Monday 29 November 2022
10:00am to 13:00pm
The 40/Twenty Suite, Warrington Conference Centre, Halliwell Jones Stadium, Mike Gregory Way, Warrington, WA2 7NE

NHS Cheshire and Merseyside

Meeting of the Integrated Care Board

Agenda

Chair: Raj Jain

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
10:00am	**Preliminary Business**			
ICB/11/22/01	Welcome, Introductions and Apologies	Chair	Verbal	-
ICB/11/22/02	Declarations of Interest *(Board members are asked to declare if there are any declarations in relation to the agenda items or if there are any changes to those published in the Board Member Register of Interests)*	Chair	Verbal	-
ICB/11/22/03	Minutes of the previous meeting: • 27 October 2022.	Chair	Paper Approval	*Page 3*
ICB/11/22/04	Board Action Log	Chair	Paper For note	*Page 16*
ICB/11/22/05	Board Decision Log	Chair	Paper For note	*Page 18*
10:10am	**Standing Items**			
ICB/11/22/06	Report of the Chief Executive	GU	Paper For note	*Page 21*
ICB/11/22/07 **10:20am**	Warrington Together – report of the Place Director	CM	Paper & Presentation For note	*Page 31*
ICB/11/22/08 **10:30am**	Resident Story	CM	Presentation For note	*Page 48*
10:40am	**ICB Key Update Reports**			
ICB/11/22/09	Executive Director of Nursing & Care Update Report	CD	Paper For noting	*Page 55*
ICB/11/22/10 **10:55am**	Cheshire & Merseyside System Month 7 Finance Report	CWi	Paper For noting	*Page 91*
ICB/11/22/11 **11:10am**	Cheshire & Merseyside ICB Quality and Performance Report	AM / CD	Paper For noting	*Page 112*
11:25am	**ICB Business Items**			
ICB/11/22/12	Cheshire and Merseyside ICS Digital Strategy	JL / RPJ	Paper For endorsement	*Page 135*
ICB/11/22/13 **11:40am**	ICB Equality, Diversity and Inclusion Update Report	CWa / CS	Paper For noting	*Page 200*
ICB/11/22/14 **11:55am**	Consensus on the Primary Secondary Care Interface	RPJ	Paper For endorsement	*Page 208*

AGENDA NO & TIME	ITEM	LEAD	ACTION / PURPOSE	PAGE NUMBER
ICB/11/22/15 **12:10pm**	Winter Plan 2022-2023 Update	AM	Paper For noting	*Page 225*
ICB/11/22/16 **12:25pm**	Cheshire and Merseyside ICP Board – feedback from the first meeting	Chair	Paper For noting	*Page 236*
12:35pm	**Sub-Committee Reports**			
ICB/11/22/17	Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Commitee	TF	Verbal For noting	-
ICB/11/22/18	Report of the Chair of the Cheshire & Merseyside ICB Primary Care Committee	TF / CWa	Paper For noting	*Page 254*
ICB/11/22/19	Report of the Chair of the Cheshire & Merseyside ICB Finance, Investment and Resources Committee	TF / CWi	Paper For approval	*Page 267*
12:50pm	**Other Formal Business**			
ICB/11/22/20	Responses to questions raised by Members of the Public in relation to items on the agenda	Chair	For noting	-
ICB/11/22/21	Closing remarks, review of the meeting and communications from it	Chair	Verbal For Agreement	- -
13:00pm	**CLOSE OF MEETING**			

Date and time of next meeting:
26 January 2023
10:00am – 13:00pm, Floral Pavilion, Marine Promenade, New Brighton, Wirral, CH45 2JS

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

Speakers

AH	Anthony Middleton, Director of Performance and Planning, C&M ICB
CD	Christine Douglas MBE, Director of Nursing and Care, C&M ICB
CM	Carl Marsh, Warrington Place Director, C&M ICB
CWa	Clare Watson, Assistant Chief Executive, C&M ICB
CWi	Claire Wilson, Executive Director of Finance, C&M ICB
GU	Graham Urwin, Chief Executive, C&M ICB
JL	John Llewellyn, Chief Digital Offcier, C&M ICB
RPJ	Rowan Pritchard-Jones, Medical Director, C&M ICB
TF	Tony Foy, Non-Executive Director, C&M ICB

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

Integrated Care Board Meeting in Public

Held at
The Sports Hall, Everybody Health and Leisure,
Crewe Lifestyle Centre, CW1 2BB

Thursday 27 October 2022
10:00am to 12:30pm

UNCONFIRMED Draft Minutes

MEMBERSHIP		
Name	**Initials**	**Role**
Raj Jain	RJA	Chair, Cheshire & Merseyside ICB (voting member)
Steven Broomhead	SBR	Partner Member, Chief Executive, Warrington Borough Council **(voting member)**
Christine Douglas MBE	CDO	Director of Nursing and Care, Cheshire & Merseyside ICB **(voting member)**
Tony Foy	TFO	Non-Executive Director, Cheshire & Merseyside ICB **(voting member)**
Adam Irvine	AIR	Partner Member, Chief Executive Officer, Community Pharmacy Cheshire and Wirral (CPCW**) (voting member)**
Erica Morriss	EMO	Non-Executive Director, Cheshire & Merseyside **ICB (voting member)**
Ann Marr OBE	AMA	Partner Member, Chief Executive, St Helens & Knowsley Teaching Hospitals NHS Trust and Southport and Ormskirk Hospital Trust **(voting member)**
Graham Urwin	GUR	Chief Executive, Cheshire & Merseyside ICB **(voting member)**
Claire Wilson	CWI	Chief Finance Officer, Cheshire & Merseyside ICB **(voting member)**
Joe Rafferty CBE	JRA	Partner Member, Chief Executive Office, Mersey Care, Sefton Council **(voting member)**
Rowen Pritchard-Jones	RPJ	Medical Director, Cheshire & Merseyside ICB **(voting member)**
IN ATTENDANCE		
Dr Fiona Lemmens	FLE	Regular Participant, Associate Medical Director, Cheshire & Merseyside ICB
Anthony Middleton	AMI	Regular Participant, Director of Performance and Improvement, Cheshire & Merseyside ICB
Christine Samosa	CSA	Regular Participant, Director of People, Cheshire & Merseyside ICB
Clare Watson	CWA	Regular Participant, Assistant Chief Executive, Cheshire & Merseyside ICB
Mark Wilkinson	MWI	Place Director –Cheshire East
Louise Barry	LBA	Chief Executive Officer - Healthwatch

Chris Hart	CHA	Voluntary Sector Representative
John Llewellyn	JLl	Chief Digital Officer, ICB
Helen Charlesworth-May	HCM	Executive Director, Adults Health and Integrated Care, Cheshire East Council, representing Lorraine O'Donnell
Ruth Du Plessis	RDu	Director of Public Health, St Helens Council, representing ChaMPs
Kathryn Sullivan	KSU	Chief Executive, CVS Cheshire East
Carol Allen	CAL	Admin Support – Cheshire and Merseyside ICB

Apologies		
Name	**Initials**	**Role**
Ian Ashworth		Regular Participant, CWAC Director of Public Health, ChaMPs representative
Cllr Paul Cummins		Partner Member, Cabinet Member for Adult Social Care, Sefton Council **(voting member)**
Warren Escadale		Regular Participant), Voluntary Sector North West (VSNW)
Lorraine O'Donnell		Chief Executive, Cheshire East Council

Item	Discussion, Outcomes and Action Points	Action by
	Preliminary Business	
ICB/10/22/01	**Welcome, Introductions and Apologies**	
	The Chair introduced himself and outlined the housekeeping rules. RJA welcomed the members of the public present at this meeting of the Integrated Care Board (ICB) for NHS Cheshire and Merseyside. Thanks were expressed to Cheshire East place for hosting the meeting today. All members introduced themselves. RJA reminded those present that this was a meeting held in public and confirmed that some public questions had been received in advance of the meeting. RJA confirmed that although it would not be possible to address all during the meeting, all questions would be answered in writing and published on the ICB website. Apologies for absence were Noted.	
ICB/10/22/02	**Declarations of Interest**	
	There were no declarations of interest pertinent to the items being discussed today.	
ICB/10/22/03	**Minutes of the previous meeting – 29 September 2022**	
	The following corrections were made to the previous minutes: • The attendance should be corrected to reflect that Cllr Paul Cummins had attended the meeting ICB/9/22/05, Report of the Chief Executive: the reference to "the announced budget and the requirements of the NHS" should read: "the recently announced mini budget and the Government's letter setting out requirements of the NHS" • ICB/9/22/11, Update on the Cheshire and Merseyside People Board section that reads: "pleased to see wider primary care engagement and would welcome more work on including PCNs". should read "pleased to see wider primary care engagement and would welcome more work on,	

Item	Discussion, Outcomes and Action Points	Action by
	including primary care" as it should apply to primary care more broadly and not be limited to PCNs" • The attendance should be corrected to reflect that Diane Blair (Chief Executive, Healthwatch Sefton) had not attending the ICB public meeting The Board Approved the Minutes of the September 2022 meeting subject to these changes.	
ICB/10/22/04	**Board Action and Decision Logs**	
	Copies of the action and decision logs were provided to the Board prior to the meeting and RJA Noted that there were no outstanding actions requiring further update for this meeting.	
	Standing Items	
ICB/10/22/05	**Report of the Chief Executive (Graham Urwin)**	
	GUR presented the Chief Executive Report to the Committee. There were three items of note: 1. The internal staff consultation process had commenced to put together a single management structure (Corporate and Place) 2. The autumn 2022 Covid-19 booster campaign whichwas underway 3. The Royal Liverpool University Hospital move was now complete. The successful move took place over a phased period. Members were also requested to approve the recommendation to change the ICB's named Freedom to Speak Up Guardian. Queries and Responses: • Congratulations were extended to the team at LUFHT who worked hard to achieve the move into the new Royal site, with uninterrupted patient care • There were high level proposals in place around the deployment of the system's share of the £500m social care discharge funding to support the care system over the winter. C&M should receive £26M: ○ 40% will support the Marketplace to enable more staff to receive a wage. ○ 60% will be utilised for packages of care, to get more people discharged from hospital • The good work of the "Living Well" bus operating across Cheshire and Merseyside were highlighted. Over 3000 onsite Covid-19 vaccinations had been completed, as well as several health checks • The question was raised around staff morale and the support offered to staff given the period of change for staff. CSA provided an outline of support on offer for staff, namely: ➢ A wide range of support for staff was available in terms of health and wellbeing over the next three weeks whilst the consultation was live ➢ Planned HR drop-in sessions. "We Are One Briefings" were taking place fortnightly where staff had the chance to ask questions. The Occupational Health offer had been enhanced through the Employee Assist Programmes RJA asked whether we have a Cheshire and Merseyside Children's Citizen Panel And asked for it be considered. Maria Auston ICB Associate Director of Communications and Empowerment agreed to look at how this could be progressed if appropriate • Board Members were encouraged to promote the vaccination programme	CWA

Item	Discussion, Outcomes and Action Points	Action by
	The Integrated Care Board: • **Noted the contents of the report.** • **Approved the recommendation regarding the change in the ICB's named Freedom to Speak Up Guardian.**	
ICB/10/22/06	**Welcome to Cheshire East (Mark Wilkinson and Helen Charlesworth-May)**	
	MWI and HCM presented the Cheshire East paper and the associated appendices for noting. MWI noted that there were some consistent themes running through the presentation, the resident story and the marketplace. A key number of areas were highlighted: • The purpose of the presentation was to outline the significant inequality within Cheshire East • Deprivation exists across Cheshire East, today's focus was Crewe • The planned arrival of HS2 presented a significant opportunity to drive the economic regeneration of Crewe • It was incumbent on partners to ensure that the economic regeneration was matched by regeneration of Health and Wellbeing (for the people of Crewe to benefit) • Data driven insights would be used to improve services delivered, with particular focus on the most disadvantaged people in our communities e.g., Crewe • Plans for future growth in Crewe were promising • The Cheshire East approach was to: ▪ View strategies and plans through the lens of 'wants' as well as 'need' ▪ Develop our partnership ▪ Build on strong foundations in primary care ▪ Grow our eight Care Communities including Crewe ▪ Focus on aligning economic value to health value Queries and Responses: • EMO queried the workforce pathways ➢ HCM: The Care Academy was being setup. There were opportunities to bring Young People in particular, into care roles through the Apprenticeship Scheme. Trained in the Local Authority and out to other roles ➢ Deborah Woodcock (Director of Children's Services) and HCM have a short-term intervention with colleges, which was beneficial ➢ Growing the care workforce was a long-term endeavour. • How will the 25% reduction of Public Health spend affect the challenge of Health Inequalities in Cheshire East? ➢ Cheshire East Council had been able to set money aside for long-term investment in Health Inequalities Comments: • The Adults and Health Committee of the Cheshire East Council agreed to invest in a pilot for smoking cessation • Residents would be paid to quit smoking as an experiment based on research	

Item	Discussion, Outcomes and Action Points	Action by
	The Integrated Care Board: • **Noted the contents of the report and presentation.**	
ICB/10/22/07	**Resident's Story**	
	Resident's Story Update: Social Prescribing MW provided some background information as context for the resident's story: The College of Medicine was running 'a beyond pills campaign' that highlighted the importance of social prescribing. Highlighted was the contribution that social prescribing can make to better outcomes, fewer side effects to improve mental, physical, and social health, delivering major savings to the NHS. This provided a 'hands on' Social Prescribing Programme supporting individuals who lived in Cheshire and were registered at GP practices within the Primary Care Networks. The programme supported individuals with a wide range of social, emotional, or practical needs to take greater control of their own health and wellbeing. Individuals could be referred to the Alternative Solutions programme via their GP practice. On referral to Alternative Solutions, individuals were assigned an individual link worker who provided tailored support, working as a partner towards improved health and wellbeing. Board Members watched a short video of service users telling their story on how the Social Prescribing Team had helped. **The Integrated Care Board:** • **Noted the presentation.**	
	ICB Key Update Reports	
ICB/10/22/08	**Cheshire & Merseyside System Month 6 Finance Report (Claire Wilson)**	
	The report updated the Board on the financial performance of Cheshire and Merseyside ICS ("the System") for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g., Cash Management and Better Payment Practice Code) and utilisation of available 'Capital' resources for the financial year. A number of key areas were highlighted: • The financial position had worsened by £10M within month across the whole system • A year-to-date deficit position of £55M • Plan to deliver a £30M deficit by the end of the year • Cost Improvement Plan (CIP) year to date (YTD) performance remain low, particularly the recurrent elements of CIP • Financial risks associated with the delivery of the financial position were set out in the paper • ICB Risks & Mitigations - Following a review of the month 6 financial position, a number of risks were emerging that would require actions to mitigate during the year for the ICB to achieve the planned surplus of £19.7M	

Item	Discussion, Outcomes and Action Points	Action by
	• Collectively assessing the unmitigated risk as a system to be £74M. A key area of focus around mitigating risks • A national protocol would be implemented if organisations changed their forecast from the original plan Queries and Responses: • TFO queried the risk as related to the £113M (above plan) spent by the provider agency costs ➢ Provider agency spending was a significant challenge and risk. The best solution would be to have recruitment and permanent/substantive staff in post. The operational day to day pressures/workforce gaps and sickness levels do not always permit this to maintain safe staffing levels, and therefore need to have temporary agency staff ➢ The financial expectation was to deliver a 10% saving on the level of agency used the previous year. Due to the workforce gaps temporary staff were required as wards and departments must be safely staffed • SBR queried whether there were plans to recover the deficit of £27M that exists within the former Cheshire CCG area? ➢ The Cheshire East Place system has had a financial deficit for a number of years. This related to the financial position of East Cheshire NHS Trust, which declared itself not financially viable in 2015. A financial recovery plan was in place ➢ The report represents the former CCGs legacy position. The comparative information was used to drive the best use of money ➢ CWI also outlined that will look to include within future reports the outline of recovery plans being developed at Places • JRA queried what the Provider Efficiencies Schemes recurrent savings plan looked like ➢ Individual provider organisations were developing their own financial internal efficiency plans. Progress within some organisations remained slow. The collaboration at scale workstreams were being looked at across the system (drug costs, collaborative bank, procurement at scale and financial systems). This would be led by an SRO. **The Integrated Care Board:** • **Noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.** • **The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting**	
ICB/10/22/09	**Cheshire & Merseyside ICB Quality and Performance Report (Anthony Middleton)**	
	AMI provided an update on the Cheshire and Merseyside ICB Quality and Performance Report. An overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact and mitigations. A number of key areas were highlighted: • The Urgent and Emergency Care System continued to experience	

Item	Discussion, Outcomes and Action Points	Action by
	significant pressure across the whole of NHS Cheshire & Merseyside • Bed occupancy was high • Planned Care: A real change and improvement in addressing the backlog created during the Covid-19 period, when elective activity was suspended • Cancer: An area impacted during Covid-19. A significant drop in referrals during the Covid-19 period, even with cancer services which were maintained. Organisations were working hard to get the backlog down to the level pre-Covid-19. A robust, ambitious target, trying to get the backlog level reduced, comparable to pre-Covid-19 by the end of March 2023, to deliver the 62-day standard (a key clinical measure) • Mental Health: A system which has bed pressures, has growth in demand, has workforce challenges in delivering a range of services Queries and responses: • RAJ queried the safety of patients with the additional long waits (12-hour delays) in A&E ➢ As a professional body weekly meetings were underway to consider the issues around Quality and Safety within the organisations (around reporting and learning from incidents that have occurred). Listening to the patient experience and how that could be improved ➢ There were challenging times ahead in terms of winter, identifying the risks and how the risks were shared within the organisations ➢ There were extreme pressures in the Emergency Department (ED). The Leadership Team must do as much as possible to support patients and staff in ED Comments: • Healthwatch Cheshire East had recently completed A&E Watches at Leighton Hospital over a period to look at the experiences of people accessing the A&E Department. The report was submitted to Leighton Hospital. They reported on the incredibly committed staff who were trying to make the best of the experience for people attending A&E • Collectively Healthwatch could provide insight into personal stories and personal patient experiences at the point of entry as well as those waiting a long time for treatment in the community • Patient Initiated Follow-up: There was an opportunity for both improved patient experience and allocating capacity elsewhere • There was an issue with Health Inequalities • The percentage of patients with Learning Disabilities (LD) who were not having their Annual Health Check was a concern • A detailed discussion around patients with LD took place at the Quality and Performance Committee. Information was outlined in the highlight report. The issue was being addressed • People with Learning Disabilities should not wait until the end of the year to undergo Health Checks. There should be a focus of supporting people with LD and Autism to have better access to health • Chief Executives were encouraged to discuss the experience of people with Learning Disabilities and the strategy to narrow the inequality gap **The Integrated Care Board:** • **Noted the contents of the report and take assurance on the actions contained.**	
ICB/10/22/10	**Executive Director of Nursing & Care Report (Christine Douglas)**	

Item	Discussion, Outcomes and Action Points	Action by
	CDO report provided assurance from the Executive Director of Nursing & Care to the Cheshire and Merseyside (C&M) Integrated Care Board (ICB) on the quality, safety and patient experience of services commissioned and provided across the geographical area of Cheshire & Merseyside. A number of key areas were highlighted: • • Due to the timing of the publication of this report it does not include detail on the recent Kirkup/East Kent maternity services report and its main findings, however by way of short verbal update: • An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Several missed opportunities were identified within the review • Areas of failures were identified (teamwork, professionalism, compassion, safety and listening) • Actions were produced from the report around monitoring safety and performance, standards of clinical behaviour • Five recommendations within the Kirkup Report, including • 1) Establishment of a Task Force • 2) Looking at how can further embed compassionate care at under grad and post graduate education level • CDO outlined that a detailed report will be presented at the next ICB Quality and Performance Committee • CQC State's Care Report which identified significant gap in workforce across NHS and Social Care • CDO proposed that a further detailed Health and Social Care Workforce Report to be brought back to the Board via future Director of Nursing and Care Report to Board. **The Integrated Care Board:** • **Noted the content of the report.** • **Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration.** • **Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.**	CDO CDO/CSA
	ICB Business Items	
ICB/10/22/11	**Continuous Glucose Monitoring (Rowen Pritchard-Jones)**	
	RPJ gave a presentation on Continuous Glucose Monitoring (CGM) and Flash Glucose Monitoring (FGM). NICE had issued updated guidance on criteria for use of CGM and fFGM and recommended that patients with Type 1 diabetes and some patients with Type 2 diabetes were offered this option. NICE have made these recommendations after economic analysis had shown them to be cost effective. There were significant outcome benefits for patients and longer-term cost saving benefits for the system through improved diabetes control because of the new devices. A number of key areas were highlighted:	

Item	Discussion, Outcomes and Action Points	Action by
	• There were many patients with diabetes who lived a challenging life, injecting themselves several times a day, taking multiple blood tests to check blood sugar levels • The long-term health impact of living with diabetes for patients was huge • NICE guidance brings forward some of the most important changes to the care of diabetes that has been seen in many years • Continuous glucose monitoring measures glucose levels and alerts patients • Robust guidance was available that as a system could be adopted for the benefit of patients • Finance remained a challenge; based on modelling and understanding the wider impact of patient health There is a risk in implementing the guidance in terms of the cost of devices, which is significant, and there are expected to be additional workforce impacts as more patients require specialist input to ensure they are provided the best option for their circumstances. • Devices were becoming cheaper as production was scaled up • £0.5M would be saved as a result of patients not arriving in ED with hypoglycaemia • There was a significant variation depending on where you lived in Cheshire and Merseyside. All patients must have access to the service • The impact of limb amputation was £2.5M a year • Quality impact on the patient was huge • Impact on the patient's families was lifelong • Long term return on investment must be considered Questions/Comments were received: • The implementation plan would be key to successful delivery of the programme • The roll-out must seek to address existing health inequalities (not inadvertently exacerbate them). There was a role for the wider system, including the VCFS in developing the implementation plan. needed to quantify these **The Integrated Care Board:** • **Approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and** • **Approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28.** • **Requested that in 12 months' time the Board be provided with a progress update on the implementation of the guidance and impact on addressing inequalities .**	
ICB/10/22/12	**Provider Collaborative Update (Joe Rafferty)**	
	JRA presented the Provider Collaborative paper to the Board. The Provider Collaborative was made up of of NHS providers pursuing equitable, sustainable connected physical and mental health services that deliver improved health and wellbeing for people in their communities. Done at Place across the whole of Cheshire and Merseyside, in partnership with local communities and a wide range of agencies.	

Item	Discussion, Outcomes and Action Points	Action by
	A number of key areas were highlighted: • The Provider Collaborative looked at Mental Health, Physical Community Services and Learning Disabilities Services • Primarily work was undertaken in a community space, some in a bed-based space • Managing a great deal of risk in these services • An important collaborative mechanism for the ICB • Collaboration at scale, to enable better care at Place • The intention to bring a Strategic Case to the Board for full consideration (i.e., proportion and governance arrangements) Questions/Comments were received: • The Board welcomed the focus on prevention, considering prevention and support for people through their care pathway • Some reservations regarding the intent to bring a strategic outline case to the Board without fully understanding what it means for Place, Local Authorities. Agreed for a further discussion to be head between JRA, SBR and GUR **The Integrated Care Board:** • **Noted the content of the report.** • **Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.**	JRA
ICB/10/22/13	**System Finance Assurance Report (Claire Wilson)**	
	CWI presented the System Financial Assurance Update paper circulated prior to the meeting. The NHS was managing a number well understood operational and financial challenges as the NHS recovered from COVID, prepared for winter and managed rising costs of inflation. The finance report, elsewhere on the Board agenda, set out how these challenges translated to financial risk in the delivery of financial plans. At its last meeting, the Integrated Care Board (ICB) asked for an update on the arrangements in place to support financial delivery and assurance in delivering financial commitments. The paper set out arrangements for financial assurance to support delivery of the financial plan. A number of key areas were highlighted: • There was a significant amount of work needed to support financial delivery and assurance in delivering financial commitments • The paper outlined assurance processes put in place collaboratively across the system to develop the plans this year • The paper showed how issues were being monitored, escalated, tracked associated with delivering those plans at individual organisation level • The development of a a financial accountability framework for the system • A Chief Executive workshop planned around accountability • A set of tactical arrangements were in place to cover the next couple of months.	

Item	Discussion, Outcomes and Action Points	Action by
	• The importance of developing a financial strategy • Waiting on the Financial National Guidance • Board Members to provide any feedback for considering as part of Financial Accountability Framework **The Integrated Care Board:** • **Noted the contents of the report and the development of the financial accountability framework.**	
ICB/10/22/14	**Winter Planning 2022-2023 (Anthony Middleton)**	
	AMI introduced the detailed paper on Winter Planning 2022/23. A key number of areas were highlighted: • The Urgent Care System was under pressure • A weekly Winter Planning Operational Group was underway, constructed from every single Provider and Place, predominately for learning • Over the past weeks, Place-based reviews were happening led by GUR. Members had been discussing their plans as part of this review. • Table One in the papers showed that the system had secured close to £14M additional funding to mobilise 205 more beds • There was a strong National Performance Framework around how the money is utilised across systems • Key component of this year's approach was the Falls Service. On the whole across all nine places in Cheshire and Merseyside there is a robust, proactive falls service evident in all systems, however some variation with regards reactive falls services across the places, a key component for us to address • Virtual Wards: Roll out plans were Approved for this year and next year At the Board meeting in July. Occupancy levels in the current Virtual Wards is approximately 30% • Plans for Mental Health Provision. Mental Health Services had received a small amount of funding, less than £1M in total • ICBs were asked to setup a Strategic Co-ordination Centre to pull together real time information around Urgent Care pressures across all sectors Questions/Comments were received: • Need to focus on Adult and Children vaccination (covid-19, pneumonia, and flu) • There was not a lot of detail on Respiratory conditions. This was a risk for people, especially with cold homes. It was essential to consider Respiratory for both Adults and Children • The comment was made that the paper was NHS focused. A lot of work happened at Place across the Voluntary Sectors and with Local Authorities • Beneficial to know the totality of the Winter Plan of the ICS's • The development of 'warm places' established for people with difficulty with energy poverty were an example of working together as a system • The Voluntary Sector had a range of initiatives developed in Cheshire East • The Cheshire East Place draft Winter Plan would be discussed at the Council Leadership Meeting and the Place Partnership Board Meeting next week	

Item	Discussion, Outcomes and Action Points	Action by
	The Integrated Care Board: • **Noted the contents of this report for information.** • **Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting**	AMI
12.10pm	**Sub-Committee Reports**	
ICB/10/22/15	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee (Tony Foy)**	
	TFO presented the Report of the Remuneration Committee Chair to the Board .from the meetings of 28 September 2022 and 13 October 2022. Main items considered at the meetings included: • Committee Terms of Reference (September and October) • Update on Partner Member remuneration update • National award for VSM pay update A number of key areas were highlighted: • The report detailed the areas considered in the Executive Summary • The Remuneration Committee Meeting of the 13 October 2022, considered confidential, employee specific matters • Section 3 of the report provided an update on Partner Member Pay remuneration and national decision on pay award for Very Senior Managers (VSM) • Minor amendments were made on Section 5 to the Terms of Reference requiring the Boards approval **The Integrated Care Board** • **Noted the items covered by the Remuneration Committee.** • **Approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).**	
ICB/10/22/16	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee (Tony Foy)**	
	TFO provided the Board Members with an update on key issues for consideration, approval and matters of escalation considered by the C&M ICB Quality and Performance Committee. A number of key areas were highlighted: • The report was designed to provide assurance to the Board on the work of the C&M ICB Quality & Performance Committee • The Committee had received a presentation from Cancer Alliance who had undertook a roadshow in May • Receiving views from people receiving cancer treatment • The national cancer patient experience survey was undertaken, designed to monitor progress on cancer care • Annual Health Checks for people with Learning Disabilities would be discussed at the Quality and Performance Committee • Look for alternative Annual Health Checks evidence. Improvements would be monitored on the Annual Health Checks • Maternity issues would be sent to the System Quality Group for in-depth analysis. The final report will go to the Quality Committee or direct to the	

Item	Discussion, Outcomes and Action Points	Action by
	Board **The Integrated Care Board:** • **Noted the contents of the report.**	
ICB/10/22/17	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee (Clare Watson)**	
	CWA provided an update on the Transformation Committee which has been established to support NHS Cheshire and Merseyside in the delivery of its statutory duties. A number of key areas were highlighted: • The first meeting of the Transformation Committee provided oversight and assurance for the delivery of the 'at scale commissioning service development agenda'. Page 174 of the report outlined what was considered at the meeting. • The recommended Terms of Reference required Board approval. The revision related to ensuring the full range of statutory duties the Committee would assure the Board on were included and the Committee Membership was refined **The Integrated Care Board:** • **Noted the report** • **Approved the revised terms of reference attached to the paper.**	
	Other Formal Business	
ICB/10/22/18	**Responses to questions raised by Members of the Public in relation to items on the agenda**	
	RJA advised the Board and members of the public present that questions that had been received before the meeting will be addressed and the responses would be made available on the website.	
ICB/10/22/19	**Closing remarks from the Chair, review of the meeting and communications from it:** • The Chair thanked Members and presenters for a constructive meeting • There had been good challenge from attendees on the reports presented • The Board was focusing on key priorities • Board Members were thanked for their contributions	
12.20pm	**CLOSE OF MEETING**	
Date of Next Meeting:		
28 November 2022		

End of Meeting

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log 2022-23

Updated: 10 November 2022

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-03	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**	Requested CWA and CDO provide a Workforce Update at the next Board Meeting.	Claire Wilson	28-Nov-2022	*Workforce Update report included within the Director of Nursing and Care Report*	COMPLETED
ICB-AC-22-04	27-Oct-2022	**Executive Director of Nursing and Care Report - Recommendations within the Kirkup Report**	An independent investigation was commissioned in February 2022, reviewing 202 cases, evidence from family listening sessions, clinical records, interviews with clinical staff. Agreed to take the Kirkup recommendations to the Quality Committee for consideration.	Christine Douglas	28-Nov-2022	*Quality Committee*	ONGOING
ICB-AC-22-05	27-Oct-2022	**Continuous Glucose Monitoring Update**	Requested that in 12 months' time the Board be provided with a progress update.	Rowen Pritchard-Jones	01-Oct-2023		ONGOING
ICB-AC-22-06	27-Oct-2022	**Provider Collaborative Update**	Agreed that a strategic business case relating to increased delegation be brought to the Board for consideration.	Joe Rafferty	28-Nov-2022	Requestion to receive Business Case at February Board has been received.	ONGOING
ICB-AC-22-07	27-Oct-2022	**Winter Planning 2022-23**	Agreed that an updated position on winter resilience plans was reported to the Board at a future meeting	Anthony Middleton	28-Nov-2022	Winter Resilience Plan update report included on agenda for November 2022 meeting	COMPLETED
ICB-AC-22-08							NEW
ICB-AC-22-09							NEW
ICB-AC-22-10							NEW

CHESHIRE MERSEYSIDE
INTEGRATED CARE BOARD

Action Log No.	Original Meeting Date	Description	Action Requirements from the Meetings	By Whom	By When	Comments/ Updates Outside of the Meetings	Status
ICB-AC-22-01	01-Jul-2022	**ICB Constitution**	The following changes to the ICB constitution will be made:- 1) The wording for section 3.7.2 will be reviewed and revised subject to the agreement of the	Clare Watson	27-Oct-2022	*Amendments will be included as part of any overall proposed amendments for approval that will come to the Board in*	COMPLETED

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 November 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommend… completion / subsequent consideration
ICB-DE-22-01	01-Jul-2022	**ICB Appointments (Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Executive Members of the Integrated Care Board:- 1) Claire Wilson, Director of Finance; 2) Professor Rowan Pritchard Jones, Medical Director 3) Christine Douglas MBE, Director of Nursing and Care.. They also agreed that Marie Boles, Interim Director of Nursing and Care, will fulfil this position until the substantive postholder commences.	
ICB-DE-22-02	01-Jul-2022	**ICB Appointments (Non-Executive Board Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Non-Executive Members of the Integrated Care Board:- Neil Large MBE, Tony Foy and Erica Morriss.	
ICB-DE-22-03	01-Jul-2022	**ICB Appointments (Partner Members)**		The Chair of the ICB, the CEO of the ICB and the Chair of the ICB Audit Committee agreed the following appointments as Partner Members of the Integrated Care Board:- Ann Marr OBE and Dr Joe Rafferty CBE.	
ICB-DE-22-04	01-Jul-2022	**ICB Constitution**		The Integrated Care Board approved:- 1) The NHS Cheshire and Merseyside Constitution subject to some agreed updates (see action plan ref: ICB-AC-22-01 for details). 2) The Standards of Business Conduct of NHS Cheshire and Merseyside. 3) The Draft Public Engagement/Empowerment Framework of NHS Cheshire and Merseyside. 4) The Draft Policy for Public Involvement of NHS Cheshire and Merseyside.	
ICB-DE-22-05	01-Jul-2022	**Scheme of Reservation and Delegation**		The Integrated Care Board approved:- 1) The Scheme of Reservation and Delegation of NHS Cheshire and Merseyside. 2) The Functions and Decisions Map of NHS Cheshire and Merseyside. 3) The Standing Financial Instructions of NHS Cheshire and Merseyside. 4) The Operational Limits of NHS Cheshire and Merseyside.	
ICB-DE-22-06	01-Jul-2022	**ICB Committees**		The Integrated Care Board approved:- 1) The core governance structure for NHS Cheshire and Merseyside. 2) The terms of reference of the ICB's committees. It also noted the following:- i) The proposed approach to the development of Place Primary Care Committee structures which will be subject to further reporting to the Board. ii) The receipt of Place based s75 agreements which govern defined relationships with and between specified local authorities and the ICB in each of the 9 Places.	
ICB-DE-22-07	01-Jul-2022	**ICB Roles**		The Integrated Care Board agreed the lead NHS Cheshire and Merseyside roles and portfolios for named individuals, noting that the Medical Director will be the SIRO and the Executive Director of Nursing and Care will be the Caldicott Guardian.	
ICB-DE-22-08	01-Jul-2022	**ICB Policies Approach and Governance**		The Integrated Care Board:- 1) Noted the contractual HR policies that will transfer to the ICB alongside the transferring staff from former organisations. 2) Endorsed the decision to adopt NHS Cheshire CCG's suit of policies as the ICB policy suite from 1st July 2022. 3) Agreed to establish a task and finish group to set out a proposed policy review process, using the committee structure for policy approval. 4) Noted the intention to develop a single suite of commissioning policies to support an equitable and consistent approach across Cheshire and Merseyside.	
ICB-DE-22-09	01-Jul-2022	**Shadow ICB Finance Committee Minutes Approval**		The Board agreed that the minutes of the Cheshire and Merseyside Shadow ICB Finance Committee held on 30th June 2022 can be submitted to the first meeting of the ICB's established Finance, Investment and Our Resources Committee.	
ICB-DE-22-10	04-Aug-2022	**Cheshire & Merseyside ICB Financial Plan/Budget**		1) The Board supported the financial plan submission made on 20th June 2022 in relation to the 2022/2023 financial year. 2) The Board approved the initial split for budgetary control purposes between 'central ICB' and 'Place' budgets for 2022/23 resulting in a headline 20%/80% split respectively.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 November 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommend... completion / subsequent consideration
ICB-DE-22-11	04-Aug-2022	**Cheshire & Merseyside System Month 3 (Quarter One) Finance Report**		The Board noted the Month 3 Financial Report.	
ICB-DE-22-12	04-Aug-2022	**Cheshire & Merseyside Month 3 (Quarter One) Performance Report**		The Board noted the Month 3 Performance Report and requested that the next report includes data around mental health indicators and the wider primary care service.	
ICB-DE-22-13	04-Aug-2022	**Establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire**		The Board approved the clinical case for the establishment of a North Mersey comprehensive stroke centre for hyper-acute services for the population of North Mersey and West Lancashire subject to an ongoing financial review.	
ICB-DE-22-14	04-Aug-2022	**Virtual Wards – update on their expansion across Cheshire and Merseyside**		The Board noted the Virtual Wards update.	
ICB-DE-22-15	04-Aug-2022	**Responses to questions raised by Members of the Public in relation to items on the agenda**		The Board agreed to respond to all public questions raised prior to the August meeting.	
ICB-DE-22-16	29-Sep-2022	**Chief Executive Report**		1) The Board approved entering into the Sefton Partnership Board Collaboration Agreement 2) The Board approved the recommendation to delegate authority to the Chief Executive and the Assistant Chief Executive to sign off collaboration agreements or memorandum of understanding from other places noting that any arrangements requiring S75 or pooled budget agreements would be submitted to the ICB Board for approval.	
ICB-DE-22-17	29-Sep-2022	**Liverpool University Hospitals NHS Foundation Trust Clinical Service Reconfiguration Proposal**		1) The Board approved the proposals for the five LUHFT major service changes, which are contained in a business case (and outlined in Section 4 of this paper) and informed by a formal public consultation 2) The Board noted the decisions of NHS England against the proposals for the four of the five service areas (vascular, general surgery, nephrology and urology) that are in the scope of NHS England commissioning responsibilities.	
ICB-DE-22-18	29-Sep-2022	**Developing the Cheshire and Merseyside Integrated Care Partnership (ICP)**		1) The Board approved the appointment of Louise Gittins as the designate Chair of the ICP 2) The Board approved the process for the appointment of a vice chair	
ICB-DE-22-19	29-Sep-2022	**Report of the Audit Committee Chair**		1) The Board approved the Committee recommendation to agree the proposed amendments to the Terms of Reference of the ICB Audit Committee 2) The Board approved the Committee recommendation to appoint an ICB Counter Fraud Champion and the stated named post to undertake this role 3) The Board approved ICB Information Governance Policies and statements / Privacy notices and their subsequent publication	
ICB-DE-22-20	29-Sep-2022	**Report of the Chair of the ICB Quality and Performance Committee**		The Board approved the proposed amendments to the revised Terms of Reference for the ICB Quality & Performance Committee	
ICB-DE-22-21	29-Sep-2022	**Report of the Chair of the ICB System Primary Care Committee**		The Board approved the proposed amendments to the Committees Terms of Reference subject to membership from LPS being included.	
ICB-DE-22-22	27-Oct-2022	**Chief Executive Report**		1) The Board noted the contents of the report. 2) The Board approved the recommendation change in the ICB's named Freedom to Speak Up Guardian.	
ICB-DE-22-23	27-Oct-2022	**Welcome to Cheshire East**		The Board noted the contents of the report and presentation.	
ICB-DE-22-24	27-Oct-2022	**Residents Story Update - Social prescribing**		The Board noted the presentation.	
ICB-DE-22-25	27-Oct-2022	**Cheshire & Merseyside System Month 6 Finance Report**		1) The Board noted the contents of this report in respect of the Month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. 2) The Board requested CWA and CDO provide a Workforce Update at the next Board Meeting.	
ICB-DE-22-26	27-Oct-2022	**Cheshire & Merseyside ICB Quality and Performance Report**		The Board noted the contents of the report and take assurance on the actions contained.	
ICB-DE-22-27	27-Oct-2022	**Executive Director of Nursing and Care Report**		1) Noted the content of the report. 2) Noted that CDO would be taking the Kirkup recommendations to the ICB Quality and Performance Committee for consideration. 3) Noted that a Workforce update will be provided within the next Director of Nursing and Care report to the Board Meeting.	
ICB-DE-22-28	27-Oct-2022	**Continuous Glucose Monitoring**		1) The Board approved the retirement of the current Cheshire & Merseyside Continuous Glucose Monitoring (CGM) policy, and 2) The Board approved the recommendations for CGM and flash glucose monitoring within NICE NG17, NG18 and NG28. 3) Requested that in 12 months' time the Board be provided with a progress update.	

CHESHIRE AND MERSEYSIDE INTEGRATED CARE BOARD

Decision Log 2022 - 2023

Updated: 10 November 2022

Decision Ref No.	Meeting Date	Topic Description	Conflicts of interest considered and agreed treatment of the conflict	Decision (e.g. Noted, Agreed a recommendation, Approved etc.)	If a recommend… completion / subsequent consideration
ICB-DE-22-29	27-Oct-2022	**Provider Collaborative update**		1) Noted the content of the report. 2) Agreed that a strategic outline business case for the Collaborative to receive greater delegated responsibilities from the ICB be brought to a future meeting of the Board for consideration.	
ICB-DE-22-30	27-Oct-2022	**System Finance Assurance Report**		The Board noted the contents of the report and the development of the financial accountability framework.	
ICB-DE-22-31	27-Oct-2022	**Winter Planning 2022-23**		1) The Board noted the contents of this report for information. 2) The Board agreed that an updated position on winder resilience plans is reported to the Board at a future meeting	
ICB-DE-22-32	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Remuneration Committee**		1) The Board noted the items covered by the Remuneration Committee. 2) The Board approved the recommendation to agree the proposed amendments to the Terms of Reference of the ICB Remuneration Committee (Appendix A).	
ICB-DE-22-33	27-Oct-2022	**Report of the Chair of the Cheshire & Merseyside ICB Quality and Performance Committee**		The Board noted the contents of the report.	
ICB-DE-22-34	27-Oct-2022	**Report of the Cheshire & Merseyside Chair of the ICB Transformation Committee**		1) The Board noted the report 2) Approved the revised terms of reference attached to the paper.	

NHS Cheshire and Merseyside Integrated Care Board Meeting

Chief Executives Report

28 November 2022

Agenda Item No	**ICB/11/22/06**
Report author & contact details	Graham Urwin, Chief Executive
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Graham Urwin, Chief Executive

Chief Executives Report (November 2022)

<table>
<tr><td>Executive Summary</td><td colspan="5">This report provides a summary of issues not otherwise covered in detail on the Board meeting agenda. This includes updates on:
External Audit Provider for the ICB
ICP Strategy Update
Harmonisation of Clinical Commissioning Policies Update
NEPTs
EPRR Annual Return Update
Covid-19 Autumn Booster Update
Publication of the C&M Five Suicide Prevention Strategy
NIHR Update
Academical Health Science Network Update
Industrial Action
Adult Social Care Discharge Fund
Decisions undertaken at the Executive Committee.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
note the content of the report
approve the recommended delegation of authority to the ICB Audit Committee</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td>X</td><td></td><td>X</td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td>X</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No</td></tr>
<tr><td>Next Steps</td><td colspan="5">None</td></tr>
</table>

Chief Executives Report (November 2022)

1. Introduction

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

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

2. External Audit Provider for the ICB

2.1 A new external audit provider is required by the ICB for the 2023/2024 financial year due to the existing contract expiring at the end of March 2023 (for audit service provision in respect of the 2022/2023 financial year).

2.2 The ICB (through the Audit Committee as per its terms of reference regarding the appointment of external audit) has initiated a procurement process, which is progressing well and is expected to conclude within the required national timelines (which requires the ICB to award a new contract by the end of December 2022),

2.3 The procurement process is still anticipated to be completed by the end of the November, but as the next ICB Board meeting is scheduled for the 26 January 2023, it is recommended that the Board on this occasion delegate authority to the Audit Committee to make the contract award decision at its Committee meeting on the 13 December 2022.

2.4 Approval in December by the Audit Committee will ensure completion of the contract award process, contract sign-off and mobilisation in preparation for the new contract commencement on 1 April 2023 in line with guidance. The Board will receive the outcome of the contract award decision via the Audit Chairs Report to the Board at its January 2023 meeting.

The Board is recommended to delegate authority to the Audit Committee to make the contract award decision on behalf of the ICB at its 13 December 2023 meeting.

3. ICP Strategy Development Update and ICB Five Year Forward Plan

3.1 As has been previously reported to the Board, the Department of Health and Social Care issued statutory guidance[1] for the production of an Integrated Care Partnership (ICP) Strategy by December 2022. The approach used to develop the ICP Strategy has been to build on our existing strategic plans including the 2021-25 HCP Strategy, the 2022 All Together Fairer Report and associated approved strategies and plans. Additionally, we have worked with the nine Cheshire and Merseyside Healthwatch organisations to ensure that the plans will reflect the main current challenges being experienced by our residents in relation to their health and wellbeing; including cost of living pressures and challenges accessing some services in a timely manner.

3.2 Throughout September and October 2022, the approach and content has been discussed with a range of stakeholders and we are in the process of incorporating the content into a single document. The content will not only include the Cheshire and Merseyside wide priorities but also has summaries of our nine Health and Wellbeing Board/Place Strategies, allowing the public to see the whole picture in one document. The draft strategy will be widely shared with stakeholders by the end of November 2022, to allow for feedback, prior to being shared with the Cheshire and Merseyside Health and Care Partnership (HCP) and considered for publication by the HCP at its meeting on 22 December 2022. The national guidance outlines there will be a need to update this strategy during 2023-24 to reflect updated local Joint Strategic Needs Assessment information and to respond to revised national guidance expected in June 2023.

3.3 As the existing strategies have been engaged upon in their development, we have not undertaken more extensive public engagement activities at this stage, but plan to do so after publication. This will be joined up alongside existing engagement processes in Places, in relation to Health and Wellbeing or Place Plan developments and in relation to the ICB Five Year Forward Plans that will be developed during the early part of 2023.

4. Harmonising Clinical Commissioning Policies Update

4.1 As the successor body to the nine former Clinical Commissioning Groups (CCGs) within Cheshire & Merseyside, the Integrated Care Board (ICB) has inherited the clinical commissioning policies of each CCG through the national transfer order.

[1] https://www.gov.uk/government/publications/guidance-on-the-preparation-of-integrated-care-strategies

4.2 As the single statutory body for the whole Cheshire and Merseyside population, the ICB cannot continue to operate different policies across the population and therefore needs to develop a single, harmonised suite of commissioning policies to be applied consistently across Cheshire and Merseyside.

4.3 To this end, a review is underway to consider:

- the latest evidence based clinical practice
- the current commissioning landscape
- the legislation and the duties of the ICB.

4.4 As part of this Project there is a multi-disciplinary steering group in place (with Executive Sponsor of Rowan Pritchard-Jones, ICB Medical Director) to ensure that health care services are available to meet the reasonable needs of the population, with engagement of key stakeholders across Cheshire and Merseyside and engagement with patients as part of the review process and project.

4.5 All 112 clinical commissioning policies have been assessed and a comprehensive review process is underway to consider the quality, equality and financial impact of any future harmonisation or change. Recommendations based on this process, will be taken through the Steering Group and to the appropriate Board sub-committees for ratification, followed by submission for approval to the ICB Board. A detailed progress update will be brought to January 2023 Board meeting for discussion.

5. Non-Emergency Patient Transport Services (NEPTS)

5.1 There are five NEPTS contract across the Northwest. In Cheshire and Merseyside, Northwest Ambulance Service (NWAS) has the contract for the Merseyside region (and in Cumbria, Greater Manchester, and Lancashire) and West Midlands Ambulance Service (WMAS) for the Cheshire region (including Warrington and Wirral).

5.2 The NWAS contract expired in June 2021 but was extended under COVID-19 ‘Command and Control’ arrangements until March 2023, whereas the WMAS contract is not due to expire until March 2024.

5.3 Work is underway looking at designing the specifications for the NEPTS service that will be used for a new procurement exercise. However, to enable the completion of this work and engagement with partners to help with the design of the specification, and to ensure continuity of the service delivered by NWAS, the Northwest ICBs have been asked to extend the existing NWAS contract for a further 12 months. It is my intention to support this extension in collaboration with our North West ICBs.

5.5 Lancashire and South Cumbria ICS are the lead Commissioners for NEPTS, and we will work closely with them , agreeing our governance arrangements, to ensure that a NEPTS service is procured that meets the needs of our population.

6. EPRR Annual Return to NHSE

6.1 Following the completion of the annual EPRR Core Standards assurance process, the ICB is declaring an overall EPRR compliance assurance rating of non-compliant (60%) for 2022/2023. This rating should not be perceived as poor as the EPRR Team are delivering against each NHS Core Standard for EPRR following the ICB becoming a Category 1 responder from the 1st July 2022, with the position fully in the first year of establishment. However, it does indicate that there are significant opportunities for the organisation to further improve over the coming year, through the implementation and monitoring of effective action plans through EPRR governance structures as well as the recruitment of the EPRR Team.

6.2 Peer Reviews have been undertaken with neighbouring ICB's as a benchmarking tool; both Greater Manchester and Lancashire and South Cumbria ICB's are also declaring non-compliant for 2022/23.

6.3 Due to the timeline required for the submission of the Statement of Compliance to NHS England, approval was sought and received to do so via the Executive Team, however a more up to date report will be received by the Board at its meeting in January 2023 outlining the plans to address partial and non-compliant standards.

7. Autumn 2022 COVID-19 Booster Programme Update

7.1 The Autumn booster offer is now into its 11th week in Cheshire and Merseyside. Overall uptake for all eligible cohorts as of 13 November 2022 is 53.7%. Whilst this uptake is lower than the last autumn booster and spring booster Cheshire and Merseyside are is performing the best in the Northwest region. Focussed communications and targeted hyperlocal offers are being used in low uptake areas with access and inequalities funding is supporting the ongoing offer from the Living Well Bus.

7.2 Whilst our local Trusts frontline Health care worker vaccination booster uptake in Cheshire and Merseyside is performing better than other subregions within the northwest, the uptake is disappointing and intense work is ongoing at each Trust to improve the position as rapidly as possible.

7.3 Cheshire and Merseyside is also leading the way for the Northwest in vaccinating our Care home residents and staff. All care homes across Cheshire and Merseyside have been offered a visit. This is a fantastic achievement to have prioritised and vaccinated this group.

7.4 Between the 5 September and 15 November 2022, the Cheshire and Merseyside programme has delivered 692,426 seasonal boosters which has doubled over the last month and over 16,000 primary doses as part of the evergreen offer. All cohorts are now open, and an offer of a vaccination will be made to all citizens by mid-December.

7.5 We are continuing with the Living Well service (offered by Cheshire Wirral Partnership) which is a system wide offer, directed by Place to target hard to reach, seldom heard groups to offer the autumn booster and evergreen offer. To date the service has delivered almost over 7,000 COVID-19 vaccinations and 1,100 health screenings across 129 clinics.

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

8. Publication of the Cheshire and Merseyside Five Year Suicide Prevention Strategy

8.1 On the 15 November 2022, the Champs Public Health Collaborative published a brand-new five-year strategy[2] that will aim to prevent as many suicides as possible and reduce the number of people impacted by suicides in the subregion.

8.2 Sadly, according to the Office for National Statistics (ONS), in Cheshire and Merseyside there were 278 registered deaths by suicide in 2021, which may have affected over 37,500 people due to the knock-on impact that suicides have on the people around them.

8.3 The new Cheshire and Merseyside Suicide Prevention Strategy has been created in close collaboration with those who have personal experience of suicide, as well as stakeholders and partners from across the private, public and third sectors, to ensure it meets their needs as much as possible.

8.4 I would like to commend the excellent work that has been undertaken to produce this strategy and its supporting materials. Along with our partners, the ICB will actively work collectively to make Cheshire and Merseyside a place where all suicides are prevented.

9. National Institute for Health and Care Research (NIHR)

9.1 The NIHR is entering a phase of change and looking to bring together the three Integrated Care Systems (ICS) in the Northwest for a single research structure. All partners are working very closely and collaboratively to produce a much better-connected research environment. Cheshire and Merseyside ICS will be central in coordinating and delivering this ambition and NHS and academic partners have already met and agreed this collaborative approach.

[2] https://www.champspublichealth.com/suicide-prevention/

10. Letter of Support for AHSN relicense

10.1 The ICB has recently supported the relicensing application of the Innovation Agency (the Academic Health Science Network for the Northwest Cost for the period 2023-2028. We welcome the opportunity to work in partnership with the Innovation Agency in the coming years to deliver our transformation work in the Cheshire and Merseyside Region. Phil Jennings, Chief Executive of the Innovation Agency is due to present to the Board at its meeting in January 2023 on the work of the Innovation Agency and the support it can provide the ICB going forward.

11. Industrial Action

11.1 Trade unions representing NHS staff have advised the Secretary of State for Health and Social Care that they are in dispute over the 2022/23 pay award. A number of the unions are balloting or have signalled their intention to ballot their NHS members to take part in industrial action. The Royal College of Nursing (RCN) are the first trade union to conclude their ballot and met the threshold in 174 NHS Trusts in England. In Cheshire and Merseyside, all except three Trusts met the threshold; these were East Cheshire, Warrington & Halton, and Southport & Ormskirk.

11.2 Planning to mitigate the impact of industrial action is taking place at national, regional, and local levels and HR and EPRR teams within the ICB are involved in this. Anthony Middleton, Director of Performance and Planning is the Lead for the C&M ICS. A way of maintaining safe staffing levels during periods of industrial action is through derogations, which are exemptions provided to a member or service from taking part in strike action. Derogations must be agreed with Trade Unions and Trusts will discuss and request derogations locally with their Staff Side / Trade Unions.

11.3 Whilst there have been requests from the NHS to discuss derogations nationally and regionally, Trade Unions are currently holding a position that they are not yet prepared to enter discussions on derogations. Local representatives have therefore also been largely unwilling to start these discussions to date.

11.4 The ICB also directly employs 114 RCN members who were balloted for industrial action. The threshold was narrowly reached, therefore industrial action by RCN members will also take place within the ICB. As an ICB we will look to support our staff who are RCN members as and when they choose to take industrial action.

11.5 Dates for industrial action have not yet been announced and Trade Unions must provide 14 days' notice to all relevant employers before industrial action can begin. On 15 November Unions representing more than a million staff working across the NHS met with health secretary Steve Barclay to discuss the growing workforce crisis. There has been no indication yet of a potential resolution to this dispute therefore the NHS's task now is to be prepared for any potential industrial action so there is minimal disruption to patient care and emergency services can continue to operate as normal.

12. Social Care Discharge Fund

12.1 The Department of Health and Social Care (DHSC) has announced that 60% (£300m) of the £500m Social Care Discharge funding would go to integrated care boards in order to improve bed capacity, freeing up hospital beds through quicker discharge, and 40% (£200m) will be allocated directly to councils in order to bolster the social care workforce. It is good news that this has been confirmed as recurrent funding. The funds will be allocated in the coming weeks, for use over the rest of 2022. It is separate from the additional funding announced by chancellor in the autumn statement.

12.2 The Cheshire and Merseyside ICB population is considered to be c5% of the national population however we have been allocated 6.4% (c£19.2m) of the national resource, which recognises that as an ICB we have more non criteria to reside patients in our hospitals compared to that of the England average.

12.3 The DHSC website[3] identifies the allocations per Council, summarised for Cheshire and Merseyside below:

Local Authority	£allocation
Cheshire East	£1,208,865
Cheshire West	£1,222,682
Halton	£532,610
Knowsley	£814,213
Liverpool	£2,464,256
Sefton	£1,270,738
St Helens	£802,380
Warrington	£686,448
Wirral	£1,500,308
Total:	**£10,502,500**

12.4 Each of our Place Directors are working with their respective Local Authority and provider colleagues to activate plans that will increase capacity and reduce the number of non-criteria to reside patients that are occupying hospital beds.

[3] https://www.gov.uk/government/publications/adult-social-care-discharge-fund-local-authority-and-integrated-care-board-icb-allocations

12.5 With regards the funding that the ICB will receive directly, in the first instance we will replicate the national NHS allocation formula at place level but as we firm up plans if any place is unable to spend any of its allocation we will look to redistribute the underspend across Cheshire and Merseyside so to enable the best use of the funding to enable us to deliver biggest difference for our population.

13. Decisions taken at the Executive Committee

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

- **Area Prescribing Committee Prescribing Recommendations** – the Executive Team considered a paper outlining a number of NICE Technology Appraisals (TAs) and the prescribing recommendations against them. NICE TAs are based on clinical evidence showing how well a medicine or treatment works and the economic evidence showing how well the medicine or treatment works in relation to how much it costs the NHS. The NHS is legally obliged to fund and resource medicines and treatments recommended by NICE's TAs. The Executives approved the recommendations within.
- **Prometheus Contract Extension** – the Executive Team considered a paper regarding mental health patient conveyance and observational support in hospitals and the need to extend the contract of the current provider of services until the end of March 2023 at a cost of c£635k and utilising funding received via the Mental Health Act funding. The service provided by Prometheus is the provision of a 24/7 conveyance solution to support individuals who had been placed on a Mental Health section, and to provide appropriate and therapeutic observation of patients detained on a S136 within an Acute Hospital Place of Safety (PoS). This service helps to alleviate the pressures upon North West Ambulance Service (NWAS), Cheshire and Merseyside Police Forces and Local Authorities, and to improve the experience and care of our mental health (MH) patients. The Executives approved the recommendations within.
- **Employee Lease Car/Salary Sacrifice Scheme** – the Executive Team approved the establishment of an employee lease car/salary sacrifice scheme, with details to be made available to employees in the near future.
- **Expansion of Employment Advisors in Improving Access to Psychological Therapies (IAPT) across Cheshire & Merseyside** – the Executive Team considered a paper on and approved the recommendation to roll out the delivery model for the employment advisory service across Cheshire and Merseyside and the signing of a Memorandum of Understanding with the Department of Work and Pensions (DWP). This is a service that brings together therapists and employment advisors to work collaboratively on person centred care, supported those facing work difficulties due to common mental health conditions to either get back to work after long periods of absence, or find new employment after long periods of unemployment. The service is funded annually by DWP.

Integrated Care Board Report

28 November 2022

Place Director Report – Warrington

Agenda Item No	**ICB/11/22/07**
Report author & contact details	Carl Marsh, Place Director (Warrington)
Report approved by (sponsoring Director)	-
Responsible Officer to take actions forward	Carl Marsh, Place Director (Warrington)

Place Director Report – Warrington

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

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

Warrington Together
Place Director Report

November 2022

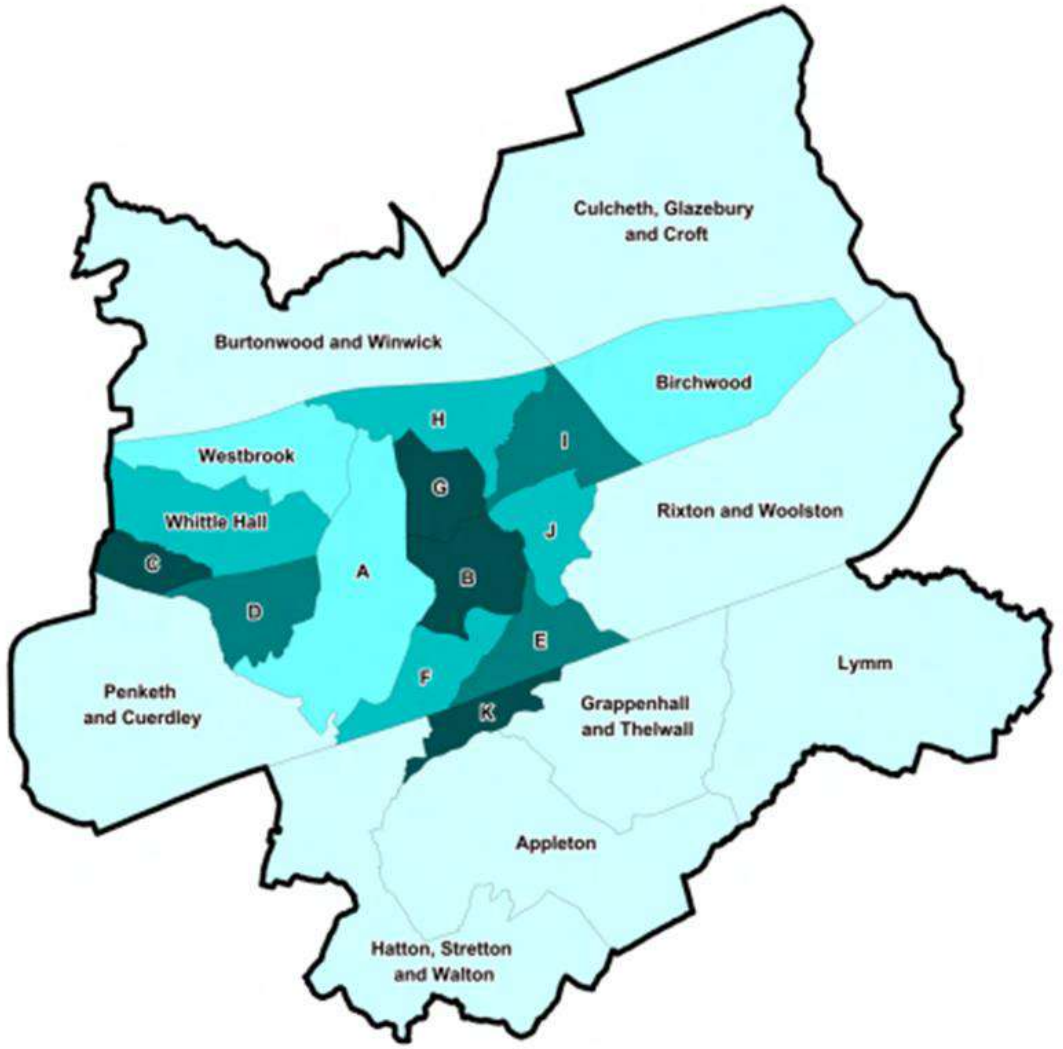
Overview

1. Warrington Place
2. Our Context
3. Vision and Priorities
4. Our Integration Journey
5. The delivery framework for Warrington

Our Place

Warrington together
Together for a happier and healthier Warrington

Population c. 210,000	Four Neighbourhood teams	Five Primary Care Networks
26 GP Practices	One Acute Hospital Trust	One Community Service Provider
One Mental Health Service Provider	One Local Authority	22 wards



Our Warrington Place

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Together for a happier and healthier Warrington

Warrington is a large unitary authority in Cheshire, known for its thriving economy and has a population of more than 200,000 people.

The Borough is a blend of rural villages and new town developments, with areas of prosperity in the affluent outer suburbs, and high levels of deprivation prevalent in the inner wards.

Warrington's population has continuously risen over the years with the development of Warrington town, bringing cultural diversity and vibrancy, and economic growth through new, often global, businesses and this is expected to continue.

As our population ages, the health and care system faces significant pressure, as we prepare to support higher levels of frail older people and rising instances of dementia and long-term conditions with a diminishing workforce.

People Projections

The number of under 65's is estimated to decrease by approx. 8,400 from 2018 - 2043

Warrington currently has a high proportion of middle-aged people aged 45- 59 who will turn 65 between 2026 and 2041

Projection from 2018 – 2043
98% increase in 85-89 year olds
138% increase in those aged 90+

Alcohol-related hospital admissions amongst those aged under 18 years are currently significantly higher in Warrington than the average for England. However, the long-term trend shows substantial reductions in the rate of admissions.

Obesity prevalence is an issue locally. Estimates suggest that almost two-thirds (64%) of the Warrington adult population are at an unhealthy weight. This is slightly higher than the average for England.

Life expectancy at 65 for both males and females remains significantly lower than England.

