocus HCP Strategy 2024-2029 aligned to 'All Together Fairer'	Maintain	Maintain	Neil Evans & Ian Ashworth	30/08/24	**On Track**
Complete JFP 2024-29 *(delayed Board approval until post General Election)*	Maintain	Maintain	Neil Evans	31/07/24	**On Track**
Develop an update to propose a refreshed ICB operating model	Maintain	Maintain	Clare Watson	30/11/2024	**On Track**
Identify ICB health inequalities funding that will be overseen by the HCP Committee to support delivery of Marmot the C&M All Together Fairer strategy and ambitions. To be presented to July HCP Meeting	Maintain	Maintain	Ian Ashworth	31/07/24	**On Track**

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Assurance Rating**
Approval of updated HCP Strategy (To be approved by HCP – August) & Joint Forward Plan 2024-29 (ICB Board - July)	July 2024		**Acceptable Assurance**
Reporting on progress of delivery plans during 2024-25 (ICB Board and delegated Board Committee)	In line with delivery dates in plan		
Joint Overview & Scrutiny of HCP Strategy and Joint Forward Plan	As required		
NHSE Systems Oversight Framework	Quarterly Review with NHS England		
Gaps in assurance			
JFP requires annual refresh and needs to reflect both short and longer term (five year) description of ICB priorities.			

Actions planned	Owner	Timescale	Rating
Seek approval to updated HCP Strategy and JFP	Clare Watson	31/08/24	**On Track**
Development of ICB Integrated Business Plan to describe delivery of Joint Forward Plan and ICB Corporate, Operational and Financial Planning priorities	Neil Evans	31/08/2024	**On Track**
Development of MOU with NHS England in relation to system oversight operating model	Clare Watson/Anthony Middleton	31/08/2024	**On Track**

ID No: P11	Risk Title: The ICB is unable to address inadequacies in the digital infrastructure and related resources leading to disruption of key clinical systems and the delivery of high quality, safe and effective health and care services across Cheshire and Merseyside.
Risk Description (max 100 words)	The ICB is responsible for leading ICS-wide cyber security. C&M is a complex system including the ICB, all 16 NHS providers, 349 GP practices and other related health and care services. Risks may arise from a Cyber security attack (either direct to one or more organisations or to one of their suppliers), lack of investment in resilient infrastructure and / or lack of appropriately skilled staffing. This could lead to possible financial and / or data loss, disruption to the delivery of patient care and/or damage to the reputation of one or more organisations in Cheshire and Merseyside.

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Rowan Pritchard-Jones	John Llewelyn	Medical	Strategy & Transformation

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequality, Improving Outcomes and Access to Services Enhancing quality, productivity and value for money	Transformation	B – within the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
27/6/24	02/07/24	15/10/24

	Inherent Score	Q1 Score	Q2 Score	Q3 Score	Q4 Score	Target Score	Target Date	Risk Appetite / Tolerance
Likelihood	5	4				4	31/3/25	The ICB has a low tolerance for risks impacting patient safety. The aim is to moderate to a (2x8) over two years as resources and capacity allow.
Impact	4	4				4		
Risk Score	20	16				16		

Rationale for score & progress in quarter (max 300 words)	There is the potential for patient harm, major effect on quality of clinical care, significant financial loss, significant loss of trust and confidence of stakeholders and adverse national media (impact 4). Current controls are sufficient to reduce the likelihood to likely (4). The possibility of a cyber-attack cannot be completely removed, and a residual risk will remain, but the implementation of the 5-Year Cheshire and Merseyside Cyber Security Strategy aims to reduce likelihood to unlikely (2) over the lifetime of the strategy. It is anticipated that limited investments possible in 2024-25 will maintain the risk at the current level.

Current Key Controls		**Rating**
Policies	IT Security Policy (individual IT Service providers and organisations); IT Umbrella Policy, NHS England's CareCERT process, National Cyber security policy for England, What Good Looks Like success criteria, technical & data architecture standards, IT policies, information governance policies.	**A**
Processes	Cyber security systems & processes, Security audits & penetration tests, Digital maturity assessment, DSPT assessment & submissions, Cyber Associates Network, ICB monitoring of system wide cyber security standards.	**A**
Plans	Digital and Data Strategy 2022-2025, Cyber Security strategy,Investment (280k) & delivery plan in 2024/25, Cyber incident / Business continuity plan	**A**
Contracts	Cyber security monitoring tools inc. IT Health and Cynerio, IT provider contracts, data sharing agreements	**A**
Reporting	Digital Services Delivery Board (ICB infrastructure only), Digital Transformation & Clinical Improvement Assurance Board, Strategy & Transformation Committee	**A**

Gaps in control
ICS / ICB Capacity and investment to respond to continuously evolving threat. Gaps in ICB cyber leadership (Head of Cyber Security) and out of hours response capacity. Lack of organisational & system level monitoring and reporting of standards, compliance & risks. Further work required to raise awareness and understanding of cyber security at Board level & for all staff.

Actions planned	Expected outcome		Owner	Timescale	Rating
	Likelihood	Impact			
Cyber Security training for ICB Board	Reduce	Maintain	RPJ / JL	TBC	On Track
Further desktop Cyber exercise	Reduce	Maintain	JL / SP / MIAA	30/09/24	On Track
Benchmarking BAF/digital/cyber risks and associated processes across all healthcare organisations in Cheshire and Merseyside	Reduce	Maintain	JL / SP / MIAA	30/09/24	On Track
Develop a process for the transparent governance of provider level risks	Reduce	Maintain	JL / SP / MIAA	30/09/24	On Track
Define clear incident management and support in major incidents with ICB providers	Maintain	Reduce	CTO	30/09/24	On Track
Scope options and define requirements for Cyber security delivery model	Reduce	Maintain	JL / SP / MIAA	31/12/24	On Track
Explore opportunities to improve collaboration and sharing of Cyber resource across the Cheshire and Merseyside system	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Investigate and conclude upon the need for third party incident response capacity creating a business case for investment if deemed appropriate.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Explore opportunity to standardize cyber tooling across C&M and procure at scale	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Analyse & map across C&M organisations, critical service/supply chain security assurances and gaps. Identify significant exposure points and report with recommended actions	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Work with ICB procurement & IG to create standard security and assurance procurement & contracts requirements & share across all organisations within the ICS.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
Undertake a skills survey across Digital teams within the ICS, analysing data to identify gaps in organisations and across the footprint and build out a training needs assessment based upon the outcomes.	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track
DSPT becomes aligned to Cyber assessment framework in 24/25	Reduce	Maintain	JL / SP / MIAA	31/03/25	On Track

To be completed for BAF risks and risks escalated to ICB Committees (rated high, extreme or critical)

Assurances available to lead committee and ICB Board			
Source	**Planned Date /Frequency**	**Date/s provided**	**Committee Rating**
Cyber dashboard reporting to Digital Services Delivery Board / S&T Committee / Board	Quarterly (from Sept 24)		**Partial**
S&T Committee and Board approval of ICS Cyber Security Strategy	March 2024	28/03/24	
Penetration testing – IT Providers and Trusts	Annual (March)		
Cyber Essentials accreditation – IT Providers and Trusts	Annual		
MIAA audit of DSPT in line with the mandated scope set out in the DSPT Independent Assessment Guide reported to Audit Committee	Annual	25/06/24	
2024-25 delivery plan progress reports	Quarterly (from Sept 24)		
Approval of delivery plans for future years.	Annual (April)		
Gaps in assurance			
No oversight of compliance with cyber security standards at organisation and system level across C&M Funded delivery plans beyond 2024-25 yet to be established			

Actions planned	Owner	Timescale	Rating
Develop cyber dashboard to provide oversight of compliance with key Cyber standards at organisation level	JL / SP / MIAA	30/09/24	**On Track**
Formalise Cyber risk reporting to the Board	JL / SP / MIAA	30/09/24	**On Track**
Review provider SLA's and existing Cyber investment to realign to requirements in the Cyber strategy.			

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

ICB Corporate Risk Register – Quarter One

Agenda Item No: ICB/07/24/23

Responsible Director: Clare Watson, Assistant Chief Executive

Corporate Risk Register – Quarter One

1. Purpose of the Report

1.1 The purpose of the report is to present the Corporate Risk Register (CRR) for review by the Board.

2. Executive Summary

2.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

2.2 There are currently 10 risks on the CRR at Appendix One, including five critical risks and five extreme risks. The most significant risks are:

- QU05 – Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm, currently rated as critical (20).
- QU09 – East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm, currently rated as critical (20).
- WSC7 – In relation to women's services, if patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely, currently rated as critical (20).
- F8 – Common risk across places in relation to cost pressures resulting in potential overspends and may impact on the ICB's ability to achieve its statutory financial duties, currently rated as critical (20).
- F9 – Common risk across places in relation to potential inability to deliver efficiency improvements and may impact on the ICB's ability to achieve its statutory financial duties, currently rated as critical (20).

2.3 Further details of the mitigation strategies are provided in section 9 and in the individual risk summaries at Appendix Four. All of the risks on the CRR have been subject to scrutiny and review by the relevant ICB Committee and further information is included in the highlight reports elsewhere on the agenda.

2.4 Since the last report to Board:

- The Board Assurance Framework has been refreshed for 2024-25, including a new BAF risk P11 in relation ICB leadership for system wide digital infrastructure. Subject to approval this will replace the operational risk 8DR, but 14DR in relation to the operational risk to the ICB will be retained.
- QU07 - Inadequate compliance with the CHC National Framework due to constrained market and workforce which leads to delays in assessment and unmet need has reduced from extreme (16) to high (12) and is proposed for de-escalation.

- There has been movement in the risk scores for some places as indicated in appendix 2.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **NOTE** the Corporate Risk Register, progress in completing mitigating actions, further action planned, and assurances provided; and consider any further action required by the Board to improve the level of assurance provided.

- **APPROVE** the closure of risk 8DR subject to approval of new BAF risk P11 and the de-escalation of risk QU07.

4. Reasons for Recommendations

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

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

5. Background

5.1 The ICB's Corporate Risk Register comprises those risks escalated from Committee and Directorate risk registers as having a current score of 15+.

5.2 The Corporate Risk Register is distinct from the BAF as it reflects the significant risks escalated up from across the organisation for the attention of the Board (bottom up). These require additional scrutiny and potentially cross organisational response by virtue of their potential to disrupt achievement of the ICB's strategic and operational objectives. The scale of the corporate risk register reflects the current risk environment and covers the full scope of

organisational activity. The BAF in contrast reflects a smaller number of principal risks (6-10) identified by the Board as the significant strategic challenges to delivery of the ICB's strategic objectives (top down).

5.3 The Corporate Risk Register has been compiled from current Committee and Directorate Risk Registers and provides an update on the reports presented to the Board in January and May 2024.

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

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

6.1 The CRR supports the objectives and priorities of the ICB through the identification and effective mitigation of the most significant risks across the organisation which, if realised, may impact on delivery.

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

7.1 The effective mitigation of the most significant risks across the organisation supports the achievement of the Annual Delivery Plan.

8. Link to meeting CQC ICS Themes and Quality Statements

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

8.1 The establishment of effective risk management systems is vital to the successful management of the ICB and local NHS system and is recognised as being fundamental in ensuring good governance. As such the CRR underpins all themes, but contributes particularly to leadership, specifically QS13 – governance, management, and sustainability.

9. Risks

9.1 There are currently 10 risks on the CRR, including five critical risks and five extreme risks. A summary of the current and proposed mitigations in respect of each risk is set out below with further detail provided in the individual risk summaries at Appendix Four.

9.1.1 **QU05 - Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm**, currently rated as critical (20). Risk score across the ICB remains at 20. Variation of scores across the 9 places are primarily due to changing demand across each local authority area (demand includes children, young people and adults). Work is being undertaken across Cheshire and Merseyside to further support this area. The SRO for the programme has been identified as the Place Director Cheshire West.

9.1.2 **QU09 - East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm,** currently rated as critical (20). Risk is specific to Cheshire East Place. Improvement plans are currently being developed between East Cheshire Trust and partners. Local ECT assurance meetings, supported by analytical data and report scrutiny, are established and running. Commissioner assurance being obtained through Clinical Quality Performance Meetings, with upward reports to be received into the Q&P Committee of the ICB. Actions planned to increase control have been completed or are now established as on-going control measures.

9.1.3 **WSC7 – In relation to women's services, if patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely**, currently rated as critical (20). Current controls include oversight by LMNS and local CQPGs and the Patient Safety Incidence Response Framework. Key further action is the clinical design work for medium and long term in the programme plan.

9.1.4 **F8 - Common risk across places in relation to cost pressures resulting in potential overspends and may impact on the ICB's ability to achieve its statutory financial duties**, currently rated as critical (20). Current controls include delegated budgets, budgetary control and expenditure approvals process and financial monitoring and reporting. Key further action is being taken to address cost pressures in relation to CHC and prescribing.

9.1.5 **F9 - Common risk across places in relation to potential inability to deliver efficiency improvements and may impact on the ICB's ability to achieve its statutory financial duties**, currently rated as critical (20). Current controls include financial recovery plans and efficiency schemes, programme and project management, monitoring, and reporting. Key

further actions planned include development of longer-term financial plans delivering recurrent efficiencies.

9.1.6 **QU08 - Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience**, currently rated as extreme (16). Risk score across the ICB has reduced from 25 down to 16. Plans to address gaps in controls have progressed, with work on-going to establish reporting dashboards to support assurance and oversight. ICB Business Intelligence Team have developed Power BI tools to facilitate this work and are now reporting a progress update whereby the Quality Dashboard is ready to be tested and, if successful, rolled out.

9.1.7 **PC1 - Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)**, currently rated as extreme (16). This is to be mitigated primarily through ICB and place level recovery plans and workforce plans, led by the Primary Care Workforce Steering Group.

9.1.8 **WSC3 - Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals**, currently rated as extreme (16). The C&M system is already financially challenged and therefore the risk score reflects that new expenditure and investment may not be possible in the current financial climate; this is as much about the wider availability of public sector capital as the C&M situation. A Finance and Estates Group is due to be established in June 2024 (as part of the emerging Programme governance and reporting arrangements). Further actions include baseline mapping to support the design phase and finance and estates modelling to support the options development – the latter action has a longer-term timescale of November 2024 – January 2025.

9.1.9 **WSC4 - If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north-west region**, currently rated as extreme (15). A 'Clinical Leaders Group (CLG)' has been established to support the programme board. is expected to be in place by autumn 2024. The CLG will lead the model of care work on behalf of Programme Board, with Specialised Commissioning and Clinical Network Leads also involved in the design work. Capital and revenue implications of the future model of care, interim model of care and counterfactual case are to be formulated by the Finance and Estates Group from by winter 2024.

9.1.10 **14DR - There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / data loss, disruption to services and patient care and/or**

damage to the reputation of the organisation, currently rated as extreme (16). Current controls include a range of cyber security software systems and associated processes to detect and prevent potential attacks. As described above (8DR) a Cyber Security Strategy has been developed.

9.2 All committees and sub-committees of the ICB are responsible for ensuring that risks associated with their areas of responsibility are identified, reflected in the relevant corporate and / or place risk registers, and effectively managed. Each of these risks has been scrutinised and reviewed by the relevant ICB Committee. Risks considered and actions / decisions taken are detailed in the highlight reports elsewhere on the agenda. Sources of assurance in relation to key controls are summarised in appendix three and detailed in the individual risk summaries in appendix four.

10. Finance

10.1 There are no financial implications arising directly from the recommendations of the report. However, the report does include financial risks F8 and F9, which are described in section 9 above and detailed in the appendices.

11. Communication and Engagement

11.1 No patient and public engagement has been undertaken.

12. Equality, Diversity and Inclusion

12.1 Risks QU05, PC1, WSC3, WSC4 and WSC7 and have the potential to impact on equality, diversity and inclusion in service delivery, outcomes, or employment. The mitigations in place and planned are described in more detail in the risk summaries at appendix three.

11.2 Risks QU09, QU08 and PC1 have the potential to impact on health inequalities. The mitigations in place and planned are described in more detail in the risk summaries at appendix four.

13. Climate Change / Sustainability

13.1 There are no risks currently on the CRR which impact on the delivery of the Green Plan / Net Zero obligations, but there is a risk ‘in the pipeline’ which, subject to review by the Transformation Committee, will meet the criteria for escalation.

14. Next Steps and Responsible Person to take forward

14.1 Senior responsible leads and operational leads for each risk will continue to develop and improve the controls in line with the targets and progress the mitigation actions described in section 9 and in the individual risk summaries at appendix three. Updates will be provided through the regular CRR report to the Board.

12. Officer contact details for more information

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

13. Appendices

Appendix One: Corporate Risk Register
Appendix Two: Place Risk Distribution
Appendix Three: Risk Assurance Map
Appendix Four: Risk Summaries

Appendix One

Corporate Risk Register – July 2024

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
Assistant Chief Executive Directorate								
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)	Primary Care	Clare Watson	**16**	**16**	**16**	9	A – Within current quarter
Finance Directorate								
WSC3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	Women's Services	Claire Wilson	**16**	**16**	**16**	8	C – Beyond financial year
F8	Common risk across places in relation to cost pressures resulting in potential overspends and may impact on the ICB's ability to achieve its statutory financial duties	Finance, Investment & Our Resources	Place Directors	**25**	**20**	**20**	12?	B – Within financial year
F9	Common risk across places in relation to potential inability to deliver efficiency improvements and may impact on the ICB's ability to achieve its statutory financial duties	Finance, Investment & Our Resources	Place Directors	**25**	**20**	**20**	12?	B – Within financial year
Medical								
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm.	Quality & Performance	Rowan Pritchard-Jones	**20**	**20**	**20**	10	A – Within current quarter
8DR	A cyber-attack on individual organisations and / or multi organisation systems may compromise availability or integrity of IT and information systems	Strategy & Transformation Committee	John Llewellyn	**20**	**16**	**16**	8	A – within the next quarter

Risk ID	Risk Title	Committee	Senior Responsible Owner	Inherent Risk Score (LxI)	Current Risk Score (LxI)	Previous Risk Score (LxI)	Target Score	Risk Proximity
	which would severely impact the ability to deliver safe, high quality patient care **PROPOSE REPLACED BY BAF RISK P11**							
14DR	There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	Strategy & Transformation Committee	John Llewellyn	**16**	**16**	**16**	12	A – within the next quarter
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	Women's Services	Christine Douglas	**15**	**15**	**15**	10	C – Beyond financial year
Nursing and Care								
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	Quality & Performance	Christine Douglas	**20**	**20**	**20**	8	A – Within current quarter
QU07	Inadequate compliance with the CHC National Framework due to constrained market and workforce which leads to delays in assessment and unmet need **FOR DE-ESCALATION**	Quality & Performance	Christine Douglas	**16**	**12**	**16**	8	A – Within current quarter
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	Quality & Performance	Christine Douglas	**25**	**16**	**16**	10	A – Within current quarter
WSC7	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	Women's Services	Christine Douglas	**20**	**20**	**20**	8	A – Within current quarter

Appendix Two
Place Risk Distribution – July 2024

Risk ID	Risk Title	Current Risk Score									
		ICB Wide	Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
F8	Cost pressures resulting in potential overspends and may impact on the ICB's ability to achieve its statutory financial duties	20	20	20	10↓	10	10 (New)	16↑	10	N/A	12↓
F9	Potential inability to deliver efficiency improvements and may impact on the ICB's ability to achieve its statutory financial duties	20	20	20	10 (New)	12	10↓	16 (New)	12↓	6↓	N/A
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	16	12↓	12↑	8	16	12↓	16↑	16↓	20↑
QU08	Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience	16	8↓	8↓	12	15↓	16	16	6↓	9↓	16↑
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm	20	20	N/A							

NHS
Cheshire and Merseyside

Appendix Three

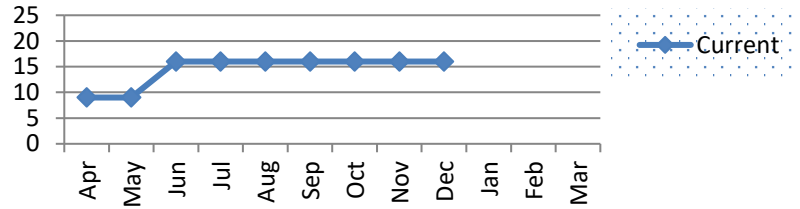
Corporate Risk Register – Risk Assurance Map – July 2024

Risk ID	Risk Title	Current Risk Score	Controls					Assurances			
			Policies	Processes	Plans	Contracts	Reporting	1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
PC1	Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)	16	G	G	A	G	G	Place contract oversight – ***In place***	System pressures updates to Primary Care Committee – ***In place*** Primary Care Workforce Steering Group – ***In place***		**Reasonable**
WSC3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool, combined with revenue implications, will negatively impact on the successful delivery of proposals.	16	G	G	G	G	G	Programme management oversight		Independent financial economic modelling - ***Planned***	**Substantial**
QU09	East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm	20	G	G	G	A	G	Regular reporting/ updates to CQPM Bi-monthly SHMI quality improvement meetings	Reporting to Quality & Performance Committee – ***Planned***		

Risk ID	Risk Title	Current Risk Score	Controls					Assurances			
			Policies	Processes	Plans	Contracts	Reporting	1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
14DR	There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation	16					G	Management oversight of IT provider delivery DSPT plan delivery & oversight		National secure email accreditation – ***In place*** DSPT Audit – ***Planned*** Penetration testing - ***Planned***	**Substantial**
WSC4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the north west region	15	G	G	G	G	G	Programme management oversight	Independent clinical senate to review case for change, model of care, options appraisal and business case - ***Planned***	NHSE Service Change Assurance **-** ***Planned***	**Substantial**
QU05	Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm	20	A	G	A	R	A		Key issues reporting to Quality & Performance Committee – ***In place***		**Reasonable**
QU08	Reduced standards of care across all sectors due to	16	A	A	A	A	A		Reporting to Quality & Performance		**Reasonable**

Risk ID	Risk Title	Current Risk Score	Controls					Assurances			
			Policies	Processes	Plans	Contracts	Reporting	1st line of defence	2nd line of defence	3rd line of defence	Assurance Rating
	insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience								Committee – ***In Place***		
WSC7	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely	**20**	**G**	**G**	**G**	**G**	**G**				**Substantial**

Appendix Four
Risk Summaries

ID No: PC1	Risk Title Sustainability and Resilience of Primary Care workforce (General Practice, Community Pharmacy & Dental Services)			
	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	3	16	
Current Risk Score	3	4	16	
Risk Appetite/Target Risk Score	1	3	9	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christopher Leese, Associate Director of Primary Care/ Tom Knight, Head of Primary Care	Place Primary Care Leads ICB PC Manager (JJ) Senior Commissioning Mgr (LD)	Assistant Chief Executive/ Place Primary Care Structures	System Primary Care Committee Report to Finance Committee

Strategic Objective	Function	Risk Proximity	ICB Executive	ICB Executive
	Quality, performance, transformation, commissioning.	A– Within current quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
01/07/2022* *Legacy CCG Risk*	01/07/24	10/10/24

Risk Description
Resilience and sustainability of Primary Care in terms of demand, workforce pressure and external factors such as industrial action, peaks in public concern such as (A Strep). Almost all previous CCG risk registers for Primary Care had a variation of this risk for GPs on their risk

register; which has been further expanded in April 2023 to include similar pressures across Community Pharmacy and General Dental Service provision. National issue and risk contractual performance is reduced as GPs, dental practices and Pharmacies struggle to recruit suitably qualified and experienced staff. Workforce pressures impacting on opening hours and access to services. Individual examples of place based practice resilience and operational concerns should be captured on local place risk registers, but this combined issue needs capturing on the overall corporate ICB risk register so that there can be assurances in respect of the overall resilience and sustainability of primary care – and that enabling factors should as workforce are included.
At **June 2023**: This risk has been **increased** to reflect the ongoing pressures in general across Community Pharmacy, Dental and General Practice, where a lack of key trained primary professional staff, in particular GPs, Pharmacists and Dentists (in the NHS family) is causing issues. This increase follows further discussions at both the System Primary Care Committee in April and the new Primary Care Workforce Steering Group in May, and reflects a number of place-level related risks across C&M.

Linked Operational Risks	

Current Controls		**Rating**
Policies	National Stocktakes and Guidance in relation to Primary Care Delivery Plan for recovering access to Primary Care https://www.england.nhs.uk/publication/delivery-plan-for-recovering-access-to-primary-care/	G
Processes	System Primary Care Committee Managed operationally at place level through place structures/ governance. Escalation to System PCC Working with National Team and DH on workforce issues and support. Primary Care Workforce Steering Group reporting	G
Plans	Primary Care Strategic Framework – ICB level and Place level Place workforce plans Clinical Strategy Workforce/ People plans via People Board inc Primary Care Workforce Strategy ICB engagement with HEE and Liverpool Dental School Dental Improvement Plan GP retention plan (submitted May 2023) ICB Access Recovery plan (to Board October)	A
Contracts	GMS PMS APMS GDS PDS Contracts updated Local Enhanced/Quality Contracts/ Directed Enhanced Services Community Pharmacy Contracts	G
Reporting	Primary Care workforce Steering Group/	G

	Community Pharmacy National Workforce Development Group NHSE National Teams (looking at wider workforce issues across Primary Care) Place reporting to place primary care structures/ forums Place reporting to System Primary Care Committee through reporting template already agreed noting a clearer risk principle escalation process is to be developed System Primary Care Committee reporting through to North West Regional Structures Reporting to PSRC Committee and through community pharmacy commissioning Team	

Gaps in control

Risk escalation process to be refined further between place and system – have all place got Integrated Workforce Groups
Reporting between People Board and SPCC to be developed
Consistent single set of data to be discussed at WSG and reported to People Board/ SPCC

Actions planned	Owner	Timescale	Progress Update
Risk escalation principles	PC Leads/ CL	January 2024	Place risk levels established and the risk summary to be updated to reflect distribution of risk across places and collaborative actions to mitigate
Primary Care Workforce Steering Group	JG/ CL	Complete	Established from May
Dental Improvement Plan workforce actions	TK	Ongoing	Improvement Plan submitted to SPCC June 23/ work underway Update to SPCC February 24 on Q4 23/24 progress and seek approval for new 24/25 plan
ICB PCARP response	CWatson	Ongoing	Programme board set up and meeting from June Primary Care Access Recovery Improvement Plan approved by ICB Board in November

Assurances

Planned	Actual	Rating
Closing BI data gaps for Workforce (Ongoing)	Regular updates at SPCC on System Pressures	G
	First meeting of PC workforce steering group held May 2023	G

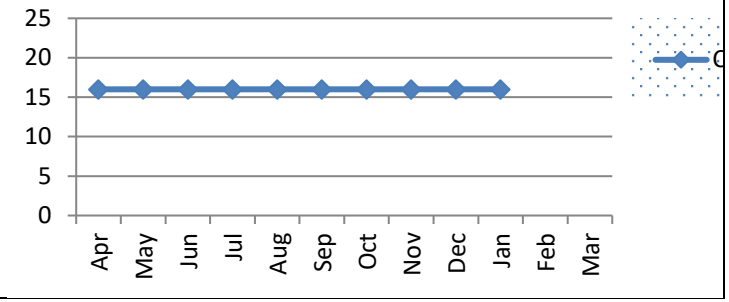
Gaps in assurance

Some BI data gaps remain

Actions planned	Owner	Timescale	Progress Update
Working with National Team and DH on workforce issues and support.	JJ	Ongoing	

Working locally with LPCs and contractors to understand & quantify issues and where required managing risk via contractual compliance routes/ local arbitration processes.	JJ	Ongoing	
Tracking the C&M risk against national and regional closure rates for comparison.	JJ	Ongoing	

ID No: WSC 3	Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool will negatively impact on the successful delivery of proposals.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Operational Lead	ICB Directorate	Responsible Committee
Claire Wilson	Frankie Morris / Jenny Hannon	Finance	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Enhancing Productivity and Value for Money	Finance	**C –** beyond the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	01/07/2024	06/10/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***

Failure to secure the required financial resources for the transformation of women's hospital services in Liverpool will negatively impact on the successful delivery of proposals. The appraisal of options will consider relative capital costs / revenue implications and the deliverability of proposals in this context. It is likely that all proposals will require a level of capital funding. In addition, a dedicated programme budget is required that will include the budget for key programme roles and involvement activities.

Current Controls		Rating
Policies	ICB SOs and SFIs	G
Processes	Finance and estates group to be established; applications for national capital if available; programme budgeting	G
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3-year delivery plan for maternity plan (2023); Involvement activity plan(s)	G
Contracts	N/A	G
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.	G

Gaps in control **[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]**

C&M system is already financially challenged – any new expenditure and investments may not be possible in the current financial climate.

Actions planned	Owner	Timescale	Progress Update
Agree programme budget / resourcing plan	CW / CP	Mar 24	
Establish finance and estates group	CW / JH	Jun 24	
Undertake baseline mapping to support design phase	CW / JH	Jul – Oct 24	
Undertake finance and estates modelling to support options development	CW / JH	Nov – Jan 25	

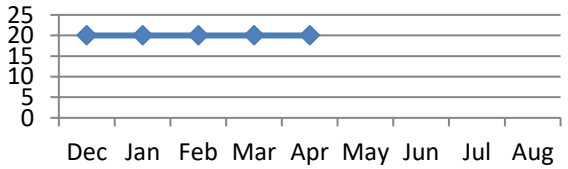
Assurances

Planned	Actual	Rating
Independent financial / economic modelling may be required to support the development and assessment of options – to be considered as part of programme budgeting		G

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

		Timescale	Progress Update

ID No: QU09	Risk Title: East Cheshire Trust Summary Hospital Mortality Index (SHMI) is above the expected range which could be an indicator of sub-optimal care of patients resulting in avoidable harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
20	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Medical Director - Rowan Pritchard- Jones	ADQSI – East Cheshire	Medical	Quality and Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/09/23	01/07/2024	Sept-2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]

The SHMI is the ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. A 'higher than expected' SHMI should not immediately be interpreted as indicating bad performance and instead should be viewed as a 'smoke alarm' which requires further investigation. SHMI is not a direct measure of quality of care and cannot be directly used to identify avoidable deaths, however, it may be an indication of poor quality of care which could lead to increased avoidable harm and avoidable deaths.		
Current Controls		**Rating**
Policies	Summary Hospital-level Mortality Indicator (SHMI) - Deaths associated with hospitalization, England, May 2022 to April 2023; National Guidance on learning from deaths, National Quality Board, 2017; Acutely ill adults in hospital: recognizing and responding to deterioration NICE clinical guideline (CG50); Acute Kidney injury: prevention, detection, and management NICE (NG148); Sepsis: recognition, diagnosis and early management NICE (NG51); Intravenous fluid therapy in adults in hospital NICE (CG174); Acute Hospital Discharge '100 day challenge', Letter David Sloman July 2022; Hospital discharge and community support guidance, NHS England, July 2022	**G**
Processes	Rapid Quality Review (RQR) and subgroups **(RQR stepped down and now moved to bimonthly SHMI Quality Improvement Meeting)**; Quarterly mortality reports to East Cheshire Trust (ECT) Safety and Quality standards committee and ECT Board; Contract Quality and performance Meeting (CQPM) to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee Quality leads meetings and Quality and Performance Assurance Group at Place; C2Ai monthly analytics and reports	**G**
Plans	CQPM workplan to ensure ongoing mortality/ SHMI reporting and oversight; ECT SHMI reduction action plan; ECT deteriorating patient group established; Winter Plan to support timely discharge and admission avoidance. SHMI driver diagrams and improvement plan	**G**
Contracts	NHS Cheshire and Merseyside ECT contract; Quality schedules- Mortality Reviews	**A**
Reporting	SHMI Quality Improvement Meeting reporting into NHS Cheshire and Merseyside Quality and Performance Committee; ECT reporting into Safety and Quality Standards Committee and ECT Board; Mortality and SHMI performance oversight through CQPM and Place Quality and Performance Assurance Group- escalations to NHS Cheshire and Merseyside Quality and Performance Committee made through Place Key Issues report	**G**
Gaps in control ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***		

QR SHMI Improvement Plan- developed and being refined. Driver diagrams now in place. These have been informed through work within the 'In hospital' and 'out of hospital' subgroups (which have now been stood down). Quality improvement work in ECT on hydration and deteriorating patient has started. Mortality Reviews/ Structured Judgement reviews (SJR) are being rolled out across medicine. Development of the SHMI dashboard is ongoing. Some assurance has been received around: coding of palliative care- this is being done in general practice. The analysis showed more work required to prevent dehydration of frail elderly and recognition and timely escalation of deteriorating patient. No care delivery issues identified with out of hospital care and support. The Trust regularly report to their board on learning from deaths. This is being strengthened as part of the improvement plan.

C2Ai data is now being reported monthly. Analysis and case review of people who die out of hospital within 30 days of discharge has been completed.

SHMI dashboard in development with ICB BI and Trust BI support.

Actions planned	Owner	Timescale	Progress Update
RQR SHMI Improvement Plan (in development)	John Hunter	December 2023	SHMI improvement plan in place. This has been supplemented by SHMI driver diagrams. Completed (updated Feb-24)
Subgroups to meet to complete analysis of issues and agree diagnostic actions	Paul Bishop/ John Hunter	November 2023	Review of people dying within 30 days of discharge has been completed. This showed no lapses of care and that most were expected to die. Areas for improvement around discharge planning (seen in two cases) is being followed with through Place quality leads meetings. Completed (updated Feb-24)
RQR meetings to continue until assurance that the issues are understood and agreement of the improvement plan	Rowan Pritchard-Jones	November 2023	It was agreed in November to close down the rapid quality review meetings and replace them with a SHMI quality improvement meeting which will meet bimonthly. The first meeting was held on 15th December 2023. Completed- now had 2 SHMI quality improvement meetings. Next meeting April 2024
Improvement plan to be developed	Amanda	Draft by September	As above: Improvement plan and driver diagrams completed. Ongoing review of progress to be through the

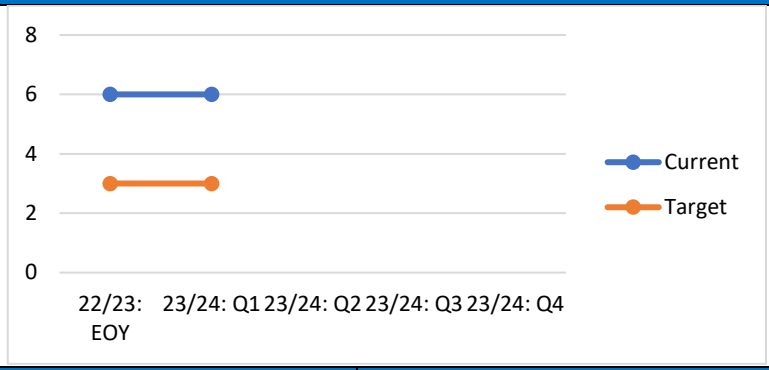
	Williams	Final by November 2023	SHMI Quality Improvement Meeting. Completed (updated Feb-24)
Quality improvement work around hydration and deteriorating patient to be progressed	Kate Daly-Brown	October 2023	Quality Improvement work agreed and commenced with medical wards. This is part of the SHMI Improvement Plan. Update provided at SHMI quality improvement meeting on 23rd Feb. Ward staff are actively engaged with quality improvement work.
Monthly data analysis/ scrutiny of report from C2Ai	John Hunter/ Rowan Prtichard-Jones	ongoing	Monthly reports are now being received, analysed and will inform the SHMI dashboard. Ongoing review monthly by Medical Director and John Hunter.
Case review of out of hospital deaths within 30 days of discharge	Paul Bishop	November 2023	Case reviews were completed and reported back to the RQR group in November 2023. Completed (updated Feb-24)
Peer review of mortality reviews in ECT	John Hunter	tbc	These are no longer required. Noted for removal (updated Feb-24)

Assurances		
Planned	**Actual**	**Rating**
Need a regular focus and report to NHS Cheshire and Merseyside Quality and Performance Committee- frequency to be agreed	SHMI quality improvement meetings bimonthly to monitor progress against improvement plan. Updates will inform reports to Quality and performance Committee.	
Ongoing oversight and scrutiny of improvement plan both within ECT and across the system at Place through CQPM	Regular reporting/ updates to CQPM, however, the oversight will be through SHMI quality improvement meetings until assurance of progress received.	

Gaps in assurance ***[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]***

Some assurance given around:
Mortality review process being embedded in all divisions.
Reporting of avoidable harm being routinely measured and reported (C2AI data)

Evidence of Quality Improvement methodology relating to fundamentals of care. However, ongoing oversight required until improvements seen.			
Actions planned	**Owner**	**Timescale**	**Progress Update**

ID No: 14DR	Risk Title: There is a risk of the ICB's critical information systems suffering a failure due to a cyber security attack leading to possible financial / Data loss, disruption to services and patient care and/or damage to the reputation of the organisation.			
	Likelihood	**Impact**	**Risk Score**	**Trend**
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	4	16	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	4	3	12	

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
John Llewellyn, Chief Digital Officer	Cathy Fox	Medical Directorate	Digital Transformation & Clinical Improvement Assurance Board/ Transformation Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Strategic Objective
TBC	Digital, transformation	**A** – within the next quarter	Corporate	TBC

Date Raised	Last Updated	Next Update Due
26/01/24	Febuary 2024	April 2024

Risk Description

Current Controls		Rating
Policies		
Processes	- Anti-virus software applied on network. - Appropriate firewall protection in place on network. - Robust patching process in place. - Organisation proxy server in place to minimise internet infiltration. - Data migrated to the Office 365 cloud is also subject to benchmarking security controls to review stored files and email attachments for malicious links and prevents emails from known spam and phishing campaigns. - Emails containing known phishing links are automatically quarantined via Office 365 and Dark Trace E-mail.	

	- Artificial Intelligence system Darktrace Antigena is also installed which is monitoring the infrastructure to detect nefarious activity. Darktrace is configured to automatically block (without human intervention) when high trust high + severity models have been breached. - All trust machines and servers are enrolled onto the national Microsoft defender for endpoint monitoring system.	
Plans	• Cyber Security Strategy progressing through governance approval process.	
Contracts		
Reporting		

Gaps in control
- Possibility of a cyber-attack cannot be completely removed; therefore, residual risk remains. - Whilst Cyber Security defences continuously evolve, organised and sophisticated cyber-attack groups constantly their attack tools, techniques, and processes. - Recurrent investment to maintain current controls. - Staff Awareness, lots of communications but not always read. - Trust board awareness of Cyber Risks. - Head of Cyber Security post held in vacancy control

Actions planned	**Owner**	**Timescale**	**Progress Update**
- Trust Board training	CF / SP	March 2024	Date to be agreed and scheduled.
- Multi Factor Authentication pilot complete and rollout being planned place for all Office 365 accounts.			

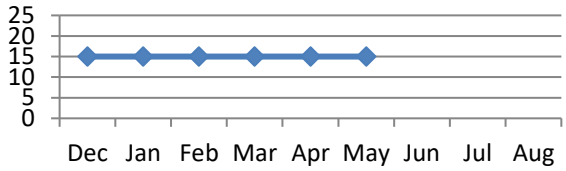
Assurances		
Planned	**Actual**	**Rating**
- Robust programme of security audits established. - Two IT providers have achieved Cyber Essentials +	- Robust programme of security audits established. Two IT providers have achieved Cyber Essentials + - need to check re MMDA	
- ICB e-mail address have been certified by the national secure email accreditation.	- ICB e-mail address have been certified by the national secure email accreditation.	

- Annual Penetration tests carried out by Digital to ensure network integrity. - Organisation has achieved “standards met” in national Data Protection Toolkit review. - IT Service providers IT Security teams are all members of the Cyber Associates Network for threat intelligence and cyber awareness updates. -	- Annual Penetration tests carried out by Digital to ensure network integrity. - Organisation has achieved “standards met” in national Data Protection Toolkit review. - I T Service providers IT Security teams are all members of the Cyber Associates Network for threat intelligence and cyber awareness updates.	

Gaps in assurance

Actions planned	Owner	Timescale	Progress Update

ID No: WSC 4	If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the North West region.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	3	5	15	
Current Risk Score	3	5	15	
Risk Appetite/Target Risk Score	2	5	10	

Senior Responsible Leads	Operational Leads	Directorate	Responsible Committee
Chris Douglas / James Sumner	Mandish Dhanjal / Lynn Greenhalgh / Fiona Lemmens	Medical	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in access, outcomes and experience; Improving Population Health and Healthcare	Medical	**C –** beyond the financial year	Principal	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	01/07/2024	06/010/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***

If the programme is unable to deliver an agreed a model of care, women's hospital services in Liverpool may not be able to meet clinical service specifications and could become clinically unsustainable leading to a loss of services; this could lead to further negative impacts on other providers across C&M and the North West region. Without an agreed clinical model of care that meets the required commissioning specifications, there is a risk that complex services requiring specialist multidisciplinary support may be de-commissioned or lost from Liverpool. For example LWHT already has to send pregnant women with complex cardiac conditions to Manchester for co-located specialist care, and may not be able to continue as the Maternal Medicine Centre for C&M without the required infrastructure, expertise and support. A

snowball effect may follow the loss of any complex obstetrics and gynaecology services from Liverpool due to the loss of reputation and consequent difficulties with recruitment and retention of senior medical staff. This could significantly affect higher risk obstetric services in Liverpool and would necessitate a region-wide clinical reconfiguration. Any major impact on obstetrics services in Liverpool would also create a higher residual level of risk for women experiencing acute emergencies.

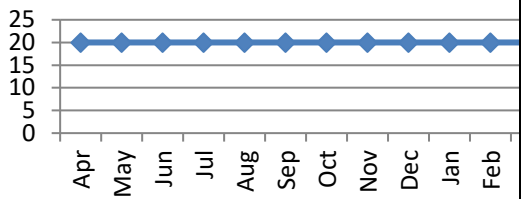
Current Controls		**Rating**
Policies		**G**
Processes	Establishment of Clinical Leaders Group and clinical engagement forum; NHSE Service Change Assurance Process	**G**
Plans	C&M Joint Forward Plan 2023-2028; NHSE 3 year delivery plan for maternity plan (2023)); Programme engagement plan(s)	**G**
Contracts	N/A	**G**
Reporting	Regular reports to the Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.	**G**
Gaps in control **[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]**		

Actions planned	**Owner**	**Timescale**	**Progress Update**
Clinical Leaders Group (CLG) to lead model of care work on behalf of programme board.	CLG	Autumn 24	
Specialised commissioning and clinical network leads to be involved in design	CLG	Autumn 24	
Finance, estates, workforce and digital workstreams to support model of care design and modelling work	CP	Autumn 24	
Capital and revenue implications of future model of care, interim model of care and counterfactual case (do nothing) to be worked up	Finance grp	Winter 24	
Support for strategic case from Liverpool and C&M NHS leaders to be sought	RJ / GU / JS	Winter 24	

Assurances		
Planned	**Actual**	**Rating**
• NHS Stage 1 Service Change Assurance – June 2024 • As required, independent clinical senate to review case for change, model of care, options appraisal and business case. • NHS Stage 2 Service Change Assurance – date TBC		**G**

Gaps in assurance *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*			
Timescale		**Progress Update**	

ID No: QU05	Risk Title: Need for neurodevelopmental (ASD/ADHD) assessments exceeds capacity leading to delays and unmet need resulting in patient harm

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	4	20	
Current Risk Score	5	4	20	
Risk Appetite/Target Risk Score	2	4	8	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
16	12	12	8	9	12	16	16	20

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lisa Ellis	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improve population health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2022	01/07/2024	04/10/2024

Risk Description *[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]*

ASD and ADHD services have suffered from demand outstripping capacity causing significantly long waiting times. There is a risk of harm due to the significant, adverse impact of long waiting times on children, young people and adults with suspected Autism and/or ADHD. The impact includes:

1. Crisis leading to poorer individual outcomes and avoidable acute and mental health hospital admissions.
2. Increased risk of self-harm and suicide (people with Autism are 16 times more likely die because of suicide than the general population

3. Poorer mental health and wellbeing outcomes and greater risk of school exclusion and family breakdown.
4. Perpetuating the risk of health inequalities for people with neurodevelopmental and other co-existing conditions including learning disabilities.

There is a financial risk due to the increased costs/ spend in the system due to the increasing demand. There is an increase in non-contract spend on private providers as more people seek access via Right to Choose and opt out of long NHS waiting lists.

Current Controls		Rating
Policies	Autism Assessment Framework; The assessment pathways for Autism and ADHD are governed by NICE Clinical Guidelines. Autism: CG128 (CYP) and CG142 (Adults) and ADHD: CG72; Transforming Care Programme.	**A**
Processes	CQPGs/ CQPMs to monitor performance of NHS commissioned services; Reports to Cheshire and Merseyside Quality and Performance Committee; Close working with Parent Carer Forums at Place - co-production. Performance reports presented to Quality and Performance Committee; Quality and Performance Groups at Place; LD focus area at Cheshire and Merseyside System Quality Group- April 2023; Quality schedules - long wait harm reviews	**G**
Plans	Cheshire Neurodevelopmental Clinical Network - strategic plans and implementing best practice; ASD/ ADHD included in SEND improvement plans at Place; Quality schedules - long wait harm reviews	**A**
Contracts		**R**
Reporting	Quality and Performance reported through: CQPG/ CQPM, Quality and Performance Groups at Place/ C&M Quality and Performance Committee, SEND/ LA reporting - SEND scorecards and dashboards at Place. Reporting from SEND Sub-Group to System Oversight Board (SOB)	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

C&M ICB Commissioners developing joint and strategic approach to commissioning for Autism and ADHD; No lead across C&M for ASD/ ADHD; Increased investment for both assessment and evidence-based support required - but difficult in current financial climate.

Actions planned	Owner	Timescale	Progress Update
Multiple strategic actions across health & education and to reduce waiting times.	TP Programme Leads/ Transformation ADQs		

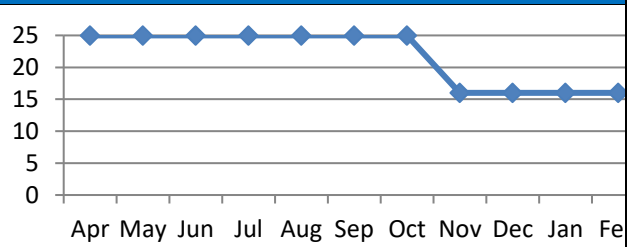
Assurances

Planned	Actual	Rating

NHSE Baseline assessment of demand, data, demographics etc.	Q&P key issues reporting- monthly standard agenda item	**A**

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]			
Quality & Performance Committee require regular reporting for oversight and assurance.			
Actions planned	**Owner**	**Timescale**	**Progress Update**
SEND Lead to provide focus report to Q&P Committee (frequency to be agreed)	Julie Hoodless	TBC	

ID No: QU08	Risk Title: Reduced standards of care across all sectors due to insufficient capacity and limited monitoring systems leading to avoidable harm and poor care experience

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	5	5	25	
Current Risk Score	4	4	16	
Risk Appetite/Target Risk Score	2	5	10	

Cheshire East	Cheshire West	Halton	Knowsley	Liverpool	Sefton	St Helens	Warrington	Wirral
8	9	12	15	16	16	6	9	16

Senior Responsible Lead	Operational Lead	Directorate	Responsible Committee
Christine Douglas	Lorna Quigley	Nursing and Care	Quality & Performance

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Improving Population Health	Quality	A – within next quarter	Corporate	Manage

Date Raised	Last Updated	Next Update Due
15/11/2023	01/07/2024	Sept-2024

Risk Description [Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]
Demographic issues aging population & global pandemic and underinvestment in workforce, latent harm through pandemic, increasing demand, capacity issues, retention issues due to stress / pressure, social care impact preventing flow out of Trusts, under investment social care, market forces, delays to follow ups.

Current Controls	Rating

Policies	Discharge Policy; UEC Standards; Long waits guidance; National FNC / CHC Framework; D2A guidance; SCC guidance, Fuller Report; PSIRF	**A**
Processes	C&M ICB SCC, Local harm review process, Incident reporting, pathways; Risk stratification; CQRM / CQPG at place;	**A**
Plans	Urgent Care Recovery Plan 2023; People Cell; Workforce Recruitment and Retention Programme (including international recruitment); Virtual Ward Expansion; Winter Plans; Local delivery of plans to mitigate workforce shortage.	**A**
Contracts	NHS Standard Contract; shortened version, individual patient contracts.	**A**
Reporting	System Quality Group; Quality Dashboard Reporting to Q&P Committee; Q&P Group at each 'Place'; Local Quality reporting mechanisms e.g. CQPG.	**A**

Gaps in control *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

Synthesis & consistency of policy into action; Maturity of processes and shift from 9 CCGs to single entity; Quality dashboard not fully established & inconsistency between places.

Actions planned	Owner	Timescale	Progress Update
Development of UEC patient safety principles for Trusts. Primary Care Quality forum being developed. Host commissioner arrangements to be strengthened	EW CW HM	Q1	Work on track to enable roll out and adoption across all Trusts. Preparatory work commenced. Process in place, to be implemented and tested.

Assurances

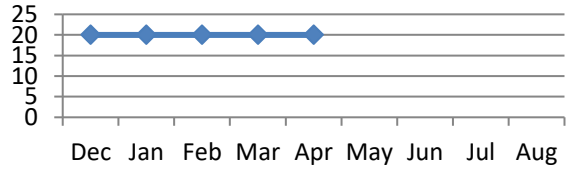
Planned	Actual	Rating
Oversight will be established ensuring consistency for providers		

Gaps in assurance *[areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]*

Data Gaps in relation to quality dashboards not fully established to give oversight of risks and issues.

Actions planned	Owner	Timescale	Progress Update
Further development of the quality dashboard	AM	Q2	

ID No: WSC6	If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely.

	Likelihood	Impact	Risk Score	Trend
Initial Risk Score *[assess on 5x5 scale, this is the score before any controls are applied]*	4	5	20	
Current Risk Score	4	5	20	
Risk Appetite/Target Risk Score	2	4	8	

Senior Responsible Lead	Senior Responsible Lead	ICB Directorate	Responsible Committee
Christine Douglas / James Sumner	Lynn Greenhalgh / Natalie Hudson / Oliver Zuzan	Nursing and Care	Women's Services Committee

Strategic Objective	Function	Risk Proximity	Risk Type	Risk Response
Tackling Health Inequalities in access, outcomes and experience Improving Population Health and Healthcare	Quality	A – within next quarter	Principal	Manage

Date Raised	Last Updated	Next Update Due
17/01/2024	01/07/2024	06/10/24

Risk Description ***[Description of risk and rationale for score – think about the cause, what this might lead to (the risk) and the consequences if this happens]***

If patient safety, quality risks and clinical issues in the current model of care cannot be sufficiently mitigated, avoidable patient harm and poorer patient outcomes are likely. The LWH/LUHFT Partnership Board joint risk register details several clinical quality and safety risks, some of which may not be sufficiently controlled or mitigated and could result in such adverse patient consequences. For example, there is a risk that acutely deteriorating women cannot be managed on site at Crown Street reliably. In addition, there is a risk that women presenting at other acute sites (e.g. A&E) or being treated for conditions unrelated to their pregnancy or gynaecological condition at other sites, do not get the holistic care they need.

These risks are driving the Women's Hospital Services Programme to find solutions that enable the long-term clinical sustainability of these services, as well as identifying short and medium term solutions to reduce clinical safety and quality risks and support the stability of services.

Current Controls		Rating
Policies	Patient Safety Incidence Response Framework (PSIRF)	G
Processes	LUHFT / LWFT individual boards and Partnership Board oversight of clinical risks / issues. Local CQPGs and Quality forums; LMNS ICB monitors and oversees safety ambition trajectories and outlier status of providers	G
Plans	LWFT Improvement Plan	G
Contracts	Standard NHS Contract; Specialised services contracts; NHSE Maternal Medicine Network Centre contract.	G
Reporting	Reporting to System Oversight Group, Programme Board, WSC, Provider Trust Boards (LWFT, LUHFT, AHCFT, CCCFT) and Liverpool Joint Committee.. Exception reporting to NHS C&M ICB.	G

Gaps in control [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

Actions planned	Owner	Timescale	Progress Update
Deliver LWFT improvement plan that includes short term actions and mitigations.	JS	From Feb 24	LWFT Trust Board, System Oversight Group, Programme Board and WSC have had updates. Programme Board SRO report to go to all key stakeholders in March.
Clinical design work for medium and long term in programme plan for autumn.	CP	Autumn	
Health inequalities in outcomes to be a key factor in design work.	CP	Autumn	
Insights from hard-to-reach groups and equalities groups to be reflected in design work.	CP	Autumn	

Assurances

Planned	Actual	Rating
	Plan for short term mitigations of safety and quality risks in place and being managed by LWFT and the LWFT / LUHFT Partnership Board.	G

Gaps in assurance [areas where controls are not in place or are not effective, or where we cannot be assured of their effectiveness]

		Timescale	Progress Update

NHS
Cheshire and Merseyside

Meeting of the of the Board of NHS Cheshire and Merseyside

25 July 2024

Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative Annual Work Plan

Agenda Item No: ICB/07/24/24

Responsible Director: Graham Urwin,

CMAST Annual Work Plan

1. Purpose of the Report

1.1 This report is the Annual Work Plan of the Cheshire and Merseyside Acute and Specialist Trusts Provider Collaborative (CMAST). It is provided to the ICB for discussion and to support transparency and endorsement.

1.2 The document is a product of the membership's work and endorsed by our Leadership Board. Our objectives remain consistent, our priorities and projected outputs form an integral part of the ICS' delivery plan and have come from our programme structures, which include and involve a wide range of stakeholders including Place, primary care and the ICB.

1.3 The sharing of this work plan with the ICB will be supplemented, on the day, by a presentation which will aim to detail a number of our successes, challenges and current system contributions.

2. Executive Summary

2.1 CMAST is a membership organisation and operates on the basis of an established programme structure. Our vision and priorities have been shared and explored with the ICB previously and during the last year have been reviewed and validated by our Leadership Board. Our current programmes deliver in a number of critical and complex areas: elective recovery and transformation; diagnostics recovery and transformation; clinical pathways; and efficiency at scale.

2.2 Our programmes form an integral part of the system plan and deliverables. We aim to play a full and engaged role in system plans, initiatives and commitments. As such the majority of our plans are well known and understood to the ICB operationally. Nevertheless, it is important for CMAST to present this information to the ICB and for the Board to have clarity on the activities being undertaken and an opportunity to explore any areas of interest.

2.3 It should be noted that CMAST hosts a number of programmes on behalf of the whole Integrated Care System (ICS) and therefore all providers. These programmes are our efficiency at scale and our diagnostics programmes.

2.4 CMAST Trusts are part of the ICS as well as this provider collaborative. The work detailed within the Annual Work Plan is part of the Trusts' combined contribution to the system. It is additive and above and beyond pre-existing system commitments and contributions, individual cost improvement programmes and actions and commitments to wider partners and through Place.

2.5 Our Annual Work Plan (Appendix One) is built up from and based upon a significant amount of detail and is supported by objectives, goals and deliverables, including metrics, from each programme. Some of this detail is not contained within the Annual Work Plan but is available as an appendix (upon request). We have taken this decision following a review of approaches with our peers across the north of England who have similarly recognised the value of developing a report that can connect with a variety of audiences ranging from the general public to our ICB and partners.

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- review the Annual Work Plan and provide any comment
- note the scale, breadth and alignment of the CMAST commitments with ICB priorities
- endorse the programme of work

4. Reasons for Recommendations

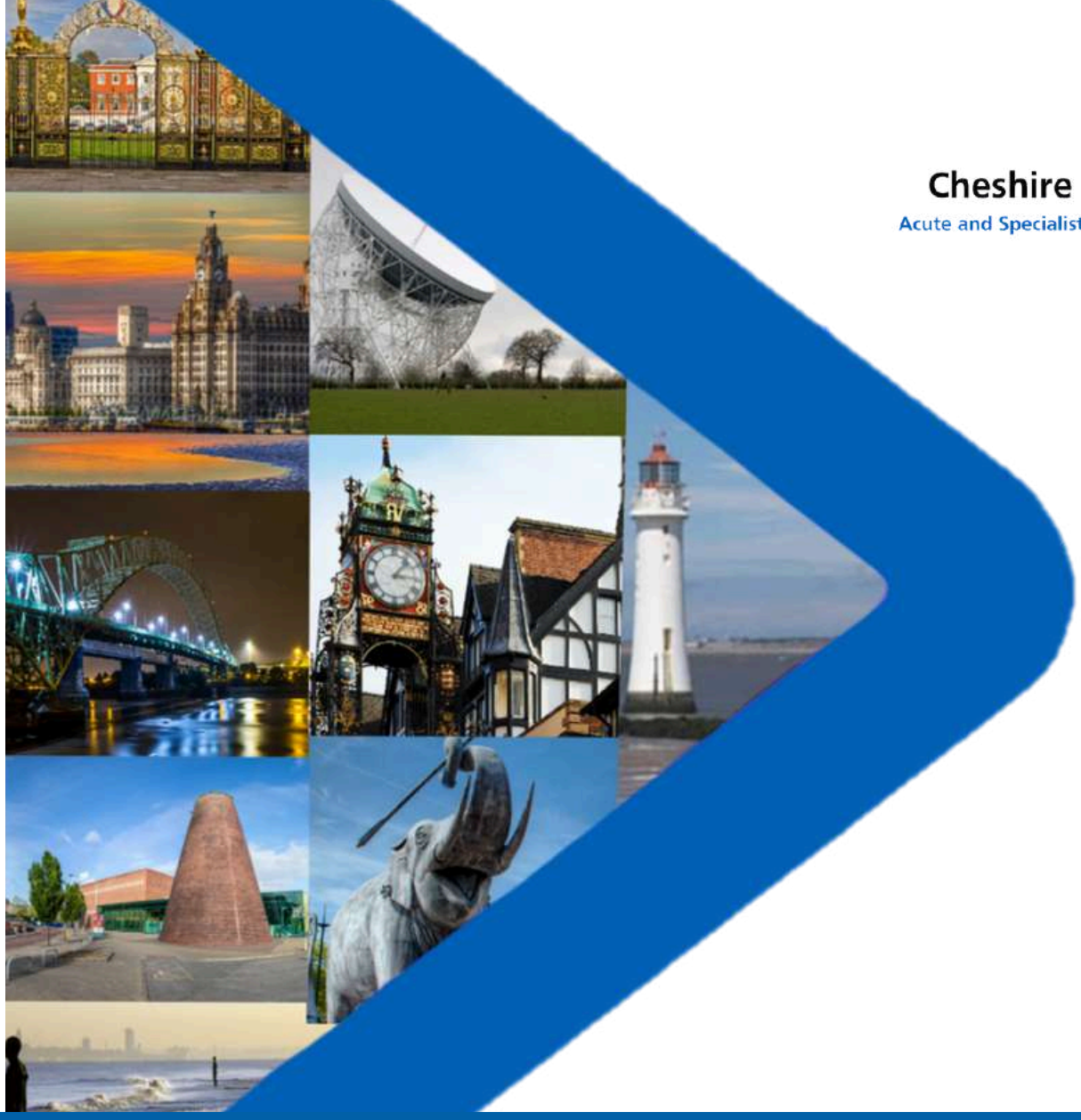
4.1 Our programmes form an integral part of the system plan and deliverables. It is important that both our commitments and contribution are recorded and acknowledged.

5. Officer contact details for more information

- Ann Marr – CEO MWL NHS Trust, CMAST Chair and ICB Board Member
- Linda Buckley – CMAST Managing Director

6. Appendices

Appendix One: CMAST Annual Work Plan



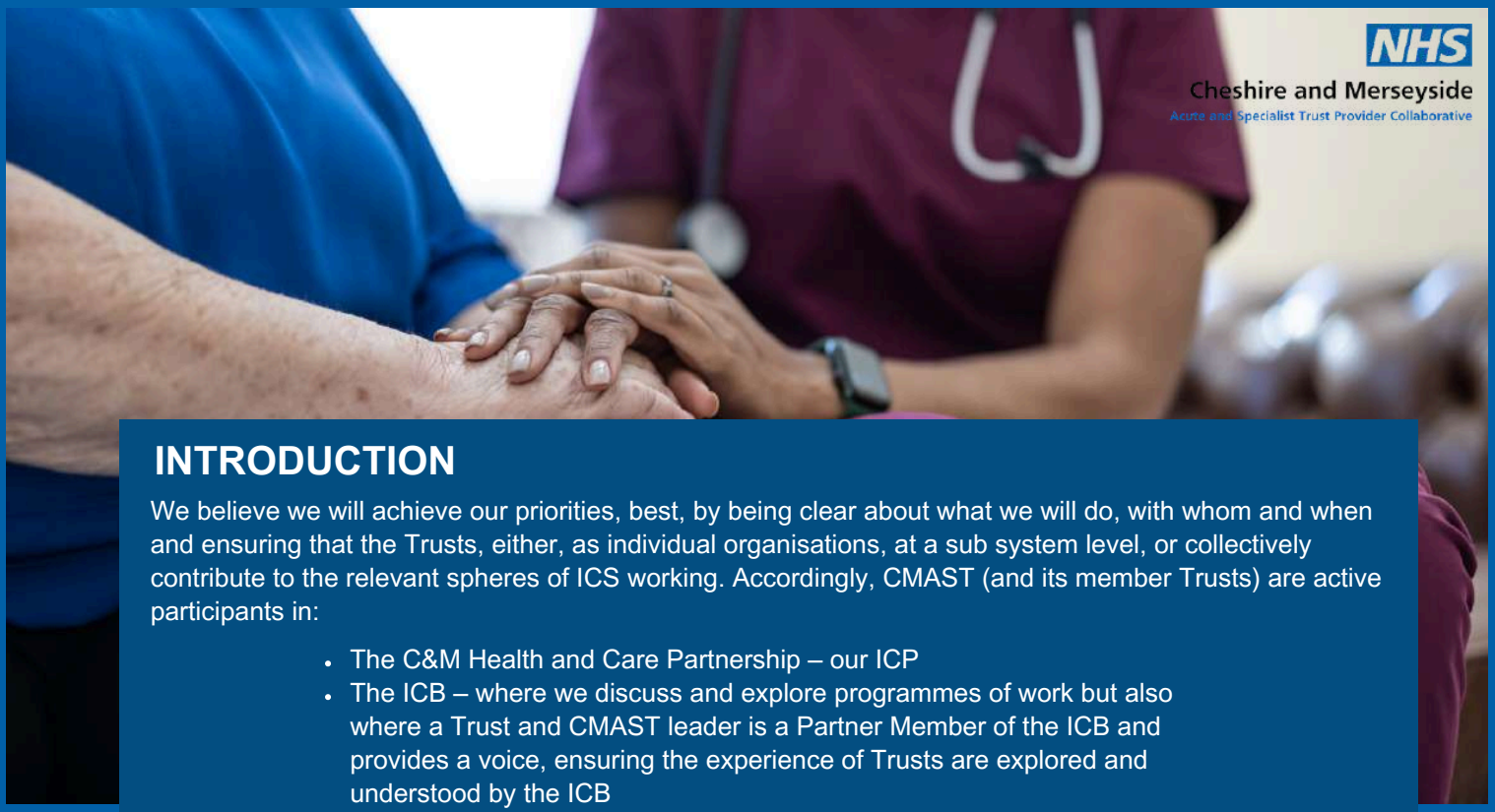
NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

CMAST
Annual Work Plan
2023/24

Cheshire and Merseyside Acute and Specialist Trust Provider Collaborative (CMAST)

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Contents



INTRODUCTION

We believe we will achieve our priorities, best, by being clear about what we will do, with whom and when and ensuring that the Trusts, either, as individual organisations, at a sub system level, or collectively contribute to the relevant spheres of ICS working. Accordingly, CMAST (and its member Trusts) are active participants in:

- The C&M Health and Care Partnership – our ICP
- The ICB – where we discuss and explore programmes of work but also where a Trust and CMAST leader is a Partner Member of the ICB and provides a voice, ensuring the experience of Trusts are explored and understood by the ICB
- Through Place – where Trusts continue to play a strong local role but also explore and advocate for the work of CMAST as a collaborative

Our vision has been refined but provides consistency and a link to our foundations:

OUR VISION IS TO WORK COLLECTIVELY FOR A SINGLE HEALTHCARE SYSTEM TO PROVIDE HIGH QUALITY, TIMELY, EFFICIENT AND PRODUCTIVE SERVICES TO EVERYONE IN CHESHIRE AND MERSEYSIDE.

We recognise that each member Trust of CMAST is also a member of their local Place or Places. It is critical that as anchor institutions and deliverers of care, Trusts are, and remain connected to their own locality and population. Our Places, typically, bring together primary care, local authorities and wider care and voluntary sector stakeholders. They demonstrate the full potential of integrated working. CMAST seeks to echo this broad range of participation through its own work programmes.

Our current CMAST programmes and key areas of focus cover elective and diagnostics recovery and transformation, efficiency at scale and clinical pathways. We have a Trust CEO SRO and Chair Sponsor position identified for each work programme, alongside a Place Director representative on each of the key programme's boards.

We recognise our mutual interdependency, each other's strengths and our shared opportunities. We know that outcomes are likely to be better when we work together, enhancing our resilience and reducing unwarranted variation. Our shared goal is to achieve more for our patients while improving and enhancing the quality of patient care we provide.

Ann Marr
Executive Lead, CMAST

Linda Buckley
Managing Director, CMAST

CMAST Membership

- Alder Hey Children's Hospital NHS Foundation Trust*
- The Clatterbridge Cancer Centre NHS Foundation Trust
- Countess of Chester Hospital NHS Foundation Trust*
- East Cheshire NHS Trust
- Liverpool Heart and Chest Hospital NHS Foundation Trust
- Liverpool University Hospitals NHS Foundation Trust
- Liverpool Women's NHS Foundation Trust
- Mersey and West Lancashire Teaching Hospitals NHS Foundation Trust*
- Mid Cheshire Hospitals NHS Foundation Trust*
- Warrington and Halton Teaching Hospitals NHS Foundation Trust
- Wirral University Teaching Hospital NHS Foundation Trust
- The Walton Centre NHS Foundation Trust
- North West Ambulance Service NHS Trust**

*Also a part of the MHLDC Provider Collaborative
** Key system partner

CMAST is a collaboration and to that extent a virtual membership organisation. Its members are all of the acute and specialist trusts in Cheshire and Merseyside.

Our collaborative is drawn from Trusts that provide a range of acute services and which extend to a number of specialist care areas: paediatrics; neurology; cancer; cardio thoracic and women's.