Warrington's Health and Wellbeing Across the Lifecourse

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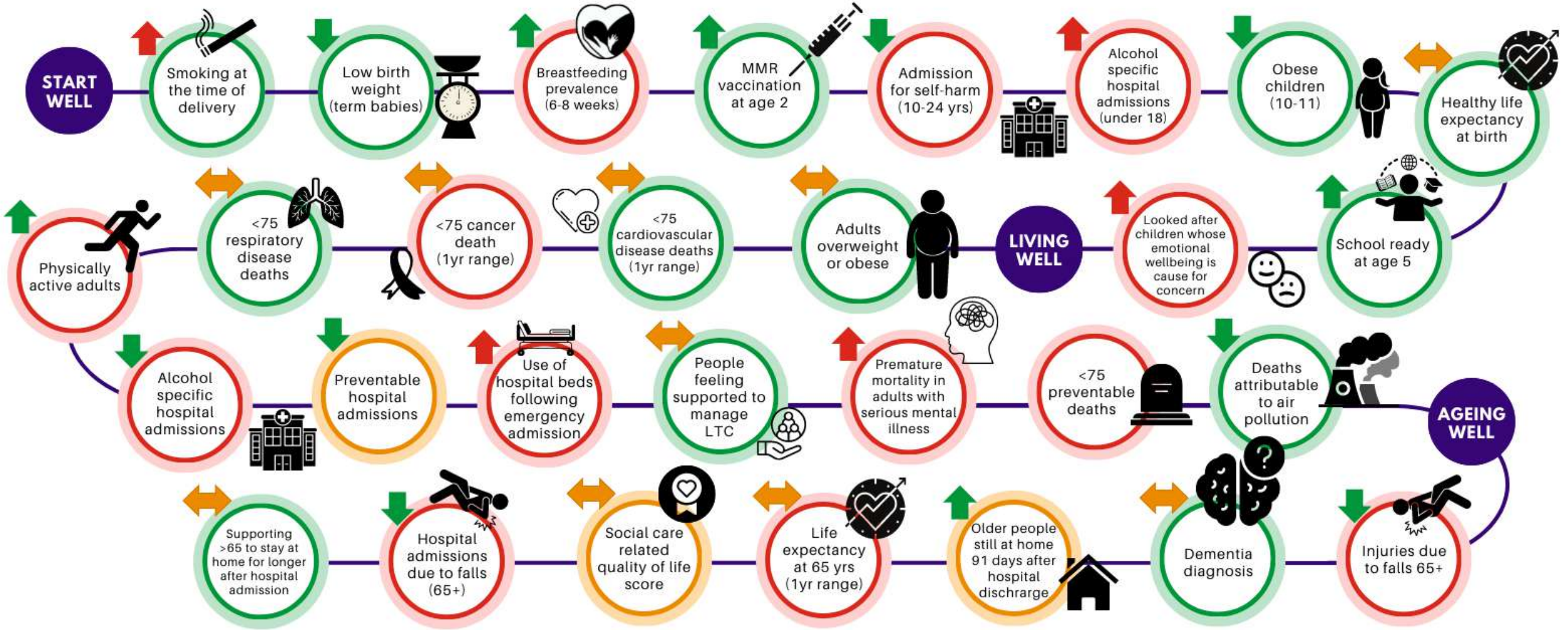

KEY

Statistical significance to England
- Worse
- No diffferent
- Better

Direction of travel
- Worse than last period
- Similar to last period
- Improved since last period

Current population
Figures mid-2020 estimate

Under 18	18 - 64 yrs	Over 65
44,177	125,168	40,052

Key focus for Warrington

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The health and social care system in Warrington faces a number of challenges that cut across services and communities. Our main challenges need to be addressed in the short, medium and long term.

Quality We want all services to be safe, of excellent quality and effective at meeting personal outcomes.

Financial challenges and significant unfunded cost pressures for all health and care organisations remain.

Choice People, including carers, require choice and control over the services that they use, and the home that they live in, the right to access and receive information to inform choice. This is directly linked to market capacity and the cost of care.

Market capacity does not meet our demand. Since March 2020, there has been a increase in requests for support Further to this, the length of stay in hospital is lengthened unnecessarily due to the capacity challenge and longer stays in hospital lead to poorer outcomes for patients.

Demand, due to our ageing population, is a major challenge now and for the future. Services that people require are also becoming more complex, with predictions showing an increase in instances of dementia and mobility support needs.

Workforce is the biggest issue that the health and social care sector faces, and in Warrington, our predicted reducing working age population makes this a clear challenge for the next decade.

What Our Communities Say

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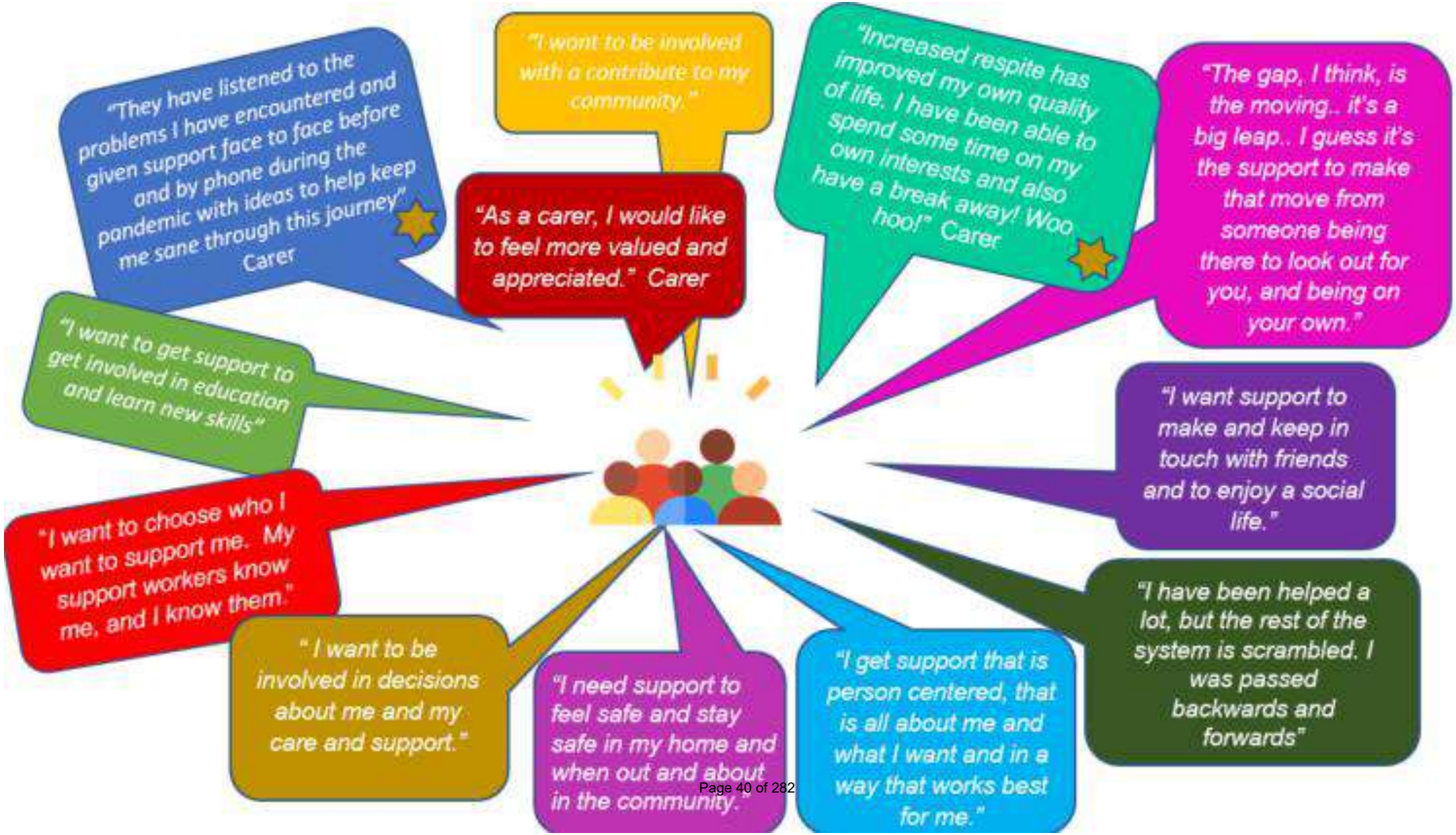


Our Vision and Ambitions

Warrington together
Together for a happier and healthier Warrington

Vision

Warrington is a place where we work together to create stronger neighbourhoods, healthier people and greater equality across our communities.

Well Warrington Core Outcomes

1. **People will live longer and those years will be lived in good health (increased healthy life expectancy for all)**
2. **The gap in life expectancy between the most and least deprived communities will be reduced (inequalities index)**

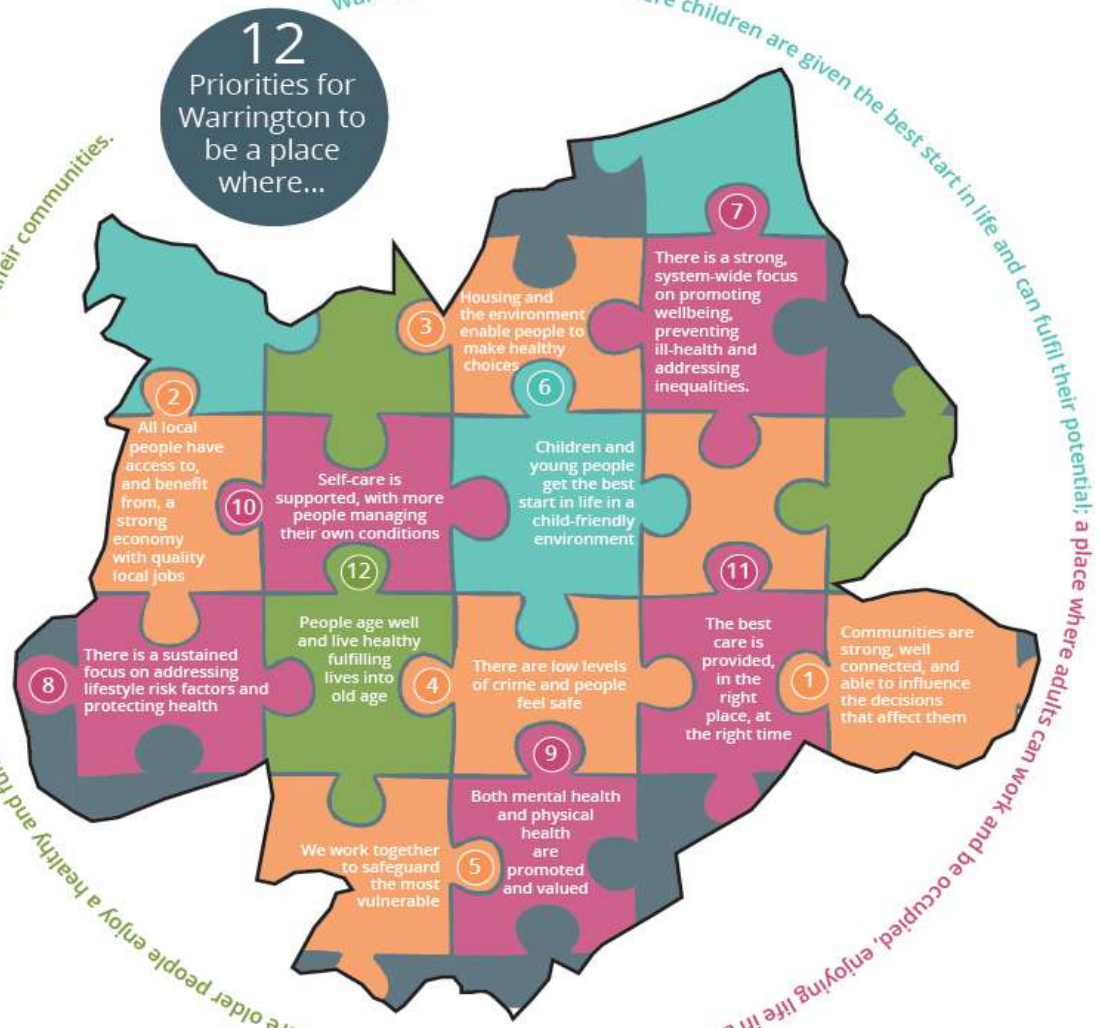
Ambitions for the People of Warrington

- ✓ **To live in healthy, safe and sustainable communities.**
- ✓ **Have the skills and resources needed to improve their life chances.**
- ✓ **Value Wellbeing and active independent lives.**
- ✓ **Improved quality of life through accessing appropriate, quality care when and where they need it.**

Building on our Health and Wellbeing Strategy 2019-2023

Our health and care priorities

Warrington will be a place where children are given the best start in life and can fulfil their potential; a place where adults can work and be occupied, enjoying life in a vibrant and healthy borough; a place where older people enjoy a healthy and fulfilling old age, feeling safe and connected within their communities.



Mental Health

Low level anxiety and depression

Poverty

Food and fuel poverty, cost of living, warm homes

Living Well

(Connected Communities)
Universal offer including information resources

Integrated Health and Care

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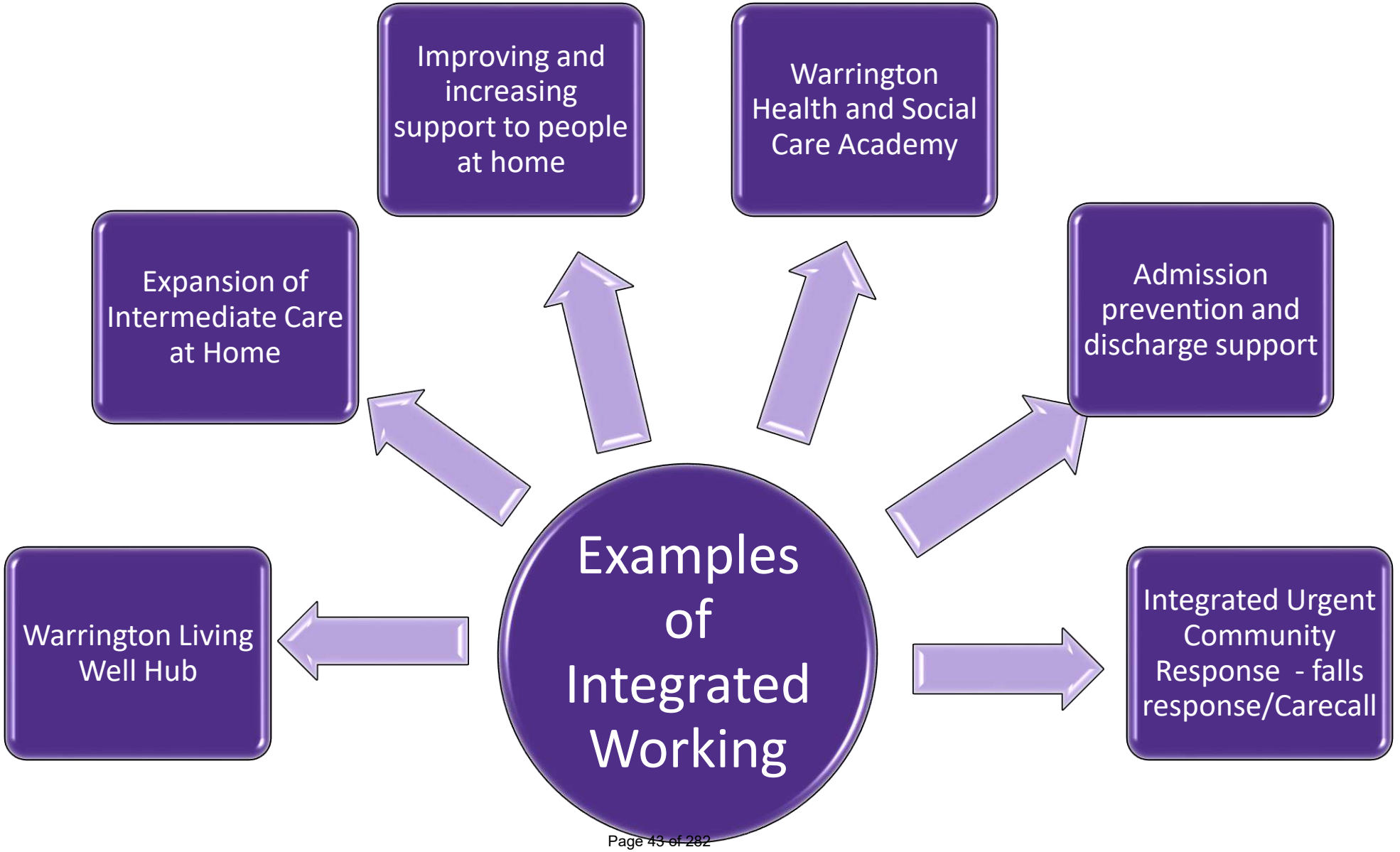

Our delivery framework

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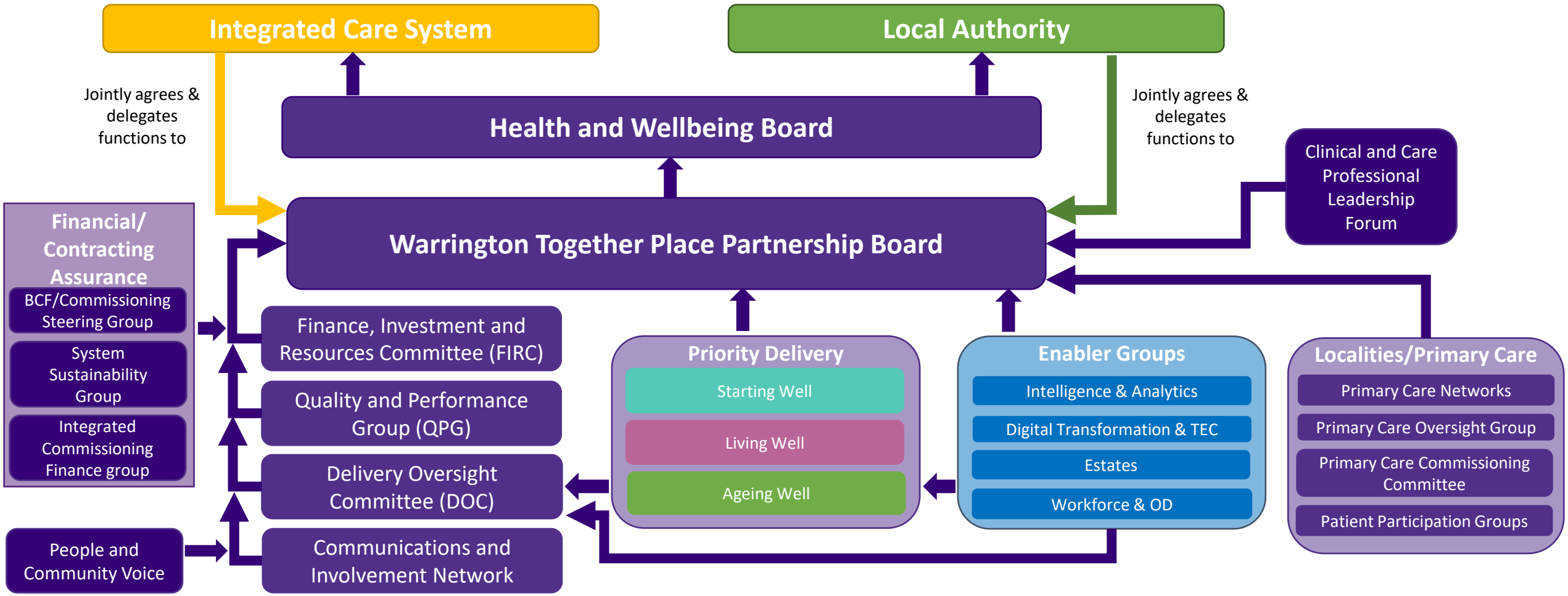

Our integration journey

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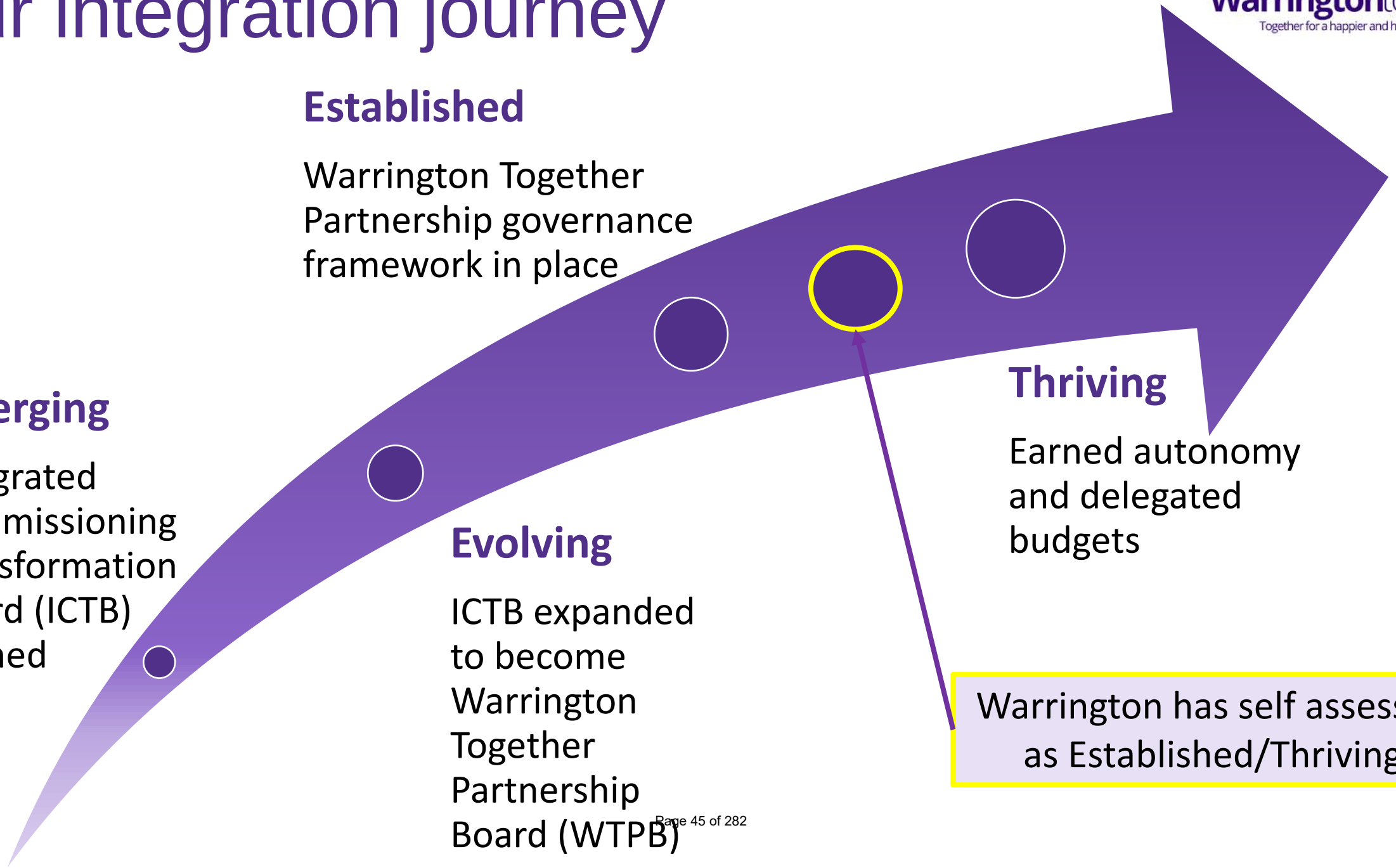
Together for a happier and healthier **Warrington**



Emerging

Integrated Commissioning Transformation Board (ICTB) formed

Evolving

ICTB expanded to become Warrington Together Partnership Board (WTPB)

Established

Warrington Together Partnership governance framework in place

Thriving

Earned autonomy and delegated budgets

Warrington has self assessed as Established/Thriving

Place Development

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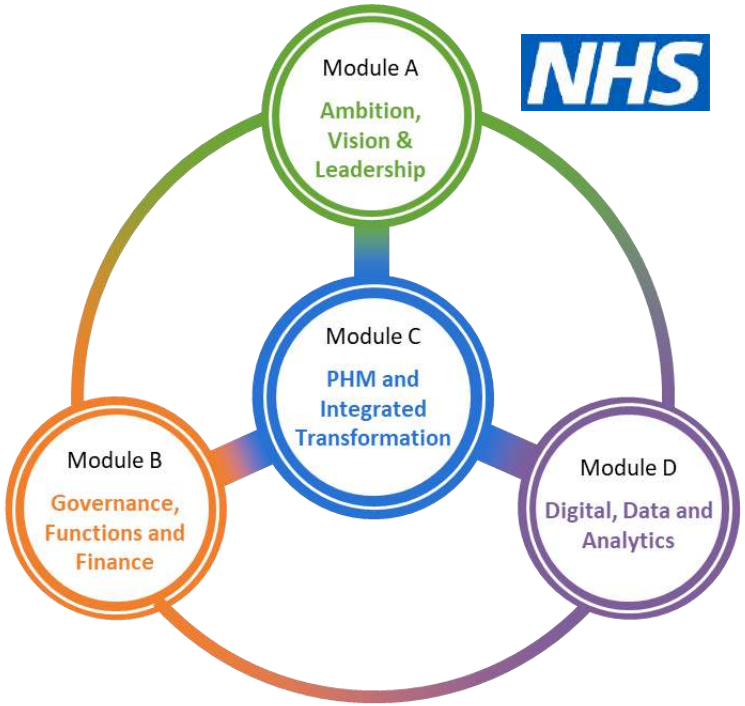
System Transformation Peer Support Programme for Health and Wellbeing Boards

Local Government Association

ICS Population Health and Place Development Programme



Care and Health Improvement Programme

Why we do it

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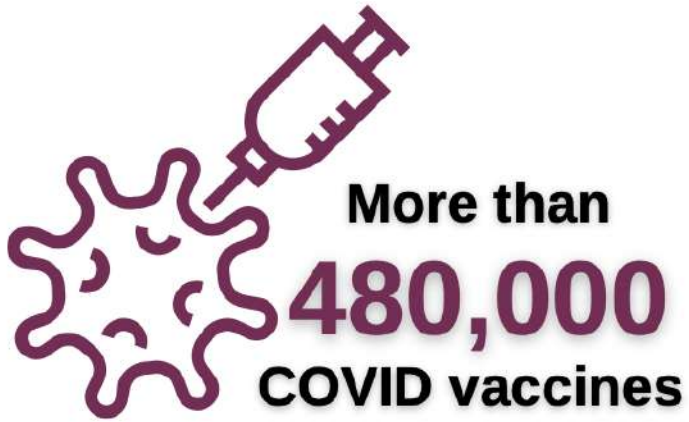
Together for a happier and healthier **Warrington**



NHS
Bridgewater Community Healthcare
NHS Foundation Trust

Warrington Children's Physiotherapy and Occupational Therapy

Patient Story: Elspeth Calvert

Introduction

Patient Journey:

- Referred to Paediatric Physiotherapy service, and was assessed 13.05.15
- Currently known to Physiotherapy, Occupational Therapy, Respiratory Physiotherapy
- Also known to Tertiary Centre, Alder Hey Children's Hospital
- Diagnosis of Spinal Muscular Atrophy, Type 2
- Degenerative Neuromuscular Condition
- Affects protein for neurones sending messages to muscles, leading to weakness
- Spinal Rod Surgery for NM Scoliosis in July 2022

Patient Feedback: Positive

What did the Patient find Positive about their Experience?

- Staff nice and kind
- Working at the right pace
- Staff understand what works for her

Parent Feedback

- Professional
- Knowledgeable
- Work with Elspeth as an individual

Patient Feedback: Negative

What did the Patient find Negative about their Experience?

- Things change eg sore hips at presents
- Can be long time between reviews
- Need regular reviews for equipment

Parent Feedback

- Disparity between provision with other Trusts
- Frequency of reviews, availability of staff
- Funding for services eg hydro and equipment

Patient Involvement

How was the Patient Involved in their Care or Treatment Decisions?

- Elspeth actively involved in her treatment decisions
- Physiotherapy programme
- Standing programme
- Sleep system
- Surgery
- Explanations given with clinical reasoning
- Parent feedback that Elspeth consents when she understands the reasons behind treatment

Lessons Learned:

Possible Improvements Arising From Patient Experience

- A patient handbook
- Explanation of services and patient journey
- Possible referrals / roles / information
- Spider diagram! Warrington / AHCH / Private provision
- Co-ordinator of patient care
- Service changes – Impact on families eg Teams renamed / rehomed / contact details

NHS
Bridgewater
Community Healthcare
NHS Foundation Trust

Thank You…

to our wonderful patient and Mum for their valuable feedback.

Rebecca Emery
Clinical Specialist for Paediatric Physiotherapy
Team Lead for Warrington Paediatric Occupational Therapy and Physiotherapy Service

0844 264 3614
bchft.enquiries@nhs.net
www.bridgewater.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Executive Director of Nursing & Care's Update Report

Agenda Item No	**ICB/11/22/09**
Report author & contact details	Chris Samosa – Director of People Kerry Lloyd – Deputy Director of Nursing & Care
Report approved by (sponsoring Director)	Chris Douglas – Executive Director of Nursing & Care
Responsible Officer to take actions forward	Chris Samosa – Director of People Kerry Lloyd – Deputy Director of Nursing & Care

Executive Summary

The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside (C&M) with an overview of the current position in relation to:

- the framework for quality governance and assurance
- work underway to ensure safety in the urgent and emergency care pathway
- the workforce position for C&M.

Quality Governance and Assurance

In April 2021, the National Quality Board (NQB) issued guidance on 'Managing Risks and Improving Quality through Integrated Care Systems'. The report detailed how Integrated Care Systems (ICS) through the strengthening of collaboration and partnership working across health and social care, provides significant opportunity to improve quality, but also highlighting how structural change can put quality, including safety, at risk.

The NQB suggested that the key requirements for quality oversight in ICSs were to:

1. Ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
2. Continually improve the quality of services, in a way that makes a real difference to the people using them.

The NQB sets out some key principles for systems to adopt in delivering their overarching quality, including safety responsibilities, set out below:

- Quality as a shared commitment
- Population focused vision
- Co-Production
- Clear and transparent decision making
- Timely and transparent information sharing
- Subsidiarity.

National Guidance on 'Quality Risk Response and Escalation in ICS' was issued by the NQB in June 2022, that supersedes and brings together the NQB Guidance on Risk Summits and NHSE Quality Escalation Framework and aligns with the NHS Oversight Framework (NHSOF), Perinatal Quality Surveillance Model and Patient Safety Incident Response Framework.

Management of risk to quality is tiered and aligned to organisational operating frameworks that include:

- Provider quality governance
- Place quality governance
- System Quality Governance
- Regional & national quality governance

Through the evolution of the Cheshire & Merseyside System Quality Group (SQG), Quality & Performance Committee, alongside the Place Based Partnerships, oversight and assurance of quality is being managed in accordance with levels of risk and associated escalation.

As the delegation of services previously commissioned via NHS England develops, the framework for quality governance will further evolve to adapt and incorporate the breadth of commissioned services, and align with the regional and national operating framework for NHS England. Work is currently underway with the regional team to align systems and processes for quality oversight for these services through the Pre-Delegation Assessment Framework (PDAF) work programme.

<u>Maintaining Safety in Urgent and Emergency Care</u>
Maintaining safety in urgent and emergency care, particularly during periods of intense demand, is of paramount importance. A national letter, issued in August 2022 outlined steps to increase capacity and operational resilience in urgent and emergency care ahead of winter, including reducing ambulance handover delays (AHD), reduction of overcrowding in emergency departments (ED), reducing hospital occupancy and timely discharge, all of which are inextricably linked and known to have a detrimental impact to patient safety and experience.

Work at both regional and ICS level is taking place to ensure there is a consistent and systematic approach to understanding and acting upon increasing risk at system level, that supports those working at the frontline to take appropriate action to mitigate and control risk at organisational level. This work aligns with the quality governance framework previously described within the paper, whilst recognising and supporting dynamic risk assessment at the front line.

<u>Workforce</u>
The report also provides an overview of the workforce challenges facing our health and social care system and describes the collective action being taken. The paper outlines some of the key drivers of workforce supply and demand, from a national and local perspective; subsequently detailing the Cheshire & Merseyside position.

The paper includes the details of the five Cheshire & Merseyside (C&M) workforce priorities of:

- System wide workforce planning
- Creating new opportunities
- Promoting health and wellbeing
- Maximising and valuing the skills of our staff
- Creating a positive and inclusive culture.

<table>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• Note the content of the report and request additional information/assurance as appropriate
• Agree the frequency of future reporting requirements.</td></tr>
<tr><td>Key issues</td><td colspan="5">A clearly defined and understood quality governance framework is essential in managing new and emerging risks to quality and safety of services. Work is ongoing to define and manage those risks to be overseen within place-based partnerships and those requiring escalation at system level and beyond.

Patient safety within urgent and emergency care is a key priority for the system, this is particularly important in times of intense demand. The ability to oversee and mitigate both inter and intra organisational risk is being led within the auspices of the quality governance framework as previously described within the paper.

The national People Plan is clear in its ambition that we need more people, working differently, in a compassionate and inclusive culture, including having more people in training and education and subsequently recruited to ensure that our services are appropriately staffed.

It is also evident that the workforce will need to work differently by embracing new ways of working in teams, across organisations and sectors, and supported by technology. Importantly we must foster a compassionate and inclusive culture by building on the motivation to look after and value our people, create a sense of belonging and promote a more inclusive service and workplace.</td></tr>
<tr><td>Key risks</td><td colspan="5">• that structural change could impact oversight of quality
• that patient safety is negatively impacted by demand for urgent and emergency care services
• that workforce supply continues to diminish
• that workforce retention rates continues to rise
• that our workforce is not representative of the communities we serve.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
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<tr><td>X</td><td>X</td><td>X</td><td colspan="2">X</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">Not Applicable</td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No conflict of interest identified</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">Not Applicable</td></tr>
</table>

Equality, Diversity and Inclusion	The nature of the paper, as a position statement on quality governance, patient safety and workforce, does not require an Equalities Health Impact assessment (EHIA) to be undertaken.
Health inequalities	Not Applicable
Next Steps	The development of a workforce dashboard will support the consistent and systematic reporting of achievement of the ICBs ambition to recruit and retain a skilled, resilient and representative workforce.
Appendices	NQB Guidance 2022 - National Guidance on Quality Risk Response and Escalation in Integrated Care Systems

The Director of Nursing & Care's Report

1. Executive Summary

1.1 The purpose of the paper is to provide the Integrated Care Board (ICB) for Cheshire & Merseyside with an overview of the current position in relation to:

- Emerging framework for quality governance and assurance
- Work underway to safety in urgent and emergency care
- Workforce

1.2 **Quality Governance and Assurance**. In April 2021, the National Quality Board (NQB) issued guidance on 'Managing Risks and Improving Quality through Integrated Care Systems'. The report detailed how Integrated Care Systems (ICS) through the strengthening of collaboration and partnership working across health and care, provides significant opportunity to improve quality, but also highlighting how structural change can put quality, including safety, at risk.

1.3 The NQB suggested that the key requirements for quality oversight in ICSs were to:

- ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
- continually improve the quality of services, in a way that makes a real difference to the people using them

1.4 The NQB sets out some key principles for systems to adopt in delivering quality, including safety responsibilities, set out below:

- Quality as a shared commitment
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- Co-Production
- Clear and transparent decision making
- Timely and transparent information sharing
- Subsidiarity.

1.5 National Guidance on 'Quality Risk Response and Escalation in ICS' was issued by the NQB in June 2022, that supersedes and brings together the NQB Guidance on Risk Summits and NHSE Quality Escalation Framework and aligns with the NHS Oversight Framework (NHSOF), Perinatal Quality Surveillance Model and Patient Safety Incident Response Framework.

1.6 Management of risk to quality is layered and aligned to organisational operating frameworks that include:

- Provider quality governance
- Place quality governance
- System Quality Governance
- Regional & national quality governance.

1.7 Through the evolution of the Cheshire & Merseyside System Quality Group (SQG), Quality & Performance Committee, alongside the Place Based Partnerships, oversight and assurance of quality is being managed in accordance with levels of risk and associated escalation.

1.8 As the delegation of services, previously commissioned via NHS England, grows, the framework for governance will need to adapt in order to accommodate the breadth of commissioned services and align with the regional and national operating framework for NHS England.

1.9 **Maintaining Safety in Urgent and Emergency Care.** Maintaining safety in urgent and emergency care, particularly during periods of intense demand, is of paramount importance. A national letter and associated framework were issued in August 2022. The letter outlined steps to increase capacity and operational resilience in urgent and emergency care ahead of winter, including reducing ambulance handover delays (AHD), reduction of overcrowding in emergency departments (ED), reducing hospital occupancy and timely discharge, all of which are inextricably linked and known to have a detrimental impact to patient safety and experience.

1.10 Work at both regional and ICS level is taking place to ensure there is a way of understanding and acting upon increasing risk at system level, that supports those working at the frontline to take appropriate action to mitigate and control risk at organisational level. This work aligns with the quality governance framework previously described within the paper, whilst recognising and supporting dynamic risk assessment at the front line.

1.11 **Workforce.** The report also provides an overview of the workforce challenges facing our health and social care system and describes the collective action being taken. The paper outlines some of the key drivers of workforce supply and demand, from a national and local perspective; subsequently detailing the Cheshire & Merseyside position.

1.12 The paper includes the details of the five Cheshire & Merseyside (C&M) workforce priorities of:

- System wide workforce planning
- Creating new opportunities
- Promoting health and wellbeing
- Maximising and valuing the skills of our staff
- Creating a positive and inclusive culture.

2. Quality Governance in NHS Cheshire & Merseyside

2.1 In April 2021, the National Quality Board (NQB) issued guidance on 'Managing Risks and Improving Quality through Integrated Care Systems'. The report detailed how Integrated Care Systems (ICS) through the strengthening of collaboration and partnership working across health and care, provides significant opportunity to improve quality, but also highlighting how structural change can put quality, including safety, at risk.

2.2 The NQB suggested that the key requirements for quality oversight in ICSs were to:

- ensure the fundamental standards of quality are delivered – including managing quality risks, including safety risks, and addressing inequalities and variation
- continually improve the quality of services, in a way that makes a real difference to the people using them.

2.3 The NQB sets out some key principles for systems to adopt in delivering their overarching quality, including safety responsibilities, set out below:

- Quality as a shared commitment
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- Timely and transparent information sharing
- Subsidarity.

2.4 National Guidance on 'Quality Risk Response and Escalation in ICS' was issued by the NQB in June 2022, that supersedes and brings together the NQB Guidance on Risk Summits and NHSE Quality Escalation Framework and aligns with the NHS Oversight Framework (NHSOF), Perinatal Quality Surveillance Model and Patient Safety Incident Response Framework.

2.5 Management of risk to quality is layered and aligned to organisational operating frameworks that include:

- Provider quality governance
- Place quality governance
- System Quality Governance
- Regional & national quality governance.

2.6 C&M has developed a risk-based approach to quality governance at Provider/Commissioner level, that aligns with NQB guidance and the NHSO.

2.7 Whilst all organisations will have a statutory Board in place that will look to hold the organisation to account for the delivery of its service, two place-based areas in C&M have a System Improvement Board in place, in recognition that some risks to quality cannot be resolved solely by single organisations but require system improvements to be made.

2.8 Through contractual oversight aligned to each place-based model, all organisations have a formal forum for quality governance and oversight to be considered. It is anticipated that this level of individual provider oversight will evolve into the place-based partnership forum that consider the patient journey in its entirety.

2.9 Risks that emanate from place-based discussions are escalated by exception via the C&M Quality & Performance Committee (QPC). The QPC meets monthly and receives reports from each of the place-based quality teams that includes matters for assurance, alert and those of an advisory nature. The QPC acts as the decision-making forum for those organisations who may require increased quality assurance mechanisms to be enacted.

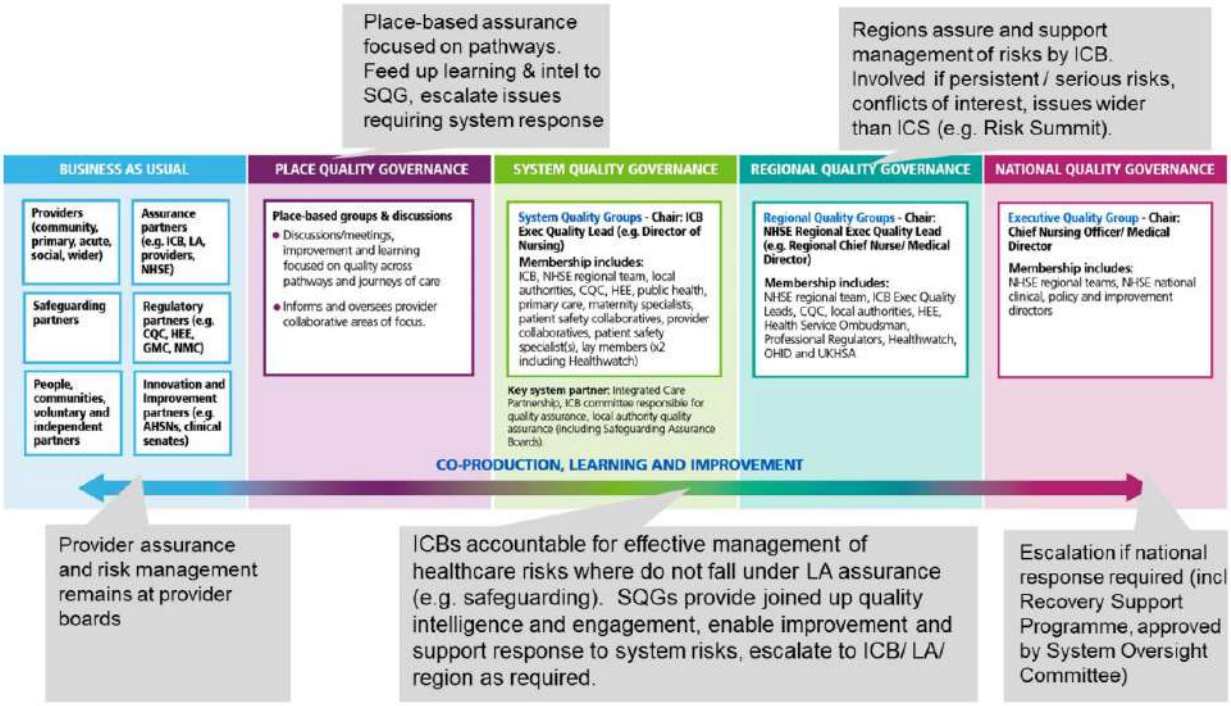
2.10 The QPC has an annual workplan that incorporates the statutory functions in relation to quality oversight, alongside thematic analysis of programmes. As a sub-committee of the ICB, the QPC, via the Director of Nursing and Chairs reports, will highlight those matters requiring ICB attention. The Director of Nursing and Care also provides regional assurance at North West level via the Regional System Quality Group mechanism.

2.11 The C&M System Quality Group (SQG) is an informal space where a range of stakeholders meet to triangulate intelligence in relation to quality risks and develop actions for quality improvement. The SQG meets quarterly, taking a thematic focus to its workplan, and includes representation from Providers, Regulators, NHS England, Healthwatch, Local Authority and Place based Leads. Based upon intelligence sharing the SQB may make decisions as to which matters require escalation through formal routes into QPC.

2.12 As the delegation of services, previously commissioned via NHS England, grows, the framework for governance will need to adapt in order to accommodate the breadth of commissioned services and align with the regional and national operating framework for NHS England.

2.13 Figure One illustrates the approach taken manage quality governance across C&M on a risk-based perspective.

Figure One



3. Safety in Urgent & Emergency Care

3.1 The Royal College of Emergency Medicine (RCEM) describes Emergency Departments (ED) as VUCA environments: volatile, uncertain, complex and ambiguous, and suggest that 'crowding' can exacerbate the risks to safety. There are a number of safety areas that, while not unique to EDs, are certainly more prevalent with a higher risk in ED, these include:

- absconding of patients, especially those with concerns about capacity
- screening for (and managing) social concerns (e.g. trafficking, safeguarding, homelessness)
- drug and alcohol misuse
- the effect of the ED environment on human factors (e.g. frequent changes of personnel, crowding, time pressures)
- issues related to follow up and review of patients.

3.2 Certain patient groups will also have unique requirements:

- Frequent attendees
- Those in custody
- Patients with frailty
- Patients with mental health problems
- Patients with cognitive impairment.

3.3 The RCEM describe those interventions that are considered ‘high value’ in driving and maintaining safety in ED, they include:

- developing a safety culture: Measure safety, governance meetings, safety huddles, encourage report/visible system of reporting
- procedural safety: use of checklist for invasive procedures
- handovers; standardise and document all handovers (departmental, individual, between departments)
- regular in-vivo simulation
- robust (and rapid) results handling processes (including confirming ‘afferent loop’)
- visible, consistent and effective supervision and induction
- processes for embedding learning from incidents, complaints, mortality reviews

3.4 The Nursing and Care directorate for C&M are working with regional and other NW ICBs to develop a risk-based protocol that is evidence based (using ECIST and RCEM guidance) and aligns with the OPEL escalation framework. This protocol will support in managing clinical risk during periods of escalating demand, in ensuring that the fundamentals of care are in place to support those within the ED, alongside assessment of systemic risk, that includes those awaiting review by the North-West Ambulance Service (NWAS). Once finalised, the protocol will be embedded within the quality governance framework previously described within the paper.

3.5 The C&M November 2022 SQG will consider system risk in this area. The group will hear presentations from both NWAS and Adult Social Care that will outline current position and risks to quality and safety. It is anticipated that the SQG will then break into place-based areas to problem solve and develop a set of quality improvement actions that can be brought forward into local systems.

4. Workforce

4.1 In July 2020, the national NHS People Plan was published, setting out its priorities. The plan was clear in its ambition; we need more people working differently, in a compassionate and inclusive culture, including having more people in training and education (who are subsequently recruited to ensure that all our services are appropriately staffed).

4.2 The way we work will need to evolve, with staff embracing new working methods in teams, across organisations and sectors, all supported by technology. Most importantly, we must foster a compassionate and inclusive culture by building on the motivation to look after and value our people, also creating a sense of belonging and promoting a more inclusive service and workplace.

4.3 The NHS People Promise has been developed following feedback from staff on what matters most to them, specifically on what would improve their work experience. In Cheshire and Merseyside, we believe that the People Promise should not just apply to NHS staff – and aspire to adopt this ideology across all health and care organisations.

4.4 The People Promise states:

- We are a team
- We work flexibly
- We are always learning
- We are safe and healthy
- We each have a voice that counts
- We are recognised and rewarded
- We are compassionate and inclusive.

4.5 Cheshire and Merseyside face significant workforce challenges across the totality of our health and care providers, including our wider primary care colleagues and independent social care providers. These can be summarised as follows:

4.6 **Workforce Supply.** Across Cheshire and Merseyside NHS providers are reporting that they currently have circa 3000 vacancies and in social care there are circa 7000 vacancies. There are 19% of jobs in social care that are offered on zero hours contracts and the average hourly rate is between £9.50 and £11.06.

4.7 There are arrange of actions underway to support improvements to supply which include:

- Coordinated recruitment events for health care support workers taking place
- Investment with Liverpool City Region Combined Authority and the Cheshire and Warrington Local Enterprise Partnership to encourage local youngsters to consider careers in health and care, with work placements, presentations and careers events taking place in schools and colleges.
- Work in partnership with the Department of Work and Pensions to upskill careers advisors on the potential opportunities across health and care
- Opening Doors Programme in partnership with Housing associations across Cheshire and Merseyside to encourage tenants to train as health care support workers.
- Work with further education re encouraging those with BTEC/ T Level qualifications to consider careers in health and social care
- We will work with local partners, further education colleges, and higher education institutes to develop new roles and new entry routes into careers and we will create more apprenticeship programmes
- We will provide more high quality placements and listen and act upon what students tell us
- The Cheshire and Merseyside International recruitment team are involved in the ethical recruitment of staff for medical, nursing, imaging and AHP teams
- The staff who were recruited to support the COVID vaccination programme are being offered the opportunity to become part of the Reservist bank which will have the ability to be mobilised at short notice Pilots are taking place with Local authorities as well as NHS providers
- In partnership with HEE (the National learning hub for volunteering) and the North West Voluntary Services we are looking to develop further our offer for volunteers, creating development opportunities and routes into employment and ensuring that volunteers can safely and confidently join the workforce.

4.8 **Workforce Attrition and Turnover.** NHS Turnover is currently circa 14.5% and in social care circa 26% with many staff leaving the sector to work in hospitality and distribution sectors. Nursing leaver rate 6.5% (25% leave due to retirement, 13% work life balance) and more Registered Nurses leave in their first-year post qualification than in each of the subsequent years 2-10 years. There is a midwifery: leaver rate 7% (31% leave due to retirement, 35 % leave in years 1-5) and AHPS: leaver rate 6.5% (49% of those who leave are under 34 years. Retirement accounts for 12.8% of AHP leavers)

4.9 Actions underway to reduce attrition and turnover rates include:

- a Cheshire and Merseyside Retention lead has been employed to work with NHS Providers to share best practice, understand reasons for leaving, explore collaborative approaches to development, preceptorship, rotation programmes etc
- an experienced nurse has been engaged to interface with social care to support registered nurses in care homes, ensure access to appropriate online training etc
- the People Board has funded a Practice Education Facilitator to work with social care to ensure that training and supervision / support can be provided between health and care
- six legacy mentors are being recruited to support newly qualified staff across Cheshire and Merseyside
- provision of coaching in primary care through the Primary Care Training hubs.

4.10 **Workforce Wellbeing**. C&M has a current sickness rate of circa 6% across NHS Providers. The Quarter 2 2022/23 National Quarterly Pulse Survey results included data that suggests that all engagement scores have improved since Quarter 1 29022/23. There were large numbers of staff (79.3%) aware of how to access support from their HWB hub which is above the NHS overall by +3%. People feeling supported by their organisation around their HWB has improved by +3.1% and is above the NHS overall by +1.

4.11 There was a general decline in the scores received regarding how motivated people are at work and if there are opportunities for them to show initiatives in their role. The percentage of people feeling demotivated and stressed has increase slightly. The percentage of people who feel well informed about important changes taking place in their organisation is -0.2 below the NHS overall. Negative feedback to Leaders is due to high workload, unsupportive management, being short staffed and having a lack of resources

4.12 There are a range of health and wellbeing initiatives in place including work with Rugby League Cares, support for those working with Long COVID, the mental health resilience hub and targeted interventions for staff groups. A domestic violence programme has been commissioned to develop support for staff who are the victims of domestic violence. Recognising the profile of staff in the sector, there are a range of initiatives to support staff who are working through the menopause.

4.13 **Workforce Profiling.** C&M have an ageing workforce. In primary care 28% of staff are aged over 55 and in other NHS Providers, 19% of staff are over 55 years. In Social Care, there are 28% of staff are over 55 years. There are a range of partnership programmes in place to encourage young people into the health and social care workforce, including work with local partners, further education colleges, and higher education institutes to develop new roles and new entry routes into careers and we will create more apprenticeship programmes, alongside maximising the opportunity for staff to remain in the work place through flexible hours, flexible retirement options etc.

4.14 In relation to specific workforce targets, in 2019 the Government set out a national ambition to recruit an additional 50k nurses by March 2024. Three overall workstreams contribute to the target:

- Domestic recruitment
- International recruitment (IR)
- Retention.

4.15 Alongside registered nurse recruitment, there is a national drive to build the numbers of Health Care Support Workers (HCSW) within the NHS. Introduced in 2019, the HCSW programme is aimed at supporting NHS trusts to increase their HCSW recruitment, minimise vacancies, avoid reliance on temporary staff and so provide greater continuity of care for patients, and to support more people to progress into nursing and midwifery roles in the future.

4.16 C&M Trusts have agreed targets for both the IR and HCSW programmes, proportionate to size and provision type.

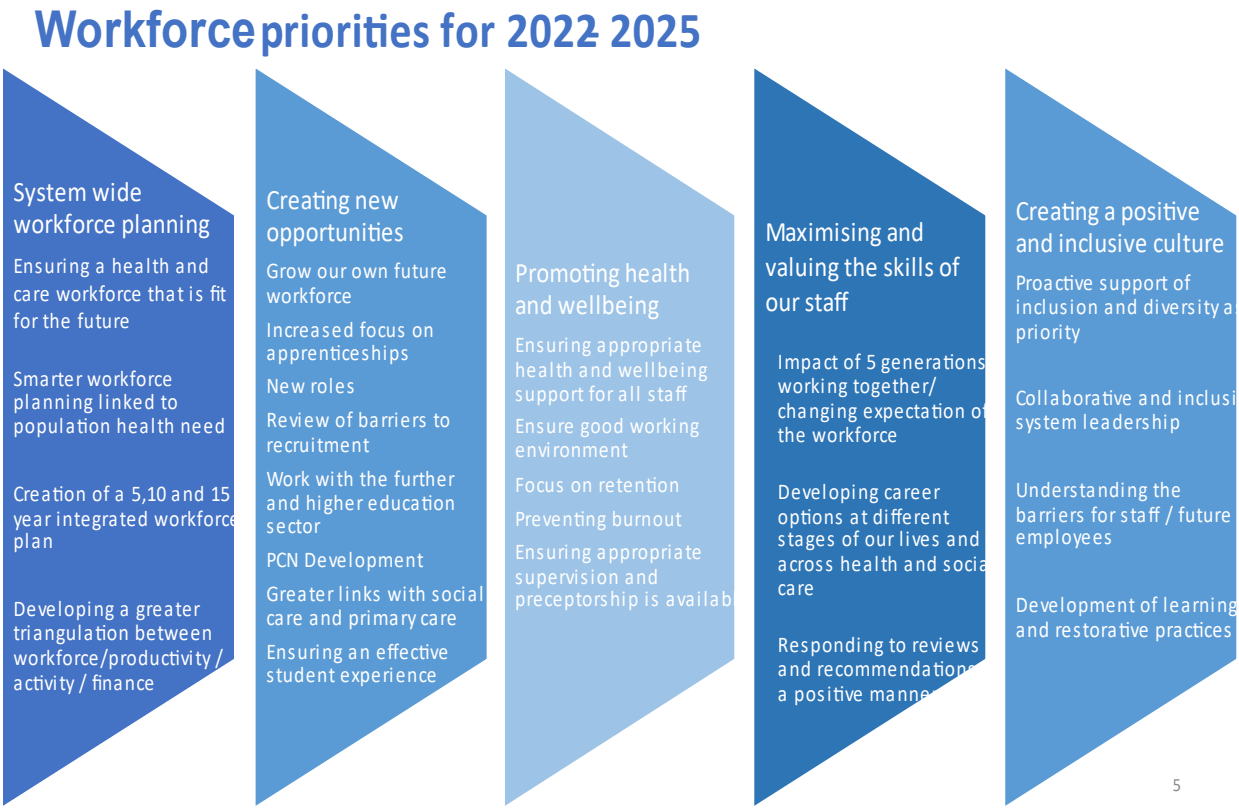
4.17 Based upon IR submissions in September 2022:

- 16 of the 17 NHS Providers in C&M are participating in the programme
- 5 of the 16 NHS Providers in C&M are RAG rated Green (>75% of total commitment achieved)
- 2 of the 16 NHS Providers in C&M are RAG rated Amber (65-75& of total commitment achieved)
- 9 of the 16 NHS Providers in C&M are RAG rated Red (<65% of total commitment achieved).

4.18 Based upon HCSW submissions in September 2022:

- All NHS Providers in C&M are participating
- 11 of the 17 NHS Providers in C&M have seen a positive shift in establishment vacancy difference
- 6 of the 17 NHS Providers in C&M have seen a negative shift in establishment vacancy difference.

4.19 The Cheshire and Merseyside People Board have determined that the priorities for the next 5 years are as follows:



4.20 Over the next 15 years, the health and care workforce will change significantly. We already have a roadmap in the NHS Long Term Plan which sets out a new service model for the 21st century: increasing care in the community; redesigning and reducing pressure on emergency hospital services, more personalised care, digitally enabled primary and outpatient care and a focus on population health and reducing health inequalities. The NHS Long Term Plan also identifies areas where earlier diagnosis, new and integrated models of care, and better use of technology offer the potential to significantly improve population health and patient care. Together, these provide a major opportunity for a multi professional workforce to come together to deliver 21st century care.

4.21 To deliver this vision and keep pace with advances in science and technology will require both continued growth in our workforce and its transformation to one that is more flexible and adaptive, has a different skill mix and through changes in ways of working, has more time to provide care.

4.22 In Cheshire and Merseyside, we will support the development of primary care hubs in the integration of primary care and community health services so that staff are working in different ways, with a greater focus on preventative care and establish much stronger links between health and social care. There will be new roles and significant changes to existing roles, requiring an increase in data science and digital skills, as technology and scientific innovation transform care pathways and clinical practice, and enable more efficient ways of working. Our people will need the skills, education and training to realise the potential of these exciting new roles, to extend their practice in current roles and to work in multidisciplinary teams that facilitate more integrated, person-centred care

4.23 We also need to transform the way our entire workforce, including doctors, nurses, allied health professionals (AHPs), pharmacists, healthcare scientists, dentists, non-clinical professions, social workers in the NHS, commissioners and volunteers, work together. Work will be much more multidisciplinary, people will be able to have less linear careers, and technology will enable our people to work to their full potential as routine tasks (and some more complex ones) are automated. Improved technology will also mean that services are organised and delivered more efficiently, which will contribute to improved productivity.

4.24 To serve our patients and citizens in the best way possible we must improve the experience of our people. At every level we need to pay much greater attention to why many of them leave the health and care sector, taking decisive action in both the short and medium term to retain existing staff and attract more people to join. Our people really are our most valuable asset.

5. Recommendations

5.1 **The Board is asked to:**

- Note the content of the report and request additional information/assurance as appropriate
- Agree the frequency of future reporting requirements.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Executive Director of Nursing & Care's Update Report

Appendix A

- **National guidance on Quality Risk Response and escalation in Integrated Care Systems**

Classification: Official

Publication approval reference: PAR1497

National Guidance on Quality Risk Response and Escalation in Integrated Care Systems

National Quality Board

6 June 2022

Contents

Introduction, purpose, and aims

This guidance builds on the National Quality Board's (NQB) Guidance on System Quality Groups (SQGs) and sets out how quality concerns and risks should be managed within Integrated Care Systems (ICSs) in collaboration with NHS England (NHSE) and wider partners. It supersedes and brings together the NQB Guidance on Risk Summits and NHSE Quality Escalation Framework and Trigger Tool, and aligns with the NHS Oversight Framework (NHSOF), Perinatal Quality Surveillance Model and Patient Safety Incident Response Framework[1].

The document is for system leaders as they develop their approach to quality management, providing clarity on:

- The expected approach to managing system-level concerns and risks – including categorising concerns, reporting, escalating, de-escalating and monitoring

- The expected role of Integrated Care Systems (namely Integrated Care Boards (ICBs) and local authorities), working with NHS England (NHSE) and wider partners in managing quality concerns and risks - this includes expected roles when there are multiple commissioners (e.g. Integrated Care Boards (ICBs) and Local Authorities; NHSE and ICBs; multiple ICBs)

- What should happen when there are quality concerns that justify escalation to a regional or national response due to the consequences or potential for learning, including complex, significant or recurrent concerns that may require regulatory action and service closures. Examples: significant quality failings across a pathway, material concerns about the leadership or culture within a provider or ICB, lack of timely and sustained traction to address regulatory non-compliance.

Quality care is understood in the guidance according to the NQB Shared Commitment's definition, as care that is **safe, effective**, provides a **personalised experience,** is **well-led** and **sustainably resourced**. The NQB is also clear that quality care must be **equitable,** focused on reducing inequalities and addressing wider determinants. Based on this definition, **this guidance considers the full range of health and care services and providers**, including services commissioned by the NHS (either ICB or NHSE), jointly commissioned by the NHS and local authorities, and commissioned by local authorities from NHS providers and non-NHS providers (e.g. under public health grant).

[1] The PSIRF is the framework for responding to patient safety incidents in providers.

As per the Guidance on System Quality Groups, this document will be updated as the new operating model evolves. Three annexes are included: a) Glossary of Key Terms; b) TORs for Rapid Quality Review Meetings; c) TORs for Quality Improvement Groups.

Key principles for effective quality management

In the Guidance on System Quality Groups, the NQB emphasised the importance of all ICSs having effective structures and infrastructure in place to support quality management, combining quality planning, quality assurance/ control and quality improvement functions. The NQB set out the role that System Quality Groups and wider forums (e.g. ICB Quality Committees) would play in quality management (see Figure 2), providing model Terms of Reference and clarifying the expected relationships between Integrated Care Boards (ICBs), Local Authorities and other partners (e.g. NHSE). It also highlighted the significant opportunity that ICBs now have to **improve quality structures in order to reduce bureaucracy and support integration.**

These same principles, responsibilities, governance arrangements and relationships are the basis for this document and must be taken on board by system leaders as they develop their approach to managing quality risks within ICSs[2]. Figure 2 provides an overview of the expected responsibilities for quality risk management at different geographies.

To work effectively, there is a need for strong partnership working and intelligence-sharing across organisations, including shared ownership of risk. Clear reporting and governance arrangements must be in place within and beyond ICSs, including alignment with Regional Quality Groups[3].