All members fund a small CMAST coordinating team which is supplemented by a number of programme budgets. All members continue to be signed up to the CMAST joint working agreement and have established a Committee in Common to support delegated system decision making where this is required.

Priorities

Priorities

- Reducing health inequalities
- Improving access to services and health outcomes
- Stabilising fragile services
- Improving pathways
- Supporting the wellbeing of our staff and developing more robust workforce plans
- Achieving financial sustainability

In delivering our priorities we aim to enhance patient, family and carers' experience through more efficient, effective, safe and timely treatment.

The Plan makes it clear where Trusts have a lead delivery responsibility or through our, already, well established approach to partnering with the ICB on issues like system redesign, system investment underpinned by risk and gain share or efficiency at scale programmes which may require ICB sponsorship or action with relation to evidenced recommendations.

CMAST considers that its leadership and contribution in the ICS is clearly defined and uncontentious in the areas we identify as our priorities (see our programmes section) and that routes have already been established to provide appropriate and proportionate assurance on Trust delivery to the ICB on significant system contributing work streams via the CMAST Leadership Board and Trust contributions to the C&M Operating Plan.

As ICS working continues to evolve and develop we remain open and a partner in continuing this dialogue with the ICB and don't see our current remit as either a defined end point or destination, for example, it would seem logical for CMAST to play a role in specialised commissioning, as the remit of this work develops we will continue to flex and provide a wider perspective, resilience and strength to matters of wider interest to the system, as has recently been evidenced through our contributions to the ICB Recovery Programme.

This document is intended for consideration by the ICB and to consolidate already existent and well-established ways of working.

Wider and ongoing system engagement and dialogue will continue alongside this work as CMAST has sponsored and championed since its establishment.

Promoting equity, quality and responding to inequalities

NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

Health inequalities and equity of access to all services is of paramount importance to all CMAST programmes. Where applicable our projects include providers adopting the 14 Prevention Pledges, providing an ongoing commitment to the implementation of the Marmot Principles and, for example, are supported through a provider-by-provider breakdown of missed appointments and how these can be considered through a health inequalities lens.

Our health inequalities initiatives in our Elective Programme are overseen by the Health Inequalities Working Group, which is chaired by Dr Sinead Clarke and includes EDI leads from across all Places and CMAST providers. We have developed Health Inequalities dashboards at trust level. These dashboards are being rolled out through the C&M Business Intelligence Portal and will cover all items linking health inequalities with elective recovery interventions across waiting lists, outpatients and beyond following a pilot in Q4 23/24. We expect the dashboards to be used by both the programme and Trusts to support and enhance decision making.

A further example of our work in this area relates to a Learning Disability/Autism waiting list pilot which seeks to explore the disparities in Learning Disability data across C&M by performing a gap analysis between CIPHA (population health analytics tool) and Hospital EPR (Electronic Patient Record) systems.

Our main ambition for this programme is to allow for a system-wide mandate to be drafted to ensure all providers are using the same interventions in relation to our LD/A patients and their waiting lists processes.

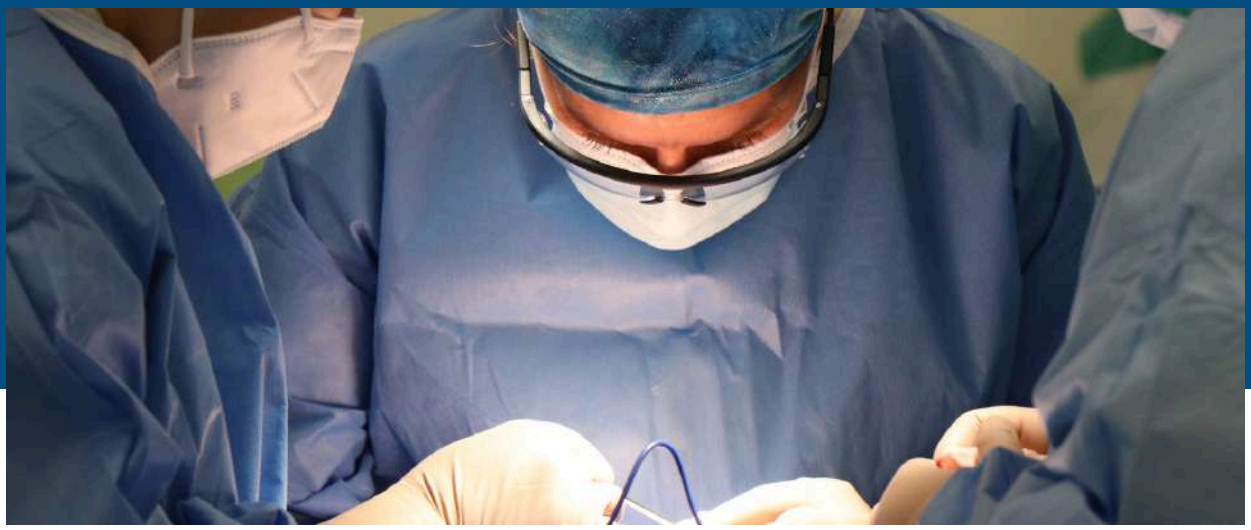
Our Diagnostics Programme has implemented a monthly performance dashboard which includes monitoring of waiting times and activity rates. We use this health inequalities dashboard to ensure that we improve the overall rates of activity and waiting times for the whole of the C&M population. Comparable approaches have also been developed and developed within our elective programme. Our approaches also supports targeted interventions and tracking to maximise access, patient choice and prioritising a focus on areas with higher deprivation.

Quality

Quality of care is at the centre of the work that CMAST lead and deliver. The quality of care that we collectively provide is central to the best possible patient experience being realised.

For each of the CMAST programmes there is an enquiring focus on quality and how system change affects patients their families and carers. As a collaborative CMAST Trusts have invested in this important area by funding a role to ensure this lens is reflected in the work and focus of each of our Programme Boards.

The delivery priorities for 2024/2025 will continue to be subject to the same quality focus and will include the progression of quality impact assessments, benefits realisation and stakeholder feedback.



CMAST Programmes

We currently have several agreed areas of focus and delivery with the ICB and have planned for these to continue and through 2024/5, for example, reflecting and engaging with the ICB Recovery priorities.

CMAST Strategic Priorities	Clinical improvement and transformation				
	Sustainability and value				
CMAST Programmes	Clinical Pathways	Elective Recovery and Transformation	Diagnostics	Efficiency at Scale	

We have several agreed areas of focus and delivery with the ICB and have planned for these to continue and through 2024/5, for example, reflecting and engaging with the ICB Recovery priorities.

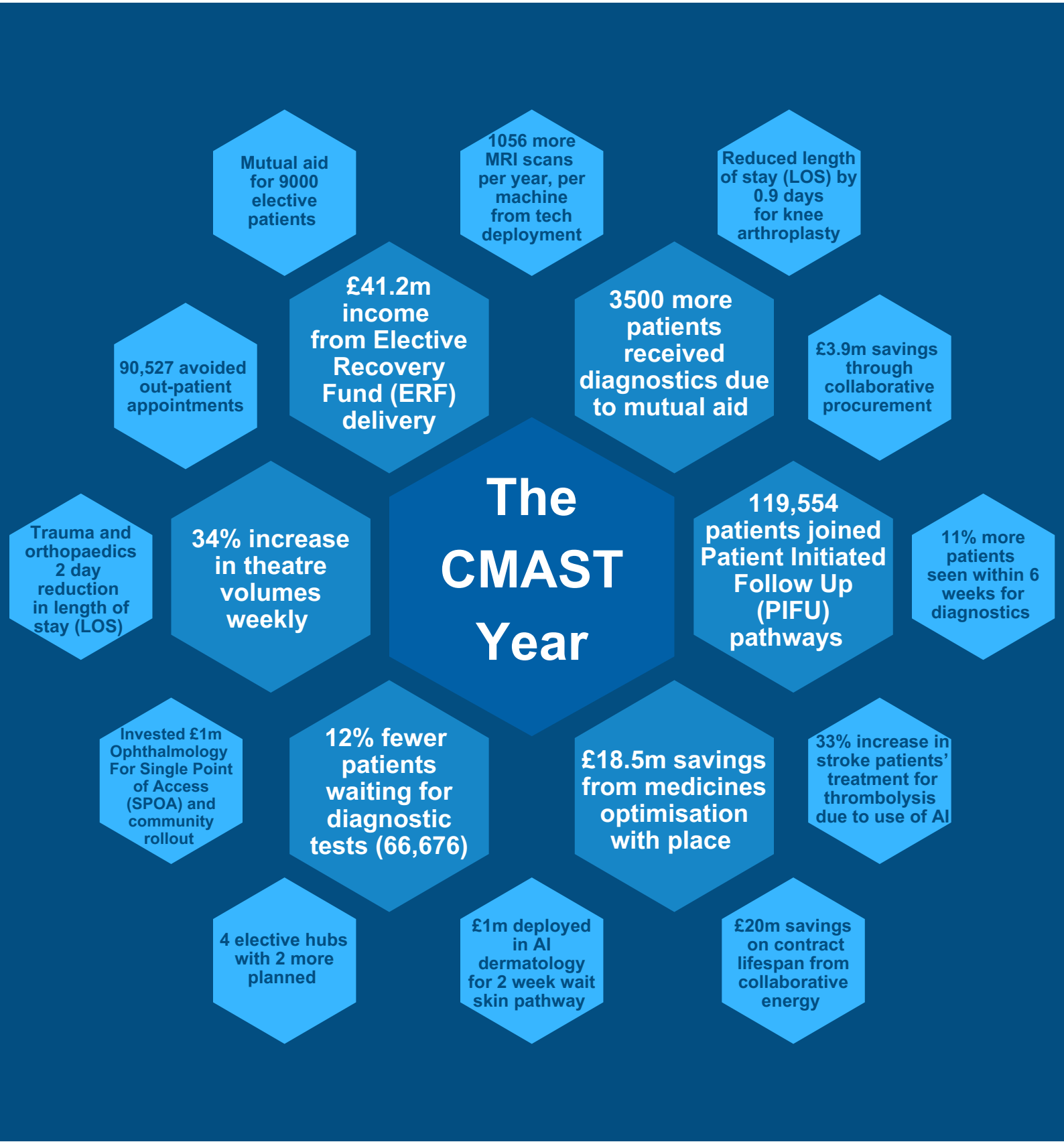
Our priorities are largely clear and obvious, if challenging and align with national priorities. Priorities include elective recovery, increasing diagnostic activity and capacity, aligned to continued cancer delivery via Cheshire and Merseyside's well-established Cancer Alliance. Our Efficiency at Scale programme targets productivity and the identification of opportunities for better use or resources. These areas, coupled with any emerging national or regional priorities, provide a tight focus on patient centred delivery and fulfilment of Trust NHS planning commitments.

Our programme reporting forms part of our monthly CEO discussion and oversight and is considered to be CMAST business as usual.

In addition to our core delivery priorities, we have several clinical improvement, innovation and redesign focussed programmes of work under our Clinical Pathways Programme. This programme works with fragile services or services prioritised for review and enhancement by our leadership. Specialities are supported to undertake a structured, methodical process with a focus on GIRFT and Further Faster evidence bases

Our 2023/4 deliverables are held and available upon request as an annex to be read alongside this document.

The CMAST Year 2023/24



2024 / 2025 Delivery Priorities

NHS
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Acute and Specialist Trust Provider Collaborative

Elective Recovery

Senior Responsible Officer: Janelle Holmes
Programme Director: Jenny Briggs

Scope

The Elective Recovery Programme was established in January 2021. The aim of the programme was to restore and recover NHS services after the pandemic and we agreed that we would work together to address unwarranted variation and inequity in access, across the population of Cheshire & Merseyside.

We are now entering our third year and have built a high performing, award winning programme team, winning the "Provider Collaboration of the Year" award at the 2023 HSJ wards.

Delivery

The Elective Recovery Programme is a delivery focussed programme, with tangible metrics and deliverables across 6 key workstreams.

The programme leadership team is led by CEO SRO Janelle Holmes, provides oversight and escalation.

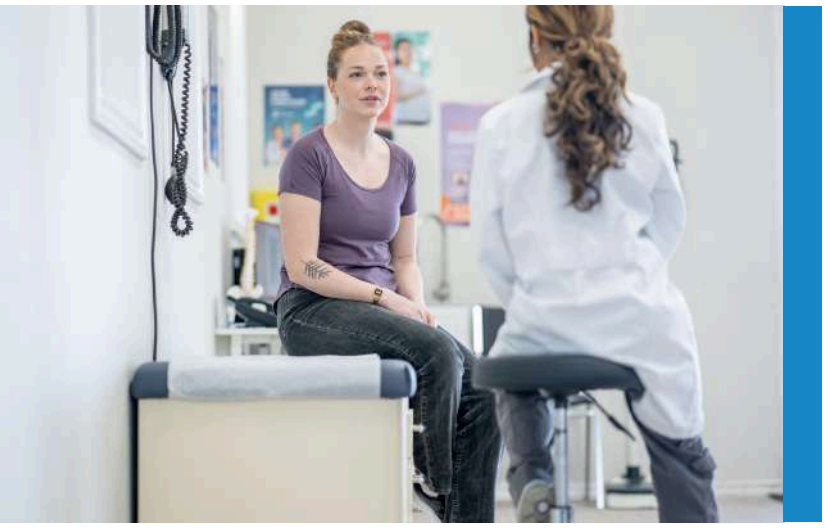
The programme team has representation from provider COOs, Medical Director's Group, CIOs group, Nursing, Finance and Places.

Photo courtesy of Warrington and Halton Teaching Hospitals NHS Foundation Trust

We share a programme board with the Clinical Pathways Programme to ensure interdependencies between the programmes are understood and managed, and the programme board is accountable to the CMAST Leadership Board.

Photo courtesy of Warrington and Halton Teaching Hospitals NHS Foundation Trust Theatre team

Elective Recovery

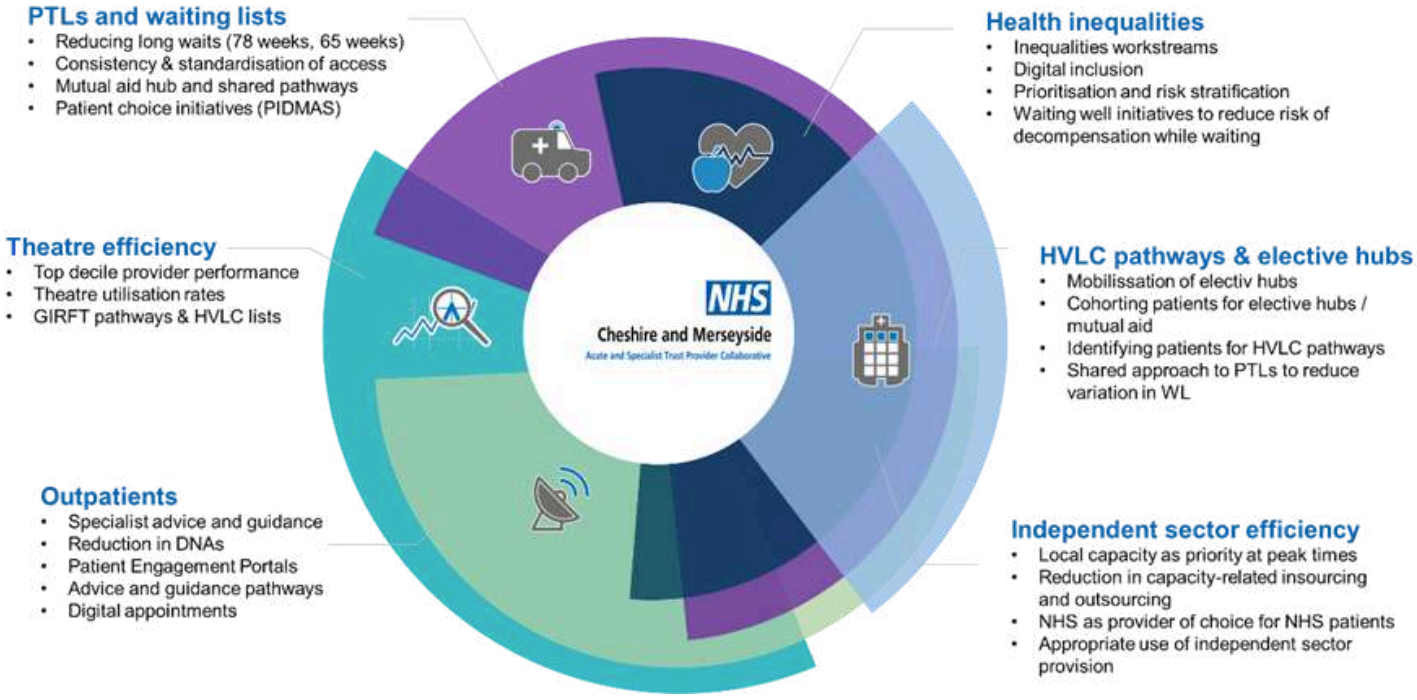


Delivery

We have reviewed and reshaped this year's programme objectives in line with the NHS Planning Guidance for 2024/25, and all our programme workstreams fit into three focus areas:

1. Reducing long waits, and improving waiting list management
2. Reducing variation between providers
3. Improving productivity and efficiency within the providers

In order to deliver against our three programme objectives we have established a range of workstreams that sit within six project areas:



PTLs and Waiting Lists

Building on the success of the last two years we will continue with our PTL management (Primary Targeting List) approach to waiting list management. We meet regularly with all providers, (including independent sector providers with NHS patients on their waiting lists), to review the waiting lists with particular focus on long waits. These sessions provide an independent 'check and challenge' around interpretation of access policies and national guidance as well as support for accessing system-level support such as mutual aid.

So far we have been successful in supporting a reduction in the variation in wait times between providers both for OP and surgical treatment, and plan for this trend to continue.

We have also formed a 'mutual aid hub' to facilitate mutual aid requests inside and outside of the C&M system, and this team leads the national patient choice initiative 'PIDMAS' (Patient Initiated Digital Mutual Aid System). We are preparing for another PIDMAS launch later this year, and have the systems and processes ready to facilitate that on behalf of the ICB.

Elective Recovery

Theatre efficiency

Last year we implemented a local theatre productivity dashboard and worked intensively with trusts to improve the theatre utilisation rates. We also completed two cohorts of our "Theatre Academy" which won two silver awards at the 2024 HSJ Partnership Awards. This training programme delivered expert theatre transformation training to over 50 people from within providers.

This year we will be working with those individuals to support them to continue delivering theatre efficiency programmes within their organisations.

In addition we will continue with intense theatre improvement support to those organisations that have biggest opportunities for improvement, as identified through our theatre productivity dashboard.

Photo courtesy of The Walton Centre NHS Foundation Trust

Outpatients

Our Outpatient Improvement Programme is one of our longer standing project areas with a well established governance structure that reports into the elective recovery programme. We have developed a comprehensive outpatient improvement dashboard which we will continue to use to track and monitor progress against key OP metrics and identify opportunities for improvement and shared learning.

We work closely with the regional OP team, and colleagues from neighbouring systems to share ideas and intelligence.

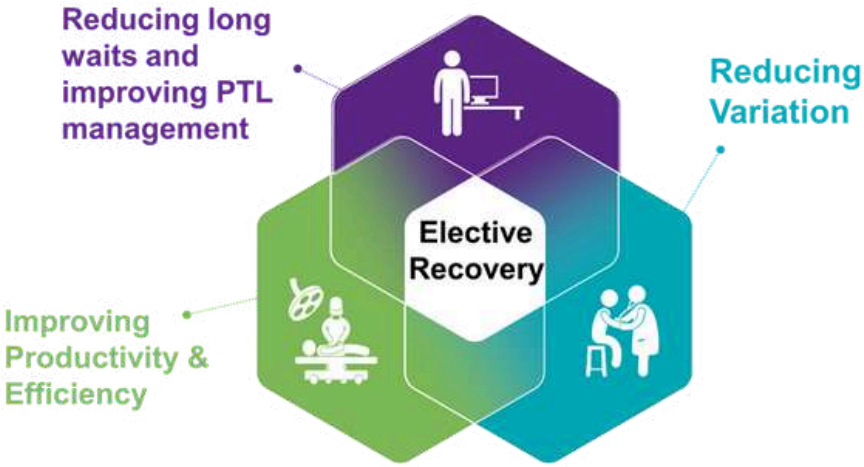
We are using the national "Further Faster" methodology to bring together improvement tools and techniques and best practice both at trust level, and specialty level. This includes focus on:

- Specialist advice between Primary & Secondary Care to avoid the need for hospital appointments
- Patient Initiated Follow Ups (PIFU) to enable patients to choose when they may need to access follow up care
- DNAs to reduce any wasted slots, and ensure patients get the care they need as appropriate
- Utilising the digital Patient Engagement Portals to engage with patients about their care, pathways and treatments

Our **GIRFT (Get it Right the First Time)** Further Faster Programme – the Outpatient Transformation Programme will work closely with the GIRFT, CPP and Elective Recovery Programmes to deliver the outpatient component of the GIRFT Further Faster Programme. The Outpatient Transformation Programme will support:

- **Health Inequalities** – the Outpatient Transformation Programme will support the reduction of health inequalities in outpatient care across the system.
- **Digital Enablement** – The Outpatient Transformation Programme will support the implementation and uptake of digital tools to improve outpatient care across the system.

Elective Recovery



Independent sector efficiency

As a system we have a good track record of strategically utilising independent sector capacity to support our overall capacity requirement. However, over the last year we have seen an increase in ad-hoc insourcing and outsourcing care of independent sector by our NHS providers at peak times, despite having central facilities that are not fully utilised. We have introduced greater scrutiny on the waiting list and performance management for independent sector providers to ensure the same targets and standards are being applied as for NHS providers.

The PTL team now meet with IS providers to review long waits and waiting list management practices and will continue to monitor this to reduce risk of waiting times breaches from IS providers.

We have also established a task and finish group to review ad-hoc IS spend to ensure we are not incurring costs for ad-hoc provision where there is local capacity available. Now we have a well-functioning mutual aid hub, CEOs have agreed that we will seek to utilise local capacity before any capacity-related IS provision is agreed. We will be working closely with high-spend trusts to support access to local capacity where possible before incurring unnecessary IS costs.

Clinical Pathways

Senior Responsible Officer: Simon Constable
Programme Directors: Jenny Briggs / Helen Murphy

Scope

The Clinical Pathways Programme (CPP) facilitates C&M providers to work together to address unwarranted variation and inequality in access, experience or outcomes in key specialties across the population of Cheshire & Merseyside. We focus on populations, improving resilience in smaller teams, and ensuring that specialisation and consolidation occur where this will provide better outcomes and value.

The programme is delivered through a range of system-led schemes, clinical network programmes, and trust-level workstreams. The CPP team lead and support specialty clinical networks as the key vehicle to enable change at scale; gaining clinical consensus in the development of new clinical pathways and service models, and driving best practice.

In 2024/25, we will continue to support five-core CPP specialities as well as other supported clinical networks across C&M.

Photo courtesy of the ENT team at Liverpool University Hospitals NHS Foundation Trust

Three key commitments have been established, which will be implemented through an internally designed Programme lifecycle reflecting best practice methodologies. This approach ensures that all CPP specialties receive fair and equitable support and crucially, the central focus of this lifecycle is to demonstrate tangible benefits throughout the 2024/25 period and beyond.

Our Vision:

- **Patient Centred:** Improving patient experience and outcomes, and reducing inequity of care
- **Sustainable:** Developing service models that are resilient and fit for the future
- **Innovative:** Harnessing new technologies and innovations to improve care and productivity

Clinical Pathways

Ophthalmology:

In 2024/25, CPP will support in the management of multiple workstreams and associated agreed deliverables. These will include, but not be limited to:

- Delivery of the 2 key funded projects:
  - Glaucoma Monitoring Service Pilot
  - Eyecare Accelerator project – encompassing a Single Point of Access (SPoA) pilot and an Advice & Guidance (A&G) pilot
  - The evaluation and outcomes of these pilots will inform the future strategy for ophthalmology across C&M.
- GIRFT and Further Faster: implement the GIRFT gateway review recommendations and further faster principles where possible.
- Glaucoma Enhanced Referral Service: explore opportunities to implement service across C&M.
- Pre and post operative cataract services: ensuring consistent provision of services across C&M.
- Primary and secondary care interface: explore opportunities to improve communication between primary and secondary care within ophthalmology, including the use of digital tools to support.

Other elements of the network priorities will be to maintain focus on further clinical pathway development and pursue collaboration opportunities to optimise Ophthalmology services across C&M.

Gynaecology:

In 2024/25, CPP will support in the management of multiple workstreams and associated agreed deliverables. These will include, but not be limited to:

- Menopause: Focused on collaboration with Primary Care as part of the Menopause Academy, an evaluation of an ongoing pilot will take place, inclusive of patient engagement and data analysis.
- Opportunities to promote and scale the model into other geographical locations within C&M will also be evaluated. This pilot will be supported by the build and utilisation of a benefit dashboard to track quantitative and qualitative metrics.
- Referral Optimisation: Supporting Mid Cheshire to formalise internal processes for the benefit of other providers across C&M to learn from and ultimately to meet and exceed waiting list targets.
- Endometriosis: Supporting the Special Interest Group, with a particular focus on exploring greater collaboration between Wirral and Liverpool based endometriosis services, alongside considering opportunities with Mersey and West Lancashire to enable an Endometriosis northern secondary care ‘hub’.
- Ambulatory Care – Clinical Pathways Focus: Support clinical pathways working group to deliver significant changes to clinical pathways following approval of TIF funding to Liverpool Womens; Hospital; intended to enhance ambulatory care capacity and utilisation which will benefit the provider, region and improve patient experience and outcomes.

Clinical Pathways

ENT:

In 2024/25, CPP will support ENT to achieve their mission statements of:

- We will work together to eliminate 65-week waiters by September 2024 and maintain this through to 2025 and beyond.
- We will work together to forward plan for achieving the elimination of 52-week waiters against the planning guidance target.
- We will work together to achieve the agreed objectives for long term transformation.
- We will demonstrate change at scale across C&M and will be supported by CMAST in demonstrating benefits achieved.

A clinically led event has taken place in April 2024 aimed at setting clear and measurable objectives for the next 12 months. Central to this, was the focus on ENT as part of GIRFT Further Faster and the establishment of three key workstreams; Pre-Appointment, During Appointment and Post Appointment.

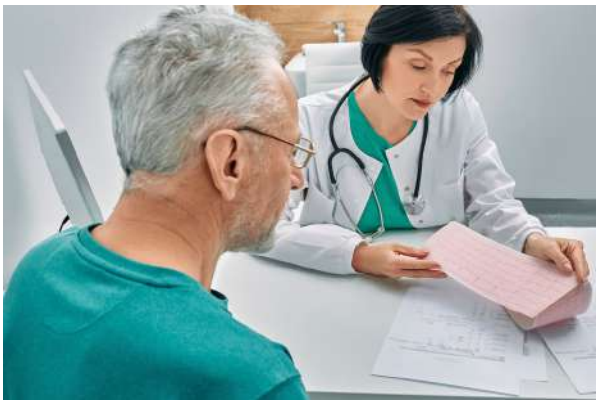
These workstreams will work collaboratively to reduce variation across C&M and will be led by providers who have seen substantial benefit in embedding Further Faster recommendations within their organisation.

Cardiology:

In 2024/25, CPP will support the C&M Cardiology Provider Alliance to consider the outputs from the GIRFT review with an initial focus on catheter lab utilisation and a strategy to support this.

A robust data collection is taking place to support the alliance, alongside a framework for the development of a robust options appraisal to determine the C&M Catheter Lab Strategy.

A workshop is planned for May 2024, following this a programme plan will be developed with agreed metrics defined.



Dermatology:

Dermatology Digital Workstream

The aim of the digital work stream is to enhance patient care and streamline processes through the implementation of innovative digital solutions tailored to the specific needs of dermatological services in the region.

Key deliverables in the next 6 months:

- Complete procurement of a single telederm solution for Cheshire & Merseyside
- Continue roll-out of telederm platform
- Review of teledermatology usage for ‘live’ practices
- Develop a business case for future funding of teledermatology

Future deliverables:

- Explore AI opportunities
- Explore usage of teledermatology for Inflammatory conditions

Photo courtesy of the Dermatology team, Mid Cheshire Hospitals NHS Foundation Trust

Clinical Pathways

Skin Cancer Pathway Workstream

The Cancer Pathway work stream will work in collaboration with the Cancer Alliance is to optimise early detection, diagnosis, and treatment pathways for skin cancer patients, ensuring timely access to specialised care and improved outcomes across the region.

Dermatology Inflammatory Conditions Pathway Workstream

The aim of the Inflammatory Conditions Pathway work stream is to develop comprehensive and patient-centred strategies for the diagnosis, management, and ongoing care of individuals with inflammatory skin conditions, fostering collaboration among healthcare providers and enhancing access to specialised treatments and support services. In the short-term data will be used, with regards to longest waits etc to decide on what conditions to focus in first.

Dermatology Transformation Workstream

The Clinical Transformation workstream aims to modernise and optimise clinical practices, workflows, and protocols, fostering innovation, improving efficiency, and ultimately enhancing patient outcomes and experiences within dermatological care across the region.

Key Deliverables:

- Agree 2WW referral standard across C&M, for example all referrals need to have an image attached or they will be rejected.
- Review mutual aid, explore formal C&M arrangements to enable C&M to meet workforce and capacity challenges
- Explore centralised hub model

Supporting other Clinical Networks

Orthopaedics:

The outline plan for 2024 – 2025 includes:

- Reduce length of stay to be in line or better than the national average for primary arthroplasty
- Reduce length of stay to be in line or better than the national average for fractured neck of femur
- Review C&M approach to the ongoing management of open fractures to ensure compliance to best practice and national standards
- Focus on opportunities to improve outpatient performance using the Further Faster toolkit
- Work with MSK Alliance to ‘standardise’ the protocols in place for MSK interface service
- Review ambulatory provision across C&M and standardise a clinical pathway for these patients to ensure they get their treatment in a timely way reducing complications and expediting recovery which in turn will reduce impact on elective patients.

Alongside this, there will be further trust collaboration to optimise orthopaedic surgery equitably across C&M ensuring that our system resources such as the Elective Surgical Hubs are available to patients across C&M if needed to access timely treatment and care.

Clinical Pathways

Urology

Urology have set their priorities for 2024/25 and have recruited two clinical leads to chair the two Benign networks which exist within C&M to support to deliver these.

The key areas of focus include:

- Urology Investigation Units
- Urinary Tract Infections
- Transurethral Resection of Bladder Tumour (TURBT)
- Lower Urinary Tract Symptoms (LUTS)
- Embedding Further Faster – specifically recommendations Advice and Guidance, PIFU etc.

A launch event is planned for May 2024 to formalise these priorities with updated membership and a new terms of reference.

MSK

The 2024/25 priorities for the MSK network include:

- Data quality improvement: making sure accurate information is being reported and shared.
- Undertake an audit of the detailed service offer in place at all C&M MSK providers.
- Develop a proposal for MSK triage / interface services across C&M.
- Continue to support the roll-out of the Apos Health product.

Perioperative

The Peri-Operative Medicine Clinical Network was formed in January 2024. The network aims to reduce delays to surgery, reduce on-the-day cancellation, standardise best practice & clinical pathways where possible and improve outcomes for patients.

The key areas of focus include:

- The development of an optimal prehabilitation service strategy for C&M.
- Implement GIRFT/Further Faster recommendations following the GIRFT gateway review in March 2024.
- Continue to support the use of digital tools (such as C2Ai and Surgery Hero) where appropriate.
- Explore shared decision making.
- Support the delivery of the mandated national five core requirements.

General Surgery

The General Surgery Elective Recovery Clinical Network is responding to the restoration of elective recovery and the backlog of waiting lists with a focus on the largest backlog across all procedures in general surgery (hernia and gallbladders) and implementing GIRFT Gateway Review recommendations.

The objectives for 2024 - 25 are:

- Standardising pathways for Primary Inguinal Hernia
- Standardising pathways for Gallbladders (laparoscopic cholecystectomy)
- Improving day case rates for the above to meet national benchmarks
- Ensuring equity of access via mutual aid/surgical hubs
- Reducing unwarranted variation and standardising emergency appendicectomy pathways
- Reducing length of stay for emergency laparotomy
- Reducing length of stay for elective resection for colon cancer and
- Using risk stratification tools (C2ai and CIPHA) to inform pre-op work ensuring patients are fit for surgery
- Outpatient opportunities will be identified using the Further Faster Checklist

Clinical Pathways

Children and Young People (CYP)

The CMAST CYP Alliance was established in November 2023 to bring together senior CYP leadership from CMAST member trusts to improve access to and drive service improvements for CYP in the region by collaboratively delivering against the agreed core priorities and projects.

The CPP programme provides the link with elective recovery and clinical pathway transformation to ensure children are included and prioritised within elective recovery initiatives where appropriate.