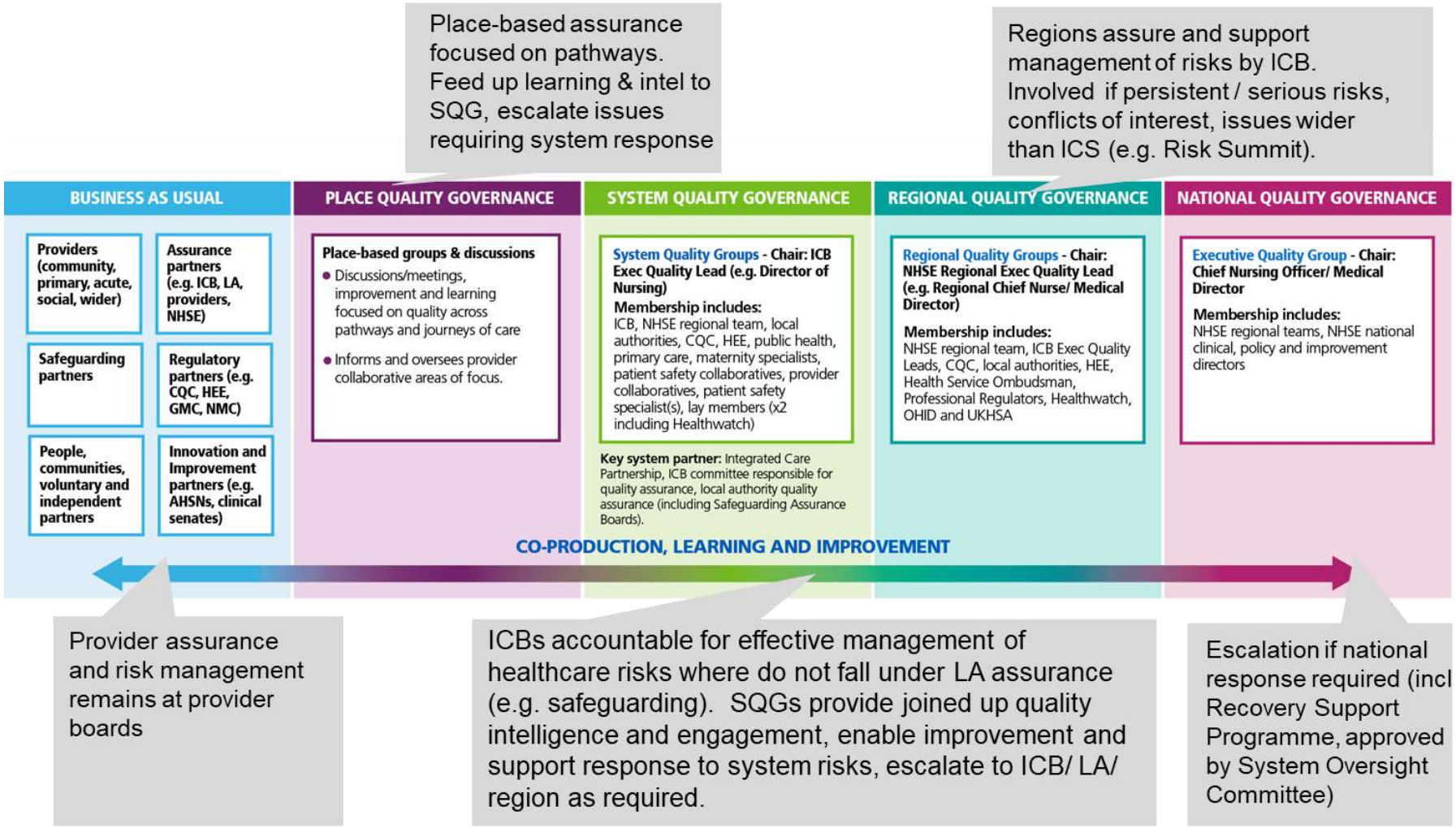
Below we set out the expected approach to management of system-level quality concerns and risks. This aligns with the forthcoming **NHSE Guidance on System Quality Risk Management**, which will set out key principles and examples of good practice for risk management, including: agreed system risk appetite statements; common language and scoring; and risk frameworks which clearly link to associated accountability and governance frameworks, and which cover quality alongside wider risk frameworks (e.g. performance, operational, financial).

[2] Key principles include: having a clear line of sight, including concerns and risks; investing in building an improvement culture; having streamlined, agile and lean quality structures which are standardised where possible and support partnership working and intelligence sharing; and working closely with staff and people drawing on services to support effective quality management.
[3] Regional Quality Groups have replaced Regional QSGs to align with changes at system level. We expect these to include discussion about independent providers with a view to use existing contractual levers to bring about improvement.

It is crucial that NHSE regional and national teams adopt a system-first approach wherever possible when managing risks. Risks should be managed as close to the point of care as possible, where successful mitigation is not possible then escalation and management at the next level occurs as linked to the designated risk framework and overseen by the ICS. However, as the Guidance on System Quality Groups made clear, there will be situations in which **NHSE and other regulators have the right to intervene,** particularly if there are complex, significant and/or recurrent risks. Further details on triggers for NHSE involvement are provided below.

Note that for independent sector providers as there is no NHSE regulatory remit for oversight of quality or quality governance, other regulators and commissioners must use their contractual levers to influence place, ICS and regional quality governance.

Figure 2: Overview of Quality Governance, NQB Guidance on SQGs



Overarching approach to quality risk response and escalation

The refreshed approach to quality risk management is based on three main levels of assurance and support from the NHSE regions with the ICS partners:

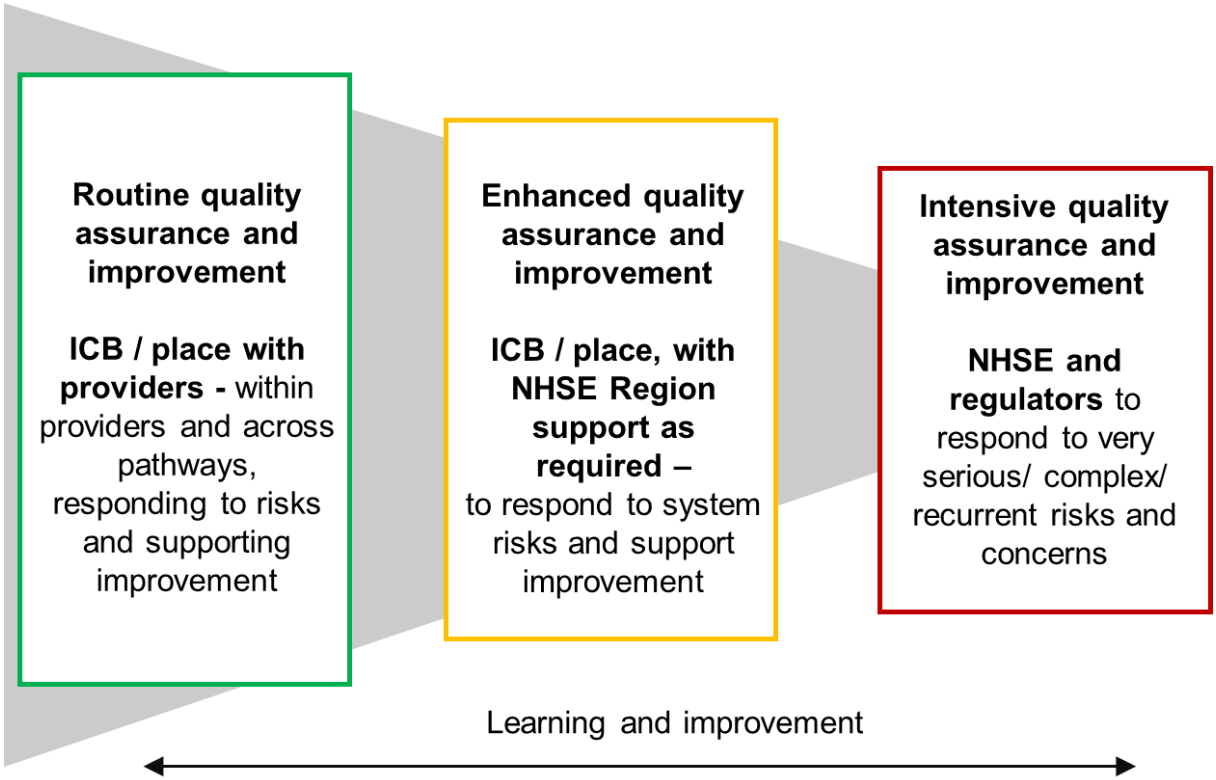
1. **Routine quality assurance and improvement** – activity when there are no risks or minor risks which are being addressed effectively. Includes standard monitoring and reporting, due diligence and contract management

2. **Enhanced quality assurance and improvement** – undertaken when there are quality risks that are complex, significant and/ or recurrent and require action/ improvement plans and support

3. **Intensive quality assurance and improvement** – a last resort, when there are very complex, significant or recurrent risks, which require mandated intensive support led by NHSE and regulators. For health services, this includes mandated support from NHSE for recovery and improvement (e.g. Intensive Support Team, maternity support).

The three levels apply to different geographies – places, ICSs, pathways and journeys of care. Figure 4 provides an overview of the three levels.

Figure 4: Overview of main levels of quality assurance and improvement



Decisions on how to move through the escalation process must be taken as close to the point of care as possible, reflecting effective risk profiling and accountability arrangements. Generally, it is expected that for health services the move into enhanced assurance will be authorised by the ICB, and the move into intensive assurance by NHSE. However, the decision will need to reflect the risk profile and regulatory and accountability arrangements.

The approach is based on the following core components:

Component	Description
Effective risk profiling	• To determine the approach and actions required. Timely, triangulated data, aligned with the Patient Safety Strategy for healthcare concerns/ risks • Each ICS must have commonly agreed metrics to measure quality and an active list of quality risks at each level. These may be agreed through the SQG, with risks relating to health services integrated in the main risk register for the ICB. • The Quality Risk Profiling Tool is an analytical tool which triangulates key data to profile risks. The tool is currently being updated to support ICSs.
Rapid Quality Review Meetings (See TORs in Annex B).	• Meetings to rapidly share intelligence, diagnose, profile risks and develop action/improvement plans • May be stood up at short notice by ICBs or wider partners (e.g. Local Authority, NHSE, other regulators), where there is deemed to be a significant or immediate risk to quality, including safety, which is not being addressed in wider discussions (e.g. oversight) • Replace former Single Item QSGs and Risk Summits.
Action/ improvement plans	• Set out the required actions for mitigation and actions. Must include KPIs, action owners, timescales and success criteria, and reflect contractual processes and requirements and regulatory frameworks • Where multiple commissioners (e.g. ICB / local authorities or multiple ICBs), must include coordinated actions for improvement • For healthcare risks, plans should align with any existing improvement plans or support offers to prevent duplication or misalignment of effort. Where the system or trust is already in receipt of mandated national support via the NHS Recovery Support Programme the relevant System Improvement Director (system) or Improvement Director (trust) must be consulted.
Quality Improvement Groups (See TORs in Annex C).	• Set up to plan, co-ordinate and facilitate the delivery of the required changes / improvement. May be standalone groups or integrated into wider improvement /assurance processes (e.g. NHS Oversight Framework).

Below we provide further information on expected roles/ responsibilities of the different partners. This is primarily for services by ICBs and of course will need to be adapted to reflect different commissioning and accountability arrangements (e.g. local authority commissioned services, NHSE commissioned services).

Routine Quality Assurance and Improvement – Led by provider/ ICB

Business as usual activity and reporting within providers (including independent sector providers), provider collaboratives/ networks for service delivery, place-based structures, ICB/ICSs, including independent providers, provider collaboratives and networks.

Overview	ICB-led action, with providers, at place level	ICB-led action, with providers, at system level	Regional NHSE action	National NHSE/ other regulatory action
Category of risk: • **No risks**: The quality of care is meeting expected standards • **Minor risks:** There are one or more areas where care is not meeting the required standards. However, these concerns can be managed at place level (e.g. GP practice assurance) and there are active action/ improvement plans to meet the required standards which are consistently delivered against.	**Activity:** • Integrated quality review meetings, specific meetings (e.g. Local Safeguarding Children Partnerships, Safeguarding Adult Boards, case management reviews), oversight meetings, contract management • Dynamic monitoring of quality. Focus on trajectories, variation and inequalities • Effective assurance processes in place that align with consistent indicators used at different geographies • Contractual actions to improve quality **Reporting:** • Minor and moderate concerns reported to place-based structure and ICB/ICS. Shared through SQGs and wider discussions.	**Activity:** • Integrated quality review meetings, specific meetings, SQG meetings, ICB Quality Committee meetings, oversight meetings, (sub-) contract management • Dynamic monitoring of quality. Focus on trajectories, variation in quality and outcomes, and inequalities • Liaison with ICB/ICS to agree/ accept contractual actions to improve quality • Advice and suggestions for quality improvement may be made by the organisations within the ICS with a view to preventing low-level risks developing into more significant concerns **Reporting:** • Minor and moderate concerns may be included on ICB risk registers.	**Activity:** • Limited involvement from NHSE regions where NHSE is not commissioner. Focused on supporting cross-ICB/ICS learning and intelligence • Where NHSE is commissioner (or joint commissioner), quality meetings dynamic monitoring, contractual actions and improvement actions must be undertaken **Reporting:** • Minor concerns in NHSE-commissioned services may be on regional or national risk registers (not the case for non-NHSE commissioned services).	**Activity:** N/A **Reporting:** • Minor concerns in NHSE-commissioned services may be on national risk registers where nationally commissioned (not the case for non-NHSE commissioned services) • The Emerging Concerns Protocol, used by regulators to share intelligence and information when there are emerging concerns, may provide a source of intelligence for enhanced assurance discussions. It is important that this intelligence is shared in a timely manner with all relevant partners.

Enhanced Quality Assurance and Improvement – Led by provider/ ICB in most circumstances

Implemented when concerns/ risks are identified that require more frequent and intensive oversight to gain confidence that care is of sufficient and consistent quality, that action/ improvement plans are leading to the desired outcome and that the improvements in care are sustained. May include regulatory action, including enforcement action (aligned with NHSOF segment 3) and contractual actions (e.g. service development and improvement plans, suspension of service, termination of contract). The enhanced approach will be agreed and supported by Regional NHSE teams, based on the risk profile and support needs. See triggers for regional involvement in Overview column.

Overview	ICB-led action, with providers, at place level	ICB-led action, with providers, at system level	Regional NHSE action	National NHSE/ other regulatory action
Category of risk: • **System concerns:** there are a number of areas where the quality of care does not meet the required standards, plans (e.g. PSIR policy and plans) in place are not delivering sustainable improvement at the pace required and /or there are recurrent quality issues that are not being addressed • **Triggers include:** quality concerns across pathways of care, PSIR policy and plans not in place, significant safety concerns, significant contract breaches/ contractual notices, issues outside of the providers' / ICBs' control, lack of confidence in improvement, conflicts of interest, recurrent failure to meet CQC standards **Triggers for NHSE regional involvement:**	**Activity:** • Rapid Quality Review meetings, replacing Single Item QSGs. Providers, ICBs/ ICSs (including local authorities) and regulators (including NHSE regions) may be at these discussions, with reporting linkages to System Quality Groups and ICB Quality Committees. Rapid Quality Reviews may be stood up rapidly at the request of partner organisations (e.g. NHSE, CQC) and may result in links to NHSOF processes where regulatory action may be being considered. • Action/ Improvement Plans must be developed to address risks/ issues. Providers/ provider collaboratives are expected to develop these plans collaboratively with commissioners (e.g. ICB/ NHSE). Should align with wider improvement plans as required • Quality Improvement Groups may be set up to	**Activity:** • Enhanced approach is place or system-led unless there is a conflict of interest or rationale why this should not be the case. See triggers for regional involvement in Overview column. • Rapid Quality Review meetings • Action/ Improvement Plans • Quality Improvement Groups **Reporting:** • System concerns must be shared with System Quality Groups and be included on system and ICB/ICS risk registers and shared with affected NHSE regions.	**Activity:** • For services commissioned by ICB, Regional NHSE involvement agreed with ICBs. Trigger to review of NHSOF segment allocation. May also include a 'check and challenge' function through the Regional Quality Groups and wider discussions (e.g. oversight). • Where NHSE is commissioner (or joint commissioner), arrangements again agreed with ICB based on accountabilities. • Rapid Quality Review meetings, Action/ Improvement Plans, Quality Improvement Groups (or equivalent oversight). **Reporting:** • Significant concerns must be shared with Regional Quality Groups (or	**Activity:** • Risks/ concerns requiring national attention / involvement reported regional and national NHSE governance (as appropriate) • Regional Support Groups/ System Oversight Committee will decide on NHSE regulatory action. Other regulators may also act. **Triggers for NHSE national involvement:** • Requires national action - e.g. outdated policy, national commissioning issue • NB: if national regulatory action is required, would move into level 3 intensive, aligned with NHSOF segment 4.

• Lack of assurance that the material issue/ concern is being addressed or managed in a timely and effective manner by the ICB/ ICS • Material concerns regarding the structure, leadership, and culture of an ICB • System tensions or conflicts of interest, e.g. significant whistleblowing report about ICB exec lead • Significant failings representing a threat to service users/ staff and requiring immediate response, including within independent providers • Same risk recurs in close proximity (6-12 months)/ programmes not led to sustainable improvement, including within independent providers • Issues outside of ICB control. Or service is commissioned by NHSE.	oversee delivery of action/ improvement plans, with clear success criteria. For healthcare risks, these should be integrated into wider improvement and assurance groups where they are in place • Contractual actions to improve quality • Additional activity: inspection visits, walk arounds, targeted quality assurance visits • For providers spanning ICS boundaries (e.g. ambulance trusts, specialist services) or with multiple commissioners, must be agreement as to who leads the process (e.g. coordinating commissioner under relevant contract, or one ICB on behalf of all where multiple affected contracts) and to agreed actions being applied across boundaries.	equivalent) and may be escalated nationally. • System concerns may be on regional or national risk registers.	

Intensive Quality Assurance and Improvement – Led by NHSE and other regulators

Implemented as a last resort, when there are very significant, complex or recurrent risks, which require mandated or immediate support from NHSE for recovery and improvement, including support through the Recovery Support Programme, or from wider regulators. The intensive approach must be agreed based on the risk profile and support needs within the ICB. This assurance level covers previous **NHSE Risk Summits**.

Overview	ICB-led action, with providers, at place level	ICB-led action, with providers, at system level	Regional NHSE action	National NHSE/ other regulatory action
Categories of risk: • **Very significant, complex of recurrent risks:** care quality has fallen, or is at risk of falling, well below the standards expected. All options are exhausted to respond to recurrent/ significant quality risks, conflicts of interest, or risks / concerns. The provider/ group or providers has not delivered on the improvement trajectory agreed; there is a significant risk to, or significant impact on, the quality of care **Triggers include:** • Very significant failings, representing a threat to service users/ staff and requiring immediate response, including within independent providers • A need to act rapidly to protect service users and / or staff.	**Activity:** • Rapid Quality Review meetings • Action/ Improvement Plan, with clear objectives and success/ success criteria • Quality Improvement Groups For healthcare risks, these may be incorporated in wider oversight forums set up by ICBs e.g. linked to a broader set of mandated support measures.	**Activity:** • Rapid Quality Review meetings • Action/ Improvement Plan • Quality Improvement Groups For healthcare risks, these may be incorporated in wider oversight forums set up by ICBs e.g. linked to a broader set of mandated support measures.	**Activity:** • Includes commissioner action (e.g. suspension or termination of contract), regulatory action (e.g. CQC enforcement action) • Support via regions, for trusts/ ICBs in NHSOF 3. Recovery plans must be in place. **Reporting:** • Very significant, complex or recurrent concerns shared with Regional Quality Groups for inclusion on regional risk registers and escalated nationally. • Concerns relating to challenged providers/ ICSs reported to Regional Support Groups/ System Oversight Committee. ICBs and provider chairs must be notified and kept informed.	**Activity:** • Risks/ concerns requiring national attention / involvement reported through regional and national NHSE governance (as appropriate) • System Oversight Committee will decide on NHSE regulatory action in consultation with Regional Support Groups. Other regulators may also act. **Triggers for NHSE national involvement:** • Very significant, complex or recurrent risks in challenged providers/ ICBs (NHSOF segment 4) • Requires national action, e.g. outdated policy, national commissioning issue

Annex A: Glossary of Key Terms

Rapid Quality Review Meeting	Multi-stakeholder meetings set up to give specific, focused consideration to quality concerns/ risks, facilitate rapid diagnostic work and agree action and improvement plans. The meetings can be called at short notice by ICBs or wider partners (e.g. Local Authorities, NHSE, CQC). The meetings may inform regulatory action. **These meetings replace Single Item QSGs and Risk Summits**.
Emerging Concerns Protocol	A protocol through which a wide range of health and care regulators can share intelligence on emerging/ existing quality concerns. This includes setting up a Regulatory Review Panel to share and assess information and inform next steps.
NHS Oversight Framework	NHS England's Oversight framework applying to Integrated Care Boards (ICBs), NHS trusts and foundation trusts. The framework is based on a single set of oversight metrics, used to flag potential issues and prompt further investigation of support needs. The metrics align with five national themes: quality of care, access and outcomes; preventing ill health and reducing inequalities; people; finance and use of resources; and leadership and capability.
Recovery Support Programme	NHS England's mandatory support provided when there are significant quality concerns or risks within a Trust or ICB, as defined by the NHS Oversight Framework.
Quality Improvement Group	Multi-stakeholder group set up to plan, coordinate and facilitate the effective and sustained delivery of action/ improvement plans to mitigate and address quality concerns and risks. Quality Improvement Groups are organised by ICSs with system partners (e.g. NHSE, CQC, HEE, GMC, NMC).
Quality	The NQB defines of quality according to five elements: safe, effective, positive experience, well-led and sustainable, plus equitable.
Risk Appetite	The Institute of Risk Management defines the risk appetite as "The amount of risk that an organisation is willing to seek or accept in the pursuit of its long-term objectives". Normally set against categories of risk rather than individuals of risk.
System Quality Group	A forum at ICS level that brings together system partners to engage, share intelligence on learning, opportunities for improvement and concerns/risks, and develop system responses to deliver and mitigate them. This replaces existing Quality Surveillance Groups (QSGs) See the NQB's Guidance on System Quality Groups.

Annex B: TORs for Rapid Quality Review Meetings

Purpose:

Rapid Quality Review Meetings are multi-stakeholder meetings set up to facilitate rapid diagnosis of quality concerns/ issues and to agree next steps, including action/ improvement plans.

Their purpose is to:

- Give specific and focused consideration to quality concerns/risks raised, sharing intelligence, including with providers where quality risks have been identified
- Facilitate rapid, collective judgements to be taken about quality within the provider / sector/ pathway in question
- Identify actions needed as a result of the risk(s) identified, summarised in an Action/ Improvement Plan, which may be taken forward by a **Quality Improvement Group**. This may include actions at provider, sector or pathway level. Clear success criteria must also be agreed in the Action/ Improvement Plan, which align with NHSOF criteria for health as appropriate.

The role of attendee organisations:

Rapid Quality Review Meetings should be ICB-led where possible, subject to accountability arrangements (e.g. NHSE commissioned services) and regional involvement considerations (e.g. conflicts of interest).

Participants in Rapid Quality Review meetings will have sufficient authority to take the necessary decisions on behalf of their respective organisations and actions to help drive actions at pace. Where decisions are required to be approved by additional bodies / structures, the participants must drive this decision making at pace so as not to become the time-limiting factor in making necessary changes.

Minimum members:

- Relevant provider(s) (including independent providers) / provider collaboratives
- ICB/ place - Executive Lead for Quality, contract managers, System Improvement Director
- Local Authorities

- NHSE Regional Clinical Director
- CQC
- HEE
- Lay members with relevant lived experience

Other system partners will be invited depending on the issue, e.g. regulators (e.g. NMC, GMC, OFSTED, PHSO), public health, police, primary care, maternity and neonatal, specialised or direct commissioning, deaneries.

There may be some circumstances in which system partners may wish to meet without providers.

Chair:

Rapid Quality Review meetings should be chaired by the ICS (ICB Exec Lead for Quality and/or Local Authority representative). NHSE Regional teams may co-chair or chair where the agreed triggers for regional involvement have been met. Conflicts of Interest must also be considered when deciding chairing arrangements (e.g. the ICB cannot chair if the ICB is the subject of the quality concern).

Reporting:

- Agreed actions made in Rapid Quality Review meetings must be summarised in an action/ improvement plan and reported to System Quality Groups and ICBs/ Local Authority assurance (as appropriate).
- The actions may be incorporated into wider processes or taken forward by a Quality Improvement Group as relevant.
- The key themes and outcomes should also be reported to the Regional Quality Group (RQG).

Annex C: TORs for Quality Improvement Groups

The establishment of a Quality Improvement Group may be instigated by the ICB, a local authority, NHSE or wider regulators; or a provider or group of providers may request that the ICB establish a Quality Improvement Group. The group should usually be convened by the ICB, but may be convened by the NHSE region if necessary (e.g. where services are commissioned/ jointly commissioned by NHSE).

Purpose:

The key purpose of the Quality Improvement Group is to support planning, coordination and facilitate the sustained delivery of actions to mitigate and address the quality risks/ concerns within an individual provider or across the providers in the local system more generally. It will do this by:

- Providing advice and support to the provider(s)/ ICB to address quality risks/ concerns, including identifying required responses and planning for mitigation of risks
- Providing a mechanism for facilitating direct assurance of the achievement of milestones within the action/ improvement plan, including ensuring that there are clear arrangements for confirming that the action / improvement plan has been successfully delivered
- Reviewing and challenging outstanding actions, ensuring that the most robust approaches are being considered
- Escalating to System Quality Group, ICB, Regional Quality Group and wider partners (e.g. NHSE, local Authority, CQC) where appropriate.
- Ensuring that learning is embedded in ongoing continuous improvement.

The Group will meet monthly until most or all of the following conditions are met:

- Achievement of the milestones in the Action/ Improvement Plan and assurance that these have been embedded in a sustainable way

- All members, and the ICS/B/ Regional Quality Group, agree that the relevant milestones have been achieved and there is a clear plan and capacity to deliver any outstanding milestones.

The role of member organisations:

Members of the group will have sufficient delegated authority to take the necessary decisions and actions on behalf of their respective organisations to help drive actions at pace. Where decisions are required to be approved by additional bodies / structures, the role of the group members is to drive this decision making at pace so as not to become the time-limiting factor in making necessary changes.

Minimum members:

- Relevant providers (including independent sector providers)/ provider collaboratives
- ICB/ place-based Executive Lead for Quality, senior contract manager, System Improvement Director
- Local Authorities – adult and children's services
- NHSE Regional Clinical Director
- CQC
- HEE
- Healthwatch/ lay members with relevant lived experience

Other partners will be invited depending on the issue, e.g. public health, primary care, maternity and neonatal, OFSTED, police other professional regulators, deaneries.

Responsibilities of members:

Providers/ provider collaboratives May include: Chief executive; Medical Director; Director of Nursing and Midwifery;	• Work with the ICS/B, NHSE and partners to agree the action / improvement plan • Share progress and provide assurance against key milestones relating to quality and performance • Update the group if there are concerns that key milestones may not be achieved • Escalate any new quality or performance concerns to the group including information on steps taken by the provider to manage and mitigate risk.

Director of Midwifery; Director of Quality Governance; Director of Finance; Chief Operating Officer, or each provider	• Work with partners to deliver, enable and support quality and performance improvement • Ensure that learning is embedded in ongoing improvement.
ICB/ Place-based Executive Lead for Quality (or nominated deputy)	• Chair the group as appropriate. Where the service is jointly commissioned with the Local Authority, the Local Authority may chair or co-chair • Regional NHSE teams may co-chair or chair where regional triggers for involvement have been agreed (e.g. conflicts of interest) or the service is commissioned/ jointly commissioned by NHSE • Ensure that services commissioned from providers meet the quality and performance requirements of contracts • Manage risks and mitigations within the contractual arrangements and ensure pace in quality and performance actions • Where there are multiple commissioners (e.g. health commissioners and local authorities), ensure that action/ improvement plans include coordinated actions and take account for the different contractual and regulatory frameworks • Lead commissioner engagement in respect to provider issues and outcomes on behalf of the local population • Work with the providers and partners to develop action/ improvement plans, track progress against milestones relating to quality and performance • Work with the providers and partners to agree direct assurance processes for relevant milestones • Engage and communicate with relevant stakeholders. • Work with partners to establish and sustain processes to deliver quality and performance improvement • Ensure that learning is embedded in ongoing improvement.
Local Authorities	• Co-chair the group where services are commissioned by the Local Authority • Work with health commissioners to ensure that services commissioned from providers meet the quality and performance requirements of contracts • Manage risks and mitigations within the contractual arrangements and ensure pace in quality and performance actions • Where there are multiple commissioners (e.g. health and local authorities), ensure that action/ improvement plans include coordinated actions and take account for the different contractual and regulatory frameworks • Lead commissioner engagement in respect to provider issues and outcomes on behalf of the local population • Work with the provider and partners to develop action/ improvement plans, track progress against milestones relating to quality and performance. • Work with the provider and partners to agree direct assurance processes for relevant milestones • Engage and communicate with relevant stakeholders. • Work with partners to establish and sustain processes to deliver quality and performance improvement • Ensure that there are effective information flows between co-opted Local Authorities and other relevant stakeholders • Ensure that learning is embedded in ongoing improvement.
NHSE Regional Clinical Quality May include Regional Chief Nurse; Regional	• May co-chair or chair the group (as above) • Work with the provider(s), ICB and partners to track progress against milestones relating to quality and performance • Work with the provider(s), ICB and partners to agree direct assurance processes for relevant milestones • Provide subject matter expertise • Engage and communicate with relevant stakeholders • Escalate where national involvement / action is required

Medical Director; Regional Chief Midwife and Lead Obstetrician	• Work with partners to ensure systems and processes are in place to deliver quality and performance improvement • Ensure that systems and processes are in place to continually review changes and that they are embedded in practice
Care Quality Commission	• Ensure that the necessary actions are taken, and timely progress is being made against milestones relating to quality and performance, in line with the CQC inspection methodology • Engage and communicate with relevant stakeholders. • Where appropriate to share information/flag concerns identified as part of CQCs routine monitoring to support quality and performance improvement • Consider need for a regulatory response, engaging with all key partners in process
Health Education England	• To report on progress in assuring the milestones within the action/ improvement plan related to relevant workforce education and training elements. • To report on progress in trainee educational issues that impact on the delivery of services within the provider or ICS.
Healthwatch/ lay members with relevant lived experience	• Work with partners to ensure patient voices are heard and included as part of the meeting and progress.

It is the responsibility of each member representative to ensure that information and reporting on progress and outcomes is disseminated to appropriate individuals within their own organisations and back into the group. All parties will ensure relevant wider stakeholder engagement is in place.

Chair:

The Group should normally be chaired by the ICB Exec Lead for Quality or Local Authority representative. NHSE Regional teams may co-chair or chair, where the triggers for regional involvement have been met.

Reporting:

The Quality Improvement Group is accountable to the System Quality Group/ ICB (or ICB Quality Committee) and the Regional Quality Group.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Cheshire and Merseyside System Finance Report – Month 7

Agenda Item No	**ICB/11/22/10**
Report author & contact details	Mark Bakewell – Deputy Director of Finance
Report approved by (sponsoring Director)	Claire Wilson – Executive Director of Finance
Responsible Officer to take actions forward	Claire Wilson – Executive Director of Finance

Cheshire and Merseyside System Finance Report – Month 7

<table>
<tr><td>Executive Summary</td><td colspan="5">This report updates the Board on the financial performance of Cheshire and Merseyside ICS (“the System”) for 2022/23, in terms of relative position against its financial plan as submitted to NHS England in June 2022, alongside other measures of financial performance (e.g. Cash Management and Better Payment Practice Code) and utilisation of available ‘Capital’ resources for the financial year.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• Note the contents of this report in respect of the Month 7 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.</td></tr>
<tr><td>Key issues</td><td colspan="5">As at 31 October 2022 (Month 7), the ICS ‘System’ is reporting an aggregate deficit of £56.8m against a planned deficit of £25.0m resulting in an adverse year to date variance of £31.9m.</td></tr>
<tr><td>Key risks</td><td colspan="5">Outlined within the main paper</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td></td><td colspan="2"></td><td></td><td></td></tr>
<tr><td>Route to this meeting</td><td colspan="5"></td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">n/a</td></tr>
<tr><td>Patient and Public Engagement</td><td colspan="5">n/a</td></tr>
<tr><td>Equality, Diversity and Inclusion</td><td colspan="5">n/a</td></tr>
<tr><td>Health inequalities</td><td colspan="5">n/a</td></tr>
<tr><td>Next Steps</td><td colspan="5">Continued monitoring of financial forecasts for revenue and capital allocations. Further development of cost improvement plans and system wide efficiency opportunities. Development of financial strategy to support future financial sustainability.</td></tr>
<tr><td>Appendices</td><td colspan="5">Appendices 1-7 gives details of the narrative in the main body of the report.</td></tr>
</table>

Cheshire and Merseyside System Finance Report – Month 7

Executive Summary

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

Key Performance Indicators

Key Performance Indicator			Performance last month	Performance this month	Trendline
Financial position - ICB	Year to date under/(over) performance against plan	£m's	-7.4	-10.6	
Financial position - Providers	Year to date under/(over) performance against plan	£m's	-17.3	-21.3	
Capital	Year to date under/(over) performance against plan	£m's	-32.6	-31.7	
Provider cash balances	Cash balance at month end	£m's	763.8	758.9	
CIP performance	Year to date delivery as % of full year plan	%	41%	55%	
CIP recurrent performance	% of delivery which is recurrent	%	34%	35%	
Agency expenditure	Variance against plan year to date	£m's	-20.9	-24.1	

M7 Performance - Revenue

As at 31st October 2022 (Month 7), the ICS 'System' is reporting an aggregate deficit of £56.8m against a planned deficit of £25.0m resulting in an adverse year to date variance of £31.9m.

As set out in the table below, comprises a lower-than-plan year-to-date surplus position of £0.8m for CCGs/ ICB (compared to a plan profile value of £11.5m) and a year-to-date deficit in the NHS providers of £57.7m (compared to plan profile of £36.4m).

Sector	2022/23 Annual Plan £m Surplus / (Deficit)	2022/23 YTD Plan £m Surplus / (Deficit)	2022/23 YTD Actual £m Surplus / (Deficit)	YTD Variance £m Surplus / (Deficit)	2022/23 Forecast £m Surplus / (Deficit)	Forecast Variance £m Surplus / (Deficit)
CCG/ICB	19.7	11.5	0.8	(10.6)	19.7	0.0
NHS Providers Trusts	(50.0)	(36.4)	(57.7)	(21.3)	(50.0)	0.2
Total System	**(30.3)**	**(25.0)**	**(56.8)**	**(31.9)**	**(30.3)**	**0.2**

The ICB and NHS providers continue to forecast achievement of the annual planned deficit of £30.3m. However, a small number of organisations are informally reporting that delivery of their plan is at risk and so the wider system will need to determine if mitigations can be found elsewhere to offset this potential overspends against plan. Further details are set out later in this report.

M7 Performance - Capital

As at 31st October 2022, progress of the system's local operational capital programme expenditure (excluding impact of IRFS16) remains below year-to-date planned values by £31.7m as described in the main body of the report. However, all Trusts are forecasting to deliver to plan by the end of the year and the delivery against plan in month did improve this month.

Primary Care Capital has been provisionally allocated to places for Improvement Grants and GP IT. A separate paper is being presented to the Primary Care Committee for review and approval.

System Finance Report to 31st October 2022 (Month 7)

Background

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

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

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

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

5) As a result, the additional surplus above plan of £6.7m originally reported by CCGs has been transferred to the ICB.

Key movements in month

6) The key movements between month 6 and month 7 are as follows:

Financial position

- Month 7 YTD system financial performance has worsened by £1.8m to £56.8m deficit (YTD plan of £25.0m deficit).
- Unmitigated net risk remains consistent with month 5 at £74m.
- CIP YTD performance has improved by £45.9m in month to £182.6m (full year plan is £330.9m).

Revenue allocations

- £5.0m Long COVID – non recurrent funding to support services commissioned to the end of 2022/23.
- £1.9m COVID Therapeutics – to ensure ongoing local service provision from the beginning of October 2022 and to support transition to more sustainable services over the longer term.
- £0.9m Delegated Pharmacy – resource from Q1 to support Q2-4 pressures.
- £0.6m Primary Care Transformation SDF – allocations to support GP retention, mentors and fellowships for those new to practice nursing.
- £0.5m Supporting People at Home - regional scaling.
- £0.5m Mental Health SDF – non recurrent funding to support winter pressures.
- £0.5m Prevention SDF – quarter 3 allocations for Tobacco & Alcohol projects.
- £0.3m Cancer SDF – additional allocations for Target Lung Health Checks and Cancer Alliance.

Month 7 (October) Performance

ICB/CCG performance

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

8) The ICB is currently reporting a year-to-date surplus of £0.8m compared to an original planned surplus of £11.5m resulting in an adverse variance to plan of £10.6m as per the below table.

	2022/23 YTD Plan (M4-7) £ 000's Surplus / (Deficit)	2022/23 YTD Actual (M4-7) £ 000's Surplus / (Deficit)	2022/23 YTD Variance (M4-7) £ 000's Surplus / (Deficit)	2022/23 YTD % Variance (M4-7) £ 000's Surplus / (Deficit)
System Revenue Resource Limit	**1,978,918**			
ICB Net Expenditure				
Acute Services	1,055,024	1,055,256	(232)	0.0%
Mental Health Services	188,101	193,169	(5,068)	-2.7%
Community Health Services	201,967	202,331	(364)	-0.2%
Continuing Care Services	97,206	100,690	(3,484)	-3.6%
Primary Care Services	203,155	203,759	(605)	-0.3%
Other Commissioned Services	5,366	5,300	66	1.2%
Other Programme Services	20,608	21,343	(735)	-3.6%
Reserves / Contingencies	(6,311)	1,866	(8,177)	129.6%
Delegated Primary Care Commissioning including:	179,884	178,431	1,453	0.8%
a) Primary Medical Services	156,667	154,188	2,478	1.6%
b) Pharmacy Services	23,217	24,243	(1,025)	-4.4%
ICB Running Costs	15,729	15,929	(200)	-1.3%
Total ICB Net Expenditure	**1,960,728**	**1,978,074**	**(17,346)**	**120.0%**
TOTAL ICB Surplus/(Deficit)	**18,190**	**844**	**(17,346)**	**-0.9%**
**** NB - CCG Q1 Adjustment***	***(6,716)***	***-***	***6,716***	***0.5%***
Adjusted Surplus	***11,474***	***844***	***(10,630)***	***-0.4%***

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

a. Mental Health - increased volume and value of packages of care, including out of area placements and non-contracted activity.
b. Primary Care Services - current underspend on prescribing and GPIT but this is not expected to continue to the end of the year.
c. Community Services – overspend relating to independent sector contracts, Intermediate care and reablement.
d. Continuing care - Overspend relating to increases to volume and price for continuing care packages and funded nursing care.
e. Reserves – due to accepted planning risks as outlined below with mitigations being developed with partners and place teams.
f. Primary Care Delegated budgets – overspend areas include enhanced services, estates and other local discretionary expenditure.
g. Delegated Pharmacy pressures (ICB responsibility from 1st July 2022) pressures being managed with NHS I/E.
h. Efficiency savings are built into the year-to-date position and reflects a favourable position of £3.5m but a significant proportion of this is non-recurrently delivered. Development of recurrent savings is a key area of focus.

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

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

NHS Provider Performance

12) The table below summarises the combined NHS provider position to the end of October 2022 reflecting a year-to-date cumulative deficit position of £57.7m compared to a year-to-date profile plan figure of £36.4m. Further detail is provided in Appendix 2.

	M7 YTD Plan £m	M7 YTD Actual £m	M7 YTD Variance £m	Annual Plan £m	M7 Forecast ACTUAL £m	M7 Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	(0.4)	(0.4)	0.0	4.6	4.6	0.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.1)	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.5	1.5	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.0)	(14.3)	(10.3)	(3.1)	(3.1)	0.0
East Cheshire NHS Trust	(2.3)	(2.3)	0.1	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.4	2.0	0.6	2.3	2.3	0.0
Liverpool University Hospitals NHS Foundation Trust	(11.9)	(18.3)	(6.4)	(30.0)	(30.0)	(0.1)
Liverpool Women's NHS Foundation Trust	0.8	0.3	(0.5)	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	2.9	2.9	0.0	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(7.3)	(8.4)	(1.1)	(10.4)	(10.4)	0.0
Southport And Ormskirk Hospital NHS Trust	(10.9)	(10.9)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(1.7)	(1.7)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.9	1.7	0.8	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	1.4	1.7	0.3	2.9	2.9	0.3
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.6)	(7.9)	(0.3)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.4	0.4	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.9	(3.7)	(4.6)	0.0	0.0	0.0
Total Providers	**(36.4)**	**(57.7)**	**(21.3)**	**(50.0)**	**(50.0)**	**0.2**

13) Six provider Trusts have reported an adverse year to date deficit position for months 1-7, resulting in an adverse position compared to plan of £21.3m.

14) Although providers continue to forecast achievement of the annual planned £50m deficit, several risks will require management as a system to ensure delivery of the plan, which are explained further below. Key pressures relate to underachievement on delivery of planned cost improvement programmes, rising inflation with regard to energy and operational pressures associated with continued provision of escalation bed capacity.

15) National Guidance has been published for those systems and providers who wish to deteriorate their forecast. To do so, several investigative and assurance actions need to be carried out, the development of a recovery plan is a key component of this. The consequences for deteriorating forecast include:
    a. Double-lock sign off for any revenue investments above £50k by Provider and ICB and a triple-lock sign off for any revenue investments above £100k by Provider, ICB and NHSE regional team.
    b. A review of capital allocations by NHSE National team
    c. Increased oversight and sign off workforce controls particularly with respect to Bank and Agency.

16) Enacting this guidance is to be seen as a last resort and does constitute a breach of statutory duty.

17) Further analysis of the year-to-date position demonstrates that the adverse position is a result of higher than anticipated pay costs (£124.6m) offset set by favourable movements in Income (£116.2m) and non-operating expenditure (£5.2m) as per the table below.

Surplus / (Deficit)	2022/23 Year-to-date				2022/23 Forecast			
	Plan	Actual	Under/(over) spend		Plan	Actual	Under/(over) spend	
	£m	£m	£m	%	£m	£m	£m	%
Income excluding COVID Reimbursement	3,262.2	3,377.3	115.1	3.5%	5,596.0	5,742.8	146.8	2.6%
COVID-19 Reimbursements	6.8	7.9	1.1	16.2%	10.7	11.3	0.6	5.9%
Total Income	3,269.0	3,385.2	116.2	3.6%	5,606.7	5,754.1	147.4	2.6%
Pay	(2,119.1)	(2,243.7)	(124.6)	5.9%	(3,632.8)	(3,774.2)	(141.4)	3.9%
Non Pay	(1,129.5)	(1,147.5)	(18.0)	1.6%	(1,926.7)	(1,940.5)	(13.8)	0.7%
Non Operating Items (exc gains on dispos	(56.9)	(51.7)	5.2	(9.1%)	(97.2)	(89.2)	8.0	(8.3%)
Total Expenditure	(3,305.4)	(3,442.9)	(137.4)	4.2%	(5,656.7)	(5,803.9)	(147.2)	2.6%
C&M NHS Providers	**(36.4)**	**(57.7)**	**(21.3)**	**0.6%**	**(50.0)**	**(49.8)**	**0.2**	**(0.0%)**

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

- **Countess of Chester NHS Foundation Trust**
  Key drivers to the £10.3m variance to plan are a high level of substantive vacancies resulting in high levels of agency and bank spend, increased energy costs, insourcing capacity and Waiting List Initiative (WLI) costs incurred to deliver elective recover. CIP performance is marginally behind plan, but being delivered non-recurrently, resulting in a future pressure.

- **Liverpool University Hospitals NHS Foundation Trust (LUFT)**
  The adverse position reported to date is driven by energy and non-pay inflation costs, escalation beds open to accommodate patients with no criteria to reside, and premium pay costs being incurred to address sickness, vacancies, and escalation capacity. The CIP has been delivered in month, but a large amount has been delivered non-recurrently, creating future financial pressure. Elective activity levels remain below the pre-pandemic levels.

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

- **Warrington & Halton Teaching Hospitals NHS Foundation Trust (WHH)**
  Small adverse variance to plan due to continuation of escalation bed capacity originally planned to be closed. However, straight line forecast indicates concern over Trust's ability to break-even over the next 5 months. The main drivers are A&E spend due to increased demand and reduced flow. Escalation beds are open to accommodate this issue. Agency remains high and CIP delivery is a concern as it is supported by non-recurrent savings

  Wirral University Teaching Hospitals NHS Foundation Trust
  The Trust set an ambitious plan to deliver a breakeven position for the year. The adverse variance to plan is as a result of 64 open escalation beds, use of corridor care in ED, increased energy costs, the unfunded element of the pay award and the Trust's underperformance in respect of recurrent CIP.

- **Liverpool Womens Teaching Hospital NHS Foundation Trust**
  This is the first month that LWH have reported off plan. Key drivers are use of agency and premium rate staffing to cover frontline clinical roles, costs of implementing Ockenden recommendations above funding received and non-pay inflation. Sickness and vacancies are also driving WLIs and agency usage in the medical workforce.

Provider Agency Costs

19) ICB Providers set a plan for agency spend of £113.3m, compared to actual spend in 21/22 of £139.2m. The system is required to manage agency costs within budget and to demonstrate reduced reliance on agency staffing year on year.

20) Agency spend is being closely monitored with approval required from NHS England for all non-clinical agency above £50k. In Month 7, agency spend is £89.2m (£24.1m above plan) with all Trusts except for Southport and Ormskirk and Mid Cheshire reporting adverse to plan. The forecast spend being reported by Trusts is £127m (£14m above plan) but given current spend levels, this is an optimistic assessment and would require significant reduction in run rates for it to be achieved.

21) Agency spend levels have been triangulated with changes to vacancy rates, sickness levels and agency spend to aid understanding of the drivers. See appendix 3 for detail by Provider.

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

23) Detailed staffing analysis is being coordinated across the system to provide a consistent assessment of the additional staffing levels experienced over the last 2 years and the reasons for the increase. This will be reported to the Board as we develop our work on productivity improvement and our wider financial strategy as part of the planning process for 2023/24.

Efficiencies

ICB Efficiencies

24) The ICB is currently reporting a £3.5m favourable variance to plan YTD mostly because of non-recurrent benefits released by CCGs in Q1. The ICB is currently forecasting to achieve the planned efficiencies of £68.8m. However, there remains a level of unidentified efficiency as highlighted below that requires identification to deliver the plan.

25) The ICB has established a programme approach to identification, development and tracking of efficiencies and this is a key focus of the corporate executive team and Place Directors. Detailed reports will be developed for future reporting periods to allow the Board and Finance, Resources, and Investment Committee to seek further assurance on delivery of the recurrent target.

Provider Efficiencies

26) Provider efficiency schemes are £3.8m behind plan at month 7, efficiencies of £139m have been delivered to date compared to a plan of £142.8m. However, only £48m of this has been delivered recurrently (£91m non-recurrently) and this is a key risk to the underlying financial position of the system. The detail by provider is included in Appendix 4.

Risks & Mitigations

ICB Risks & Mitigations

27) Following review of the month 7 financial position several risks are emerging that will require actions to mitigate during the year in order for the ICB to achieve the planned surplus of £19.7m.

28) The current ICB financial risk review has identified potential risks of £63.1m of 22/23 financial year risks with a series of potential mitigations assessed at a value of £43.1m leaving a residual unmitigated risk of £20.0m. Key risks are included in the table below:

Risk	Gross Risk £m	Residual Risk after Mitigations £m
Drawdown funding not received	-7.7	-7.7
Additional System Efficiencies	-16.1	-3.5
ICB Additional Efficiencies/Operational Pressures	-39.3	-8.8
Total ICB	**-63.1**	**-20.0**

29) The ICB is working alongside system partners to ensure mitigation plans are in place to manage risks including the following:

- Follow up with NHSE national team regarding the recent withdrawal of previously approved drawdown funding (and previously agreed with CCGs as part of 2:1 agreement in 2019/20) and understanding of consequential impact.
- Agreement of recovery plans for 'places' currently off track to plan (Wirral, East and West Cheshire).
- Review of ICB expenditure budgets for review of SDF and HCP programmes to identify any areas of potential slippage.

Provider Risks & Mitigations

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

For Cheshire and Merseyside, £203.5m of gross risk is being reported across providers, with mitigations being pursued for £150m of this, leaving a net risk position of £53.5m. Non delivery of CIP, energy inflation, and premium pay pressures are being flagged as the main risks at month 7. This net risk is not reflected in forecast positions, with all Trusts continuing to report in line with plan at this stage but there are active discussions with a small number of providers where the risk of being unable to deliver in line with plan is becoming more likely.

The system will be required to identify additional underspends and mitigations to offset the impact where providers are unable to deliver their plan. The consequences for both the system and individual organisation of not delivering its plan have been set out in the forecast variance protocol by NHS England. Cross system discussion amongst CEOs and CFOs is ongoing to explore all opportunities available.

Other Performance Indicators

Cash

ICB

30) The ICB is expected to manage its cash balances during the year so that the closing cash balance at bank should be no greater than either 1.25% of the monthly drawdown.

31) The cash balance for the ICB at the end of October was £3.6m which equates to 0.9% of the cash drawdown for October. This improved from September due to increased focus on cash management but still reflects further requirements to understand the cash patterns of the new organisation, budget holder responsibilities and workflow arrangements to clear invoices.

C&M NHS Providers

32) From a provider perspective total cash levels as detailed in Appendix 5 have reduced by 17% from the level at the end of the 2022/23 financial year. Aggregate provider balances as at month 7 were £758.9m, compared with £912.1m at the end of 2021/22.

Better Payment Practice Code

ICB

33) The ICB Better Payment Practice Code cumulative performance by value at the end of October was:
    a. 100% of invoices to NHS suppliers and 87% of invoices to Non-NHS suppliers by value were paid on time.
    b. performance by volume was 90% for NHS suppliers and 90% for Non-NHS suppliers.

34) The target for both measures is 95% and therefore unfortunately the Better Payments Practice Code (BPPC) target was not fully met but again reflects the challenges whilst the transitions towards the ICB operational model and staffing structure is finalised.

35) A number of factors continue to have affected the ICBs ability to meet the target to date including the ICB / place operating model is finalised, and subsequent coding and approval of this significant volume of invoices causing delays to payments. Improving this position will be a key area of focus for the ICB over coming months which will be helped by the agreement of the staffing structure and roles and responsibilities within the operating model.

C&M NHS Providers

36) For providers as set out in the table included in Appendix 6, only 3 providers are currently meeting the targets for invoice payment by both value and number measures within the 95% target.

37) Prompt settlements of invoices to small private and charitable sector suppliers is regarded as critical, particularly considering the current economic landscape.

Capital

38) The 'Charge against Capital Allocation' represents the System's performance against its operational capital allocation, which is wholly managed at the System's discretion. Spend in relation to National programmes and other items chargeable to the Capital Direct Expenditure Limit (CDEL) are effectively administered on the behalf of systems, and therefore under/overspending does not score against System's Capital performance.

39) As per the table below, at month 7, progress of the system's operational capital programme expenditure (excluding IFRS 16 impact) remains below year-to-date planned values by £31.7m. Given increasing lead times for equipment and rising construction costs the position will be reviewed alongside providers this month in order to identify a realistic forecast and actions to be taken to secure spend within the allocated envelope.

40) The 2022/23 plan included a 5% overspend, equating to £12m, which needs to be managed in year.

Primary Care Capital

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

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

43) Proposals for £4.1m GPIT spend have been received from each Place. Following ICS review these have been approved in principle by NHSE.

Strategic Capital

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

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

45) Business cases to bid for these funds have been submitted and the vast majority of funds allocated for Mental Health, TIF, CDC, NHP and Diagnostics. Digital Diagnostics and Frontline digitisation are yet to be allocated.

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

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

Recommendations

The Integrated Care Board is asked to:

- Note the contents of this report in respect of the month 7 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year.

Officer contact details for more information

Claire Wilson
Executive Director of Finance
Cheshire and Merseyside ICB

Mark Bakewell
Deputy Director of Finance
Cheshire and Merseyside ICB

Appendix 1

2022/23 plan submissions by CCG / NHS provider

CCG / ICB	Full Year Plan (Deficit) / Surplus
	£ 000's
NHS HALTON CCG	(3,340)
NHS KNOWSLEY CCG	12,051
NHS SOUTH SEFTON CCG	(4,051)
NHS SOUTHPORT AND FORMBY CCG	(6,336)
NHS ST HELENS CCG	(1,905)
NHS WARRINGTON CCG	(2,302)
NHS WIRRAL CCG	7,499
NHS CHESHIRE CCG	(28,814)
NHS LIVERPOOL CCG	20,101
Total CCG Position	**(7,788)**
NHS LIVERPOOL CCG - as ICB Host	26,766
Total ICB Planned (Deficit/Surplus)	**19,669**

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

Appendix 2

System Financial Position: Combined Year-to-date Financial Position by Organisation as at Month 7 (31st October 2022)

	M7 YTD Plan £m	M7 YTD Actual £m	M7 YTD Variance £m	Annual Plan £m	M7 Forecast ACTUAL £m	M7 Forecast VARIANCE £m
CCGs/ICB	11.5	0.8	(10.6)	19.7	19.7	0.0
	11.5	**0.8**	**(10.6)**	**19.7**	**19.7**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	(0.4)	(0.4)	0.0	4.6	4.6	0.0
Bridgewater Community Healthcare NHS Foundation Trust	(0.2)	(0.1)	0.0	0.0	0.0	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.5	1.5	0.0	2.9	2.9	0.0
Countess of Chester Hospital NHS Foundation Trust	(4.0)	(14.3)	(10.3)	(3.1)	(3.1)	0.0
East Cheshire NHS Trust	(2.3)	(2.3)	0.1	(2.6)	(2.6)	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.4	2.0	0.6	2.3	2.3	0.0
Liverpool University Hospitals NHS Foundation Trust	(11.9)	(18.3)	(6.4)	(30.0)	(30.0)	(0.1)
Liverpool Women's NHS Foundation Trust	0.8	0.3	(0.5)	0.6	0.6	0.0
Mersey Care NHS Foundation Trust	2.9	2.9	0.0	5.7	5.7	0.0
Mid Cheshire Hospitals NHS Foundation Trust	(7.3)	(8.4)	(1.1)	(10.4)	(10.4)	0.0
Southport And Ormskirk Hospital NHS Trust	(10.9)	(10.9)	0.0	(14.2)	(14.2)	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	(1.7)	(1.7)	0.0	(4.9)	(4.9)	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	0.9	1.7	0.8	1.6	1.6	(0.0)
The Walton Centre NHS Foundation Trust	1.4	1.7	0.3	2.9	2.9	0.3
Warrington and Halton Teaching Hospitals NHS Foundation Trust	(7.6)	(7.9)	(0.3)	(6.1)	(6.1)	0.0
Wirral Community Health and Care NHS Foundation Trust	0.4	0.4	0.0	0.7	0.7	0.0
Wirral University Teaching Hospital NHS Foundation Trust	0.9	(3.7)	(4.6)	0.0	0.0	0.0
Total Providers	**(36.4)**	**(57.7)**	**(21.3)**	**(50.0)**	**(50.0)**	**0.2**
Total System	**(25.0)**	**(56.8)**	**(31.9)**	**(30.3)**	**(30.3)**	**0.2**

Note: brackets denote deficit/overspend.

Appendix 3

Agency spend: Current Performance and Forecast Outturn as at Month 7 (31st October 2022)

PROVIDER:	Month 7 YTD			Month 12 Forecast		
	Plan	Actual	Variance	Plan	Forecast	Variance
	£m	£m	£m	£m	£m	£m
Alder Hey Children's NHS Foundation Trust	0.0	0.8	0.8	0.0	0.8	0.8
Bridgewater Community Healthcare NHS Foundation Trust	2.9	3.4	0.5	5.0	5.7	0.7
Cheshire and Wirral Partnership NHS Foundation Trust	1.8	4.2	2.4	3.1	6.1	3.0
Countess of Chester Hospital NHS Foundation Trust	4.9	11.0	6.1	8.4	11.5	3.1
East Cheshire NHS Trust	4.2	6.3	2.1	7.7	9.0	1.2
Liverpool Heart and Chest Hospital NHS Foundation Trust	0.4	0.7	0.3	0.7	1.1	0.4
Liverpool University Hospitals NHS Foundation Trust	7.3	10.0	2.8	12.2	15.6	3.4
Liverpool Women's NHS Foundation Trust	0.5	2.0	1.5	0.8	2.0	1.2
Mersey Care NHS Foundation Trust	10.3	11.0	0.7	17.7	18.9	1.2
Mid Cheshire Hospitals NHS Foundation Trust	12.2	12.2	(0.0)	21.0	19.1	(1.9)
Southport And Ormskirk Hospital NHS Trust	5.5	4.0	(1.5)	9.4	6.8	(2.6)
St Helens And Knowsley Teaching Hospitals NHS Trust	6.0	6.4	0.5	10.2	8.9	(1.3)
The Clatterbridge Cancer Centre NHS Foundation Trust	0.0	1.0	1.0	0.0	1.5	1.5
The Walton Centre NHS Foundation Trust	0.0	0.1	0.1	0.0	0.2	0.2
Warrington and Halton Teaching Hospitals NHS Foundation Trust	5.9	8.7	2.8	10.2	10.2	0.0
Wirral Community Health and Care NHS Foundation Trust	1.0	1.4	0.4	1.7	2.1	0.4
Wirral University Teaching Hospital NHS Foundation Trust	2.3	6.0	3.7	5.0	7.9	2.8
Total Providers	**65.2**	**89.2**	**24.1**	**113.3**	**127.3**	**14.0**

Analysis of vacancy rates and sickness levels against agency cost increases since 2019/20

	Vacancy Rate			Latest sickness rate	Agency cost increase since 2019/20 (£m)
TRUST	**Mar-20**	**Sep-22**	**Movement**		
Alder Hey Children's NHS Foundation Trust	1.60%	1.50%	-0.10%	6.20%	0.3
Bridgewater Community Healthcare NHS Foundation Trust	14.70%	10.60%	-4.10%	6%	1.2
Cheshire and Wirral Partnership NHS Foundation Trust	5.00%	9.10%	4.10%	8.50%	4.7
Countess of Chester NHS Foundation Trust	7.70%	9.60%	1.90%	4.90%	16.1
East Cheshire NHS Trust	6.00%	8.80%	2.80%	8.10%	4.2
Liverpool Heart and Chest Hospital NHS Foundation Trust	6.20%	3.10%	-3.10%	3.70%	- 0.7
Liverpool University Hospitals NHS Foundation Trust	7.80%	7.50%	-0.30%	3.70%	0.5
Liverpool Women's NHS Foundation Trust	3.80%	10.20%	6.40%	5.80%	2.0
Mersey Care NHS Foundation Trust	8.10%	5.60%	-2.50%	7.90%	1.5
Mid Cheshire Hospitals NHS Foundation Trust	8.90%	12.20%	3.30%	4.90%	13.1
Southport and Ormskirk Hospital NHS Trust	12.60%	10.80%	-1.80%	6.50%	- 6.3
St. Helens and Knowsley Teaching Hospitals NHS Trust	4.10%	6.40%	2.30%	6.00%	3.2
The Clatterbridge Cancer Centre NHS Foundation Trust	4.80%	7.40%	2.60%	5.30%	- 0.3
The Walton Centre NHS Foundation Trust	6.70%	4.70%	-2.00%	5.20%	- 0.4
Warrington and Halton Teaching Hospitals NHS Foundation Trust	8.60%	11.80%	3.20%	6.10%	5.0
Wirral Community Health and Care NHS Foundation Trust	5.60%	5.40%	-0.20%	6.40%	0.3
Wirral University Teaching Hospital NHS Foundation Trust	7.20%	3.90%	-3.30%	6.10%	2.5
Cheshire & Merseyside	**7.10%**	**7.30%**	**0.20%**	**5.70%**	**46.7**
NATIONAL	**7.20%**	**9.20%**	**2.00%**	**4.90%**	**N/a**

Appendix 4

System Efficiencies: Current Performance and Forecast Outturn as at Month 7 (31st October 2022)

	M7 YTD Plan £m	M7 YTD Actual £m	M7 YTD Variance £m	Annual Plan £m	M7 Forecast ACTUAL £m	M7 Forecast VARIANCE £m
CCGs/ICB	40.1	43.6	3.5	68.8	68.8	0.0
	40.1	**43.6**	**3.5**	**68.8**	**68.8**	**0.0**
Providers:						
Alder Hey Children's NHS Foundation Trust	7.5	6.7	(0.8)	14.5	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	2.2	2.2	0.0	4.2	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	4.7	4.3	(0.4)	8.3	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	6.0	5.6	(0.4)	13.4	13.4	0.0
East Cheshire NHS Trust	2.7	2.8	0.1	5.5	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	2.9	2.6	(0.2)	4.9	4.9	0.0
Liverpool University Hospitals NHS Foundation Trust	45.9	48.0	2.1	75.0	75.0	0.0
Liverpool Women's NHS Foundation Trust	3.3	3.9	0.6	5.6	5.7	0.1
Mersey Care NHS Foundation Trust	13.3	13.3	(0.0)	22.8	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	9.8	9.5	(0.3)	16.8	16.8	0.0
Southport And Ormskirk Hospital NHS Trust	4.6	4.6	0.0	10.8	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	12.4	12.4	0.0	28.1	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	3.9	3.8	(0.2)	6.8	6.8	(0.0)
The Walton Centre NHS Foundation Trust	2.6	2.6	0.0	4.9	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	6.7	6.7	0.0	15.7	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	2.4	2.2	(0.2)	4.1	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	12.2	8.0	(4.2)	20.8	20.8	0.0
Total Providers	**142.8**	**139.0**	**(3.8)**	**262.2**	**262.3**	**0.1**
Total System	**182.9**	**182.6**	**(0.3)**	**330.9**	**331.1**	**0.1**

Recurrent/Non-recurrent split of Provider CIP delivery

PROVIDERS	Recurrent				Non Recurrent				TOTAL			
	M7 YTD Actual £m	M7 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M7 YTD Actual £m	M7 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m	M7 YTD Actual £m	M7 YTD Variance £m	Forecast ACTUAL £m	Forecast VARIANCE £m
Alder Hey Children's NHS Foundation Trust	1.4	(3.3)	4.4	(5.3)	5.2	2.5	10.1	5.3	6.7	(0.8)	14.5	0.0
Bridgewater Community Healthcare NHS Foundation Trust	0.8	(0.2)	1.1	(0.7)	1.5	0.2	3.1	0.7	2.2	0.0	4.2	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.6	0.4	2.8	0.1	2.7	(0.7)	5.5	(0.1)	4.3	(0.4)	8.3	0.0
Countess of Chester Hospital NHS Foundation Trust	2.5	0.1	5.5	0.0	3.0	(0.5)	7.9	0.0	5.6	(0.4)	13.4	0.0
East Cheshire NHS Trust	0.5	(1.3)	1.6	(1.9)	2.3	1.4	3.9	1.9	2.8	0.1	5.5	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	1.9	(0.3)	3.7	(0.1)	0.7	0.1	1.2	0.1	2.6	(0.2)	4.9	0.0
Liverpool University Hospitals NHS Foundation Trust	8.0	(7.8)	13.0	(19.0)	39.9	9.9	62.0	19.0	48.0	2.1	75.0	0.0
Liverpool Women's NHS Foundation Trust	1.6	(0.6)	2.8	(1.4)	2.2	1.2	2.9	1.5	3.9	0.6	5.7	0.1
Mersey Care NHS Foundation Trust	8.9	(0.2)	15.6	0.0	4.4	0.2	7.2	0.0	13.3	(0.0)	22.8	0.0
Mid Cheshire Hospitals NHS Foundation Trust	3.5	(0.1)	6.2	(0.9)	6.0	(0.2)	10.6	0.9	9.5	(0.3)	16.8	0.0
Southport And Ormskirk Hospital NHS Trust	4.0	(0.5)	8.4	(2.4)	0.5	0.5	2.4	2.4	4.6	0.0	10.8	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	6.6	(5.8)	22.1	0.0	5.8	5.8	6.0	0.0	12.4	0.0	28.1	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	1.4	(1.2)	2.4	(2.1)	2.3	1.0	4.4	2.1	3.8	(0.2)	6.8	0.0
The Walton Centre NHS Foundation Trust	1.2	(0.8)	2.7	(1.4)	1.4	0.8	2.2	1.4	2.6	0.0	4.9	0.0
Warrington and Halton Teaching Hospitals NHS Foundation Trust	0.7	(1.9)	6.5	0.0	6.0	2.0	9.2	0.0	6.7	0.0	15.7	0.0
Wirral Community Health and Care NHS Foundation Trust	1.1	(0.5)	2.3	(0.3)	1.1	0.3	1.8	0.3	2.2	(0.2)	4.1	0.0
Wirral University Teaching Hospital NHS Foundation Trust	2.2	(5.8)	5.6	(8.2)	5.7	1.7	15.2	8.2	8.0	(4.2)	20.8	0.0
Total Providers	**48.0**	**(29.9)**	**106.8**	**(43.6)**	**91.0**	**26.1**	**155.5**	**43.7**	**139.0**	**(3.8)**	**262.3**	**0.1**

Appendix 5

Provider Cash: Cash balances as at Month 7 (31st October 2022)

PROVIDER:	MONTH 7 ACTUAL £m	31/03/2022 BALANCE £m	% INCREASE/ DECREASE TO MONTH 12 £m
Alder Hey Children's NHS Foundation Trust	82.4	91.5	(9.9%)
Bridgewater Community Healthcare NHS Foundation Trust	24.3	26.2	(7.0%)
Cheshire and Wirral Partnership NHS Foundation Trust	36.0	41.1	(12.5%)
Countess of Chester Hospital NHS Foundation Trust	26.3	40.9	(35.7%)
East Cheshire NHS Trust	37.4	37.3	0.4%
Liverpool Heart and Chest Hospital NHS Foundation Trust	41.0	42.7	(4.0%)
Liverpool University Hospitals NHS Foundation Trust	116.7	211.4	(44.8%)
Liverpool Women's NHS Foundation Trust	5.5	11.2	(50.6%)
Mersey Care NHS Foundation Trust	98.7	84.2	17.2%
Mid Cheshire Hospitals NHS Foundation Trust	15.9	26.7	(40.5%)
Southport And Ormskirk Hospital NHS Trust	4.7	18.5	(74.6%)
St Helens And Knowsley Teaching Hospitals NHS Trust	80.6	54.2	48.8%
The Clatterbridge Cancer Centre NHS Foundation Trust	75.5	80.7	(6.4%)
The Walton Centre NHS Foundation Trust	41.6	40.7	2.1%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	38.4	44.7	(14.0%)
Wirral Community Health and Care NHS Foundation Trust	18.1	23.8	(24.2%)
Wirral University Teaching Hospital NHS Foundation Trust	15.7	36.4	(56.8%)
Total Providers	**758.9**	**912.1**	**-17%**

Appendix 6

Provider BPPC: Performance against BPPC targets as at Month 7 (31st October 2022)

Providers	Month 722/23			
	BPPC	BPPC	BPPC	BPPC
	NHS - By Value	NHS - By Number	Non NHS - By Value	Non NHS - By Number
Alder Hey Children's NHS Foundation Trust	64.1%	67.2%	86.2%	81.7%
Bridgewater Community Healthcare NHS Foundation Trust	99.9%	98.7%	99.5%	99.5%
Cheshire and Wirral Partnership NHS Foundation Trust	86.4%	83.3%	91.3%	93.5%
Countess of Chester Hospital NHS Foundation Trust	91.9%	83.6%	89.7%	89.4%
East Cheshire NHS Trust	99.3%	93.7%	94.8%	94.4%
Liverpool Heart and Chest Hospital NHS Foundation Trust	99.5%	96.2%	98.7%	96.6%
Liverpool University Hospitals NHS Foundation Trust	97.5%	85.1%	93.3%	90.1%
Liverpool Women's NHS Foundation Trust	80.0%	39.2%	86.1%	81.6%
Mersey Care NHS Foundation Trust	94.8%	94.9%	93.2%	95.2%
Mid Cheshire Hospitals NHS Foundation Trust	93.8%	69.4%	91.1%	91.4%
Southport And Ormskirk Hospital NHS Trust	96.1%	83.6%	96.0%	90.9%
St Helens And Knowsley Teaching Hospitals NHS Trust	87.2%	93.8%	97.3%	95.7%
The Clatterbridge Cancer Centre NHS Foundation Trust	98.6%	98.7%	99.4%	98.1%
The Walton Centre NHS Foundation Trust	75.3%	58.9%	89.3%	88.6%
Warrington and Halton Teaching Hospitals NHS Foundation Trust	83.7%	79.1%	92.6%	91.9%
Wirral Community Health and Care NHS Foundation Trust	84.6%	88.8%	92.7%	91.0%
Wirral University Teaching Hospital NHS Foundation Trust	94.5%	89.8%	94.9%	95.1%

Appendix 7

Provider Capital: Current Performance and Forecast Outturn as at Month 7 (31st October 2022)

(based on formal reporting to NHSEI)

Excluding IFRS16 Impact

PROVIDER:	M7 YTD PLAN £m	M7 YTD ACTUAL £m	M7 YTD VARIANCE £m	ANNUAL PLAN £m	M7 FORECAST ACTUAL £m	M7 FORECAST VARIANCE £m
Alder Hey Children's NHS Foundation Trust	3.0	3.8	(0.8)	8.9	8.9	0.0
Bridgewater Community Healthcare NHS Foundation Trust	1.6	0.6	1.1	2.1	2.1	0.0
Cheshire and Wirral Partnership NHS Foundation Trust	1.8	1.2	0.6	2.6	2.5	0.1
Countess of Chester Hospital NHS Foundation Trust	6.1	5.9	0.2	19.9	19.9	0.0
East Cheshire NHS Trust	3.6	0.7	2.8	6.1	6.1	0.0
Liverpool Heart and Chest Hospital NHS Foundation Trust	4.9	3.2	1.7	11.3	11.3	0.0
Liverpool University Hospitals NHS Foundation Trust	32.8	21.6	11.3	62.6	62.6	0.0
Liverpool Women's NHS Foundation Trust	7.2	3.3	3.9	8.8	8.8	0.0
Mersey Care NHS Foundation Trust	5.1	4.2	0.9	11.1	11.1	0.0
Mid Cheshire Hospitals NHS Foundation Trust	14.5	13.8	0.8	37.9	38.0	(0.0)
Southport And Ormskirk Hospital NHS Trust	5.0	4.3	0.7	11.3	11.3	0.0
St Helens And Knowsley Teaching Hospitals NHS Trust	3.2	1.2	2.1	4.5	4.5	0.0
The Clatterbridge Cancer Centre NHS Foundation Trust	4.2	0.7	3.6	7.0	7.0	0.0
The Walton Centre NHS Foundation Trust	3.3	1.2	2.0	5.7	5.7	0.0
Warrington and Halton Teaching Hospitals NHS Foundation	4.5	3.8	0.7	12.5	12.5	0.0
Wirral Community Health and Care NHS Foundation Trust	5.3	4.1	1.2	9.4	9.4	0.0
Wirral University Teaching Hospital NHS Foundation Trust	6.6	7.5	(1.0)	11.9	11.9	0.0
Total Charge against System Operational Capital Plan	**112.6**	**80.9**	**31.7**	**233.7**	**233.6**	**0.1**
System Operational Capital Allocation				**221.8**	**233.6**	**11.8**

Note: brackets denote deficit/overspend

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Quality and Performance Report

Agenda Item No	**ICB/11/22/11**
Report author & contact details	Andy Thomas
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Quality and Performance Report
Board Summary

Executive Summary	The attached presentation (Appendix A) provides on overview of key sentinel metrics drawn from the 2022/23 Operational plans, specifically Urgent Care, Planned Care, Cancer Care, Mental Health and Primary Care, as well as a summary of key issues, impact, and mitigations.				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • note the contents of the report and take assurance on the actions contained.				
Key issues	• the urgent and emergency care system continues to experience significant pressure across the whole of NHS Cheshire & Merseyside. • significant backlog for both elective and cancer care.				
Key risks	• impact on ambulance response times, ambulance handover times, long waits in ED resulting in poor patient outcomes and poor patient experience. • long waits for cancer and elective treatment resulting in poor outcomes.				
Impact (x) (further detail to be provided in body of paper)	**Financial**	**IM &T**	**Workforce**	**Estate**	
			X		
	Legal	**Health Inequalities**	**EDI**	**Sustainability**	
		X			
Route to this meeting	n/a				
Management of Conflicts of Interest	n/a				
Patient and Public Engagement	n/a				
Equality, Diversity, and Inclusion	n/a				
Health inequalities	n/a				
Next Steps	n/a- regular report				
Appendices	Appendix A – Sentinel Metrics				

Quality and Performance Report
Board Summary

1. Urgent Care

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

1.2 All acute hospitals across the system report daily against a nationally defined set of Operational Pressures Escalation Levels (OPEL). Trusts across C&M have been consistently reporting at OPEL 3 for an extended period. OPEL 3 is defined as 'the local health and social care system is experiencing major pressures compromising patient flow'. Trusts often report that they are close to OPEL 4, the highest level of escalation. North West Ambulance Service (NWAS) is consistently reporting at Resource Escalation Action Plan (REAP) Level 4, its highest escalation, with C&M recently under the greatest pressure across the NW region in terms of handover delays and Category 2 response times.