The vision is that all Cheshire & Merseyside children and young people with health needs will receive the right care in the right place. The programme has 3 main workstreams:

Elective Recovery

Aim:

- Reduce waiting times for elective recovery and deliver care in an appropriate setting

Priorities:

- Community hubs (dental)
- Surgical hub for high volume / low complexity
- Work with the wider CYP system to describe regional challenges for mental health services in the acute provider setting

Urgent Care

Aim:

- Improve access for CYP who need urgent care and reduce the number of unwarranted ED attendances

Priorities:

- Map community nursing and virtual ward offers across the region and develop a common set of standards for care
- Support adoption of ED advice and guidance tools
- Facilitate RSV vaccination response

CYP Diagnostics

Aim:

- To support the development of the C&M CYP Diagnostics strategy

Priorities:

- Support regional solution for routinely collecting and analysing paediatric diagnostic data
- Develop common set of standards and pathways for paediatric diagnostic activity and services

Paediatric workforce also remains a priority work area for the Alliance. It is recognised that this is a cross-cutting priority as it impacts on each of the priority areas listed above. As such the Paediatric Workforce workstream and associated projects will be established following the implementation of the above workstreams.

Diagnostics

Senior Responsible Officer: Liz Bishop
Programme Director: Tracey Cole

Scope

Our Programme includes all diagnostic tests such as pathology, imaging, endoscopy, screening programmes, cardiorespiratory, neurophysiology and more covering patients of all ages.

The scope of our work includes all activity for patients registered with a GP in Cheshire and Merseyside but also includes care delivered to non-C&M patients through these Trusts. Our work influences both physical and mental health and reflects our transformation ambitions beyond any one single organisation.

We are responsible for:

- Transformation at scale beyond a single organisation.
- Improvement against agreed trajectories, quality outcomes and reduced waiting and reporting times at C&M level
- Interoperability with existing C&M Programmes such as Digital, Cancer Alliance, CVD and more
- Delivery of the five year forward view triple aim of improved population health, quality of care and cost control

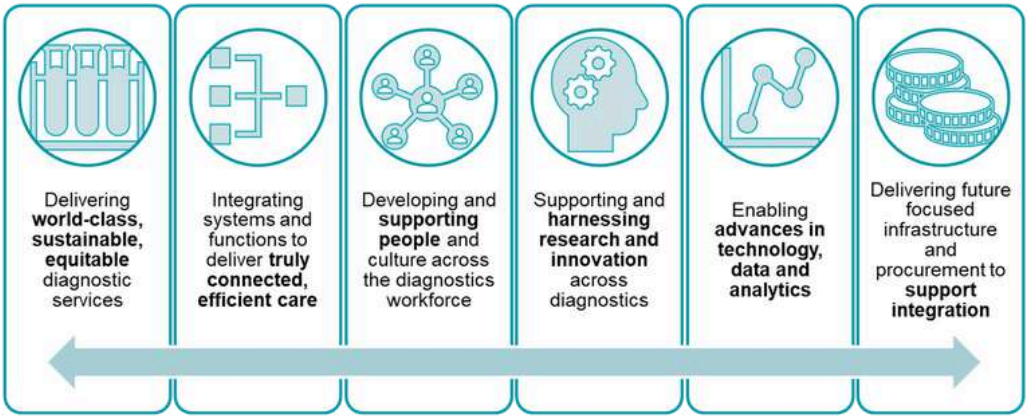
We advocate for and promote interoperability with existing C&M Programmes such as Digital, Cancer Alliance, CVD and more.


Photo courtesy of the Audiology Service at East Cheshire NHS Trust

Diagnostics

Strategic Direction

The Diagnostics Programme has set out an ambitious 5-year strategy (2023-2028) to deliver against six key priorities:



To deliver we will:

Delivery

Our commitments for 2024/5

Focus

Our programme's in year focus is on:

- Reduce waiting times across all specialities
- Increase productivity
- Improved turnaround times – processing and reporting
- Deploying digital investment, including AI, to increase collaboration though alignment with ICB digital lead
- System wide transformation – pathology
- Mutual aid and workforce solutions

Photo courtesy of the Transfusion Team at Warrington and Halton Hospitals NHS Foundation Trust

Diagnostics

Cost Avoidance Schemes

If we...	Then we...	As a result...
Expand use of mutual aid	Reduce use of in/outsourcing	Avoid £2.5m spend
Surveillance test only at clinically recommended intervals	Remove 1000 patients from endoscopy lists	Avoid £0.3m spend
Adhere to NICE Vitamin D guidelines	Reduce inappropriate blood tests	Avoid £5 spend per test
Open endoscopy hub in Warrington	Reduce cancelled patients by 1%	Avoid £011m spend

Photo courtesy of The Walton Centre NHS Foundation Trust

Reduce Waiting Times Schemes

If we...	Then we...	As a result...
Monitor productivity and support trusts to meet national measures in: • Endosopy • CT • MRI • Non Obstetric Ultrasound (NOUS) • Echos	Ensure that: • Endoscopy - 95% lists ultilisation • CT- 4 scans per hour • MRI - 2.5 scans per hour • NOUS - 3 scans per hour • Echos - 45 min per test	95% of patients seen within 6 weeks. No patient waits more than 13 weeks.
Implement C&M Radiology Reporting Collaborative.	Deliver increase in quality, reduced duplication and reduced reporting waits.	Meet Royal College of Radiology (RCR) Guidelines: • CT - 95% urgent within 7 days • CT 95% routine within 28 days • MRI - 90% urgent within 7 days • MRI - 95% routine within 7 days
Implement histopathology review actions.	Maximise our efficiency and resilience in histopatholgy.	80% cancer cell path samples reported within 10 working days.

Diagnostics

Digitise and Innovate

If we...	Then we...	As a result...
Implement a standardised Pathology LIMS (Laboratory Information Management System) across 5 core trusts.	Reduce duplicate tests and ensure that patients don't need to attend repeat appointments.	Save £10m over 10 years across the system.
Implement Prostate Artificial Intelligence (AI).	Ensure abnormal tests are prioritised.	Save consultant reporting time enabling other images to be reported on quicker.
Pilot Echo AI.	Potentially reduce appointment times from 45 min to 20 min.	Increase capacity, reduce waiting times and reduce IS spend.
Implement Chest X Ray AI.	Ensure abnormal tests are prioritised.	Reduces report turn around time and impact on urgent care.

Photo courtesy of the Endoscopy Team Liverpool University Hospitals NHS Foundation Trust

Support Workforce Resilience Schemes

If we...	Then we...	As a result...
Launch a Physiological Sciences Network.	Provide support and resilience for Healthcare Scientists.	Ensure 40+ Physiological Science tests have a strong workforce.
Run single recruitment campaigns across C&M.	Ensure we do it 'once and well' attracting staff to their preferred trust.	Reduce vacancy rates.
Implement actions following 'stay conversations'.	Ensure we adjust to help staff remain in post.	Reduce use of bank and agency staff.
Work with regional and national partners to maximise training opportunities for hard to recruit roles.	Ensure that we have a pipeline of staff coming into our system.	Ensure we have resilience for years to come.

Efficiency at Scale

Senior Responsible Officer: Ged Murphy
Programme Director: Nina Russell

Scope

The Efficiency at Scale Programme (E@S) spans both provider collaboratives and works in partnership with the ICB to support the delivery of a key collaboration opportunities across the system with a keen focus on core expectations within the NHS planning guidance:

- Develop robust plans that deliver specific efficiency savings and raise productivity.
- Put in place strong oversight and governance arrangements to drive delivery.

The stakeholders have identified a vision, a set of targets and key goals which have supported the creation of a prioritised work programme.

Vision: Work with system partners to identify and reduce unwarranted variation, ensuring quality and value for money benefits realisation with a focus on corporate services and system collaboration.

Delivery

The opportunities for collaboration across Cheshire and Merseyside are extensive, whilst the programme has not wanted to limit itself to just corporate services transformation, it has had to take the decision to limit the initial areas of focus.

The service functions which have been selected based on quality improvement opportunity, national priorities, operational pressures, and possible level of efficiencies. The initial areas of focus:

Function	Workplan
Finance	• Single financial ledger • Automation opportunities
HR/Workforce	• E-Rostering • Workforce planning • Scaling people services
Legal	• Development of C&M knowledge hub • Legal Collaboration (LUHFT/LWH/LHCH) • C&M insurance review
Medicines Optimisation	• Individual medicines review projects • Medicines optimisation • Drug rebates • High-cost drugs and homecare
Procurement/Purchase at Scale	• Supply chain • Procurement rolling contracts workplan • C&M wide strategy/digital opportunities • Energy/estates/digital
Risk and Governance	• Infection control • Governance IT systems • Risk Management/Corporate Governance

Efficiency at Scale

Estates & facilities and digital; are core functions included in the system purchase at scale opportunities, with a category deep-dive taking place in early 2024 to support the development of detailed workplans going forward.

All providers in Cheshire and Merseyside committed to completing the national corporate services data collection in July 2023 which allowed the system to complete a detailed benchmarking exercise and highlight variations for further examination.

The programme is focused on achieving a cross section of results which support the system. The programme work is governed through the following structures:

Each focus area has an executive level senior responsible offer plus programme manager/director, with a significant number of C&M providers having direct attendance and representation at the E@S board.

Photo courtesy of Liverpool Heart and Chest Hospital NHS Foundation Trust HIMSS Team

The programme is using the National Corporate Services Transformation Programme to support the workstream development and benefits realisation.

and during 23/24 identified and adopted the following aim and core principles to support delivery:

The programme is keen to build on the successes of 23/24 which saw the rapid development of an evolving workplan which led to the delivery of:

- Medicines optimisation combined E@S and Place programmes achieved £18.5m savings.
- C&M collaborative schemes (excludes individual trust procurement CIPs) saved £3.8m FYE.
- C&M collective approach to the national energy contract will realise £8m of savings from April 2025 when the contract comes into effect and £20m over the life of the contract.

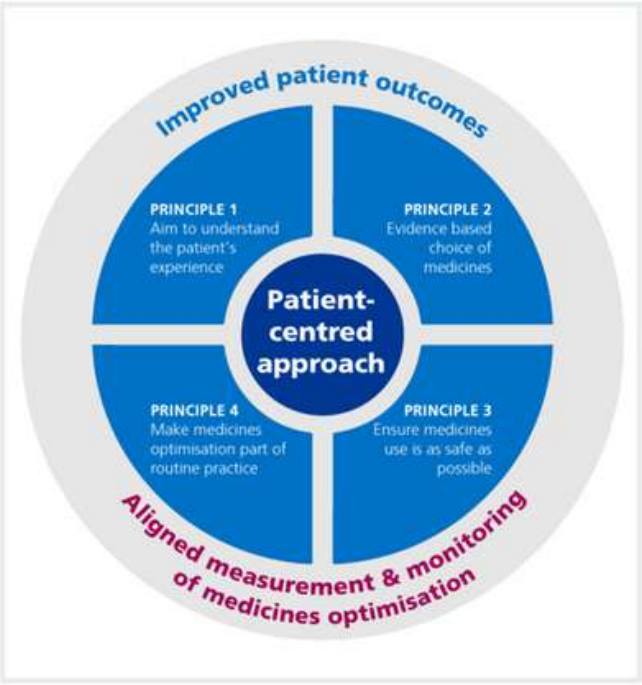
Efficiency at Scale

Medicines Optimisation

Cheshire and Merseyside have a very established ICB Medicines Optimisation and Pharmacy Group which has clear set of priorities and has created a C&M Medicines Improvement Group to support delivery. This group is chaired by the ICB Chief Pharmacist and now has a track record for successful delivering quality and efficiency schemes.

Medicines optimisation looks at the value medicines deliver, making sure they are clinically effective and cost effective.

The focus is to ensure that people are getting the right choices of medicines, at the right time, and are engaged in the ongoing prescribing process by their clinical teams. Cheshire and Merseyside are aligned with the NHS England Medicines Optimisation programme and has adopted the following core principles to support delivery:



(NHS England » Medicines optimisation)

In July 2023 the NHS England Medicines Optimisation Executive Group (MOEG) released guidance describing 16 national medicines optimisation opportunities for the NHS in 2023/24. ICBs were recommended to select at least 5 opportunities to focus and deliver on alongside their local medicines optimisation priorities. The ICB, providers and Specialist Commissioning have worked collectively to develop the 24/25 workplan whilst ensuring the system meets its requirements regarding the nationally recommended opportunities and the following areas of focus have been selected as part of the E@S programme:

- Addressing problematic polypharmacy
- Improving uptake of the most clinically and cost-effective medicines
- Using best value biologic medicines in line with NHS England commissioning recommendations
- Using best value direct-acting oral anticoagulants

It is important to note that further medicines optimisation and pharmacy improvement schemes are being completed within the ICB Medicines Optimisation and Pharmacy Group and will cover off other national priorities.

Core workstreams in 24/25 will include:

- Individual Medicines Review Projects
- Polypharmacy optimisation across C&M
- C&M wide oral nutrition review
- High-cost drug review with a focus on using best value biologic medicines
- Homecare improvement and optimisation
- General medicines optimisation and drug rebate management

Efficiency at Scale

Procurement and Purchase at Scale opportunities

C&M has a very established procurement network which supports C&M purchase at scale opportunities throughout 23/24. The team are excited to build on these opportunities in 24/25 whilst developing a local procurement and supply chain strategy which is aligned to the national NHS commercial strategy.

The core aim of the NHS is to deliver safe, effective, productive, and efficient healthcare to patients will be supported by procurement/commercial functions by delivering the following strategic commercial outcomes:

- Building the foundations of a best-in-class commercial organisation
- Embedding a resilient commercial and supply chain operating model
- Enabling the delivery of medium and long-term NHS priorities
- Improving patient pathways and healthcare outcomes
- Securing cash-releasing, total cost efficiencies
- Delivering a social value aligned to the national procurement policy

The delivery of these outcomes will benefit patients, our people and NHS suppliers.

Core workstreams in 24/25 will include:

- Development of a single C&M procurement and supply chain strategy
- Supply chain optimisation
- Purchase at scale rolling contract workplan
- C&M digital opportunities
- C&M estates opportunities
- Implementation of national contracts as appropriate

Efficiency at Scale

Finance

C&M have prioritised the following workstreams during 24/25:

- Development of a business case for a single financial ledger
- Optimisation of appropriate automation opportunities within finance sub-functions.

These are continuing to build on the work that has taken place in 23/24 and are seen as key enablers to support the long-term financial strategy of the system.

Legal

Following a review of the 19 legal opportunities highlighted within the National 'Corporate Services: Improvement Opportunities and Resources Report' the system has identified the following opportunities and is continuing to progress these in 24/25:

- The implementation of the legal service collaboration across LUHFT, LWH and LHCH.
- Continue to explore the opportunities relating to additional indemnity insurance policies across Cheshire and Merseyside with a focus on purchase at scale and rationalisation where appropriate.
- Develop an implementation plan for a single Legal Knowledge Hub across Cheshire and Merseyside in partnership with the national team.

Workforce/HR

The E@S programme will support the wider Scaling People Services agenda which is being led by the ICB and HRDs and two specific workstreams have been identified to be hosted by the E@S programme:

- E-Rostering procurement - Alignment of roster contracts to support potential for future single C&M contact for roster provision.
- Workforce Decision Intelligence Project - To use innovative ways to address our workforce challenges and meet our population's needs.

Photo courtesy of Aintree University Hospital Urology Team

Photo courtesy of Wirral Diagnostics Centre

CMAST

Development

We recognise that effective collaboration and system working is not about resting on your laurels and standing still but evolving, developing, improving and partnering to further embed progress and capacity within the ICS and providing more and better care to our residents and patients.

CMAST was delighted to be selected as one of the Provider Collaborative Innovators and to secure the exposure to national policy thinking and peer support and challenge that this programme provided to us.

We were also delighted that the work our of system through our elective recovery and transformation programme was recognised by the HSJ and our peers as their Provider Collaboration of the Year 2023.

We have been pleased over the last year to take a number of significant system decisions which have moved us forward on our collaborative journey. These have included individual board decisions related to the system implementation of a laboratory information management system (LIMS) which will now be implemented as a system, once, with CMAST and programme responsibility and the continued development of our pathology hub model.

During the year ahead we remain committed to exploring and consolidating our contribution toward ICS and system leadership. This is an area we will keep revisiting and discussing with partners. There is undoubtedly more momentum to be gained through collaboration across all providers whether social care, primary and community care and mental health as well as acute providers.

Governance

CMAST operates at several different levels of activity as may be required by the task or focus required of it.

CMAST also operates and facilitates a federated model of collaborations, connections, and networks across our system through its professional groups. These provide a vehicle through which work can be progressed, initiated, or delegated (from the Board) and encourage and support collaboration across professional disciplines.

Where decision making is required which is beyond the responsibility of a professional group or the combined authority of the CMAST CEOs, CMAST has the ability to initiate a committees' in common process to support combined and aligned system decision making across each of our statutory trusts or a subset of these. Depending upon the views and inputs of CMAST Trusts and their Boards' our decision-making framework allows for these decisions to be taken by either CEOs or CEOs with Trust Chairs.

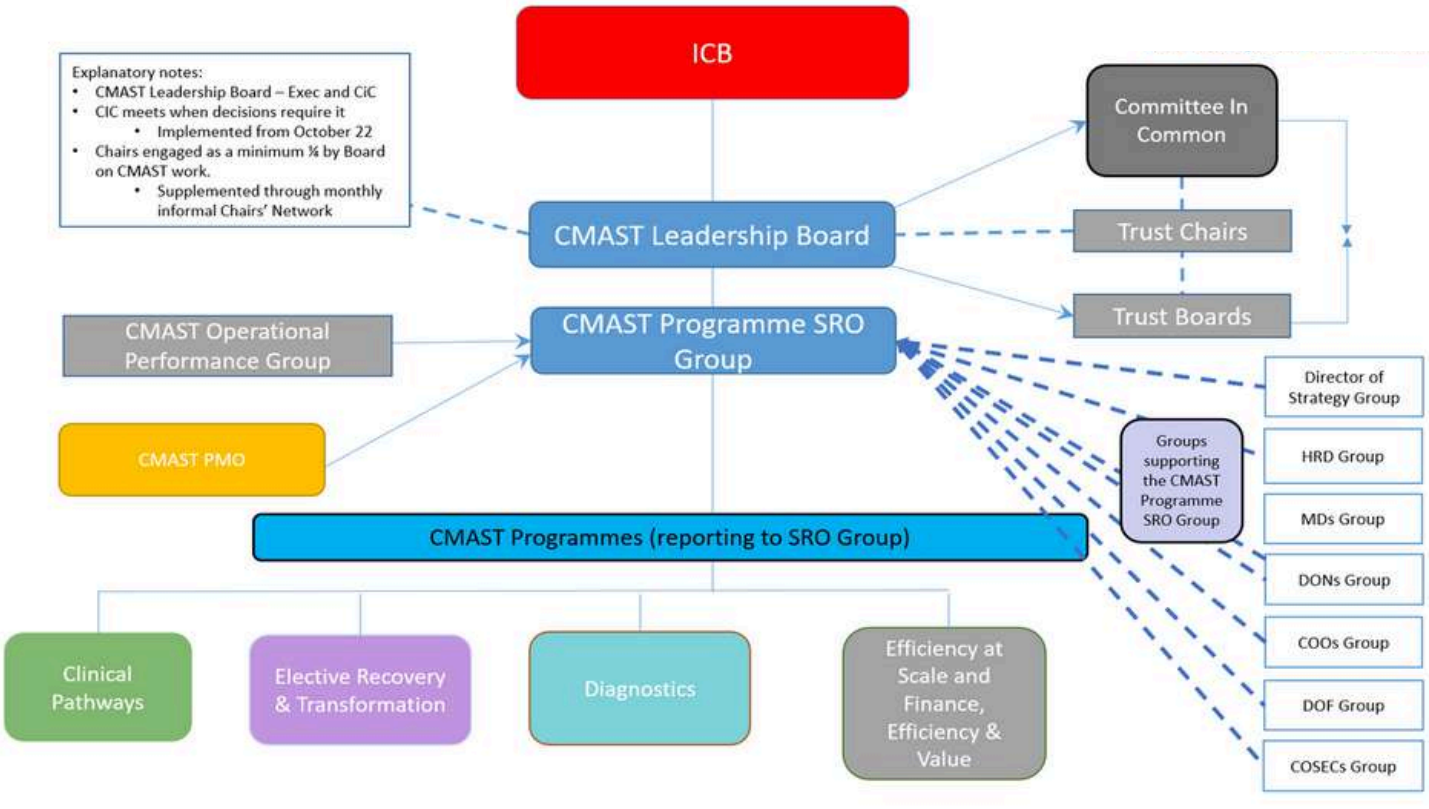
Our work, priorities, values, and behaviours are set out within our Joint Working Agreement and are refined and documented through an agreed annual workplan (this document) which identifies key milestones and provides a platform to begin to describe anticipated decision-making points associated with our programmes of work.

Our governance framework and connections with our programmes and professional groups are described in an annex.

Detailed delivery targets, metrics and detail have been developed and signed off by our leadership Board. These commitments will be periodically reported to the Leadership Board, throughout the year, and are reviewed monthly through CMAST's established programme governance.

Governance

Annex one



NHS
Cheshire and Merseyside
Acute and Specialist Trust Provider Collaborative

CMAST Annual Work Plan 2023/24

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NHS
Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

Cheshire and Merseyside Mental Health, Learning Disabilities & Community Services Provider Collaborative

Progress to Date & 2024/25 Workplan

- The presentation provides a description of the progress made to date since the June 2023 paper and details of the workplan for 2024/25 aligned to a value proposition submitted by the provider collab to the ICB in January 2024.
- We intend to use the opportunity to demonstrate how the opportunities identified in the HCP strategy of enhancing community services as a means to addressing some of the long standing C&M issues could look.
- We will discuss what we need from the ICB to be able to take more significant steps to deliver a shift left
- We will also be providing information on the achievements of the MH programme and next steps in terms of the long term plan for MH.
- The request to the ICB board will be endorsement of our current plan, ICB exec level engagement into the developing community strategy and support for the next stage of moving acute care into the community

2023/24

NHS
Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

MHLDC Strategic Objectives

- To level-up the standards and outcomes of community, mental health and learning disability services ensuring they make a leading contribution to place and system-wide transformation.
- To work towards a rebalance of the system by securing investment in community-based services as an alternative to hospital care.
- To support the system to address the financial position through efficiencies derived at scale from our collaborative work.
- To operate as a trusted and reliable partner in our system and with our places.
- To transform our workforce to meet the future health and care challenges of our system.

The workplan for 2023/24 was:

- **Community urgent care**
  - **Urgent Community Response**
  - **Intermediate care**
- **Community services for children and young people**
- **Access to care / fragile services**
- **Mental health transformation**
- **Workforce transformation**
- ***Virtual Wards (from January 2024)***

2023/24

Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

Access to Care:

We said we would…	
Develop comparable waiting time data and monitoring processes for community services	Community services waiting time data is now available on the Cheshire and Merseyside (C&M) Business Intelligence Portal (BIP). Community data quality group established to address the significant issues in access to community services data.
Identify fragile services	Clinical networks established for services identified as vulnerable / at risk.
Develop clinical networks between small and vulnerable services	The community waiting times and fragile services work was paused in 2024 in response to the requirement to align resources with the C&M recovery programme

Community Urgent Care:

We said we would…	
Develop a platform for intermediate care data from which improvements can be made	Consistent and comparable Intermediate care data now available on the C&M BIP, with the ability to view key performance metrics of individual providers
Increase utilisation of Urgent Community Response (UCR) services	UCR referrals from NWAS have increased by 290% from Q1 23/24 to Q1 24/25
Identify other initiatives to allow patients to remain safe and well in their usual place of residence	Significant variation between urgent community response services has been identified in both commissioning of services and operational delivery models across C&M

Virtual Wards:

We said we would…	
Provide a review of the VW programme in C&M and recommendations for development of the service	18 recommendations have been identified to improve utilisation, capacity and effectiveness of virtual wards. A health economic review of the service has identified a financial opportunity in out of hospital care through Virtual wards
Increase capacity and utilisation of Virtual wards	By March 2024 Virtual Wards in C&M have treated 10’950 patients VW in C&M provide a cost benefit opportunity of £645 per patient
Provide an analysis of the cost effectiveness of VW care compared to standard care	VW utilisation has seen week on week improvement following approval of the review / recommendations Funding allocation for Virtual wards has been reduced in recognition of the continuing financial pressures

2023/24

Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

Workforce Transformation

We said we would…

Develop new community and mental health roles

Identify opportunities for training and development at scale

Develop a cadet scheme

The Community Workforce programme had a resource allocation of one 0.4FTE workforce programme manager. As such, the focus was on managing the delivery of the Health Education England (HEE) funded projects

The HEE work included the development of a successful NHS Cadets scheme in Wirral, Knowlsey and St Helens. Other successful schemes include 'Beat the Burnout', which worked with team members in vulnerable services to develop staff resilience.

The MHLDC Workforce transformation programme has not been resourced for 2024/25 and is not currently due to continue after August 2024

Community Services for Children and Young People:

We said we would…

Improve visibility of community waiting times for CYP in Cheshire and Merseyside and use provider collaboration to address issues of access to Physical health and mental health services

Develop alternatives to acute hospital based services for CYP where

Co-design an improved vision for CYP community services and a real focus on what good community services should look like

Children and Young people in areas of Cheshire and Merseyside now have access to virtual ward based care as an alternative to an inpatient stay with 95-100% utilisation of available capacity.

Access to community based services has improved in areas where the collaborative has targeted intervention. As an example, The number of patients waiting for Paediatric Speech and language services reduced from 5605 in April 2023 to 4660 in April 24

As the CYP workstream developed the synergy with the CYP alliance work and the BEYOND programme have become evident and the MHLDC programme was formally merged into the CYP alliance in 2024

**ICB Board to receive CYP MH update as a separate agenda item*

2023/24

Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

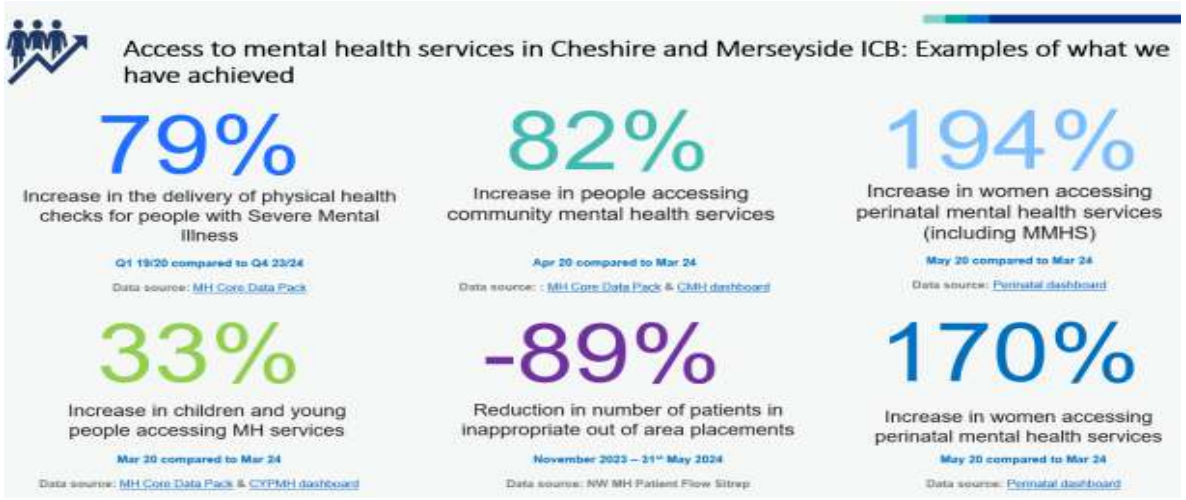
Mental Health Programme:

We said we would…

Continue to lead mental health transformation for those priorities agreed to be best undertaken 'at scale'.

Maintain oversight of all 'place' led Mental Health Long Term Plan ambitions and fulfils appropriate ICB, regional and national reporting requirements

Ensure that quality and timely mental health care is provided for everyone who needs it, and to tackle inequalities in access, experience, and outcomes.



- **Single model of care for Mental Health Crisis Care**
- Additional 5 new **Mental Health School Teams** identified via wave 11 bringing total number of MHST to 31 across the system
- Majority of PCNs met criteria for having access to a transformed model of care and access targets for **community mental health** exceeded by 27%
- Every area now has **24/7 mental health crisis provision** for adults, children and young people
- 3 new **MH Response Vehicles**
- Expenditure on **observational support** for people conveyed to an ED significantly reduced
- **Recovery rates** and **waiting time targets** for access to **NHS Talking Therapies** (IAPT) were exceeded at ICB level and within all 9 places.
- NHS **problem gambling clinic** opened in Liverpool
- **Strategic framework for aligning service model design and mental health workforce planning** has been developed, and initial implementation has commenced

2024/25 Workplan

NHS
Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative

	Virtual Wards	UCR	Falls	IV at Home	DOS
WHAT What will we do (SMART objective)	We will achieve target occupancy of 80% for VWs. Specifically, we will increase the utlisation of VW beds from 60% to 80% by September 2024 **and** increase the number of beds from 430 to 590 by April 2025.	Increase the number of C&M UCR referrals from 2,860 per year to 5,405 per year by April 2025	Reduce the number of Acute bed days as a result of falls for the aged 65+ population from 30,345 bed days per year (upper 4th quartile) to 23,649 bed days per year (national CCG median).	Reduce the number of acute bed days for people receiving IV medication by 4,959 bed days per year.	Ensure that all Directory of Service profiles are accurate
HOW How will we do it?	We will develop general virtual wards. Based on feedback from VW site teams, and other ICBs, we will move away from disease-specific pathways and broaden the access criteria into VWs. Formally integrate virtual wards with UCR services, bringing about a more streamlined access process Implement singular clinical leadership across VWs and UCRs to develop and enhance clinical engagement and knowledge of community urgent care services Develop a business case demonstrating the clinical and cost effectiveness of VW expansion in C&M	We will engage with NWAS and Paramedic leaders to develop clear, consistent referral pathways from 999 & 111 into all UCR services Develop clearer referral pathways from care homes into UCR services **and** develop targeted communications with care homes to raise awareness of UCR services Develop standard self-referral pathways and easy access for high intensity users Demonstrate financial benefits of UCR to develop business proposal for investment in community services	Develop UCR and falls teams' pathways to provide an urgent response to patients following falls as well as future falls prevention inputs to patients at risk. Work with Chief Pharmacists on reducing polypharmacy and known correlation with falls.	Expand the scope of the IV Elastomeric project to incorporate all OPAT IV services and all C&M Places. Present a business case in Q3 demonstrating the clinical and cost effectiveness of Elastomerics in delivering home based intravenous therapy Improve access to OPAT services by improving clinical awareness and referral pathways and identifying variation and gaps in service provision between providers	Work with providers to develop their DOS profiles into an accurate description of service acceptance criteria, opening times etc. Where possible, facilitate digital referrals to services based on DOS profiles and ITK links Develop community urgent care hubs, linked to DOS profiles, that set out clear information about the community offer in each place and offer referring clinicians a single point of access to community urgent care services

The extent to which improvements can be made will be dependent on the funding strategy for community services

Outcomes: what could the impact be?