1.3 Within Acute Trusts, OPEL 3 is manifested by high bed occupancy, including significant and rising numbers of patients no longer meeting the criteria to reside in hospital, who now occupy over 20% of hospital beds. In conjunction with the continued underlying level of COVID-19 (5% of hospital beds occupied by patients with COVID-19 at time of this report), this in turn means that there are insufficient beds to admit patients from the Emergency Department or direct admissions requiring beds.

1.4 The impact on ED of delays from decision to admit is crowding in department and in waiting areas and corridor care, with the numbers of patients waiting more than 12 hours in A&E from a decision to admit increasing steeply over recent months.

1.5 This has an onward impact in terms of ambulance handover delays which have risen substantially in September and October, with significant numbers of delays seen at almost all Acute Trusts and ultimately significant delays to ambulance response times, particularly Category 2 calls, which although better improved from the same period in 2021, are still much longer than the Cat 2 standard of 18 minutes.

1.6 The majority of C&M acute Trusts with an Emergency Department are reporting occupancy in a range from 97%-100%, despite the opening of additional beds, i.e., escalation capacity usually reserved for winter throughout the summer due to the sustained pressure on bed capacity. The lower occupancy levels reported in the performance tables reflect the inclusion of specialist Trusts.

1.7 As the OPEL declaration relates to the local health and social care system as a whole, it should be noted that constant OPEL 3 or higher pressures reflect that community and mental health capacity is full, that there is pressure on GP and/or Out of Hours services, and that social services are severely constrained in their ability to facilitate care packages, discharges to care settings etc.

1.8 In terms of mitigations, the ICB is implementing a range of actions in response to the national winter planning guidance, coordinated by the Winter Planning Operational Group. This is detailed in a separate update on Winter Planning 2022/23.

1.9 These mitigations include plans to open an additional 205 beds over the course of the winter. The first tranche of beds (76) was planned to be opened over the course of October, however in response to current pressures this has been accelerated and 130 of the 205 beds are now open.

1.10 In addition, the ICB has identified a Place level 'best practice checklist' for admission avoidance and discharge and is holding a series of Place Review meetings to stress test plans, 6 out of 9 of which have now been held.

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

2. Elective Care & Diagnostics

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

2.2. Due to the backlog of elective patients that built up during the pandemic, the numbers of patients waiting over 104 weeks for treatment grew from 30 in April 2021 to a peak of 1,235 in February 2022. Following focused work on long waits across C&M, by the end of July 2022, long waits were substantially reduced, and C&M had zero patients waiting over 104 weeks except for legitimate exemptions relating to patient choice.

2.3. The current priority is on eliminating waits in excess of 78 weeks by the end of March 2023. As at the week ending 06 November 2022, 3,481 patients across Cheshire & Merseyside were waiting over 78 weeks.

2.4. Whilst long waits for elective treatment are a recognised issue for all Trusts, the largest backlogs are at Liverpool University Hospitals (1,971), Countess of Chester (342) and St Helens & Knowsley (490) which together account for just over 80% of the 78-week challenge. The Elective Recovery Programme is leading on work across C&M to support Trusts with the management of their waiting lists, with a particular focus on supporting LUHFT and Countess of Chester. Current clearance rates are consistent with achievement of the elimination of 78 2week waits, but this is subject to risk of disruption due to winter pressures and potential industrial action.

2.5. The challenge of reducing and ultimately eliminating long waits relies not only on the actions of individual trusts, but also on collaborative efforts to increase elective activity, which includes work to improve theatre utilisation across the whole of C&M, and also the expansion of capacity through the creation of elective hubs, with the Cheshire & Merseyside Elective Centre at Clatterbridge opening in October, and the Cheshire & Merseyside Elective Centre at Broadgreen opening in January 2023.

2.6. Elective recovery is measured in terms of value-weighted elective activity for access to the Elective Recovery Fund. By this measure, the latest published data for the month ending 31 July 2022, taken from SUS puts C&M at 93.4% of 2019/20 spend value compared to 91.3% for the North West, and 94.9% for England.

2.7. A national ambition has been set for diagnostic activity across a range of common diagnostic tests to be at 120% of pre-pandemic levels. Currently C&M is performing at 106.4% for the latest reporting period.

3. Cancer

3.1. A sharp and sustained rise in urgent suspected cancer referrals (consistently 120% of pre-pandemic levels), capacity constraints experienced during each wave of COVID-19, alongside ongoing diagnostic backlogs and workforce constraints has resulted in the total cancer waiting list increasing considerably.

3.2. The over 62-day cancer backlog stands at 2,205 as of 23 October 2022. The 2022/23 ICB operational plan aims to reduce this to 713 by March 2023 which is a level judged to allow delivery of the 62-day access standard for treatment.

3.3. C&M performance against the key operational waiting time standards is below plan: Although more patients than ever ae being seen within 14 days, high demand has seen performance remain below standard at 73.97% against the 14-day urgent referral 93% standard (compared to 71.07% for the Northwest).

3.4. Performance stands at 66.1% against the 28-day faster diagnosis 75% standard, 94.87% against the 31-day first treatment 96% standard, which is below target but above the NW region average.

3.5. The Cheshire and Merseyside Cancer Alliance (CMCA) maintains oversight of performance across C&M including a system level Patient Tracking List (PTL), targeted support for the most challenged trusts, including LUHFT and Southport & Ormskirk who have been provided with additional resources to support rapid improvement.

4. Mental Health & Learning Disabilities

4.1 Increased demand, acuity and complexity of cases continue to cause system wide pressure and adverse impacts on MH acute care flow. The ICB is not currently meeting the national ambition to eliminate out of area placements for adults in acute inpatient care as a result.

4.2 MH Delayed Transfers of Care are on an ongoing challenge, with issues escalated via Multi Agency Discharge Events, A&E boards, economy wide meetings, and more recently with NHS England discharge meetings.

4.3 Workforce is a significant risk in terms of delivery of the LTP ambitions, across a wide range of staffing groups.

4.4 Additional non-recurrent funding has been secured to facilitate an extension of S136 observational support in acute hospital places of safety until 31st March 2023. ICB Executive Directors have provided a mandate for further system-wide discussions to address some of the delays in S136 processes. If delays are reduced, the requirement for Prometheus observational support will reduce.

4.5 In terms of performance, access remains significantly below trajectory in a number of LTP areas. Recovery Action Plans have been agreed with NHSE/I for out of area placements, Individual Placement and Support Services, Perinatal MH services and IAPT access, as it is acknowledged that trajectories cannot be achieved by year end, in line with LTP ambitions.

4.6 Although currently anticipated to be one year behind trajectory as a result of workforce challenges, progress is positive in respect of perinatal MH access. However, ongoing data quality issues are resulting in this currently not being reflected in nationally published data. Work is underway to address this.

4.7 MH in School Teams have been implemented in all nine places and continue to contribute to Children and Young People's MH access rates. However, further work is required to ensure that all this activity is captured in data sets and appropriately reported.

4.8 Access to Physical Health Checks for people with Severe Mental Illness (SMI) are continuing to improve following the deployment of additional non-recurrent funding to support tailored outreach services.

4.9 For annual health checks for people over 14 with a learning disability, this is a GP enhanced service. The uptake of LD AHCs has significantly improved in Cheshire and Merseyside over the last couple of years, achieving an average of 71.7% in 2021-22. Work continues to maintain the accuracy of the GP Learning Disability register, to ensure that LD patients are invited for LD AHCs as appropriate. Early uptake data indicates that the delivery profile remains like the previous year, therefore as in previous years it is anticipated that delivery will peak in Q3 and Q4.

5. Summary/Recommendations

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

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Quality and Performance Report

Appendices

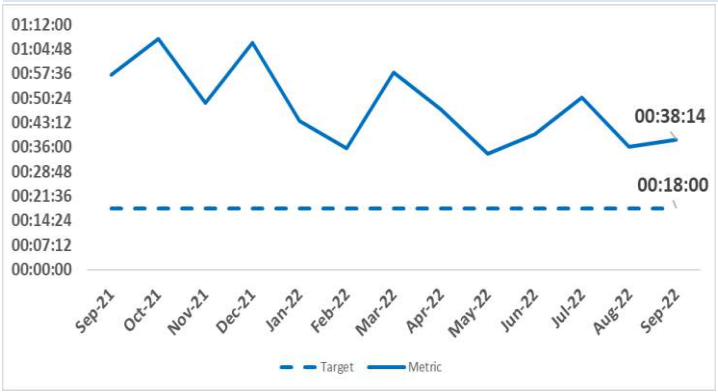
- **Appendix A:** Sentinel Metrics

NHS
Cheshire and Merseyside

Appendix A – Key Sentinel Metrics

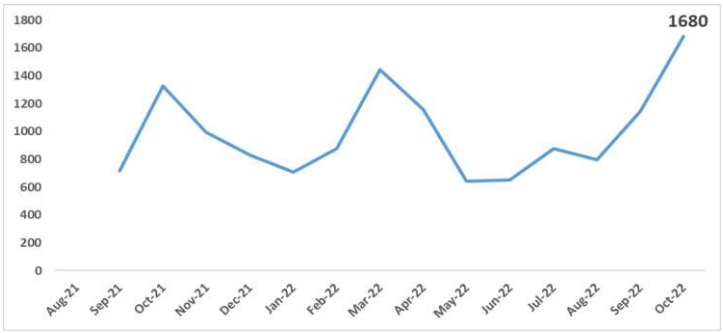
Section I: Urgent Care

Ambulance Response times – Cat 2



Organisation	Jul-22	Aug-22	Sep-22
Cheshire & Merseyside	00:50:28	00:36:06	00:38:14
North West	00:39:07	00:41:12	00:44:35
England	00:54:08	00:36:06	00:40:57

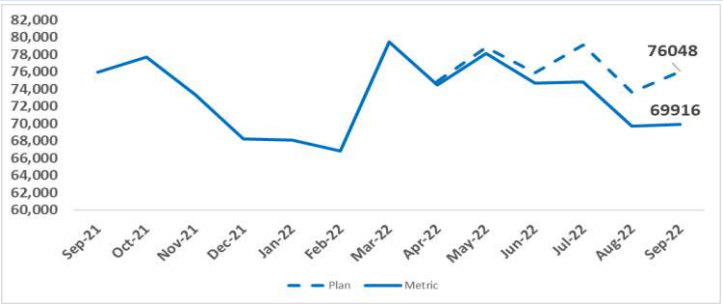
Ambulance Arrival to handover >60 mins

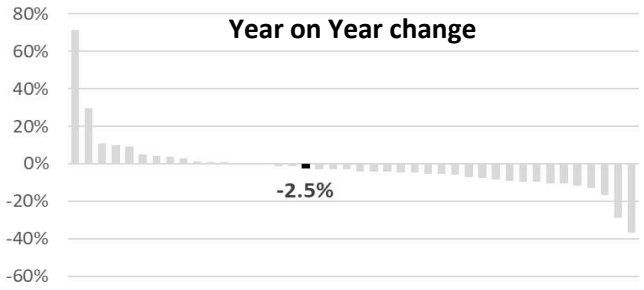


Organisation	Jul-22	Aug-22	Sep-22	Oct-22*
Cheshire & Merseysic	876	796	1142	1680
North West	3517	3407	3990	5108
England				

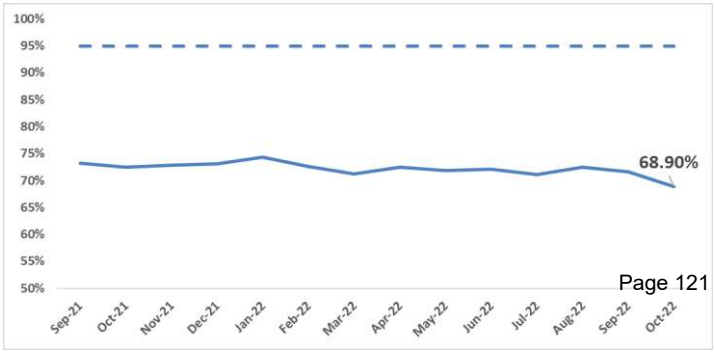
* - Local NWAS data to 31st October

A&E Attendances (Type 1)





A&E 4 Hour Standard



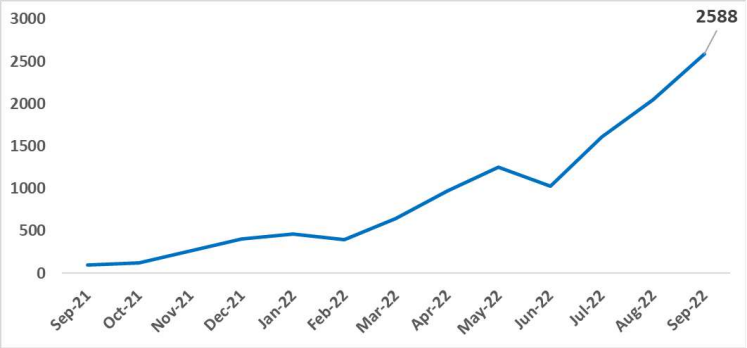
Organisation	Jul-22	Aug-22	Sep-22	*Oct-22
Cheshire & Merseyside	71.10%	72.50%	71.60%	68.90%
North West		68.90%	66.30%	65.30%
England		71.30%	67.90%	66.60%

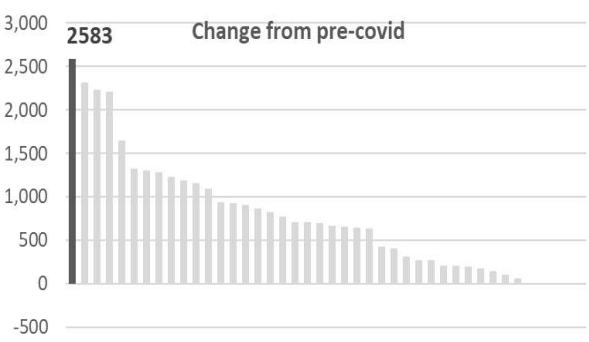
* - To 24th October

NHS
Cheshire and Merseyside

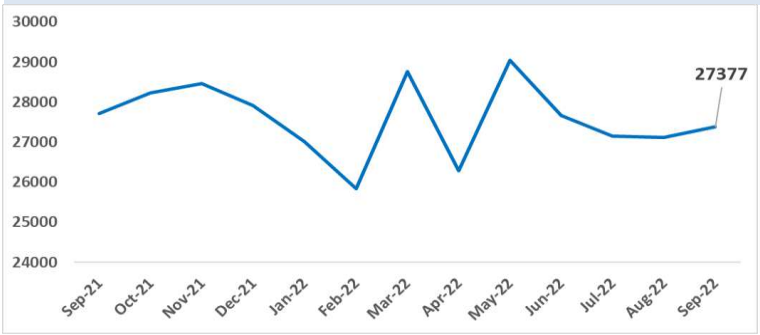
Section I: Urgent Care

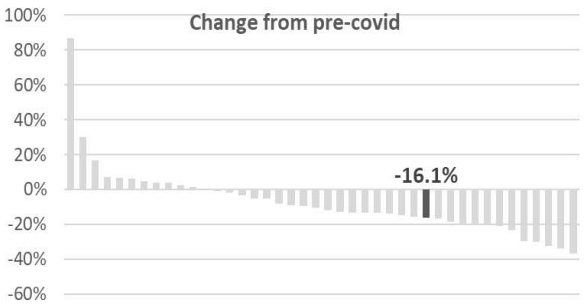
A&E 12 hour delays from decision to admit



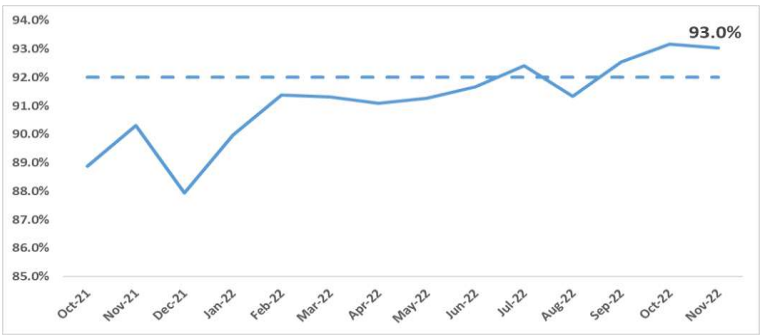


Total Emergency admissions





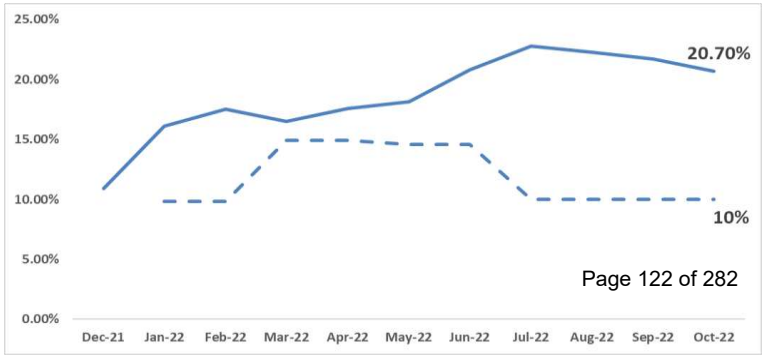
Bed Occupancy General & Acute



Organisation	Aug-22	Sep-22	Oct-22	Nov 22*
Cheshire & Merseyside	91.3%	92.5%	93.2%	93.1%
North West	92.1%	92.9%		
England	92.6%	93.4%		

* - Daily average to 7th November

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



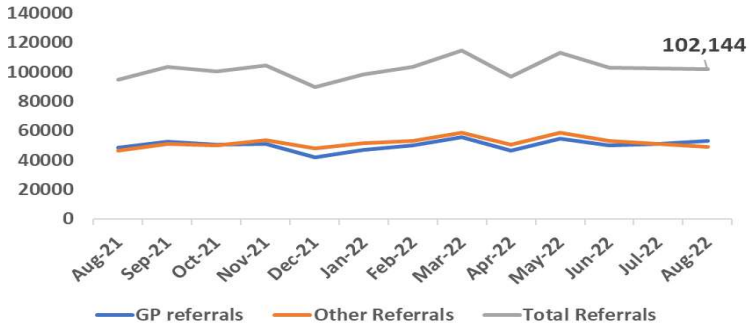
Organisation	Jul-22	Aug-22	Sep-22	*Oct-22
Cheshire & Merseyside	22.80%	22.30%	21.70%	20.70%
North West	18.7%	18.9%	18.5%	18.3%
England				

* On 30th October

NHS
Cheshire and Merseyside

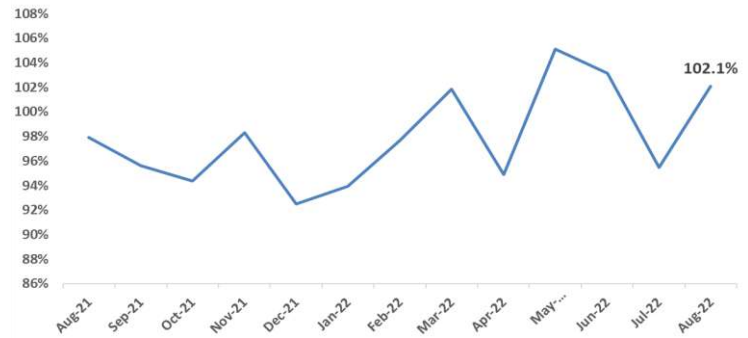
Section II: Planned Care

Referrals - August 22



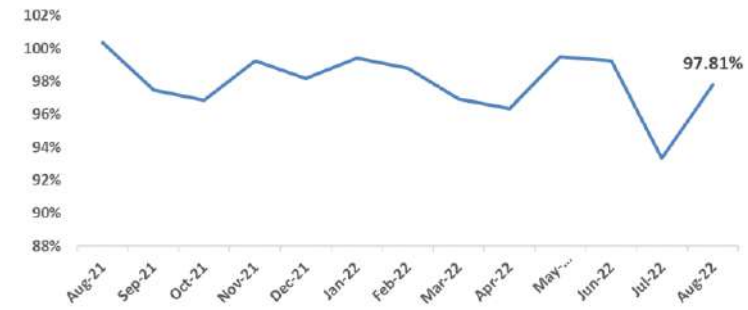
Organisation	Jun-22	Jul-22	Aug-22
Cheshire & Merseyside	102,951	102,259	102,144
North West	231,542	230,357	243,472
England	1,775,937	1,798,905	1,745,570

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



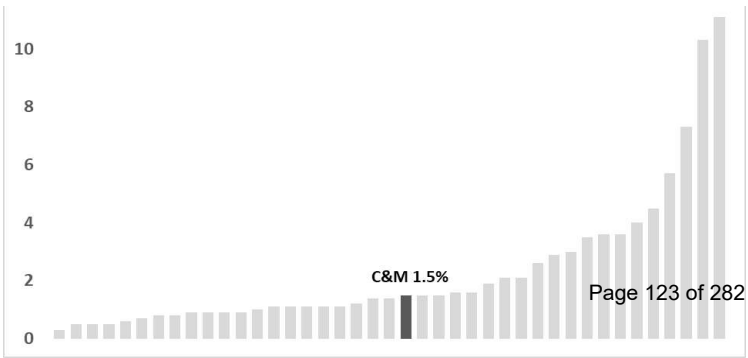
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	103.2%	95.5%	102.1%
North West	N/A	N/A	N/A
England	99.0%	95.1%	96.7%

Outpatient Follow-up % of pre-COVID activity - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	99.25%	93.31%	97.81%
North West	N/A	N/A	N/A
England	102.10%	97.46%	99.83%

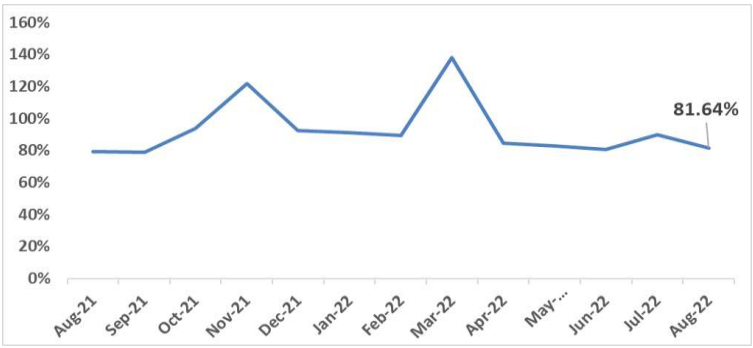
Patient Initiated Follow-up (PIFU) ICS Benchmark - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	2.2%	1.0%	1.5%
North West	1.4%	1.0%	1.5%
England	1.6%	1.6%	1.5%

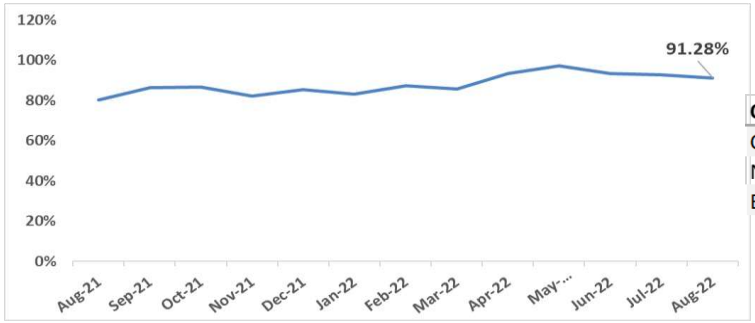
Section II: Planned Care

Elective inpatient admissions % of pre-COVID activity - August 22



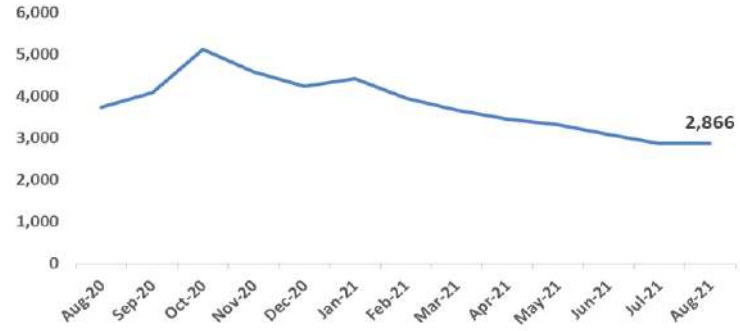
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	80.78%	89.95%	81.64%
North West	N/A	N/A	N/A
England	84.22%	87.23%	81.24%

Day cases % of pre-COVID activity - August 22



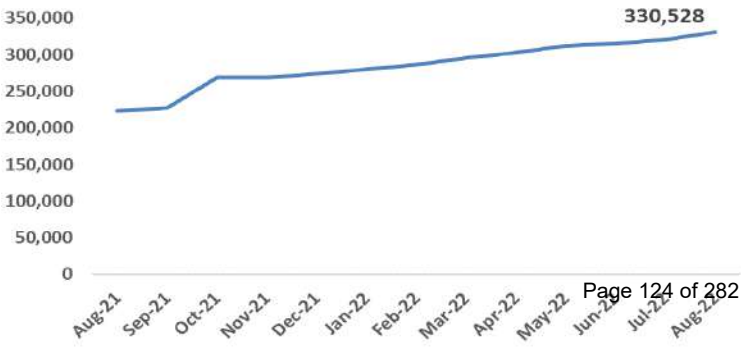
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	93.39%	92.80%	91.28%
North West	N/A	N/A	N/A
England	94.69%	95.54%	95.05%

The number of people waiting 78 Weeks or more - August 22



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	3094	2866	2866
North West	8416	8793	9345
England	53911	51838	50888

Waiting list (RTT total incompletes) - August 22



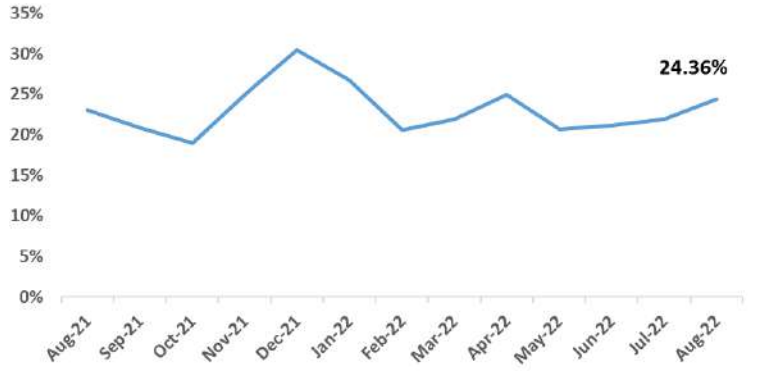
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	315,138	320,215	330,528
North West	907,213	928,072	951,384
England	6,248,645	6,351,957	6,507,743

Section II: Planned Care

Diagnostic Activity: % of pre-COVID activity (March 2019 to February 2020) - August 22

Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	101.84%	94.18%	106.39%
North West	100.65%	93.84%	102.91%
England	101.20%	93.98%	105.15%

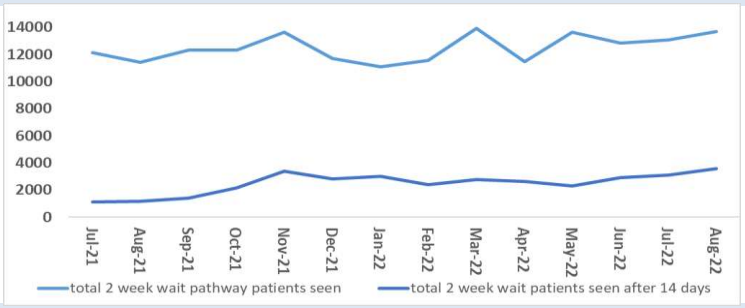
Diagnostic 6 week wait – objective no more than 1%



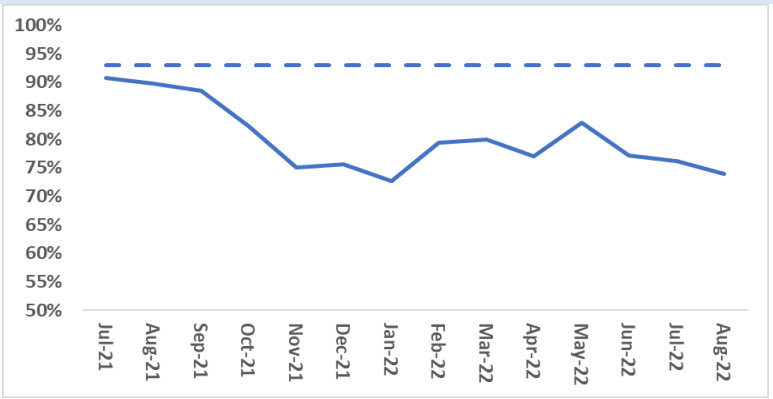
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	21.16%	21.92%	24.36%
North West	26.90%	26.30%	30.63%
England	70.73%	70.73%	73.17%

Section III: Cancer Care

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

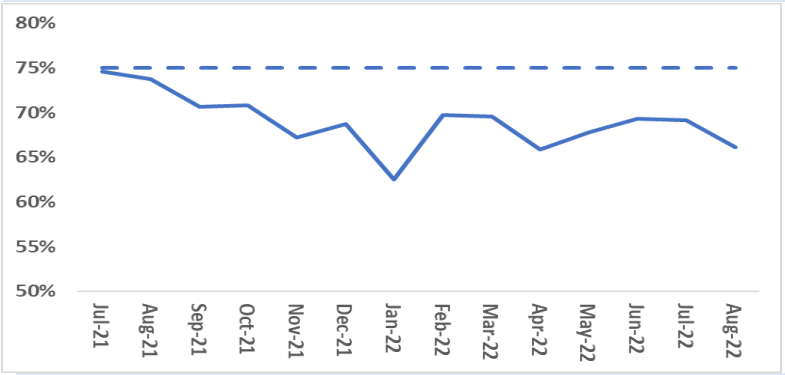


% of patients who waited for less than 14 days to be seen after referral



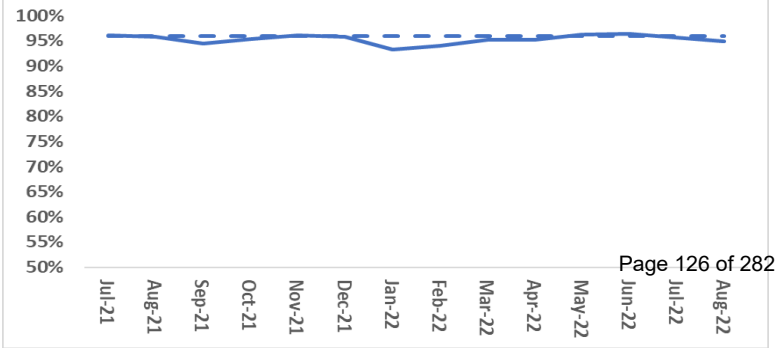
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	77.16%	76.15%	73.97%
North West	75.20%	75.80%	71.07%
England	77.70%	77.80%	75.60%

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



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	69.30%	68.90%	66.10%
North West	67.60%	66.30%	65.30%
England	70.30%	71.09%	69.45%

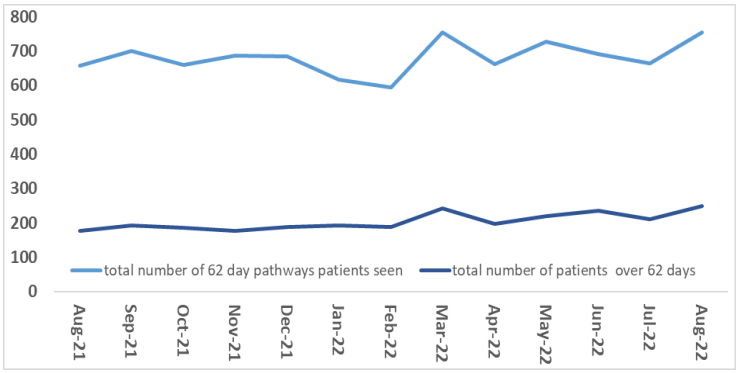
% of patients diagnosed with cancer receiving treatment within 31 days of diagnosis



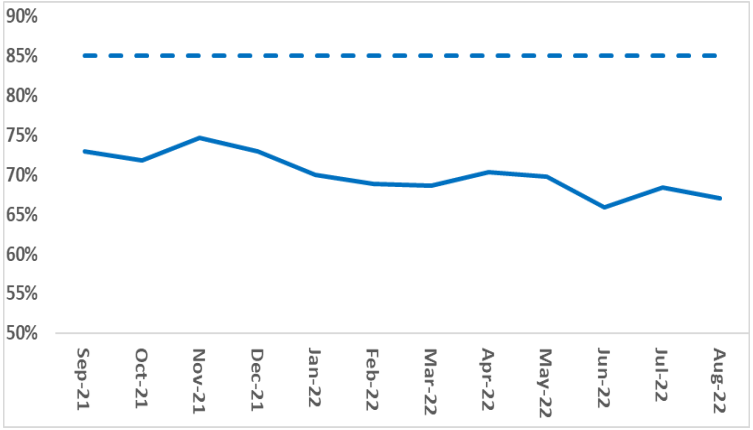
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	96.10%	96.30%	94.87%
North West	93.00%	94.40%	93.10%
England	91.80%	92.90%	92.09%

Section III: Cancer Care

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



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



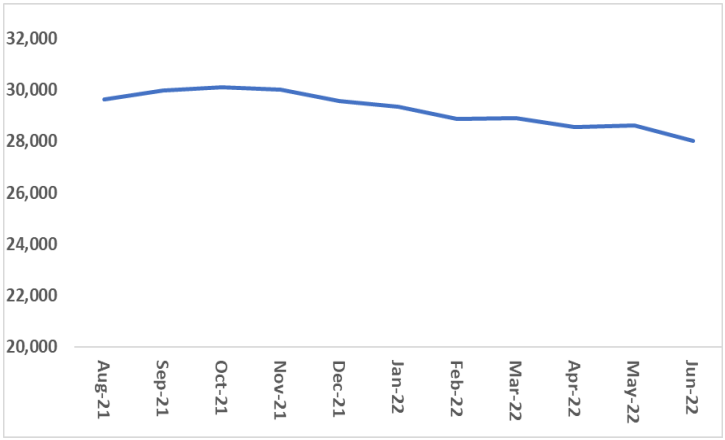
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	65.10%	68.37%	67.57%
North West	59.00%	61.30%	60.70%
England	59.90%	61.60%	61.90%

Over 62 day cancer backlog *as at 23rd Oct 22

Organisation	Jul-22	Aug-22	Sep-22	Oct-22
Cheshire and Merseyside	1805	1741	1938	2205
North West	4675	4489	5422	5948
England	30414	31036	33814	33207

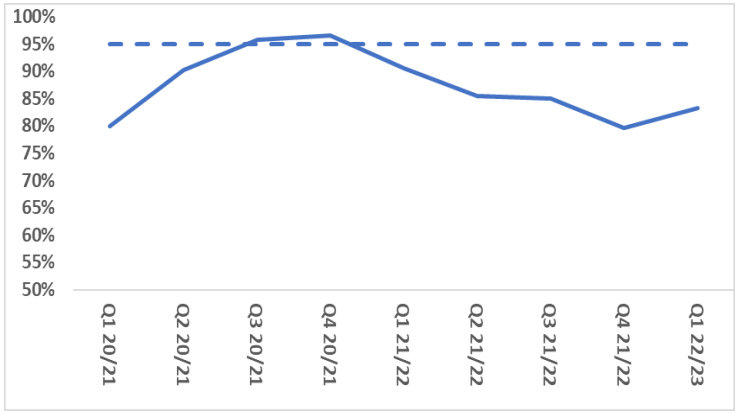
Section IV: Mental Health

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



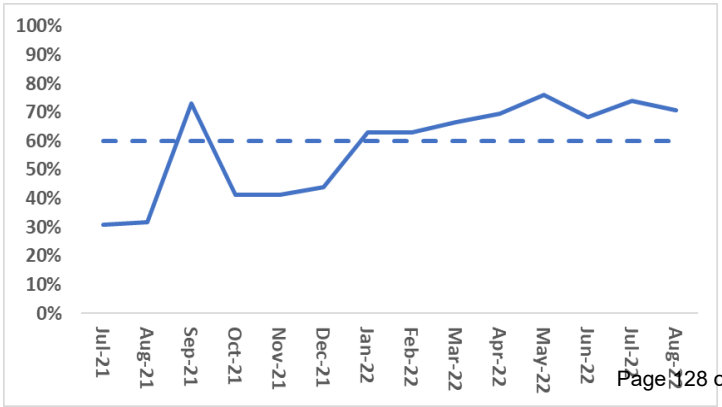
Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	28560	28610	28010
North West	92591	94070	93827
England	677230	689380	691935
Source: NHS Futures core data pack			

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



Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	85%	79.6%	83.3%
North West	85%	90.9%	71.0%
England	59%	61.9%	68.1%
* *12 months to end of quarter*			

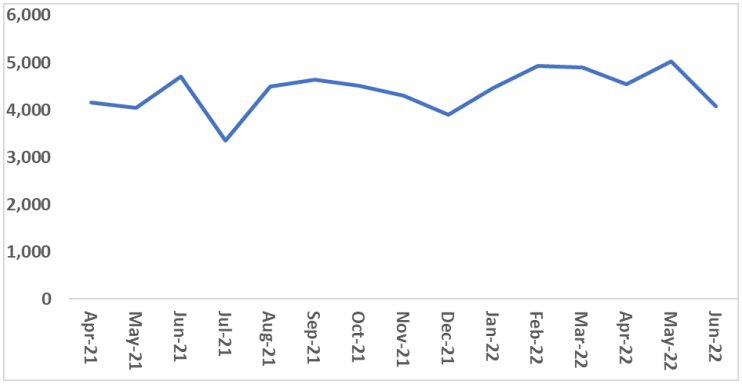
% of open referrals on EIP pathway that waited for treatment within two weeks *rolling 3 months



Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	68.18%	74.07%	70.83%
North West	-	-	-
England	67.80%	68.80%	69.50%

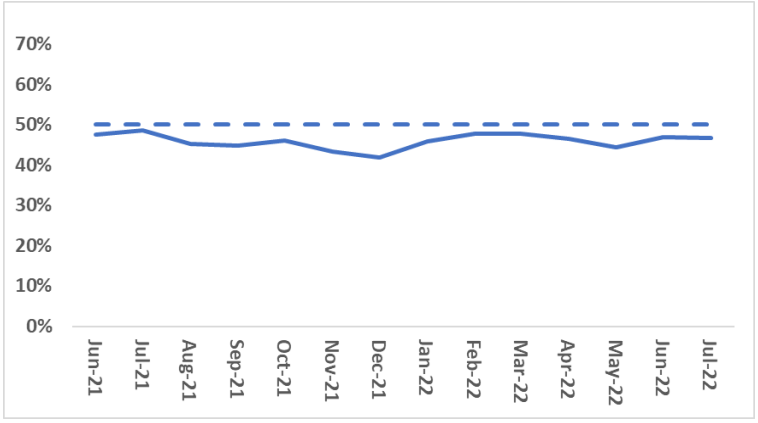
Section IV: Mental Health

IAPT access: No of people entering NHS funded treatment



Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	4535	5020	4080
North West	13538	14682	12789
England	96515	110327	98827
Source: NHS Futures core data pack			

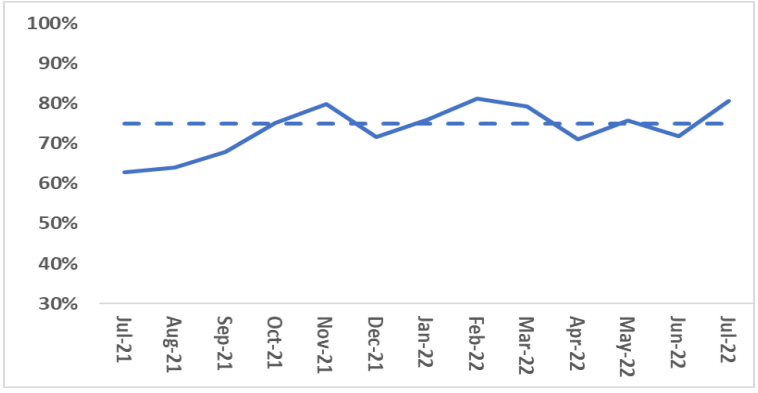
IAPT recovery: % of people that attended at least 2 treatment contacts and are moving to recovery



Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseysi	46.00%	44.38%	47.03%
North West	49.00%	49.00%	47.00%
England	50.50%	50.10%	49.60%

*Benchmarking is a month in arrears

The percentage of IAPT Waiting under 6 weeks



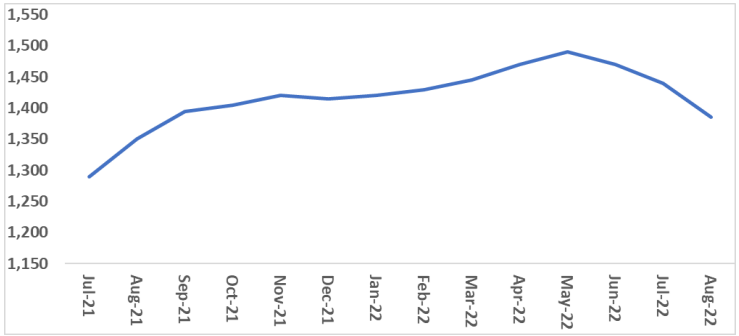
Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseysi	71.00%	75.65%	71.91%
North West	69.00%	71.00%	68.00%
England	74.20%	76.10%	73.20%

*Benchmarking is a month in arrears

NHS
Cheshire and Merseyside

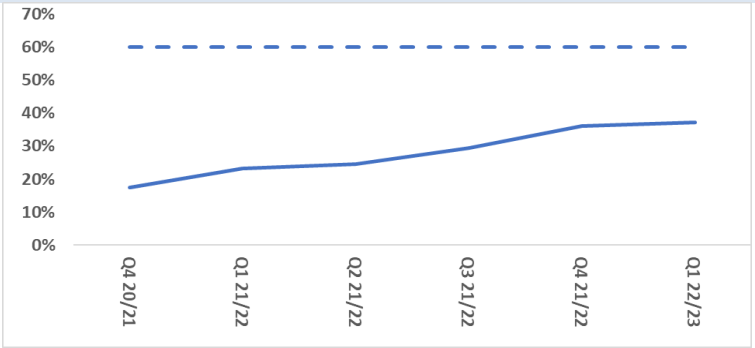
Section IV: Mental Health

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



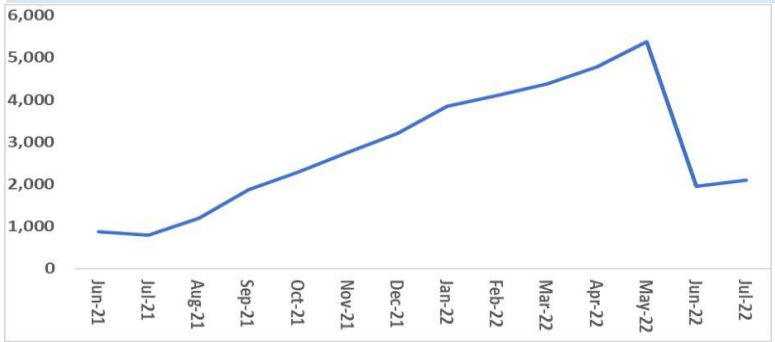
Organisation	Jun-22	Jul-22	Aug-22
Cheshire and Merseyside	1,500	1,440	1,385
North West	5,540	5,545	5,525
England	45,410	44,865	44,790

Physical health checks for people with severe mental illness



Organisation	Q3 21/22	Q4 21/22	Q1 22/23
Cheshire and Merseyside	29.4%	36.2%	37.2%
North West	32.1%	41.7%	42.0%
England	34.9%	42.8%	43.5%
source: NHS Statistics SMI published data			

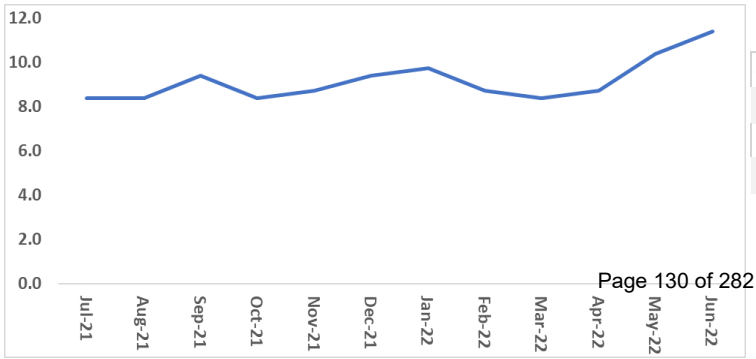
Total number of inappropriate adult acute mental health out of area placements bed days : *rolling 3 month periods*



Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	5380	1960	2095
North West	9110	5555	5560
England	54090	51390	52815
Source: NHS Futures OAP report			

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

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

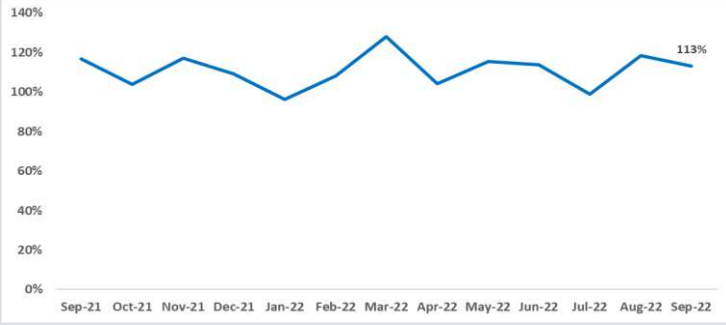


Organisation	Apr-22	May-22	Jun-22
Cheshire and Merseyside	8.72	10.39	11.4
North West	9.05	10.47	11.4
England	7.28	7.73	7.01

NHS
Cheshire and Merseyside

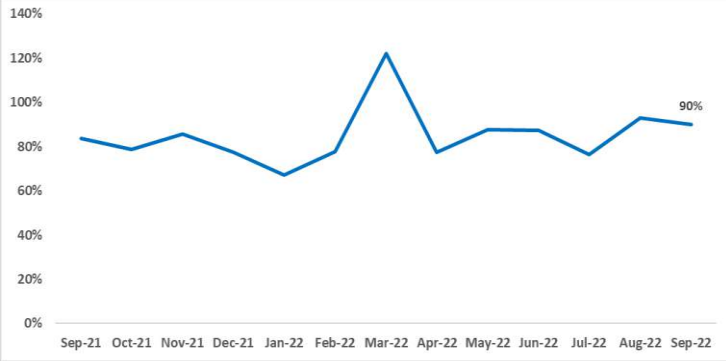
Section V: Primary Care

Total appointments delivered against pre-covid baseline



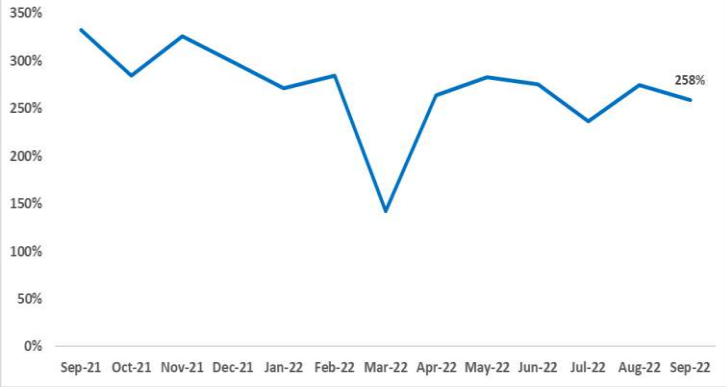
Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	100.1%	118.5%	113.2%
North West	99.7%	122.4%	113.8%
England	98.5%	117.7%	111.1%

Face to Face appointments delivered against pre covid baseline



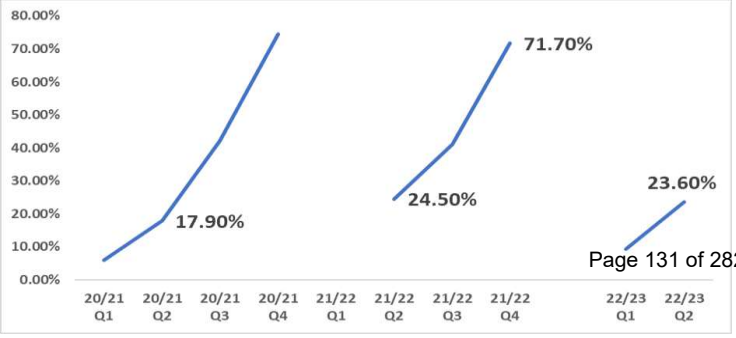
Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	76.5%	92.9%	89.8%
North West	81.2%	94.0%	93.3%
England	81.0%	93.5%	92.9%

Telephone appointments delivered against pre-covid baseline



Organisation	Jul-22	Aug-22	Sep-22
Cheshire and Merseyside	236.2%	274.5%	258.4%
North West	278.8%	322.6%	299.9%
England	225.1%	256.6%	241.0%

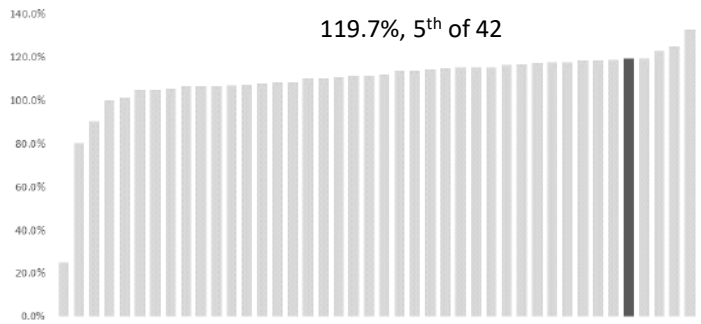
Number of people aged 14+with a learning disability on the GP register receiving an annual health check



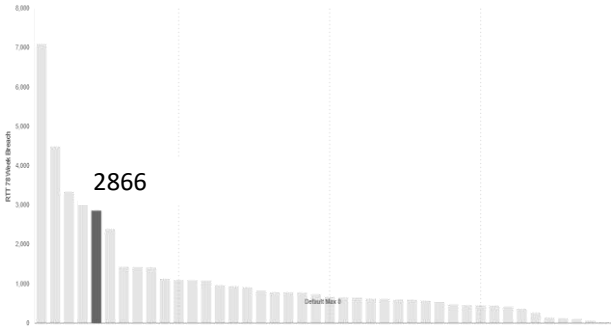
Organisation	Jul-22	Aug-22	Sep-22
Cheshire & Merseyside	14.1%	18.7%	23.6%
North West	13.8%	18.7%	24.1%
England	15.0%	20.2%	26.0%

ICB – National Performance Ambition Metrics

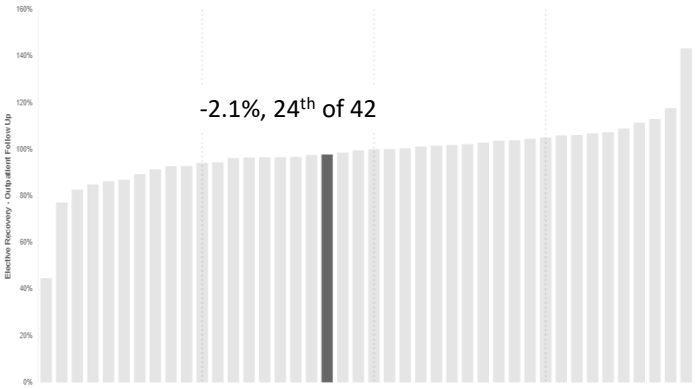
Increase diagnostic activity to 120% pre-pandemic levels



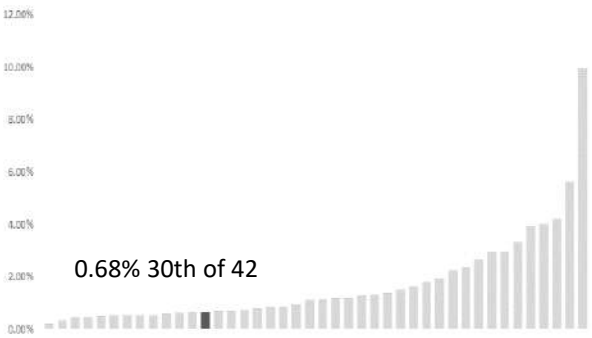
Eliminate 78 week waiters by the end of March 2023



25% reduction in outpatient follow up attendances

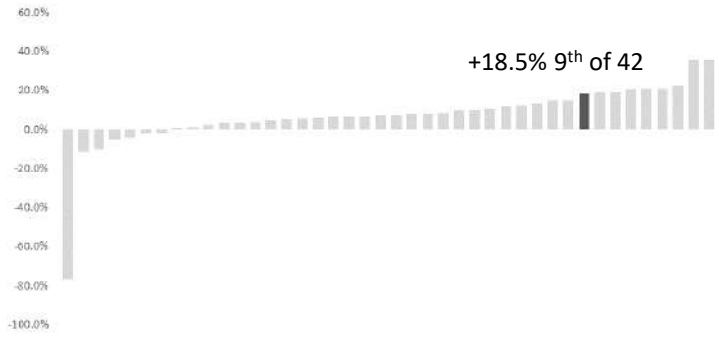


5% of outpatient attendances to convert to PIFU pathways

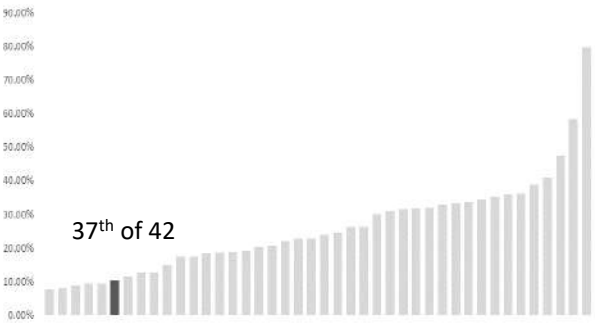


10% more patients to complete treatment through a combination of completed pathways (4% via clock stops and 6% via Advice & Guidance deflections)

Clock stops



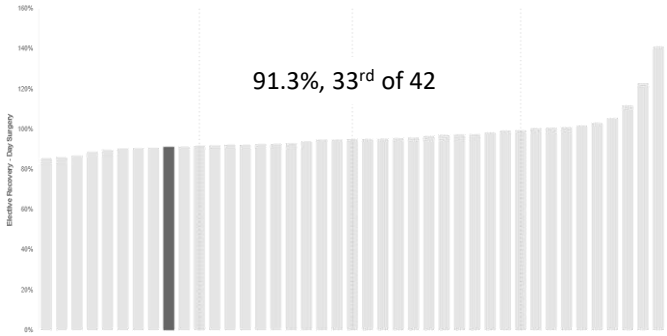
Advice & Guidance



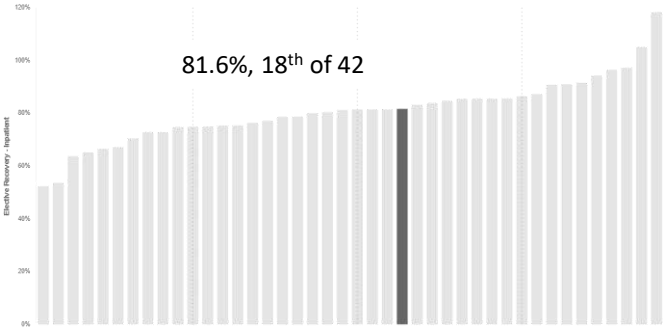
ICB – National Performance Ambition Metrics

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

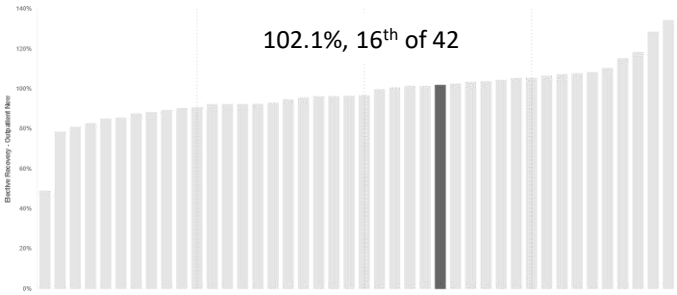
Day case



Ordinary admissions



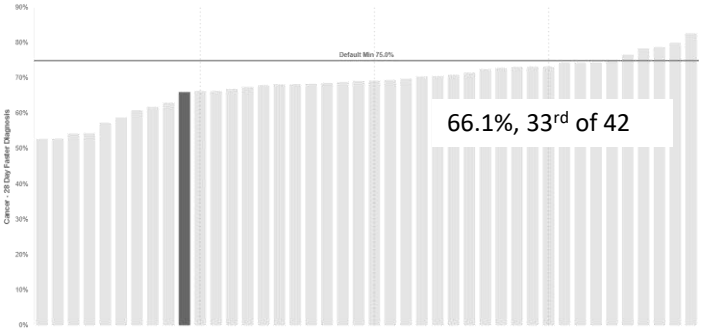
Outpatient new



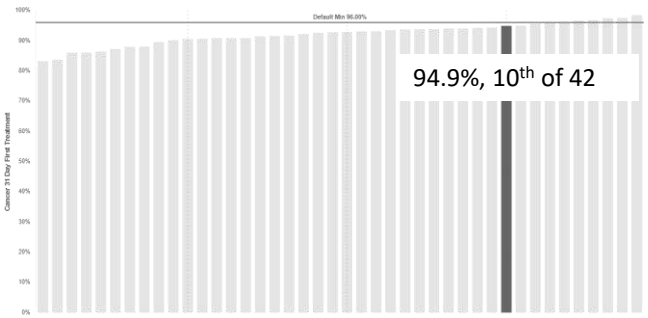
ICB – National Performance Ambition Metrics

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

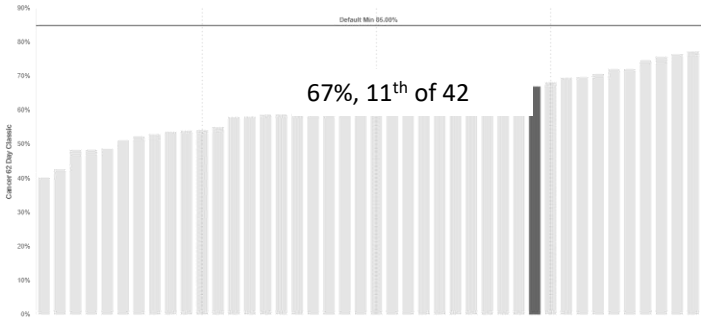
28 day faster diagnosis (75% standard)



31 day decision to treat (96% standard)



62 day referral to treat (85% standard)



NHS Cheshire and Merseyside Integrated Care Board Meeting

Date: 28th November 2022

Cheshire and Merseyside ICS Digital and Data Strategy

Agenda Item No	**ICB/11/22/12**
Report author & contact details	John Llewellyn, Chief Digital Officer John.Llewellyn@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director)	ICB Executive Group – 27th October 2022 ICB Transformation Committee – 10th November 2022
Responsible Officer to take actions forward	John Llewellyn, Chief Digital Officer

ICS Digital and Data Strategy

<table>
<tr><td>Executive Summary</td><td colspan="5">The ICS Digital and Data Strategy has been developed following widespread engagement across the system, socialisation of a draft strategy for further feedback and refinement before receiving endorsement from the ICB Executive Group and ICB Transformation Committee. The report outlined below provides additional details around this process, the outcomes and the next planned steps following ICB Board endorsement and subsequent approval of the strategy.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td></td><td></td><td></td><td></td><td>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• ENDORSE the ICS Digital and Data Strategy with a view to formal approval at a subsequent ICB Board meeting.</td></tr>
<tr><td>Key issues</td><td colspan="5">The strategy addresses three key issues:
• The need to address systemic inequalities through ‘levelling up’ to at least a minimum standard / equity of provision in:
  • Digital Infrastructure
  • Access to Care Record Systems
  • Digital Skills
  • Digital Inclusion
  • Access to linked datasets
  • Access to specialist expertise.
• Using our understanding of system needs to drive change, through provision of actionable insight that enables putting ‘intelligence into action’
• Ensuring future needs are better met and managed through investment in digital and data. Every £ spent will have a direct impact on care delivery, planning or transformation, and subsequently has a direct impact on improving outcomes for individuals or the population more broadly.</td></tr>
<tr><td>Key risks</td><td colspan="5">The key risks mainly relate to next stage development following approval of the strategy, namely:
• The need to confirm sources, types and amounts of funding available to support strategy delivery
• The need for a detailed, costed implementation plan for the strategy
• Application of the prioritisation framework outlined in the strategy based on the level of funding and availability of skilled resource to deliver against the strategy goals.</td></tr>
<tr><td rowspan="3">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td></td><td>X</td><td>X</td><td colspan="2">X</td></tr>
</table>

Route to this meeting	The final draft strategy (and the summary strategy) were presented to the ICB Executive Group on 27th October 2022 and the ICB Transformation Committee on 10th November 2022. It was endorsed by these groups with a summary of the feedback given in Section 3.3 of the report below.	
Management of Conflicts of Interest	There are no known conflicts of interest.	
Patient and Public Engagement	In developing the strategy, a number of adult and children and young people co-design panels were undertaken with members of our local population to gain insight on key themes to be covered.	
Equality, Diversity and Inclusion	An Equality Impact Assessment (EIA) has yet to be completed for the strategy, however the development of the strategy has been undertaken in line with Public Sector Equality Duty principles and an EIA will be presented with the strategy once it is ready for formal approval by ICB Board.	
Health inequalities	Addressing health inequalities is at the heart of the digital and data strategy, outlining how we plan to put 'intelligence into action' through the use of increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to 'turn the dials' on improvement in their health and care outcomes in an equitable way. The strategy also addresses digital exclusion, and building on research that has already taken place, a number of actions are proposed to ensure that proactive steps are taken to ensure that everyone who struggles to access and engage with digital technologies has the opportunity to do so or is provided with an alternative means of service (to ensure we retain equity of provision) for health and care.	
Next Steps	Following endorsement and subsequent approval at ICB Board, the next steps will be to develop (in conjunction with Places) costed, prioritised implementation plans for the key commitments outlined in the strategy.	
Appendices	**Appendix A**	Final Draft ICS Digital and Data Strategy
	Appendix B	Final Draft Summary Strategy

ICS Digital and Data Strategy

1. Introduction

1.1 Cheshire and Merseyside ICS have developed a Digital and Data Strategy for the next three years to primarily support the delivery of the ICS objectives as outlined the ICS Strategy 2021 – 2025.

1.2 This strategy was developed through:

- Capturing digital and data requirements, and mapping how digital and data can support the delivery of the required outcomes of the ICS Transformation programmes
- Undertaking a digital maturity assessment, based on the NHSE 'What Good Looks Like' best practice framework, for both Providers and Places
- Public and staff engagement. This included:
  - Regular engagement sessions with key senior stakeholder groups across the ICS
  - Monthly involvement sessions with cross-sector Place digital groups in all nine Places, the C&M Chief Information Officers (CIO) Group and the C&M Adult Social Care Digital & Technology Enabled Care (TEC) Group
  - Six facilitated strategy development sessions with a wide variety of stakeholders from across the health and care system through the NHSE supported 'Module D' programme
  - Two adult and two children and young people co-design panels with members of our local population.
- Development of core capability descriptions for some of the proposed 'at scale' solutions such as Shared Care Records, Patient Empowerment Portals (which provide the functionality to enable patients to access their own records and book and change appointments through the NHS App), Remote Monitoring (including Virtual Wards) and Population Health Management platform, socialised in advance to get feedback from Providers and Places
- Quantifying investment requirements from Providers and Places to meet the digital maturity gaps identified through their baseline digital maturity assessments.

1.3 The strategy covers:

- The importance of digital and data to the ICS
- The key health and care challenges across our system and how we will work with the rest of the system to deliver transformational change and improved health ad care outcomes through digital and data
- The digital and data mission, vision and goals
- Details around our commitments associated with the three key goals:
  - Strong digital and data foundations
  - 'At scale' digital and data solutions
  - System wide digital and data tools and services.
- The critical success factors required for effective delivery of the strategy

2. Strategy Documents

2.1 In developing the strategy, we wanted to make sure that the document is accessible to both staff and the public, and to harness digital where possible in order to do this. Three versions of the strategy have been developed:

- An online, interactive strategy document with click throughs to more detailed information around some of the case studies, persona stories (which illustrate what life will be like for both staff and public as the strategy is delivered) and other websites. This interactivity can be expanded in future to include videos and other on-line content to continue to enhance the online version
- An offline PDF version of the main strategy, which contains the same core content as the online version, but without some of the interactive elements noted above
- A shorter Strategy Summary PDF document, which covers the key points of the strategy and the key delivery milestones.

2.2 Once the main strategy is approved, a public facing version of the strategy will also be developed.

3. Governance and Approvals

3.1 The initial draft Cheshire and Merseyside ICS Digital and Data Strategy was presented to the ICB Transformation Committee on 22 September 2022 and it was agreed at this meeting that the draft strategy should be circulated more widely for feedback before seeking formal approval through the ICB Board.

3.2 Following this meeting, the draft strategy was sent to:

- ICB Transformation Committee members
- ICB Executive Group
- ICB Place Directors
- All 9 Place digital leads for circulation to their Place Digital Groups (which all have representatives from Local Authorities as well as NHS organisations, and some include VCFSE sector organisations such as hospices)
- Two Provider Collaborative Managing Directors
- ICB Clinical Informatics Advisory Group (CIAG) members
- Cheshire and Merseyside Chief Information Officers (CIOs) Group
- Cheshire and Merseyside Adult Social Care Digital Group members and the ADASS Digital Lead
- ICS Digital and Data Strategy Oversight Group and the wider ICS Digital team
- Everyone who attended the strategy development sessions earlier this year (from across NHS, local authority and VCFSE sector organisations).

3.3 The initial draft strategy was also presented at a number of Place Digital Groups as well as other strategic meetings during the feedback period.

3.4 Overall, feedback on the initial draft strategy was positive and supportive. A detailed analysis of all the comments provided has been undertaken and relevant changes have been made in the final draft strategy that is circulated with this paper. This includes changes to both some of the content and imagery used in the documentation. The final draft strategy has subsequently been reviewed and endorsed by the ICB Executive Group at its meeting on 27 October 2022 and the ICB Transformation Committee on 10 November 2022. The following points were raised at these meetings for further consideration:

- the strategy contains a number of case studies of previous work and a series of both staff and public personas that illustrate what their experience will be as a result of implementation of the strategy. However many of these are embedded in the interactive elements of the main strategy document, and it was suggested that these could be extracted and made available separately to Places and Transformation Programmes to help with their more detailed planning work following the strategies approval
- there is a need to ensure that the ICB governance associated with the assurance of the investment in digital and data is robust, focusses on delivering outcomes and benefits for individuals and/or the population as a whole, improves productivity, addresses key challenges (such as workforce) and demonstrates a clear return on investment (as per the 'turning the dials' concept in the strategy)
- as the ICS' workforce and other strategies are developed, explicit references to other ICS related strategic documentation should be made going forward.

3.5 A key theme in the feedback on the initial draft strategy related to the next steps beyond the strategy being approved. This revolved around three core areas:

- the need to confirm **sources, types and amounts of funding available** to support strategy delivery. National funding for 2022/23 is likely to be primarily available through targeted investment areas (such as Digital First Primary Care, Digital Social Care Records and Frontline Digitisation for Electronic Patient Record deployment) and in many cases is still in the process of being confirmed through NHSE regional office for this financial year. Funding for 2023/24 and beyond will be requested as part of the standard NHS financial planning cycle and templates to support this are expected before the end of the calendar year. In preparation for this, we have already requested digital and data funding requirements for both NHS and Local Authority Adult Social Care providers and for each of the Places, which will be reviewed and prioritised in conjunction with Place based digital engagement groups and governance once the national requirements for funding submissions are known. This puts us in a good position to respond quickly if necessary as funding becomes available
- the need for a **detailed, costed implementation plan** for the strategy – this is already in development through the ICB digital team and the plan will be managed through the ICB Digital Transformation Programme Board and assured through the ICB Transformation Committee in due course (following on-going discussions with Place based digital engagement groups and governance). This will include details on the delivery model to be used that maximises the economies of scale that working across an ICS can bring, but also ensuring that local delivery at Provider and Place level is utilised where this

is most appropriate. Such plans will be subject to review and updating at least annually during the period of this strategy

- **Application of the prioritisation framework** outlined in the strategy based on the level of funding and availability of skilled resource to deliver against the strategy goals. Again, this will be undertaken in conjunction with Place based digital engagement groups.

3.6 Subsequent papers will be developed to address these issues as part of the overall strategy implementation process. This will involve working closely with each Place to refine and align the ICS digital and data strategy with local strategies to ensure there is a clear and jointly agreed plan for addressing the key commitments in the ICS strategy in each Place. This will be overseen by a small steering group of health and care stakeholder representatives from Places that will report initially into the ICS Digital Transformation Programme Board and more formally through the ICS Transformation Committee.

3.7 It should also be noted that a strategy refresh will be required to reflect on-going developments in ICS maturity, delivery of projects in the first year of the strategy period and the impact of further engagement with other parts of the health and care system that have had the least input to the strategy to this point (such as children's social care, community pharmacy and dentistry and the VCFSE sector). The strategy will also be supplemented with more detailed sub-strategies in focused areas such as digital diagnostics, digital maternity and cyber security.

4. Recommendation

4.1 The ICB Board are asked to **endorse** the ICS Digital and Data strategy with a view to formal approval at a subsequent ICB Board meeting.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

ICS Digital and Data Strategy

Appendix A

- Final Draft ICS Digital and Data Strategy

FINAL DRAFT

Cheshire and Merseyside
Health and Care Partnership

Digital and Data Strategy 2022–2025

Investing in digital and data to enable 'intelligence into action'

Open

FINAL DRAFT

Contents

Thank you for your interest in our Digital and Data Strategy for the Cheshire and Merseyside Integrated Care System (ICS). You can navigate through to each section of our Digital and Data Strategy by using the links below. A **fully interactive version of this strategy**, containing additional features and content, can be viewed online.

Your guide to our strategy

Navigation menu

Use the interactive menu at the bottom of each page to explore our strategy.

Home | Contents | Previous Page | Next Page

Online icon

Select the online icon to access links to additional content. Please note that a **fully interactive version of this strategy**, containing additional features and content, is also available online.

Commitments

The tick symbol is used throughout our strategy to identify our commitments which will help us achieve our digital and data ambition, vision and goals.

Foreword

The decision of our Integrated Care System (ICS), here in Cheshire and Merseyside, to host Digital within the Medical Directorate speaks to our ambition that all of our digital work will be care profession led and informed to drive the best health and care outcomes for the population we serve. Our data services support this ambition and will ensure that we use the best intelligence in the planning and delivery of care to benefit those most in need.

This Digital and Data strategy describes an ambition to improve the health and well-being of our region right now and into the long term by weaving our digital and data infrastructure, systems and services throughout the pathways of care we provide. This requires **'levelling up'** our digital and data infrastructure through investment where this is most needed to improve outcomes for individuals and the population as a whole.

This approach has a clear mandate to fulfil. We must address the significant inequalities so clearly faced by parts of our population and ensure we successfully support all we serve.

Where we have developed increasingly sophisticated ways of understanding the health and care needs of our population, we are committed to turning **'intelligence into action'**. This is our ability to bring focussed, and therefore meaningful, interventions to those who most need it. Finding and intervening for those in greatest need **'turns the dials'** on improvement in the health and care outcomes of our population in an equitable way, but we must not stop there.

There are well understood trends facing the health of our citizens by way of ageing, and medical advances that see ever more survivorship, for example those who live beyond their cancer diagnosis. Our digital and data strategy must look to respond to the changes we see and future proof the health of our population by staying ahead of need and being proactive rather than simply reactive.

As we invest into 'levelling up' our digital and data systems and relentlessly drive 'intelligence into action', we will deliver high quality, safe and equitable services that underpin the health, well-being and independence of our whole population both now and into the future.

Prof. Rowan Pritchard-Jones

Medical Director,
Cheshire and Merseyside
Integrated Care Board (ICB)

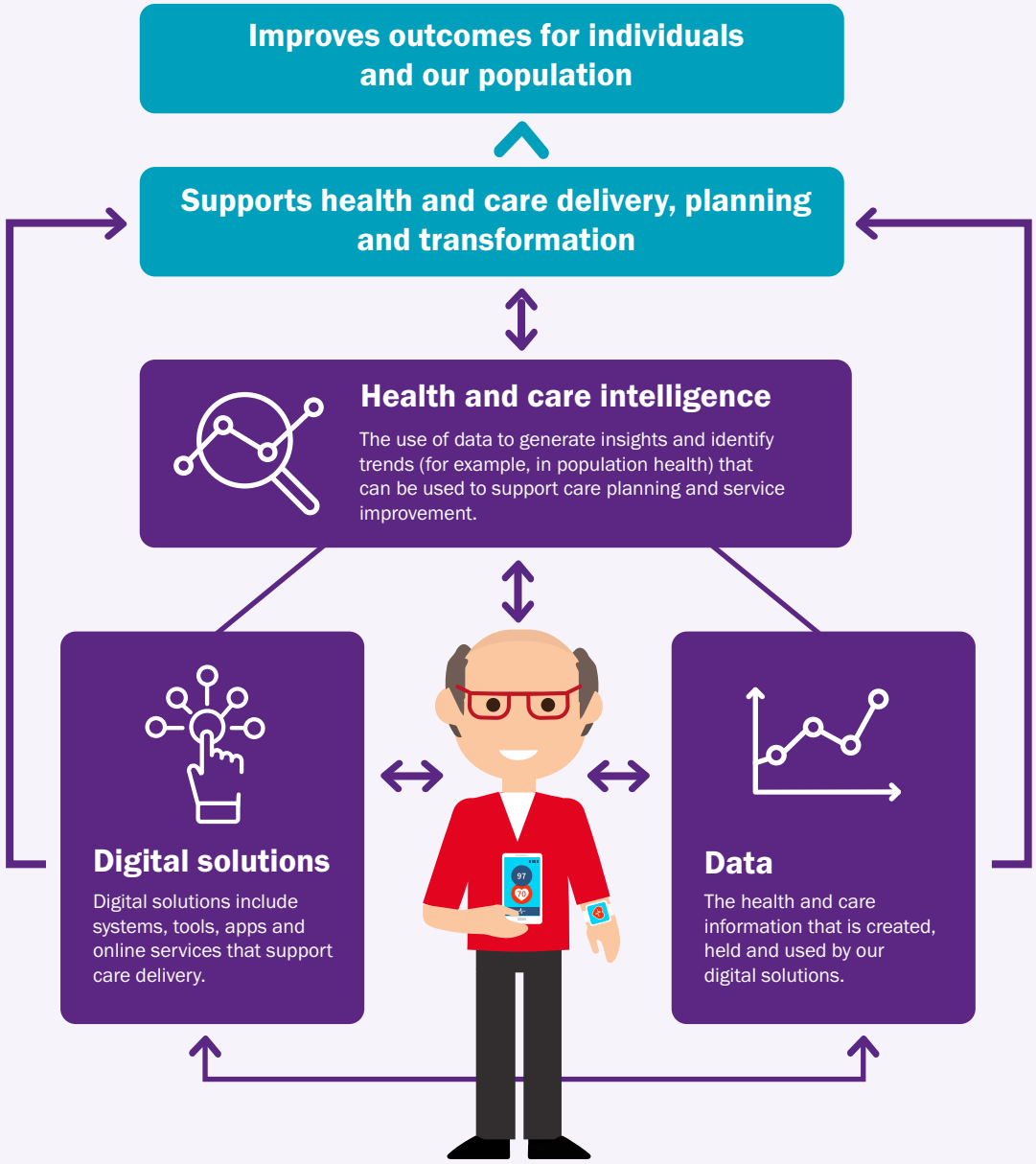
Why is digital and data important for the ICS?

Cheshire and Merseyside Integrated Care System (ICS) has a current digital strategy (called 'Digit@ll') that was written in 2018 under the Health and Care Partnership arrangements.

The Digit@ll strategy proved to be a key driver for investment in core IT systems and underpinning IT infrastructure to support health and care delivery, referenced in this strategy as **'digital solutions'**.

Read more about the North West's only heart failure 'Virtual Ward'

There is also increasing recognition that digital solutions should not be treated in isolation from the health and care **'data'** that is held inside of those systems. This data is then used to directly influence care delivery for a person, support reporting on service performance and future service planning and to understand the health and care requirements of the population ('population health'). When this data is used to create health and care **'intelligence'** it becomes powerful and can be used to drive action and improvements.



There has been significant change in the use of digital solutions since 2018, most notably because of the COVID-19 pandemic. Rapid adoption of tools such as team collaboration software, video consultations and remote monitoring has changed the way health and care staff work now and into the future. In addition, the public also markedly increased their use of online services because of the pandemic and because of this, public expectation of digitally enabled health and care services has expanded significantly. However it must also be recognised that alternatives will still need to be available for those who do not have access to digital tools and skills and may struggle to gain them. There is also an increasing public expectation that health and care services will be delivered with environmental sustainability at the core, and this is particularly true for digital which is a contributor towards the NHS achieving its 'net zero' ambition.

Cheshire and Merseyside has also seen an acceleration in the adoption of population health and intelligence tools since the start of the pandemic, enabling researchers to pioneer new models of care. This has been critical in terms of the health and care service response to the global crisis including:

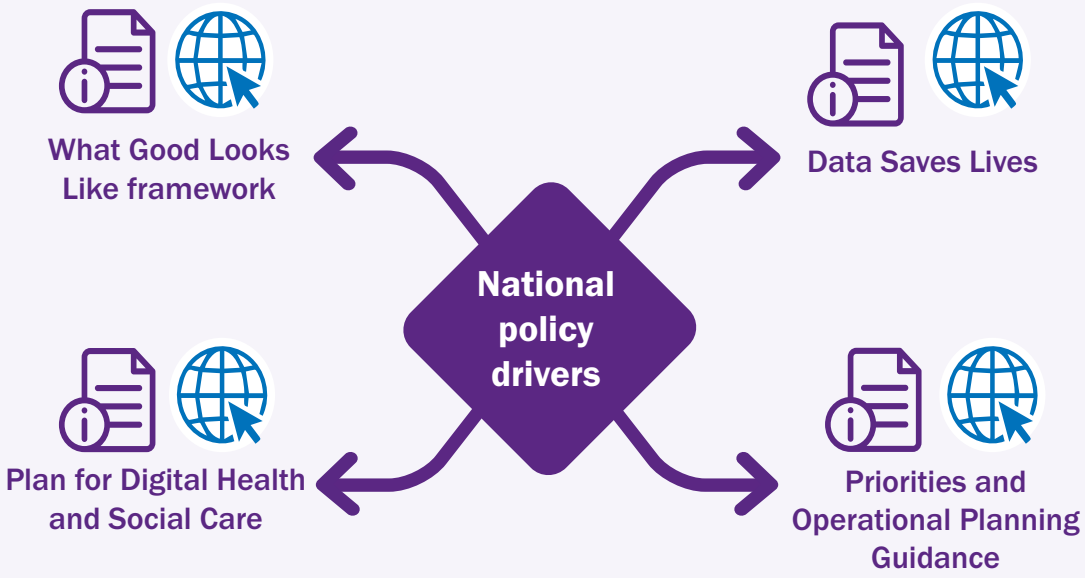
- Management of critical care bed capacity across the system at the time of greatest demand of this scarce resource.
- Planning and delivery of the COVID-19 testing and vaccination programmes.
- Increasing the safe and effective management of care of people outside of the hospital setting.
- Use of data for COVID-19 related research (in particular for clinical trials and translational research).

Read more about how our CIPHA population health management system was used to support our response to the COVID-19 pandemic.

Read more about how our IT equipment recycling project has delivered life changing outcomes for some of the most digitally excluded.

Read more about our live scenario-based cyber security training exercise to assess our system-level readiness to deal with a cyber-attack.

National policy has also reinforced the digital and data focus and provides clear guidance and impetus for health and care leaders to connect and transform services safely, securely and sustainably through the increased use of digital, data and intelligence. This includes:



This policy context ensures that as a system we are equally able to offer the core digital and data enablers through all services and service providers to our population. This **'levelling up'** of the digital and data provision will ensure that benefits stemming from investment will be experienced by everyone whatever their location within Cheshire and Merseyside. The public can expect at least a minimum common standard of digitisation in health and care services by 2025 and through **'digital inclusion'** initiatives will be supported in their own use of digital and data tools, widening access to care through greater choice.

Digital, data and intelligence are increasingly critical elements for the efficient and effective delivery of health and care services. The key concepts relating to digital, data and intelligence referenced in this strategy are:

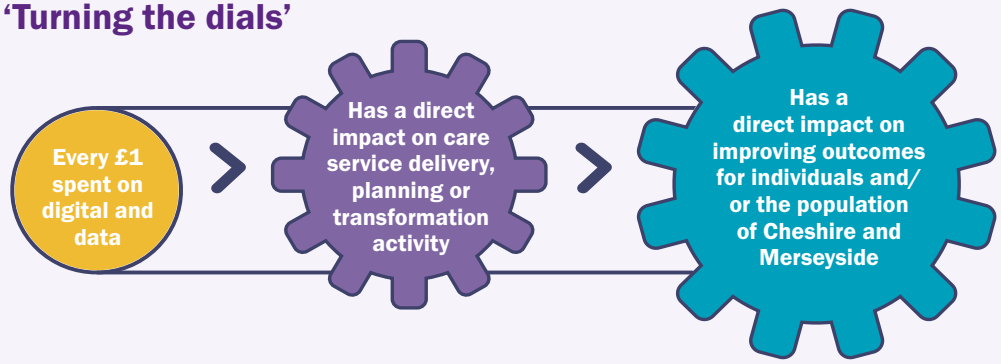
'Levelling up'

Investment in digital infrastructure, systems, tools and services so that health and care staff and the public in all of our Places can expect at least a minimum common standard of digitisation of health and care services by 2025 at the latest.

'Intelligence into action'

Investment in data and intelligence solutions and services that utilise the data from local, ICS and national systems to provide intelligence and drive change in how health and care service performance can be improved.

'Turning the dials'



In the following sections we will:

- outline the health and care challenges faced;
- describe our vision, mission and goals;
- use stories of fictional personas to illustrate what the digital and data transformation will deliver for different population groups and for staff.

FINAL DRAFT

Understanding the challenges in Cheshire and Merseyside

Cheshire and Merseyside ICS represents a large and diverse geographical footprint.

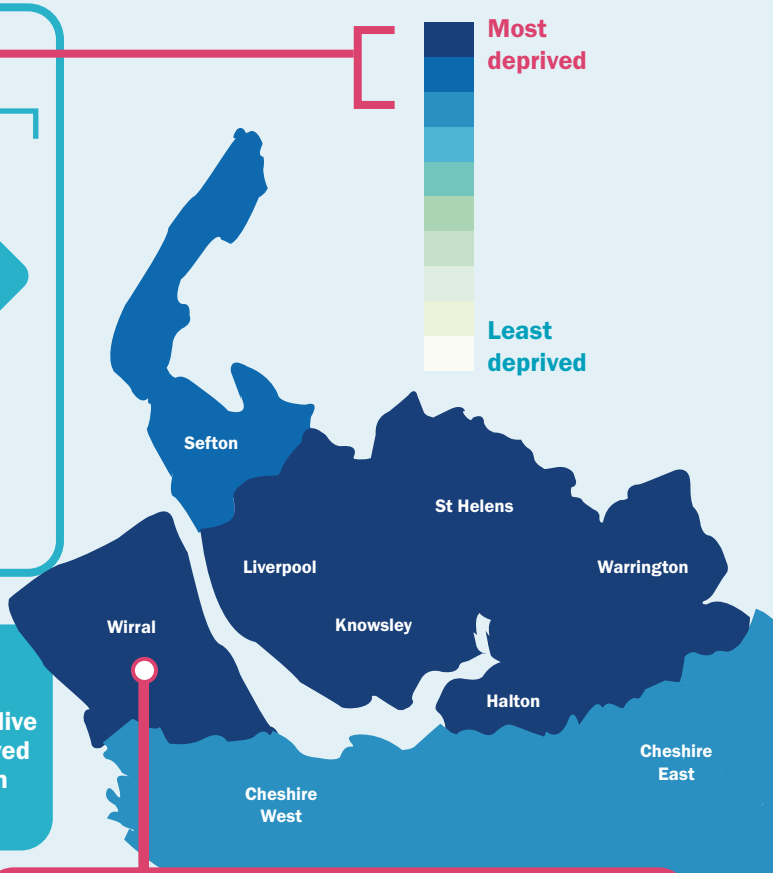
There are 2.7 million people living across areas of both significant wealth and substantial deprivation. The mental and physical health and care challenges are faced by some of the most deprived neighbourhoods with the greatest health inequalities in England.

19.6% England average **vs** **28.6%** Cheshire and Merseyside

The Index of Multiple Deprivation (IMD) is the official measure of relative deprivation in England and uses the following indicators as part of its scoring.

- Employment
- Income
- Education
- Health
- Crime
- Barriers to housing and services
- Living environment

^ Improving Health and Wellbeing in Cheshire and Merseyside Strategy 2021-2025



What impact does this have on our people?

Deprivation is a substantial cause of Digital Exclusion

26% of our children (0-15 years) live in poverty

33% of our population live in the most deprived neighbourhoods in England

^ Improving Health and Wellbeing in Cheshire and Merseyside Strategy 2021-2025

Reduced quality of life and disability-free years

^ Age UK Briefing: Health and Care of Older People in England 2019

Increased mental health problems in adults and children

^ The COVID-19 pandemic, financial inequality and mental health

Deaths due to:

Heart disease · Cancer · Respiratory conditions · Alcohol and drugs

are **higher** than the England average

^ Comparisons and inequalities in healthy life expectancies, disability-free life expectancies and life expectancies

Reduced life expectancy

People in the most deprived areas of Cheshire and Merseyside can live 15 years less than those in wealthier areas. In one local authority, there is a difference in life expectancy at birth of 11-years (women) and 13.8 years (men) between the most and least deprived areas.

^ All together fairer: health equity and the social determinants of health in Cheshire and Merseyside

Deprivation has a direct impact on mental health and socioeconomically disadvantaged children and adolescents are two to three times more likely to develop mental health problems. One in four people experiencing a mental health problem is in significant debt, and people with mental health problems are three times more likely to be in financial difficulty*.

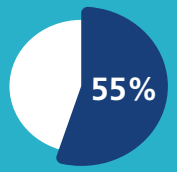
The pandemic has negatively impacted the health of the nation over and above the immediate impact of COVID-19 itself and the numbers awaiting investigations and treatments has increased significantly.

Digital exclusion is another facet of deprivation and socioeconomic inequalities. If the ICS is to drive digital and data enabled improvement to health outcomes, then it is essential to ensure digital skills and access to technologies is in reach for those most in need. This is set out in more detail in Section 8.

In this complex backdrop digital and data are key enablers to supporting aligned provision and ensure that the public experience maximum benefit from addressing the many factors that impact physical and mental health, wellbeing and independence.

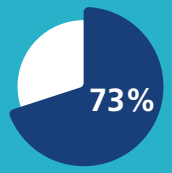
* The COVID-19 pandemic, financial inequality and mental health

The impact of the pandemic on health



Percentage of those waiting for investigations and treatments post COVID-19

Most deprived — **Least deprived**



Percentage of people experiencing mental health problems

^ All together fairer: health equity and the social determinants of health in Cheshire and Merseyside

The relationship between male suicide and unemployment

10% increase in unemployment

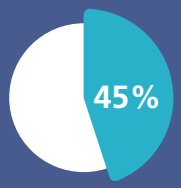
leads to

1.4% increase in male suicides

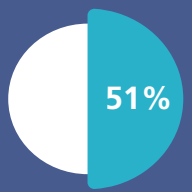
^ The COVID-19 pandemic, financial inequality and mental health

The relationship between digital exclusion and deprivation

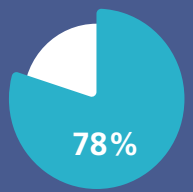
Digitally excluded people:



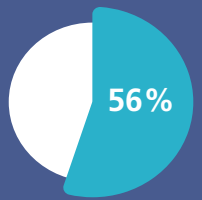
Earn less than £11.5k per year



Are over 65 years of age



Left school before 16

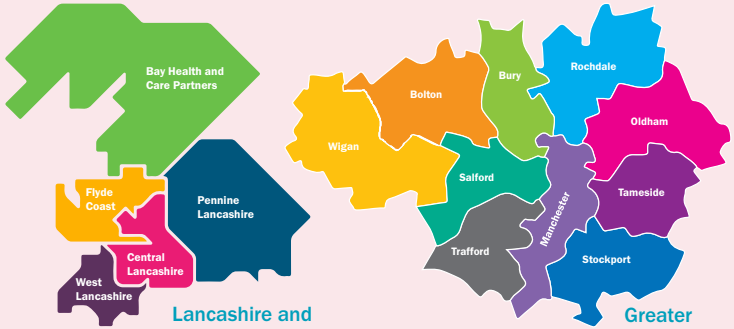


Have a disability or long-term condition

^ Digital inclusion guide for health and social care

Bringing together key participants to improve health and care

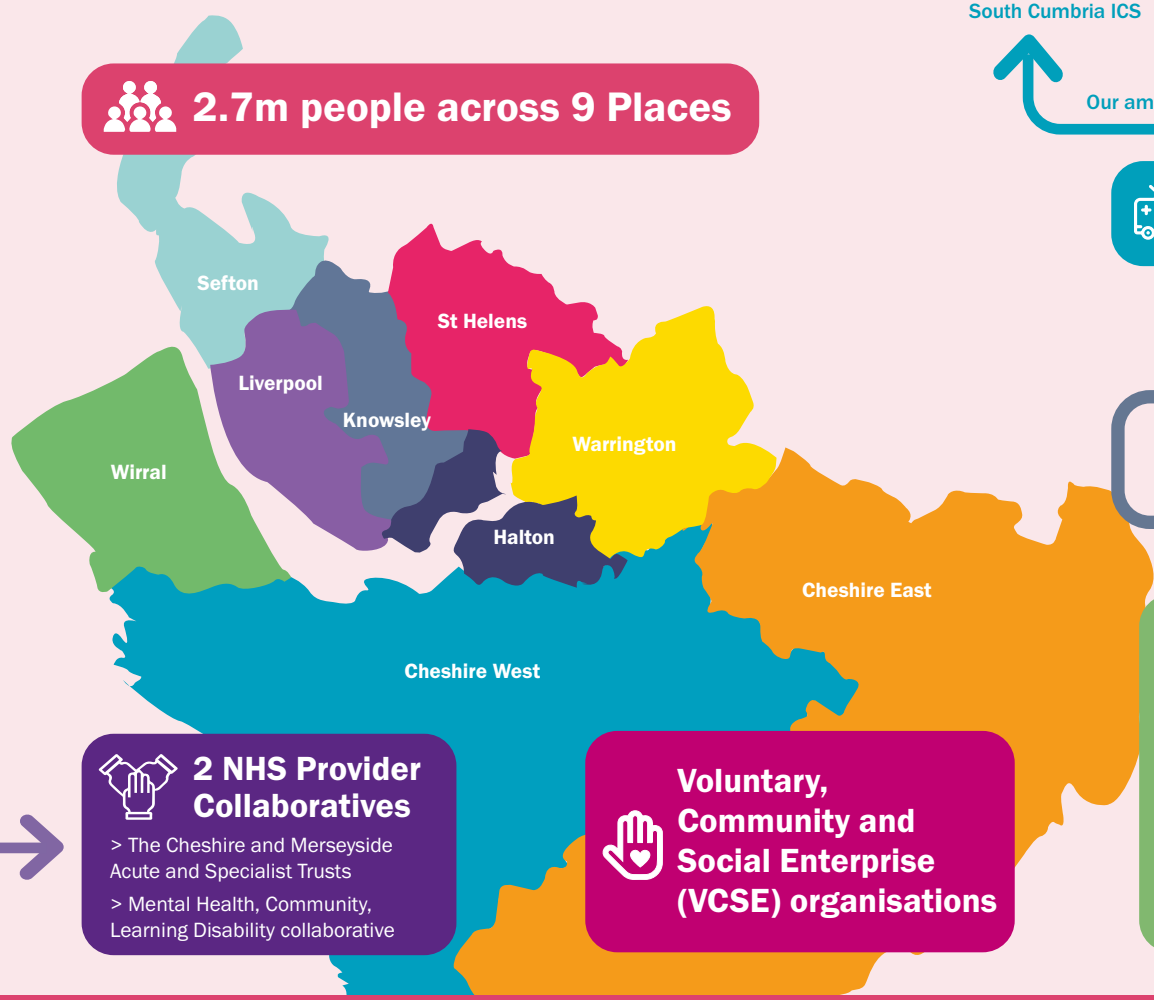
The Integrated Care System (ICS) creates an umbrella and an operating model under which this complex map of stakeholders can find new ways of working together, aligned around the needs of the local population.



17 NHS Providers

> Alder Hey Children's NHS Foundation Trust
> Bridgewater Community Healthcare NHS Foundation Trust
> Countess of Chester Hospital NHS Foundation Trust
> Cheshire and Wirral Partnership NHS Foundation Trust
> Clatterbridge Cancer Centre NHS Foundation Trust
> East Cheshire NHS Foundation Trust
> Liverpool Heart and Chest Hospital NHS Foundation Trust
> Liverpool University Hospitals NHS Foundation Trust
> Liverpool Women's Hospital NHS Foundation Trust
> Mersey Care NHS Foundation Trust
> Mid Cheshire Hospital NHS Foundation Trust
> St Helens and Knowsley Teaching Hospitals NHS Trust
> Southport and Ormskirk Hospital NHS Trust
> The Walton Centre NHS Foundation Trust
> Wirral University Teaching Hospital NHS Foundation Trust
> Wirral Community NHS Foundation Trust
> Warrington and Halton Hospitals NHS Foundation Trust

2.7m people across 9 Places



2 NHS Provider Collaboratives

> The Cheshire and Merseyside Acute and Specialist Trusts
> Mental Health, Community, Learning Disability collaborative

Voluntary, Community and Social Enterprise (VCSE) organisations

Our ambulance service also supports

1 Ambulance Service

> North West Ambulance Service

55 Primary Care Networks

375 GP practices

9 Local Authorities

> Cheshire East Council
> Cheshire West and Chester Council
> Halton Borough Council
> Knowsley Council
> Liverpool City Council
> Sefton Council
> St Helens Council
> Warrington Borough Council
> Wirral Council

The overarching vision, mission and objectives of the ICS are set out in the 2021-2025 ICS Strategy.

These are focussed on tackling the big issues that need to be addressed to improve health and reverse the widening gaps in life expectancy between the poorest and wealthiest in our population, with a particular emphasis on tackling the impact of the COVID-19 pandemic to ensure that there is not an irreversible deepening of poverty and health inequity across Cheshire and Merseyside.

The ICS footprint is broken down into **Places**, which are made up from a series of health and care **Providers** and other health and care organisations.

Cross provider working is also supported by the formation of ICS wide **Provider Collaboratives**.

Places and Provider Collaboratives are the key organisational structures that will enable the changes digital and data seek to support.

Our ICS Vision, Mission and Strategic Objectives

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 longer.

Mission

We will tackle health inequalities and improve the lives of the poorest fastest. We believe we can do this best by working in partnership.

Objectives

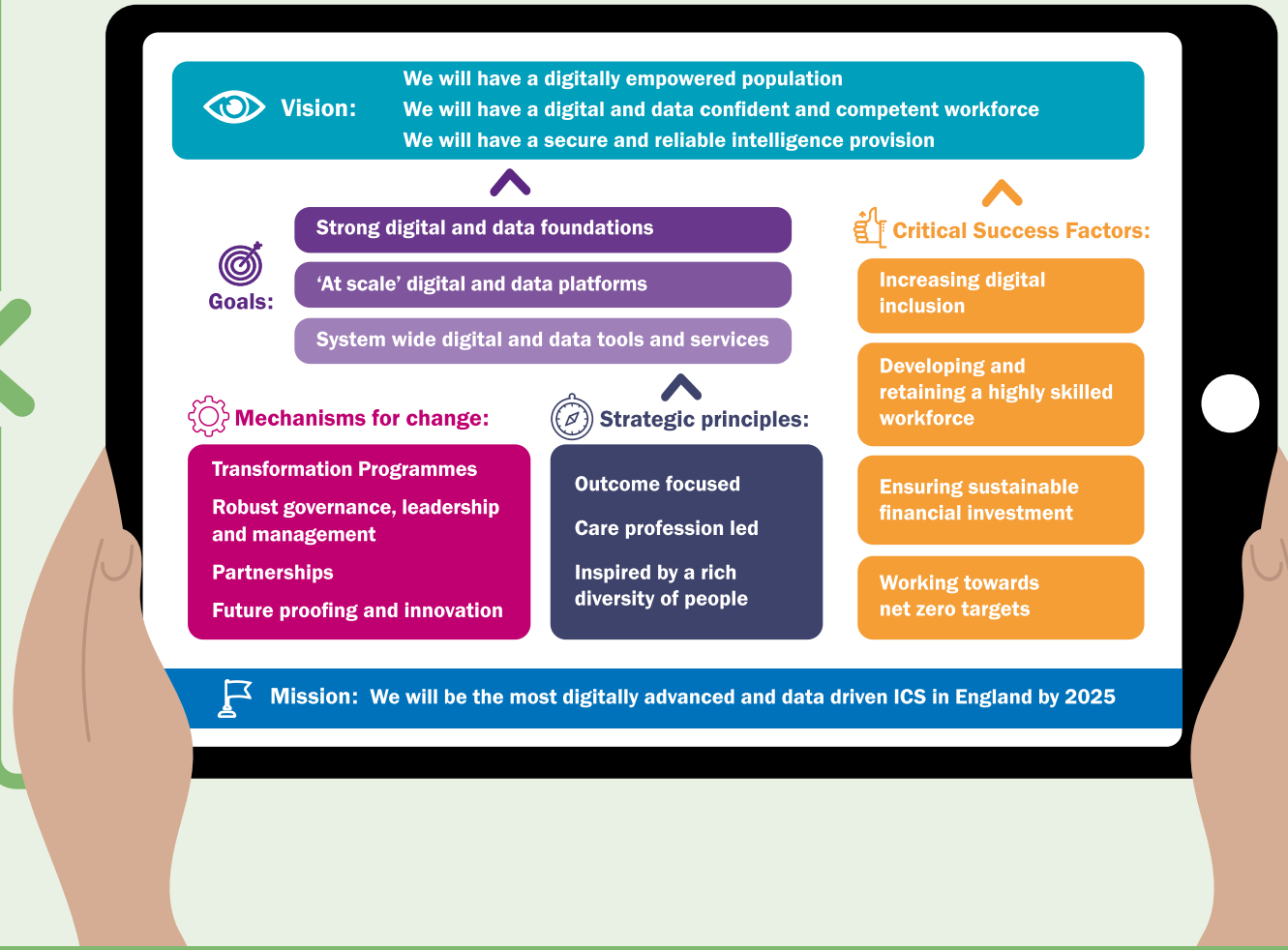
- Improve population health and healthcare
- Tackling health inequality, improving outcomes and access to services
- Enhancing quality, productivity and value for money
- Helping the NHS to support broader social and economic development

Digital and data vision, mission and goals: How digital and data can help to address the challenges

The purpose of the ICS Digital and Data Strategy is to support the achievement of the ICS vision, mission and objectives.

This alignment is visually outlined on this page and shows how the digital and data work will put **'intelligence into action'** across the ICS and positively impact its population.

Our ICS digital vision, mission and goals

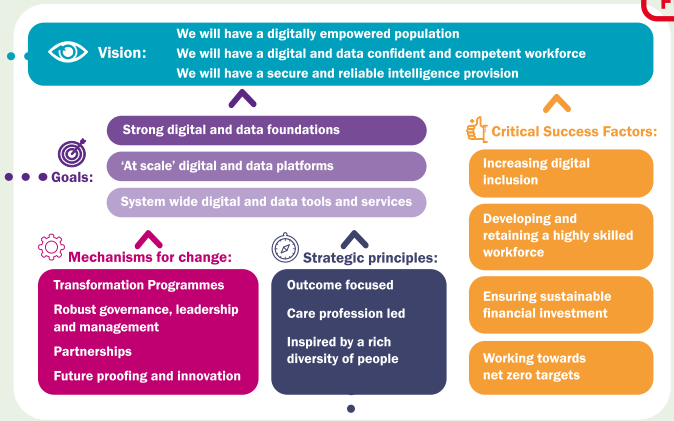


The ambition for the digital and data teams in Cheshire and Merseyside ICS is to become the most digitally advanced and data driven ICS in England by 2025. It underpins our **vision** for digital and data, where we want to see:

A digitally empowered Cheshire and Merseyside population taking increased control of their own physical and mental health and well-being.

A data and digital confident and competent workforce able to deliver safe, effective and efficient care.

A secure and reliable insight and intelligence provision, underpinning joined up care planning and able to understand and help meet evolving population need.



To deliver this vision, our **goals** are the provision of:

Strong digital and data foundations, delivering reliable, seamless and secure digital and data infrastructure and associated support services, fundamental care records solutions and integrated data sets across the Cheshire and Merseyside health and care system.

'At scale' digital and data platforms, providing core solutions which are mainstreamed and embedded in health and care service delivery and planning at all levels. This includes platforms for shared care records, remote care, intelligence delivery and patient empowerment.

System wide digital and data tools and services, which build on those core platforms and directly support the delivery of the ICS health and care objectives. This includes the use of solutions for population health management and business intelligence and solutions and apps that meet the specific needs of one or more specific groups of the population.

There are principles that need to be held close whatever actions are taken to achieve these goals. These principles are guidance to inform and underpin change for all stakeholder across the system. These **principles** are:

Outcome focused – any digital or data solution must be laser focussed on supporting the delivery of improved outcomes for individuals, families, communities and/or the population as a whole.

Care profession led – best practice pathways must drive the digital and data approach to enhancing care outcomes, improve care safety and increase productivity, and initiatives need to have the active sponsorship and leadership of those delivering care to ensure benefits are realised.

Inspired by a rich diversity of people – the diversity in both the community cultures and the health and care needs of the population must be valued and reflected in digital and data solution development to meet those needs both now and into the future.

To deliver these digital and data goals, we need practical **mechanisms for change**, and the ICS and its stakeholder bodies will be utilising:

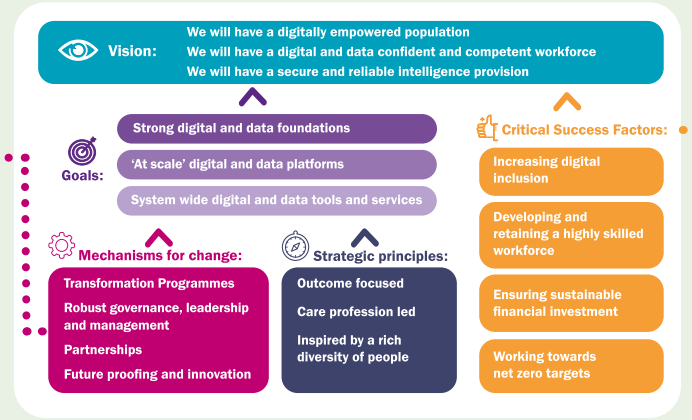
Transformation Programmes, already empowered to change care pathways and deliver improved outcomes for the population, and through which digital and data can accelerate their progress.

Robust governance, leadership and management so that the ICS can assure delivery of high quality, safe digital and data solutions that meet the needs of health and care staff and the public.

Partnerships, including the Places and Provider Collaboratives as outlined in the previous section, but also working with academia, the public, staff and others to deliver sustained change.

Future proofing approaches so that the ICS can identify, assess, and adopt any new innovations that can enhance or speed up delivery of its objectives.

It is also important that in every action taken because of this digital and data strategy we build in the parallel **Critical Success Factors (CSF)** of:



Increasing digital inclusion to ensure that as service provision becomes more digitised, more people are able to experience the benefit of digital investment in their health and care services and no-one experiences any reduction in access to services (in line with the 'Empower citizens' domain of the 'What Good Looks Like' framework).

Developing and retaining a highly skilled workforce who are digital and data confident and competent, and where our digital and data specialists working in health and care are nurtured and inspired.

Ensuring sustainable financial investment so that digital and data initiatives are invested in for sustainable ongoing use and benefit realisation, with a clear and consistent prioritisation process for investment to ensure decision making is transparent and consistently serves need across the whole population.

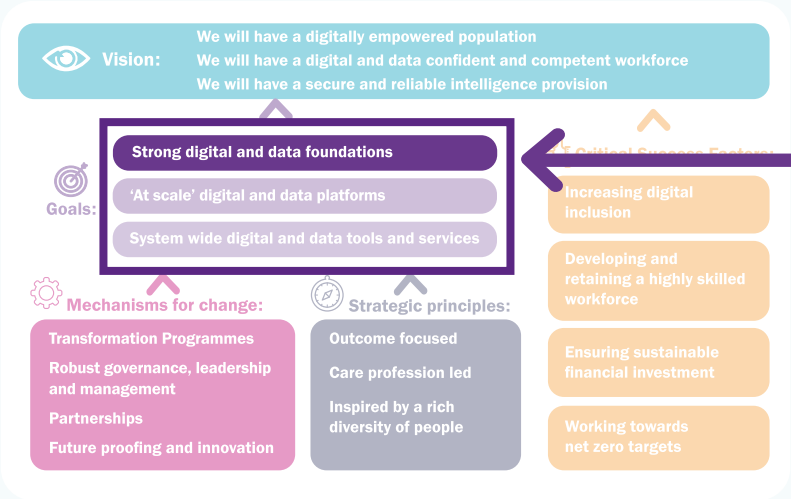
Working towards net zero targets, addressing climate change and utilising digital and data to support delivery of the ICS Green Plan deliverables.

Fundamental to the success of the strategy is that it is always clear how a digital and data programme or system is contributing to 'turning the dials' on outcomes for those of the population most in need.

Goal 1: Strong digital and data foundations

An assessment of the digital and data maturity of health and care providers and Places was undertaken to better understand the current levels of investment in digital and data. This included detailed assessments of underpinning infrastructure as well as broader assessments against the 'What Good Looks Like' success criteria.

The result of the assessment clearly shows that there is a need to invest in core technologies and services to ensure that there is increased equity of provision across the whole of the system to improve the effectiveness and safety of care for all of the population. This **'levelling up'** of the basic digital and data infrastructure and systems will ensure we build the strong foundations on which to deliver our ambition.



To level up the digital infrastructure:

We will ensure every member of health and care staff in NHS and Local Authority Adult Social Care providers that needs access to digital equipment to undertake their role will have access to reliable and fit for purpose access devices by **March 2025**.

We will ensure health and care staff in NHS and Local Authority Adult Social Care providers have access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside, by **March 2025**. This will be facilitated by working in partnership with other public services and network providers to access initiatives such as Gov Roam and the rollout of 5G through initiatives such as LCR Connect.

We will ensure for NHS Providers, 90% of NHS trusts will have a minimum standard Electronic Patient Record (EPR) by **December 2023**, and 100% by **March 2025**. Appropriate convergence of EPRs will be encouraged where possible to make it easier for staff to use them and ease the interoperability challenge.

We will ensure for Adult Social Care, 80% of CQC registered adult social care providers (residential and non-residential) will have adopted a Digital Social Care Record (DSCR) by **March 2024**. This is in line with the 'Plan for Digital Health and Social Care' requirements.

To level up the data and intelligence infrastructure:

We will ensure access to ICS wide person level health and care linked datasets by **March 2023** as a corner stone for population health analytics.

We will ensure the broadening of linked datasets available for analytics to include those outside of health and care such as education and housing by **March 2024**, through working with the ICS, Local Authority and national partners.

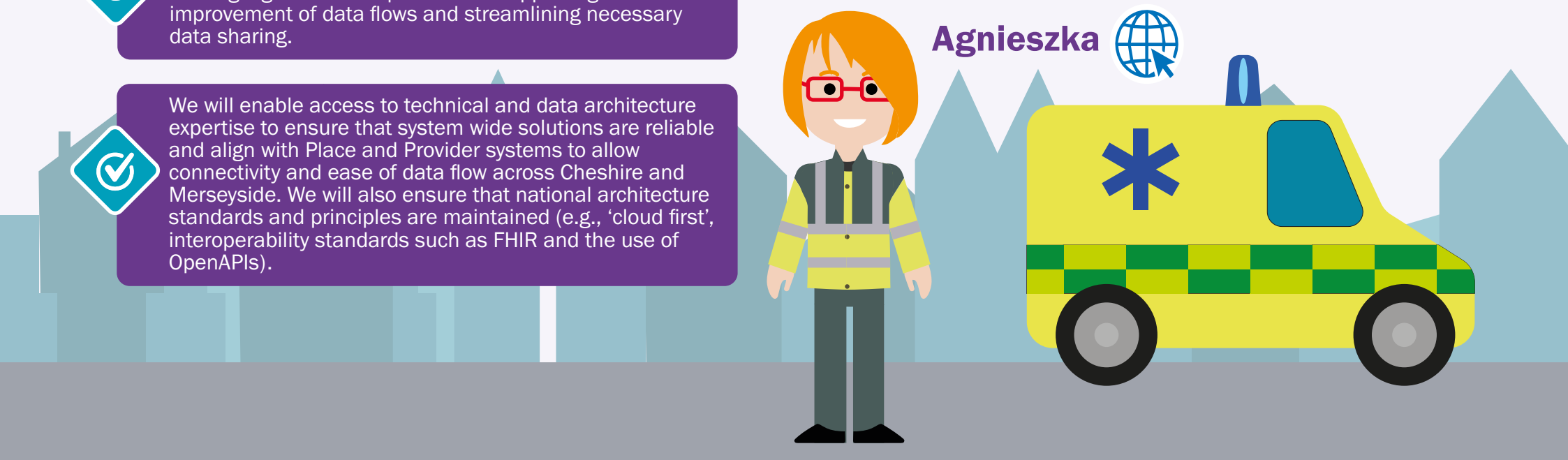
We will ensure the transfer of core health and care information between providers, within relevant Information Governance agreements and for the purposes of direct care, population health management, care planning and research, will be undertaken through a single health and care data architecture by **March 2025**. To support this we will:

- Expand the information governance framework to include implementation of Data Sharing Agreements for use of data for research and innovation and full compliance with national data opt-out by **March 2023**.
- Implement electronic management of data sharing agreements via the Information Sharing Gateway by **March 2023**.

Samara

To level up 'safe practice':

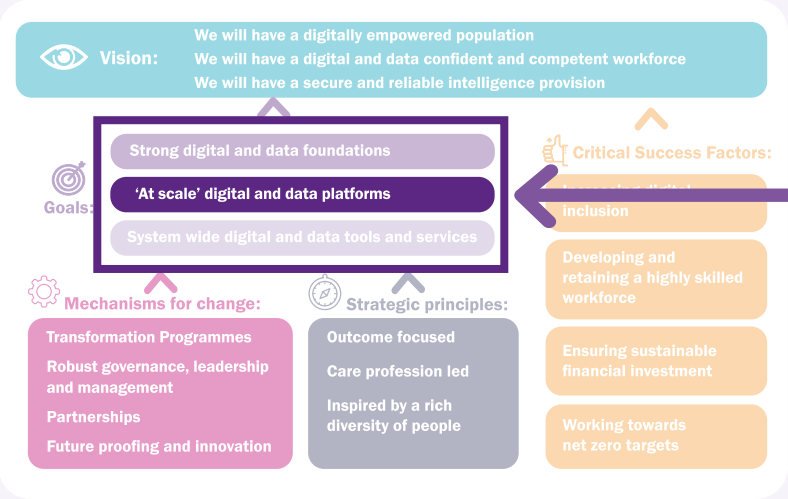
- We will ensure the provision of cyber security services including cyber security operations, incident response and assurance that complements and works alongside local health and care provider cyber security functions.
- We will enable access to clinical safety subject matter expertise to ensure that the digital and data solutions in use across Cheshire and Merseyside are DCB0129 compliant (i.e., have appropriate safeguards associated with clinical and care hazards) and have been implemented in line with 'best practice' clinical safety standards (as outlined in DCB0160).
- We will enable access to Information Governance subject matter expertise to enable statutory health and care providers to operate safely with regards to information sharing legislation and protocols – supporting the improvement of data flows and streamlining necessary data sharing.
- We will enable access to technical and data architecture expertise to ensure that system wide solutions are reliable and align with Place and Provider systems to allow connectivity and ease of data flow across Cheshire and Merseyside. We will also ensure that national architecture standards and principles are maintained (e.g., 'cloud first', interoperability standards such as FHIR and the use of OpenAPIs).
- We will ensure digital environmental sustainability support to ensure that any system and Place based digital and data initiatives support the ICS' Net Zero ambitions as outlined in the ICS' Green Plan.
- We will ensure data quality to establish a common approach for improvement in data quality across the ICS so that our decisions are based on sound data.
- We will ensure data safety so that the public can be reassured that their data is used lawfully, with respect, held securely and that the right safeguards will be in place (through supporting adoption of the 'Five Safes' model and the Caldicott Principles).



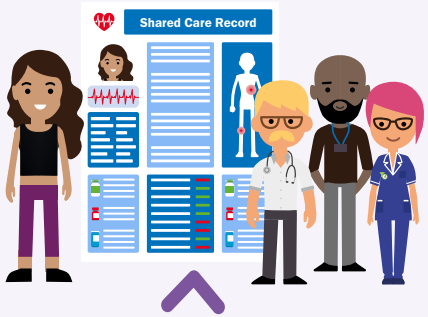
Goal 2: 'At scale' digital and data platforms

Cheshire and Merseyside ICS will continue to develop and expand its strategic digital and data platforms for use within all health and care providers and at all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population.

The availability of consistent access to 'at scale' platforms further enables **'levelling up'** of the digital and data provision. Being able to act at scale also enhances the opportunities to deliver cross-ICS **'intelligence into action'**.

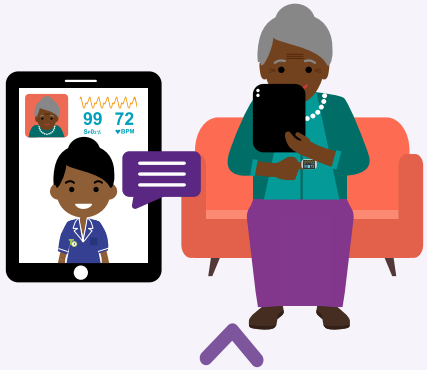


'At scale' solutions



Shared Care Records

Patient Empowerment Portals (PEPs) and Person Held Records (PHRs)



Remote Care

Intelligence Delivery Platforms

Shared Care Records

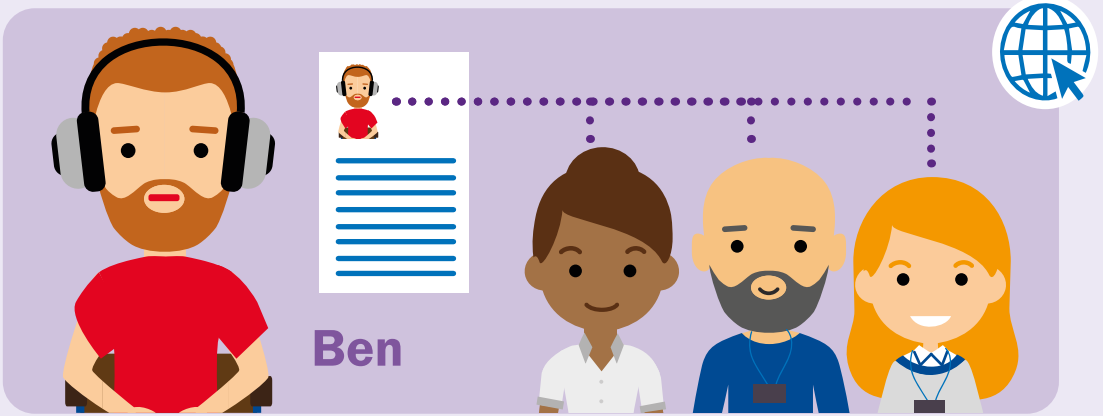
Shared Care Records allow staff in health and care providers across Cheshire and Merseyside, who are directly involved in care delivery, to securely access a digital view of an individual's health and care records. This supports **improved decision making** to help provide better, **safer care** when it is most needed.

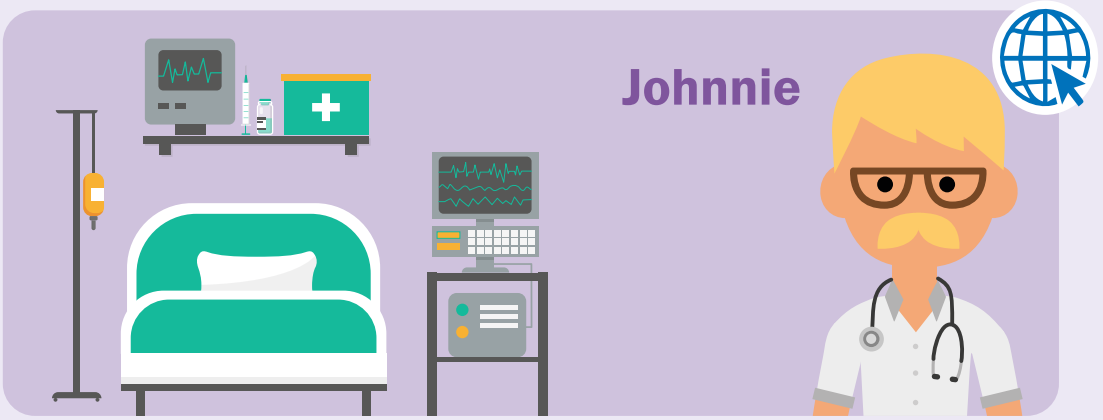
Cheshire and Merseyside ICS will continue to provide a system-wide platform (Share2Care, incorporating eXchange and the Medical Interoperability Gateway (MIG)) for sharing care documentation and structured care records, primarily from primary and secondary care, across the whole system.