Annualised opportunity equivalent to 77,902 acute bed days OR 213 beds OR £32.7m

Virtual Wards

Total Opportunity: 38,872 bed days

Methodology: 213 additional occupied beds. Assuming that each VW bed day is equivalent to 0.5 an acute bed day

Data source: C&M VW bed occupancy data

UCR

Total Opportunity: 27,375 bed days

Methodology: extrapolation of 11 additional referrals per week across 5 UCR providers

Data source: W&H Newton UCR opportunity

Falls

Total Opportunity: 6,696 bed days

Methodology: difference in bed days between C&M current position and national CCG median

Data source: Model Health System

OPAT

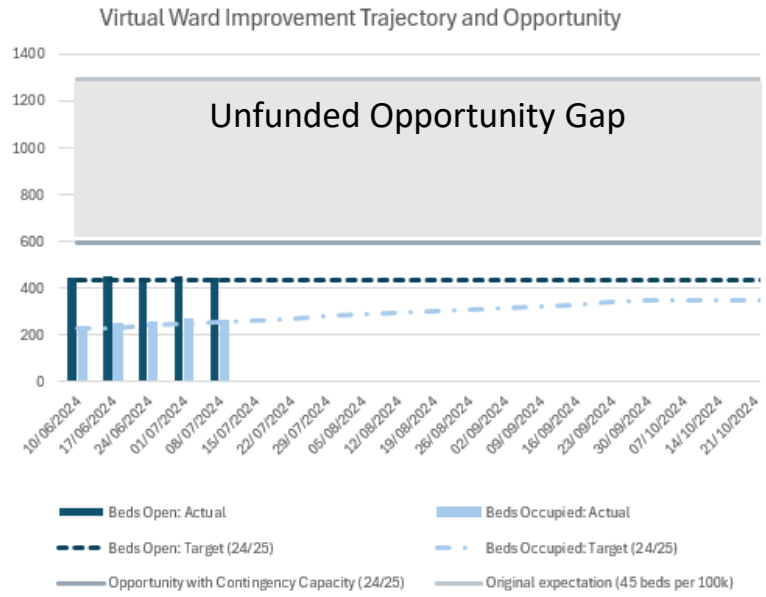
Total Opportunity: 4,959 bed days

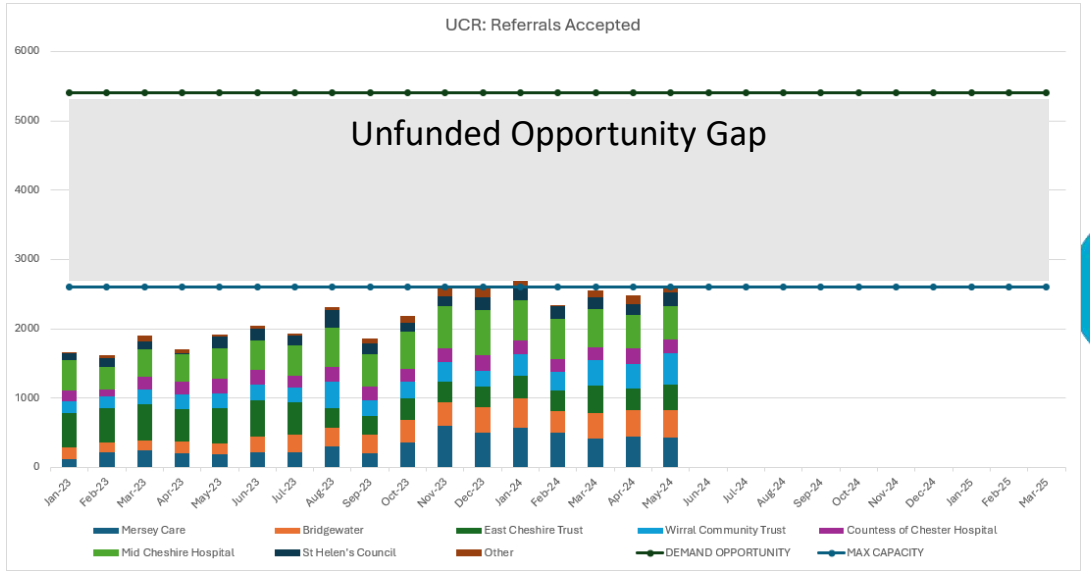
Methodology: 2,024 additional bed days estimated for elastomeric project across 4 providers extrapolated to cover 9 acute providers

Data source: Elastomeric business case

Limitations

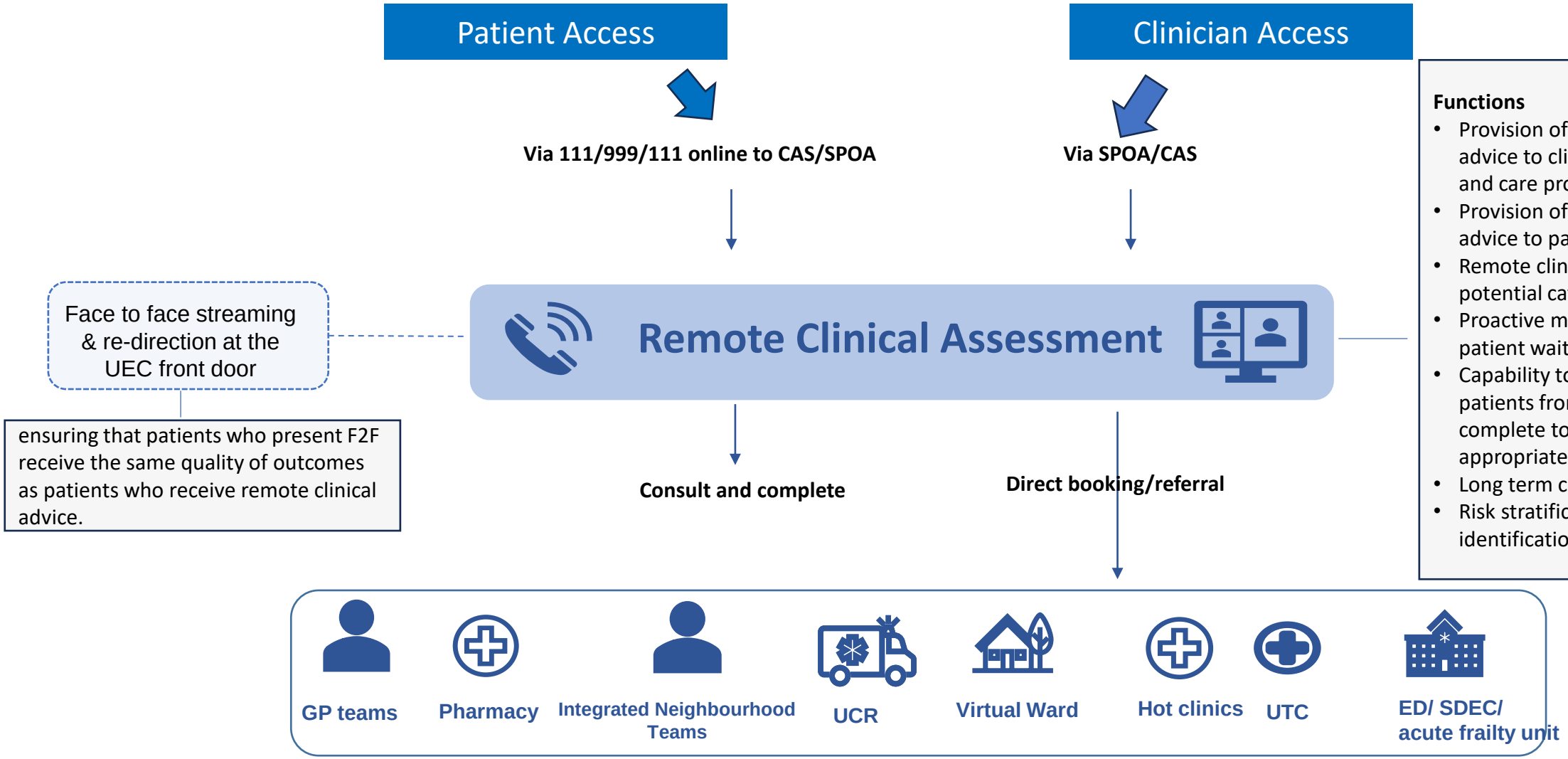
Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative





Integrated Community Care Approach:

Cheshire and Merseyside
Mental Health, Learning Disabilities and Community Collaborative



Inputs: what do we need?

- **PMO & Change Management:**
  - Option 1: Expansion of existing MHLDC team
  - Option 2: Alignment of existing PMO resources from across the system

PMO resources to deliver

- **Clinical Services investment:**
  - This is additional investment, over and above already agreed commitments into the services
    - Increasing activity in community services will require additional investment

Clinical resources to scale up activity

- **ICB Executive sponsorship**
- Agreement to scale up community services
- Integrated community services strategy

ICB Support

NHS
Cheshire and Merseyside

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Consolidated Workforce Report

Agenda Item No: ICB/07/24/26

Responsible Director: Christine Samosa, Chief People Officer

Consolidated Workforce report

1. Purpose of the Report

1.1 This paper (and supporting presentation (Appendix One)) provides the Board with a consolidated review of the Integrated Care Board (ICB) and Integrated Care System (ICS) workforce issues and actions throughout the past year.

2. Executive Summary

2.1 This report provides an overview of some of the activities of NHS Cheshire and Merseyside's People Team during 2023/24 (Section Six) and also describes the workforce challenges facing our health and social care system (Section Seven) and our actions to ensure that we have a sustainable, highly skilled and valued workforce for the future across health and social care.

2.2 The report also includes an overview of the Cheshire and Merseyside Staff Survey (System) results for 2023 (Section Eight). The results are presented against the seven areas of the national People Promise and the key themes of staff engagement and morale. The supporting presentation provides an additional high-level overview of the staff survey scores for each of our 16 Trusts and how they compared with each of their peer groups. Organisations are currently sharing their own results and developing localised action plans in line with staff feedback. The results and report provides an oversight of what it feels like to work in the NHS in Cheshire and Merseyside.

2.3 The Cheshire and Merseyside ICS People Board have oversight of the workforce agenda and the aspirations linked to the national long term workforce plan.The report also details what the People Board for the period 2023 – 2024 has focussed on (Section Nine).

3. Ask of the Board and Recommendations

3.1 **The Board is asked to:**

- **consider** the content of this report and seek any further information on the plans around our workforce.

4. Reasons for Recommendations

4.1 The implementation of the staff survey action plan for NHS Cheshire and Merseyside will be monitored by the ICBs People Committee, which reports through to the Finance, Investment and Our Resources Committee.

4.2 The Integrated Care System People Board will monitor performance of the system priorities, with regular reports to the Board of NHS Cheshire and Merseyside.

5. Background

5.1 The ICB requested at its March 2024 meeting that an annual report of the People Team be brought to its May meeting, together with details of the staff survey results for all 16 NHS Providers.

5.2 NHS Cheshire and Merseyside ICB was established 01 July 2022 and as at 31 March 2024, directly employed around 1000 staff, most of whom work in a hybrid way (office based/home working). Throughout 2022/2023 the majority of staff went through organisational change which inevitably impacted on morale, psychological safety and wellbeing and accordingly it was important that the People Team ensured that staff engagement and organisational development were at the heart of everything that we did.

5.3 In 2022, the ICB took part in the national staff survey which provided an insight into how staff were feeling, what mattered to them and what actions were required to make the ICB a great place to work.

5.4 Over the past year, arrangements have been put in place to respond to the feedback from the Staff Survey results (2022), including significant engagement activity to share and discuss the results, seeking further information, feedback, and wider intelligence. This resulted in the development of a comprehensive action plan themed around the key areas of engagement, morale and the seven areas of the NHS People Promise.

5.5 The Cheshire and Merseyside ICS People Board has responsibility for the implementation of the strategic workforce agenda in line with the national expectations of ICS People functions as detailed below:

- supporting the health and wellbeing of all staff: people working and learning in the ICS feel safe and supported in their physical and mental health and wellbeing, and are therefore better able to provide high-quality, compassionate care to patients.
- growing the workforce for the future and enabling adequate workforce supply: the system is retaining, recruiting and, where required, growing its workforce to meet future needs. The ‘one workforce’ across the ICS is representative of the local communities served.
- supporting inclusion and belonging for all and creating a great experience for staff: people working and learning in the ICS can develop and thrive in a compassionate and inclusive environment. Issues of inequality and inequity are identified and addressed for all people working in the system. The workforce and leaders in the ICS are representative of the diverse population they serve.
- valuing and supporting leadership at all levels, and lifelong learning: leaders at every level live the behaviours and values set out in the People Promise

and make strides so that this is the experience of work for all of their 'one workforce'.

- leading workforce transformation and new ways of working: service redesign is enabled through new ways of working, which make the most of staff skills, use of technology and wider innovation – to both meet population health needs and drive efficiency and value for money.
- educating, training and developing people, and managing talent: education and training plans and opportunities are aligned and fit for the needs of staff, patients and citizens, including to enable new ways of working and support meaningful and personalized career journeys.
- driving and supporting broader social and economic development: leaders ensure that their organisations leverage their role as anchor institutions and networks to create a vibrant local labour market, promote local social and economic growth in the wider community, support all ICS partners to 'level up', address wider health determinants and inequalities at the heart of poor health.
- transforming people services and supporting the people profession: high quality people services are delivered by a highly skilled people profession to meet the future needs of the 'one workforce', enabled by technology infrastructure and digital tools.
- leading coordinated workforce planning using analysis and intelligence: integrated and dynamic workforce, activity and finance planning meets current and future population, service and workforce needs, across programme, pathway and place.
- supporting system design and development: the system uses organisational and cultural system design and development principles to support the establishment and development of the integrated care board (ICB), and the integrated care partnership (ICP). The organisational development approach creates a system-wide culture that: is driven by purpose; enables people, places and the system to fulfil their potential; is connected to the people served by the system and those delivering services.

5.6 Our health and social care workforce is made up of staff who work in hospitals, community clinics, GP practices, dental practices, pharmacies, care homes and people's homes, as well as community centres, the ICB and in many other locations and environments.

5.7 We recognise that staff consistently go above and beyond what is required of them and deliver outstanding care for our communities, irrespective of what part of the service they work in. Many of our staff are also carers and have to balance the needs of their families and dependents with managing challenging and busy roles.

5.8 We must also acknowledge the work of our many volunteers, carers and the faith sector that assist services and patients and support their communities to be resilient. We could not deliver our health and care services without those who work so tirelessly in the service of communities. They are caring and compassionate, tenacious and innovative. As a system we recognise the importance of improving education and employment opportunities across health

and care and the impact this has on improving the health and wellbeing of the local population. We must also recognise that the majority of our workforce also live in our community and so the challenges faced by our populations also impact on our staff.

6. ICB People Team Annual Report

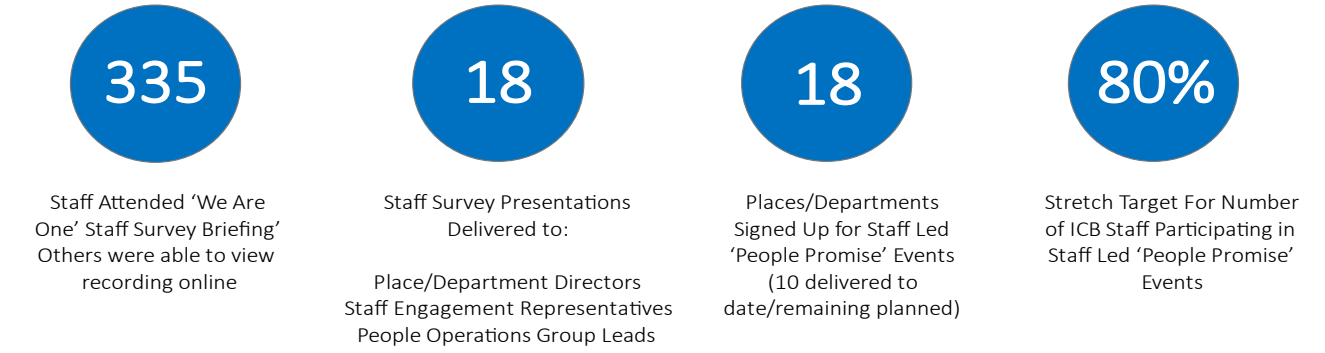
6.1 **The ICB Workforce.** In 2022, the ICB took part in the national staff survey which provided an insight into how staff were feeling, what mattered to them and what actions were required to make the ICB a great place to work. Over the past year, arrangements have been put in place to respond to the feedback from the Staff Survey results (2022), including significant engagement activity to share and discuss the results, seeking further information, feedback, and wider intelligence. This resulted in the development of a comprehensive action plan themed around the key areas of engagement, morale and the seven areas of the NHS People Promise.

6.2 The results of the 2022 and delivery of the resultant agreed actions led to the establishment of an integrated work programme entitled “Improving Staff Experience” with cross functional leadership across People, Communications, Estates, Information Technology and Governance. The work programme was delivered across 5 pillars (Figure One):

Figure One: 5 Pillars

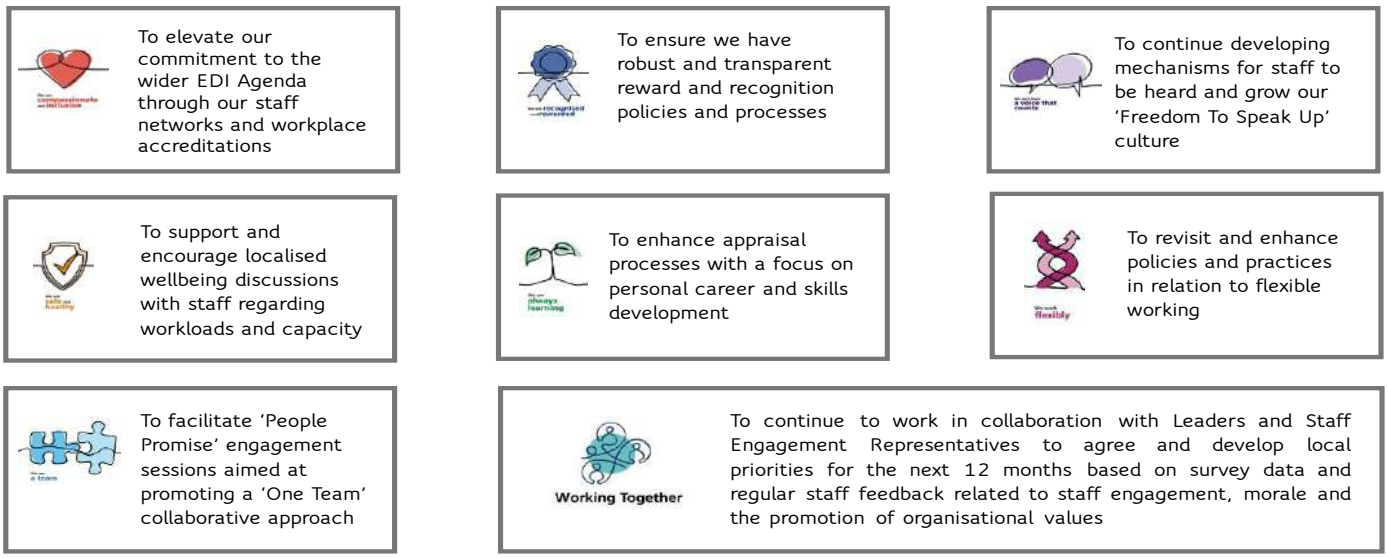
6.3 A year on and the ICB had a response rate of 77% in the 2023 staff survey and this provided a robust platform from which improvements can continue. A range of awareness and development sessions have been held to share the results of the survey and to develop appropriate action plans (Figure Two). These sessions have taken place at both corporate and place level to ensure full staff engagement and ownership.

Figure Two: Staff Survey 2023 results engagement



6.4 The sessions have resulted in the following priorities for 2023-24 being developed (Figure Three):

Figure Three: ICB Staff Priroities 2023-24



6.5 **Staff Engagement.** In May 2023, we established our Staff Engagement Forum (SEF) which has now grown to a membership of circa 30 staff members representing teams across the organisation. The SEF have been instrumental in supporting two way communication and engagement as well as the development of our staff experience initiatives.

6.6 Working with SEF and our staff networks a campaigns calendar has been developed, to support and engage our staff in a number of national and local Health & Well-Being, Equality, Diversity and Inclusion campaigns and events throughout the year.

6.7 During the past year events have been held to promote Black History Month, Disability History Month and LGBT History month. Campaign activity has also supported awareness campaigns including Carers Week, Self-Care Week,

Menopause Day and Freedom to Speak Month with involvement of respective networks to support this activity.

6.8 During Disability History Month the focus was on how to lead the change to tackle discrimination and support disabled people working across the health and care sector. It was an exciting opportunity to recognise and celebrate the 1 in 5 NHS staff who bring personal lived experience of disability and long-term health conditions to their careers, teams, leadership, and patient care.

6.9 It is recognised that not all disabilities are visible or immediately apparent and staff were encouraged to record their disability on ESR and have open conversations with their managers. There is now a dedicated page on the staff intranet offer support to our disabled staff.

6.10 Black history month focused on the Power of the Pledge with staff pledging to raise awareness, actively becoming anti racist and challenging racism in the workplace.

6.11 We are continuing to develop our health & wellbeing support offer to staff with enhanced information and signposts available on the staff hub. A network of 18 Mental Health First Aider has been established to provide an informal range of staff wellness support, promotion and signposts. The Mental Health First Aiders also offer a range of “happy to chat” sessions both in person and on-line to link in with national and local mental wellbeing campaigns.

6.12 Across November and December 2023, we ran a range of physical and mental wellbeing sessions to promote Self Care Month. This was also supported by information sessions in relation to a number of areas including Menopause Awareness sessions.

6.13 **Staff Networks.** In response to engagement and staff feedback activities, the ICB has established a range of staff networks, including:

- BAME staff network
- Disability and neurodiverse staff network
- Menopause network
- LGBTQ network
- Working Carers network
- Military families’ support network
- Early Career network
- Adoptive Parents network.

6.14 Each network has an ICB Executive Director sponsor to provide support, advice and guidance and networks have a charter to underpin their working arrangements, activity and operations.

6.15 **The ICB People Committee.** The ICB People Committee is now well established and receives a range of data which is subsequently reported through to the finance, investment, and resources committee. A monthly dashboard is produced and is shared with all Directors and discussed at

Executive Team meetings, with more detailed reports shared locally to drive targeted improvements.

6.16 Throughout the year a number of staff have transferred into the ICB including teams from NHSE, Mersey Internal Audit Agency, the Commissioning Support Unit (CSU)and the Local Midwifery and Neonatal Service (LMNS).

6.17 Robust vacancy control is in place to ensure that the ICB will meet its running cost reduction target of 30% by 2025.Sickness levels remain at around 3%, however sickness levels have increased throughout the year and this is now the subject of additional focus to enable managers to support people into getting people back into work effectively and in a supported way.

6.18 Workforce risks are reviewed at each meeting of the People Committee. The assurance function of the People Committee is also supported by a range of management, operational and engagement mechanisms including People Operations Group, Staff Engagement Forum, Staff Networks, Staff Partnership Forum, and Freedom to Speak Summit.

6.19 **Workforce Profile.** As at 31 March 2024, NHS Cheshire and Merseyside employed 1,081 staff (Table One). The headcount has increased by 46 compared to last year's headcount which was reported as 1035 on 31 March 2023. The gender split of our current workforce is Female 77.15% and Male 22.85%.

6.20 Over the course of the last financial year, there have been several TUPE transfers into the organisation which equated to approximated 55 new staff joining the ICB (Table One).

Table One: ICB Headcount

Pay Band	Headcount
Band 2	8
Band 3	43
Band 4	80
Band 5	125
Band 6	145
Band 7	208
Band 8A	153
Band 8B	119
Band 8C	74
Band 8D	19
Band 9	39
Medical	30
VSM	35
Board (off payroll)	3
Total	**1,081**

6.21 NHS Cheshire and Merseyside's Staff Turnover Rate for 2023-24 has been calculated by dividing the total Full Time Equivalent (FTE) Leavers in-year by the average FTE Staff in Post during the year.

6.22 The Total FTE Leavers in year was 126.94. The Average FTE Staff in Post during the year was 971.41 (2022-23 - 948.45). The Staff Turnover Rate for the year was 13.07% (2022-23 – 13.49%).

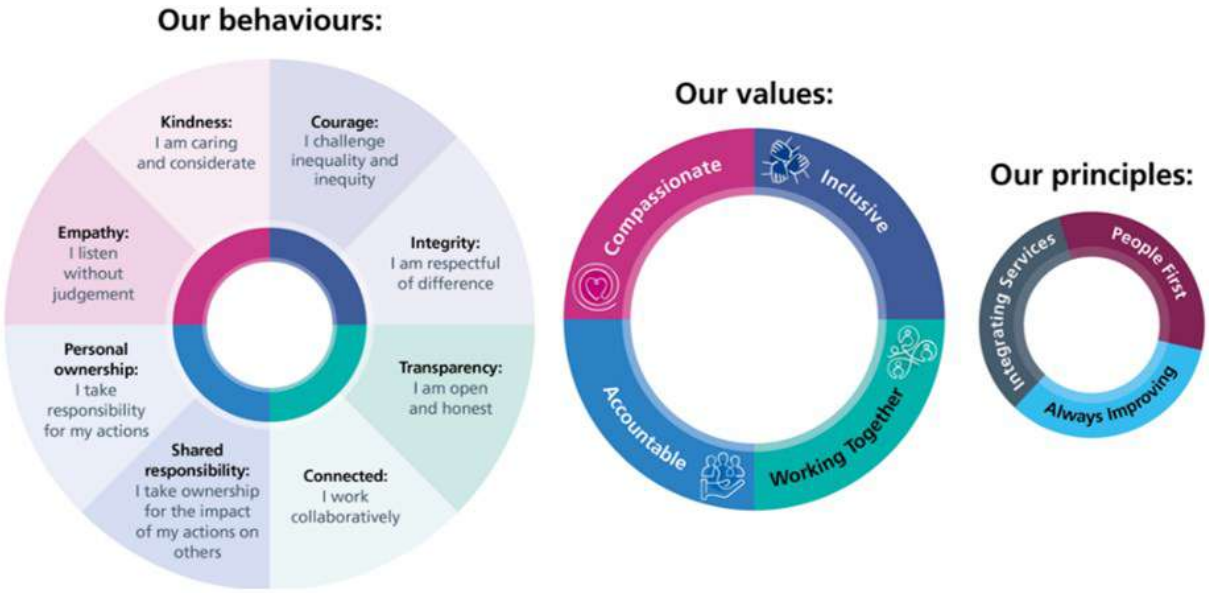
6.33 Throughout the period NHS Cheshire and Merseyside's staff turnover rate was reported regularly to its Board, through the Finance, Investment and Our Resources Committee and to the Executive Team. Workforce data provided to NHS Cheshire and Merseyside by Midlands and Lancashire Commissioning Support Unit outlined all recorded reasons for staff leaving NHS Cheshire and Merseyside with the top three reasons being:

- Mutually Agreed Resignation Scheme
- Voluntary Resignation – Promotion
- Retirement Age.

6.34 A MARS scheme was run during Q3 and a proportion of the leavers during Q4 will have been those who left as part of the scheme.

6.35 **Our Cultural Operating Principles, Values and Behaviours.** The NHS Cheshire and Merseyside Culture Framework of the ICB has been agreed, detailing the organisation's cultural operating principles, values and behaviours (Figure Four).

Figure Four: ICB behaviours, values and principles



6.36 **Talent Management.** Work has been undertaken to explore building executive team bench strength to plan for any risks to business continuity and preparing for succession planning. The talent management agenda is planned to respond to the NHSE competency framework for Board and Executive level roles.

6.37 Career conversations and staff aspiration discussions have been built into the review of the ICB appraisal process.

6.38 **Learning and Development.** Learning and development activity planning is focused on:

- achieving statutory / mandatory compliance in line with national standards
- optimising existing Learning and Development offers available to NHS C&M ICB staff via system partners including provider organisations, the Northwest Learning and Development Collaborative including NHS NWLA and wider health and care partners
- ensuring optimal utilisation of the apprenticeship levy.

6.39 The NHS Cheshire and Merseyside ICB Leadership Programme is focused on building baseline leadership skills. The modules include:

- Module 1: Values-based leadership.
- Module 2: Leading with cultural competence.
- Module 3: Systems Leadership
- Module 4: Leading continuous improvement.

6.40 For clinical teams there is also a module on Clinical Leadership.

6.41 Further training developments include:

- Information Governance Training
- Oliver McGowan E-Learning
- Launch of NHS Cheshire and Merseyside Population Health Academy.

6.42 **Organisational development.** Organisational Development continues to be focused on creating the conditions for integration through collaboration and enabling new ways of working. A senior leadership forum has been developed which meets on a bimonthly basis and brings together senior leaders with directorship responsibilities for developmental sessions and opportunities to tackle complex organisational challenges in a developmental context.

6.43 **Leadership development.** Leadership development continues to focus on the following agendas:

- Board development - Aligned to a system piece of work to explore the potential for streamlining approaches to NHS Board development.
- Executive development - Focused on executive development to respond strategically to operational recovery priorities.
- Team development - Aligned to a system piece of work to explore the potential for streamlining approaches to baseline leadership development.
- Senior leadership development – Focused on market ready leadership, responsive to the Health and Care Act ambitions for integrated care systems.

6.44 **Workforce Equality Diversity and Inclusion.** NHS Cheshire and Merseyside holds statutory, regulatory and compliance related responsibilities for the delivery of the equality, diversity and inclusion agenda to include:

- Delivery of its public sector equality duty under the Equality Act, 2010
- Delivery against its specific duties - setting equality objectives

- Delivery of improved organisational performance against key metrics including the Equality Delivery Systems, Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), annual NHS staff survey and the Gender Pay Gap (GPG).

6.45 Diagram Five shows how the ICBs people team is working to meet its public sector equality duty and cultivating an inclusive culture.

Figure Five: Working towards greater workforce equity 2023-2026

6.46 **Workforce Equality Diversity and Inclusion.** NHS Cheshire and Merseyside has identified 3 priority areas for workforce improvement.

- Disability,
- Ethnicity and
- Sexual orientation/trans gender.

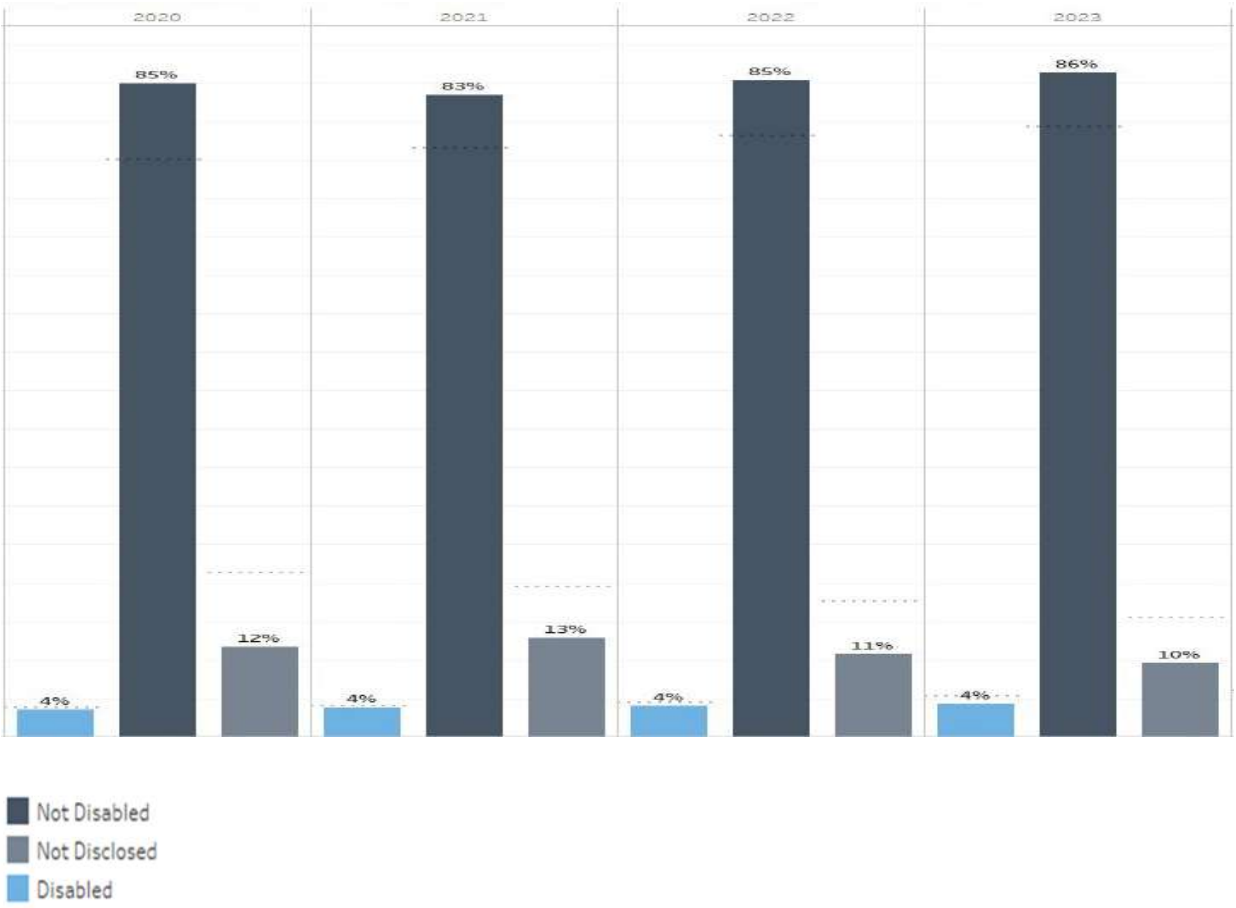
6.47 Considerable evidence consistently shows that the less favourable treatment of black, Asian and minority ethnic (BAME), disabled staff and staff from Lesbian, gay, bisexual, trans, queer, and intersex (LGBTQI+) communities in the NHS[1] , through poor treatment and opportunities, has significant a significant impact on staff well-being, patient outcomes and on the efficient and effective running of

the NHS and that the measures needed to address such discrimination will benefit patient care and organisational effectiveness

6.48 NHS Cheshire and Merseyside is committed to supporting improvements in equity outcomes and experiences for workforce. As an employer, we take seriously our responsibilities to review our own performance against national standards including the Workforce Disability and Race Equality Standards, the Equality Delivery System and the NHSE EDI improvement Plan.

6.49 **Disability.** Between December 2020 and December 2023, the overall level of disability reporting has remained below 90% peak of 2023. However, this is higher than the regional average. Except for 2023, the percentage of disabled people employed by the ICB is consistent with the regional average. The percentage of those choosing not to disclose their disability status, remains below the regional average and shows a decreasing trajectory (Figure Six).

Figure Six: ICB Workforce - Disability – Percentage Split by year Dec 2020 – Dec 2023 Source: ESR (dotted lines shows regional Average)



6.50 Our last Workforce Disability Equality Standards results (March 2023) revealed that only 4% of disabled people (headcount) were employed by the CM ICB. However, Table Two shows that there has been a steady month on month increase in this figure between then and March 2024 when it stood at 5.32%.

Table Two: ICB Workforce Disability Standards results (as of March 2023)

Component	March 2023 (Prev Year End)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Staff Self-Declared as Disabled (%)	3.98%	3.92%	4.13%	4.14%	4.17%	4.34%	4.62%	4.56%	4.65%	4.86%	4.96%	5.20%	5.32%

6.51 **Ethnicity.** Between December 2020 and December 2023 there has been a decrease in the overall level of ethnicity reporting – within the ICB/legacy CCGs from a peak of 98% in 2022 to 93% in 2023. The percentage of white people employed remains consistently higher than the regional average and the percentage of BAME people employed remains consistently lower (Figure Seven).