We will ensure this platform is available in all NHS and Local Authority Adult Social Care providers, enabling sharing of a core set of health and care data across the whole health and care system by **March 2024**.

Wirral, Cheshire East, Cheshire West and St. Helens Places have existing Shared Care Records solutions at Place, providing a deeper level of care record information available to providers in their Place.

We will further support all Places to ensure that all NHS and Local Authority Adult Social Care provider organisations of the ICS are connected to integrated life-long health and social care records by **March 2024**, enabled by core national capabilities, local health records and shared care records, giving individuals, their approved caregivers and their care team the ability to view and contribute to the record.





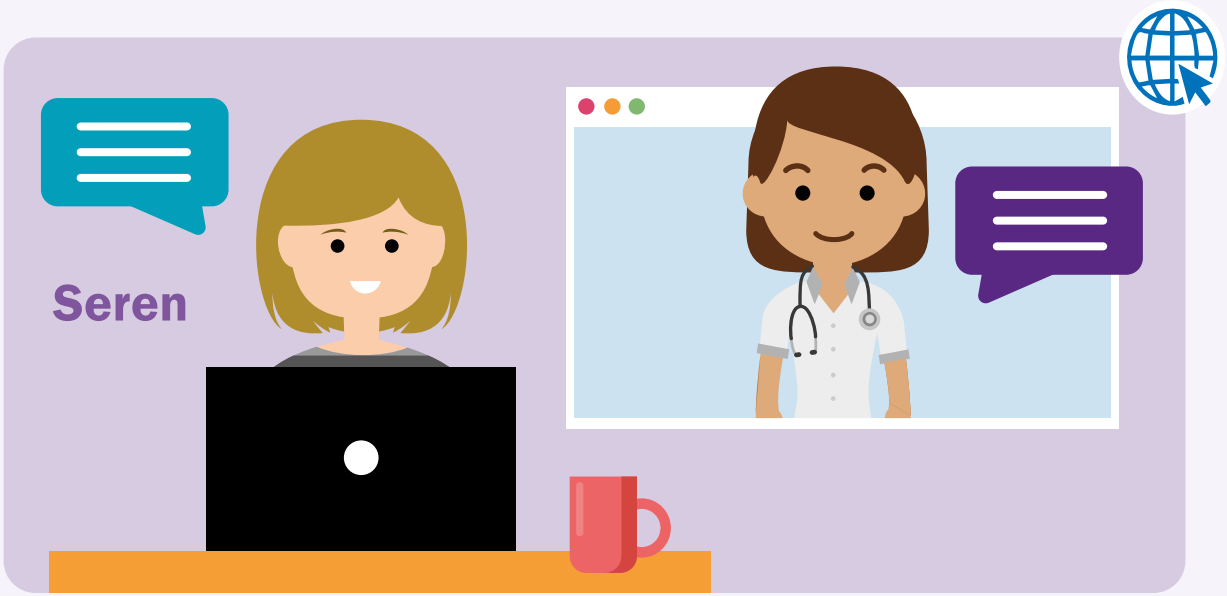
Patient Empowerment Portals (PEPs) and Person Held Records (PHRs)

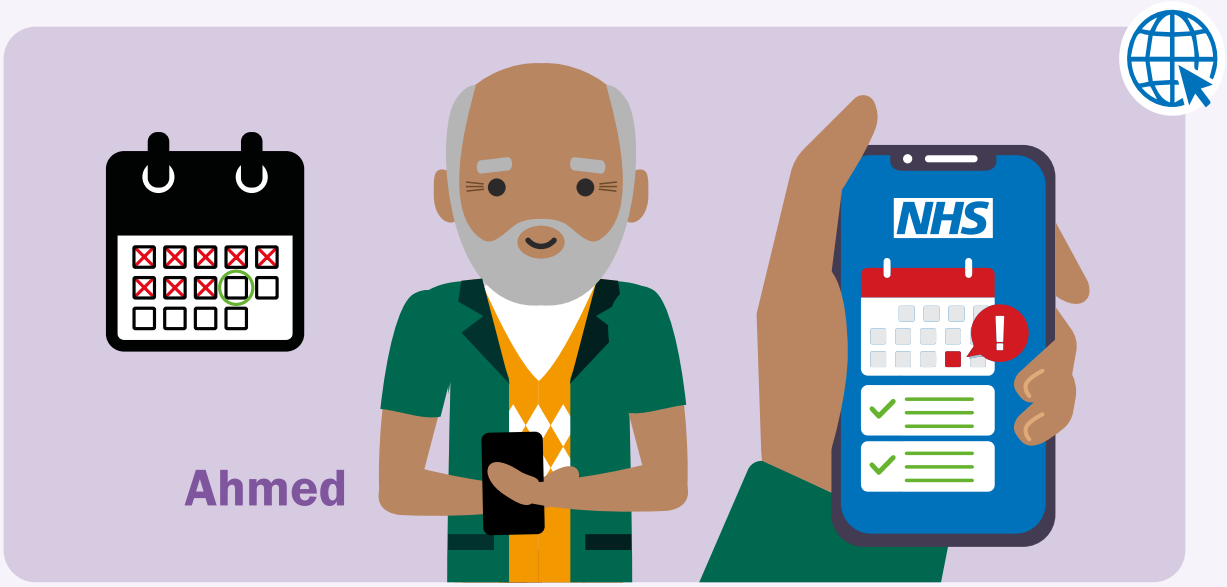
We will enable people to increasingly self-manage their long-term conditions, mental health, care plans and wellbeing by providing people access to services that best suit individual needs as well as the increasing resilience to cope with the physical and psychological demands of living with and / or recovering from illness. From a digital point of view this self-management includes being able to book and change appointments, access their health and care record and access advice and guidance on their care.

Any solutions in place will integrate with the NHS App to allow seamless access to a variety of provider or Place led Patient Empowerment Portals (PEPs) and Person Held Records (PHRs). Some Places, such as Cheshire East, already have a well-established PEP embedded into their care pathways, whilst a number of other Places are in the process of implementing a similar solution. PEPs should also link to the ICS Shared Care Record to support access to records.

Cheshire and Merseyside ICS will continue to support rollout of PEP platforms for use by Providers where this meets Provider and Place needs.

We will ensure that all Providers have implemented a PEP that integrates with NHS App (as the 'front door' to health and care service for an individual or their carers) by **March 2025**.





Remote Care

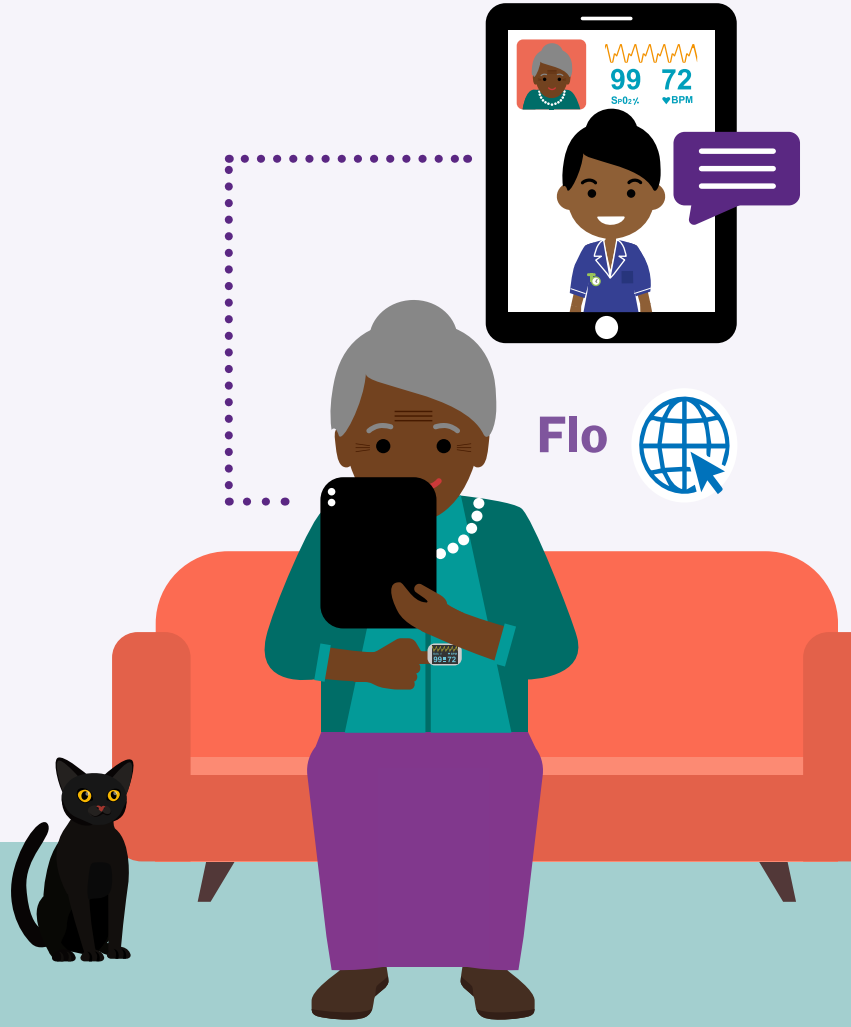
Remote Care is a way of using technology to allow an individual to monitor their own physical and mental health and wellbeing, with the support of relevant health and care workers, from their usual place of residence. Adopting easy-to-use equipment that can be provided by care teams, a person or their carer can record vital signs, as well as other useful information about their health which are then electronically and securely sent to a monitoring hub of experienced health and care professionals for review. Any moments or trends of concern are then identified, and the appropriate follow up action taken when and if needed. Evidence tells us that remote care avoids multiple GP appointments as well as hospital attendances and admissions.

We will continue to build on the existing Remote Care platform delivering virtual ward and Long Term Condition (LTC) monitoring services, and expand this offering to deliver additional virtual ward beds (40 to 50 virtual ward 'beds' per 100,000 of the population by **March 2024**.

We will also continue LTC monitoring for other specialties, as well as support for the wider NHS@Home programme which will drive the focus of the platform going forward. This will include:

- Supporting the availability of digital monitoring of vital signs for people in care homes and at home, contributing towards the national aim of a further 500,000 people being supported by this technology by **March 2023**.
- Develop a tech-enabled annual physical check for people with severe mental illness by **March 2023**.

We will also agree the care pathways where this platform can be used for supporting 'Care@Home' applications such as environmental monitoring and medicines management of those living at home (or in supported accommodation) to ensure they remain safe as part of the discussions regarding alignment with Technology Enabled Care (TEC) developments in Adult Social Care. Agreed pathways where people are supported in this manner will be in place by **March 2024** and prevention and detection technologies will be used to protect the 20% of care home residents who are identified as at high risk of falls by **2024**.



Intelligence Delivery Platforms

There are two distinct types of intelligence delivery platforms in Cheshire and Merseyside and they are both fundamental to promoting **'intelligence into action'** across the system. There is a dedicated population health platform and then a series of platforms more focussed on the design, monitoring and improvement of service models utilised by frontline health and care services.

Population Health Platform

Within Cheshire and Merseyside, the aim is to improve the physical and mental health, wellbeing and independence of the people living in the area and to reduce health inequalities through a wider awareness of those things that can have a significant impact on health such as access to housing, employment, and education. One way to do this is by using Population Health Management to better understand people's health and care needs and how they are likely to change in the future.

Combined Intelligence for Population Health Action (CIPHA) is the core population health management platform for the ICS, its Transformation Programmes and Places. Cheshire and Merseyside ICS will continue to develop CIPHA, which was established as part of the COVID-19 pandemic response, to help transform health and care services through the utilisation of data. As a result, of programmes of work such as System P combined with the CIPHA platform, the ICS can identify populations at risk of adverse outcomes, patterns and trends to support those with the greatest health and care needs, evaluate the success of interventions and campaigns and manage resources effectively to deliver the very best standard of care.

We will continue the development of the CIPHA Platform to include further Population Health Management reporting that enables the identification, segmentation and evaluation of cohorts for the targeting of interventions. The work here will align with the overall population segmentation approach as being developed by the System P programme, which will focus on identification of populations most vulnerable and at risk of adverse outcomes, and developing services for those population segments most in need of improved health and care outcomes. It is intended to embed CIPHA reporting in action via System P and Population Health Board Programme/Networks by **March 2023**.

Platforms for service design and performance monitoring and reporting

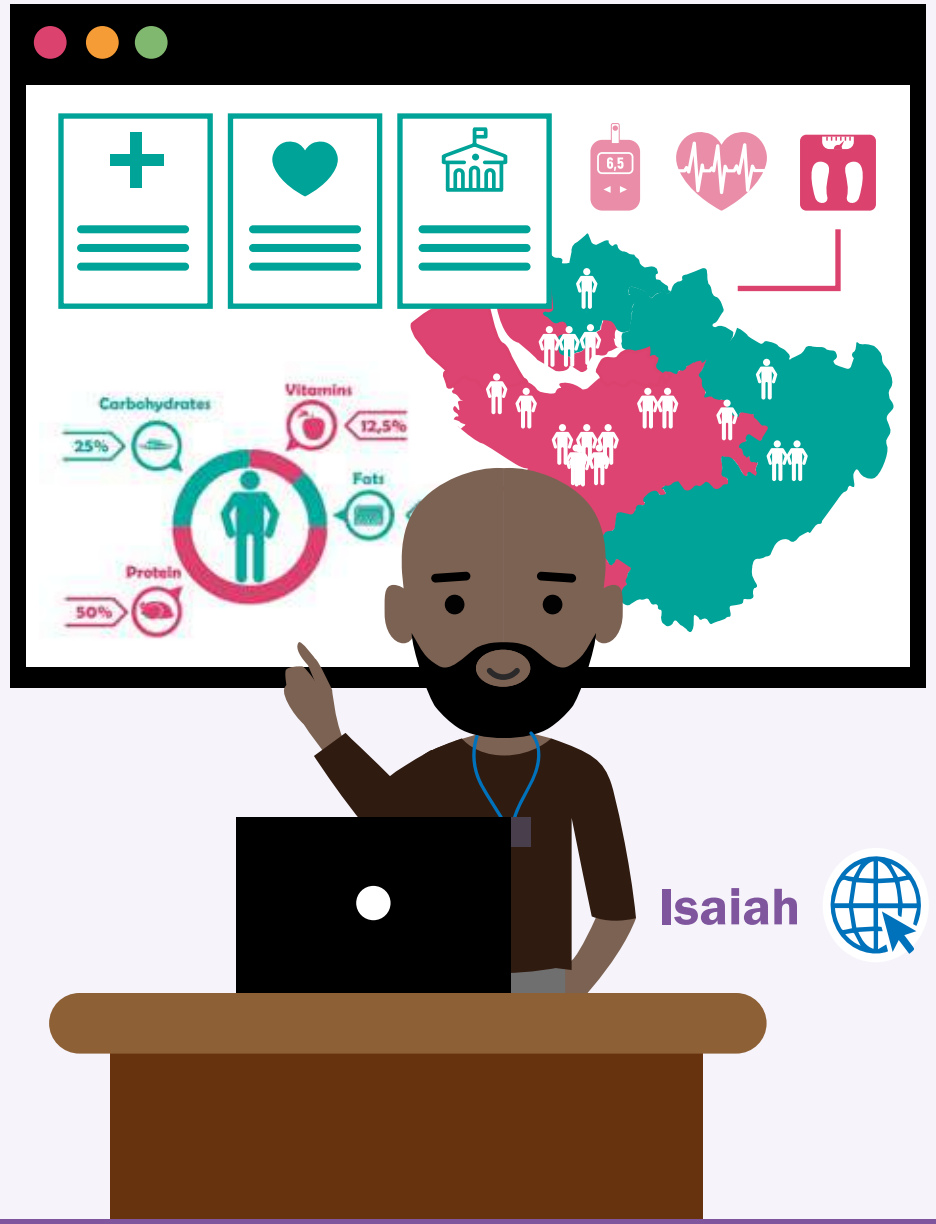
The ICS utilises a large scale and evolving picture of metrics across multiple initiatives that demonstrate activity and outcome changes and identifies the critical Key Performance Indicators (KPIs) of success. Multiple perspectives including time, cost, access, habits, ethnicity, age, treatments, in absolute and relative terms are captured to reflect the scale and variation of the initiatives that are in progress at any given time. At the time of this strategy development, the metrics across the critical ICS transformation programmes number over 200, such is the breadth of initiatives underway and the anticipated impact.

The ICS already has two key intelligence delivery platforms in place to support business intelligence and population health management services:

- Public View is the core performance tool across the ICS for national and local metrics
- Aristotle holds Performance drill down and Population Health Reporting to compliment CIPHA/Public View, but is based on the same data sources.

In addition, the ICS and its constituent organisations use DSCRO data provided by Arden and GEM CSU and the NHS National Data Platform for access to national data sets.

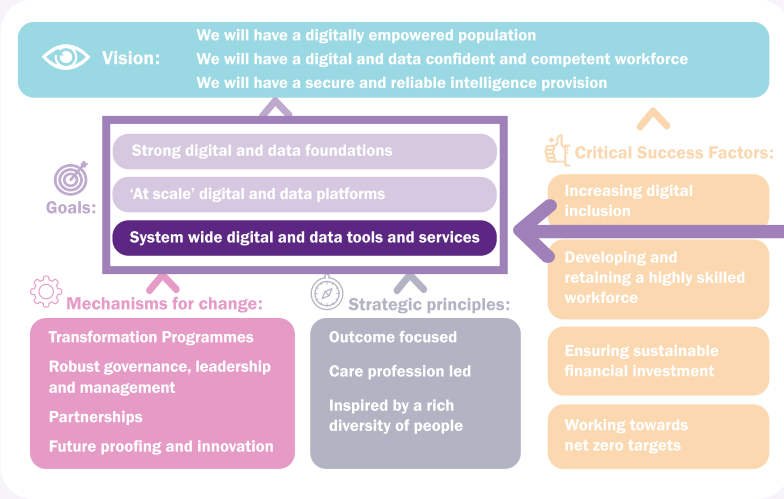
We will embed Public View across Providers and Service Planners to include access, quality, activity, outcomes and workforce, containing national and local flows and underpinned by granular detail on Aristotle by **March 2023**.



Goal 3: System wide digital and data tools and services

The ICS will further leverage the 'at scale' platforms through the development of ICS level applications, tools and services that support delivery of the ICS health and care objectives.

These solutions or services will have agreement through Place and ICS governance structures that they are best delivered across an ICS footprint, in part to ensure a 'levelling up' in terms of access and benefit across the system, and fall into two distinct areas - population health and business intelligence services and digital tools and services.



Population health and business intelligence services

ICS wide business intelligence services will create automated analytics to develop 'one version of the truth' across the ICS. To do this:

- We will implement ICS wide Capacity and Demand reporting (based on an Operational Intelligence Hub) in the areas of urgent care (inclusive of community and mental health) and elective care by **March 2023** (with further development 2023/24) to enable an ICS wide view to inform both planning and operations.
- We will implement a Trusted Research Environment (TRE) on the CIPHA platform by **March 2025** so that data can be mobilised for research and innovation for our partner organisations, particularly for Stage 3 clinical trials and translational research.
- We will implement a single, mature performance information system (activity, finance, quality and outcomes) that all partners can access by **March 2024**.
- We will work with providers to create analytical networks and assist in streamlining of data flows, processes and quality across the ICS.
- We will work with local authority and public health analytical networks and strengthen joint work programmes in delivery of the ICS objectives.

Developing **'one version of the truth'** through automated analytics will support the delivery of the six key business intelligence service areas across the ICS, namely:

Business intelligence areas

Bespoke data and analytics

To answer a specific question by utilising data from various sources that cannot be automated. Includes planning round, support to business cases on impact of changes, longer term strategic work with research partners to evaluate interventions.

Population health and inequality

To show the epidemiology of a cohort such as age, deprivation, ethnicity, protected characteristics, geography and understand the differences in the health and care status of a population.

Population health management

To stratify a population for risk of a certain outcome, enabling identification of cohorts for direct care and patient level monitoring of outcomes to understand impact.

COVID

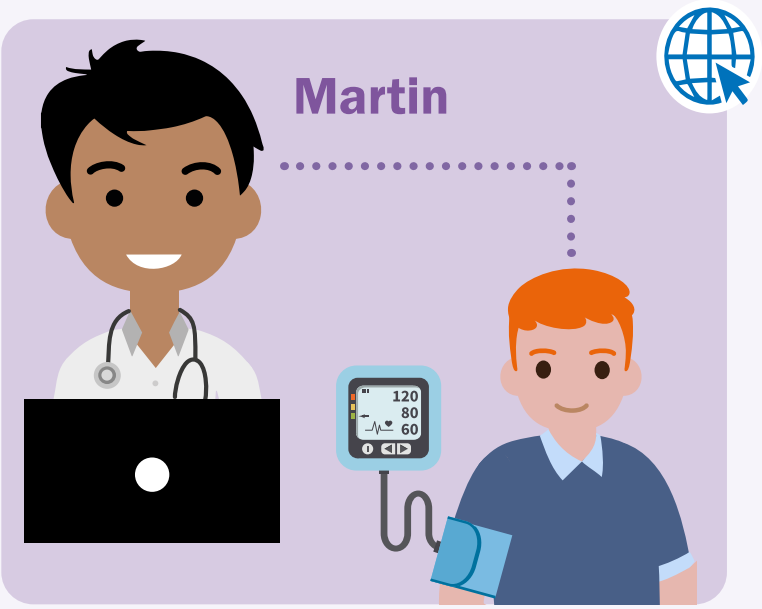
To monitor and model capacity and demand to support covid and long covid. Examples includes testing, vaccinations and tooling to manage covid services and enable elective recovery.

Performance

To monitor the performance of a system in terms of a set of Key Performance Indicators against targets, peers and over time. Examples include indicators that measure finance, activity, workforce, access, process or outcome.

Capacity and demand

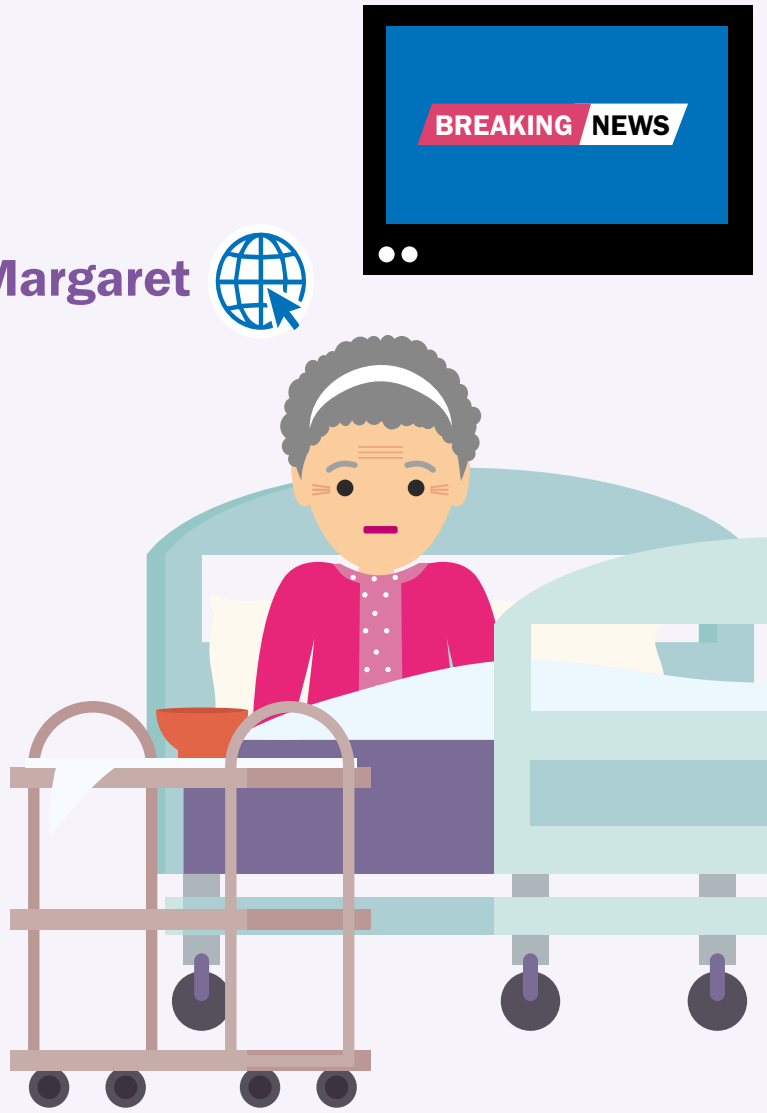
To predict the future demand for services and monitor the capacity against current demand in currencies such as activity, occupancy and workforce.



Digital tools and services

The ICS is supporting the delivery of digital system-wide tools and services that are used by all relevant stakeholders in Cheshire and Merseyside to ensure equity of provision and leverage economies of scale. These include:

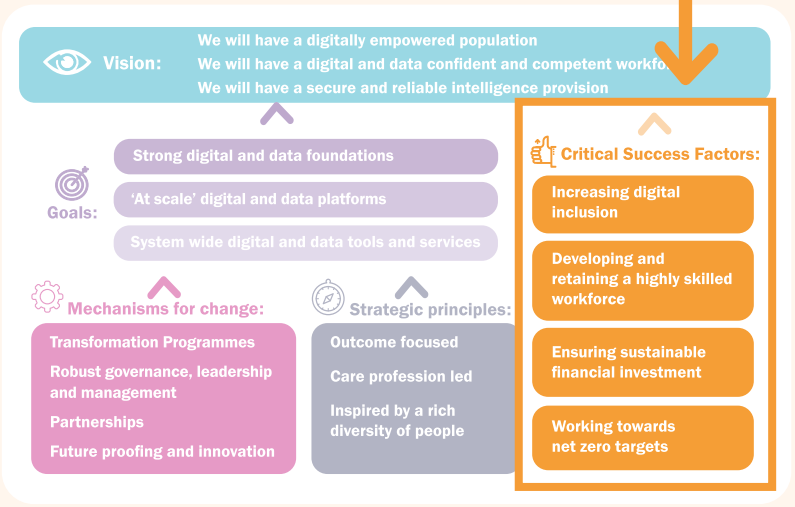
- The implementation of Robotic Process Automation (RPA) to perform and automate high-volume repetitive tasks (using process flows), to free up time for their clinical and/or non-clinical workforces, through a rollout plan in line with a clear evidence base of productivity benefits by **March 2024**. This builds on the work done by Trusts such as Alder Hey, who are establishing an RPA Centre of Excellence.
- The delivery of Office 365 optimisation and training services to frontline health and care staff to support the use of these business-critical tools by **March 2023**.
- Supporting the on-going development of primary care through the establishment of a common online and video consultation platform, implementation of high-quality clinical decision support tools and the rollout of accredited apps for people to support management of their own physical and mental health and wellbeing by **March 2023**.
- To safely refer patients directly from community optometry services to hospital specialists and to share diagnostic imaging between primary and secondary care to support diagnosis without the need for additional scans or photos by **March 2023**.
- Support the rollout of electronic care records into care homes and other providers of social care including domiciliary care by **March 2024**.



Critical Success Factors

The implementation and delivery of this strategy can only be regarded as successful if, alongside the technical developments, a small number of additional critical conditions are met.

We define these as the Critical Success Factors (CSFs) for the strategy. These conditions are outlined below. This section will outline the ICS' approach to addressing these Critical Success Factors.



Critical Success Factors

Developing and retaining a highly skilled workforce

Increasing digital inclusion

Working towards net zero targets

Ensuring sustainable financial investment

Developing and retaining a highly skilled workforce

Workforce development and providing leadership to change process and culture is critical to the success of this strategy. The benefits for the public will be achieved through the skills and dedication of the workforce to implement change, both the digital and data specialists who will be implementing and supporting the tools, and the wider workforce who will be using them to transform care. This will require:

- Ongoing skills investment
- Time and space to learn
- Environments to share and develop best practice

This means the ICS is committing to supporting the development of enhanced skill sets and new practices for both the technical experts and the health and care professionals who lead the change. This is in line with the requirements of the 'Support people' domain of the 'What Good Looks Like' framework.

For our digital and data specialists, this will mean:

- Adopting professional standards in digital and data services and ensuring professional accreditation of digital and data staff.
- Attracting new talent into the digital and data professional body in the health and care sector.
- Retaining and developing existing talent.
- Pooling talent from across the system.

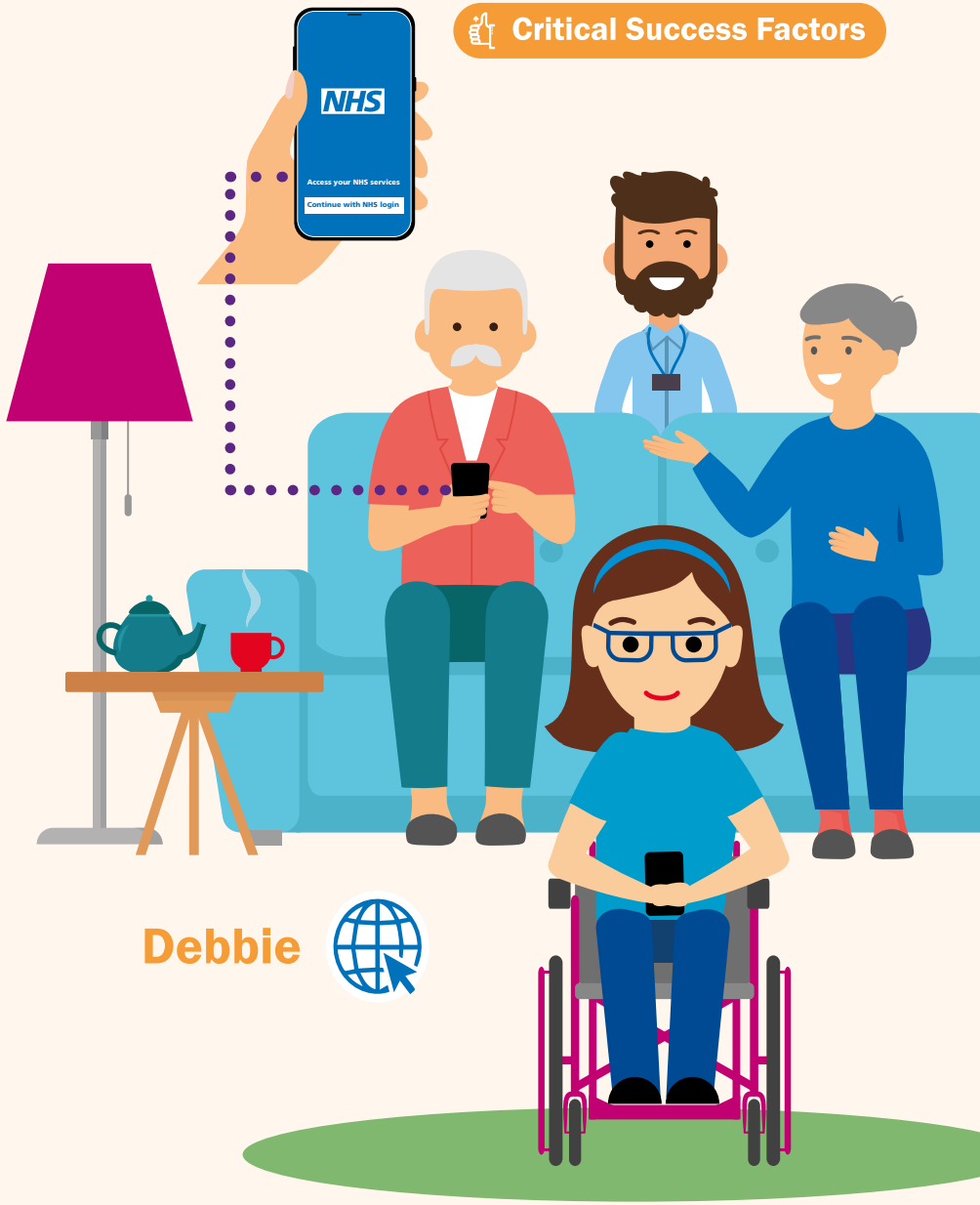
For the wider workforce, the focus will be on:

- Provision of digital and data skills training at scale.
- Development of Digital and Data Champions.
- Identifying future clinical and care digital and data leaders.

Increasing digital inclusion

People will need skills to utilise digital and data platforms and be able to benefit from them. The 2019 figures show that 11.3m people nationally still lack the skills to effectively navigate the Internet. The ICS will work with all providers and at Place level to ensure that everyone who struggles to access and engage with digital has the opportunity to do so or is provided with an alternative means of service. To ensure we retain equity of provision those who cannot or prefer not to access digital services, traditional services will remain. Enabling improved access to digital health and care services will be done via:

- Understanding the need – research will be undertaken by **March 2023**.
- Ensuring widespread adoption of the Digital Inclusion Impact Assessment by **March 2023**.
- Providing access to connectivity and equipment for the most digitally excluded groups by **March 2024**.
- Targeted support to get people using the NHS App as the digital 'front door' to health and care services by **March 2025**.
- Development of skills for individuals and their carers through development of digital buddies and digital carers hubs by **March 2025**.



Working towards net zero targets

The ICS is committed to the NHS environmental sustainability ambition.

The ICS Green Plan commits to: a focus on (digital and data enabled) ways to streamline care and support service functions; to improve the use of resources; and to reduce carbon emissions.

The Rethink / Reduce / Recycle and Reuse concept drives innovation and practical objectives in digital and data that support the overall drive towards net zero.

Ensuring sustainable financial investment

Resources in the system are constrained, and health and care services remain under considerable pressure. The commitment is to return to pre-COVID levels of activity and to address the impact of pent-up demand.

Investment in digital and data during a financially constrained period is a challenge but it is a key way to deliver against these key NHS pressures by focussing on where care is needed the most through **'levelling up'** and applying evidence-based **'intelligence into action'**. In this way the investment can demonstrably show the benefit and **'turn the dials'** on outcomes.

Within this context, there are 2 key aspects of sustainable financial investment for the purposes of this strategy - accessing investment and the prioritisation of investment funds.

Accessing investment

The 'Who pays for What?' policy will consolidate national funding for transformational digital and data projects into a single fund and will support ICSs as they are increasingly given control over the financial resources with which to deliver their digital and data plans. As funding is devolved down to ICSs to invest in their systems through 'Who pays for What?', the funding principles and the associated business case and assurance processes will ensure this investment is focussed on delivering tangible outcomes. At the time of writing of the strategy, 'Who pays for What?' is still in consultation and financial allocations to support delivery of the objectives outlined in this strategy are unclear.

An approach to sustainable financial planning and a more robust sustainable investment plan is expected to be completed by **December 2022**.

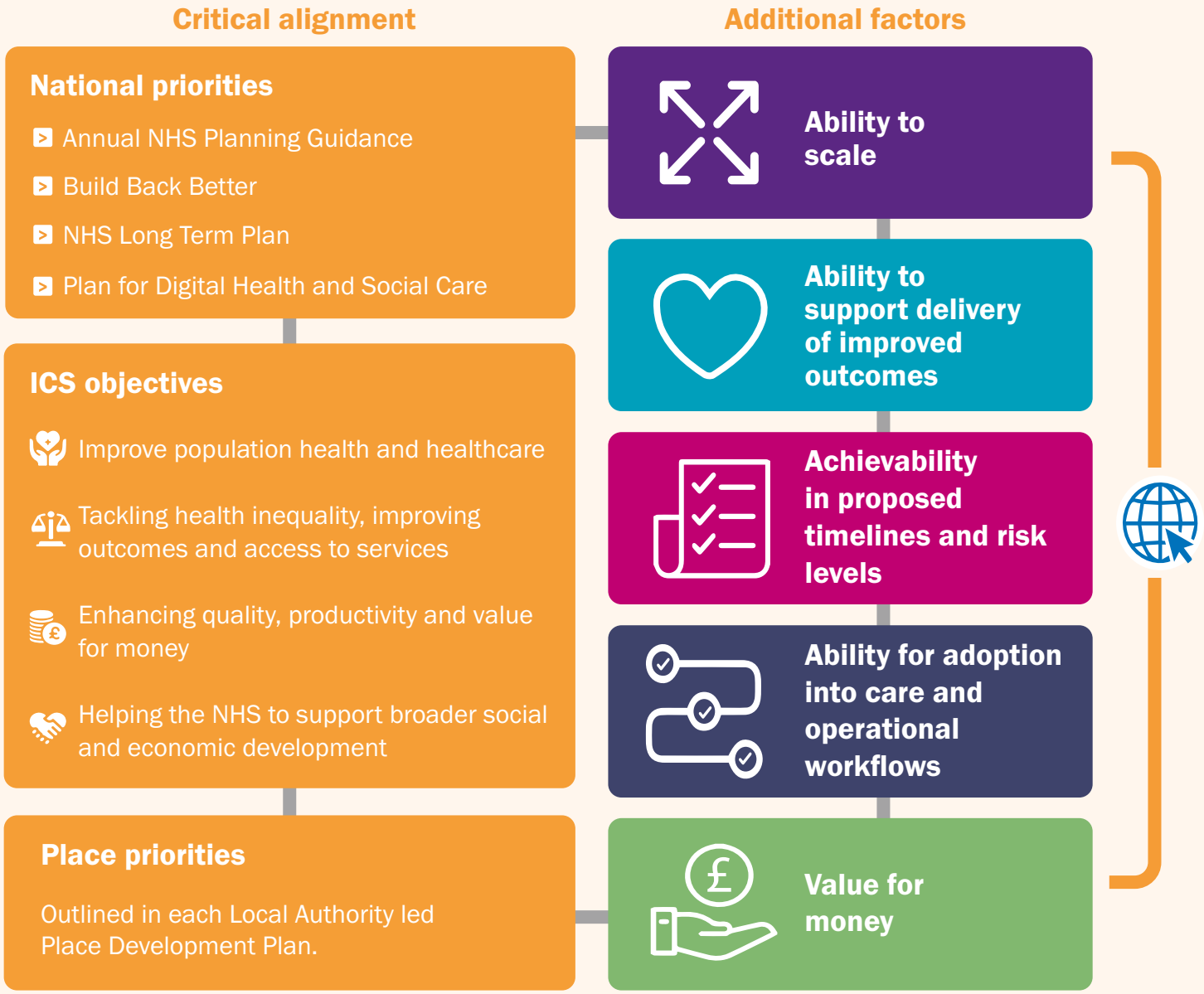
Prioritisation of investment funds

The ICS will make future investment decisions and an approach to prioritisation that will create most impact in the **'levelling up'** and **'intelligence into action'** agendas.

We can look to 'level up' digital maturity across stakeholders in the system whilst ensuring that we remain at the forefront of digital and data utilisation to improve outcomes where possible. Initial work is seeing a range of investment in digital and data by NHS Providers in Cheshire and Merseyside. As a % turnover, this is between 1.7% – 6.1% and thus illustrates the additional work needed by some to ensure a match to those that are 'leading edge' in terms of their digital and data utilisation.

We will make sure that all our investments are **informed by public involvement** and **aligned with key national and local priorities** and take into account **additional factors that will affect overall impact**.

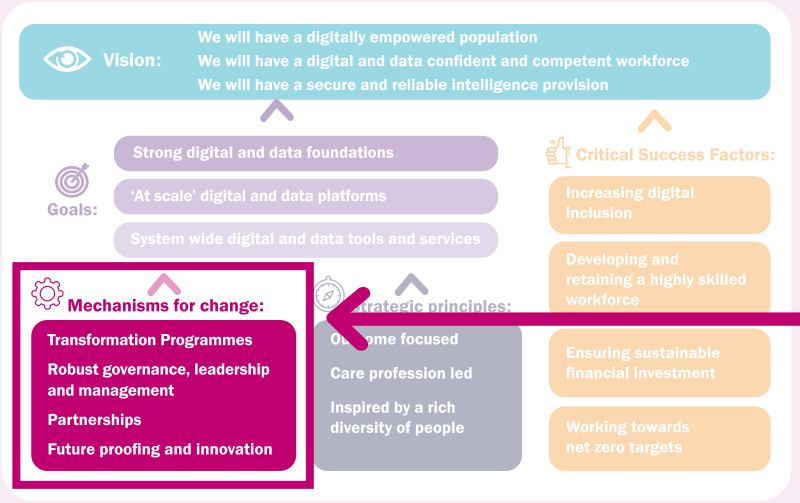
As ICS access to investment and decision-making increases then the **prioritisation approach will evolve and consolidate to deliver a flexible and transparent process** for the allocation of funds to digital and data programmes. This will ensure ongoing visibility of benefits realisation for the public.



Mechanisms for implementing transformational change

Creating momentum to drive 'intelligence into action' and positively impact the population outcomes requires explicit mechanisms for change and for ongoing monitoring. Perhaps most particularly with digital and data solutions, it is important to acknowledge they cannot be successful in 'turning the dials' in isolation.

This strategy outlines four key mechanisms for implementing the required change, which are outlined below.



Transformation Programmes

Robust governance, leadership and management

Partnerships

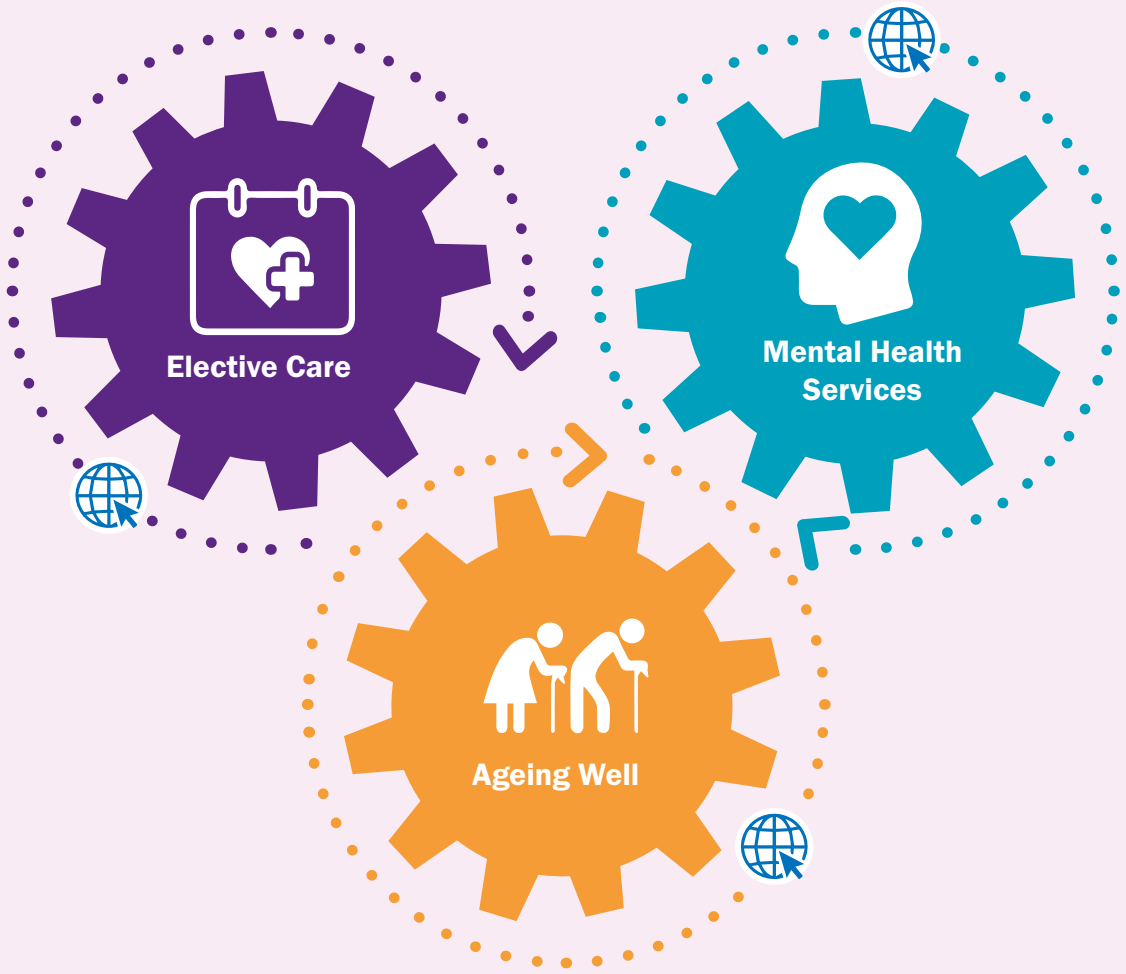
Innovation and future proofing our Digital and Data Strategy

Transformation Programmes

One of the critical mechanisms for delivering digital and data informed change are the ICS Transformation Programmes. These represent a combination of existing ICS and nationally funded programmes that work through individual Providers, Provider Collaboratives and Places to deliver critical change including digital and data solutions.

A significant amount of work has been undertaken to understand the outcomes these programmes have been established to achieve and the initiatives in place to deliver those improved outcomes. We have rigorously assessed where digital and data initiatives support transformation now and in the future. These 'outcome maps' provide the basis to understand how the investment in digital and data can positively impact on individual and population level outcomes. Click on the information icon against three of our key transformation programmes to find out more.

The ICS Transformation Programmes do not represent the full extent of transformation activity across the whole Cheshire and Merseyside system as there is a vast level of change activity being led at Place and organisation level. However close working with the ICS level Programmes is essential to ensure the more local programmes are well placed to take advantage of what digital and data have to offer and to create meaningful feedback loops on digital and data requirements and future ambition. This process will develop and evolve over time and be managed through collaborative working and strong governance.

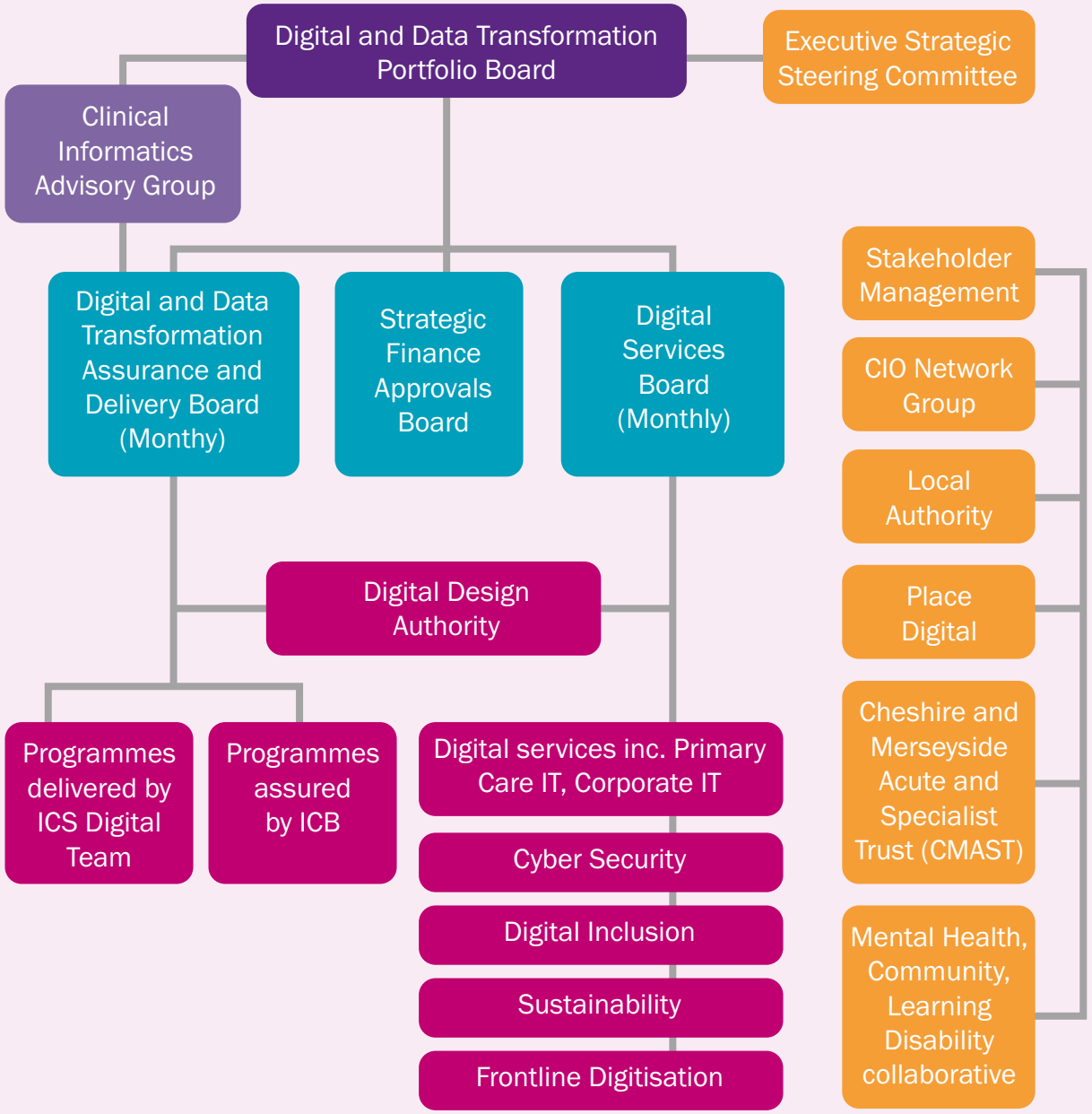


Robust governance, leadership and management

The governance arrangements for digital and data, reporting through the ICS Transformation Board is visually summarised on this page.

The governance represents a commitment to care profession leadership as part of the Medical Directorate and a strong oversight of ICS delivered digital and data programmes and services with robust assurance to ensure alignment with ICS-wide standards and plans.

Draft Target Operating Models (TOMs) for both digital and data / business intelligence services have been developed and are expected to be agreed before the end of 2022. The governance and associated target operating model of the ICS digital and data teams also supports the 'Well led' domain of the 'What Good Looks Like' framework.



The key portfolios for digital services, and their alignment to the 'What Good Looks Like' framework are summarised below.

Chief Digital Information Officer

Associate Director of Digital Operations

Policy: Data Saves Lives, Who Pays for What, What Good Looks Like (WGLL) - Well Led, Ensure Smart Foundations

Statutory: Robust governance and financial management

Function:

- System-wide strategic finance
- ICS Business Plan, finance management, procurement and HR
- Policy, investment and approvals
- ICS internal transformation/ transition programme governance
- Communications
- Business case development and approval
- Administration, logistics and events
- Market and supplier management (incl. commercial/ procurement)
- ICS digital governance and reporting
- Digital Performance Management oversight and KPI
- Cheshire and Merseyside ICS executive and national engagement

Chief Technology Officer

Policy: Data Security and Protection Toolkit (DSPT), Technology code of practice, What Good Looks Like (WGLL) - Safe practice, Fundamental Technology capabilities

Statutory: Data protection

Function:

- Enterprise, business and technology architecture
- Information Governance (Deputy SIRO)
- BI information and data architecture
- Portfolio run, service and change management (ITIL)
- Live services and supplier performance
- Business continuity and disaster recovery
- Preventative and responsive support services (Emergency preparedness)
- Digital capability and maturity framework (incl. WGLL)

Transformation Programme Director

Policy: Data Saves Lives, Digital, Data and Technology standards, What Good Looks Like (WGLL) - Improve care, Empower citizens.

Function:

- Transformation programme management delivery
- Strategic clinical networks
- Long Term Plan programme
- Digital transformation programmes
- ICS wider digital transformation portfolio management (Assurance)
- Shared programme management office (incl. funding distribution and programme finance)
- User and product led design
- Change and campaign management
- Benefits management, knowledge, insight and learning

Health and Care Professional Leadership including CCIO

Partnerships

There are a number of key partners that are critical to changing process and culture through digital and data. Multiple organisations form the landscape to support an individual's health and care experience. These key partners include:

The public

Increased engagement with the public drives digital and data innovation that better reflects the needs of the population. This ensures greater long-term alignment with public expectation in the areas that matter most.

Valuing and being inspired by the diversity within Cheshire and Merseyside is a principle underpinning this work and the ICS has already engaged widely with care and business professionals working in health and care services as well as representatives from the public through adult and children and young people (CYP) panels. This has informed and continues to inform the development of digital and data enabled services.

A further focus of the public engagement will be as part of the Civic Data Co-operative (CDC) to ensure the ICS understands how the public expects their data to be captured and then used, particularly in relation to the opportunities of working with other system-wide stakeholders to support wider innovation and research.

Activities are to include:

- Innovation in public participation and communication around the use of health data in care and research.
- A GP engagement programme around the sharing and use of data.
- Creating an open framework for research and digital partnership.

To ensure that digital and data meets the public expectations on an ongoing basis through the ICS led programmes of work, we commit to:

- Effective and inclusive communication with the public.
- Early engagement on initiatives.
- Co-design of front-end functionality.
- Assessment of usability and accessibility of systems.
- Creation of easily accessible feedback loops.
- Deep dives into un/successful functionality factors.
- Use of public engagement initiatives to help us reach specific, seldom heard groups.

Health and care staff

A core principle of the development of this strategy has been that it is care profession led. Going forward, the involvement of care professionals will continue to be critical to ensure that digital and data driven change is meeting need and is embedded into working practices to ensure that 'fit for purpose' solutions are commissioned and delivered to support achievement of the ICS objectives.

Other health and care providers

A number of key health and care providers do not form part of the Provider Collaboratives. Therefore, we will pay particular attention to working with the following groups of providers who play a critical role in delivering health and care services in our system:

Primary care

Social care

Voluntary, Community and Social Enterprise (VCSE) sector

Academia

We will work closely with our academic partners to:

- Embed digital and data skills into pre- and post-registration education and training.
- Embed a culture of learning, research and innovation across the system.
- Gain access to early thinking and opportunities for transformational change across the system.
- Support our on-going public engagement and digital inclusion activities to ensure they are effective.
- Leverage the use of our core platforms for research purposes (particularly for clinical trials and translational research), with a particular focus on developing the Trusted Research Environment (TRE) on the CIPHA platform, for which academia will be a core development partner.
- Leverage existing translational research assets such as the North West HealthTec Cluster in Daresbury and the Digital Innovation Facility at the University of Liverpool.
- Support citizen-driven data innovation through the Civic Data Cooperative (CDC).
- Support independent evaluation of the effectiveness of benefit and outcome delivery.

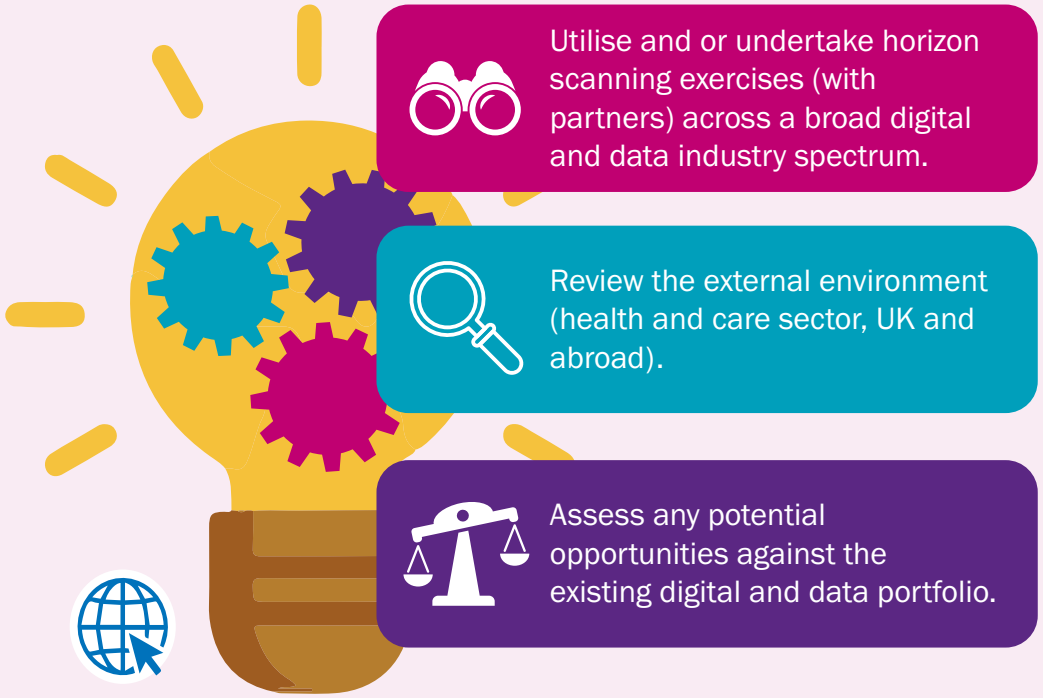
Innovation and future proofing our Digital and Data Strategy

Innovation is a core part of future proofing the digital and data strategy. Cheshire and Merseyside has a long history of digital and data innovation, driven by care professionals to address unmet needs. Alder Hey Hospital, for example, has a well-established innovation hub which focusses on the development of digital platforms, wearable devices, pre-emptive Artificial Intelligence (AI) and immersive technology to solve real world health and care problems children and young people face today. Other Trusts such as Liverpool University Hospital and the Walton Centre also have innovation functions in their Trusts which are focussing on developing 'ground up' digital and data innovations for wider spread and adoption. The ICS will actively support its health and care providers in sharing ideas and developing innovative digital and data solutions collaboratively. It will also support sharing best practice around adoption and embedding innovation into organisational culture.

The ICS will also work locally with LyvaLabs (established by Liverpool City Place) to create strong connections between health and care organisations innovation teams to develop a pipeline of digital and data innovations for potential commercialisation by **March 2024**.

As innovation continues to actively evolve, we also need to better understand and proactively manage additional opportunities. To future proof our digital and data strategy over the next 3 years and to manage risks associated with uncertainties in the external environment, the ICS will implement an innovation pipeline process that seeks to identify medium and long-term risks and opportunities and manage their evolution and impact on Cheshire and Merseyside digital programmes.

The process will regularly:



Future proofing the digital and data strategy requires the monitoring and management of both opportunities for further improvement and risks to the current thinking that could come from many sources. We will develop a defined process, supported by the ICS wide stakeholder group, that will ensure that the ICS is well placed to assess, implement and assure investment into future digital and data innovation for the benefit of its population.

Summary

Cheshire and Merseyside ICS has set a challenging and compelling ambition for digital and data.

We are committing to the levelling up of infrastructure to ensure all our population can derive the same benefit from technology. We are committing to turning 'intelligence into action' to focus on purposeful and evidence-based interventions. Through targeted resourcing and delivery, we will 'turn the dials' on improvement in health and care outcomes.

We have a great starting point and targets for delivery that will support the ICS to meet its stated ambition, vision and goals.

ICS Objective: Improve population health and healthcare

The story so far...

- Through CIPHA we have been able to harness patient level linked datasets to identify populations at risk of certain outcomes and embed the use of this data in clinical pathways for proactive care.
- Advanced population health management tools have been used to gather intelligence on where to focus key system wide public health programmes such as mass COVID testing and the COVID vaccination rollout.
- System P programme established to address multiagency, multisector challenges that negatively impact population health and to identify population cohorts to address need across the system.

Looking ahead...

March 2023

- Provide access to ICS wide person level health and care linked datasets.
- Embed CIPHA reporting in action via System P.

March 2024

- Broaden the linked datasets available for analytics to include education and housing.

ICS Objective:
Tackling health inequality, improving outcomes and access to services

The story so far...

- Some Places and Providers already have an established Patient Empowerment Portal (PEP) in place.
- The ICS has an existing Remote Care platform in place which is delivering virtual ward and Long Term Condition (LTC) monitoring services.
- To support the elective recovery programme, there has been a significant investment in transforming outpatients through the use of online and video consultation and tools to support patient initiated follow up of their own care.
- Research has been undertaken to identify the areas of our population that are most likely to be digitally excluded.
- Some initial work on getting recycling IT equipment out to digitally excluded groups has taken place.

Looking ahead...

March 2023

- Increase the availability of digital monitoring of vital signs for people in care homes and at home to support national targets.
- Develop a tech-enabled annual physical check for people with severe mental illness.
- In primary care, establish a common online and video consultation platform, implement high-quality clinical decision support tools and rollout accredited apps for people to support the management of their own physical and mental health and wellbeing.
- Ensure widespread adoption of the Digital Inclusion Impact Assessment for all existing and new digital and data initiatives.
- Embed existing tools to support elective recovery including online and video consultation and PIFU support.

March 2024

- Additional virtual ward beds (40 to 50 virtual ward 'beds' per 100,000 of the population in place.
- Prevention and detection technologies will be used to protect the 20% of care home residents who are identified as at high risk of falls.
- Provide access to connectivity and equipment for the most digitally excluded groups.

March 2025

- All NHS Providers will have a Patient Empowerment Portal (PEP) that integrates with NHS App.
- Targeted support to get people using the NHS App as the digital 'front door' to health and care services.
- Develop digital buddies and digital carers hubs.

The story so far...

- Investment in digital equipment and infrastructure has been variable across health and care providers.
- Digitising care records has also been variable across Providers. We have previous successes in Cheshire and Merseyside through national programme investment, and our system has one of the most digitally advanced hospitals in the UK (Alder Hey NHS FT). However, we still have hospitals with no Electronic Patient Record (EPR) which are predominantly paper based in their processes, and although Adult Social Care providers have electronic case management systems, Digital Social Care Records (DSCRs) generally do not exist in other providers of adult social care.
- eXchange / Share2Care has been established as the common platform to share care documentation between health and care providers.
- Four Places have their own detailed Place based Shared Care Record in operation.
- Through the Digital Diagnostics Capability Programme (DDCP), a diagnostics IT Network suitable for Radiology Imaging, Pathology and all other diagnostics has been established and cloud storage infrastructure to reduce reliance on on premise storage has been implemented.
- implementation of a Vendor Neutral Archive (VNA) and common Picture Archiving and Communications System (PACS) viewer across Cheshire and Merseyside to enable image sharing and remote radiology reporting more easily.
- Pilot activity on the ability of Robotic Process Automation (RPA)) to perform and automate high-volume repetitive tasks.
- Public View has been implemented as the core performance tool across the ICS.

ICS Objective: Enhancing quality, productivity and value for money

Looking ahead...

- eXchange / Share2Care platform available in all NHS and Local Authority Adult Social Care providers.
- 80% of CQC registered adult social care providers (residential and non-residential) will have adopted a DSCR.
- All NHS and Local Authority Adult Social Care provider organisations connected to integrated life-long health and social care records.
- Implement and oversee delivery of RPA with an expanding rollout plan in line with a clear evidence base of productivity benefits.
- Implement a single performance information system that all partners can access.

March 2023

- Implement e-referral and image sharing for community optometry services.
- Implement ICS wide Capacity and Demand reporting for urgent care (inclusive of community and mental health) and elective care.
- Embed Public View across all Providers and Service Planners in the ICS.

December 2023

- 90% of NHS Provider trusts will have a minimum standard EPR.