Figure Seven: ICB Workforce - Ethnicity - Percentage Split by year Dec 2020 – Dec 2023 (dotted lines shows regional Average)

6.52 Our last Workforce Race Equality Standards results (March 2023) revealed that only 4.7% (head count) of people of BAME heritage were employed by the CM ICB. However, the table below shows that there has been a steady month on month decrease in this figure between then and March 2024 when it stood at 4.17% (Table Three).

Table Three: Workforce Race Equality Standards (as of March 2023)

Component	March 2023 (Prev Year End)	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BME Staff (%)	4.70%	4.55%	4.55%	4.01%	4.36%	4.45%	4.30%	4.24%	4.14%	4.04%	4.14%	4.24%	4.17%

6.53 To demonstrate its support for improving ethnicity outcome, the ICB articulated an ambition to become intentionally anti-racist and published its anti-racism statement in September 2023. Individual members of the board made their own pledges to committing to becoming anti-racist allies, and the ICB Chief Executive was identified as the champion/sponsor for the anti-racism agenda. Additionally, the board approved our intention to implement the Northwest BAME Assembly's Anti-Racism Framework.

6.54 During the months of September and December 2023, key functions and places completed the Anti-racism self-assessment looking at the following areas:

- Mission, Values, and Culture
- Leadership and Staff Morale
- Engagement and Decision Making
- Tracking Racial Disparities
- External Relationships.

6.55 **Targeted Anti-racism Leadership development.** In February 2023, the ICB board attended a development session on anti-racism. The purpose of the session was to support the board to achieve: a shared understanding of anti-racism, to understand the implications of an anti-racist approach; and to develop its understanding of the purpose of its leadership in this area and how it holds itself accountable for change. To date, two out of the five deliverables have been achieved (Table Four).

Table Four: ICB progress against Anti-racism leadership development

Key Drivers	Direct Deliverable	Supporting Actions	CM ICB Evidence
Leading from the front	The appointment of an executive or director level EDIsponsor with a commitment to advancing anti-racism withinthe organisation.	• This senior director level EDI sponsor has a clear role description, including annual personal development performance goals related to advancing anti-racism.	CEO is the Exec sponsor for the Race
		• Must report as a minimum into an executive director and / or chief executive officer and be considered a part of the wider senior leadership team to facilitate and enable change on racial equity.	
Anti-racism as Mission Critical	Evidence of how the organisation has acted to make antiracism work mission critical in the past year.	• An anti-racism statement to be produced and published detailing organisational commitment to racial equity.	Antiracism statement has been published on CM ICB website
Actions Not Words	An organisation must have set and published at least one stretch goal that goes beyond legal or NHS assurance frameworks compliance.	• Implementation of equality and inclusion KPIs with a focus on addressing race-based disparities.	
We do this together	The organisation can demonstrate progress over the last 12 months of reducing an identified health inequality.	• The organisation can demonstrate working in partnership to reduce a specific health inequality through an anti-racism lens and publish progress within the organisational annual report.	
Zero Tolerance	The organisation must have communicated clearly that it takes a zero-tolerance approach to racist abuse from service users or staff members.	• Explicit processes for addressing instances of racist abuse, discrimination and harassment should be developed within or in addition to current organisational disciplinary procedures	

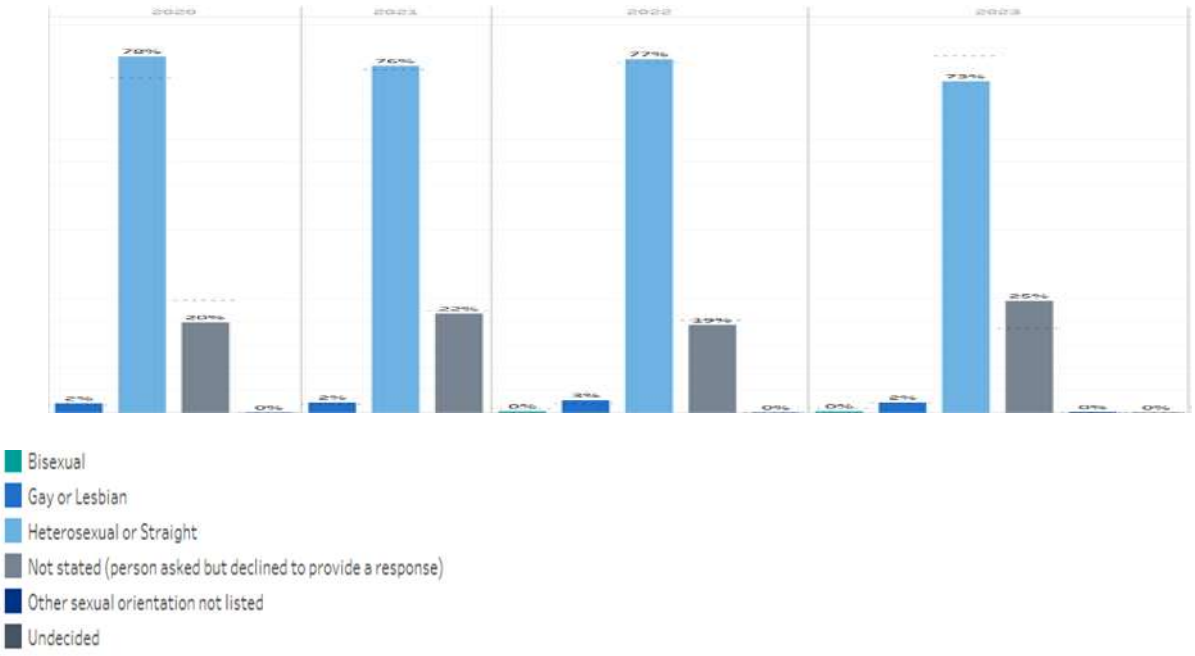
6.56 **Sexual Orientation.** There is a significant under-reporting of the number of employees declaring their sexual orientation (less than 80%) within the ICB/legacy CCGs. The trend over the previous three years is decreasing from a peak of 80% in 2020 and 2022 to 75% in 2023. The percentage of people who are gay/lesbian and bisexual employed remains consistent with regional average. (Figure Eight).

6.57 As of March 2024 (Table Five) there has been an increase in the reporting of gay or lesbian and bisexual people working for the ICB, when compared with March 2023; and a corresponding reduction in those who chose not to share their sexual orientation. It is evident that more needs to be done to encourage to the significant number of those in 'Not stated' category to disclose their sexual orientation status.

Table Five: ICB Workforce - Sexual Orientation (as of March 2024)

Sexual Orientation	FTE	% of Total
Bisexual	4.80	0.49%
Gay or Lesbian	24.31	2.48%
Heterosexual or Straight	714.42	72.98%
Not stated (person asked but declined to provide a response)	233.42	23.84%
Other sexual orientation not listed	1.00	0.10%
Undefined	1.00	0.10%
Grand Total	**978.94**	**100.00%**

Figure Eight: ICB Workforce - Sexual Orientation - Percentage Split by year Dec 2020 – Dec 2023 (dotted lines shows regional Average)



6.58 **On going work.** The following outlines key areas of work:

- During 2023 three equality staff networks, representing BAME, disabled and LGBTQI+ staff, were established to strengthen and promote disabled staff voices; increase the ICB's understanding of disabled staff experiences, and to support the organisation with identifying measures to improve experience and outcomes for the BAME, disabled and LGBTQI+ staff communities.

- Implementing equality standards i.e.:
  - The Disability Confident Scheme – Level 1
  - NW BAME Assembly Antiracist Framework – Bronze level
  - Navajo Standard.

  These standards are multi-levelled and aim to address systemic and institutional discrimination that may exist within the ICB. They require commitment to the continuous review of progress and being intentional about actions for change. They will enable us to meet our commitments for:
  - Increasing the diversity of our board and senior leadership teams.
  - Ensuring that our recruitment processes are inclusive and accessible.
  - Communicating and promoting vacancies widely within our local communities.
  - Fair and inclusive access to employment and progression opportunities.
  - Fair and transparent talent management.
  - Offering interviews to disabled people.
  - Developing processes to support managers to work with their staff members to anticipate, identify and provide reasonable adjustments as required.

  - Supporting all existing employees who acquire a disability or long-term health condition, enabling them to stay in work.
  - Reducing inequities in the rates of bullying and harassment between those with these protected characteristics and those without.

- To encourage staff engagement in this work network members will work with the People Team to share their experiences of working for the ICB, promote celebratory events and showcase progress made towards improving staff outcomes.

- Whilst there are a range of reporting and procedures in place for staff reporting incidents of harassment, bullying or abuse, including speak up processes and HR processes. We will be working with Freedom to Speak Up Guardians and champions to ensure speaking up processes mitigate barriers preventing staff from using them, including the recruitment of FTSU champions with the above-mentioned characteristics.

- Supporting improvements in organisational culture by working with others to ensure the effective implementation of the Values and Behaviours Framework.

- Undertaking a range of activities to promote Black, Disability and LGBTQI+ History Months and other relevant events during the year.

7. The Cheshire and Merseyside NHS Workforce

7.1 The Cheshire and Merseyside NHS workforce equates to circa 87,000 staff including our colleagues in Primary Care and is made up of substantive, bank and agency staff. Throughout 2023/24 there has been a reduction in the use of agency staff and Cheshire and Merseyside Trusts collectively achieved the national target of agency staff equating to no more than 3.7% of the pay bill.

7.2 It is recognised that temporary staffing through the use of local staff banks provides the flexibility that many require to enable them to manage competing pressures, and this has continued to be an attractive employment model for many.

7.3 **The NHS Long Term Workforce Plan.** The national long term workforce plan was published in the summer of 2023 and has three areas of focus:

- Train
- Retain
- Reform.

7.4 The Government announced additional funding to support the expansion of training places, introduction of new apprenticeship programmes and creation of new volunteering opportunities. Universities are now actively planning for increased training provision, however at a local level there is a need to ensure that there are appropriate expansion of good quality, clinical placements,

supervision, and appropriate development. The ICB works in partnership with NHSE (previous HEE teams) to ensure that the Cheshire and Merseyside Multi-professional Education and Training Investment Plan (METIP)informs any training place expansion and commissioning of new training programmes.

7.5 In order to support the 'retain' element of the plan the ICB has a dedicated retention lead who supports Trusts to address the challenges of staff retention. We are fortunate to have eight of the national People Promise /Exemplar Trusts in Cheshire and Merseyside and there is evidence that a focus on this area can result in reduced turnover. The current rate of turnover across Cheshire and Merseyside is 11.3% compared with 13.2% at the start of the financial year.

7.6 The aim of the People Promise Exemplar sites is to to deliver interventions set out in the People Promise together in one place, at the same time, in order to achieve improved outcomes and optimum staff satisfaction and retention. The learning from the Exemplar sites across Cheshire and Merseyside is reported through quarterly Staff Retention Forum and regular newsletters.

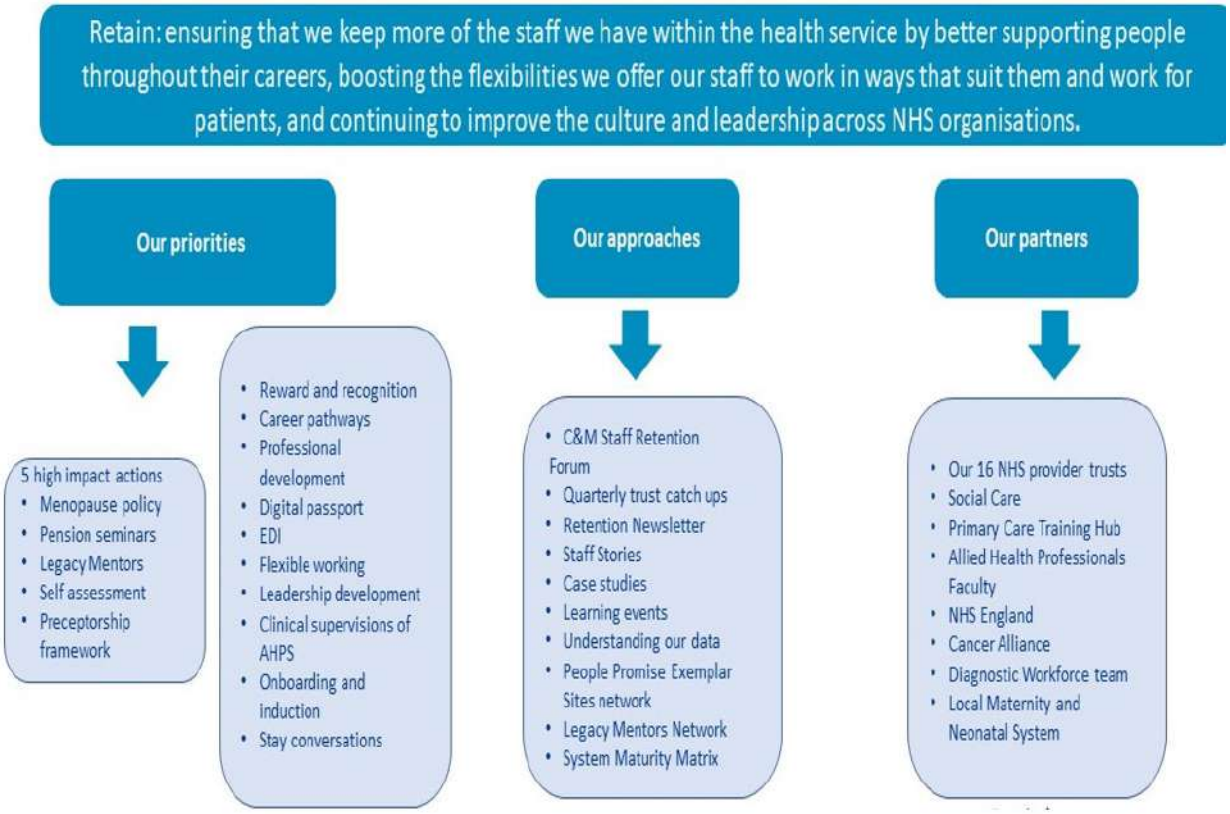
7.7 Across all of the Trusts we have continued to introduce and support the 'legacy mentors' programme. Legacy mentors are experienced nurses, or colleagues in other regulated professions, usually in late career, who provide coaching, mentoring and pastoral support to our NHS people who are at the start of their careers or who are newly appointed into the NHS. We have six Trusts with Legacy Mentors.

7.8 The retention priorities remain aligned to the national five high impact actions. These actions are:

- menopause support,
- legacy mentor implementation,
- Implement the National Preceptorship Framework,
- completion of the national nurses and midwifery self-assessment tool (with quarterly returns) and
- encourage staff to attend pensions webinars.

7.9 Figure Nine also describes the approach regarding working towards the ambition of the Long Term workforce Plan – retain.

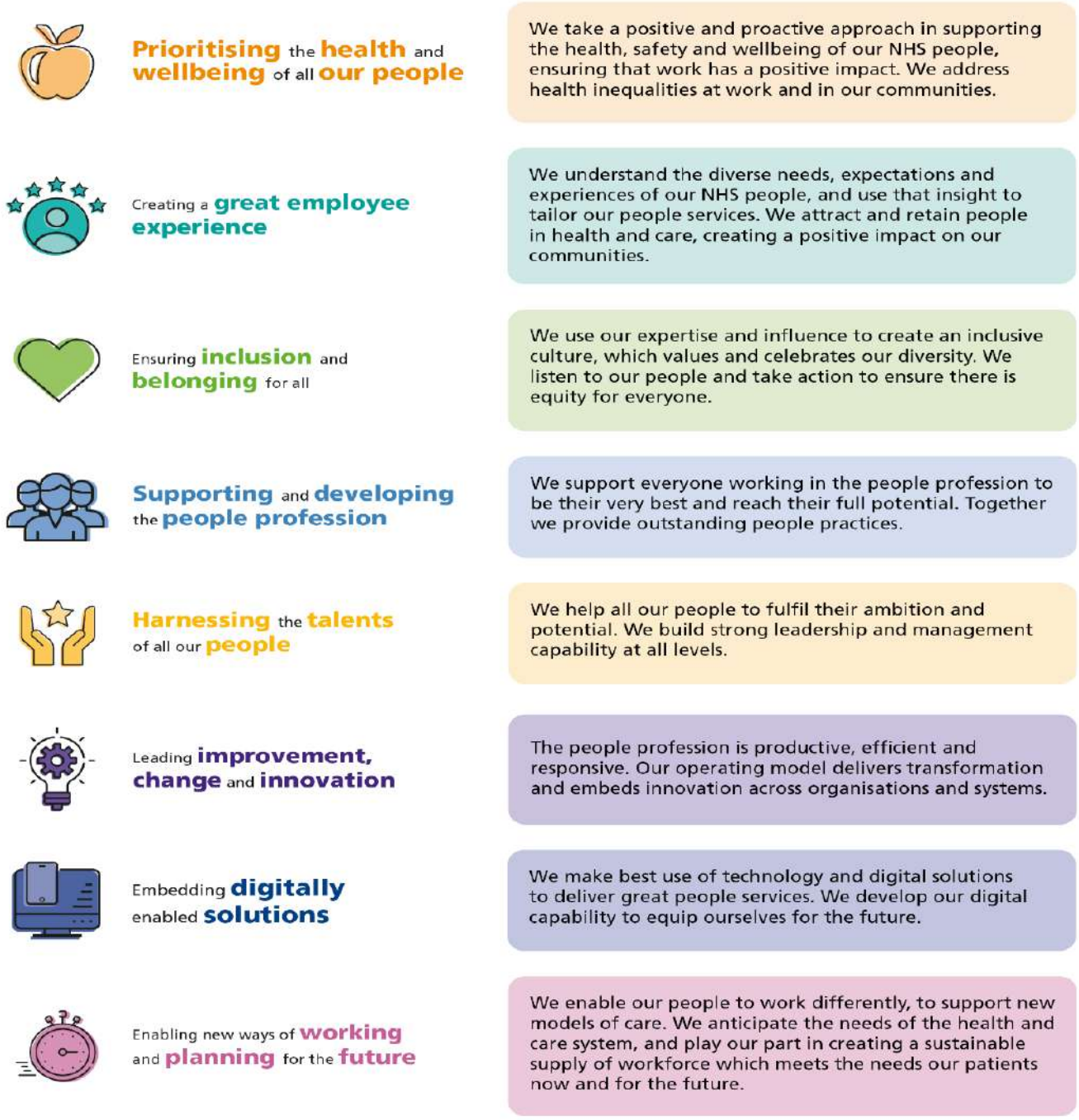
Figure Nine: Working towards the ambition of the Long Term workforce Plan – retain



7.10 **Scaling People Services.** In 2021, the Future of NHS HR and OD report, outlined the 10-year strategy for HR and OD in the NHS and focused on the following areas outlined in Figure Ten.

7.10 In order to identify system opportunities for collaboration and potential for 'scaling people services' a significant information gathering exercise was undertaken across C&M in the Autumn of 2023 and HRD's/CPOs identified 14 areas where collaborative working would reap benefit, by improving quality and the employee experience, removing duplication, inconsistency and creating efficiencies, maximising use of specialist skills and building resilience, or maximising technological developments (RPA).

Figure Ten: Focused areas of the Future of NHS HR and OD report



7.11 To maximize the opportunity that scaling provides, the national scaling programme states that it should be built around four principles which will underpin the work we do in this area: simplify, standardize, automate, and consolidate. The priorities have been determined as follows (Table Six).

Table Six: National Scaling Programme priorities

Time Scale	Programme
Quick wins	Core Board Development
	Policies
Short Term	AfC Job evaluation
	HR systems /E Roster
	Workforce information/analytics
	EDI
	Leadership Development
Medium/Longer term	Apprenticeships
	Recruitment
	Employment services
	Bank staffing

8. Staff Survey Cheshire and Merseyside System Results

8.1 Over 30,0000 staff responded to the survey equating to 47.85% of the workforce, this represented a 2.3% increase in response rates or 2,651 staff compared to the previous year. The system staff engagement score was (6.95) and staff morale (6.02). This compared against the 2022 scores of (6.85) and (5.82) respectively.

8.2 Following a review of the results and comparison to other system peer groups, NHS Cheshire and Merseyside system showed an improvement in 6 out 8 of all the available People Promise Themes including Staff Engagement and Morale. (Scores for 'We Are Safe & Healthy' was not available due to a national data issue).

8.3 The most improved scores were "We are Always Learning", "We are Recognised and Rewarded" and "Morale". There were also improvements in "Staff Engagement" compared to 2022. "We each have a Voice that Counts" and "We are Compassionate and Inclusive" remained consistent when compared to 2022.

8.4 In 2023 our system scores are consistent with the national median for all available People Promise themes, Morale and Staff Engagement, except for "We are Compassionate and Inclusive" which was above the national median score.

8.5 'Liverpool Heart and Chest Hospital' scored highest nationally across all 8 available themes, when benchmarked against their peer group.

8.6 The People Team will continue to work collaboratively with Trusts through a series of established networks and associated regional and national programmes to further embed the themes of the People Promise and increase overall staff engagement and morale.

8.7 The attached presentation (Appendix One) provides detailed information on each of the People Promise scores.

9. Cheshire and Merseyside People Board

9.1 The Cheshire and Merseyside People Board met on a quarterly basis during the year and have been undertaking a review of its terms of reference to ensure it relects the change in focus from monitoring the use of workforce development funding to becoming far more strategic in nature and ensuring that workforce plans inform the commissioning of appropriate training places and that appropriate supply is available to ensure a sustainable workforce.

9.2 The People Board have considered presentations on the equality and diversity profile and approach across social care, the state of the nation report into social care workforce, the proposal for a collaborative Primary Care staff bank, the workforce planning processes and challenges , supply data of students entering training courses, together with the changes in education including T level courses.

9.3 The Multi Professional Education Training Investment Plan (METIP) has been modelled using historic demand and supply data and the Cheshire and Merseyside Plan has been submitted to NHS England.

9.4 The People Board has established a number of sub groups, including a Primary Care workforce group, a social care and Voluntary sector group and a supply and programmes group.

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

Objective One: Tackling Health Inequalities in access, outcomes and experience.

The workforce agenda, including the education and employment of our current and future workforce is critical in improving health inequalities in our local populations.

Objective Two: Improving Population Health and Healthcare

In order to ensure that services are accessible there needs to be appropriate staff, with the right skills, in the right environments, and who are reflective of the populations we serve.

Objective Three: Enhancing Productivity and Value for Money

Workforce, activity and finance need to be triangulated to ensure that we are working at optimum productivity levels and that staffing levels and costs are regularly reviewed.

Objective Four: Helping to support broader social and economic development

The provision of employment supports the social and economic development of Cheshire and Merseyside.

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

12.1 The workforce strategy and approach is a key component of the annual delivery plan and supports the Long Term NHS Workforce plan and People Promise targets.

12. Link to meeting CQC ICS Themes and Quality Statements

Theme One: Quality and Safety
The provision of appropriately skilled staff supports high quality patient care

Theme Two: Integration
The focus of the workforce agenda spans both health and social care.

Theme Three: Leadership
The management and development of staff, including good communication, provision of health and wellbeing, support and career development is essential to the effective running of health services and the recruitment and retention of staff.

13. Risks

14.1 There are a range of workforce risks that are managed through the People Committee and then to the Finance and Resource Committee and Risk Committee however there are no risks pertinent to this report .

14. Finance

15.1 There are no financials requests resulting from this report.
The provision of national workforce development funds has now ended.

15. Communication and Engagement

16.1 There are no communication and engagement implications of this report

16. Equality, Diversity and Inclusion

17.1 Equality, diversity and inclusion is a core element of the report and function of the People Team.

17. Next Steps and Responsible Person to take forward

18.1 The work of the ICB People Team will continue to be monitored via the ICB People Committee and the ICS work through the People Board.

18. Officer contact details for more information

Christine Samosa
Chief People Officer
Christine.samosa@cheshireandmerseyside.nhs.uk

19. Appendices

Appendix One: Summary presentation of the Cheshire and Merseyside NHS Staff survey results 2023.

NHS
Cheshire and Merseyside

Cheshire & Merseyside ICS
Staff Survey 2023
May 2024

Staff Survey 2023

Response Rates/Content

NHS
Cheshire and Merseyside

Response Rate

47.85%

Compared to 45.2% in 2022

Participation

33,191

Compared to 30,540 in 2022

Survey Content

7	21	107		
Themes	Sub- categories	Survey Questions	Organisation	Place/Department
7 Elements of the 'People Promise' plus an engagement and morale score	Questions directly related to sub-categories of each of the 'People Promise themes'	• Your job • Your team • People in your organisation • Your managers • Your health, Wellbeing and Safety at work • Your personal development • Your organisation • Background information	Themes/sub scores presented as a whole organisation	Themes/sub scores/questions, broken down for areas with a minimum of 10 respondents

NHS
Cheshire and Merseyside

Staff Survey 2023

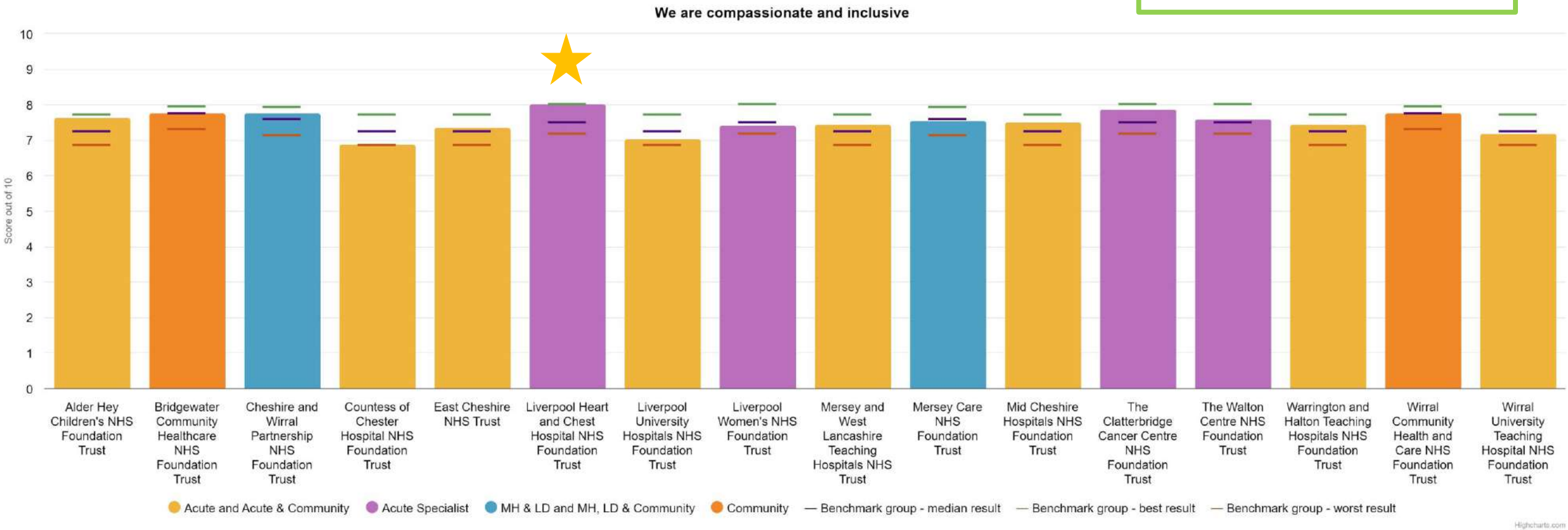
Cheshire & Merseyside ICS Results

Staff Survey 2023

We Are Compassionate and Inclusive

Cheshire and Merseyside

ICS Score Increased From 7.33 to 7.40



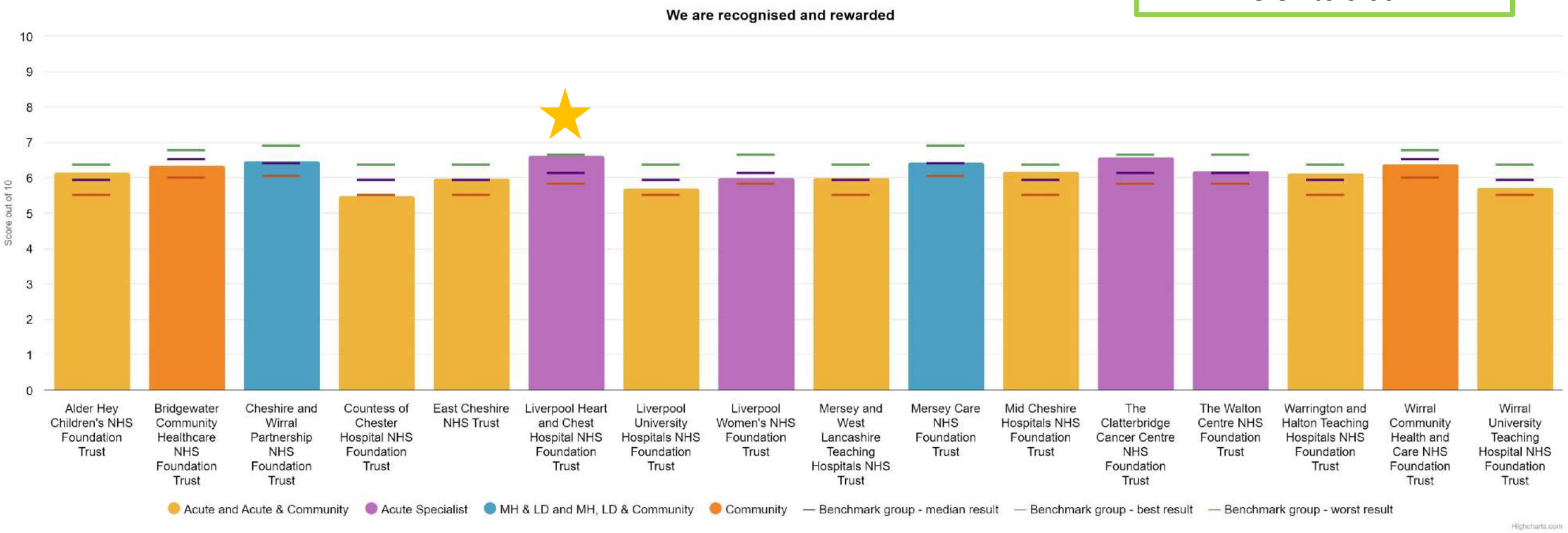
National Benchmark Group Best Result

Staff Survey 2023

We Are Recognised and Rewarded

Cheshire and Merseyside

ICS Score Increased From 5.84 to 6.06



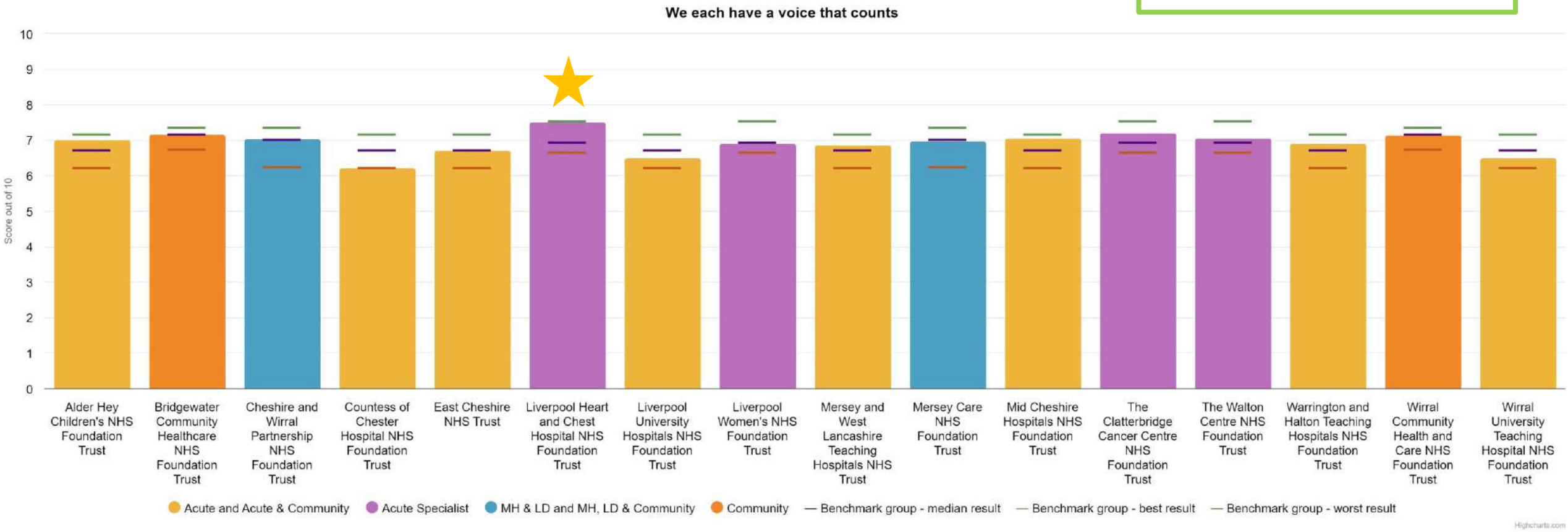
National Benchmark Group Best Result

Staff Survey 2023

We Each Have A Voice That Counts

NHS Cheshire and Merseyside

ICS Score Increased From 6.78 to 6.81

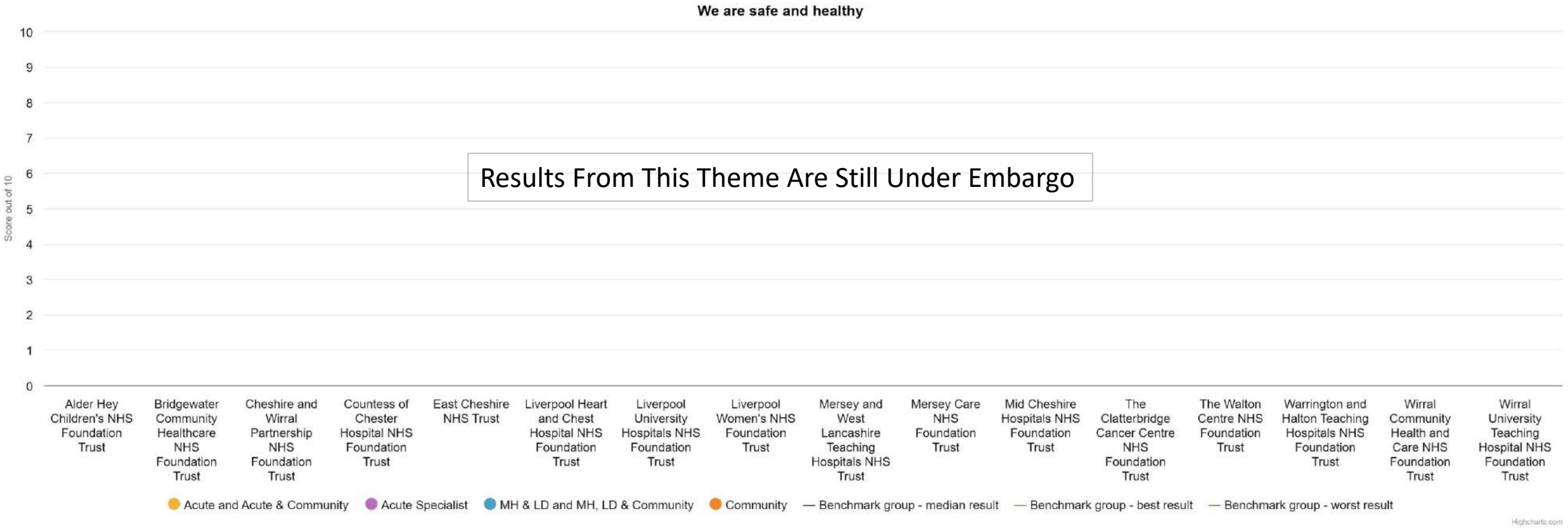


★ National Benchmark Group Best Result

Staff Survey 2023

We Are Safe & Healthy

NHS Cheshire and Merseyside



Staff Survey 2023

We Are Always Learning

NHS Cheshire and Merseyside

ICS Score Increased From 5.24 to 5.58

National Benchmark Group Best Result

Staff Survey 2023

We Work Flexibly

Cheshire and Merseyside

ICS Score Increased From 6.08 to 6.24

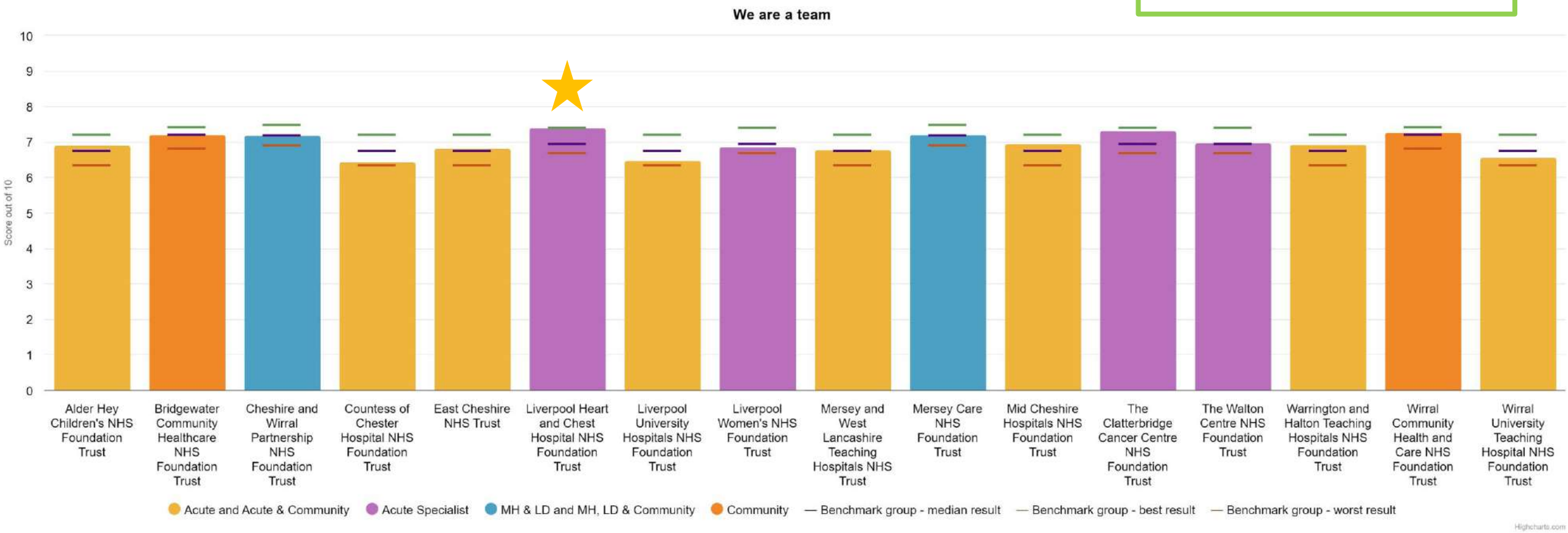
National Benchmark Group Best Result

Staff Survey 2023

We Are A Team

NHS
Cheshire and Merseyside

ICS Score Increased From
6.73 to 6.85



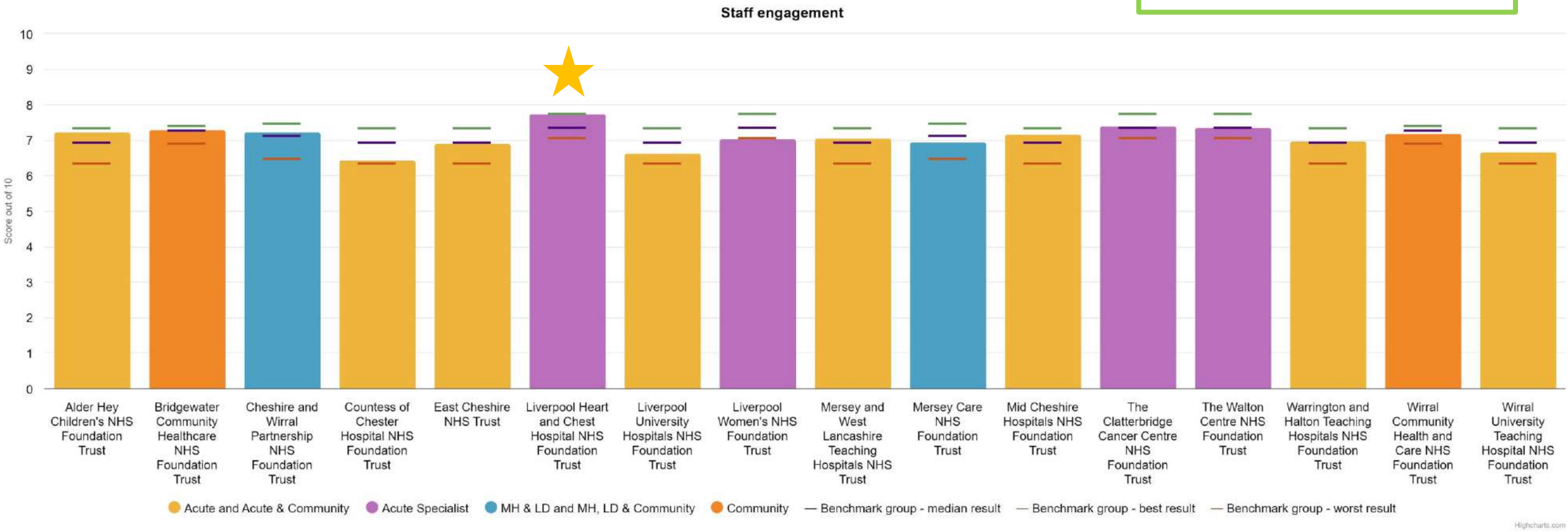
National Benchmark Group Best Result

Staff Survey 2023

Staff Engagement

NHS Cheshire and Merseyside

ICS Score Increased From 6.85 to 6.95



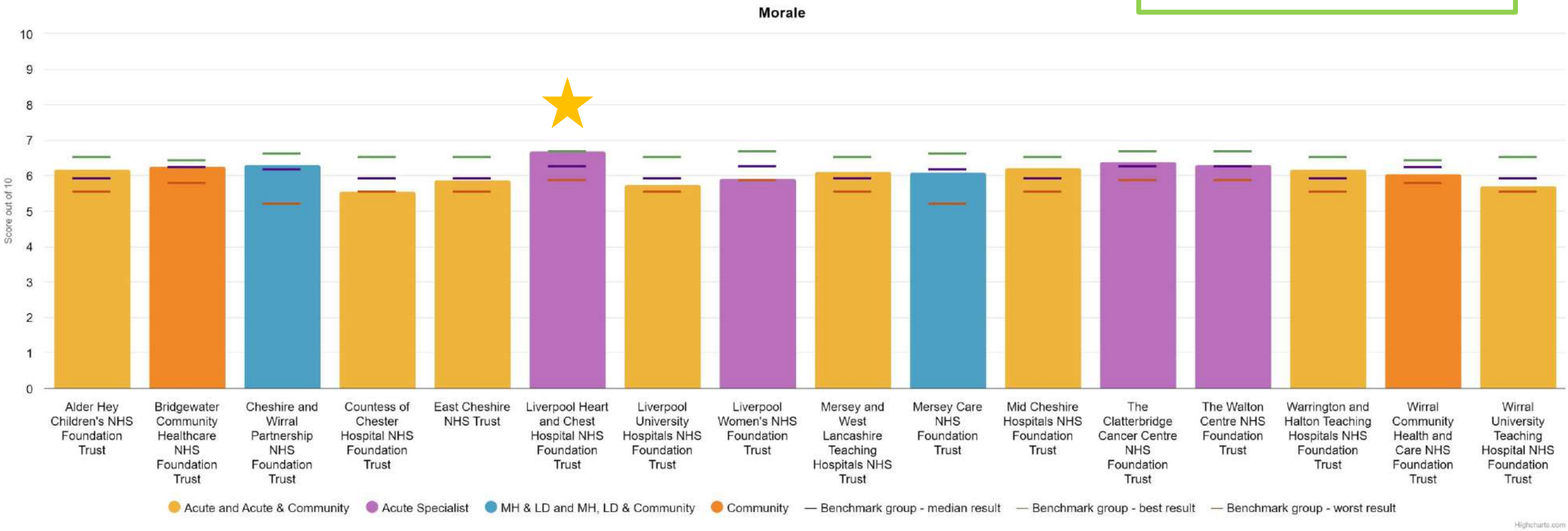
★ National Benchmark Group Best Result

Staff Survey 2023

Morale

Cheshire and Merseyside

ICS Score Increased From 5.82 to 6.02



National Benchmark Group Best Result

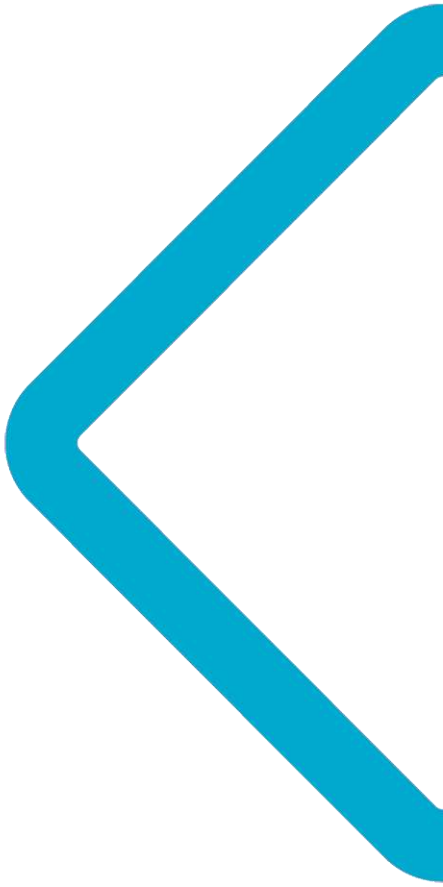
Staff Survey 2023

ICS People Promise Themes Ranked

NHS
Cheshire and Merseyside

1	People Promise 1:	We are compassionate and inclusive	7.40
2	People Promise 7:	We are a team	6.85
3	People Promise 3:	We each have a voice that counts	6.81
4	People Promise 6:	We work flexibly	6.24
5	People Promise 2:	We are recognised and rewarded	6.06
6	People Promise 5:	We are always learning	5.58
	People Promise 4:	We are safe and healthy	TBC

End of Presentation



NHS
Cheshire and Merseyside

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

Held at the Boardroom, The Department, Lewis's Building, 2 Renshaw Street, Liverpool, L1 2SA

Thursday 28th March 2024
09:30 – 13:30

Unconfirmed Draft Minutes

Recording available at: https://www.youtube.com/watch?v=l7b5-C3eFYc

MEMBERSHIP	
Name	**Role**
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Neil Large, MBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member) (Joined via MS Teams)
Councillor Paul Cummins	Partner Member, Cabinet Member for Adult Social Care, Sefton Council (voting member)
Ann Marr, OBE	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital NHS Trust (voting member)
Erica Morriss	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Dr Naomi Rankin	Partner Member, Primary Care (GP) Partner Member (voting member)
Prof. Hilary Garratt, CBE	Non-Executive Director, Cheshire & Merseyside ICB (voting member)
Prof. Joe Rafferty, CBE	Partner Member, Chief Executive Office, Mersey Care NHS FT, (voting member)
IN ATTENDANCE	
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Director of People, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)

Prof. Ian Ashworth	Director of Population Health, Cheshire & Merseyside ICB (Regular Participant)
Sarah Thwaites	Chief Executive, Healthwatch Liverpool
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Jennie Williams	(Minutes) Senior Executive Assistant, Cheshire & Merseyside ICB

External Speakers in attendance	
Name	**Role**
Deborah Butcher	Sefton Place Director, Cheshire and Merseyside ICB
Mark Bakewell	Liverpool Place Director, Cheshire and Merseyside ICB
Louise Robson	Chair of Health Innovation, North West Coast
Jonathan Griffiths	Associate Medical Director of Primary Care, Cheshire and Merseyside ICB
Andrea Astbury	Deputy Director of Strategy & Integration Liverpool Place Interim DIA Programme Director C&M
Jim Hughes	Strategic Advisor, Mersey Care NHS FT

APOLOGIES NOTED	
Name	**Role**
Prof. Steven Broomhead, MBE	Partner Member, Chief Executive, Warrington Borough Council (voting member)
Cllr Louise Gittins	Chair, Cheshire and Merseyside Health and Care Partnership
Rev Canon Dr Ellen Loudon	Vice Chair, Cheshire and Merseyside Health and Care Partnership
Adam Irvine	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Warren Escadale	Chief Executive, Voluntary Sector North West (Regular Participant)

Item, Discussion, Outcomes and Action Points
ICB/03/24/01 - Welcome, Apologies and Confirmation of Quoracy
All present were welcomed to the meeting and advised that this was a meeting held in public. The meeting was declared quorate. Apologies for absence were noted as above.
ICB/03/24/02 - Declarations of Interest
There were no declarations of interest made by Members that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.
ICB/03/24/03 - Chairs Opening Comments
The Chair discussed the British Social Attitudes survey results which showed that in 2023, the public had the lowest confidence they have ever had since the surveys inception. The confidence of the public in the NHS is of critical importance in terms of quality of care, and also of staff feelings and how they manage in the most challenging of times to deliver high quality care. NHS Cheshire and Merseyside is leading the Five Year Joint Forward Plan that articulates key priorities and will work with public, patients, staff, trade unions and clinical leaders to improve the satisfaction of the public with the NHS.

Item, Discussion, Outcomes and Action Points
ICB/03/24/04 – Resident Story
The Board were introduced to the story of Ruth Little. The Chair reiterated that patient stories are shared with the Board in order to bring the patient into the room. The Board thanked Ruth for sharing her story which can be viewed here – https://vimeo.com/726753769/64afef67a8
Leadership Reports
ICB/03/24/05 – Report of the ICB Chief Executive
The Chief Executive explained to the Board that the NHS is in a very difficult place and the consequence of covid will take many years to recover from. The success of the NHS will be linked to the financial context, where the NHS has seen an unprecedented year of inflationary pressure, such as the increase in fuel bills for hospitals and the increase in consumables. Furthermore: • Industrial action that has taken place across the last year has created another overlaying and difficult environment, and whilst the rights of staff to take part in industrial action is respected, it de-stabilises the way in which the NHS works. • In the last month there has been a period of improvement and ambulance response times have consistently improved in the North West, and are some of the best in the country. • In the last month A&E performance has improved, the longest waiting patients has reduced significantly since the last period of industrial action, again with some of the best performance in the country. • The reduction in cancer backlogs are some of the fastest in the country. • The redesign of stroke pathways is the second best performance in the country against published gold standards for patients attending our hospitals with stroke. The Board meeting should be used to celebrate successes and improvements, and whilst the NHS will experience a difficult year, it is the Board's responsibility to see improvement on the standard of access, quality and outcome for our patient's month on month. **Thirlwall Inquiry** The Integrated Care Board have fully co-operated with the inquiry and have submitted 75 items of evidence on behalf of predecessor organisations for which the ICB are legally responsible for. The Chair of the Inquiry does not want to make the ICB a core participant and does not believe the ICB are likely to face significant or explicit criticism for the roles of any current ICB employees, or the former CCG's. The process has been open and transparent. **Measles** The Chief Executive asked the ICB Director of Population Health to provide an update to the Board regarding the work and actions underway to prepare and respond to the measles outbreak national incident. The ICB Director of Population Health advised the Board that there are sporadic cases of measles in Cheshire and Merseyside and in the North West and it is important that the measles, mumps and rubella vaccination programme continues across the nine places. Community pharmacies are supporting schools with vaccinations and access is increasing. GP's and Primary care are undertaking national call and recall programmes. The Livewell bus is also going out to schools and communities. The Board Discussed – • Ensuring the uptake of MMR vaccine improves in young people and welcomed the vaccine programme. • Health Care Partnership Draft Strategy and the importance of attending to prevention, supporting people in the community, changing the urgent care pathway and the part the Board will play in ensuring a draft set of measures can be used to hold the NHS to account as a part of the partnership, and what outcomes the NHS are asked to contribute to. There are nine beacon indicators which each of the nine areas look at as a system with Health and Wellbeing Boards. Keen to put in place metrics around oral health and children's wellbeing and the prevention of dental caries and dental admission.

Item, Discussion, Outcomes and Action Points

- Primary and Secondary prevention, and metrics which contribute to life expectancy. All Together Fairer have a ringfenced pot of money for investment this year, which will increase in future years and is an attempt to ensure what is delivered today, is not crowded out for the future. It is investment in long-term intergenerational payback.
- the highest quality evidence must be gathered to make good decisions about responding to problems. From the clinical constitution, it is clear that we need to get better at managing wellness rather than always responding to sickness. High quality health intelligence will be social intelligence which feeds back to health care partners.
- NHS Providers have published a toolkit that helps NHS Trust Boards to think what their role is in prevention.

The Board Resolved to -

- **note the updates as outlined within the report.**

ICB/03/24/06 – Report of the ICB Director of Nursing and Care

The Director of Nursing and Care provided an update to the Board on the ICB's local maternity and neonatal system (LMNS) which is responsible for the delivery, oversight, and assurance of the national three-year plan for Maternity and Neonatal which has four key themes within the three-year plan:

• Listening to Women and Families with compassion
• Growing, retaining and supporting our workforce
• Developing a culture of safety, learning and support
• Standards and structures that underpin safer, more personalised, and more equitable care.

An updated position of outcomes of Care Quality Commission inspections for maternity services within Cheshire and Merseyside as well as findings from the latest inpatient women's survey for maternity services experiences has now been completed. A deep dive into identified themes will be scheduled and fed back to the Quality and Performance Committee.

The Board was informed about the CQC women's survey for 2023,which was published in February 2024 and that the report provided an improvement in many areas. The LMNS works with providers to support delivery and ensures compliance with the maternity incentive scheme year 5. Board was informed that all C&M providers declared full compliance with submissions, which were approved by each provider's board and signed off by the ICB Chief Executive and submitted on 1st February 2024.

The Beyond Programme continues to support the health equity collaborative between Barnardo's and The Institute of Health Equity and Cheshire and Merseyside is one of three ICB's as a part of the pilot. Four young people have been recruited as health champions working alongside the beyond programme. Work is ongoing to reduce the rates of asthma and respiratory illness.

National Day of the Nurse takes place on 12th May 2024 and National Day of the Midwife takes place on 5th May 2024. The theme for 2024 is Economic Power of Care, and the ICB will be holding an event to celebrate.

The Board Discussed -

- Assurance that the key themes from the Maternity and CQC reports have been developed alongside the LMNS. It is important to look at the performance of the service, and the impact on those receiving the care.
- Equality and Diversity Data – The Director of Nursing and care assured the board that they are working on a data set with the business intelligence team to look at measuring health inequalities across the system, comparing to the rest of the region. The LMNS has challenged the ICB to look at diversity, particularly within maternal mortality, neonatal death and maternal injury. Once metrics are available these will be included in performance reports.

Item, Discussion, Outcomes and Action Points

- The CHC Programme review is in progress and on 1st April 2024 120 members of staff will be transferred into the ICB. Management of change with current staff will be undertaken following this transfer. The review continues with an implementation programme plan with the aim of completion in Summer 2024. The Director of Nursing and Care committed to bring an update to the next Board meeting on the progress around the CHC Review programme.
- All Together Smoke Free ambitions – a workshop was undertaken last month with all nine local authorities and treatment tobacco dependency programmes.

Actions

- **Equality and Diversity with Protected Characteristics - the Chair would like a report back to May 2024's Board via the Quality Committee on the assurance around the access and outcomes for marginalised communities in relation to maternity services/ neonatal services**
- **The Chair requested a ICB CHC Review progress report at the May 2024 Board meeting.**

The Board:

- **Noted the contents of the report for assurance purposes.**

ICB/03/24/07 – NHS Cheshire and Merseyside Finance Report, Month 11

The Executive Director of Finance provided an update to the Board for Month 11 to the end of February 2024 and highlighted the following key areas:

- previous reports have briefed the Board on a risk to the financial performance of the system of up to £40m as of February 2024, with an additional £20m worth of risk associated with ongoing industrial action. Confirmed funding has now been allocated for industrial action, but with an additional month of cost. The position excluding industrial action has improved to a risk of £30m from £40m, the confirmed allocation from industrial action means that some of the costs will reflect as an over-spend in position with a pressure of £20m in current forecasts.
- this month, the ICB formally adjusted the forecast with NHS England to give a deficit of £50m as a system by the end of the year. This was worked on throughout March to look at mitigations; to note - the formal forecast could only be changed this month for the first time.
- the departure of the way the ICB delivered its plan using non-recurrent measures is stark, and whilst the ICB are away from plan in the forecast this year, this has been undertaken with a lot of non-recurrent measures. Underlying financial position is significantly lower than the position reported formally. This will be addressed in the next financial year.
- there is a repayment process in the NHS that means any deficit reported this year will need to be repaid in a couple of years' time. There are brought forward services of approximately £20m that will offset the ICB's own deficit, however there will still be a residual deficit. Once the repayment processes have been worked through, this will be brought back to a future meeting.

The Board:

- discussed the deterioration from the beginning of the year to the current position - in the ICB, the key drivers are the overspends and pressures associated with continuing health care (CHC) and mental health packages of care, together they account for £60m forecast by the end of the year, around half of which has been influenced through the price of care packages that have significantly exceeded levels of inflation funded for, the other half is the significantly increased demand over the year. Prescribing has seen an increase in inflation, with some mitigation over the months due to QIPP programmes. CHC and mental health packages of care in the ICB are the biggest factors influencing overspend. Part of which has been mitigated by holding investment or slippage of programme budgets, which is an underlying position to be tackled urgently. On the provider side, the deterioration is largely in relation to the impact of industrial action which hasn't been fully funded, as well as pressures in relation to urgent care.
- the Chair emphasised for the ICB and the budget control it has, the importance of the work undertaken with the CHC review.

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• gave thanks to the Director of Finance and the team in getting the ICB to this position. • discussed the knock-on effect for future years, and the financial challenges ahead; that plans will be developed, there are areas which will have an impact on improving care for patients as well as improving value. **The Board:** • **Noted the content of the report.** • **Approved the revised financial position reported at Month 11, noting the provider positions, the forecast impact of industrial action, and the risks to delivery of the financial plan.**
ICB/03/24/08 - Highlight report of the Chair of the ICB Finance, Investment and Resources Committee
The Board received an update from the Chair of the ICB Finance, Investment and Resources Committee highlighting that it has been an extremely challenging year, and provided assurance that systems and processes are robustly checked to provide accurate information. It is the committee's role to scrutinise budgets to ensure effective in-year management. Deep dives have been undertaken on CHC and prescribing. Recovery plans with providers and in Place have been undertaken, most recently in Cheshire East. The Board Assurance Framework risk P7 and the raising of the risk score to 16 was discussed within the finance committee, the recommendation to raise will come to Board in May 2024. A review of own workforce risk has been requested due to financial implications. **The Board noted the contents of the report.**
ICB/03/24/09 - NHS Cheshire and Merseyside Integrated Performance Report
The Director of Performance and Planning provided the Board with an overview of the integrated performance report for March 2024 which included an overview of key metrics drawn from the 2023/24 Operational plans, specifically covering Urgent Care, Planned Care, Diagnostics, Cancer, Mental Health, Learning Disabilities, Primary and Community Care, Health Inequalities and Improvement, Quality & Safety, Workforce and Finance. The following was highlighted to the Board: **Urgent Care** – objectives set for this year was a 76% attainment of standard; next year's objective will be 78%, which is part of a staged recovery back to pre-pandemic delivery. 70% of standard was delivered in the first three weeks of March 2024. A Super MaDE event has been held since 22nd March 2024. Cheshire and Merseyside is the first ICB to undertake such an event as a whole system, and which has shown benefits in four-hour performance which has been at 73% for six days. It was highlighted that the average response time for a category 2 ambulance call was 43 minutes in February 2024; expected response times for March are 30 minutes. The Northwest will be the only ambulance service that has been able to deliver the category 2 response time of 30 minutes in the country. **Elective** – this month there will have been in the region of 30 patients who have experienced a wait time in excess of 78 weeks; these patients are deemed clinically complex. A further 60 patients have exceeded the 78 week wait through choice. Approximately 3500 patients have waited 65 weeks, and the challenge is to eliminate waits of this length by September. 130,000 patient activities have been affected by industrial action during this year, but despite this the Cheshire and Merseyside system has delivered more planned activity during 23/24 than in 22/23. **Cancer** – the current number of patients on active cancer waiting lists is 20% lower than pre-pandemic. Treatment waiting times have been reducing since January 2024. There is a standard for 75% of patients to be seen and diagnosed within 28 days and this is on track for delivery in March 2024. The Board discussed:

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- challenges to mental health services and issues with referral to talking therapies for patients with greater need and support. Work is being undertaken with digital access to talking therapies to access demand and differentiate channels into services. A deep dive into mental health will take place at the next Quality and Performance Committee.
- the Cheshire and Merseyside Mental Health Programme Clinical leads have been looking into dementia diagnosis rates. It is anticipated that new drug treatments for dementia will get licences in spring / early summer which will then go through NICE accreditation. Once accredited, delivering a dementia service will be a huge challenge for all ICB's.
- a review has been completed around the governance process of HACI, and performance is monitored through quality schedules through 9 places. Held a workshop last month re HACI and what we are doing in the nine places and presented to Quality and Performance Committee last month. Will be holding a deep dive into all aspects of HACI including primary and secondary care. The Director of Nursing and Care committed to share the outputs of that review.
- Dental recovery plan – there will be a set of metrics with outcomes of patient experience; Healthwatch are on the improvement board.
- the ICB have made significant progress in collaboration, however there has not been enough progress in integration. Transformational projects over the coming year that the board will be sighted on, alongside the delivery of today initiatives will help to rebalance focus.

Action:

- **The Associate Medical Director will bring an update to May 2024 board on dementia diagnosis from the Cheshire and Merseyside Mental Health programme.**

The Board noted the contents of the report and took assurance on the actions raised.

ICB/03/24/10 - Highlight Report of the Chair of the ICB Quality and Performance Committee

The Board received an update from the Chair of the ICB Quality and Performance Committee , with the following key areas highlighted:

- Urgent and emergency care – assurance given to the board on the work undertaken by the system quality group who have worked on a toolkit for care when emergency departments are busy or become crowded, demonstrating the flow.
- Care homes - report by place recognised the variation as reported by the CQC of the care home experiences across Cheshire and Merseyside, assured by evidence of co-operative work undertaken between the NHS and Local Authority. Key themes identified for improvement such as infection prevention control and falls.

The Board noted the report.

ICB/03/24/11 - Report of the ICB Directors of Place

The Liverpool and Sefton Place Directors provided an update to the board to highlight the work of the 9 local Place Teams and to provide assurance to the board on how teams are delivering objectives as an ICS. Place Directors will collaborate to continue with good areas of practice and to scale up projects.

Liverpool

- commitments to tackling health inequalities, the characteristics of the local system and the approach required around population health management.
- national funding received to enhance programmes of work around the data lead approach to tackling inequalities which supports, is in line with some of the workstreams reported in the Liverpool Strategic Futures Report.
- work with systems partners around urgent care and diagnostics has been undertaken, looking to improve the flow of patients into and out of hospital settings.

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- work in women's health hubs with Primary Care Networks and some health care providers offering service to a proportion of the population.
- Recommendations of the Liverpool Clinical Services Review detailing progress made against the 12 recommendations, highlighting the partnership working to move forward.

Sefton

- Working collaboratively through the urgent care board to improve the discharge to assess offer in home first. New programme called Better at Home, integrated with the local authority looking keeping people with frailty at home for longer. The extra care housing programme will have 90 new extra units of care housing in 2026 in Southport.
- Investment on capital programmes to support care homes with environmental issues for people with higher acuity. A significant amount of council capital programme has been targeted into this.
- A lot of work has been undertaken on complex lives, homelessness and mental health, trying to accelerate the work undertaken in Southport with the ACES programme to support people with adverse childhood experiences, as a consequence of which have become homeless or drug / alcohol dependant.
- Nominated for the Municipal Journal Award for the baby bonding and attachment service with Mersey Care NHS FT which was joint working as the ICB, council and Mersey Care.

The Board discussed:

- the change in format to Place reports welcomed with a greater understanding of Place, with the request to quantify impacts with narrative benefits.
- Liverpool urgent care work governance - plans are a part of the local implementation plan running through local governance, urgent care boards and reported up into the urgent care improvement plan. Liverpool are a Tier 1 system with a lot of oversight from regional and national colleagues. The governance route will be refreshed with clear transformation projects brought through the Assistant Chief Executives team, transformation committee and Board.
- Newton Diagnostic will be shared with the Board for implementation once complete. The draft report shows opportunities to avoid admission to hospital where there are already services in place with service capacity, too many patients are being discharged to too high a level of care dependency.
- Investment in social care – Place Directors would like to work closely with Directors of Adult Social Services around future investment in domiciliary care. There are 1000 hours more of domiciliary care required per week to support Southport and outside Sefton hospital patch.

The chair requested more information on implementation and metrics in Place reports and would like to hear more from Place Directors about what they want from the Board. There was also an ask of the Board to provide an indication of a forward plan as to what Board would like to see from Place Directors.

Action:
The Sefton Place Director will take back to Place Director colleagues who meet regularly to pose the question about what they would want from the Board.