March 2024

- Every member of health and care staff in NHS and Local Authority Adult Social Care providers will have access to reliable and fit for purpose access devices.
- Health and care staff in NHS and Local Authority Adult Social Care providers will have access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside.
- 100% of NHS Provider trusts will have a minimum standard EPR.

March 2025

ICS Objective:
Helping the NHS to support broader social and economic development

The story so far...

- Digital has developed a clear set of objectives as part of the overall ICS Green Plan.
- Discussions are ongoing regarding the establishment of a single architecture for data and intelligence, as well as a single platform for data for research purposes.
- Liverpool City Region have established LyvaLabs to help exploit innovation arising from health and social care providers through commercialisation and business development support.
- Wider digital skills development of the health and care workforce has been undertaken on a variable basis by health and care organisations.

Looking ahead...

March 2023

- Rollout the Office 365 e-learning service and expand the amount of training available through this hub.

March 2024

- Develop a pipeline of digital and data innovations for potential commercialisation.

March 2025

- All staff in NHS and Local Authority Adult Social Care providers have a core set of digital and data skills and competence to underpin the increased use of digital and data in their 'day to day' work.
- Deliver against each of the specific targets outlined in the digital and data section of ICS Green Plan.
- Transfer of core health and care information between providers for direct care, population health management, care planning and research, through a single health and care data architecture.
- Implement a Trusted Research Environment (TRE) to support clinical trials and translational research.

Find out more

You can download print friendly and easy read versions of this strategy by visiting our website:

www.cheshireandmerseysidepartnership.co.uk

For more information about our digital and data plans to enable 'intelligence into action' connect with us online:

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

ICS Digital and Data Strategy

Appendix B

- Final Draft Summary Strategy

Cheshire and Merseyside ICS Digital and Data Strategy: 2022 – 2025

Summary

Contents

Foreword

Our digital and data work will be care profession led and informed to drive the best health and care outcomes for the population we serve and will ensure that we use the best intelligence in the planning and delivery of care to benefit those most in need.

This Digital and Data strategy describes an ambition to improve the health and well-being of our region right now and into the long term by weaving our digital and data infrastructure, systems and services throughout the pathways of care we provide. This requires **'levelling up'** our digital and data infrastructure to help address the significant inequalities so clearly faced by parts of our population and ensure we successfully support *all* we serve. We are committed to turning **'Intelligence into Action'**. where we have increasingly sophisticated ways of understanding the health and care needs of our population, and then finding and intervening for those in greatest need to **'turn the dials'** on improvement in their health and care outcomes in an equitable way.

As we invest into 'levelling up' our digital and data systems and relentlessly drive 'intelligence into action', we will deliver high quality, safe and equitable services that underpin the health, well-being and independence of our whole population both now and into the future.

Prof. Rowan Pritchard-Jones
Medical Director
Cheshire and Merseyside Integrated Care Board (ICB)

Summary

1. Why is Digital and Data important for the ICS?

Cheshire and Merseyside Integrated Care System (ICS) has a current digital strategy (called 'Digit@ll') that has been a key driver for investment in key IT systems and underpinning IT infrastructure to support health and care delivery ('**digital' solutions**). These solutions should not be treated in isolation from the health and care **'data'** that is held inside of those systems. When this data is used to create health and care '**intelligence**', its value increases significantly, providing insight into the healthcare needs of the population. Reducing the gap between data and action enables health and care services to exploit opportunities to reduce suffering and decrease mortality.

Since development of 'Digit@ll', there has been rapid adoption of digital tools such as team collaboration software, video consultations, remote monitoring and the adoption of digital diagnostics, that has changed the way health and care staff work now and in the future. There has also been accelerated use of population health and intelligence tools since the start of the pandemic, enabling researchers to pioneer new models of care. The public expectation of digitally enabled health and care services has also expanded significantly, although alternatives will still need to be available for those who do not have access to digital tools and skills. Public expectation also means that health and care services will be delivered with environmental sustainability at the core in support of the NHS Net Zero ambition.

National policy through the 'What Good Looks Like' framework has also reinforced the digital and data focus. Clear guidance is provided, along with the impetus for health and care leaders to connect and transform services safely, securely and sustainably through the increased use of digital, data and intelligence for the efficient and effective delivery of health and care services. They can be used to directly have a positive impact on the health and care outcomes for individuals and the population as a whole; **'intelligence into action'.** We set out how we will show that every pound spent on digital, data and intelligence has a greater return, delivering a positive impact on health and care services which in turn improves the relevant health and care outcomes for a person and or a community; **'turning the dials through digital, data and intelligence'**.

2. Understanding the Challenges and Key Stakeholders in Cheshire and Merseyside

Cheshire and Merseyside ICS represents a large and diverse geographical footprint. There are 2.7 million people living across areas of both significant wealth and substantial deprivation. The mental and physical health and care challenges are faced by some of the most deprived neighbourhoods with the greatest health inequalities in England.

Deprivation has a direct impact on mental health and socioeconomically disadvantaged children and adolescents are two to three times more likely to develop mental health problems.

The pandemic has negatively impacted the health and wellbeing of the nation over and above the immediate impact of Covid-19 itself and the numbers awaiting investigations and treatments have increased significantly.

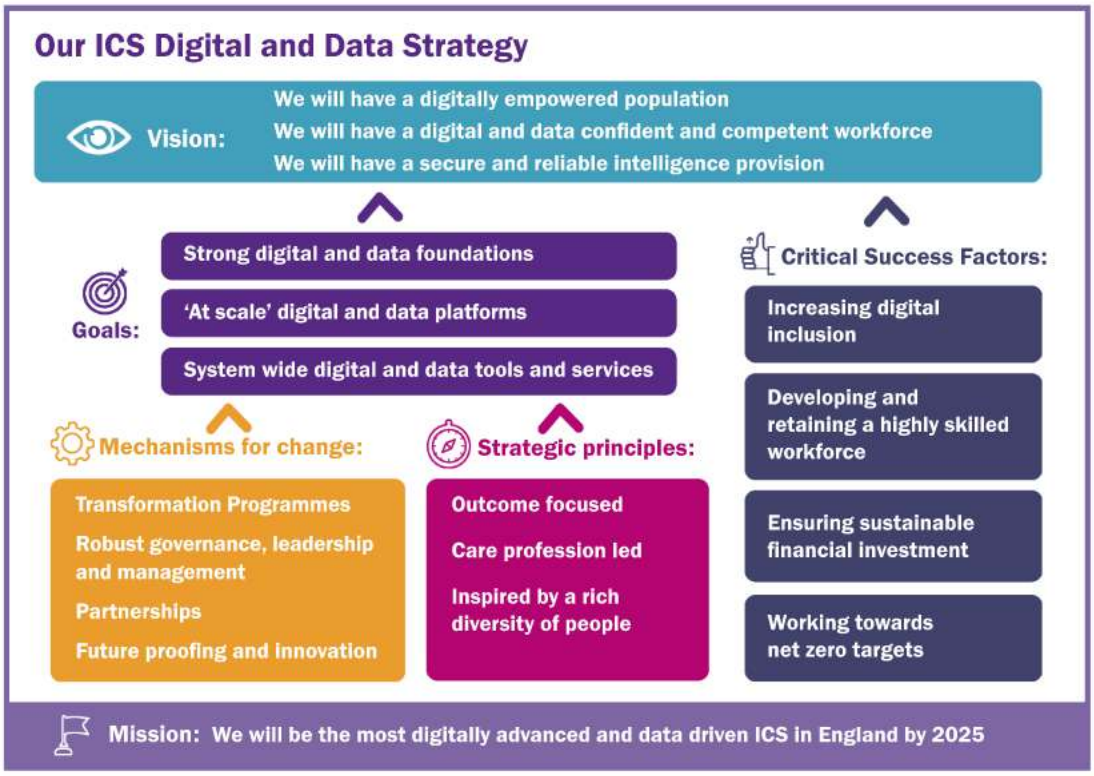
Digital exclusion is another facet of deprivation and socioeconomic inequalities and can increase health inequalities further.

Against this complex backdrop, digital and data are key enablers to improving care. There is an opportunity to standardise care and ensure that the public receives maximum benefit from addressing the most significant factors that impact physical and mental health, wellbeing and independence.

The Integrated Care System (ICS) creates a common framework and provides an operating model under which a complex map of stakeholders can find new ways of working together, aligned around the needs of the local population.

The ICS footprint is broken down into Places, which are made up from a series of health and care organisations. Cross provider working is also supported by the formation of ICS wide Provider Collaboratives. Places and Provider Collaboratives are the key organisational structures that will enable the transformational changes digital and data seek to support for the local population.

The overarching vision, mission and objectives of the ICS are set out in the 2021-2025 ICS Strategy. These are focussed on tackling the big issues that need to be addressed to improve health and reverse the widening gaps in life expectancy between the poorest and wealthiest in our population. The purpose of the ICS digital and data strategy is to support the achievement of the ICS vision, mission and objectives.



3. Our Digital Goals

3.1 Building Strong Digital and Data Foundations

Digital Maturity Assessments clearly show that there is a need to invest in core technologies and services to ensure that there is increased equity of provision across the whole of the system to improve the effectiveness and safety of care for all of the population. This **'levelling up'** of the basic digital and data infrastructure and systems supports safe practice and ensures we build strong foundations on which to deliver our ambition.

3.2 'At scale' Digital and Data Platforms

The ICS will continue to develop and expand its strategic digital and data platforms for use within all health and care providers and in all Places to leverage the benefits of at-scale investment and deliver improved outcomes for the population. This includes:

- **Shared Care Records** - supports **improved decision making** to help provide better, **safer care** when it is most needed
- **Patient Empowerment Portals (PEPs) and Person Held Records (PHRs)** - enabling people to increasingly **self-manage their long-term conditions**, mental health, care plans and wellbeing by providing access to services that **best suit individual** needs as well as their **increasing resilience**
- **Remote Care -** using technology to allow an individual to monitor their own physical and mental health and wellbeing, with the support of relevant health and care workers, from their usual place of residence, **reducing demand and improving care quality through early identification of issues**

- **Digital Diagnostics –** allows the person to choose when and where their diagnostic examination will take place, with the most appropriate laboratory and clinician providing the study to the requesting clinician
- **Intelligence Delivery Platforms - t**he ICS will continue to:
    - Use DSCRO data provided by Arden and GEM CSU and the NHS National Data Platform for access to national data sets
    - Utilise **Combined Intelligence for Population Health Action (CIPHA)** as the core population health management platform for the ICS, its Transformation Programmes and Places. Ongoing development will:
        - Enable alignment with the overall Population Health approach (as being developed by System P)
        - Further **identification of populations at risk of adverse outcomes, patterns and trends** to support those with the greatest health and care needs
        - **Evaluate the success of interventions** and campaigns and manage resources effectively to deliver the very best standard of care
        - **Explore Secure Data Environments** for researchers.
    - Increasingly provide a large scale and evolving picture of metrics across multiple initiatives that demonstrate activity and outcome changes and identifies the critical Key Performance Indicators (KPIs) of success

3.3 System Wide Digital and Data Tools and Services

The ICS will further leverage the 'at scale' platforms through the development of ICS level applications, tools and services that support delivery of the ICS health and care objectives. This includes:

- **Population Health and Business Intelligence Services -** ICS wide business intelligence services will create automated analytics to develop 'one version of the truth' across the ICS for use in epidemiology based analytics, population health management, capacity and demand modelling and performance, as well as responding to bespoke requirements.
- **Digital Tools and Services -** the ICS is supporting the delivery of digital wide tools and services that are used by all relevant stakeholders in Cheshire and Merseyside to ensure equity of provision and leverage economies of scale. This includes a wide variety of applications including Robotic Process Automation (RPA), Office 365 training and Clinical Decision Support tools.

4. Critical Success Factors

The implementation and delivery of this strategy can only be regarded as successful if alongside the technical developments a small number of additional critical conditions are met. These Critical Success Factors (CSFs) are:

4.1 Developing and retaining a highly skilled workforce

The ICS is committing to supporting the development of enhanced skill sets and new practices for both the digital and data experts and the health and care professionals who lead the change.

Investment in formal professional standards, talent development and retention is key for the digital and data specialists.

For the wider workforce the focus will be on digital and data skills, development of specialist champions and investment in future digital leaders.

4.2 Increasing Digital Inclusion

People will need skills to utilise digital and data platforms and be able to benefit from them. The ICS will work with all providers and at Place level to ensure that everyone who struggles to access and engage with digital technologies has the opportunity to do so or is provided with an alternative means of service (to ensure we retain equity of provision).

4.3 Working towards Net Zero targets

The ICS is committed to the NHS environmental sustainability ambition. The ICS Green Plan commits to: a focus on (digital and data enabled) ways to streamline care and support service functions; to improve the use of resources; and to reduce carbon emissions. The Recycle / Rethink / Reduce / Reuse concept drives innovation and practical objectives in digital and data that support the overall drive towards Net Zero.

4.4 Ensuring sustainable financial investment

Investment in digital and data during a financially constrained period is a challenge but it is a key way to deliver against these key NHS pressures by focussing on where care is needed the most through **'levelling up',** and applying evidence-based '**intelligence into action'**. In this way the investment can demonstrably show the benefit and **'turn the dials'** on outcomes for individuals and the population as a whole.

4.4.1 Accessing investment

As funding is devolved down to ICSs to invest in their systems, the funding principles and the associated business case and assurance processes will ensure this investment is focussed on delivering tangible outcomes.

4.4.2 Prioritisation of Investment Funds

The ICS will make future investment decisions and utilise an approach to prioritisation that will create most impact in the '**levelling up'** and '**intelligence into action'** agendas.

We can look to 'level up' digital maturity across stakeholders in the system whilst ensuring that we remain at the forefront of digital and data utilisation to improve outcomes where possible. There is currently a range of investment locally in digital and data and as a result, an imbalance exists in population experience.

All our investments are informed by public involvement and aligned with National Priorities, ICS objectives and local Place priorities. In addition, prioritisation factors will also be considered in making the critical investment decisions including ability to scale, ability to deliver improved outcomes, achievability in proposed timeframes, likelihood of embedded adoption into working practice and value for money.

As the ICS access to investment and decision-making increases then the prioritisation approach will evolve and consolidate to deliver a flexible and transparent process for the allocation of funds to digital and data programmes and ensure ongoing visibility of benefits realisation for the public.

5. Mechanisms for implementing transformational change

Creating momentum to drive **'intelligence into action'** and positively impact the population outcomes requires explicit mechanisms for change and ongoing monitoring. Perhaps most particularly with digital

and data solutions, it is important to acknowledge they cannot be successful in **'turning the dials'** in isolation. This strategy outlines four key mechanisms for implementing the required change:

5.1 Transformation Programmes

One of the critical mechanisms for delivering digital and data enabled change are the **ICS Transformation Programmes.** These represent a combination of existing ICS and nationally funded Programmes that work through individual Providers, Provider Collaboratives and Places to deliver transformational change. Rigorous assessment of where digital and data initiatives support change now and into the future has taken place and informs how the investment in digital and data can positively impact on individual and population level outcomes.

The ICS Transformation Programmes do not represent the full extent of transformation activity across the whole Cheshire and Merseyside system as there is a vast level of change activity being led at Place and organisation level. Close working with Places is essential to ensure the more local programmes are well placed to take advantage of what digital and data have to offer and to create meaningful feedback loops on digital and data requirements and future ambition.

5.2 Robust Governance, Leadership and Management

Governance arrangements provide strong oversight of ICS delivered digital and data programmes and services and robust assurance to ensure alignment with ICS wide standards and plans.

Draft Target Operating Models (TOMs) for both digital and data / business intelligence services have been developed and are expected to be agreed before the end of 2022.

5.3 Partnerships

Multiple organisations form the landscape to support an individual's health and care experience. There are several key partners that are critical to changing process and culture through digital and data over and above the Provider collaboratives and Places.

5.3.1 The Public

Increased engagement with **the public** also drives digital and data innovation that better reflects the needs of the population. This ensures greater long-term alignment with public expectation in the areas that matter most.

5.3.2 Health and Care Staff

A core principle of the development of this strategy has been that it is care profession led. The involvement of care professionals will continue to be critical to ensure that digital and data driven change is meeting need and is embedded into working practices to ensure that 'fit for purpose' solutions are commissioned and delivered to support achievement of the ICS objectives.

5.3.3 Other Health and Care Providers

A number of key health and care providers do not form part of the Provider Collaboratives but play a critical role in delivering health and care services in our system and additional initiatives are being therefore being supported by the ICS with a focus on Primary Care, Social Care (Adult and Child) and the Voluntary, Community and Social Enterprise (VCSE) sector.

5.3.4 Academia

We will work closely with our academic partners to increase alignment on development of solutions to support research needs and collaborate in the use of existing and new tools to continually increase the effectiveness of health and care provision through application of translational research.

5.4 Innovation and Future Proofing our Digital and Data Strategy

Innovation is a core part of future proofing the digital and data strategy. Cheshire and Merseyside has a long history of digital and data innovation, driven by care professionals wanting to address unmet needs. The ICS will actively support its health and care providers in sharing ideas and developing innovative digital and data solutions collaboratively. It will also support sharing best practice around adoption and embedding innovation into organisational culture.

The ICS will also implement an innovation pipeline process that seeks to identify medium- and long-term opportunities and manage their evolution and impact on Cheshire and Merseyside digital programmes and the health and care outcomes experienced by the population.

6. Summary

Cheshire and Merseyside ICS has set a challenging and compelling ambition for digital and data. We are committing to the **levelling up** of infrastructure to ensure all our population can derive the same benefit from technology. We are committing to turning **'intelligence into action'** to focus on purposeful and evidence-based interventions. Through targeted resourcing and delivery, we will **'turn the dials'** on improvement in health and care outcomes.

We have a great starting point and targets for delivery that will support the ICS meet its stated ambition, vision and goals.

Appendix 1 – Summary of our Commitments to deliver the Digital Goals

Goal 1: Building Strong Digital and Data Foundations

To level up digital infrastructure we will ensure:

- **Every member of health and care staff in NHS and Local Authority Adult Social Care providers that needs access to digital equipment to undertake their role will have access to reliable and fit for purpose access devices by March 2025**
- **Health and care staff in NHS and Local Authority Adult Social Care providers will have access to reliable, seamless and secure network infrastructure to enable them to deliver their role, wherever they are working in Cheshire and Merseyside, by March 2025**. This will be facilitated by working in partnership with other public services and network providers to access initiatives such as Gov Roam and the rollout of 5G through initiatives such as LCR Connect
- **For NHS Providers, 90% of NHS trusts will have a minimum standard Electronic Patient Record (EPR) by December 2023, and 100% by March 2025**. Appropriate convergence of EPRs will be encouraged where possible to make it easier for staff to use them and ease the interoperability challenge
- **For Adult Social Care, 80% of CQC registered adult social care providers (residential and non-residential) will have adopted a Digital Social Care Record (DSCR) by March 2024**. This is in line with the 'Plan for Digital Health and Social Care' requirements.

To level up data and intelligence infrastructure we will ensure:

- **Access to ICS wide person level health and care linked datasets by March 2023** as a corner stone for population health analytics
- **The broadening of linked datasets available for analytics to include those outside of health and care such as education and housing by March 2024,** through working with the ICS, Local Authority and national partners
- **The transfer of core health and care information between providers, within relevant Information Governance agreements and for the purposes of direct care, population health management, care planning and research, will be undertaken through a single health and care data architecture by March 2025**. To support this we will:
    - Expand the information governance framework to include implementation of Data Sharing Agreements for use of data for research and innovation and full compliance with national data opt-out by March 2023
    - Implement electronic management of data sharing agreements via the Information Sharing Gateway by March 2023.

To level up 'safe practice' we will ensure:

- **Provision of cyber security services** including cyber security operations, incident response and assurance that complements and works alongside local health and care provider cyber security functions
- **Access to clinical safety subject matter expertise** to ensure that the digital and data solutions in use across Cheshire and Merseyside are DCB0129 compliant (i.e., have appropriate safeguards

associated with clinical and care hazards) and have been implemented in line with 'best practice' clinical safety standards (as outlined in DCB0160)

- **Access to Information Governance subject matter expertise** to enable statutory health and care providers to operate safely with regards to information sharing legislation and protocols – supporting the improvement of dataflows and streamlining necessary data sharing
- **Access to technical and data architecture expertise** to ensure that system wide solutions are reliable and align with Place and Provider systems to allow connectivity and ease of data flow across Cheshire and Merseyside. We will also ensure that national architecture standards and principles are maintained (e.g., 'cloud first', interoperability standards such as FHIR and the use of OpenAPIs)
- **Digital environmental sustainability support** to ensure that any system and Place based digital and data initiatives support the ICS' 'net zero' ambitions as outlined in the ICS' 'green plan'
- **Data quality** to establish a common approach for improvement in data quality across the ICS so that our decisions are based on sound data
- **Data safety** so that the public can be reassured that their data is used lawfully, with respect, held securely and that the right safeguards will be in place (through supporting adoption of the 'Five Safes' model and the Caldicott Principles).

Goal 2: 'At scale' digital and data platforms

- We will ensure that the **Share2Care platform is available in all NHS and Local Authority Adult Social Care providers**, enabling sharing of a core set of health and care data across the whole health and care system **by March 2024**
- We will further support all Places to ensure that all NHS and Local Authority Adult Social Care provider organisations of the ICS are **connected to integrated life-long health and social care records by March 2024**, enabled by core national capabilities, local health records and shared care records, giving individuals, their approved caregivers and their care team the ability to view and contribute to the record.
- We will ensure that **all Providers have implemented a Patient Empowerment Platform (PEP) that integrates with NHS App (as the 'front door' to health and care service for an individual or their carers) by March 2025**
- We will continue to build on the existing Remote Care platform delivering virtual ward and Long Term Condition (LTC) monitoring services, and expand this offering to deliver **additional virtual ward beds (40 to 50 virtual ward 'beds' per 100,000 of the population by March 2024.** We will also continue LTC monitoring for other specialties, as well as support for the wider NHS@Home programme which will drive the focus of the platform going forward. This will include:
    - **Supporting the availability of digital monitoring of vital signs for people in care homes and at home, contributing towards the national aim of a further 500,000 people being supported by this technology by March 2023**
    - **Develop a tech-enabled annual physical check for people with severe mental illness by March 2023.**
- We will also agree the care pathways where this platform can be used for supporting 'Care@Home' applications such as environmental monitoring and medicines management of those living at home (or in supported accommodation) to ensure they remain safe as part of the discussions regarding alignment with Technology Enabled Care (TEC) developments in Adult

Social Care. **Agreed pathways where people are supported in this manner will be in place by March 2024 and prevention and detection technologies will be used to protect the 20% of care home residents who are identified as at high risk of falls by 2024.**

- We will continue the development of the CIPHA Platform to include further Population Health Management reporting that enables the identification, segmentation and evaluation of cohorts for the targeting of interventions. The work here will align with the overall population segmentation approach as being developed by the System P programme, which will focus on identification of populations most vulnerable and at risk of adverse outcomes, and developing services for those population segments most in need of improved health and care outcomes**. It is intended to embed CIPHA reporting in action via System P and Population Health Board Programme/Networks by March 2023.**
- We will **embed Public View across Providers & Service Planners to include access, quality, activity, outcomes and workforce, containing national and local flows and underpinned by granular detail on Aristotle by March 2023.**

Goal 3: System wide Digital and Data Tools and Services

We will:

- **Implement ICS wide Capacity and Demand reporting (based on an Operational Intelligence Hub) in the areas of urgent care (inclusive of community and mental health) and elective care by March 2023 (with further development 2023/24)** to enable an ICS wide view to inform both planning and operations
- **implement a Trusted Research Environment (TRE) on the CIPHA platform by March 2025** so that data can be mobilised for research and innovation for our partner organisations, particularly for Stage 3 clinical trials and translational research
- **Implement a single, mature performance information system (activity, finance, quality and outcomes) that all partners can access by March 2024**
- Work with providers to create analytical networks and assist in streamlining of data flows, processes and quality across the ICS
- Work with Local Authority and Public health analytical networks and strengthen joint work programmes in delivery of the ICS objectives.

The ICS is supporting the delivery of digital system wide tools and services that are used by all relevant stakeholders in Cheshire and Merseyside to ensure equity of provision and leverage economies of scale. These include:

- Implementation of **Robotic Process Automation (RPA)** to perform and automate high-volume repetitive tasks (using process flows), to free up time for their clinical and/or non-clinical workforces, through a rollout plan in line with a clear evidence base of productivity benefits **by March 2024**. This builds on the work done by Trusts such as Alder Hey, who are establishing an RPA Centre of Excellence
- Delivery of **Office 365 optimisation and Training services** to frontline health and care staff to support the use of these business-critical tools **by March 2023**
- Supporting the on-going development of primary care through the establishment of a **common online and video consultation platform**, implementation of **high-quality clinical decision**

support tools and the rollout of **accredited apps for people** to support management of their own physical and mental health and wellbeing by **March 2023**

- To **safely refer patients directly from community optometry services to hospital specialists** and to **share diagnostic imaging between primary and secondary care** to support diagnosis without the need for additional scans or photos **by March 2023**
- Support the **rollout of electronic care records into care homes and other providers of social care** including domiciliary care **by March 2024**.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Equality, Diversity and Inclusion update report.

Agenda Item No	**ICB/11/22/13**
Report author & contact details	Andy Woods- Senior Governance Manager Equality Diversity Inclusion (EDI). Andrew.woods3@nhs.net
Report approved by (sponsoring Director)	This report has been approved by Clare Watson (Assistant Chief Executive) and Chris Samosa (Chief People Officer).
Responsible Officer to take actions forward	Andy Woods- Senior Governance Manager EDI

Equality, Diversity and Inclusion update report

<table>
<tr><td>Executive Summary</td><td colspan="5">Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with responsibility for paying ‘due regard’ to the Public Sector Equality Duty (Section 149, Equality Act 2010) and for all mandated regulatory Equality Diversity and Inclusion (EDI) requirements. The board will need to provide visible leadership to advance equality of opportunity across the ICB and wider system and lead the ICB to become a more inclusive employer.

Therefore, the report’s purpose is to:
• update and assure the Board on EDI activity to date, from both a workforce and patient perspective.
• outline key short-term priorities and next steps prior to developing a robust EDI framework and operating model that meets the ambitions of the ICB, post April 2023.
• highlight the current short term resource constraints and mitigations.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to note:
• the work undertaken to date from a workforce and patient perspective.
• the key priorities that need to be progressed before April 2023.
• the current resource constraints to deliver against some deliverables have been highlighted and mitigations are being explored by relevant Executive Officers.</td></tr>
<tr><td>Key issues</td><td colspan="5">Key short-term priorities and deliverables have been outlined in the report, prior to the Associate Director of EDI (Peoples Directorate) who will be post from April 2023, (section three).</td></tr>
<tr><td>Key risks</td><td colspan="5">Current EDI resource constraints to deliver against some of the short-term priorities are highlighted in the report below. Mitigations are in place and further support options are currently being explored in the short term from a workforce perspective by the Chief People Officer and from a patient EDI perspective by the Assistant Chief Executive.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td colspan="2">IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td></td><td colspan="2"></td><td>X</td><td></td></tr>
<tr><td>Legal</td><td colspan="2">Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td>X</td><td colspan="2">X</td><td>X</td><td></td></tr>
<tr><td>Route to this meeting</td><td colspan="5">The contents of this report have been discussed at length with key Executives, including Assistant Chief Executive and Chief People Officer from July 2022. The Paper noted by the ICB entitled ‘Assurance for substantial change’ on the 29th September 2022, section three, outlined the importance and standards required of Board members ‘when paying ‘due regard’ to the PSED prior to making any decisions.</td></tr>
</table>

Management of Conflicts of Interest	No conflicts of interest have been identified.
Patient and Public Engagement	Not applicable directly to the paper but Patient and Public Engagement with the public and stakeholders who share protected characteristics are integral to paying 'due regard' to the Public Sector Equality Duty (PSED).
Equality, Diversity and Inclusion	The report highlights key activity that supports the ICB to meet its Specific duties and Public Sector Equality Duty (Equality Act 2010) and mandated regulatory requirements and key priorities moving forward.
Health inequalities	The completion of the Equality Delivery Systems 2022 (Section 2.5) and the creation of interventions and action plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the Core20Plus5 approach.
Next Steps	ICB will receive a paper in February 2023 to approve specific statutory requirements to set Equality Objectives and Publish Equality Information (EDI Annual report), and mandated regulatory requirements (Equality Delivery System implementation) and provide an update on progress against key priorities outlined in the report below.
Appendices	None

Equality Diversity and Inclusion Update Report

1. Executive Summary

1.1. Cheshire and Merseyside Integrated Care Board (ICB) is the organisation with responsibility for paying 'due regard' to the Public Sector Equality Duty (Section 149 Equality Act 2010) and for all mandated regulatory Equality Diversity and Inclusion (EDI) requirements. The Board will need to provide visible leadership to advance equality of opportunity across the ICB and wider system and lead the ICB to become a more inclusive employer.

1.2. Therefore, the report's purpose is to:

- update and assure the Board on EDI activity to date, from both a workforce and patient perspective.
- Outline key short-term priorities and next steps prior to developing a robust EDI framework and operating model that meet the ambitions of the ICB post April 2023.
- Highlight the current short term resource constraints and mitigations.

2. Introduction / Background

2.1 As a statutory organisation, NHS Cheshire and Merseyside ICB will be subject to the Equality Act 2010 and the Public Sector Equality Duty provisions. It must, in the exercise of its functions, have 'due regard' to the three aims of the Public Sector Equality Duties outlined below:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act
- advance equality of opportunity between people who share a protected characteristic and those who do not.
- foster good relations between people who share a protected characteristic and those who do not.

2.2 The Act explains that having 'due regard' for advancing equality involves:

- removing or minimising disadvantages suffered by people due to their protected characteristics.
- taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

2.3 Due regard' means that the ICB must ensure they are giving *advanced* consideration to issues of 'equality and discrimination' before making any commissioning or policy decisions that may affect or impact on people who share protected characteristics. It is vitally important to consider equality implications as an integral part of the work and activities that the ICB does. Failure to do so is unlawful.

2.4 The Equality Act 2010 also places Specific Duties on the ICB to ensure transparency, and to assist in the performance of this duty, the Equality Act 2010 (Specific Duties) Regulations 2011 require public authorities to publish:

- Equality Objectives, at least every four years.
- demonstrate their compliance with the public sector equality duty.
- publish Equality information including the Gender Pay Gap regulations 2017 (Workforce).

2.5 Mandated or regulatory EDI requirements include:

- Equality Delivery Systems (EDS) which is a generic system designed for both NHS commissioners and NHS providers. The ICB has adopted the new EDS 2022 toolkit for implementation in 2022 to 2023. The EDS 2022 aims to help local NHS systems and organisations, in discussion with local partners and local populations, review and improve their performance for people with characteristics protected by the Equality Act 2010. By using the EDS 2022, NHS organisations can also be helped to deliver on the Public Sector Equality Duty. EDS 2022 is aligned to NHS England's Long Term Plan and its commitment to an inclusive NHS that is fair and accessible to all. The EDS 2022 comprises eleven outcomes spread across three Domains, which are:
  - commissioned or provider services (requires an integrated approach)
  - workforce Health and Wellbeing
  - inclusive leadership.

2.6 The outcomes are evaluated, scored, and rated using available evidence and insight. The completion of the EDS, and the creation of interventions and actions plans in response to the EDS findings, can contribute to NHS system and provider organisations achieving delivery on the Core20Plus5 approach.

2.7 Other mandated regulatory requirements include

- Accessible information Standard
- The Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES). Note this is currently applicable to NHS Trusts only however is expected to be extended to ICBs in 2023.

3. Workforce/ Organisational Development update and key priorities

3.1 The Chief People Officer will act as the Senior Responsible Officer for EDI, Workforce and Organisational Development at Board level.

3.2 Demographic profiling is an essential characteristic of health and care workforce planning and modelling. It enables us to sense check our progress against national imperatives for the equality, diversity and inclusion relayed in the NHS People Promise 2022, NHS Long Term Plan 2019, NHS Model employer 2019 and the Messenger Review 2022 and more locally, the Northwest NHS anti racism framework 2022 and CQC Well Led framework.

3.3 Since the transition to NHS Cheshire and Merseyside on the 1st of July 2022, activity to monitor and address workforce inequalities in line with the ICB public sector equality duty have included:

- The ICB has recruited an Associate Director of EDI, who will be in post from April 2023. This key role will provide strategic and operational leadership across the ICB.
- Working towards a single amalgamated workforce demographic profile to inform our regulatory duty to report to the Workforce Race Equality Standard and in the future Workforce Disability Equality Standard
- Working towards a single workforce profile to inform our statutory duty to report on the gender pay gap
- Ongoing development of a framework to build internal cultural competence capability
- The roll out of the staff survey to understand any differentials in staff experience in context of recruitment, access to development, experience of work and engagement with just culture principles within HR systems and processes.
- Equality impact assessments pertaining to large scale change effort underpinning the transition of the 9 CCGs to a single ICB
- Ongoing monitoring of diversity in the ICB in the senior leadership tiers at Board, Executive and succession lines of senior leadership body
- Working with our local trusts to develop a dedicated workforce policy to support people who are transitioning gender in the workplace.
- Working with our local trusts to develop a dedicated workforce policy to support Reservists and Adult Cadets and also to develop a standard narrative for public facing websites on our support offer for the Armed Forces community in Cheshire and Merseyside. The ICB has recently signed the Armed Forces covenant.
- Exploration of access to regional system-based resources of support for underrepresented groups including local staff equality networks, health and wellbeing provision and support
- Exploration of system opportunities to drive positive action approaches to recruitment at all levels of the ICB workforce to achieve diversity.

3.4 Priorities for tackling workforce inequalities in Year 1 of the ICB lifecycle will include but not limited to:

- Development of cultural competence across the organisation to drive a Just culture
- Inclusive leadership development.
- Robust reporting and monitoring of the WRES and gender pay gap reporting outcomes to drive local action planning.
- Leadership recruitment overhaul responsive to the NHS Future of NHS Human resources and organisational development report, 2021.
- Invest in workforce health inequalities including responsiveness to growth of mental health related illness and MSK as the single two highest indicators of sickness absence across the NHS.
- Board development to drive visible leadership and decision making for equality, diversity and inclusion.
- Implementation of EDS 2022, Domains two and three.

4. Patient facing EDI update and key priorities

4.1 The Senior Responsible Officer for EDI from a patient perspective is the Assistant Chief Executive Officer.

4.2 Since the transition to NHS Cheshire and Merseyside on the 1st of July 2022, activity in line with the ICB public sector equality duty, from a patient perspective have included:

- Service change and transformation –EDI teams continue to provide Equality Impact Assessment (EIA) support, including for areas of substantial service change which included Liverpool University Hospitals Clinical Services Reconfiguration (29th September 2022) and Redesign of Stroke Services in North Mersey (4th August 2022), both of which were presented to the ICB.
- the ICB report on the 'Assurance process for substantial change (29th September 2022, section three) outlined the importance of the Board to pay 'due regard' and standards and processes required. The EDI team have met with Associate Director of Strategy and Collaboration and further meetings are scheduled with team in November 2022 to ensure EDI considerations are embedded throughout the substantial service change process. This included a meeting on the 14 November 2022 on the development of a single Equality Impact Assessment template and guidance are embedded within the ICB programme management process.
- the EDI team continues to Facilitate the Patient Focused Equality Forum, which is made up of NHS Provider equality leads from across Cheshire and Merseyside and key officers from across the healthcare system. The group meets on a bi-monthly basis. This group works collaboratively to share best practice, identify issues, and provide recommended actions to their respective organisations to address health inequalities and barriers in accessing healthcare services to improve patient journey, experience and outcomes. Key priority areas have included:
- System wide Implementation of EDS 2022 Domain 1 –This work is focusing on key Core20plus5 areas via strong collaboration between commissioners ICB, NHS Providers and other key stakeholders including Healthwatch organisations.
- Transgender Clinical best practice- developing a clinical best practice guide for NHS Providers, working in conjunction with key stakeholders who have lived experience.
- contract compliance- There are EDI indicators in NHS Provider contracts across Cheshire and Merseyside to monitor compliance. The indicators from a Patient facing perspective are as follows:
- evidence service change/ redesign proposals at the beginning and end of the process to ensure that the ICB is sighted and assured by the decision-making process that the Provider has paid 'due regard' to their statutory duties.
- action plan to be submitted to update on progress in relation to Reasonable Adjustments, Accessible Information Standard, improving access to services for people who are Deaf or hard of hearing and areas to address improving access to services for people whose first language is not English and an annual audit of compliance of reasonable adjustments.
- evidence in the public domain (website) of Specific duties.

- Procurement – the EDI team have supported the evaluation around compliance for both APMS Sefton and Liverpool Place procurements.
- an informal ICB EDI Task and finish group was established and was represented by the EDI team, Commissioners and the CSU during transition from CCGs to the ICB and identified short- and medium-term priorities, which have been incorporated into the report (March 2022 to July 2022). The Group will be re-instated in December 2022 to provide oversight on delivery against short term priorities, outlined in the report.
- website – The EDI section on the ICB website is currently being refreshed and this work will be completed by February 2023.
- Equality Objectives and Annual EDI reports have been developed in draft form in readiness for February 2023 ICB report and the outcome of EDS 2022 implementation results.

5. Resource constraints and mitigations

5.1 EDI resource constraints have been identified from both a Workforce (the implementation of EDS 2022 Domains Two and three) and patient facing (contract monitoring) perspective. Both the Deputy Chief Executive and Chief Peoples Officer are in the process exploring interim support options to ensure priorities identified are progressed in the short term.

6. Next Steps and mitigation

6.1 The ICB will receive a paper in February 2023 to consider and approve specific statutory requirements to Equality Objectives and Publish Equality Information (EDI Annual report), and mandated regulatory requirements (Equality Delivery System 2022 implementation) and provide an update on progress against key priorities outlined in the report below.

6.2 From April 2023, the EDI teams across the organisation will begin to develop a robust EDI framework and operating model that meets the ambitions of the ICB.

7. Recommendations

7.1 **The Board is asked to note:**

- the work undertaken to date from a workforce and patient perspective.
- the key priorities that need to be progressed before April 2023.
- the current resource constraints to deliver against some deliverables have been highlighted and mitigations are being explored by Executive Officers.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Consensus on the Primary Secondary Care Interface

Agenda Item No	**ICB/11/22/14**
Report author & contact details	Dr J Griffiths jonathangriffiths@nhs.net
Report approved by (sponsoring Director)	Professor Rowan Pritchard-Jones, Medical Director
Responsible Officer to take actions forward	Professor Rowan Pritchard-Jones, Medical Director

Consensus on the Primary Secondary Care Interface

<table>
<tr><td>Executive Summary</td><td colspan="5">Patient demand is high and capacity is stretched. Anything we can do to streamline patient pathways and reduce contact points will us to manage the current pressures.

We have recently published a Consensus on the Primary Secondary Care Interface. This can be read in full in Appendix A.

The consensus provides a set of principles that clinicians are encouraged to consider at the interface between Primary and Secondary Care in order to reduce unnecessary bureaucracy and inappropriate workflow. If followed, these principles will improve patient care by reducing potential delays in arranging or delivering interventions as well as, critically, improving relationships between clinicians.

This work has been undertaken collaboratively with clinicians from both Primary and Secondary Care including the Cheshire and Merseyside Medical Directors and the Cheshire and Merseyside LMCs. It has subsequently been endorsed by the Mersey Faculty of the Royal College of General Practitioners.

The consensus has been disseminated to Primary Care via the former CCGs, the Cheshire and Merseyside Primary Care Providers Leadership Forum and directly to the Primary Care Network Clinical Directors. It was disseminated to Secondary Care from the Health and Care Partnership Communications team out to the Trusts communications teams with an ask to forward to Medical Directors to further cascade, and subsequently to Trust CEOs following a meeting with them to promote.

We have further promoted on social media and has been positively acknowledged by many systems across the country.

Board is asked to endorse the consensus and approve further work to embed.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• Endorse the consensus.
• Agree on the proposed actions for implementation:
  • Ongoing promotion to Secondary Care via the Trust Medical Directors
  • Recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside</td></tr>
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- Approval of work to be undertaken to explore the feasibility of creating a reporting mechanism for clinicians to use when they feel the consensus is not being followed.

</td></tr>
<tr><td>Key issues</td><td>

- GPs are short of appointments yet spend time dealing with work that should have been done in other parts of the system
- Hospital clinicians are looking for greater clarity on referral documentation
- Nationally there is a greater focus on Interface work following the letter from Amanda Doyle on 26th September (B1998-supporting-general-practice-pcn-and-teams-through-winter-and-beyond-sept-22.pdf (england.nhs.uk)). Section 3 of this letter highlights the need to reduce bureaucracy and tackle issue between Primary and Secondary Care.

</td></tr>
<tr><td>Key risks</td><td>

- Principles must be turned into long lasting embedded change to support patient outcomes. This takes time and leadership and is a challenge in the current pressurized clinical environment.

</td></tr>
<tr><td>Impact (x)
(further detail to be provided in body of paper)</td><td>
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<tr><th>Financial</th><th>IM &T</th><th>Workforce</th><th>Estate</th></tr>
<tr><td></td><td></td><td>X</td><td></td></tr>
<tr><th>Legal</th><th>Health Inequalities</th><th>EDI</th><th>Sustainability</th></tr>
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<tr><td>Route to this meeting</td><td>

During the Covid-19 pandemic in late summer of 2021 we began to see increasing numbers of patients presenting to Emergency Departments and subsequently being admitted. At the same time there was an increase in adverse media publicity about NHS services, particularly General Practice.

A System Pressures Task and Finish group was created to look for any actions that could ease pressures being faced. Views were canvassed from all health care professionals across Cheshire and Merseyside and approximately 80 individual comments and recommendations received for things that could be done to improve the situation. A key theme was that we could improve system pathways and patient care at the Interface between Primary and Secondary Care. We embarked upon collaborative work to create a set of principles as fully described in the consensus document. These principles, if followed, address many of the recommendations received.

The principles were initially drafted and shared with the System Pressure task and finish group. This group included representatives from all ‘sectors’ of the health economy – Primary Care, Acute Trust, Mental Health, Community Trust, Specialist Trust etc. Once finalised within the group, the principles were shared with additional colleagues from Primary Care including LMCs, as well as the Trust Medical Directors group and various other consultant colleagues. The Primary Care Providers Leadership Forum were also invited to contribute, and you will see some Community Pharmacy representative input and membership.

</td></tr>
<tr><td>Management of Conflicts of Interest</td><td>n/a</td></tr>
</table>

Patient and Public Engagement	The consensus has been shared with Healthwatch.
Equality, Diversity and Inclusion	No, this did not seem required for this piece of work
Health inequalities	No, not applicable for this work.

Next Steps	• To encourage our 9 Places to discuss the consensus locally to 'bring it to life'
	  ○ We would expect Place Clinical Directors to create Primary Secondary Care Interface (PSCI) Groups to develop appropriate pathways using the Consensus
	  ○ Place Clinical Directors can also engage with local clinicians to promote the document and encourage it to be followed.
	  ○ It will be important for Place Clinical Directors alongside Trust Medical Directors to consider how to fully embed the Consensus with all clinical staff throughout all organisations.
	  ○ Dr Peter Chamberlain is supporting the Place Clinical Directors across Cheshire and Merseyside with this work.
	• To further promote to Trust Medical Directors at their meetings
	• Consideration of creating a process whereby clinicians can highlight where they feel the Consensus is not being followed:
	  ○ A reporting mechanism could be put in place to aid this
	• Ongoing social media activity to raise the profile of this work and highlight Cheshire and Merseyside ICB
	• The Medical Leadership Team will discuss this on an ongoing basis with the Place Clinical Directors who are tasked with progressing the work and establishing Primary Secondary Care Interface Groups. There are likely to be at least three such groups covering, for example, North Mersey, Mid Mersey and Cheshire & Wirral.

Appendices	**Appendix A:** Consensus on the Primary Secondary Care Interface Document

Consensus on the Primary Secondary Care Interface

1. Executive Summary

1.1 Patient demand is high and capacity is stretched. Anything we can do to streamline patient pathways and reduce contact points will assist us to manage the current pressures.

1.2 We have recently published a Consensus on the Primary Secondary Care Interface. This can be read in full via Appendix A.

1.3 The consensus provides a set of principles that clinicians are encouraged to consider at the interface between Primary and Secondary Care in order to reduce unnecessary bureaucracy and inappropriate workflow. If followed, these principles will improve patient care by reducing potential delays in arranging or delivering interventions as well as, critically, improving relationships between clinicians.

1.4 This work has been undertaken collaboratively with clinicians from both Primary and Secondary Care including the Cheshire and Merseyside Medical Directors and the Cheshire and Merseyside LMCs. It has subsequently been endorsed by the Mersey Faculty of the Royal College of General Practitioners.

1.5 The consensus has been disseminated to Primary Care via the former CCGs, the Cheshire and Merseyside Primary Care Providers Leadership Forum and directly to the Primary Care Network Clinical Directors. It was disseminated to Secondary Care from the Health and Care Partnership Communications team out to the Trusts communications teams with an ask to forward to Medical Directors to further cascade, and subsequently to Trust CEOs following a meeting with them to promote.

1.6 We have further promoted the consensus on social media and this has been positively acknowledged by many systems across the country.

1.7 The Board is asked to endorse the consensus and approve further work to embed this work across Cheshire and Merseyside .

2. Introduction / Background

2.1 During the Covid-19 pandemic in late summer of 2021 we began to see increasing numbers of patients presenting to Emergency Departments and subsequently being admitted. There was, additionally, an increase in adverse medial publicity about NHS services, particularly General Practice.

2.2 A System Pressures Task and Finish group was created to look for any actions that could ease pressures being faced. Views were canvassed from all health care professionals across Cheshire and Merseyside and approximately 80 individual comments and recommendations were received identifying things that could be done to improve the situation. A key theme was that we could improve system pathways and patient care at the interface between Primary and Secondary Care. We embarked upon collaborative work to create a set of principles as fully described in the consensus document. These principles, if followed, address many of the recommendations received.

3. Recommendations

3.1 The Board is asked to:

- **Endorse** the consensus.
- **Agree** on the proposed actions for implementation:
  - Ongoing promotion to Secondary Care via the Trust Medical Directors
  - Recommendation for the formation of Primary Secondary Care Interface Groups based around Acute Trusts across Cheshire and Merseyside
  - Approval of work to be undertaken to explore the feasibility of creating a reporting mechanism for clinicians to use when they feel the consensus is not being followed.

5. Next Steps

5.1 To encourage our 9 Places to discuss the consensus locally to 'bring it to life'. We would expect Place Clinical Directors to create Primary Secondary Care Interface (PSCI) Groups to develop appropriate pathways using the Consensus. The proposed form and function of these groups is detailed in Appendix A

5.2 Place Clinical Directors can also engage with local clinicians to promote the document and encourage it to be followed.

5.3 It will be important for Place Clinical Directors alongside Trust Medical Directors to consider how to fully embed the Consensus with all clinical staff throughout all organisations. Dr Peter Chamberlain is supporting the Place Clinical Directors across Cheshire and Merseyside with this work.

5.4 The Consensus will also be further promoted to Trust Medical Directors at their meetings (Dr Fiona Lemmens scheduled to meet with them in November).

5.5 Consideration of creating a process whereby clinicians can highlight where they feel the Consensus is not being followed. A reporting mechanism could be put in place to aid this.

5.6 Ongoing social media activity is planned to raise the profile of this work and highlight Cheshire and Merseyside ICB.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Consensus on the Primary Secondary Care Interface

Appendix A: Consensus document

Cheshire and Merseyside
Health and Care Partnership

NHS
Cheshire and Merseyside

Consensus on the Primary and Secondary Care Interface

Contents

This document was created in collaboration with the following groups and organisations:

- Cheshire and Merseyside System Pressures Task and Finish Group
- Cheshire and Merseyside Trust Medical Directors Group
- Cheshire and Merseyside Primary Care Providers Forum
- Local Medical Committees
- Endorsed by RCGP Mersey Faculty

Foreword

Cheshire and Merseyside Integrated Care System will do all that it can to optimise their access to the right care and “pathways” to give our patients have the very best outcomes. It is essential that we embed excellent communication channels between our health and care professionals and eliminate gaps in the services we provide. Siloed working is sadly a reality, and we must grasp the opportunities within our System to address this.

I believe this consensus document represents a strong set of clinically led principles to guide reviews of pathways which have a common architecture of good quality, patient-centred communication. The consensus provides a number of guiding principles which we should all commit to when interacting with colleagues. Abiding by these principles will encourage us to keep the patient at the centre of our decision making and ensure that actions taken are completed in a timely way, by the most appropriate individual or team and understood by all.

The document covers a wide range of situations including prescribing, fit notes, diagnostics and more. It is important these are read and understood by all clinicians, and I would encourage you to discuss this further in your teams.

I envisage the consensus will provide a platform for local Places to consider their response. More detailed work will need to be done to bring the consensus to life locally and articulate what this means for specific pathways. As an ICS we will support this and promote discussion about the principles at future events for clinicians.

I commend this Consensus about the Primary and Secondary Care Interface document to you and hope and expect we can use this to break down any barriers which exist between colleagues for the benefit of the people of Cheshire and Merseyside.

Rowan Pritchard-Jones

Medical Director Designate

Cheshire and Merseyside Integrated Care Board

The Covid-19 pandemic has led to significant excess demand across the entire NHS system. It is imperative we work together while tackling increasing presentations and lengthening waiting lists.

The following principles are supported by clinical leaders in both Primary and Secondary Care. They are not rules to follow and there will be exceptions. Clinicians are trusted to make appropriate decisions based on the individual circumstances they face. The underlying intent of this document is to improve relationships between colleagues, remove unnecessary administrative burdens and bring about a more efficient system for the benefit of all of the patients we serve.

Please note: any examples given are not intended to be exhaustive.

This document should be used as a starting point for us to consider our own behaviours and initiate conversations across the system. We are aware that further work will now need to be undertaken particularly in local Places to define what some of these principles mean in reality, and we will also pull together Cheshire and Merseyside guidance where appropriate.

Principles for all

- **Treat all colleagues with respect**

- **Remember to keep the patient at the centre of all we do**

- **There is an underlying principle that clinicians should seek to undertake any required actions themselves without asking other teams or services to do this**
  - Clinicians will, of course, need to operate within the limits of their professional competency and are only able to undertake actions if they have access to the relevant investigations or treatments.

- **Whoever requests a test is responsible for the results of that test**
  - This includes ‘chasing’ the results, receiving the results, actioning the results/determining management plan, and informing the patient of the results.
  - There may be some exceptions around shared care and potentially A&E. Generally, EDs should refrain from asking GPs to chase investigation results, if the ED requests an investigation, it should be responsible for chasing the results.
  - We recognise that transfers of care from A&E attendances are a particular area of potential difficulty and would suggest that local solutions are put in place and clearly communicated to Primary and Secondary Care clinicians in line with RCEM guidance.
  - Consideration needs to be given to the management of incidental findings, whether these need further investigation and if so, by who. We urge local systems to clarify such pathways to avoid duplication, inappropriate investigation, or failure to further investigate where appropriate. As a general

rule we would expect the requesting clinician to take responsibility for informing the patient of the findings and dealing with these, if within their competency. If urgent action is required, we would not expect this to be passed onto another clinician.

- **Ensure robust systems are in place for patients to receive results of investigations, and that they understand what is going to happen**
  - Secondary Care colleagues should avoid directing patients to the GP for results and vice versa.
  - It is the responsibility of the clinician requesting a test to review the result.

- **Ensure patients are kept fully informed regarding their care and 'what is going to happen next'**
  - This includes how they should raise concerns about clinical deterioration that should avoid directing them to other services (unless appropriate such as directive to attend ED when clinically required)
  - Ideally this should be in a written format and referenced within the discharge summary.
- **Consider picking up the phone to speak to colleagues if in doubt**
  - Organisations should consider how they might facilitate easy, prompt access for this.

- **Consider a process of 'Waiting Well' for patients referred to secondary care**
  - Consider communicating with patients on waiting lists to ensure they know their referral has been received, how long the wait may be and what to do in the event of deterioration in their condition.
  - This will likely require work at Place level across Primary and Secondary Care so that this process can start at the point of referral with the Primary Care clinician empowered with up-to-date knowledge around what the patient should expect.

- **The clinician who wishes to prescribe medication for the patient should undertake appropriate pre-treatment assessment and counselling**
  - They are responsible for communicating the rationale for treatment, including benefits, risks & alternatives, arranging any follow-up requirements that might be necessary, and documenting all of this in any related correspondence.

- **Try not to commit other individuals or teams to any particular action or timescale.**

Principles for Primary Care

- **When referring to secondary care please ensure you are clear in your 'ask'**
  - Why are you referring this patient? Are you looking for advice, diagnosis, treatment?
  - Please describe the reason for referral, and don't just put 'please see GP summary/consultation'
  - Ensure an up-to-date medication list is available along with investigations to date
  - What are the patient expectations?
  - If referring looking for a diagnostic procedure, please check local pathways for open access opportunities (this could include endoscopy, cardiology investigations or paediatric blood tests)
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Secondary Care.
  - Place based systems should ensure that access to community phlebotomy/diagnostics is available and understood by clinicians

- **When referring to secondary care please ensure appropriate Primary Care assessments have been made**
  - Check local pathways for pre-referral criteria and potential investigations
  - Consider consultant advice and guidance
  - Consider other sources of help and guidance
  - Consider when face to face assessment may add value before referral (both elective and emergency)
  - Remember, it can be helpful to have a face-to-face conversation with a patient who requires Rapid (2 week wait) Referral to ensure understanding of the pathway being used and to record physical/frailty status of the patient

- **When referring to secondary care please clearly communicate to the patient who you are referring them to, for what and what to expect (if known)**
  - At this current time as we recover from the impact of the Covid-19 Pandemic please advise patient that waiting lists may be long and that first contact may be a remote consultation.
  - Consider the use of Easy Read patient leaflets (where available) to inform about their condition

- **When referring with the expectation that an operative procedure may ultimately be required, please consider optimising any Long-Term Conditions**
  - BP control for hypertensives, glycaemic control for those with diabetes etc.
  - Please do empower patients to optimise their own health in the waiting period – smoking cessation advice, weight advice etc
  - This will reduce the impact of last-minute cancellations in pre-op clinic

Principles for Secondary Care

- **Ensure clear and timely communication to the GP following patient contacts**
  - This applies to both Outpatient encounters as well as on discharge from admission and A&E.
  - Please highlight any changes in medication and reasons for any changes
  - Please avoid using abbreviations and acronyms. These may be commonplace within your team but may not be understood in Primary Care.
  - Be clear about what follow up is required, how it will be provided and how any outstanding test results will be reviewed
  - Be explicitly clear about any requests/actions for the GP
    - If you want the GP to 'monitor' U&E for example, please say why, how often, for how long and what your expectations are if results are/remain abnormal
    - If you need a repeat test within a short period of time e.g., 2 weeks, please arrange this to avoid potential delays.

- **Avoid asking General Practice to organise specialist tests**
  - If you want the patient to have their blood test closer to home, then provide the blood form and enable community phlebotomy.
  - Place based systems should ensure that access to community phlebotomy/diagnostics is available and understood by hospital colleagues.
  - If a clinician wishes the patient to have further tests prior to next review they should look to undertake these investigations themselves

- **If patients need a fit note (sick note) then please provide one**
  - Please also ensure this is for an appropriate period (if you know they need 3 months off work don't issue a 2 week note)
  - Please issue fit notes from Out-Patients if these are required rather than sending back to the GP
    - Trusts should ensure fit notes are available for colleagues in Out-Patients

- **If immediate prescribing is required from Outpatients, please prescribe**
  - We would suggest work on ePrescribing for hospitals is accelerated
  - For longer term medications please prescribe an initial course of at least 14 days

- **Discharge medications for longer term medications should cover an initial period of at least 14 days, or longer as locally agreed**

- **Make use of the Discharge Medicines Service, nationally commissioned from community pharmacy**
  - This should be used for all appropriate patients to ensure they benefit from this essential service and that safety improvements are realised upon transfer of care.
  - Ensure all electronic referrals made under this system contain the nationally agreed dataset and use the electronic platform commonplace across Cheshire & Merseyside.

- The toolkit references both high risk medicines and high risk patients appropriate to send information on – this should be the minimum.

- **When recommending ongoing prescribing from the GP please check locally agreed Prescribing Formulary first**
  - Important to check that the suggested medication is appropriate for the GP to prescribe
  - Each local system will have a clinically agreed Prescribing Formulary which will detail appropriateness of prescribing and by whom.

- **Refer all patients discharged on a smoking cessation pathway from secondary care to the community pharmacy Smoking Cessation Advanced Service once it is available (expected 2022/23)**

- **Please put follow up plans in place for patients who self-discharge**
  - By definition these patients are thought to be unwell and vulnerable. They may have chosen to decline in-patient treatment, but they are still in need of our care; which may mean appropriate follow up in clinic is arranged.
  - This also includes providing appropriate discharge care and medication.

- **Please ensure any DNAs are not automatically discharged without clinical review**
  - Also please ensure any discharge is communicated to patient and GP with reason why.
  - If patients are transferred to patient initiated follow up (PIFU) or seen on symptoms pathways, please ensure you clearly reference the criteria to access a further appointment (SOS)

- **Please arrange onward referral without referring back to the GP where appropriate**
  - A hospital clinician should be expected to arrange an onward referral if:
    - The problem relates to the original reason for referral. E.g., patient referred to respiratory with breathlessness and respiratory consultant thinks it is a cardiac problem, the respiratory consultant should do the referral to cardiology.
    - A serious and very urgent problem comes to light. E.g., CT chest shows a renal tumour. Respiratory consultant should arrange the urgent referral to renal
  - If the problem is unrelated to the original reason for referral, this can be passed back to the GP. e.g., patient in respiratory clinic describes abdominal symptoms – this should be passed back to the GP to consider.

Reference documents used to inform these principles

- GMC Good Medical Practice
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-medical-practice

- GMC Good Practice in Prescribing and Managing Medicines and Devices
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/good-practice-in-prescribing-and-managing-medicines-and-devices

- GMC Good Practice in Delegation and referral
  - https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/delegation-and-referral/delegation-and-referral

- BMA guidance on Primary and Secondary Care working together
  - https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/primary-and-secondary-care/primary-and-secondary-care-working-together

- NHS England guidance on Improving how Secondary Care and General Practice work together
  - https://www.england.nhs.uk/publication/improving-how-secondary-care-and-general-practice-work-together/

- Professional Behaviours & Communication Principles for working across Primary and Secondary Care Interfaces in Northern Ireland
  - https://www.rcgp.org.uk/-/media/Files/RCGP-faculties-and-devolved-nations/Northern-Ireland/2019/RCGP-principle-leaflet-2019.ashx?la=en

- Royal College of Emergency medicine Guidance when discharging patients to General Practice
  - Discharge_to_General_Practice_011221.pdf (rcem.ac.uk)

- Royal College of Emergency Medicine guidance for management of investigation results in the Emergency Department
  - RCEM_BPC_InvestigationResults_200520.pdf

Following your local health and care organisations on social media is an easy and effective way to get accurate and timely information.

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Health and Care Partnership

#CMConcensus

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Winter Planning 2022/23 - Update

Agenda Item No	**ICB/11/22/15**
Report author & contact details	Andy Thomas (andy.thomas@cheshireandmerseyside.nhs.uk)
Report approved by (sponsoring Director)	Anthony Middleton, Director of Performance and Planning
Responsible Officer to take actions forward	Andy Thomas, Associate Director of Planning

Winter Planning 2022/23 - Update

<table>
<tr><td>Executive Summary</td><td colspan="5">PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter was issued 12 August 2022, followed by further national guidance on 18 October 2022 under the banner ‘Going further on our winter resilience plans’. This significantly extended the scope of the winter response required from ICBs and the wider system.

This report provides an update on the response to the supplementary guidance.

The ICB response to this will be coordinated via the Winter Planning Oversight Group and an updated position will be reported to the Board in due course.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
note the contents of this report for information
note that a receive a further update will be received at the January 2023 Board meeting.</td></tr>
<tr><td>Key issues</td><td colspan="5">As per executive summary</td></tr>
<tr><td>Key risks</td><td colspan="5">Based on the most current winter plan submissions, key system risks remain as follows:
Discharge, ability to reduce proportion of patients not meeting criteria to reside in hospital
Workforce, encompassing recruitment, retention, skill mix/shortages, gaps in rotas, sickness etc. These issues are apparent across medical, nursing, AHPs, ambulance service, and social are including domiciliary care
Significant risk to elective programme, diagnostics, cancer backlog
UTCs/ability/capacity for streaming to primary care services
Confidence of clinicians to refer into admission avoidance and step-down services such as Virtual Wards
Communications plans for Winter – extent to which public can be informed and engaged in helping the system to navigate winter pressures.</td></tr>
<tr><td rowspan="3">Impact (x)
(Further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td>Estate</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td>Sustainability</td></tr>
<tr><td></td><td>X</td><td>X</td><td>X</td><td>X</td></tr>
<tr><td>Route to this meeting</td><td colspan="5">NHS England Winter Planning Guidance, and the ICB’s response to it, have been discussed at the Executive Team Meeting in August and</td></tr>
</table>

	September, and at regular meetings of the Winter Planning Operational Group chaired by the Director of Performance & Planning. • This group has coordinated the required ICB outputs in response to the national guidance in line with NHS England's deadlines.
Management of Conflicts of Interest	n/a
Patient and Public Engagement	n/a, report relates to implementation of national guidance
Equality, Diversity and Inclusion	*Have you completed an Equality Impact assessment (EIA) to ensure the ICB can evidence it has paid 'due regard' to the Public Sector Equality Duty?* – No, report related to implementation of national guidance on winter planning
Health inequalities	Winter plans take account of health inequalities in terms of their focus on vulnerable cohorts of patients and wider issues such as fuel poverty and cost of living.
Next Steps	• The Executive Team Meeting will continue to receive updates from the Winter Planning Operational Group and monitor progress on implementation of winter plans as required. • It is envisaged that progress on implementation and performance against key winter metrics will be reported to Board in January 2023.
Appendices	

Winter Planning 2022/23 - Update

1. Executive Summary

1.1 ***PR1929 Next steps in increasing capacity and operational resilience in urgent and emergency care ahead of winter*** was issued 12 August 2022, setting out high-level expectations for winter 2022/23. ICB level plans were submitted to NHS England in response to this on 26 September, as previously reported.

1.2 This was followed by further national guidance on 18 October 2022, under the banner ***PR2090 Going further on our winter resilience plans.*** This significantly extended the scope of the winter actions required from ICBs. An update was submitted to NHS England on 03 November in response.

1.3 The Winter Planning Operational Group has overseen the production of winter plans and the response to national guidance and assurance processes. This has been supplemented by Place Review meetings which have incorporated assurance of winter plans in particular plans to support discharge. As at the time of this report 6 out of 9 Place meetings have been held.

1.4 A key aspect of Place and Provider plans is the utilisation of the Voluntary and Community Sector (VCS) and volunteers, an overview of which is also provided in this report.

1.5 In addition, Acute providers have completed good practice checklists focused on the elements of the Urgent and Emergency Care (UEC) pathway that are delivered in hospital settings, and are working towards implementation of the relevant elements of the UEC Improvement Framework

2. Introduction

2.1 At Place level, the winter plans comprise actions across the following main themes: Managing demand and capacity, in terms of:

- Acute and community bed capacity
- Provision of Urgent treatment Centres and High Intensity User services
- Hour Urgent Crisis Response provision
- Implementing ‘out of hospital’ home-based pathways, including Virtual Wards
- Supporting Primary Care
- Increasing number and breadth of services profiled on the Directory of Services to facilitate rapid signposting to the most appropriate services
- Recruitment and retention
- Utilisation of VCS and volunteers
- Local communications campaigns
- Discharge – increasing capacity on discharge pathways.

2.2 Winter Plans have been a key theme of Place Review conversations, with a particular focus on Discharge

3. Winter Planning Update

3.1 ***PR2090 Going further on our winter resilience plans*** was issued 18 October 2022. It calls for significant expansion of the system winter response across a broad range of areas by ICBs and NHS Providers as previously reported to the Board. Within this there are several areas which require a particular focus from the ICB as detailed below.

3.2 **Falls:** Systems are to have a community-based falls response service for people who have fallen at home including care homes. To be in place by 31 December 2022, 8am-8pm 7 days per week. All C&M Places have a falls response in operation, and work is ongoing to ensure that these services meet the recommended national specification as fully as possible.

3.3 **Virtual Wards:** ICBs are to maximise use of virtual wards and consider an Acute Respiratory Infection (ARI) hub to support same day assessment. The ICB is working to ensure that VWs are effectively utilised both in terms of addressing the right patient cohort and optimising referrals. There are plans in place to open 587 Virtual Wards beds across Cheshire & Merseyside by the end of March 2023, currently 110 beds are open with 55 utilised.

3.4 **Support to Care Homes:** There is a requirement to provide additional support for care homes to reduce unwarranted variation in ambulance conveyance rates, working with care homes to identify and access alternative interventions and sources of support. All 9 C&M Places have a support offer in place for Care Homes, with homes aligned to a Primary Care Network and/or GP Practice and with an assigned PCN clinical lead. As with Falls services, further work is ongoing to ensure that these services meet the recommended national specification as fully as possible.

3.5 **Bed capacity:** Maximise use of physical and virtual ward capacity, including delivery of additional beds including previously moth-balled beds. Cheshire & Merseyside is already working to deliver additional hospital and community beds following bids made for additional bed capacity in June and is on track to deliver 205 additional beds by January 2023, with a phased increase each month. Several hospitals have accelerated the opening of these beds to meet current pressures, with 130 of the 205 open as at the end of October. The ICB is exploring further contingency options to further increase bed capacity, subject to funding.

3.6 **System Control Centres:** All systems are required to set up a 24/7 System Control Centre (SCC). Systems are to develop their operating model for approval and ensure their SCC is operational by 1 December 2022. The Director of Performance and Planning is leading a programme of work to set up the SCC.

3.7 **Discharge:** In addition to maintaining focus on the high impact actions from the 100-day challenge, Places, including Local Authority colleagues have been working to identify additional actions that can be implemented in anticipation of the distribution of the Cheshire & Merseyside share of a £500m national fund to support social care, the details of which have just been announced.

4. Place Winter Plans

4.1 Winter Plans have been a key theme of Place Review conversations, with a particular focus on Discharge and can be summarised as follows in Table One:

Table One

Place	Discharge/Winter Planning Update
Cheshire West	Agreed system action plan to reduce numbers of patients with no-criteria to reside (NCTR) including partners committing additional resources at risk to secure additional intermediate care capacity within Care Homes, rapids/reablement and care at home. Continuing to maximise admission avoidance opportunities including UCR support to Care Homes/domiciliary care, virtual wards, and falls.
Cheshire East	Actions to reduce NCTR numbers and length of stay within system wide plan for the at home care market; Home First model of care, 'Hospital Discharge to Home Scheme' launched at Mid Cheshire Hospitals NHS FT; increased General Nursing Assistant capacity; additional 200 hours per week Rapid Response Care linked to East Cheshire Trust Frailty team at the front door, Care4CE mobile nights & East Cheshire Trust out of Hours District Nursing co-located to maximise night time staffing capacity; Virtual wards; Occupational Therapist (Home First) initiative to review existing home care packages; Community Connectors (link to voluntary sector to support discharge where appropriate and support people at home) deployed into the Transfer of Care Hubs at East Cheshire NHS Trust & Mid Cheshire Hospitals Foundation Trust.
Halton	Right Care, Right Place, Right Time – comprising four main categories of intervention: Stay Well maintaining patients health in their own home; Attendance and Admission Avoidance to acute sites through care in the chemist, UTCs, UCR, virtual ward development; Capacity in social worker assessments, domiciliary care, blocked transitional beds; Discharges managed in a timely manner with increase discharge to assess and a focus on home first.
Knowsley	Plans to reduce NCTR via UCR, enhanced support to Care Homes, Falls Car, Respiratory Rapid Response, Virtual Wards, enhanced domiciliary care, step up beds and Walk in Centre conversion to Urgent Treatment Centre specification in Kirkby.

Place	Discharge/Winter Planning Update
Liverpool	3 key winter priorities: Capacity Creation; Discharge & Flow; Admission Avoidance. System Discharge Group programme focusing on the national 10 best practice initiatives and the 4 specific recommendations from ECIST
Sefton	Action plan focused on Pre-hospital, In-hospital, and Discharge interventions. Discharge plans centred on Intermediate Care & reablement strategy / Home First, Transfer of Care Hub, domiciliary care re-tender, development of integrated community team model.
St Helens	Plan focused on increasing capacity (virtual wards, UCR, Broad Oak Manor plans in progress to support step down capability). Discharge and flow partnership approach, including Home First principles. Maximisation of UCR capacity, SDEC and community pathways through collaborative working supporting flow and admissions avoidance.
Warrington	System wide plans continue to develop with an agreed approach to investment projects via the adaptive reserve. Focus on decreasing attendance/admission, increasing use of SDEC, reducing overall LOS and specifically NCTR. Aligning all directives including the UEC framework, winter priorities, local recommendations from peer review and LGA work into a system wide UEC plan.
Wirral	3 Winter Plan priorities are: Home First/Virtual Wards/Care Market Sufficiency with primary aim to reduce NCTR levels. Other key supporting schemes: Acute Medical Unit Referral Triage, Fastrack POC service, 22 Discharge to Assess Beds, P1 Step Down Beds (25) & Urgent Crises Response.

5. Voluntary and Community Sector

5.1 The Voluntary and Community Sector plays a key role in enhancing system resilience through the work that volunteers in various setting carry out that reduces pressure on services, enhances patient experience and supports staff wellbeing, for example, Community First Responders, Discharge Support, ED support.

5.2 Examples of key initiatives by Place are detailed in Table Two:

Table Two

Place	VCS Update
Cheshire West	Snowangels CIC are commissioned to deliver Pathway Zero discharges across both Leighton and Countess of Chester Hospitals and support in the home/ community for up to 6 weeks post discharge. Work underway to identify additional opportunities for VCS support. Social care prescribers within Pathway 1 team able to access VCS.
Cheshire East	Help Force offer. Community Teams have developed a circle of support to reduce the reliance on Care at home (Domiciliary care) and to reduce delays in discharge these include social isolation, befriending, social activities, bereavement and listening services, digital poverty, food banks, soup and food delivery services and luncheon clubs. Cheshire East Council is looking to partner supermarkets and cleaning companies to support service users currently reliant on domiciliary care to meet food shopping/ cleaning needs. Over 40 Warm Places -places providing information and advice, warm drinks, and hot food. Transport services and low-level support at home provided by the British Red Cross. Community Connectors (links to the voluntary sector to support discharge where appropriate and support people at home) deployed into the Transfer of Care Hubs at East Cheshire NHS Trust & Mid Cheshire Hospitals Foundation Trust
Halton	Red Cross and Health at Home supporting patients settling at home, multiple partners involved in the winter warmth, cost of living and loneliness campaigns, Wellbeing Enterprises providing High Intensity User service, General Practice Wellbeing and Social Prescribing. Community Groups providing cafes, food, and clothes banks.
Knowsley	Community navigators offer signposting support to residents and the Hospital discharge team can organise support from a range of voluntary services in Knowsley to ensure food parcels and other support is available. Adults in Knowsley who are disadvantaged for any reason, be it poverty, disability, age, or other circumstances which prevent them from having ‘a good life’ can access personalised support from ‘A Good Life’, a project provided by Knowsley Disability Concern (KDC), in partnership with Better Lives; Sight and Mind; and Tailored Advice Services in the Community (TASC). Discussions ongoing with Age UK to provide wrap around support following discharge from January 2023.

Place	VCS Update
Liverpool	RVS provide low level hospital discharge support for patients on pathway zero and pathway one, providing support to take patients home, settle in, arrange shopping and repatriation into the local community. Community connectors have strong links with CAB who can provide support to patients in relation to Income maximisation/access to benefits, and signpost to community services including healthy homes
Sefton	VCS services on the DoS and continued encouragement for staff to use DoS for local service awareness. Sefton CVS provide most of these services which include discharge support and the HIU services.
St Helens	STHK volunteer services are actively engaged as part of urgent care plans. A key focus at Place is the food pantries established and ongoing fund raising, planning for more and linking in social prescribers who are visiting and making links. Work ongoing with 'warm places' and mapping these. A volunteer portal is in place. The LA have cost of living strategic group which is attended by partners. Ongoing appraisal of local place opportunities.
Warrington	Good Neighbour, Healthy at Home and Warrington Wellbeing are all developing to ensure that there are arrangements in place through volunteers directly and through supporting people to access other help either at discharge or to prevent admission, with links to Urgent Community Response and Discharge teams.
Wirral	VCS sector commissioned to support Pathway Zero discharges including telephone follow ups and going home support (transport/settling in). PCNs have extensive social prescribing roles linking patient and their families to help and support in the community.

6. Emergency Departments

6.1 As part of the winter planning process, all Acute providers have completed good practice checklists focused on the elements of the Urgent and Emergency Care (UEC) pathway that are delivered in hospital settings.

6.2 The safe flow and functioning Emergency Departments is dependent in part on the wider functioning of the UEC pathway, from anticipatory care and alternative acute and community pathways that provide alternatives to ED attendance and hospital admission, through to discharge to ensure bed availability for patients in ED requiring admission. Just as long waits for ambulances increases the risk of poor outcomes for patients, so too long waits in ED prior to admission are associated with poor outcomes.

6.3 However, it is recognised that there are specific indicators of good practice in EDs that can help EDs to maintain safe care. All C&M Trusts have undertaken, and have demonstrated a good level of compliance with self-assessment against the following:

- Streaming of all patients who could be appropriately managed by a co-located urgent/primary care service where available
- Minimum Consultant management > 16 hours a day
- Speciality and acute call down within 1 hour of referral. For tertiary units, acute physician presence in ED > 16 hours a day
- ED are granted one way referral rights with no patient being given back to ED at any time
- Mental health 24/7 liaison service
- Same Day Emergency Care (SDEC) > 12 hours a day/ 7 days a week
- Acute frailty service > 70 hours over 7 days
- Dedicated, separate to adults, Paediatric ED / secure area in place
- All Minor illness streamed to GPs
- All Minor injuries streamed to an emergency nurse practitioner (ENP)
- Required capacity (numbers of cubicles and fit to sit) in place to meet demand
- CDU adjacent or equivalent short stay Emergency patient area.

6.4 In addition, Places and Providers have adopted the national UEC Improvement Framework which defines best practice in relation to the above and emphasises strong ED shop floor leadership with real time 'command and control' achieved through a senior medical, nursing, and administrative team, with senior support during times of excessive ambulance/ED delays.

7. Recommendations

7.1 The Board is asked:

- **note** the contents of this report for information
- **note** that a receive a further update will be received at the January 2023 Board meeting.

8. Next Steps

8.1 The Executive Team Meeting will continue to receive updates from the Winter Planning Operational Group and monitor progress on implementation of winter plans as required.

8.2 It is envisaged that progress on implementation and performance against key winter metrics will be reported to Board in January 2023.

9. Officer contact details for more information

9.1 Contact details as follows:

Anthony Middleton, Director of Performance & Planning
anthony.middleton@cheshireandmerseyside.nhs.uk

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

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Cheshire and Merseyside Integrated Care Partnership – feedback from the November 2022 meeting

Agenda Item No	**ICB/11/22/16**
Report author & contact details	Matthew Cunningham , Associate Director of Corporate Affairs and Governance, matthew.cunningham@nhs.net
Report approved by (sponsoring Director)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Clare Watson, Assistant Chief Executive

Cheshire and Merseyside Integrated Care Partnership Board – feedback from the November 2022 meeting

<table>
<tr><td>Executive Summary</td><td colspan="5">The purpose of this report is to inform members of the establishment of the Cheshire and Merseyside Integrated Care Partnership (ICP) and report on its first meeting, held on the 8 November 2022.

This was the first meeting held in public of the Cheshire and Merseyside Integrated Care Partnership

Councillor Louise Gittens was appointed as Chair of the Partnership. Raj Jain was appointed as Co-Vice Chair. Work is underway in appointing the other Co-Vice Chair from the Voluntary, Community and Faith Sector (VCFS).

A period of engagement with the founding members of the Partnership (the nine Cheshire and Merseyside Local Authorities and the ICB) will need to commence to inform and approve the Terms of Reference (Appendix A) for the Partnership

A summary report (Appendix B) of the first meeting has been circulated to members and attendees of the Partnership for their use to inform colleague internally within their own respective organisations.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td></td><td></td><td></td><td></td></tr>
<tr><td>Recommendation s</td><td colspan="5">The Board is asked to:
• to note the establishment of the Cheshire and Merseyside ICP and the discussions and outcomes of its first meeting
• consider the Partnerships Terms of Reference and provide any feedback
• note that the Partnership Terms of Reference will need to return to the ICB Board at a future meeting for its approval
• note that the ICB Board will receive a summary report of the outcomes of the Health and Care Partnership Committee after each of its meetings and its confirmed minutes.</td></tr>
<tr><td>Key issues</td><td colspan="5">n/a</td></tr>
<tr><td>Key risks</td><td colspan="5">n/a</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td></td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td>X</td><td>X</td><td></td><td colspan="2"></td></tr>
</table>

Route to this meeting	Board members received an update on the development of the Health and Care Partnership at its September 2022 meeting which outlined in detail the legal standing and role of the partnership. https://www.cheshireandmerseyside.nhs.uk/media/ptdpfanz/00-icb-public-pack-v1-streamlined-compressed.pdf	
Management of Conflicts of Interest	n/a	
Patient and Public Engagement	n/a	
Equality, Diversity and Inclusion	n/a	
Health inequalities	n/a	
Next Steps	• work is underway to plan the subsequent meetings of the Health and Care Partnership that will be held in public and how to make them more accessible to members of the public • the Health and Care Partnership Board will next meet on the 22 December 2022 to review and sign off the Cheshire and Merseyside Integrated Care Partnership Strategy • progress the appointment of the Partnerships Co-Vice Chair drawn from the VCF sector • the ICB Associate Director of Corporate Affairs and Governance will be meeting in November with the Heads of Legal and other key officers within the nine Cheshire and Merseyside Local Authorities. This is to determine the actions required to engage with the Local Authorities to both shape and seek the confirmed approval routes for the adoption of the Health and Care Partnership Board Terms of Reference.	
Appendices	**Appendix A**	Draft Terms of Reference for the Cheshire and Merseyside Health and Care Partnership Board
	Appendix B	Summary Report for partners of the November 2022 meeting of the Cheshire and Merseyside Health and Care Partnership Board

Cheshire and Merseyside Integrated Care Partnership Board – feedback from the November 2022 meeting

1. Executive Summary

1.1 The Cheshire and Merseyside Integrated Care Partnership held its first meeting in public on the 8 November 2022. Referred to locally as the Cheshire and Merseyside Health and Care Partnership (HCP), meetings will be held on a bi-monthly basis. The agenda and papers for the HCP meeting on the 8 November 2022 are available online via the ICB website.[1] Future meeting dates and details can also be found on the ICB website.

1.2 At its first meeting the HCP appointed Councillor Louise Gittens as its Chair and Raj Jain as its Co-Vice Chair. An individual representing the Voluntary, Community and Faith Sector (VCFS) will also be appointed to be the Co-Vice Chair of the HCP. Work is underway regarding the appointment process.

1.3 An expansive range of partner organisations were represented at this meeting and who have committed to be active members of the HCP.

1.4 HCP members received the draft Terms of Reference (Appendix A) for the HCP and agreed that engagement should progress with the nine Cheshire and Merseyside Local Authorities to seek their input and agree the process and timelines for achieving approval of the Terms of Reference and the establishment of the HCP as a committee of the Local Authorities and the ICB. As one of the ten founding members of the HCP, the Cheshire and Merseyside ICB will also need to formally approve the Terms of Reference of the HCP at a future meeting of its Board.

1.5 It is hoped that the Terms of Reference and establishment of the HCP as a formal Committee of the ten founding members (with the Local Authorities as the other nine founding members) will be completed prior to the May 2023 meeting of the HCP. Board members are asked to consider the draft Terms of Reference and provide feedback to Matthew Cunningham, Associate Director of Corporate Affairs and Governance.

[1] https://www.cheshireandmerseyside.nhs.uk/get-involved/meeting-and-event-archive/nhs-cheshire-and-merseyside-integrated-care-board-july-1st-2022/

1.6 At its first meeting, members received presentations on the work underway progressing the Cheshire and Merseyside All Together Fairer Programme, Fuel Poverty and Health Impacts as well as the development of the Cheshire and Merseyside Integrated Care Strategy. Further detail can be found within the November Meeting Summary Report attached as Appendix B.

2. Recommendations

2.1 **The Board is asked to:**

- to **note** the establishment of the Cheshire and Merseyside ICP and the discussions and outcomes of its first meeting
- **consider** the Partnerships Terms of Reference and provide any feedback
- **note** that the Partnership Terms of Reference will need to return to the ICB Board at a future meeting for its approval
- **note** that the ICB Board will receive a summary report of the outcomes of the Health and Care Partnership Committee after each of its meetings and its confirmed minutes.

3. Next Steps

3.1 The following actions are currently being progressed:

- work is underway to plan the subsequent meetings of the Health and Care Partnership that will be held in public and how to make them more accessible to members of the public
- the Health and Care Partnership Board will next meet on the 22 December 2022 to review and sign off the Cheshire and Merseyside Integrated Care Partnership Strategy
- progress the appointment of the Partnerships Co-Vice Chair drawn from the VCF sector
- the ICB Associate Director of Corporate Affairs and Governance will be meeting in November with the Heads of Legal and other key officers within the nine Cheshire and Merseyside Local Authorities. This is to determine the actions required to engage with the Local Authorities to both shape and seek the confirmed approval routes for the adoption of the Health and Care Partnership Terms of Reference.

4. Officer contact details for more information

Clare Watson
Assistant Chief Executive
clare.watson@cheshireandmerseyside.nhs.uk

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Cheshire and Merseyside Integrated Care Partnership – feedback from the November 2022 meeting

Appendix A: Committee draft Terms of Reference

Cheshire and Merseyside Health Care Partnership (HCP)

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
19 October 2022	0.1	Initial ToR		Natalie Robinson

Review due
November 2023

1. Introduction

1.1 The engagement document: Integrated Care System Implementation produced by the DHSC and NHS England set the role of the Integrated Care Partnership as: A broad alliance of organisations and representatives concerned with improving the care, health and wellbeing of the population, jointly convened by local authorities and the NHS as equal partners in order to facilitate joint action to improve health and care outcomes and experiences, influence the wider determinants of health, and plan and deliver improved integrated health and care.

1.2 An ICP is a statutory committee, playing a critical role within the ICS with the intent to bring together a broad alliance of partners concerned with improving the care, health and wellbeing of the population, with membership determined locally.

1.3 Cheshire and Merseyside (C&M) has an established Health and Care Partnership (HCP), which has been in place since 2020 and is the committee from which the C&M ICS's ICP will develop. It has been proposed that the new ICP will be known as the HCP because this is a trusted and well-respected brand with partners and stakeholders.

1.4 The HCP is where the system comes together to develop the C&M Integrated Care Partnership Strategy and strategic priorities, in response to the evidence, and agree what we want to do differently to serve our populations.

1.5 The work of the HCP does not duplicate the work of the Cheshire and Merseyside Health and Wellbeing Boards.

1.6 These terms of reference set out the membership, remit, responsibilities, and reporting arrangements of the joint committee.

2. Role and Purpose

2.1 The primary purpose of the HCP will be to act in the best interest of people, patients, and the system as a whole, rather than representing individual interests of any one constituent partner, with membership including both statutory / non-statutory partner and individual organisational representation.

2.2 The HCP is a strong partnership, with representation from across the health and care system, who will continue to have responsibility for the statutory responsibility for the Joint Strategic Needs Assessments (JSNAs).

2.3 The HCP will be governed by a set of principles and ways of working which are based on a combination of what has been deemed important by local stakeholders together with national expectations.

2.4 The HCP will:

- Involve local organisations and people in preparing its Integrated Care Partnership Strategy that sets out how the assessed needs in relation to its area are to be met by the exercise of functions of the ICB, NHSE and Local Authorities.

- Oversee integration between the NHS and Social Care (including conversations about shared budgets / BCF; and NHS / Public Health), driving a shift of resources into prevention.

- Develop a clear view on the contribution of the Health and Social Care system into prevention and the determinants of health, including our collective "anchor" approach.

- Support the work of the Health and Wellbeing Boards (HWBBs) and respond to their Health and Wellbeing Strategies and Joint Strategic Needs Assessments.

- Enable, encourage and support partners, places and collaboratives to improve and innovate, including advocating for new approaches and transformational ways of working, improving population health outcomes and reduce health inequalities at Place by addressing complex, long term issues that require a system level integrated approach across stakeholders.

- Provide a forum to build on the joint positive working between the NHS and LAs during COVID-19

2.5 The HCP will provide assurance to the ICB on the delivery of the following statutory duties:

- *Duty to commission certain specified health services*
- *Duty as to reducing inequalities*
- *Duty as to patient choice*
- *Duty to exercise functions effectively, efficiently, and economically*
- *Duty to obtain appropriate advice*
- *Duty to promote innovation*
- *Duty in respect of research*
- *Duty to promote integration*
- *Duty as to public involvement and consultation (in accordance with ICB direction and potential Place implementation) Duties as to climate change*
- *Duty to have regard to the wider effect of its decisions in relation to—*
  (a) the health and well-being of the people of England;
  (b) the quality of services provided to individuals—
    (i) by relevant bodies, or
    (ii) in pursuance of arrangements made by relevant bodies, for or in connection with the prevention, diagnosis or treatment of illness, as part of the health service in England;
  (c) efficiency and sustainability in relation to the use of resources by relevant bodies for the purposes of the health service in England.

3. Authority

3.1 The HCP is a Statutory Joint Committee, convened under the 2022 Health & Care Act. It operates on a partnership and collaborative basis. Each of the constituent statutory partner members organisations remains responsible for discharging their sovereign statutory duties.

3.2 The meetings will be Chaired by a nominated Local Authority Political Leader, with two Joint Vice Chairs, one being the Cheshire and Merseyside ICB Chair and the other being an appointed representative of the VCSE sector.

4. Membership & Attendance

4.1 Members

4.1.1 Members are selected to be representatives of constituent partners and attend HCP meetings to promote the greater collective endeavour. Therefore, members are expected to make effective two-way connections between the Cheshire and Merseyside HCP and constituent organisations, adopting a partnership approach to working together, as well as listening to the voices of citizens, patients and the public we serve.

4.1.2 It is expected that members will prioritise these meetings and make themselves available; where this is not possible a deputy may attend of sufficient seniority who will have delegated authority to make decisions on behalf of their organisation in accordance with the objectives set out in the Terms of Reference for this group. For Local Authority (LA) representatives this will be in accordance with the due political process.

4.1.3 Representative Members will be asked to make connections between the HCP and the sector in which they are representing. The core focus of this role is not to champion the interests of any single organisation.

4.1.4 **The proposed core membership of the HCP (statutory committee) is:**

ICP Chair	Local Authority Political Leader
ICP Vice Chair (2)	NHS Cheshire and Merseyside ICB Chair Voluntary Sector Representative
ICB	Chief Executive Executive Medical Director, NHS Cheshire and Merseyside Assistant Chief Executive Director of Finance
Local Authority Partners	Political Representation x 9 (including ICP Chair) Executive x 2 Directors of Public Health x 2
Northwest Ambulance Service	
Police	X 2 (Cheshire Police, Merseyside Police)
Fire and Rescue	X 2 (Cheshire, Merseyside)
Voluntary, Community and Faith Sector	X 2 (Cheshire & Warrington, Merseyside)
Local Enterprise Partnership	X 2 (Cheshire, Merseyside)
Primary Care	X2
Provider Collaborative	X2 (CMAST, MHLDSC)
Carers	
Housing	
Healthwatch	X2
Higher Education/University	X2
Social Care Provider	

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

4.2 Attendees

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

4.2.2 Meetings of the HCP may also be attended by the following individuals who are not members of the HCP for all or part of a meeting as and when appropriate. Such attendees will not be eligible to vote.

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

5. Meetings

5.1 Quorum

The meeting will be quorate when 50% of members are present. If the quorum has not been reached, then the meeting may proceed if those attending agree, but no decisions requiring agreement by statutory bodies may be taken. If any member of the HCP has been disqualified from participating in the discussion and/or decision-making for an item on the agenda, by reason of a declaration of a conflict of interest, then that individual shall no longer count towards the quorum.

5.2 Decision-making and voting

5.2.1 The HCP will usually make decisions by consensus. Where this is not possible, the Chair may call a vote.

5.2.2 Only voting members, as identified in the "Membership" section of these terms of reference, may cast a vote.

5.2.3 A person attending a meeting as a representative of a HCP member shall have the same right to vote as the HCP member they are representing.

5.2.4 In accordance with paragraph 6, no member (or representative) with a conflict of interest in an item of business will be allowed to vote on that item.

5.2.5 Where there is a split vote, with no clear majority, the Chair will have the casting vote.

5.3 Frequency

5.3.1 The HCP will meet in public.

5.3.2 The HCP will meet six times each year and arrangements and notice for calling meetings are set out in the Standing Orders. Additional meetings may take place as required.

5.3.3 The HCP Chair may ask the HCP to convene further meetings to discuss particular issues on which they want advice.

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

5.4 Administrative Support

The HCP shall be supported with a secretariat function. Which will ensure that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead.

- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept.
- The Chair is supported to prepare and deliver reports for onward reporting.
- The HCP is updated on pertinent issues/ areas of interest/ policy developments; and
- Action points are taken forward between meetings.

6. Behaviours and Conduct

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

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

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

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

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

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

<u>Equality diversity and inclusion</u>

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

7. Review

7.1 The HCP will review its effectiveness at least annually

7.2 These terms of reference will be reviewed at least annually and earlier if required.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Cheshire and Merseyside Integrated Care Partnership – feedback from the November 2022 meeting

Appendix B: Summary report of the November 2022 meeting

SUMMARY REPORT

CHESHIRE AND MERSEYSIDE HEALTH AND CARE PARTNERSHIP BOARD

NOVEMBER 8 2022

Cheshire and Merseyside
Health and Care Partnership

Cheshire and Merseyside Health and Care Partnership – the sub-region's new statutory Integrated Care Partnership – met for the first time at the Partnership for Learning conference centre in Halewood, Knowsley on November 8th 2022. Meeting papers available here.

Consisting of representatives across the NHS, local authorities, voluntary sector, housing, police and fire and rescue, the Partnership Board provides a multi-agency forum to assess the health, public health and social care needs of people across Cheshire and Merseyside – and develop a combined strategy to address them.

Councillor Louise Gittins, the leader of Cheshire West and Chester Council, was unanimously confirmed as Chair, with Raj Jain – the Chair of NHS Cheshire and Merseyside – confirmed as vice-chair. A process to appoint a second vice-chair, to represent the voluntary sector, is already underway.

Cllr Gittins described her appointment as "an honour" and the inception of the multi-agency partnership as "a once in a lifetime opportunity to make a real difference across our communities". As a "Marmot community", she said the Partnership must come together to help tackle health inequalities across Cheshire and Merseyside.

Among the wide-ranging challenges facing the Partnership are issues including access to care – such as GP appointments – and recruitment and retention of staff in social care.

It was confirmed that a draft Terms of Reference for the Partnership Board is set to be reviewed by Cheshire and Merseyside's nine local authorities and NHS Cheshire and Merseyside, with a view to collectively agreeing a single Terms of Reference by May 2023.

Ian Ashworth, lead Director of Public Health for Cheshire and Merseyside's Population Health programme, led an update on the sub-region's progress as a "Marmot Community".

Following input from a wide range of key stakeholders across Cheshire and Merseyside, the landmark report All Together Fairer: Health Equity and the Social Determinants of Health in Cheshire and Merseyside was published in May 2022.

Featuring 22 Beacon Indicators to help measure progress, the key themes are to:

1) Give every child the best start in life
2) Enable all children, young people and adults to maximise their capabilities and have control over their lives
3) Create fair employment and good work for all
4) Ensure a healthy standard of living for all
5) Create and develop healthy and sustainable places and communities
6) Strengthen the role and impact of ill health prevention
7) Tackle racism, discrimination and their outcomes
8) Pursue environmental sustainability and health equity together

Eight NHS Trusts across Cheshire and Merseyside have now signed a “prevention pledge” commitment to embed prevention of ill-health into their service delivery.

Cllr Gittins referenced the impact that signing the prevention pledge could have if adopted by more organisations – and their workforces – across Cheshire and Merseyside, while vice-chair Raj Jain challenged partners to consider not just agreeing collective priorities, but the method with which to deliver large-scale change.

Reflecting current cost of living challenges, Ian Ashworth and NHS Cheshire and Merseyside’s Knowsley Place Director Alison Lee then delivered a joint update around the health impacts of fuel poverty.

Alison explained that there is strong evidence that people who live in cold homes are more likely to suffer from a wide range of physical health issues – as well as mental health issues such as anxiety and depression. She explained that, in Knowsley, partners are using Making Every Contact Count methodology to help support people to live better lives.

Board members recommended reaching beyond the public sector to expand this work further – for example convenience stores such as Spar and Co-op, while housing providers noted a marked increase recently in the number of residents going into rent arrears and suffering with mental health issues.

Representatives from Merseyside Fire and Rescue Service then explained how their safe and well checks could be expanded – with access to the right data and links in to organisations which can help. A commitment was also made by partners around the table to undertake suicide prevention training to further support people who are in crisis.

Although this was just the first bi-monthly meeting of Cheshire and Merseyside Health and Care Partnership, the Department of Health and Social Care has directed all statutory Integrated Care Partnerships to publish a strategy by the end of this calendar year.

Neil Evans, NHS Cheshire and Merseyside’s Associate Director of Strategy and Collaboration, described the process to achieve this – building on existing strategies such as All Together Fairer and Place Plans.

This will include work with Healthwatch colleagues to ensure it also responds to the resident voice around key issues such as the ongoing impact of COVID-19 on access to services and cost of living pressures.

At the end of the meeting partners outlined their collective commitment to work across traditional organisational boundaries and hold each other to account for delivery as well as to further develop their shared purpose – ensuring residents, service users and patients are at the centre of everything the Partnership does.

To this end, options to expand accessibility and opportunities for public involvement at future meetings will be considered and, in line with the draft Terms of Reference, actions and decisions will be recorded – with progress against key actions reported back at each meeting.

Meetings of the Cheshire and Merseyside Health and Care Partnership are held in public. The next meeting is scheduled for January 17th 2023. More information about the Health and Care Partnership is available via the NHS Cheshire and Merseyside website.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Report of the System Primary Committee Chair

Agenda Item No	**ICB/11/12/22/18**
Report author & contact details	Christopher Leese c.leese@nhs.net
Report approved by (sponsoring Director/ Chair)	Clare Watson, Assistant Chief Executive
Responsible Officer to take actions forward	Christopher Leese c.leese@nhs.net

Report of the System Primary Care Committee Chair

Executive Summary	The Committee should note the contents of the report of the System Primary Care Committee held on 20.10.2022				
Purpose (x)	**For information / note**	**For decision / approval**	**For assurance**	**For ratification**	**For endorsement**
	X		X		
Recommendation	**The Board is asked to:** • note the contents of the report.				

Key issues	The Committee discussed the following business as listed
	In **Part A** , the in-private section:
	• Agreement in respect of APMS Contracts (West Cheshire Place) Agreement of a list closure request extension (West Cheshire Place)
	• A decision for Incorporate was deferred pending legal advice
	• Agreement to an APMS Extension request for St Helens Place
	• Agreement for a Practice Merger (Sefton Place)
	• Agreement for Primary Care IT funding (Place Wide)
	• Received the minutes of the NHS England Pharmaceutical Services Regulations Committee
	• An update on the transfer of the Non Delegated Function(s) – Dental and General Ophthalmic services, in respect of detailed handover documents
	• Noted and ratified the decisions taken virtually in respect of APMS contracts in Liverpool and Improvement Grant/Capital funding for all places.
	
	In **Part B**, the public section ;
	
	• Received an update from Place Directors in relation to
	  • Access to General Practice
	  • Transformation and Development
	• Received an update on the Primary Care Operating Model including agreement to support the matrix of decision making , subject a few final amendments to the one presented at the committee, to enable place based decision making in respect of the Policy and Guidance Manual
	• Received an update on Primary Care Policy and Contracting
	• Received an update on Primary Care Finance
	• Received an update on the new Community Pharmacy Contract
	• Received an update on the next steps regarding the transfer of Dental and General Ophthalmic Services to the ICB.				

Key risks	Key risks were noted and mitigating actions confirmed for the transfer of Dental services, and the overall finance/budget.				

Impact (x) (further detail to be provided in body of paper)	Financial	IM &T	Workforce	Estate
	X		X	X
	Legal	Health Inequalities	EDI	Sustainability
	X	X		X
Management of Conflicts of Interest				
Next Steps				

Report of the System Primary Care Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
System Primary Care Committee	The role of the System Primary Care Committee shall be to oversee, coordinate and promote alignment of the functions amongst Places relating to the commissioning of primary medical services under section 82B of the NHS Act in relation to GP primary medical services and community pharmacy.	Erica Morriss

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
	20.10.22	• The Committee received an update on the Primary Care Operating Model • The Committee received an update on national and local Primary Care Contracting which defines much of the work undertaken in the primary care function. • The Committee received an update on place actions in relation to access to general practice, responses to the Fuller report, workforce and development/transformation progress in relation to primary care • The Committee received an update on the position relating to Primary Care finance • The Committee received the minutes and decisions of the Pharmaceutical Services Regulations Committee which were endorsed. This Committee regulates the Community Pharmacy Contract within the ICB, aligned currently from NHS England. • The Committee received an update in relation to key changes in relation to the Community Pharmacy Contract • The Committee received an update on the process for the ICB's transfer from NHS England of Dental

Decision Log Ref No.	Meeting Date	Issues considered
		and General Ophthalmic Services (GOS) for assurance and information. • As part of the above the Committee received a detailed initial version of key handover documentation in relation to Dental and General Ophthalmic Services (GOS)

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
	20.10.22	• Noted and ratified the decisions taken virtually in respect of APMS contracts in Liverpool and Improvement Grant/Capital funding for all places • Agreement to support in respect of APMS Contracts (West Cheshire Place) • Agreement to support the list closure request extension (West Cheshire Place) • A decision in respect of Incorporation was deferred pending legal advice and will return to the Committee in December • Agreement to support an APMS Extension request for St Helens Place which was in the terms of the options of the original agreement for a two year further extension of the original contract. • Agreement to support the Practice Merger (Sefton Place) • Agreement to support the Primary Care IT funding requests contained in the paper (Place Wide) • Agreement to support the matrix of decision making , subject a few final amendments to the one presented at the committee, to enable place based

Decision Log Ref No.	Meeting Date	Issues considered
		decision making in respect of the Policy and Guidance Manual. The final updated matrix is contained in Appendix One, this will return to the Committee in December as this version reflects the amendments verbalised at the meeting and is therefore now the final version.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
	-	-

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendations
	-	-

6. Recommendations

6.1 **The ICB Board is asked to:**

- **Note** the contents of the report and the decisions therein

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Report of the System Primary Care Committee Chair

Appendices

- **Appendix A: Matrix of Decision Making to support The Primary Care Operating**

Version 9 - Place/System level governance process – GMS/PMS and APMS

Issue	Original position	Place forum considerations	Team involvements	Comments/feedback	Final Position
General Contract Letters non formal/general correspondence	Contracts Team or escalation checking with PDs/Ads		PC Contracts Team to log		Place managed/LMC involvement as required
GMS PMS APMS Contract Variations (post decision process)	Final formality paperwork Place Director /AD sign off	As per some of the the scenarios below assuming they have gone through due process	PC Contracts Team prepare in line with PGM	Sign off at place if In line with PGM process and delegation/SOD/SFI	Place managed **in line with SFI/Sord** and PGM process, this may well be that the decision is made in place but the actual contract is signed off by another ICB officer
Remedial Notice	Place Director / AD sign off	Exec discussion depending on severity	PC Contracts Team confirm process followed in line with PGM	Sign off at place if In line with PGM process and delegation/SOD/SFI Note may involve LMC	Place managed in line PGM Process. LMC involvement Reported as part of summary update to SPCC (for information
Breach Notice and onwards sanctions agreement	Place Director / AD sign off	Should be discussed at place Execs	PC Contracts Team confirm process followed in line with PGM	Sign off at place if In line with PGM process and delegation/SOD/SFI Note involvement of LMC	Place managed in line with PGM Process LMC involvement Reported as part of summary update to SPCC (for information
Practice Merger (non urgent)	Place Director / AD signs or recommend if combined contract value above SFI	Recommend a forum discussion in line with the process to prepare/but due to contract challenge may have to come to SPCC	PC Contracts Team confirm process/application followed in line with PGM. Risk of contract challenge so also engage with ICB corporate regardless of value	Sign off at place if In line with PGM process and delegation/SOD/SFI or if above that value recommendation to SPCC. Note involvement of other practices/LMC	Place managed in line with PGM Process. Note wider process of engagement required. Final (new) contract sign off must be in line with SFIs. Reported as part of summary update to SPCC (for information) System to develop some key principles to support LMC involvement

Temporary List Closure (B.5.2 PGM noting ICB does not recognise informal list closure)	Place Director / AD signs off		PC Contracts Team confirm meets the criteria for temporary closure	ICB does not recognise informal list closure and any other circumstances must be a formal list closure	Place Managed in line with PGM process Reported as part of summary update to SPCC (for information) System to develop some key principles to support LMC involvement
Boundary Change	Place Director / AD signs off	Recommend a forum discussion	PC Contracts Team confirm process/application in line with PGM	Suggest a forum decision to enable other parties to be involved Note involvement of LMC and local practices boundary considerations. Any removal requests would need to be discussed	Place Managed in line with PGM process Reported as part of summary update to SPCC (for information) System to develop some key principles to support LMC involvement
Termination/Options of main contract including APMS contracts (non urgent)	Place Director/Execs offer a recommendation	Recommend a forum discussion to consider options	Contracts team to advise regarding APMS VEAT notices, extensions and procurement Patient Engagement team recommendations for consultation	Note - interim provision would be included as an option/ Procurement would follow general contracting process in line with legislation Urgent termination requires further work to outline process. Note involvement of LMC. Note any follow on dispersal must be undertaken in line with the PGM principles	Place Managed in line with PGM process Reported as part of summary update to SPCC (for information) System to develop some key principles to support System team to be involved at an early stage/kept updated Via appropriate place forum LMC involvement Clear risk management expectations – system PCC may request additional assurances in respect of this
Branch Surgery Closure (non urgent	Place Directors/Execs offer a	Forum discussion highly recommended (TAF group)	PC Contracts Team for process and paperwork	*Note sign off of patient engagement exercise	Place Managed in line with PGM process

where provider initiated)	recommendation (note sign off * would be required following a forum discussion) Sign off at place for patient engagement exercise	Must be engagement with OSC	Patient Engagement Team for advice and sign off in relation to the Patient Engagement exercise and OSC engagement	required as part of the approach in the PGM Place would also need to take to OSC locally and consult. Note closure due to CQC advice would be immediate and would form part of remedial notice (if capable of remedy) or Commissioner led process if C led by place up to System PCC/ Note involvement of LMC	Reported as part of summary update to SPCC (for information) System to develop some key principles to support System team to be involved at an early stage/kept updated Via appropriate place forum, must be held in public. LMC involvement
Special Allocations Scheme / Appeals **Assignment of patient direct outside of PGM**	PD/AD for Quality sign off	*Should* involve panel including AD for Quality/Safeguarding Lead and Place CD as appropriate, signed off by PD/ADQ following panel	PC Contracts Team Safeguarding Team Potentially other agencies such as Probation depending on issue	ICB to define overall appeals approach and assignment process further but for now work to local place processes There will be a central ICB collation of SAS in due course and review of schemes	Managed via place following the process in the PGM Set of system principles to be agreed Other place teams could be part of the panel, Reported as headline to system PCC only (no names, in confidential section)
Investigations – Quality. Finance, Fraud	An appropriate place led/ICB corporate Task and Finish group would be set up depending on issue and value		Finance, Quality, PC Contracting	PGM denotes some actions but otherwise would be on a case specific basis as to reporting mechanisms	Managed via place following the TAF suggestions in the PGM Set of system principles to be agreed Reported as headlines to system PCC with outcomes, in confidential section

Limited Company Applications	For legal reasons and consistency reasons these will need to go to System PCC	Should be considered by Finance representatives at place, risks assessed so some forum discussion recommended	PC Contracts team confirm in line with PGM assessment process	PGM process must be followed. Carries risk of legal challenge .	For the time being these applications should be escalated to system pcc – legal advice is currently being sought in respect of the overall approach to these applications.
PCN DES Changes (e.g core membership, orphan, disputes)	PD/AD sign off	Depending on issue a forum may be required	PC Contracts team confirm in line with PCN DES Guidance	Risk of some challenge so ICB corporate should be notified	Place Managed in line with DES process Reported as part of summary update to SPCC System to develop some key principles to support System team to be involved at an early stage/kept updated for any urgent areas LMC involvement
CQC Contract follow up	PD/AD sign off	Place contract follow up process with quality should be defined and followed (e.g quality and performance)	PC Contracts team Quality Engagement with CQC officers		Place Managed Reported as part of summary update to SPCC for RI and Inadequate System to develop some key principles to support / templates LMC involvement
Practice termination / sudden collapse and related options (e.g interim provider, urgent merger etc)	PD/AD sign off				Place Managed in line with PGM process but system alerted to ongoing issues/where support required. Reported as part of summary update to SPCC (for information) System to develop some key principles to support along the lines of interim provider policy to underpin, (Some place already have these policys in place)

					LMC involvement
Appeals GMS PMS APMS **Follow agreed process here which demarks role for place** System Level dispute resolution v2.docx	Refer to policy attached Place oversee informal initially then policy escalates		Refer to policy	Refer to policy	Refer to policy – place managed initially with escalation only at later stage, LMC involvement
Other - QOF follow up and management	Place quality and performance structures				Managed by place in line with usual quality processes. System to develop some key principles to support and expectations as an ICB.
Other quality issues (general) and performance	Place quality and performance structures and processes			Reference to PGM where applicable.	Managed by place in line with usual quality processes. System to develop some key principles to support and expectations as an ICB.

- In all cases, **place must confirm that due process under the pgm has been met.**
- There can be **no onward delegation of decision making for these areas outside of the ICB decision making process/outside of the NHS including seeking views of external partners unless an explicit part of the process.**
- **The LMC (Local Medical Committee) must be involved** as part of the pgm processes managed at place, and where not an explicit requirement place should still ensure LMC engagement in line with the overall operating model.
- **Conflict of interest** must continue to be managed through place and documented accordingly.
- **Legal advice** should be sought for areas where this could prevent challenge working with the advice and support of the contracts team

- Recommend that place have a **primary care forum** to undertake some of the detailed work up for these areas, and ensuring all relevant policy considerations are covered as above, as part of the decision making process.
- Each place will be asked to produce **a key summary of decisions made at place for onward reporting to the system primary care committee** –
- **Where indicated forums for decision should be held in public** to ensure compliance with necessary patient engagement and consultation requirements.
- **This will be reviewed in 3 months with PC leads and LMC**
- System will ask for pre assurance that these areas are in place as part of this.

NHS Cheshire and Merseyside Integrated Care Board Meeting

Report of the Finance, Investment & Resource Committee Chair

25th October 2022

Agenda Item No	**ICB/11/22/19**
Report author & contact details	Claire Wilson, Executive Director of Finance Claire.wilson@cheshireandmerseyside.nhs.uk
Report approved by (sponsoring Director/ Chair)	Erica Morriss, Chair of the Finance, Investment and Resource Committee
Responsible Officer(s) to take actions forward	Claire Wilson, Executive Director of Finance Mark Bakewell, Deputy Director of Finance

Report of the Finance, Investment & Resource Committee Chair

<table>
<tr><td>Executive Summary</td><td colspan="5">The Finance, Investment and Resource committee of the NHS Cheshire and Merseyside Integrated Care Board met on 25th October 2022.
This was the first formal meeting of the Committee.

The meeting was quorate and was able to undertake its business. Main items considered at the meeting included:
• Committee Terms of Reference
• Committee Workplan
• Month 6 ICB / ICS Finance Report
• LUFT Finance Review
• Development of the ICB Financial Strategy
• ICB Structure Update
• Digital Programme Finances
• Update on Operational Finance Policies

The next meeting of the Committee is scheduled to be held on 30th November 2022.</td></tr>
<tr><td rowspan="2">Purpose (x)</td><td>For information / note</td><td>For decision / approval</td><td>For assurance</td><td>For ratification</td><td>For endorsement</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td></td><td></td></tr>
<tr><td>Recommendation</td><td colspan="5">The Board is asked to:
• note the items covered by the Committee at its first meeting
• note the approval of the refreshed terms of reference and workplan, which are to be kept under regular review
• approve the revised Committee Terms of Reference
• note the month 6 financial position of the ICB/ ICS in respect of both revenue and capital allocations
• note that the committee approved 14 digital programme investments in respect of available national funding streams. These have additional scrutiny through Digital & Data Transformation Board and assurance on spend through Data Strategic Finance Group.</td></tr>
<tr><td rowspan="4">Impact (x)
(further detail to be provided in body of paper)</td><td>Financial</td><td>IM &T</td><td>Workforce</td><td colspan="2">Estate</td></tr>
<tr><td>X</td><td>X</td><td>X</td><td colspan="2"></td></tr>
<tr><td>Legal</td><td>Health Inequalities</td><td>EDI</td><td colspan="2">Sustainability</td></tr>
<tr><td>X</td><td></td><td></td><td colspan="2"></td></tr>
<tr><td>Management of Conflicts of Interest</td><td colspan="5">No</td></tr>
<tr><td>Next Steps</td><td colspan="5">Subject to approval of the Board, the revised Committee Terms of Reference will be published on the ICB website.</td></tr>
<tr><td>Appendices</td><td>Appendix A</td><td colspan="4">Committee Terms of Reference</td></tr>
</table>

Report of the Finance, Investment & Resource Committee Chair

1. Summary of the principal role of the Committee

Committee	Principal role of the committee	Chair
Finance, Investment & Resource Committee	The main purpose of the Committee is to • provide the Board with a vehicle to receive the required assurances, review the management of associated risks, and understand further details as deemed appropriate for the committee to consider in relation to matters concerning, finance (both revenue and capital) , resources (e.g workforce) and investment / dis-investment issues. • support the development and delivery of the ICS' financial strategy, oversee financial delivery and provide assurance on the arrangements in place for financial control and value for money across the system. • take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern and assure ICB actions as an employer.	Erica Morriss, Non-Executive Director

2. Meetings held and summary of "issues considered" (not requiring escalation or ICB Board consideration)

The following items were considered by the committee. The committee did not consider that they required escalation to the ICB Board:

Decision Log Ref No.	Meeting Date	Issues considered
-	25.10.22	**Committee Terms of References** The Committee: • noted the revised terms of reference • agreed to review the relationship between Finance, Investment and Remuneration Committee Terms of References in relation to overlap of responsibilities on decision making.

Decision Log Ref No.	Meeting Date	Issues considered
	25.10.22	**Committee Workplan** The Committee agreed the proposed workplan subject to: • a further review being undertaken after December • Capital Investment Strategy to be added to the workplan • Include 'place' recovery plans to the workplan as required
	25.10.22	**Liverpool University Hospitals NHS Foundation Trust (LUHFT) Finance Review** The Committee: • Received an update on the PWC finance review and the requirements for the organistional recovery plan to be submitted to the ICB by December 2022
	25.10.22	**Developing the ICS Financial Strategy** The Committee • Received an update on approach towards the development of the ICS Financial Strategy, also noting the related ICP / ICB Strategy components with similar timelines
	25.10.22	**ICB Structures Update** The Committee • Received an update on the workforce consultation process and next steps
	25.10.22	**Operational Finance Policies** The Committee • Received an update on the operational financial policies

3. Meetings held and summary of "issues considered and approved/decided under delegation" (not requiring escalation or ICB Board consideration)

The following items were considered and decisions undertaken by the Committee under its delegation from the ICB Board.

Decision Log Ref No.	Meeting Date	Issues considered
-	25.10.22	**Digital Programme Finance 2022-23** The Committee • Noted the digital budgets for 2022/23. • Noted the existing HCP commitments relating to the former HSLI and CIPHA programmes. • Noted that further work on the strategies for Patient Engagement Portal(PEP), Shared Care Records and Population Health Systems is required • Noted the funding available to Primary Care digital initiatives from NHS England and the opportunity for places to bid. • Noted the ongoing cost of IT transition to the ICB tenant. •Noted the potential cost pressure due to renewing Microsoft Office 365 licences The Committee also • Approved the payment of Frontline Digitisation revenue funds to Trusts, subject to confirmation of National funding and approval of Trust business cases. • Approved the payment of Digital Social Care revenue funding to Sefton Council, subject to an agreed MOU between the ICB and LA partners. These were approved in line with the ICB Scheme of Delegation (Up to £1m) within plan / allocation values.

4. Issues for escalation to the ICB Board

The following items were considered by the Committee. The committee considered that they should be drawn to the attention of the ICB Board for its consideration:

Decision Log Ref No.	Meeting Date	Issue for escalation
-	25.10.22	**Month 6 Finance Report** The Committee noted • the contents of the finance report in respect of the month 6 year to date ICB / ICS financial position for both revenue and capital allocations within the 2022/23 financial year. • The relative level of risk in delivering the forecast outturn position

5. Committee recommendations for ICB Board approval

The following items were considered by the Committee. The Committee made particular recommendations to the ICB Board for approval:

Decision Log Ref No.	Meeting Date	Recommendation from the Committee
-	25.10.22	The Board is asked to approve the revised Committee Terms of Referrence

6. Recommendations

6.1 **The ICB Board is asked to:**

- **note** the items covered by the Committee at its first meeting
- **note** the approval of the refreshed terms of reference and workplan, which are to be kept under regular review
- **approve** the revised Committee Terms of Reference
- **note** the month 6 financial position of the ICB/ ICS in respect of both revenue and capital allocations
- **note** that the committee approved 14 digital programme investments in respect of available national funding streams. These have additional scrutiny through Digital & Data Transformation Board and assurance on spend through Data Strategic Finance Group.

7. Next Steps

7.1 The committee will

- continue to meet monthly at the present time in order to provide assurances to the board as per its terms of reference and agreed workplan
- continue to monitor the financial position and associated risks both as the ICB but also as part of the ICS in order to deliver the required financial position

7.2 Subject to the approval of the Board, the revised Committee Terms of Reference will be published on the ICB website.

NHS Cheshire and Merseyside Integrated Care Board Meeting

28 November 2022

Report of the Finance, Investment and Resources Committee Chair

Appendices

- **Appendix A:** Committee Terms of Reference

C&M ICB

Finance, Investment & Resources Committee

Terms of Reference

Document revision history

Date	Version	Revision	Comment	Author / Editor
October 2022	1.0	Initial		Mark Bakewell

Approved by the ICB Board on (add date)

Review due
November 2023

1. Introduction

The Finance, Investment and Resources Committee (the Committee) is established by the Integrated Care Board (the Board or ICB) as a Committee of the Board in accordance with its Constitution.

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

The Committee and its members, including those who are not members of the Board, are bound by the Standing Orders and other policies of the ICB.

2. Purpose

High functioning Boards traditionally focus on a number of key responsibilities: setting strategy; delivery; assurance and culture and establish a number of supporting committees. This committee will provide the Board with a vehicle to receive the required assurances, review the management of associated risks, and understand further details as deemed appropriate for the committee to consider in relation to matters concerning, finance (both revenue and capital) , resources (e.g workforce) and investment / dis-investment issues.

The committee will support the development and delivery of the ICS' financial strategy, oversee financial delivery and provide assurance on the arrangements in place for financial control and value for money across the system.

The committee will also take a system view on use of resources and deployment but also provide a forum where ICB directors and ICB members can consider, govern and assure ICB actions as an employer.

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

3. Responsibilities / duties

The Committee will fulfil its purpose by:

- Defining principles for financial operations and management within the ICS and making recommendations for financial priorities including:
  - Delivery of long-term system financial sustainability and year on year system balance
  - Risk and gain share
  - Capital, investment and digital investment priorities
  - Strategic estates considerations
  - Resource distribution and funds flow arrangements.

- Securing assurance, oversight and any action to ensure delivery of the financial plan

- Enabling development of a financial strategy in support of the wider system clinical strategy including:
  - Aligning financial performance to quality and activity and workforce standards
  - Reviewing the allocation of resources to organisations taking into account the strategic objective of reducing health inequalities, improving health outcomes and supporting financial sustainability.
  - Considering the road map for resource distribution across the system to support both place and provider collaboration design over the medium term

- Provide a forum to convene ICB members and directors to consider ICB employment matters (consideration if such matters will be reserved to ICB members of directors)

The Committee has, alongside the Audit Committee, a key role in disclosing non-compliance with the ICB constitution

The Committee plays a key role for the ICB in a number of areas including

- Regular review areas of the financial governance framework (including the operational Scheme of Reservation and Delegation standing orders, standing financial instructions/limits, and prime financial policies), making appropriate recommendations to the Board on changes as required.
- Ensure risks of exceeding expenditure limits are identified and that recommendations for immediate remedial action are agreed for consideration in order to provide assurance by the Board
- Monitor and assure the delivery of efficiency savings
- Receive regular reports on Pooled Budget Arrangements as appropriate to the ICB
- Receive regular 'thematic' updates on areas of commissioned / programme expenditure to ensure alignment with strategic objectives
- Receive regular updates with regards to procurement projects
- Assure processes for procurement and contracting in line with prevailing strategy, guidance and regulations
- Approve requests for the waiver of any procurement rules for goods and services on an exception basis.

4. Delegated Powers and Authority

The Committee has the authority to:

- Investigate any activity within its terms of reference
- Seek any information it requires within its remit, from any employee or member of the ICB (who are directed to co-operate with any request made by the Committee) within its remit as outlined in these terms of reference
- Commission any reports it deems necessary to help fulfil its obligations
- Obtain legal or other independent professional advice and secure the attendance of advisors with relevant expertise if it considers this is necessary to fulfil its functions. In doing so the

Committee must follow any procedures put in place by the ICB for obtaining legal or professional advice

- Create task and finish sub-groups in order to take forward specific programmes of work as considered necessary by the Committee's members. The Committee shall determine the membership and terms of reference of any such task and finish sub-groups in accordance with the ICB's constitution, standing orders and Scheme of Reservation and Delegation (SoRD) but may/ not delegate any decisions to such groups.
- Agree C&M joint work on and Place actions on estates, procurement, supply chain, and commercial strategies to maximise value for money across the system and support wider goals of development and sustainability

In relation to Workforce, the Committee has the authority to:

- Approval of the arrangements for discharging the ICB statutory duties as an employer
- Approve human resources policies for ICB employees and for other persons working on behalf of the ICB
- Approve any other terms and conditions of services for ICB AFC employees
- Approve disciplinary arrangements for ICB employees
- Approve arrangements for staff appointments (excluding matters detailed within the Constitution)
- Approve the ICBs organisational development plans

In relation to finance, the Committee has the authority to:

- Approve Healthcare / Non-Healthcare Expenditure as set out in the Scheme of Reservation & Delegation per the relevant sections
- Approve ICB financial operational policies

In respect of Contracting & Procurement Activities, the committee has the authority in line with ICB Scheme of Reservation and Delegation to

-
- Approve the ICB procurement plans annually and note progress against procurement plans on a quarterly basis.
- Approve the commencement of any over threshold tenders.
- Approve the award of a contract at the end of a tender process.
- Approve the extension of a contract rather than procurement, where it is permitted within the original terms of the contract.
- Approve the sign off of a tender waiver in line with the SORD and Signatory list.
- Approve the publication of a Contract Notice in line with Public Contract Regulations (2015) where a procurement will not be undertaken. (could be a contract award notice (CAN), a contract modification notice (CMN) or a Voluntary Ex-Ante Transparency Notice (VEAT)

5. Membership & Attendance

5.1 Members

ICB

Non-Executive

- At least one ICB NED (Chair)

Management

- ICB Executive Director of Finance
- ICB Director of Nursing
- ICB Director of Performance and Planning
- ICB Director of HR
- A minimum of one Associate Director of 'Place' finance representative

System Partners

- A ICS NHS 'Provider' Finance Director
- A Partner NED from at least one of each of the C&M provider collaboratives
- A Partner CEO from at least one of each of the C&M provider collaboratives
- A Primary Care Representative – nominee from the Primary Care Leadership Forum
- ICS or Partner representatives supporting any conversation

A number of additional attendees may be invited

Consideration has been given to the role and connection of Provider NEDs on this committee and collaboratives. Close connection with the ICS finance community and DOF level and finance conversations, dialogue and work will be critical to the success of delivery against this agenda but supporting decision making and assurance through this Committee and to the ICB.

Notified, named deputies to support attendance and participation is encouraged.

Only members of the Committee have the right to attend Committee meetings

5.2 In attendance

The group may invite representatives from the wider system, ICB, ICS, NHSE/I region or supporting staff such as secretariat, governance, performance, direct commissioning, local authority or transformation colleagues as required to support discussions.

Where an attendee of the Committee (who is not a member of the Committee) is unable to attend a meeting, a suitable alternative may be agreed with the Chair.

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

6. Meetings

6.1 Leadership

The Committee is Chaired by an ICB NED. The Vice Chair of the Committee will be appointed from individuals who form the named membership of the Committee

6.2 Quorum

For a meeting to be quorate at least 50% of the membership must be present, with a minimum of

- two ICB executives
- one non-executive
- one partner representatives

Decisions will be taken in according with the Standing Orders. The Committee will ordinarily reach conclusions by consensus. When this is not possible the Chair may call a vote, however it is not envisaged that voting will be ether necessary or encouraged.

If a vote is required, only members of the Committee may vote. Each member is allowed one vote and a majority will be conclusive on any matter.

Where there is a split vote, with no clear majority, the Chair of the Committee will hold the casting vote.

If a decision is needed which cannot wait for the next scheduled meeting, the Chair may conduct business on a 'virtual' basis through the use of telephone, email or other electronic communication.

6.3 Frequency

At least monthly with opportunity for use and linkages with the ICS forums established and supported by the ICB, or system partners such as the collaboratives.

The Committee shall meet at such times and place as the Chair may direct on giving reasonable written notice to members. Meetings will be scheduled to ensure that they do not conflict with known existing Board meetings and are synchronized so that members can properly engage their organisations ahead of meetings.

The Board, Chair or Chief Executive may ask the Committee to convene further meetings to discuss particular issues on which they want the Committee's advice.–In these circumstances the Chair will give as much notice as possible to members.

Meetings will not, usually, be open to the public and will have the ability to schedule meetings as either face to face or electronically.

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

6.4 Format

An agenda for each meeting will be agreed with the Chair. Periodic calls for items supporting discussion will also be made from the membership.

It is anticipated that the meeting may initially have both a business and developmental focus as it established and defines its role. Sufficient time will be allocated to items to enable full exploration of issues, constructive challenge and reflection.

Advice, opinion and engagement may be sought from amongst the membership outside of the regular meetings, either as a group or on an individual basis.

Private Meetings

If an agenda indicates the requirement for a 'Private and Confidential' session of the meeting (e.g. part two) usually as a result of an issue with potential conflict of interests for committee members or of a sensitive nature, then separate agendas and minutes will be produced.

The Chair of the Committee will determine who from the attendees of the 'part one' meeting may remain in attendance for the part two business. However, the default position will be to restrict the meeting to committee members only and officers invited to specifically present and discuss the part two subject matter.

Part of the justification for establishing a private and confidential agenda will be the identification of an appropriate Freedom of Information exemption together with, where required, an assessment of the public interest test on each agenda item.

It is likely that all procurement decisions are made in Part two where potentially commercially sensitive but this may also include for non-procurement related issues where the chair deems appropriate.

6.5 Accountability and Reporting Arrangements

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

The minutes of the meetings shall be formally recorded by the secretary and submitted to the Board in accordance with the Standing Orders.

The Chair will provide assurance reports to the Board at the subsequent meeting of the Board following a meeting of the Committee and shall draw to the attention of the Board any issues that require disclosure to the Board or require action. Minutes and assurance reports of a confidential nature from the Committee will be reported to a subsequent meeting of the Board in private.

The Committee will provide the Board with an Annual Report, timed to support finalisation of the accounts and the Governance Statement. The report will summarise its conclusions from the work it has done during the year

Meeting paperwork and content can be shared within the system finance community.

6.6 Administrative Support

The Committee shall be supported with a secretariat function which will include ensuring that:

- The agenda and papers are prepared and distributed in accordance with the Standing Orders having been agreed by the Chair with the support of the relevant executive lead
- Attendance of those invited to each meeting is monitored and highlighting to the Chair those that do not meet the minimum requirements
- Records of members' appointments and renewal dates and the Board is prompted to renew membership and identify new members where necessary
- Good quality minutes are taken in accordance with the standing orders and agreed with the chair and that a record of matters arising, action points and issues to be carried forward are kept
- The Chair is supported to prepare and deliver reports to the Board
- The Committee is updated on pertinent issues/ areas of interest/ policy developments
- Action points are taken forward between meetings and progress against those actions is monitored.

7. Assurance

The assurance required of and from the group is an area which will require development as and when it discharges its functions and responsibilities. The role of audit and the audit committee will be key in this process as will any oversight arrangements established by NHSE.

8. Behaviours and Conduct

ICB values

Members will be expected to conduct business in line with the ICB values and objectives.

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

All members are required to make open and honest declarations of the interest at the commencement of each meeting or to notify the Chair of any actual, potential or perceived conflict in advance of the meeting.

All members are required to uphold the Nolan Principles and all other relevant NHS Code of Conduct requirements.

Equality and diversity

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

9. Review

The Committee will review its effectiveness at least annually

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