The Board:

- **considered the contents of the report and the work being undertaken at place to support delivery of the ICB strategic objectives**
- **noted the progress being made in each of the sections as described within the report and areas of good practice.**

COMFORT BREAK

Committee AAA Reports – Matters of Escalation and Assurance

ICB/03/24/12 - Highlight report of the Chair of the ICB Audit Committee

The highlight report of the ICB Audit Committee was presented to the board. The Chair requested Board approval for the following recommendations from the Committee–

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• approval of the proposed changes to the ICBs scheme of reservation delegation and the ICB Operational Scheme of Reservation and Delegation • amendment of Women's Hospital Services in Liverpool Committee terms of reference, changing reference within from 'approving the case for change', to 'endorsing and recommending to the board the case for change' for the Board to approve • approval of the ICBs Risk Management Strategy – proposed change to the risk matrix escalation criteria and reporting frequency to make risk management strategy more useable and acceptable for escalation to the board. Internal audit plans are on track for the end of the year. **The Board:** • **noted the contents of the report and took assurance on the actions contained.** • **approved the changes to the ICB scheme of delegation and reservation and the ICB Operational Scheme of Reservation and Delegation.** • **approved the recommended changes to the Women's Hospital Services in Liverpool Committee terms of reference.** • **approved the proposed change to the ICBs Risk Management Strategy**
ICB/03/24/13 - Highlight report of the Chair of the ICB Remuneration Committee
The Chair of the ICB Remuneration Committee provided an update to the board highlighting that the committee had previously asked for assurance about the readiness and competence of the deputies of ICB Chief Executives and Place Directors; the report received gave assurances, particularly around acting up. The report indicated the need for future development opportunities for deputies. **The Board noted the contents of the report.**
ICB/03/24/14 - Highlight report of the Chair of the ICB Children and Young Peoples Committee
The Chair of the ICB Children and Young Peoples Committee gave an update to the board. There is good progress and coalescence around 4 priorities that have been accepted, that enables focus on priorities. **The Board noted the contents of the report.**
ICB/03/24/15 - Highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee
The highlight report of the Chair of the ICB Women's Hospital Services in Liverpool Committee was presented to the Board. **The Board noted the contents of the report.**
ICB/03/24/16 - Highlight report of the Chair of the ICB Transformation Committee,
The Assistant Chief Executive provided an update to the board that at the last Board meeting, a change to the terms of reference and a change of name to the Strategy and Transformation committee was recommended. It is now recommended to the Board that the Committee is chaired by a non-executive director. The change will take into account pillar 4 and the financial and strategic objectives, the joint forward plan and health care strategy reports. The ICB Chief Digital Information Officer gave an update to the Board on cyber security and the draft Cheshire and Merseyside Cyber Strategy. The strategy is explicit in its responsibilities throughout the system, down to individual organisations. The ICB responsibility is to –

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- have an ICS wide cyber strategy which is brought to board for approval.
- identify funding for the delivery of the strategy.
- managing risks as a collective.
- investment in ICS wide plans to control risk.
- deliver a cyber security programme with metrics and measurable assurance.
- buy and build safe systems.
- have a clear and coherent response in the event of an incident.

Nine strategic objectives have been set which are governance, risk management, incident management, how tools are procured to support, how third party systems are managed, people and culture and common policies, processes and knowledge sharing.

A regional security operational centre is to be created, having a 24/7 view of threats as they happen with a 24/7 response. Acute provider collaboratives are recognised as a number one digital priority recognising that some of the solutions are in the pooling of skills into a federated centre of excellence.

The Board discussed –
Cyber Security

- the ICB IT service have been historically provided by three shared services, divided on historic geographical lines, who work closely together. Assurance model is DSP return and cyber security elements that have to be answered as a collective, this is a disjointed infrastructure which creates an overhead in management.
- Primary Care – the infrastructure a GP uses to access clinical records is funded in different ways nationally through bidding processes to access funding.
- the ambition of the cyber team is to see the system as a whole, with explicit NHS responsibilities and the strategy to be a system strategy.
- there is national funding to pump prime some of this work, capital has been received this year which has been given to a single pane of glass dashboard view. Next steps are to define what is required at the centre.

Transformation Programmes

- the Deputy Chief Executive advised that a discussion took place at Transformation Committee where the recommendation from Committee to Board was that the Data into Action Programme reporting moves from Board to Strategy and Transformation Committee.
- the board agreed to the changes to the committees' terms of reference.
- the board agreed to change the title of the committee to Strategy and Transformation Committee.
- the Strategy and Transformation committee will receive a refresh in six months' time.
- the Chair of Health Innovation North West Coast offered support and alignment to the transformation piece.

Specialised Commissioning

On 1st April 2024 the ICB take on delegated responsibility for Specialised Commissioning for 59 services. At the last board meeting the Board delegated authority to the transformation committee to approve key documents both for the ICB and as a part of a joint committee with 2 other ICB's in the North West region. The Chief Executive is to sign the delegation agreement. An internal Specialised Commissioning Operational group has been established. For 2024/25 the ICB will continue to work with the regional team who will work with and on behalf of the three ICB's. Work programmes are being developed through the operational group. The key agenda is to remove the specialised heading and it becomes a part of the integrated commissioning agenda. Some services are nationally prescribed.

The Board resolved to:

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• **approve the proposed changes to the Transformation Committees Terms of Reference, including the title of the Committee** • **approved the proposed change of reporting route for the Data Into Action programme** • **approved the ICBs Cyber Security Policy** • **noted that the risks relating to the medium to long term risks in respect to infrastructure and investments in Cyber Security are being understood and appropriate mitigation strategies are being developed, and that the Board will see this going forward within the Board Assurance Framework.**
ICB/03/24/17 - Highlight report of the Chair of the ICB System Primary Care Committee.
The Chair of the ICB System Primary Care Committee provided an update to the board on the dental improvement plan. The committee have reviewed, challenged and brought to board the ICB Dental Improvement Plan approval. Improving dental access is an absolute priority. There is confirmed funding for a two-year plan, ringfenced through underperformance. Activity can be scaled down if the ICB financial situation warrants. The Committee Chair asked the Board to note the pathways that are impacted as there has been a focus on vulnerable groups and improving inequalities for dental access. The Assistant Chief Executive reminded the Board that last spring an initial dental improvement plan was developed and brought to Board, with an ask for it to be more ambitious, and for it to take account of the new national recovery plan from the government. This plan has been discussed across the dental network and is trying to target the most vulnerable. This report is not asking Board for new funding, the identified funding is the underspend on the dental contract, which at the end of February 2024 currently performing 82.7% of contract delivery. Underspend is what is being ask to spend rather than growth funding. The Board discussed: • Dental waiting lists, using the underspend as effectively as possible, • poor dental experiences for patients. • prioritising the most vulnerable patients to come forward for their care. The Board sought assurance that there is evidence collected demonstrating success of delivery and in targeting the most vulnerable. It was reported that an improvement board will be set up in which oversight of delivery and target metrics will be pivotal, the improvement board will be supported by Healthwatch to inform metrics and information. The dental network are keen to work with the ICB and will gather these metrics. • the Director of Finance confirmed the position on funding and informed the board that the budget is underspent and ringfenced nationally. • better payment for dentists to undertake more NHS work with the hope that this will assist dentists in being able to prioritise and provide more time/availability towards NHS dentistry • access to NHS dentistry requires a co-payment, communication with patients needs to be examined so that they are aware of this. • the ICB Chair thanked colleagues for completing this piece of work and the approach taken in engaging with and hearing the experiences of the public through Healthwatch. **The Board:** • **requested for the performance report to be amended to include the key metrics that are in development around the dental access improvement plan to give the Board assurance.** • **noted the contents of the report.** • **approved the ICB Dental Improvement Plan.**
ICB Business Items and Strategic Updates
ICB/03/24/18 - Update on the ICB Primary Care Access Recovery Plan 2023-2024
The Assistant Chief Executive welcomed the Associate Medical Director for Primary Care to talk through progress made. The first response to the NHS England Recovery Access to Primary Care recovery

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document was presented to Board in November 2023. The report demonstrates the progress made against the asks of the Board following its November 2023 meeting. Continuing to work with Healthwatch to gain public understanding.

The Associate Medical Director for Primary Care gave an update to the board highlighting –

- patients want to have easy, straight forward access to their general practice. Whilst there are over one million GP appointments every month in Cheshire and Merseyside, patients are reporting that they are still struggling to see their GP. This plan is trying to tackle this, improve access for patients, improve patient satisfaction.
- Pharmacy First has been launched with most pharmacies across Cheshire and Merseyside providing additional services. Awaiting national figures on how this is working, however local pharmacies are indicating it seems to be working well so far
- cloud based telephony – a lot of money has been spent to ensure GP practices have a telephony system fit for the future. 141 new contracts have been signed. This is new technology that allows a call back and internet calling, it does not mean more people answering the phones
- additional roles reimbursement scheme – there have been 1264 additional direct patient care members of staff into Cheshire and Merseyside since December 2023. Doctors are excluded from the scheme, there is still the issue of workforce crisis in GP practice for GP's. NHS England has offered a contract to general practice for the coming year of a 2% uplift which the General Practitioners of the BMA have rejected and have gone out to referendum. 61% of GP's took part in the ballot and 99.2% said no. This is not a vote for industrial action. Any further action will take place later in the year, which could be very significant to the system.
- we are working well as part of the primary care – secondary care interface, trying to reduce bureaucracy and improve communication
- all primary care networks are working on their capacity and access improvement plans, with challenges still present around self-referral and GP retention.

The Board discussed:

- how Cloud based telephony will not increase the number of people answering calls or the number of appointments but will help capture important metrics that will enable practices to vary staffing and clinics based on demand.
- how when the ARRS system started in 2019/2020 there was a gradual increase in funding until 2023/24; funding has plateaued with no confirmation of funding for next year.
- GP Contract dispute is not about GP pay and is not the same as the junior doctors and consultant strikes who were striking for individual pay, this is about how much each GP practice receives and which allows a Practice to employ its staff
- care navigation resource and building up the diversity in roles.
- whether non-medical professionals and recruitment of certain nurses in general practice is within scope of ARRS
- the scale of challenge in stabilising and modernising primary care to meet the demand.
- how it is for the Department of Health to determine what is in the GP contract, not the ICB. The ICB maintain great relationships with GP practices and primary care.
- Physician associates – there are relatively small numbers in General Practice in Cheshire and Merseyside. There has been guidance from the BMA and Royal Collages; will be helpful to share information on physician associates on practice websites.
- consultant to consultant referrals have now started to be tracked, the number of referrals have been identified, although the numbers of GP referrals have not been identified. It is perceived that consultants are asking GP's to make referrals where this could be done by themselves (consultants).
- the National Plan was released in May 2023 with good progress across all nine places. A considerable amount of money has been invested in the ARRS scheme in other elements of the plan.
- nationally, a smaller set of more meaningful metrics are being introduced; ICB metrics can be added alongside these if supportive for the Board.

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The Board:

- **noted the update**
- **agreed to receive a further update on Access Recovery for 2024/25 its meeting in September 2024**.

ICB/03/24/19 - Establishment of the ICB Research and Innovation Committee

The Medical Director provided an update to the board on the establishment of the ICB Research and Innovation Committee.

The Board discussed:

- Diversity - would like to see a non-medical professional included on the membership of the committee. The committee has been expanded to include the Associate Medical Director who brings an improvement interest to the committee. The steering group below the committee brings together every academic institution. The committee remains in consideration of the chair being a Non-Executive Director. The ICB Chair noted the challenge for the committee to be more inclusive of the various professions within the NHS.
- that the Board needed to ensure innovation is properly represented in the roles and responsibilities. The Chair of Health Innovation North West Coast made the offer to become closely involved.

The Board:

- **noted the content of the report**
- **approved the Committees Terms of Reference, noting that it would like to see further consider of inclusion of a wider variety of professions on the Committee.**

ICB/03/24/20 - NHS Cheshire and Merseyside NHS Staff Survey 2023: Results and Actions

The Chief People officer provided an overview of the second ICB Staff Survey 2023 results and highlighted that:

- in 2023 the ICB had a response rate of over 75%, with 809 staff responding. The survey was structured around the 7 national people promise themes. There have been small improvements on the previous year, it is recognised that the results are not yet where the ICB want them to be.
- since publication on 7th March 2024 the staff engagement forums have been working to understand what the results mean to staff.
- the people committee will report on the progress of priorities under the peoples promise theme.
- Workforce Race and Equality Standard data contains information that staff chose to share through the staff survey and staff have been encouraged to update Electronic Staff Records to reflect this.
- Trust engagement scores – 34,000 members of staff across Cheshire and Merseyside completed the staff survey. There was in improvement in the score for staff engagement in 12 of the trusts with Liverpool Heart and Chest scoring the best nationally.
- each Trust will develop its own staff survey action plan which will go through Trust Boards, people committees and through working with trade unions.
- the pressures that staff are facing impacts on staff morale, their ability to come to work and do a good job but to also balance the complex lives of staff. It is important to continue to develop a number of mechanisms to test with staff what it is like to work for organisations.

The Board discussed –

- ICB undertaking more appraisals, wellbeing conversations and the lack of local reporting mechanisms – all of the nine places have Staff Engagement Forums who are engaged and come together as the organisations Staff Engagement Forum.
- a survey for general practice staff will be launched later this year and will be reported through System Primary Care Workforce group and brought back to board.

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The Board: • **noted the content of the report** • **endorsed the actions taken to review, disseminate and respond to the NHS Staff Survey results 2023.**
ICB/03/24/21 - Building a Continuous Learning and Improvement Culture for Cheshire and Merseyside
The Deputy Medical Director provided the Board with an update and highlighted: • the dual considerations for a board with the ICB as an organisation and its responsibilities to its staff, who are working in support of an Integrated Care System (ICS) as system leaders • current challenges lends itself to a continuous improvement approach and this is the mechanism to taking a different approach to become more successful both as an ICB and as a whole system. • strong financial and performance case for continuous improvement with significant qualitative benefits. It is possible to do things better and for them to cost less, with significant benefit for all staff across the ICS to empower them to feel that they are making a difference. This will only work if there is an environment where there is a level of high psychological safety embedded. • NHS Impact is a growing national approach that will influence Cheshire and Merseyside, it is important for Cheshire and Merseyside to have its own ambition. • the ambition is for the ICB to lead continuous improvement for Cheshire and Merseyside, to be the leader for the system, the convenor of partners, set the ambition for the system. Cheshire and Merseyside are being recognised by the National Clinical Director of Continuous Improvement and the Deputy Medical Director has been asked to present to the National Improvement Directors forum on our approach to leading the system in improvement. • All Age Continuing Health Care has been identified as the first area for continuous improvement. The Board discussed: • giving staff the opportunity and space to speak up about what needs to improve, given the pressure to deliver front-line services. • changing the language in the paper from saving money, to improving patient outcome and experience as well as doing it differently and thinking better • having a strong co-production with service users who have the insight to help frame what is important. • within Place there are approximately 170 members of staff who have the word transformation written in their job description, the ICB needs to give them the methodology and support to work in the transformational approach. • equipping staff with a set of skills that every NHS provider will recognise. **Action –** • **The Chief Executive asked for an amendment to the paper – that the 4th bullet in "the board is asked to" section is re-written to reflect paragraph 12.4. and that the change to be made before the board adopts. Associate Medical Director to action.** **The Board:** • **Endorsed** the ambition for NHS Cheshire and Merseyside to lead the way in health and care improvement and to be seen as a beacon of excellence locally, regionally and nationally and to play a strategic role in shaping, stretching and delivering the ambition. • **Acknowledged** the multi-year commitment required to fully embed a culture of continuous learning and improvement, recognising the ownership required by each board member. • **Endorsed** the proposal for the adoption of Continuous Improvement as an integral part pf our business-as-usual approach in all our directorates and the delivery of our strategic objectives. • **supported** the proposal that once our improvement resource has been established, all age continuing healthcare (AACHC) is our first programme area for intensive support and the implementation of systematic improvement approaches.

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• **Endorsed** the recommendation to establish a continuous improvement programme and for this to report to the transformation committee. • **recognised** that we must set the right pace and expectations by which an improvement approach can be successfully implemented and sustained. • **acknowledged** the role of the board to co-design and fully embed a culture of continuous learning and improvement, recognising the ownership required by each board member to enable this to be a success. The Board agreed to not support one of the recommendations within the paper, namely to 'approve the invest to save approach required and the establishment of a core team (circa £500k) to include Executive Leadership'. It was agreed that the Board paper be amended to reflect a revised statement that ' Once we have prioritised and aligned our existing resources into Improvement that the ICB would consider new investment through the corporate budget setting process.'
ICB/03/24/22 - Emergency Preparedness Resilience and Response Core Standards 2023-24 Assurance Report
The ICB Director of Performance and Planning presented to the board the Emergency Preparedness Resilience and Response Core Standards 2023 – 24 assurance report, noting that: • the report has been subject to discussion at the Quality and Performance Committee and as a core standard, it is presented to board. • the ICB is a core Category 1 responder under the Civil Contingency Act. An annual assurance statement is produced annually, and NHS England control the process. The process this year has changed for the North West from self-assessment by the responder, to a panel review process. Comparable scoring against last year cannot therefore be easily made due to changes in process and should not be taken as a reflection of any organisations ability to respond to an emergency situation. The Local Health Resilience Partnership have recognised this and set up a subgroup with all providers to help ensure all the processes are there and working. • The ICB's score is 40% is lower than last year, there is an action plan for improvement. Progress against the plan will be reported to and monitored by the Quality and Performance Committee. **The Board –** • **noted** the contents of the report • **acknowledged** the current position with assurance that plans are in place to support the Integrated Care System, to work towards full compliance with the NHS England EPRR Core Standards.
ICB/03/24/23 - Establishment of the ICB Data Into Action Programme
The ICB Medical Director provided an update to the board on the establishment of the ICB Data Into Action Programme, to formalise the programme and to launch the governance. Andrea Astbury and Jim Hughes were welcomed to the Board, who highlighted: • anything that pertains to big link data set or secure data environment comes under the scope of data into action. • the challenge is to pull together a huge amount of projects, co-ordinate and align assets to optimise moving forward. Transformational capacity is important so that all of the teams across the ICS have a roll in making change on the ground. • the CHAMPS network is a huge influencer in terms of thinking and it is important to pull together partner agencies including voluntary agencies. • the Data Into Action Programme Board is chaired by the ICB Medical Director, supported by Professor Rafferty, and Professor Buchan from the University of Liverpool. • a large piece of work will be undertaken to look at financial and activity analysis across the population segments with a view to considering variation. • population health academy will be brought online in the first quarter of next year. • a significant amount of work undertaken on the secure data environment has involved patient involvement and user groups and there will be awareness events with the public.

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• next key steps are a session in May to look at the deliverables for the component areas to map out against deliverables. The Board discussed: • public trust being key in this endeavour. • embedding patient and public involvement in the governance for the PPIE group. Following on from public engagement events there is public involvement, however the terms of reference for the group were in development at the time the paper was written and are not included in the meeting pack. • public health professionals in Local Authorities are being contacted to look into housing and how they are brought into multiprofessional groups. • patients are able to op-out of having their data used; a dedicated phone line has been provided on patient leaflets for opt-out options. • the partnership is not to replace the joint strategic needs assessments that happen in local areas, this is to enhance and support the different tools produced through intelligence platforms that can be used systematically in local areas. • the Board need to understand the return on investment of this programme and the impact on some important strategic goals. **The Board:** • **approved** the Data Into Action Programme reporting into the Strategy and Transformation Committee • **agreed** that given the significance of the programme that a further report is brought to Board in the future.
Meeting Governance
ICB/03/24/24 - Minutes of the previous meeting held on 25th January 2024
The Board reviewed the minutes of the meeting held on 25 January 2024. It was raised that the minutes needed a slight correction within the Finance Update section so as to reflect the net financial risk to the ICB that was reported to Board. The minutes of the NHS C&M ICB Board meeting of 25th January 2024 were approved subject to the changes being made as above.
ICB/01/24/25 – Board Action Log
The Board acknowledged the completed actions and updates provided in the document. The Board noted the Action Log and recommendations to close the completed actions.
Any Other Business
ICB/01/24/26 Closing remarks, review of the meeting and communications from it
The Chair summarised that it was a good meeting, with good discussion and challenges. The Chair thanked Board members for their continued contributions and support, and thanked members of the public for their attendance.
Consent Items
ICB/03/24/27 – Board Decision Log
The Board reviewed the decision log and confirmed that the information presented was an accurate record of substantive decisions made by the Board up to 28 March 2024. It was further noted that there were no emergent actions arising from those decisions that were due for review at this meeting. **The Board noted the Decision Log**
ICB/03/24/28 - Confirmed Minutes of ICB Committees:
• Quality and Performance Committee **• System Primary Care Committee** **• Finance, Investment and Our Resources Committee** **• Audit Committee** **• Transformation Committee** **• Children and Young Peoples Committee**

Item, Discussion, Outcomes and Action Points
• **Women's Hospital Services in Liverpool Committee**
CLOSE OF MEETING

NHS
Cheshire and Merseyside

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

Held on MS Teams

Thursday 20 June 2024, 08:30am – 10:00am

UNCONFIRMED Draft Minutes

MEMBERSHIP	
Name	**Role**
Raj Jain	Chair, Cheshire & Merseyside ICB (voting member)
Graham Urwin	Chief Executive, Cheshire & Merseyside ICB (voting member)
Tony Foy	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Claire Wilson	Executive Director of Finance, Cheshire & Merseyside ICB (voting member)
Neil Large, MBE	Non-Executive Member, Cheshire & Merseyside ICB (voting member) (Joined via MS Teams)
Erica Morriss	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Dr Ruth Hussey, CB, OBE, DL	Non-Executive Member, Cheshire & Merseyside ICB (voting member)
Adam Irvine	Partner Member, Chief Executive Office, Community Pharmacy Cheshire, and Wirral (CPCW) (voting member)
Prof. Steven Broomhead, MBE	Partner Member, Chief Executive, Warrington Borough Council (voting member)
IN ATTENDANCE	
Dr Fiona Lemmens	Deputy Medical Director, Cheshire & Merseyside ICB (Regular Participant)
Anthony Middleton	Director of Performance and Planning, Cheshire & Merseyside ICB (Regular Participant)
Christine Samosa	Director of People, Cheshire & Merseyside ICB (Regular Participant)
Clare Watson	Assistant Chief Executive, Cheshire & Merseyside ICB (Regular Participant)
Sarah Thwaites	Chief Executive, Healthwatch Liverpool
Prof. Ian Ashworth	Director of Population Health (Regular Participant)
John Llewellyn	Chief Digital Information Officer, Cheshire & Merseyside ICB (Regular Participant)
Jennie Williams	(Minutes) Senior Executive Assistant, Cheshire & Merseyside ICB
Matthew Cunningham	Associate Director of Corporate Affairs and Governance, Cheshire and Merseyside ICB
Ali Akbar	Senior Communications and Engagement Officer, Cheshire and Merseyside ICB

Laura Gibson	Senior Corporate Communications Manager, Cheshire and Merseyside ICB
Niall O'Gara	Head of Financial Services, Cheshire and Merseyside ICB
Maria Austin	Associate Director of Communications and Empowerment, Cheshire and Merseyside ICB
Lucy Laing	Guest, Associate Non-Executive Director, Insight Programme

APOLOGIES NOTED	
Name	**Role**
Christine Douglas, MBE	Executive Director of Nursing and Care, Cheshire & Merseyside ICB (voting member)
Prof. Rowan Pritchard-Jones	Medical Director, Cheshire & Merseyside ICB (voting member)
Prof. Joe Rafferty, CBE	Partner Member, Chief Executive Office, Mersey Care NHS Trust, (voting member)
Ann Marr, OBE	Partner Member, Chief Executive, Mersey and West Lancashire Teaching Hospital Trust (voting member)

Discussion, Outcomes and Action Points

Preliminary Business

ICB/06/24/01 - Welcome, Apologies and Confirmation of Quoracy

The Chair noted apologies and welcomed all present to the extraordinary board meeting, advising that this was a meeting held in public.

ICB/06/24/02 - Declarations of Interest

Lucy Laing declared a conflict of interest as Public Governor at the Countess of Chester Hospital. There were no other declarations of interest made by Members or attendees that would materially or adversely impact matters requiring discussion and decision within the listed agenda items.

ICB/06/24/03 – Chairs Opening Comments

An extraordinary Board meeting was called as the timetabling of existing Board meetings did not allow for the timing requirements to review, make recommendations and approve the annual report and accounts for the ICB ahead of submission to NHS England.

ICB Business Items

ICB/06/24/04 – NHS Cheshire and Merseyside Annual Report and Accounts 2023-24

The Director of Finance presented the annual report and accounts for the year ending 31st March 2024 highlighting that there is a legal requirement for documents to be submitted to regulators by 28th June 2024. The annual report and accounts have been to Audit Committee twice, who have conducted reviews and assurance on behalf of the Board.

The draft accounts and annual report were submitted to auditors in April 2024 and have been through both internal review and external audit process. Auditors recommended minor changes to the accounts, of which the ICB were in agreement. All statutory and financial duties have been met. Accounts show for the first time, the income and expenditure relating to pharmacy, optometry and dentistry services delegated to the ICB on 1st April 2023.

The Chair of the Audit Committee gave an update to the Board on –

- financial update and an unqualified audit opinion, which was a great result.
- the governance statement reviews the arrangements in place for the governance of the Board which

Discussion, Outcomes and Action Points
places a lot of their reliance on the head of internal audit opinion, which this year gave substantial assurance, and is a significant improvement on last year. It is of great assurance to the Board understanding that the ICB's systems and processes are vast and in which the ICB take decisions and good evidence of assurance that are operating in a sound environment. A lot of work has been undertaken on policies and systems and thanks were given to those teams with a credit to their achievements. • Value for money as a system – two issues were raised regarding the sustainability of the system and the financial challenges going forward, together with the challenges of the increased recurrent CIP's. The improvement recommendation made was to endorse the system wide medium term financial strategy. The Audit Committee are pleased with the result which is credit to all of the work undertaken over the last twelve months and gave thanks to all involved. There were no questions or comments received from the Board. **Recommendations** The Board considered the three elements provided by the Chair of the Audit Committee, great result of unqualified audit for this year, the substantial assurance around the ICB's system of assurance and associated mechanisms and value for money and the recommendation of focus on the system level strategy. • the Board accepted the recommendations provided by the Chair of the Audit Committee. • the Board approved the annual report and accounts.
CLOSE OF MEETING
Date, time, and location of Next Meeting:
25th July 2024, 9:00am – 1:00pm at Bridge Suite, DCBL Stadium Halton, Lowerhouse Lane, Widnes, Cheshire, WA8 7DZ

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

#NAME?

Action Log 2023 - 2025

Updated: **17/07/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-22-41	27/04/2023	**Cheshire & Merseyside System Month 12 Finance Report**	CWI and SBR to work together on the production of a position paper covering social care provision and funding	Claire & Steven Broomhead	TBC	Claire to discuss further with Stephen Broomhead	ONGOING	
ICB-AC-22-51	23/06/2023	**Cheshire and Merseyside Mental Health, Community and Learning Disability Provider Collaborative - Annual Work Plan 2023-2024**	JRA to present the delivery plan to the board in autumn 2023	Joe Rafferty	Autumn 2023	On the Forward Plan for July 2024 meeting	ONGOING	
ICB-AC-22-57	27/07/2023	**NHS Long Term Workforce Plan**	CSA to provide a quarterly update to Board on the progress against the NHS LTP	Chris Samosa	Jan-24	No update nationally yet on LTP	ONGOING	
ICB-AC-22-59	28/09/2023	**Report of the Chief Executive**	Right Care Right Place - GPU to return Right Care Right Place to board in due course to understand what we can do as in integrated system through each place.	Graham Urwin	Nov-23		ONGOING	
ICB-AC-22-63	25/01/2024	**Welcome, Apologies and Confirmation of Quoracy**	Following on from the Public speaking time RJA confirmed an action for GPU / RPJ / CDO to bring a paper to a future Board meeting explaining how we have the right staff, at the right quantity at the right time for our patients.	GPU / RPJ / CDO	Nov-24		ONGOING	
ICB-AC-22-64	25/01/2024	**Action Log**	RJA asked the Board to review the usefulness of the action log which in its current form does not allow the Chair, on behalf of the Board, to track actions. Comments to be given to RJA and for RJA / GPU / MCU to review in readiness for the March 2024 Board meeting	RJA/MCU/GPR	Mar-24	Comments received	COMPLETED	Board is asked to approve closure of action
IBC-AC-22-65	25/01/2024	**Report of the ICB Chief Executive**	The Chief Executive to bring a written response on the roll out of enhanced access to GP's for the three new specific diagnostic tests to the March Board meeting.	GPU	Mar-24	Update to be circulated to Board following March meeting	ONGOING	
IBC-AC-22-66	25/01/2024	**Report of the ICB Director of Nursing and Care**	Chief People Officer to bring an annual report on ICB staff, including outcomes of Staff Survey, to the May 2024 Board meeting	CSO	May-24	On July 2024 Board Agenda	COMPLETED	Board is asked to approve closure of action
IBC-AC-22-67	25/01/2024	**Report of the ICB Director of Nursing and Care**	Chief People Officer to bring update report on the strategic direction of the C&M System Workforce Board, including details on system workforce	CSO	Mar-24	Will be incorporated into Action 66	ONGOING	
IBC-AC-22-68	25/01/2024	**NHS C&M Quality and Performance Report**	Marmot Indicators: Board to receive a governance map of what is reported where and when, and on an annual basis the Board receives a report on progress against the Marmot indicators	IAS, AMI	Sep-24	to be included within Health Inequalities report to Board at September 2024 meeting	ONGOING	
IBC-AC-22-69	25/01/2024	**NHS C&M Quality and Performance Report**	Board to receive information on secondary prevention measures in primary care (link to QOF)	CWA	Jul-24		ONGOING	
IBC-AC-22-70	25/01/2024	**NHS C&M Quality and Performance Report**	The Director of Performance and Planning to investigate the data we currently collect regarding Patient Reported outcomes and incorporate into future reports to Board	AMI	May-24		ONGOING	

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Action Log 2023 - 2025

Updated: **17/07/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
IBC-AC-22-71	25/01/2024	**Report of the Directors of Place**	Board to receive a high level summary report at its November 2024 meeting on the Operating Model for Place, an understanding of the maturity of each , the learning across each Place and a focus on the priorities of each Place to drive out unwarranted variation	GPU, CWA	Nov-24	On Board Forward Plan and due at November 2024 meeting	ONGOING	
IBC-AC-22-72	25/01/2024	**NHS Cheshire and Merseyside Corporate Risk Register**	Executive Team to review the score of 6 for 'P2 inadequate diagnostic and data infrastructure' along with the Chair of the Risk Committee	GPU, AMI, RPJ	May-24	Risk reviewed and with BAF Q4 report to Board in May	COMPLETED	Board is asked to approve closure of action
ICB-AC-22-73	28/03/2024	**Report of the ICB Director of Nursing and Care**	Equality and Diversity - the Chair would like a report back to May 2024's Board via the Quality Committee on the assurance around the access and outcomes for marginalised communities.	CDO	May-24	Incorporated within the Director of Nursing and Care Report	COMPLETED	Board is asked to approve closure of action
ICB-AC-22-74	28/03/2024	**Report of the ICB Director of Nursing and Care**	The Chair requested a CHC progress report at the May 2024 Board meeting.	CDO	May-24	Incorporated within the Director of Nursing and Care Report	COMPLETED	Board is asked to approve closure of action
ICB-AC-22-75	28/03/2024	**NHS Cheshire and Merseyside Integrated Performance Report**	The Associate Medical Director will bring an update to May 2024 board on dementia diagnosis from the Cheshire and Merseyside Mental Health programme.	FLE	May-24	Not everyone with dementia has a formal diagnosis. Since 2012, the NHS has been seeking to ensure that patients suffering from dementia are given a formal diagnosis so that they can receive appropriate care and support. The Dementia 65+ estimated diagnosis rate indicator tracks this ambition by comparing the number of people thought to have dementia with the number of people diagnosed with dementia, aged 65 and over. The national target is for two thirds (66.7%) of people with dementia to be formally diagnosed. At scale dementia work in Cheshire and Merseyside is led by the C&M Mental health team supported by the Stategic Clinical Network. Throughout 23/24 the work of this team has been slowed due to the reorganisation of regional NHSE teams and Regional Clinical Networks. This restructure is now complete and the network is active again with a focus on developing a C&M wide strategy with a first draft expected in the next 2-3 months. The attention of the Board is drawn to the following points: •C&M ICB consistently met dementia diagnosis rates pre-pandemic •The most recent performance for Cheshire and Merseyside ICB is 67.2%. •3 out of 9 places have exceeded the ambition throughout 2023/24 and good practice and learning is being shared with other places •Liverpool Place currently has a focus on BAME and has established a pilot with the Chinese community. This learning will be shared. •A Cheshire & Merseyside strategy for dementia which includes prevention, diagnosis, post diagnostic support to live well and die well is being developed. This will consider specific work needed to address diagnosis for BAME communities. •Following successful pilots of the dementia diagnostic tool, DiADeM, in care home settings in Knowsley and Wirral, Cheshire & Merseyside will aim to increase use across the geography.	COMPLETED	Board is asked to approve closure of action
ICB-AC-22-76	28/03/2024	**Place Director Update Report**	The Sefton Place Director will take back to Place Director colleagues to pose the question about what they would want from the Board with regards to reporting back to the Board on progress at Place.	DBU	May-24		ONGOING	

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Action Log 2023 - 2025

Updated: **17/07/2024**

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status	Recommendation to Board
ICB-AC-22-76	28/03/2024	**Building a Continuous Learning and Improvement Culture for Cheshire and Merseyside**	The Chief Executive asked for an amendment to the paper - the 4th bullet in “the board is asked to” is re-written to reflect what paragraph 12.4 says, and subject to bullet 4 reading as paragraph 12.4 in the paper, change to be made before the board adopts. The Associate Medical Director to action.	FLE	May-24		COMPLETED	Board is asked to approve closure of action

Meeting of the Board of NHS Cheshire and Merseyside

25 July 2024

Agenda Item No: ICB/07/24/31

Confirmed Minutes of ICB Committees

Click on the links below to access the minutes:

- Audit Committee – May 2024 **(CLICK HERE)**
- Children and Young Peoples Committee – April 2024 **(CLICK HERE)**
- Finance, Investment and Our Resources Committee – May 2024 **(CLICK HERE)**
- Health and Care Partnership – March 2024 **(CLICK HERE)**
- Quality and Performance Committee – May 2024 **(CLICK HERE)**
- Quality and Performance Committee – June 2024 **(CLICK HERE)**
- Women's Hospital Services in Liverpool Committee – March 2024 **(CLICK HERE)**